Kiara

Safeguarding Adult Review

Commissioned by Luton Safeguarding Adult Board

October 2024

Kanchan Jadeja

Independent Reviewer

Spiritus Safeguarding

Table of Contents

Kiara's Voice:

Kiara

The Edge[1]

Each day began a new
Each day began with a colour.
Some brighter than the sun
Others empty and hollow

She stood up high, she stood up tall.
Some days she trembled as if to fall.

he would find the rope, find the hope.
Tied round her waist for when.
She could not cope.
But never could she loosen the noose.

Its hold round her neck
Its grip round her throat

And time would not stop.
The Clock unaware of its ticking
Fall she did not.
Rooted there she stayed.
Watching waiting

Wondering
Which would claim her first-
To which would she lose?
The rope around her waist
Or the fighting noose?

[1] Kiara asked for this poem to be placed at the start of this review and written in her favourite colour green.

What professionals observed about Kiara:

As a child. Kiara was reported to be "*a chatty lovely girl'*

The care leaver team:

"*Kiara went to university, she had aspirations, there were no signs of mental health needs as a child, she loved her mother and siblings, she received awards and made a difference in her education. Although she had a troubled background, she was positive. The service was shocked to hear what had happened to her*".

"Kiara is enjoying herself and is achieving. She was very self-reliant." From care leaver service".

"Kiara is determined she will achieve anything she put her mind to. (Recovery Plan)"

I would like to be discharged, go home with my mother, be able to work and drive again. And I would love if I can walk not using walking aids.

1. Introduction to SAR

1.1. Why was this case chosen to be the focus of the SAR?

1.1.1. A Safeguarding Adults Board (SAB), as part of its Care Act 2014 statutory duty, is required to commission SARs under the following circumstances:

"(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 (see below)

(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".[2]

1.1.2. The purpose of this SAR is to gain, as far as is possible, a common understanding about the circumstances surrounding Kiara's experience of mental health needs, abuse, homelessness, trauma, suicide ideation and self-harm within her cultural context.

- The review will consider how agencies, individually and collectively worked with her, how they could have worked more effectively with her; and each other to better understand her needs, risks, and circumstances.
- Kiara had contact with agencies involved in supporting her with her mental health, suicide ideation, self-harm, forced marriage, honour-based violence, care experience and homelessness amongst. The review aims to understand the impact of agency involvement on her.
- It is relevant to consider the key elements of the Care Act to understand what happened with safeguarding concerns raised by agencies about Kiara and with each other and the Local Authority.

1.1.3 The Care Act requires that each local authority must:

- Make enquiries, or cause others to do so, if it believes an adult who is
- experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.
- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry. Where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them.
- Co-operate with each of its relevant partners (as set out in Section 6 of the Care Act 2014) to protect the adult. In their turn each relevant partner must also co-operate with the local authority.

[2] Care Act 2014.

1.1.4 The purpose of the Act is to ensure that adults at risk have their needs assessed, reviewed, and met. The Act requires that the following practices be implemented:

- Preventing abuse, maltreatment, and neglect from happening.
- Promoting wellbeing and safety.
- Responding effectively to instances of abuse, maltreatment, and neglect. (Including self-neglect).

Safeguarding Adult Reviews should consider the interpretation and application of adult safeguarding procedures and policies and review how agencies understood their role and applied adult safeguarding principles as set out in The Care Act 2014.
The Department of Health and Social Care has set out the six principles (below) for adults safeguarding and the expectation is that these principles are consistently applied by all agencies involved with a vulnerable adult.

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

1.1.5 Kiara is a woman of South Asian ethnicity and Muslim religion. She lives in Bedfordshire. Kiara is a professional, graduated from university and she loved her job. Kiara has had a long history of professional involvement in her life, and she was classified as high risk and a 'missing person' who is at risk of suicide ideation. Kiara had a recorded history of mental health concerns, self-harm, and numerous attempts to take her own life.

1.1.6 Kiara is 28 years old and survived a significant event where she attempted to take her own life. Luton Safeguarding Adults Board (LSAB) has commissioned this Safeguarding Adult Review (SAR) to learn from how agencies worked with Kiara. This review is focussed on understanding and learning from Kiara's experiences. LSAB will use the findings and recommendations to improve outcomes for vulnerable adults in Luton.

1.1.7 The significant incident that led to this review took place in 2022. Concerns were raised by Kiara's mother, that Kiara had taken an overdose and had made a serious attempt at taking her own life. When found, she did not respond to police attempts to stop her from significant harm and she sustained significant injuries.

