OVERVIEW REPORT

DISCRETIONARY SAFEGUARDING ADULTS REVIEW

SIGNIFICANT INCIDENT LEARNING PROCESS

Evie

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Presented to Teeswide Safeguarding Adults Board
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Final: August 2025

Family/Friends Tribute to Evie

Best sister, best auntie, best friend, best daughter, and best person
Evie you brought so much joy to people, not only those close to you.
You were not afraid to be you, crazy and loving, always there for others as those close to you hoped they were there for you.
Do you remember stopping your car and getting out and dancing, you made others smile and laugh so much.
You lit up any room you entered, people loved you and gravitated towards you, that was a gift. You had an energy that made others feel alive. You were full of life and love.
Evie, you loved your mum and were lost without her, you had such a special bond.
We are so proud of what you achieved, a triple distinction and a university place. You wanted to be a paramedic which was typical of you wanting to give back to others.
Thank you for being you and bringing so much to others.
Your love and spirit will live on in all of us and we will make sure to keep your memory alive.

‘All lights turned off can be turned on’
from ‘Call your Mum’ by Noah Kahan
You are in the heart of many, truly missed.

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1. Introduction

1.1 In June 2024 the Teeswide Safeguarding Adults Board received a Safeguarding Adult Review (SAR) notification from Children's Social Care in respect of Evie. The decision was taken that agencies could have worked better together. However, as Evie's death was not due to self-neglect or neglect/organisational neglect from services, a Safeguarding Adults Review was not required. Evie's case highlighted new areas of learning, so a discretionary safeguarding adults review was instigated. This will be referred to as a SAR throughout this report.

1.2 Evie took her own life in June 2024 following an overdose at her grandparents' address. Evie had experienced long standing mental health needs and had received support from the Leaving Care service to assist her with managing her mental health and developing her independent living skills. Another element of this support was related to engage with education to succeed in university applications, support during bereavement following mother's death and advice and guidance in relation to mental health support.

1.3 There had been long standing concerns regarding suicidal thoughts and Evie had attempted suicide on a number of occasions in her childhood. The most significant incident had taken place a month after the death of Evie's mother which caused a deterioration in Evie's mental health.

1.4 The Intensive Home Treatment Team (IHTT) became involved to provide mental health support following Evie's significant suicide attempt. Evie was also supported by MIND[1] receiving support from a social prescriber.

1.5 A referral was made to adults social care to request a Care Act Assessment. However, as Evie declined this assessment the case was closed 7 days later. Safety planning was raised as a concern by Evie's Personal Advisor in the light of her constant thoughts of suicide and the context of her declining adult safeguarding support. This was on the day Evie took her own life.

2. Legal Framework:

2.1 Section 44 of the Care Act 2014 states:

> 1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
>
> (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
>
> (b) condition 1 or 2 is met.
>
> (2) Condition 1 is met if—
>
> (a) the adult has died, and
>
> (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
>
> (3) Condition 2 is met if—
>
> (a) the adult is still alive, and
>
> (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

[1] https://www.mind.org.uk

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

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

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

(b) applying those lessons to future cases.

2.2 In addition to the above SABs might select cases for either of the reasons noted in the Care & Support Statutory Guidance updated June 2020:

1. Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults

2. To explore examples of good practice where this is likely to identify lessons that can be applied to future cases

3. In any other situations involving an adult in its area with needs for care and support.

2.3 The purpose of the SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases. Whilst this review is being conducted as a discretionary safeguarding adults review, the term 'SAR' and safeguarding adults review will be referred to throughout the report.

3. Process

3.1 The Safeguarding Adults Review was carried out applying the Significant Incident Learning Process. This involves agencies producing timelines and analytical reports of their involvement and encourages learning to be identified by the staff involved in the cases and so far as possible aims to involve members of the families affected by the incidents.

3.2 Staff involved and the report writers were brought together at a Learning Event to discuss the reports and issues and themes emerging, focusing on Key Episodes identified from the reports. A Recall Day followed to discuss a first draft of the Overview Report.

3.3 The Reports provided by agencies are thorough and of a high standard. The Learning and Recall Events reflected careful consideration and a determination to learn. The recommendations made in the reports for their agencies if implemented are calculated to bring about change. Where single agency recommendations were made, this reduced the need for recommendations to be made within this overview report.

3.4 The Significant Incident Learning Process was led and the report was written by Ms Donna Ohdedar. Ms Ohdedar has the qualifications, experience, suitability and independence to undertake reviews required by statutory guidance. Ms Ohdedar has a background in law and was formerly a Head of Law in a metropolitan authority.

4. Evie

4.1 Evie was 19 when she died. Professionals describe Evie as a wonderful, charismatic girl. In Evie's early years she experienced a traumatic, abusive relationship with her mother. As a teenager she managed caring responsibilities for her Mum and experienced anxiety about her Mum's death.

4.2 Evie went on to experience four placements in 10 months before returning home. When her Mum died Evie spent some time living with her maternal grandparents. Evie reported that she did not speak to her grandparents about mental health.

4.3 Evie's grandparents did not respond to the invitation to participate in this review, and Evie's Aunt expressed a wish not to be involved. Evie's half-sister and friends have participated actively and have added an enormous amount of richness to the process. The independent reviewer and the partnership extends its sincere condolences to Evie's family and friends and also deep gratitude for those who felt they could contribute.

4.4 Evie carried a strong sense that her Mum would not want her involved with children's social care. She told children's social care her relationship with her mum would be better if she did not live with her. She rated living with her Mum as slightly higher risk than living with her grandparents.

4.5 Evie lived with both parents for the first 5 years of her life. After her parents separated she did spend a period in area 2, where her father resided. Her relationship with her father was important and when the reunification team called him to arrange contact, he promised to follow up with phone calls. It is unclear whether that happened. Evie would visit her father once a year.

4.6 Evie found school to be a supportive and safe space, and she was able to achieve well, developing over time an interest in health and social care. The support of a key person from a charity for young carers was important to her. Evie allowed her maternal aunt and her friend to be present for some appointments. Grandparents were present for some appointments.

4.7 By the time of Evie 's mum's death she had been in a coma for 6 months. Evie was managing her course work and also managing her mother's bank accounts/probate, tenancy [having received a use and occupation letter][2], grief overwhelming. She experienced stress and trauma relating to making sense of accepting the way the hospital had managed her mother's care.

5. Key Episodes

The review highlighted the following key episodes in the scoping period:

5.1 Evie's appointment with Mental Health Services

5.1.1 When Evie presented to mental health services and disclosed that she had taken an overdose, her family members were present. However, there were gaps in how they could be included in safety planning as Evie asked for them not to be involved. Alongside not contacting her mother or the charity who supports young carers.