1.1.8 At the time, Kiara was well known to services. Kiara survived this incident and has been in the care of medical and adult social care services since then. [3]Following the significant incident, a rapid review[4] took place. The primary aim

[3] In order to respect Kiara's privacy following this incident details are not shared in this review.
[4] A Rapid Review is an expedient focussed assessment conducted in response to an incident or concern involving a vulnerable adult.

of a Rapid Review is to swiftly gather and analyse relevant information to understand what happened, why it happened, and what can be learnt.

1.1.9 The focus of the Rapid Review is to identify immediate actions and make recommendations to improve practice. The emphasis on rapidity is essential to ensure that necessary measures are implemented promptly to address any immediate actions required. In Kiara's case the Rapid Review was prompt and immediate actions were taken by agencies following the incident.

1.1.10 A review would explore what work had been carried out with Kiara and whether agencies had worked together to provide her with the support and safeguarding she needed and to highlight where there were gaps in provision of service and support. This review has been carried out in line with Luton Safeguarding Adult Board approach to SARs. The primary purpose of the review is to improve future practice through recommendations to the LSAB.

1.1.11 Agencies involved in the LSAB were keen to understand the context of Kiara's suicide ideation, her multiple vulnerabilities, health inequalities, whether professionals had exercised cultural competence intersectionality in the safeguarding of Kiara as a young South Asian woman. In addition, to enquire how effective services were at working with multi- layered vulnerabilities, needs and intersectionality. It was agreed that a SAR should analyse what happened and make recommendations about how practice could be improved. Therefore, this review is about '*learning and not blaming*' with a focus on learning.

1.2. The Demographical Context of Luton. [5]

1.2.1 Luton has a very diverse, relatively young population. Socio-economic factors pertaining to Luton suggest that there is a high level of deprivation and poverty in the town. The population of Luton, according to the 2021 census, was 225,261. With 54.8% being non-white and White British were 31.8 % compared with 74.4 % nationally.

1.2.2 Christians represented 40.32%, Muslims 35.07%, No religion, 18.71%, Hindus 3.52%, Sikhs 1.43%, Other religions 0.53%, Buddhists. 0.31% and Jewish represented 0.12%. There is population churn and a '*complicated pattern of migration and turnover*'. International migration data from 2021 census indicates that nearly two in five residents were not born in Luton.

1.2.3 The town has a high level of preventable mortality which relates to inequalities in the social determinants of health. Luton 2040 [6]document suggests that many deaths could be avoided if the social and economic conditions of the area were improved. Reference Luton's population wellbeing strategy.[7]

[5] Luton 2040. A place to thrive. Luton's Population Well-being strategy: Working Together to Improve health and reduce health inequalities across the population of Luton. 2023-2028. Public Health.
[6] Luton 2040. A place to thrive. Luton's Population Well-being strategy: Working Together to Improve health and reduce health inequalities across the population of Luton. 2023-2028. Public Health.
[7] Luton 2040. A place to thrive. Luton's Population Well-being strategy: Working Together to Improve health and reduce health inequalities across the population of Luton. 2023-2028. Public Health.

1.2.4 84% of Luton's communities are within a 15-minute journey time by walking or public transport of a GP practice as compared with England's average which is about 71%. Luton has a mixed picture in terms of emotional wellbeing. There is currently a lower life satisfaction, overall, in Luton, in comparison to the national and regional rate and this is worsening.[8]

1.2.5 According to Luton 2040, health inequalities existed before COVID. In addition - Luton's Well-being strategy: Working Together to Improve health and reduce health inequalities across the population of Luton. 2023-2028 sets out the challenges facing the town to overcome health inequalities. There are mostly higher than national inequalities in healthcare and other services. In England, Black people are four times more likely than White people to be detained under the Mental Health Act. The impact of this in the diverse population in Luton requires further review and consideration. In addition, Luton's black, South Asian and minority ethnic backgrounds were most impacted upon by Covid 19. Life expectancy is lower for both male and females than the national average.

1.2.6 Pakistani and Bangladeshi (Kiara's background) individuals experienced the highest mortality in the second and third waves of covid due to urban close living. Pakistani and Bangladeshi groups are also more likely to report being in poor health and to have shorter disability-free life expectancy. This is relevant to the context that Kiara lived in, although there is little information about her specific family composition, as she is from this background, it is likely to have had an impact on her.

1.2.7 Luton aspires to adopt and embed Marmot[9] principles in becoming a health equity town providing leadership to tackle health inequalities and work towards co-production with communities.

1.2.8 This is relevant to understanding the environmental context that Kiara lived in. There is little known about her background to assess family's cultural, economic, social and health inequalities and how these impacted on her. What is known is that she struggled with housing, her mental health, relationships and maintaining her job. Kiara continues to be at high risk of suicide ideation, Complex PTSD, and mental health vulnerabilities and high level of physical injuries sustained during a serious attempt to take her own life.