5.1.2 Evie saw her GP the next day but did not mention the overdose. By the time of this appointment the information from mental health services regarding the overdose had not been communicated to the GP. The NHS contract states discharge information should be shared with the GP within 24 hours.

This is a key episode because information sharing between health organisations and the inclusion of family members and the charity for young carers, may have improved support available to Evie during this episode. The GP would have been able to offer better support to Evie during her appointment if information about the overdose had been shared.

5.2 Adult Safeguarding Concern[3]

5.2.1 When Evie's previous school made an adult safeguarding concern on the basis that Evie's friend had shared that Evie had stated that when her mum dies, she wanted to die too. This referral was not progressed as it was categorised as 'a mental health issue due to circumstances not self-neglect'. On this basis a mental health team manager from social care would be available if support was needed. It was considered protective that a care leavers review was also underway at the time. This review could only safeguard Evie, however, if information was available about the adult safeguarding concern that had been raised. Whilst feedback should have been given regarding this

[2] Letter sent to a person who occupies a property without a formal tenancy agreement, with the aim of determining future use.
[3] Raised via the local authority pathway where there is reasonable cause to suspect that the following criteria is met; the adult has needs for care and support and is experiencing, or is at risk of, abuse or neglect (Section 42) (1) (a) and (b) Care Act 2014.

outcome, the school was not notified. The GP also did not have this information and was in regular contact with Evie.

5.2.2 A second adult safeguarding concern was made by primary care community health regarding Evie not being supported. It detailed that Evie was unable to sign an agreement concerning her accommodation after her Mum had died. The decision was made to refer Evie to the early intervention and assessment team for consideration. This may then have led to that team making an internal safeguarding referral. This did not happen.

Learning point 1: This review has revealed that agencies are not aware of the best information to provide to housing to support care leavers. Additionally, housing should simplify their processes for eliciting information needed for supporting succession tenancies.

5.2.3 At this point Evie was being assisted by her personal adviser and her GP to support her housing needs. She had received a use and occupation letter which was causing additional stress for her. The housing service was not aware of safeguarding adult concerns submitted in respect of Evie nor that she was care experienced and had made attempts on her life.

5.2.4 This episode is important because there was no agency taking responsibility to convene meetings across the multi-agency network to support Evie practically and co-ordinate the care and support that Evie required including the emotional support she required at this time.

5.3 Response to Evie Taking an Overdose

5.3.1 Evie was taken to hospital after taking an overdose of insulin. Evie received daily support from the home intensive treatment team (HITT) throughout this episode. The hospital notified the GP by letter. Evie's personal advisor made joint visits with the social prescriber, showing creativity by meeting in a coffee shop. Bereavement support was delivered to Evie, and she received daily contact via text message through children's social care. Mental health services showed persistence in engaging with Evie and sustaining a significant period of intervention. The safety plan was established, and Evie experienced a safe place to disclose to during therapy. The social prescriber was working with Evie to support her with safety concerns and safety planning, particularly around her suicidal ideation. This review recognises that this was strong practice with the social prescriber going above and beyond their role. If information had been shared with the housing service, it would have been possible for greater support to be available to Evie to enable succession planning and assisting her to take over her mother's tenancy. No professional convened a multi-agency meeting during this episode.

5.3.2 This episode is important because coordination of services would have been improved by convening a multi-agency meeting.

5.4 Response to Evie calling the Crisis Clinician

5.4.1 Evie was keen to finish her college course and wanted to notify her dad of her Mums death. She also wanted to obtain the document related to their divorce. She went to area 2 to visit her father who she felt showed no emotion regarding her mother's death. She did not obtain the divorce document. At this point Evie was trying to close her Mum's bank account to enable the utilities to switch to her name. She had arranged a meeting with her head of sixth form and was in close contact with her personal adviser. By the time of her fatal overdose.

5.4.2 This episode is important because it offers an opportunity to explore how services escalate at times of heightened concern.

6. Analysis by Theme

6.1 How assessments understood family history

6.1.1 The assessments being undertaken by individual services understood Evie's family history to differing degrees. This is not unusual, as services had differing amounts of contact with Evie. In most services where there was longstanding contract the history was well understood. Others had a limited understanding of her history, with some key information not being available to them, e.g. the information about Evie being a care leaver not being known to housing services.

6.1.2 There is a narrative about Evie being a resilient child from a historical assessment undertaken by children's social care. Any decision making by an agency and the responses offered may well have been influenced by this recording. The effect of recording such as this can reduce the likelihood of Evie being recognised as vulnerable and can influence subsequent assessments and decision making. One agency described seeing Evie as an 'enigma', due to seeing her as incredibly mature.

Learning point 2: Care should be taken over the use of language and labels in recording as these can result in a variety of meaning being attached due to the way a reader interpret wording in future.

6.1.3 When Evie was assessed by adult social care, much of the positive, detailed and complex assessment work that had been undertaken during Evie's childhood appeared to be missed. Limitations in the assessment undertaken by Adult Social Care is summarised as follows.

(i) there is no recording of handover information received from children's social care

(ii) this resulted in insufficient information being held to progress the safeguarding referral made by the hospital after an overdose being progressed to a section 42 enquiry.

(iii) when the offer of a Care Act assessment was declined, no follow up was planned.

(iv) when the mental health assessment recommended community based care there was no adult social care involvement invited nor offered to determine how this might look.

(v) during the scoping period there was not joint access to systems by children's and adults social care. It is pleasing to note that this has now changed.

6.1.4 It was clear Children's Social Care had been involved to any agency who knew Evie was a care leaver. Housing services and some health settings had contact with Evie yet did not know of her care leaver status. It was open to agencies who did know this information to make contact with children's social care to find out pertinent information to inform their assessments. Corporate parenting responsibility[4] attaches to any agency who supported Evie and requires them to actively support the local authority in relation to the service they provide so that corporate parenting responsibilities are fulfilled.

6.1.5 It is clear that Evie's complex family history impacted on her and she preferred to continue with a very compartmentalised life, with professionals, family members and close friends, all in isolated pockets. Information about her mental health was not shared at Evie's request. Strong practice is recognised amongst the multitude of agencies who assessed the complex nature of the relationship Evie had had with her mother and also the relationship she had with her grandparents and her aunt during the scoping period. Evie's half-sister shared her view that Evie's grandparents and aunt were uncomfortable with Evie's contact with those outside of the central family unit. Evie had experienced abuse and trauma at different points in her life. Across agencies there is strong practice in recording this information. Agencies responded in differing and appropriate ways in relation to what this meant to Evie.

6.1.6 The reunification team had contacted Evie's father with the aim of establishing a pattern of contact and improving Evie's relationship with him. This information was not available to the multi-agency network. Whilst the full extent of the reasons of the lack of success inherent in this work were not visible to other agencies in contact with Evie, these agencies had each explored the role of Dad sensitively and reached their own conclusions. Evie had been candid with workers who supported her about her feelings of rejection from her father and that there was 'no love lost'. Within school Evie had been fearful after she had taken an overdose that social care might send her to her father's address. Thus, the relationship was understood with the different agencies through different means. Evie's half-sister had reached adulthood by the time Evie was in foster care. Evie's half-sister said that Evie had expressed her desire on numerous occasions to have extended contact. She also believed Evie had communicated with children's social care their joint desire that either her

[4] Applying Corporate Parenting Principles to Looked After Children and Care Leavers, February 2018

half-sister or her half-sister's mother should be assessed to enable Evie to be placed with them. They believe Evie's attempts to organise this had been unsuccessful. Children's social care do not have recording on this point.

Learning point 3: Agencies supporting the authority to discharge its corporate parenting responsibilities benefit from understanding a young person's early years.

6.1.7 Understanding a young person's early years includes information about relationships with family members and knowledge of step siblings or extended families who live in other jurisdictions. The corporate parenting principles apply only to local authorities. Directors of Children's Services and Lead Members for Children should nevertheless ensure that relevant partners understand how they can assist local authorities apply the principles in relation to the services those partners may provide. 'Relevant partners' include local policing bodies and Chief Officers of Police, local probation boards and probation services, youth offending teams, integrated care boards, NHS England, schools and educational institutions.

6.1.8 In order to thrive, children and young people have certain key needs that good parents generally meet. The corporate parenting principles set out seven principles that local authorities must have regard to when exercising their functions in relation to looked after children and young people, as follows:

- to act in the best interests, and promote the physical and mental health and wellbeing, of those children and young people
- to encourage those children and young people to express their views, wishes and feelings
- to take into account the views, wishes and feelings of those children and young people
- to help those children and young people gain access to, and make the best use of, services provided by the local authority and its relevant partners
- to promote high aspirations, and seek to secure the best outcomes, for those children and young people
- for those children and young people to be safe, and for stability in their home lives, relationships and education or work; and
- to prepare those children and young people for adulthood and independent living

6.1.9 A strength in the practice of a number of agencies is the in depth understanding they developed of what life was like for Evie. However, as a multi-agency network responsible for formulating risk using a collaborative approach, there was a lack of a shared understanding. This would have been improved if the safeguarding adult concern raised had been progressed and brought services together.

6.1.10 A key question for this review is why substantial information was available within assessments, yet this did not result in more safeguarding referrals being made during the scoping period. Some agencies understood the role of the Leaving Care Personal Adviser as a social work role. This led to the assumption that the responsibility would lie with that role to make a safeguarding referral. The school expressed frustration at having made a safeguarding adult concern which had not been taken forward. School acknowledge that in essence they were extracting third hand information and creating a referral from that. Some discussion took place at the practitioner event regarding what an agency should do in relation to follow up or professional challenge when referrals are not actioned. There was a reliance upon the leaving care system to support Evie, rather than considering what safeguarding Evie as an adult could look like. Equally the care leaver review, if sighted of all the relevant information, was also an opportunity for considering risk and potentially making a safeguarding adult concern. There was a clear function that would be served by formulating an individual support plan and using the multi-agency network to formulate risk. Evie worked with agencies singularly and agencies gathered together in pockets to share information. For example, the GP surgery affected multi-disciplinary team meetings within the surgery to include the mental

health nurse, mental health trust and the social prescriber. NICE guidelines[5] require an individual support plan to be formulated following a suicide attempt, opening the door to multi agency formulation of risk.

6.1.11 There appears to be a lack of information sharing between agencies which would naturally have come together such as the mental health trust and MIND. A meeting when the mental health trust, was about to discharge Evie with MIND would have been helpful to share relevant information and inform future assessments.

6.1.12 Evie worked with agencies singularly and agencies did not use their normal forums for information sharing.

6.1.13 Evidence based practice involves decision making based on family history, especially when managing a vulnerable young adult through transition between services. The newly developed pathway, implemented in the Local Authority, would have facilitated improved information sharing. This is not available across the Teeswide safeguarding partnership.

Learning point 4: Agencies should strengthen information sharing processes for vulnerable individuals accessing their service to enable risk assessments/plan to be accurate and up to date.

6.2 Evie's Voice & Coproduction

6.2.1 The experience of a person with marginalised, stigmatized or disadvantaged identities is not readily understandable to those who are more privileged. Viewing Evie through an intersectional lens helps with increasing understanding of her voice and also with service design which improves the chance of engagement.

6.2.2 The nine protected characteristics identified in the Equality Act 2010 were assessed for relevance in this review. The characteristics of age and sex were taken into account as well as the potential vulnerabilities of mental health, past trauma, status as a care leaver and a carer were recognised by agencies working with Evie.

6.2.3 Coproduction features in the Care Act statutory guidance[6]. It facilitates preventative, strengths based services and supports assessment. In a successful co productive initiative, those who access care and support are defined as people with skills. It is impossible to have a 'meeting of minds coming together to find a shared solution'[7] unless the service user's voice is front and central to decision making.

6.2.4 Strong practice has been identified in this review amongst services who designed themselves to be more accessible for Evie. It is impossible to do this without listening to Evie's voice. At the learning event it was noted that '*Evie's phone was ringing all the time'*. This was a strong indicator of what life was like and how chaotic it must have felt to have so many services involved and available to offer a bewildering array of [seemingly disjointed] inputs. The complexity of the system around Evie was visible and striking at the learning event.

6.2.5 Children's Social Care chose to communicate via daily texts. This demonstrated creativity designed to reduce the burden on Evie. Joint visits were made to Evie by the Social Prescriber and Personal Adviser, and these were offered in a coffee shop. Once again this was designed to make these services easier to access. The GP allowed special access to same day appointments, which would offer a high level of support as and when needed. In school there was an emphasis on providing support through daily check ins, designing flexible course work plans and taking action to raise alerts and respond to cries for help. School and the personal adviser linked in ways that helped integrate the support available for Evie. The Personal Adviser ensured Evie had access to her daily diary every day so that she could see when the personal adviser was free. Text chats were used to encourage face to face discussions. With hindsight, practitioners were reflective about the potential

[5] https://www.nice.org.uk/guidance/ng225
[6] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[7] https://www.scie.org.uk

to have more creative conversations with Evie. For example, a conversation in which one immediate priority was chosen and dealt with, particularly given the multitude of issues Evie was facing daily. Practitioners reflected about '*how much it would be to hold all of that'.*

6.2.6 The principles of coproduction would generally include the entire support network available for that person. Family and friends, for instance may each individually have a role in supporting whether some practically and others emotionally. On the face of it. Evie's requests to keep family members separate appeared to block this objective. The information gained within this review would suggest extended family members and friends were also an under utilised resource in sharing the responsibility to support, at least with practical tasks.