1.2.9 As highlighted in the demographic context of Luton Town, the Town is very diverse. The Chair of the LSAB and review panel are keen to understand whether what happened to Kiara is endemic and systemic and how her cultural and religious background impacted on what happened to her and the response from services to her needs her.

1.3. Terms of Reference and Key lines of enquiry:

Luton Safeguarding Adult Board agreed the following areas for this review to explore:

[8] Luton 2040. A place to thrive. Luton's Population Well-being strategy: Working Together to Improve health and reduce health inequalities across the population of Luton. 2023-2028. Public Health.

[9] Marmot principles: Based on work carried out by Sir Michael Marmot which focussed on health inequalities based on social and economic factors and their impact on life expectancy.

The following key lines of enquiry and Terms of Reference have been agreed by the LSAB:

1.4. Adult Kiara presented with many vulnerabilities:

- Kiara experienced mental health difficulties. How were these responded to and what interventions were offered to her?
- There have been allegations of forced marriage and sexual abuse towards Kiara. What information do professionals have about this, how did agencies work together to understand the impact of this and provide culturally appropriate support for Kiara?
- Kiara was in the care of the Local Authority, how well was transition planning carried out for her to have a smooth transition from children's Services to Adult Services. What wider learning is there about transitions from what happened to Kiara.
- What was known about Kiara's relationship with the wider community and/or her isolation from the community.

1.5. Trauma informed Practice from childhood to Adulthood.

- In working with Kiara, was there a trauma informed approach carried out with her?
- What traumas did Kiara face and what support was she provided?
- What trauma was caused to Kiara by the physical, emotional, and alleged sexual abuse on her and her family.
- What was the impact of culture on the trauma that Kiara faced.

1.6. To review the involvement of individual agencies

- **Statutory and non-statutory with Adult Kiara.**

  i. Establish lessons learnt from this SAR regarding how professionals worked individually and together to safeguard Adult Kiara and vulnerable adults in her household.

  ii. Consider how learning from this review can contribute to professionals and agencies working together to develop trauma informed and culturally appropriate good practice in Luton.

1.7. Key Questions for this SAR.

i. Did practitioners demonstrate a good understanding of the lived experience and circumstances of Kiara and if not, what were the barriers to this?

ii. Was the intervention provided timely, or were there delays in responding, and if so, why? Did practitioners fully consider whether Kiara had mental 'capacity' to manage her daily life and to keep herself safe?

iii. Do practitioners know who they can turn to for expert advice and support (including through a trusted assessor approach) in these areas if an adult is at risk.

iv. How does local availability of resources impact on care planning and safeguarding, systems, assessments, and solutions?

v. What learning is there from this review to better understand the nature of suicide, depression, and mental health in Kiara's cultural context.

vi. What does this review highlight about honour-based suicide; within the context of faith and culture and how that is should inform any risk assessment.

vii. Was the intervention provided in a timely manner to meet with Kiara's needs, risks and circumstances or were there delays in responding, and if so, why?

2. The Methodology

2.1. The Methodology of this Review

2.1.1. The methodology followed in this review was agreed at the outset of the review. It is based on the Luton Safeguarding Adult Board's methodology and approach to completing SARs. The purpose of this review is not to hold any individual or organisation to account. Rather, it is to inform and improve local multi-agency practice for vulnerable adults like Kiara and more nuanced responses to abuse, neglect and suicide ideation.

2.1.2. The methodology was designed to respond to the emerging and changing nature of Kiara's needs, risks, and circumstances as she recovered in hospital after an attempt to take her own life. The LSAB and her medical team were all keen for her to engage in the review, therefore time has been given to pause and keep reviewing the possibility of her engagement in the review. When Kiara was feeling well, she had told professionals that she would like to engage with the review. Therefore, time was taken to allow her to do so and hence the delay in completion of the review.

2.1.3. The reviewer and LSAB agreed a learning approach to this review. A practitioner event was held to look more closely into the experiences of practitioners and their managers in supporting Kiara's needs. During this review, several gaps were identified in the information available to the panel. In other cases, further clarification was required and the LSAB executive team and reviewer requested additional information from the relevant agencies. At times, this information took time to gather and share as this review is complex and information was not always readily available to the professionals involved.

2.1.4. The reviewer is grateful for the additional work carried out by agencies to source information even when it took a while to source and share. Agencies have worked hard to ensure that all learning is informed by evidence from their records and practitioner experiences of working with Kiara. The reviewer recognises that at times this has been with a backdrop of increased pressure on mental health services and staff and therefore this approach demonstrates their commitment to learning from what happened to Kiara.

3. The Timescale for the SAR

3.1. The initial timescale and scope agreed for this review was between 2019 and 2022. However, as the review progressed, the panel agreed that Kiara's childhood experiences were relevant to this review and therefore Children's Social Care completed an Independent Management Review.