6.2.7 Creativity, such as that of the social prescriber who would ask Evie a question such as 'if I don't hear from you, what shall I do?'. Evie answered to say 'please keep texting me'. This was considered by this review to be good practice. However, services generally function weekdays and office hours. These times were more likely to clash with Evie's responsibility to be in education. Thinking 'outside the box' was a strength in practice in Evie's case. To improve practice even more, agencies can ask themselves 'what if we worked together to ensure we don't all require things of this service user at once?'.

6.2.8 Agencies recognise that they do breach confidentiality requests from services users where needed. Evie requested that health organisations should not notify her grandparents of concerns about her mental health. However, mental health practitioners did seek grandparents views make enquiries of them to which they responded they had no concerns. This review recognises that since Evie's death a commonsense confidentiality video has been released which will provide increased clarity for professionals considering how to make finely balanced decisions to override a person's expressed wish when they are at risk.

6.2.9 When formulating a safety plan, professionals have their own professional standards when it comes to information sharing[8], as well as working to NICE quality standards and guidelines[9][10]. Family members and friends should all be considered individually in relation to who could be part of that plan and in what capacity. Since the scoping period 'Teeswide Collaborative Working and Sharing Between Professionals to Protect Adults' April 2025 has been formulated to improve understanding of local expectations.

6.3 Volume of Services / Lack of Lead Professional

6.3.1 This review has found that prior to 2024 Evie was managing to navigate relationships, studies and the responsibility of being a care experienced young carer with support. However, in 2024 there came a point where risks escalated, Evie's exposure to the burden of grief, insecure housing and lack family support increased, and multi-agency responses were required.

6.3.2 Considering the agency reports and the practitioner's views there is evidence of a multi-agency approach to Evie. Examples include the link between the GP surgery and DWP, who understood Evie was a care leaver and signposted her to the mental health nurse. However, there were shortcomings in approaches which involved one agency linking with another in that the network as a whole lacked the information it needed to provide the support needed. For example, when the Intensive Home Treatment Team attempted to contact housing direct, they were not permitted to discuss Evie with the adviser. The approach of the housing team would have been different had they understood Evie's status as a care leaver and had information been shared with them about her attempts to take her own life.

6.3.3 The multi-agency approach relied on the calling of multi-agency meetings and for those meetings to have the right professionals around the table. The lack of a shared perspective about risk led to

[8] https://www.tsab.org.uk/wp-content/uploads/2025/05/TSAB-Collaborative-Working-Info.-Sharing-Guidance-Final.pdf
[9] https://www.nice.org.uk/guidance/ng225
[10] https://www.nice.org.uk/guidance/qs189

agencies responding in different ways and a lack of overarching coordination and planning. Review participants agree that this was the case.

6.3.4 Agencies reflected on practice to understand why this was the case. The suicide attempts were each considered separately. For example, following the first overdose, Evie's explanation that she wanted to sleep was accepted. Then when further overdoses occurred agencies reflected on which of the other services, they were aware of and whether they could or should have been invited to contribute to safety planning discussions. Some agencies were already having multi-disciplinary team meetings. For example, GP, mental health nurse, mental health trust and the social prescriber held these meetings in the GP surgery. Some agencies had limited information available to them, resulting in them having a reduced ability to see Evie with all of her individual characteristics, challenges and vulnerabilities. This prevented agencies from having a wider viewpoint and seeing themselves in a lead professional role. Often agencies viewed their own role in a narrow way. They were not all cited on the same information. The lack of a safeguarding response resulted in a large volume of services all holding pockets of information and doing the best they could to share and collaborate, without any structure for a coordinated approach.

6.3.5 This review acknowledges the enormous amount of effort that went into endless phone calls, emails and referrals. The compassionate approach of professionals is evident, alongside recognition of those who went 'above and beyond their role or remit' to support Evie. An example was the social prescriber who was managing Evie's suicidal ideation. There were fluctuating levels of risk throughout the scoping period. As risk escalated, a referral to a secondary mental health service or crisis team could have been pursued to add additional support and protection.

6.3.6 The review has considered who may have been the most appropriate agency to coordinate multi agency meetings at various points in the scoping period. Whilst there was not a definitive conclusion to that, it was agreed that there was a need to do this due to the general deterioration and increasing risk factors. However, there were also several distinct issues and episodes that could have triggered a multi-disciplinary team meeting when there was clear indication and opportunity to bring agencies together. These are:

- Safeguarding referrals did not result in a multi-agency approach. This detracted from opportunities to share and formulate risk and it acted to deter persistence in making further referrals. This was the subject of discussion at the learning event.

- Evie's basic needs for housing and finances were at risk. The entrenched nature of achieving suitable succession planning for her Mum's tenancy and ensuring she continued to receive universal credit were the subject of deep frustration by many concerned professionals. Whilst the Department for Work and Pensions had attempted to alleviate the stress for Evie by switching off her claimant commitments, other professionals were attempting to help with life admin and not able to collaborate in a structured setting to reduce the burden on Evie. The role of a corporate parent encompasses the responsibility to provide support of this nature.

- After Evie's overdose she continued to disclose that she was numb and couldn't feel anything anymore. The safety plan that was needed required a multi-agency approach. Pockets of agencies knew of the work of each other. For example, MIND, the personal advisor and housing knew of the involvement of one another, yet they would not have been invited to safety planning and there was an assumption that the GP would not come to safety planning meetings. At the learning event the GP suggested that this would not have been the case.

- The last visit to Evie was not recorded. This visit provided an opportunity for the personal advisor to escalate concerns within her own organisation or to raise a safeguarding adult concern.

- Key agencies were not invited to participate in safety planning

- Evie's voice was prioritised by some agencies, who with hindsight would have shared information regardless of Evie's express requests. Services acted with compassion but there

was a misunderstanding about their ability to act under their information sharing guidance. Local information guidance has been issued since the scoping period, which would add greater clarity for agencies. [11]

- Meeting and understanding how other agencies had gathered her views may have improved the collective appreciation of professional perspectives. Where Evie lived now monitors young people who are high risk to a vulnerable young people's list. This involves weekly case discussions leading to a 'RAG' rating in relation to those on the list and the potential for escalation to Assistant Director level. A multi-agency transitions panel is being introduced imminently which will ensure that safeguarding risks are addressed as children transition into adulthood. In Evie's case her pathway plan did not change or evolve over time to match the escalation of risk. The format of this document is being revised.

6.3.7 These arising concerns were all opportunities where agencies could have come together. In line with principles of coproduction[12], there was a potential to achieve a far greater understanding of those within Evie's support network could be 'allowed in' and in what ways i.e. whether some could offer practical support with a smaller subsection who could be relied upon to provide emotional support. Had agencies known about the supportive network Evie had of friends and her half-sister, these people were happy to have provided this resource. This would also have afforded the opportunity to discuss risk, transitions and safeguarding.