3.2. The Chair's leadership has been very effective and supportive in ensuring that although there may be delays in sourcing information and gaining Kiara's voice, the timescales should be adjusted to accommodate this and respond to the complexity of this review.

3.3. The Chair of LSAB and the Reviewer met Kiara to understand her needs, risks, and circumstances. This discussion from the meeting is included in the body of the review, where necessary and appropriate.

3.4. It is important to note that Kiara told the Chair and Reviewer that she had wanted to be involved and have a voice in this review and it is positive that the review timescales were adjusted to accommodate her wish to engage in the review.

3.5. She requested that her poetry is included in the review and the poem she wanted, in green at the start of the review has been included in the report. Kiara was open, honest, and shared her views and experiences about what happened to her and what actions may have better supported her.

3.6. **The following four steps were followed in the methodology**:

3.6.1. Firstly, agencies provided the chronology and agency involvement information to the reviewer. The reviewer considered the information provided in the context of the Terms of Reference and Key Lines of enquiry, identified patterns of need, areas of good practice and areas for improvement. The chronology and agency information provided a window into how services responded to Kiara's needs, risks, and circumstances and how the partnership worked together to meet her needs and to safeguard her.

3.6.2. Secondly, having analysed the information, a practitioner event was held which investigated the interrelationship between professionals and the impact of their work on Kiara. The event was well attended and there were positive and honest conversations about Kiara, the work carried out with her. One of the difficult conversations the change in her, from the time she left university until the incident in 2022. The subsequent escalation in Kiara's mental health and suicide ideation was concerning from those who had been involved with her when she was in care.

3.6.3. The discussions focused on multi-agency practice issues, cultural competence and overall pressures in the mental health and social care systems. The professionals raised concerns about specific issues that were followed up for further additional information. Two of these issues were: the engagement with the GP and whether Kiara had been sexually abused in school as a child. These are explored in the body of the report. A follow up Independent Management Review was requested from Children's Social Care about what was known about the sexual abuse when Kiara was a child and whether there was any LADO follow up.

3.6.4. The fourth step in the methodology was to gather information about Kiara's lived experience. Throughout the course of this review, the Chair of the LSAB, Board manager, Board lead, the panel and the reviewer were regularly updated on Kiara's wellbeing and the progress of her treatment. They were informed about how she was in the hospital and what work needed to be carried out to support her. At all times, there was assurance that Kiara was receiving appropriate treatment to meet her needs.

3.6.5. The chair of the review panel, panel members and the reviewer were very keen to engage with Kiara to her views and lived experience to enhance the review. There was an agreed delay in the production of the review to give her time to engage with the process. The initial feedback was that she was keen to become involved and wanted to make a difference to others through her own experiences. This is a positive person-centred approach, taken by LSAB, in ensuring that the review is focussed on the needs of the adult being reviewed as well as learning from what happened to them.

3.6.6. Kiara's medical team carried out due diligence to ensure that she was well enough to engage in the review and have a discussion with the Chair of the LSAB and the reviewer. This discussion was primarily led by Kiara and whatever information she wanted to share about her journey. Any relevant and appropriate information from this discussion has been included in the body of this review.

3.7. Involvement of family

3.7.1. As Kiara has been involved in the review, the Review Panel agreed that it was not necessary to meet with the wider family, the reason for this is that there are some complex family issues and dynamics, and it was agreed that these were best reflected by Kiara's own voice.

3.8. The following organisations are involved in this review.

- **Bedfordshire Hospitals NHS Trust**
- **Bedfordshire Police**
- **Bedfordshire, Luton and Milton Keynes ICB -** who commission GP services.
- **East London NHS Foundation Trust** (ELFT) provides a wide range of mental health, community health, primary care, wellbeing, and inpatient services to young people, the ELFT Mental Health Team has been particularly active in this review.
- **East of England Ambulance Service**
- **Luton Borough Council Adult Social Care**
- **Luton Borough Council Children's Social Care**
- **Luton Borough Council Safeguarding in Education**
- **Luton Borough Council Housing**

4. Highlights - Areas of good practice.

4.1. The review has identified some areas of good practice in particular:

- Working together between the ELFT case worker and the Transport Police to identify Kiara if she were to attempt to take her own life at the train station.
- The ELFT worker had a good relationship with Kiara and Kiara trusted her. This was verified when Kiara met with the Chair of LSAB and the reviewer.
- The Ambulance service made safeguarding referrals when they were called to attend to Kiara following an emergency medical incident.
- While in hospital, Kiara was supported with mental and physical health when she harmed herself. There was an immediate response to a safeguarding issue when she faced sexual harm in hospital.
- The school that Kiara worked in took a special interest in supporting her and made referrals to relevant agencies when Kiara needed support. In addition, the school were insightful when Kiara's mental health was deteriorating and provided her with practical support.
- Kiara received support from the Care Leaver Team who championed her and her achievements. Kiara had a good relationship with her Personal Adviser from the Care Leaver Service.
- Good practice was noted from Police when Kiara was allocated a Police Officer to provide her with support when she was experiencing Honour Based Violence from the Honour Based Violence Department.