6.3.8 There is evidence of Evie's voice being listened to and pockets of strong practice, but challenges in communication between the services which negatively impacted on identifying the appropriate practitioners to include in multi-agency care planning and coordination. The six principles of Adult Safeguarding are therefore not apparently evidenced in a collective way.

6.3.9 Similarly, the findings in this review are also aligned to the thematic areas identified in the National SAR[13] analysis:

- Information sharing and communication
- Coordination of complex, multiagency cases
- Hospital admission and discharge arrangements
- Professional roles and responsibilities

6.3.10 Considered in the context of multi-agency coordination and identification of a lead professional, is the question of safeguarding action. Individually, practitioners did have worries and concerns about Evie but the opportunity for collective consideration was missed.

6.3.11 A key question related to risk is whether safeguarding procedures were effective and responsive, particularly when referrals were received. Children's Social Care at the time had a joint front door with a neighbouring Local Authority. Motivated by national reform, there is a timeline for change. This means each Local Authority will have its own front door and will manage its own referrals. The implementation phase will be over the next 12 months. Adult social care has their own front door. The referral made by hospital staff did result in Evie being recognised as a vulnerable adult. The referrals made by the school were not deemed to reach the threshold for risk of harm. It is important to acknowledge strengths in the raising of safeguarding adult concerns. Also, there were opportunities for other referrals to have been made to demonstrate persistence and the level of multi-agency concern.

6.3.12 In this case the risk to be considered was around harm to Evie in the light of previous overdoses, as Evie's mental health was significantly deteriorating. Thus, a safeguarding adult concern may have been warranted on more than one occasion. For example, the GP acknowledged that, due to a misunderstanding that Evie's Personal Adviser was a social worker, no safeguarding adult referral

[11] https://www.tsab.org.uk/wp-content/uploads/2025/05/TSAB-Collaborative-Working-Info.-Sharing-Guidance-Final.pdf
[12] https://www.scie.org.uk/co-production/
[13] https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

was made. Reviews provide an opportunity for professionals to reflect and improve their understanding of roles across the multi-agency network.

Learning point 5: From a systems perspective it would be helpful to consider more awareness raising activity regarding the making of safeguarding referrals.

6.3.13 Therefore, the ongoing situation as well as some of individual key practice episodes were simply not seen collectively through a 'safeguarding lens'.

6.3.14 There was an opportunity for agencies to come together much earlier. Some of these are highlighted above. In particular, housing and children's social care [who continued to support Evie into adulthood] reflected as to whether they could have called a meeting.

6.3.15 This could have led to other opportunities to consider risk for example by calling a HRAP strategic forum meeting[14]. However, these meetings take place for cases where other multi agency processes have not been successful in reducing risk or harm and where strategic case oversight is required. Instead, pockets of meetings took place and regular 'huddles' took place as well as multi-disciplinary team meetings, but concerns remained disjointed as the threshold for safeguarding was assessed as not having been met. With hindsight, some agencies who contributed to this review considered that it was arguable that Evie's case did meet the threshold. This is important in this case as we know that Evie was being seen regularly, and practical and administrative help may have reduced the significant stress she was experiencing.

6.3.16 In Evie's case, more holistic multi agency collaboration and a shared appreciation of risk is unlikely to have introduced a wider range of services, as a large number of services were already involved. However, it would have offered professionals a wider lens on the reality of her life and increased potential avenues to allow professionals to develop even more curiosity and creativity.

6.3.17 A shared process for risk assessment and management is available via a Public Protection Notice (PPN), where police believes the threshold is met for risk of harm. The option to use this process was discussed at the learning event. Officers on this occasion considered in their one interaction with Evie that she was not suffering with mental health issues and was taken to hospital. Therefore, police consider it was appropriate to not raise a PPN. Police do not have a route for PPN's to be sent to mental health services.

6.3.18 Evie was described by friends and professionals close to her as having 'compartmentalised' various aspects of her life. She was guarded about revealing the identity of those who supported her to her immediate family members. This was seen as a barrier to information sharing. When services became aware that Evie had friends and extended family who wanted to put themselves forward to care for her, there was a comment that this information was very hard to hear. It was 'tragic' that services did not understand the significance of those closest to Evie. Professionals seemed confident in their ability to breach confidentiality where there was a need to do that. For example, the GP did seek the view of grandparents and made enquiries. Evie's grandmother responded to suggest she had no concerns. It is pleasing to note that a common sense confidentiality and sharing of information video was released during the process of this review. This activity has taken place due to learning from other reviews.

6.3.19 To conclude, there is evidence of multi-agency working but this was inadequate in terms of risk formulation and coordination, despite evidence that this should have been facilitated.

6.4 Responding to Changing Levels of Risk

6.4.1 A Second Analysis of Safeguarding Adults Reviews[15] (SAR's) found that short comings in risk assessments and poor safeguarding actions were commonplace in the reviews analysed. This was a result of many factors in Evie's case. There was a lack of joint risk assessment and agencies were generally operating in silos. This can be seen to be reflected in the plans for Evie. There was no

[14] High Risk Adults Panel (HRAP)
[15] [15] https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

overall joint risk formulation and coordination for Evie. This is reflected throughout the reports and the practitioner's event as agencies were generally operating in silo.

6.4.2 However, there is evidence of some joint working such as school and the personal advisor and the mental health team and the personal advisor, but this is not consistent. This could have been built on, with the identification of others who were involved, but as there was no lead professional identified this did not happen.

6.4.3 As the weight of grief, increasingly complex life administration and the requirement to complete her studies combined, risk increased around Evie. Individual agency risk assessments and plans pertained to risks in silo. There were pockets of shared risk formulation, but there was no multi agency structure to provide a space for reflection to balance the risk of information sharing versus not information sharing. This in itself raised the potential for a safeguarding concern. Significant others in Evie's life were sharing their expressed wishes with Evie to be involved in management of risk. Evie's friend expressed her frustration and despair regarding Evie's mothers' medication remaining in the house in the light of Evie's repeated statements of intention to complete suicide. There is some evidence that Evie's grandparents had been alerted to risk. However, close friends who were important to Evie and Evie's half-sister would have liked to have been part of the safety plan, and this might have been beneficial to Evie.

Learning point 6: Awareness raising is needed in respect of the roles and remits of various professionals across the safeguarding partnership as well as the making of safeguarding referrals. Assessments must include involvement of a broad range of support networks including family and close friends. Difficult relationships in families should not deter identification of a person's support network.

6.4.4. On occasions where safety planning did include family and friends the effectiveness was reduced due to the lack of multi-agency collaboration. In February after Evie's overdose there was a safety plan made with Evie, her grandmother and friend present. The GP was unaware of the overdose so when Evie attended the surgery the GP was unable to address risks. The information arrived days later.

Learning point 7: Health settings should work to reduce the time it takes to notify GPs of high risk suicide attempts.

6.4.5 The lack of timely information sharing to the GP following the February overdose was compounded with issues of information sharing to the GP. Reliance upon electronic methods or letters is not always the most effective. This could be by a telephone call or other method of electronic alert. The combination of a long period of anticipatory grief, the trauma around the circumstances of her mother's death followed by complicated grief after the loss of a trauma bond was compounded by isolation and concerns around her housing situation. The GP, mental health trust and mental health nurse at the surgery should have had the benefit of real time updates regarding each other's actions. 'Gold' email alerts of suicide attempts are not available to the NHS Trust whose system is controlled by NHS England. Flags are not possible across health organisations. GP's use SYSTMONE which can only generate a flag for the GP. Only NHS England can control the code tables to make these flags available across NHS organisations. It was stated at the learning event that whilst the mental health nurse at the surgery can access mental health records that would not necessarily be part of standard day to day practice.

Learning point 8: All agencies should reduce the time it takes to notify a high risk suicide attempt and ensure all appropriate health settings receive the notification.

6.4.6 Strong practice is recognised in relation to the GP upon Evie's discharge from the emergency department. This overdose had been described as near fatal. The GP sent a text to Evie asking if she wanted an appointment. She responded that she did and the GP saw her that day. The GP involved the mental health nurse, social prescriber and the Department for Work and Pensions. A multi-disciplinary team meeting was needed prior to Evie's discharge to formulate as comprehensive safety plan which involved a larger number of agencies.

6.4.7 Sixth Form College had recognised that their safety plan was limited in how they could support her, again emphasising the need for a multi-agency safety plan. Agencies were left on the periphery, formulating their own safety plans. In some instances, they were recognising the limitations of their own plans and feeling powerless in how to support Evie. For example, Evie's school recognised these limitations and expressed their frustration regarding having used third hand information to generate a safeguarding referral. When the referral was not pursued, the feeling these professionals expressed was that they 'carried the burden' and wondered 'where do you go next?' This raises questions about whether professionals in the Local Authority are aware of arrangements for escalation and professional challenge.

Learning point 9: All professionals should be clear as to local arrangements to escalate or offer professional challenge around decision making. [16]

6.4.8 The February overdose was a significant turning point as described in 6.4.6. At this time there was an opportunity to have made a safeguarding referral, as this new information should have been enough to 'tip the balance' in favour of a safeguarding response. Whilst joint visits between adult social care and personal advisors were being offered, there was not one professional who understood how this level of risk met the threshold who was in a position to make that referral. Reviewing safety plans regularly with Evie would have helped to understand changing risk and improve the response.

Learning point 10: Awareness raising is needed in respect of the roles and remits of various professionals across the safeguarding partnership as well as the making of safeguarding referrals.

6.4.9 There were definite dates when it could be considered that the risks for Evie increased. Examples include the funeral, her mother's birthday and also points at which she was required to undertake difficult tasks to resolve her mother's financial affairs and tenancy after her death. As a multi-agency network, it would have been possible to consider how agencies could stay in touch and support whilst not all placing a burden upon Evie at the same time of day for instance. Professionals observed that Evie's phone was constantly ringing. Having a clear plan of who would contact Evie when would have been less burdensome for her. The compassion and strong motivation to support Evie and improve her lived experience was evident from all professionals across the network. This review has generated learning which cannot be ignored which suggests improving the system for agencies to come together is now an urgent requirement.

6.4.10 Evie was engaged in the process of succession planning in relation to her mother's tenancy. There were numerous examples of professionals offering support to her to manage this. It is pleasing to note that the housing provider is undertaking work to simplify succession planning for tenancies to reduce the complexity going forward. However, the housing team was unaware of Evie's status as a care leaver and her increasing level of risk. Evie's school and the GP made contact with Housing, but Housing felt bound by confidentiality and no information could be shared during those discussions. There was a potential opportunity for Housing to exercise more curiosity to understand during those discussions about the circumstances of her life and understand whether they could offer her more assistance. Evie was 19 and her mother had died. Whilst this information was visible, her status as a care leaver was not.

6.4.11 Agencies recognised that Evie would require bereavement support following the death of her mother. However, this input should have started before Evie's mother died in the form of anticipatory bereavement support. The hospital was providing support to Evie during this period. However, other agencies who recognised the risk could have considered earlier referrals. Following her mother's death there were referrals made such as to Cruse.[17] When this referral was rejected this was not followed up and alternatives were not considered.

6.4.12 Lack of information sharing around risks is evident throughout this review. Mental Health Trust Hospital 1 shared learning that they had had in response to a previous case that they called 'Chris's

[16] Professional Challenge Procedure | Teeswide Safeguarding Adults Board
[17] https://www.cruse.org.uk

voice'[18]. This is where concerns would be shared with family where they are considered to be high risk

Learning Point 11: 'Chris's voice' principles enables risks to be shared with family or those providing care and support.

6.4.13 In the days before Evie died there was escalating risk, and she did contact agencies and comment on how she felt life was worthless. Risk was heightened due to the fact that Evie had recently been rejected by her father when she travelled to area 2 and had not managed to secure a copy of her parents' divorce certificate. The leaving care Personal Advisor was expressing concern to her manager about the inevitability of a further suicide attempt on the same day that Evie took her own life. No agency or professional raised a safeguarding adult concern nor was a referral made to the crisis team.

6.4.14 There were safeguarding adult concerns into adult social care. The one made by the school was not taken any further and they did not receive feedback. The one made by the hospital was reviewed yet was not pursued as safeguarding instead it was considered, and support was offered. Professionals who have participated in this review reflect on other opportunities that presented themselves to make further safeguarding referrals. Likewise, the manager of the front door should be considered as key learning from this review.

6.4.15 Evie was in contact with a number of professionals who were unaware of each other and of respective roles they each played in supporting Evie. The large number of professionals involved can be reassuring across the professional network. Also, it can provide false reassurance. Without knowledge of the changing risks there was a clear potential for numerous inaccurate and unhelpful safety plans being formulated which did not take into account the escalation of risk around Evie.

Learning point 12: Risk assessments should reflect up to date risk, being dynamic in nature.

6.5 Transitions Between Services

6.5.1 Young people who reach the age of 18 can experience a 'cliff edge' in their transition between services. This is exacerbated by mis matched thresholds, which is striking in Evie's case. The system responds depending on age rather than risk. Yet a range of harms and threats may be experienced by a young person who still will not qualify for a safeguarding response. The case for a transitional approach is a strong one. It is pleasing to note that a new pathway has been devised and is being implemented in the relevant Local Authority.