- Police made appropriate safeguarding alerts; one alert was received into CMHT on 9th June 2022.
- There are other examples of good practice, and these have been covered in the body of the review.

5. LSAB, and Reviewer's Background

5.1. The Luton Safeguarding Adult Board.

5.1.1. The reviewer is very grateful to the Luton Safeguarding Adult Board Independent Chair, Strategic Business Manager and Development & Improvement Officer for their guidance throughout this review, their insight and understanding of the wider practice issues relating to adult social care in Luton. They demonstrated considerable commitment to ensuring that the review processes were robust, and that Kiara remained at central to the review. They worked with the reviewer to drill down to every detail to maximise learning, engage with Kiara and extend timescales when required.

5.1.2. Panel members and practitioners involved and consulted for this review have provided professional, honest, and fair assessments of their work with Kiara. Where necessary and appropriate, professionals have been available to discuss key areas of learning from their agency perspective in addition to panel meetings and other formal processes.

5.1.3. The Luton Safeguarding Adult Board is represented by key organisations in Luton. These organisations have been involved in the panel meetings and practitioner events in this SAR.

5.2. The Reviewer

5.2.1. The multi-agency panel commissioned an independent reviewer to complete the report – Kanchan Jadeja - an independent social care consultant. She has authored Safeguarding Adult Reviews and Local Safeguarding Practice Reviews.

5.2.2. She is currently a reviewer for the National Child Safeguarding Practice Review (Department of Education). She is a Department of Education approved Improvement Adviser for Local Authorities in Children's Social Care. She is an LGA Peer Reviewer and Safeguarding Improvement Consultant.

5.2.3. Kanchan is a qualified social worker and at various points in her career worked at leadership and improvement roles in Local Authorities and regional government. She has expertise in safeguarding children and adults. She has worked in a Whitehall Government Department, leading on youth policy and safeguarding (now - Department of Education).

5.2.4. She has contributed to safeguarding work in the voluntary sector. She was the chair (and later President) of the National Council of Voluntary Youth

Service and is currently the safeguarding trustee lead for LEAP, a National Youth charity.

6. Background to Kiara

6.1. Kiara was first known to services from birth 1995 and through to 2017 and was open to Luton Children's Social Care. She was subject to two child protection plans and was placed on a Full Care Order in 2001. Kiara spent time in care between her maternal family and foster carers. From birth Kiara had experienced childhood neglect and abuse. Kiara has two siblings whose records were not accessed for this review.

6.2. There is a good commentary of how children's social care worked with Kiara as a child and young person. Kiara was placed with her family when in the care of the local authority. This happened without appropriate risk assessments and safety plans in place. The service recognises this and reports that practice has changed since then.

6.3. Kiara's school reports and Child Looked After Reviews report a young girl who was doing well at school, both academically and socially. She had good relationships with her mother and siblings and the others she lived with in her placement. She is described as happy and sociable. This is very different to the period when Kiara presented with Complex PTSD, mental health needs, self-harm, and suicide ideation. While at school, it was reported that Kiara had been sexually abused, this was followed up as part of this review by the Local Authority Designated Officer (LADO) as historical allegations of sexual abuse. Following their investigations it was agreed that no further action was required.

When the Chair of LSAB and the reviewer met with Kiara, she told them that when she was staying with family members, she was mistreated and that social workers had not spoken to her alone or asked her and her siblings about their care. She reported that this had a significant impact on her when she was a child and as an adult.

6.4. In May 2013, there were two reported incidents of sexual abuse towards Kiara by her uncle. Kiara later retracted this, and the social worker's assessment of these incidents was that she was at 'low level of risk' of sexual abuse. There is no evidence that there was work carried out with Kiara following these allegations. The review considers this in findings below in more detail. This, and the pattern of Kiara being placed with family members who may have harmed her, gives an insight why as an adult Kiara's did not always trust professionals to support her.

6.5. It is perhaps for this reason that Kiara only wanted to work with certain professionals whom she felt comfortable with and was reluctant to attend appointments and ask for support from professionals or agencies she did not know well. She was very keen to work only with those professionals she felt safe with. The findings sections consider the reasons why later in her young adult life,

Kiara would rather sleep in the car then go to the authorities for housing support or go back to her family home.

6.6. Kiara graduated from university in 2014. Kiara had continued contact with the care leaver service, she saw her P.A when she was 18 years old and had last contact at 21 years of age in 2016.