Learning point 13: Transitional safeguarding requires whole systems change involving a partnership wide approach. The pathway introduced for social care is a starting point. Integrating with health organisations is required for a person centered approach.

6.5.2 Evie was going through many transition points, not only within/between services but also in her own life. She was now grieving not only the loss of her mother but also the loss of being a carer. This was a role that she had assumed for many years, she had spent the last several months visiting her in hospital and caring for her there. Day to day life would now look very different. The idea of working with Evie in a creative way to choose one clear priority for each day and to support her to achieve that one priority was welcomed as part of professional intervention at this time.

6.5.3 Evie transitioned well between schools with there being good information sharing. The sixth form college was made aware of Evie's history and the concerns that they held. This was positive as from the start they were able to appropriately support Evie. If this had occurred between other agencies, risk and concerns about Evie would have been shared and then could have been risk assessed and planned for.

Learning point 14: Good communication facilitated positive transition between schools. This acted to safeguard Evie as risks were shared.

[18] Chris's Voice https://www.youtube.com/watch?v=nj4VeTB9zsA

6.5.4 School did support Evie after the death of her mother. At the practitioner's event they reported that she attended school most days and they were actively supporting her in applying for universities and applying for universal credit and household benefit funds. But school did identify that their input was limited, and they did work with Evie around many aspects of her life and future. This is recognised as strong practice.

6.5.5 This review understands that should the transitions between children and adult services take place today this would be under a better managed pathway. However, in Evie's case the pathway plan and the nature of continuing support from her personal advisor was not well understood by adult social care. The information held by adult social care did not lead to a decision that safeguarding was met. Services held information that would have changed that although these were not made. Adult social care do offer joint visits with Personal Advisors, but this did not happen in Evie's case.

Learning point 15: Robust transitions between services rely on both adults and children's services understanding how to affect a seamless transfer of care.

6.5.6 It is generally considered that GPs hold all health information and as such are well placed to identify concerns and consider what support is required. It is evident that the GP was not kept informed by the mental health trust of key elements of their input. The mental health team reflected within this review that they operate on the basis that a GP would prefer to receive key pieces of information rather than flooding the GP with information. The GP in Evie's case reflected that she would appreciate more frequent touch points given that the Home Treatment Team were having daily contact. For example, the GP would have appreciated contact once per week. This may not reflect the requirements of all GPs. The Practice also had their own mental health support which Evie accessed. Again, a multi-agency meeting would have enabled this understanding of distinct role and dialogue regarding frequency of contact.

Learning point 16: Safe transitions rely on multi-agency working which allows for the entire network understanding their respective roles.

6.5.7 Whilst transitioning through services Evie's right to a private life was respected, however it could be predicted that with so much change and transition in Evie's life there would be an impact on her mental health. She reported feeling overwhelmed, which is not surprising. Having a clear transition plan co-produced with Evie could have reduced stresses in her life. This plan would identify what the stresses were and considered the best way to manage them.

Learning point 17: Transitioning between services requires careful planning and involvement of the right people to ensure there is a person centered approach.

6.5.8 Bringing agencies together to consider Evie's support needs during transition would have provided agencies, Evie and others in her life with a clear plan of how to do this and also who was responsible for each part. There were several professionals involved in her care, supporting her but this was not provided in an organised manner. By not doing so professionals were not optimising the support that could be given. There is evidence of different professionals trying to see her on the same day, each doing so without the knowledge of the other.

7. Strong Practice

7.1 This review has highlighted an opportunity that was open to services to offer bereavement support related to anticipatory grief. This applies notwithstanding the strong practice that is recognised from the hospital who supported Evie in that setting throughout her Mum's stay.

7.2 The Intensive Home treatment Team ensured consistency of staff members was maintained by those who had an important relationship with her. This was not withstanding her moves across area. This improved the therapeutic relationship and professional's ability to recognise the escalating pattern of overdoses. It is strong practice that an Occupational Therapist was linked by this team.

7.3 The tenacity of Evie's GP evidences strong practice. Not only in the speed of offering to see her, but also in developing a relationship hosting multi agency meetings the practice, contacting the Department for Work and Pensions and holding lifelong knowledge of Evie.

7.4 The Personal Advisor was creative in finding ways to engage with Evie and advocate on her behalf. The Personal Advisor appropriately escalated her concerns as risk increased around Evie.

7.5 The joint visits and positive collaboration between the Personal Advisor and social prescriber also demonstrates strong practice.

7.6 Both schools established and maintained strong relationships with Evie. School was a safe place in which she felt able to disclose. The schools communicated to facilitate a seamless transition, and it is positive that Evie had relationships with trusted adults in education settings which supported her success.

7.7 The social prescriber offered support over and above their role in supporting Evie around suicidal ideation.

7.8 Many professionals went above and beyond to support Evie with practical tasks such as supporting her with tasks around housing, closing her mum's bank account and identifying the need for a legal document from the divorce. Transitional safeguarding requires practical support as well as emotional support and both of these requirements were recognised.

8. Improvements Already Implemented

Many agencies have implemented improvements, with some internal recommendations requiring more time.

8.1 Mental health trust

The mental health trust has implemented awareness across services about what leaving care status is and what this means. 'Common sense confidentiality' is the subject of a new video for practitioners and 'Triangle of Care' is the subject of awareness raising for frontline practitioners to enable clear explanations to be given to families.

8.2 Children's social care

Robust transition pathways are in development between children's and adult services. When care leavers access their records there is a clear plan in place to support them in this.

8.3 GP practice

Systems have been improved within the practice regarding notification of suicide attempts which lead to an offer of an appointment with the GP. The 'Was Not Brought' policy for children was updated. Regular discussions take place in safeguarding meetings to discuss the impact of physical and mental health events on those with caring responsibilities.

8.4 School

Improvements have been made to staff awareness of the challenges for pupils who transition across services. Professional challenge is supported and supervision is available to professionals regularly. Awareness raiding has taken place regarding the roles of other agencies and how to build stronger links with them.

8.5 MIND

Case management systems will include missed appointments for monitoring and will be discussed in management supervision sessions.

8.6 Adult social care

Joint access to records between children's and adults' social care is now in place.

8.7 Housing team

A review of the process for succession planning is underway with a view to simplifying this.

9. Lessons Learnt

9.1 **Learning point 1:** This review has revealed that agencies are not aware of the best information to provide to housing to support care leavers. Additionally, housing should simplify their processes for eliciting information needed for supporting succession tenancies.

9.2 **Learning point 2:** Care should be taken over use of language and labels in recording as these can result in a variety of meaning being attached due to the way a reader interpret wording in future.

9.3 **Learning point 3:** Agencies supporting the authority to discharge its corporate parenting responsibilities benefit from understanding a young person's early years.