6.7. In her early adulthood, there was no indication of the vulnerabilities and risks that Kiara presented with later in her 20's. Between 2016 and 2019 there was little engagement by services with Kiara.

6.8. The question for the review is what happened in Kiara's life at that time that led her the significant deterioration in her mental health which presented as self-harm and suicide ideation and attempts.

6.9. In 2019 and 2020, there was considerable contact between the care leaver service and Kiara as her mental health deteriorated, she had taken an overdose in 2019.

6.10. In March 2020, Kiara was diagnosed with Complexed Post Traumatic Stress Disorder and EUPD – Emotional Unstable Personality Disorder. She was assessed to have Post Traumatic Stress disorder potentially because of the level of trauma she had experienced in her life. The psychiatric assessed that Kiara's condition was not based on any one incident but a life of trauma which presented as self-harm and suicide ideation.

6.11. The school she worked in made a referral to confirm that she was having 'on going stresses' with her family and she had a restraining order in place. Kiara reported that she was attacked by her uncle and grandmother and police allocated a police officer from the honour-based violence department. The records indicate that Kiara found this supportive and is identified as an area of good practice. This is particularly true for someone like Kiara who was suffering from trauma and PTSD and needed one to one support.

6.12. During this time, Kiara did not feel safe in her home and was living in her car, she was homeless, had stopped therapy and was not taking her prescribed medication. This is concerning as her mental health had deteriorated and curiosity could have been exercised about why she was living in her car, not taking medication and what support she needed, both medical and practical.

6.13. On 23rd March 2020, Kiara had thought seriously about taking her own life. As well as the diagnosis of Complex PTSD, Kiara was diagnosed with severe adjustment disorder superimposed depressive episode and it was recommended that she had treatment with anti-depressants.

6.14. Kiara told professionals that she was experiencing pressure to marry a man she did not want to marry. Mental health services referred Kiara to Karma Nirvana, a voluntary charity organisation supporting Asian women with culturally appropriate support for many areas including forced marriage. This referral is reviewed in the Findings Section.

6.15. In June 2020, Kiara was receiving support from the school psychiatrist, and he noted that no mental health worker was allocated to Kiara– this was due to a national shortage of staff, and they were recruiting to address this. Kiara was not taking her tablets and her colleague was concerned that she was not going to be seen for three months. This will have had a significant impact on Kiara.

6.16. At this time, Kiara was very vulnerable, and a Mental Capacity Assessment should have been carried out, a mental health worker should have been allocated. The level of suicide ideation was not fully known, but the response to Kiara's needs, risks and circumstances was not proportionate to her requirements at the time. If a section 42 was open, there would have been discussions between CMHT and LBC to promote a more joined up approach including sharing of information and a coordinated plan to meet her needs. It was unfortunate that this did not happen.

6.17. Kiara had moved out of the family home and a non-molestation order was in place against family members – her grandmother and uncle. This was breached and a restraining order was also breached as her family found out where she was living and harassed her and attempted to attack her.

6.18. Between – July and September 2020, Kiara was allocated a Mental health worker, but professionals did not know where Kiara was staying. Kiara did not trust agencies to provide them with her address. Agencies working with her at the time, believed that she was safely housed. She was working with a mental health worker, and it is likely that the worker was not aware that she did not have a safe place to live. There should have been further probing and a more holistic approach to where Kiara was staying and whether she was living in a safe space.

6.19. Between October and December 2020, Kiara's mental health continued to deteriorate, however she said that she does not need CC (Mental Health Care Coordinator) but wanted psychological intervention. She was reporting signs and symptoms of PTSD flashbacks, she was hypervigilant, had poor sleep and was not eating. She was clearly very vulnerable at this time.

6.20. This was at a time when there were Covid restrictions and services were under pressure from the demand for health and social care services. However, contact with Kiara could have taken place face to face as a vulnerable adult. In 2020, Kiara was very vulnerable and there were 9 contacts recorded with her in hospital records. These admissions into hospital were for self-harm and taking an overdose. Each time she was admitted hospital protocols were followed and safeguarding referrals were completed.

6.21. Between January 2021 and March 2021, the school where Kiara worked reported, to Police, that Kiara was feeling suicidal and did not want to live. Kiara was missing from the school, when police attended her home, they found her with a noose around her neck and evidence of an overdose.

6.22. Kiara had left her job which was very important to her. In a meeting with the Chair of the LSAB and the reviewer, Kiara said that she believed that family members had wanted her to leave the job so that she could get married and conform to their expectations of her.

6.23. The Police and CMHT duty worker reported that Kiara was conscious when they attended, but she was not communicating. Kiara was placed on a Section 2 of the Mental Health Act 1983 [10]. Kiara was in hospital and her mental health care level was initially stepped down by the CMHT, indicating the underlying fragility of Kiara's mental health needs at the time. However, while in hospital, Kiara's needs and risks escalated and she attempted to jump from a window. As a result of this action, Kiara was rated as high-risk missing person, and she was also rated as at high risk of suicide.

6.24. Kiara was writing poetry and using her diary at this time. She was receiving psychology support and OT input. She was receiving 1:1 staffing support because of risk of suicide. Her eating was reported to have improved.

6.25. Kiara attempted to leave the hospital with her friend, and she said that she was feeling well but she could hear voices in her head telling her to harm herself. She remained on Section 3 of the mental health act 1983[11]. The escalation to Section 3 of the Mental Health due to the increased risk of self-harm, suicide ideation and going missing from hospital.

6.26. Between April 2021 – September 2021, Kiara was in hospital on Section 3 [12] Mental Health Act; during her time in hospital, Kiara made further attempts to take her own life. She was concerned about family members knowing where she was and attacking her. Although she was severely distressed at the time, the fears from her family remained foremost in her mind.

6.27. Kiara was discharged in June 2021 and then detained again in the ward in July 2021 because of the high risk of suicide. From October and December 2021, Kiara's mental health improved, and she was assessed to be discharged from hospital.

6.28. In January 2022 to March 2022, Kiara told her worker that she was hearing voices and professionals concluded that clearly her mental health had deteriorated. The worker had built a trusting relationship with Kiara. Kiara was sleeping in her car and stockpiling medication as she had previously done so previously. This could have been a trigger to escalate her needs.

6.29. Further exploration could have been carried out with the worker about the severity of Kiara's needs, sharing information and devising a robust multiagency plan to safeguard her.

6.30. There was a referral to the crisis team, but Kiara did not feel able to access it. No other alternative appears to have been offered, or further curiosity demonstrated after she declined the crisis team support.

6.31. Police were involved a week later when they were alerted by her psychologist work colleague that Kiara had left work early and that her risks had escalated.

[10] Section 2 of Mental Health Act 1983. (As amended 2007)
[11] Section 2 of Mental Health Act 1983. (As amended 2007)
[12] Section 3 of Mental Health Act 1983. (As amended 2007)

Kiara was placed under Section 136 of the Mental Health Act and taken to Luton and Dunstable Hospital as a place of safety.

6.32. In February 2022, Kiara was found to have taken 14 Clozapine tablets indicating a severity of dosage, she was placed on Section 2 of Mental Health Act 1983 (as amended 2007) for over ten days. After this time, she was discharged to the crisis team.

6.33. Kiara continued to feel ambivalent about her relationship with her family members and at times, she was very distressed about engaging with them. Kiara said that family members contacting her was triggering her suicide ideation and trauma. This is further explored in Finding 3 on suicide ideation. Again, Kiara was discharged to crisis team, and she was appropriately 'rated as red risk'. Kiara's employment appeared to be fragile.

6.34. In March 2022, following concerning self-harming, Kiara was very vulnerable it was agreed that she has an informal stay in hospital. Between April and June 2022, Kiara reported that "she is doing really well". She was not taking her medication; however, she was living in her car and therefore homeless.

6.35. Her mother made considerable strides to get Kiara her medication, but she did not receive it as the prescription had not been sent to the GP. This was a missed opportunity as the medication was an important part of managing Kiara's severe mental health within the community.

6.36. As Kiara had said 'no' to the crisis team, she was said to have refused engagement from the team. It is not clear what assertive and robust alternatives were put in place to safeguard Kiara.

6.37. In May 2022, a Multidisciplinary Team (MDT) meeting was held to consider a risk and safety plan. Kiara was seen at an outpatient's appointment Consultant Psychiatrist, and she told the Psychiatrist that she was feeling suicidal but could not share this with her mother. The mental health service recognised that Kiara's relationship with her mother was not one where she could share her views on self-harm and suicide ideation.

6.38. In June 2022 Kiara's suicide ideation became significantly more severe as she went to Luton train station with a view to taking her own life, British Transport Police were involved. Kiara had self-harmed and said she would be taking her own life. She was discharged by the crisis team to CMHT. Sadly, Kiara was physically harmed after a significant event of self-harm and suicide ideation.

6.39. Since this attempt at taking her own life, Kiara has been in hospital with support from her medical team. At this time, there were at least three attempts of Kiara taking her own life while in hospital and when she was in the community.

6.40. However, there are also records of Kiara making progress and wanting to 'get better' and sharing her plans for her future. Kiara is reported to have a great sense of humour and entertains others when she is in a good place while in hospital.

6.41. Kiara is supported by her mother and family. It is not clear whether a risk assessment been carried out about Kiara's complex relationship with her family which at times she has reported triggers suicidal thoughts and feelings.