9.4 **Learning point 4:** Agencies should strengthen information sharing processes for vulnerable individuals accessing their service to enable risk assessments/plan to be accurate and up to date.

9.5 **Learning point 5:** From a systems perspective it would be helpful to consider more awareness raising activity regarding the making of safeguarding referrals.

9.6 **Learning point 6:** Awareness raising is needed in respect of the roles and remits of various professionals across the safeguarding partnership as well as the making of safeguarding referrals. Assessments must include involvement of a broad range of support networks including family and close friends. Difficult relationships in families should not deter identification of a person's support network.

9.7 **Learning point 7:** Health settings should work to reduce the time it takes to notify GPs of high risk suicide attempts.

9.8 **Learning point 8:** All agencies should reduce the time it takes to notify a high risk suicide attempt and ensure all appropriate health settings receive the notification.

9.9 **Learning point 9:** All professionals should be clear as to local arrangements to escalate or offer professional challenge around decision making.

9.10 **Learning point 10:** Awareness raising is needed in respect of the roles and remits of various professionals across the safeguarding partnership as well as the making of safeguarding referrals.

9.11 **Learning Point 11: '**Chris's voice' principles enables risks to be shared with family or those providing care and support.

9.12 **Learning point 12:** Risk assessments should reflect up to date risk, being dynamic in nature.

9.13 **Learning point 13:** Transitional safeguarding requires whole systems change involving a partnership wide approach. The pathway introduced for social care is a starting point. Integrating with health organisations is required for a person centered approach.

9.14 **Learning point 14:** Good communication facilitated positive transition between schools. This acted to safeguard Evie as risks were shared.

9.15 **Learning point 15:** Robust transitions between services rely on both adults and children's services understanding how to affect a seamless transfer of care.

9.16 **Learning point 16:** Safe transitions rely on multi-agency working which allows for the entire network understanding their respective roles.

9.17 **Learning point 17:** Transitioning between services requires careful planning and involvement of the right people to ensure there is a person centred approach.

10. Conclusion

10.1 There can be a 'cliff edge' for care leavers like Evie. This includes the application of different thresholds for them to access a service. It can also change the perception of a young person, resulting in them being seen as incredibly mature. Care should be taken when using language and labels in recording such as 'resilient' which can detract from seeing the vulnerability of the young person.

10.2 Practitioners must balance an adult's right to family life and understand how and when confidentiality can be breached. These are two competing tensions when a person is at risk. This case underscores learning from previous reviews and highlights the need for the work undertaken regarding 'Chris's voice' to be understood widely.

10.3 When an agency is supporting the local authority in discharging its corporate parent responsibilities and/or supporting a transition between services it is important that every agency has an opportunity to understand a young person's early years. Information sharing should be comprehensive to ensure this objective is met. Effective corporate parenting requires a commitment from the local authority to share, accompanied by a collaborative working relationship with partner agencies to support that role.

10.4 Extended family members and close friends were an underutilized resource in Evie's case particularly after her Mums death. 'Difficult relationships' seemed to prevent vital information coming through. Evie's half sister and her Mum wanted to be considered for Evie to live with her. Another close friend held similar hopes for Evie to join her family unit. 'Teeswide Collaborative Working and Sharing Between Professionals to Protect Adults' April 2025 goes some way to providing a framework for information sharing as do the principles of 'Chris' voice'. However NICE quality standards and guidance require an approach described as suicide prevention partnership to ensure the right information reaches the right agencies after suicidal ideation or attempts.

10.5 Opportunities to make safeguarding referrals, escalate, utilise guidance about professional challenge or consider public protection notices were not always taken up. These opportunities are detailed in paragraph 6.3 above. Awareness of all of these routes and guidance must be improved. Systems issues prevent 'gold' alerts of suicide attempts being made which reduces the chance of early notification to practitioners who need it most.

Risk assessments were not dynamic in that indicators of escalating risk were missed. Once Evie returned from area 2 having received no support from her father, risk was elevated. This was a time to make a safeguarding referral to ensure the multi-agency network came together to protect Evie.

11. Recommendations

Recommendation 1

Teeswide Safeguarding Adults Board should consider best practice and seek assurance from partner agencies that this is being followed in respect of bereavement support in respect of anticipation of grief. This is to supplement the work already undertaken in hospitals. Services should receive support to improve understanding of how and why referrals may or may not be accepted, and especially whether the information about a person being a care leaver can influence the support available.

Recommendation 2

Teeswide Safeguarding Adults Board should collaborate with the Safeguarding Children partnership to raise awareness about the difference between thresholds for a safeguarding response from children's social care and adults social care. This work should enable professionals to understand how to make an effective referral and what to do if this referral does not receive a safeguarding response.

Recommendation 3

Teeswide Safeguarding Adults Board should seek assurance that professionals across the multi-agency network who support services users with their housing needs understand the right information needed to

enable housing teams to liaise with them direct. This will include, for example, a person's status as a care leaver or where suicide risk is an issue.

Recommendation 4

Teeswide Safeguarding Adults Board, local authorities and Health Trusts should consider the newly introduced pathway for transition between children's and adults social care and agree with health partners an approach which integrates health organisations for a more person centred approach. Teeswide Safeguarding Children Partnership should partner with the safeguarding adults board to integrate health organisations into the new pathway. The pathway includes alerting services to service involvement in respect of a young person.

Recommendation 5

Teeswide Safeguarding Adults Board should review its multi-agency policy and procedure to ensure safety planning after suicide attempts and ideation references and follows NICE guidance and quality standards, including harnessing the support of significant others as well as family members.

Recommendation 6

Teeswide Safeguarding Adults Board should write to NHS England to highlight the learning from this review regarding the length of time permitted by the standard contract to notify GPs of high risk suicide attempts and the need to reduce it.

Appendix 1 - Terms of Reference

1. Please critically evaluate the quality of assessments and decision making. How well was the history understood for the purposes of assessment? Was the risk to Evie and her unmet needs fully understood? How were developments responded to, including changing levels of risk.

2. Please summarise the approach to Evie's status as a carer [& previously a young carer including her diversity needs under Carers (Equal Opportunities) Act 2004] How was this incorporated into assessments?

3. Could communication and information sharing have been improved post transition in light of EVIE's pattern of missed appointments/patchy compliance?

4. How well was the family supported to support a young adult moving to independence?

5. How was EVIE's voice incorporated into assessments? How did agencies respond at the times when she asked for help?

6. What was the professional view of EVIE's relationship with her grandparents? What impact did this have on securing housing for her?

7. Multi-agency discussion took place in EVIE's case. However, could communication and information sharing have been improved between agencies as part of this process? Were the correct agencies in attendance for meetings?

8. Did communication within and between services operate effectively, for instance during transitions between parts of a service or between practitioners? What role did record keeping play in this?

9. Please identify examples of good practice, both single and multi-agency.