6.42. When the Chair of the LSAB and the reviewer met with Kiara, she said that her relationship with her mother is positive and that she has considerable sympathy for her mother's vulnerabilities.

7. The Review Findings

This section outlines the findings of this review. Each finding ends with a brief list of issues and recommendations proposed for the board to consider. The LSAB could re-shape the themes from the issues and recommendations for an action plan based on what happened to Kiara.

7.1. The process of identifying the findings

The learning for this review is drawn on from the information provided by:

- agencies to the initial Rapid Review,
- further detailed chronologies as well as requests for additional information and more detailed analysis from parts of the partnership,
- the meeting between the Kiara, the Chair of the Safeguarding LSAB and the reviewer provided an insight into her experiences of professionals working with her and her own understanding about her journey through the services.

In piecing together, the findings for this review, a nuanced approach has been taken to identify and analyse the information. The reviewer and the LSAB have worked together to gather information, practitioner and manager perspectives into decision making and the wider systemic issues for this review.

This section of the report is divided into four key findings which brings together the key lines of enquiry, from the Terms of Reference first agreed with the LSAB. The key findings identified are intersectionality, multiple vulnerabilities, and cultural competence and how professionals and agencies work with these themes.

7.2. Findings Headline Chart:

1.	**A lack of adequate understanding of Kiara's voice, lived experience and complexity of need: Kiara's voice and lived experience was not fully accounted for in the assessment, planning and intervention by the professionals despite her presentation.**
2.	**The assessment and interventions with Kiara were episodic and incident-based responses. There was insufficient and disproportionate work carried out with Kiara in response to the high level of her need.**

	That is the lack of analysis of her needs including PTSD, depression, and suicide ideation and the acceptance of Kiara saying that she is well without any professional probing of those statements.
3.	**Professionals were aware of the level of suicide ideation and risk she was at, but there were episodic responses to suicide ideation. There is insufficient evidence that the services were confident and assertive in their response to suicide ideation and self-harm throughout the timescale and scope of this review.**
4.	**There was insufficient evidence of a coordinated and determined response to the multiple vulnerabilities, forced marriage, honour-based violence, physical assault, breach of non-molestation order, care experience young person, childhood trauma and homelessness.**

7.3. Finding 1: A lack of adequate understanding of Kiara's voice:

A lack of adequate understanding of Kiara's voice, lived experience and complexity of need: Kiara's voice and lived experience was not fully accounted for in the assessment, planning and intervention by the professionals despite her presentation.

7.4. How did the finding manifest in the case?

i. Kiara is described as a *"chatty lovely girl in school reports"* [13] . She is a young woman well known to services from childhood when she was in the care of the Local Authority because of concerns about neglect and abuse towards her.

ii. As Kiara's engagement with services in Luton goes back to her childhood, the expectation would be that agencies would be aware of her needs, risks, and circumstances.

iii. Allied to that it should be reasonable expectation that her voice and lived experience is known between agencies and this is shared appropriately when assessing her needs.

iv. Information from Children's Social Care Independent Management Review provides an insight into the reasons for coming into the care of the Local Authority. Information available suggests that Kiara was subject to childhood trauma, abuse, and neglect.

v. This is a pattern that is found when women have experienced sustained abuse and neglect. *For the vast majority, experience of disadvantage and trauma could be traced back to childhood, with accounts of sexual abuse, physical abuse, emotional abuse, neglect, and/or so-called family dysfunction looming large in almost all women's narratives.*[14] This childhood trauma is likely to have severely impacted on Kiara's mental health and the origins of her PTSD.

[13] Children's Social Care report.

[14] Hard Edges The reality for women affected by severe and multiple disadvantages. Sarah Johnsen and Janice Blekinsopp. January 2024. University of Edinburgh

vi. As a Child in Care, Kiara received support from the care leaver service. Until 2016, Kiara was reported to be making a successful transition into adulthood, having been to university and starting work as a teacher. Between 2016- 2019 there was no involvement with Kiara.

vii. Little is known about what happened to Kiara in this intervening period. However, in 2019, the situation changed, and her circumstances deteriorated, with agencies actively becoming involved in supporting her. Kiara's mental health was poor, she was self-harming and reported to be experiencing suicide ideation.

viii. Records highlight the engagement between Kiara and services and there are numerous occasions when she reported that "*she is fine"* and that she does not need support nor engagement of services. However, what is evidenced in agency reports is that she was not '*fine*', and she was experiencing a significant deterioration in her mental health, alongside suicide ideation and self-harm.

ix. In June 2022, after Kiara was found to have harmed herself, when asked how she was she said. "*She is ok 10:10".*[15] Further records indicate that she was not *'ok'*. In listening to her voice, professionals needed to reflect on her past, understand what life was like for now (her lived experience) and draw that together to gain a clear picture of what was happening to Kiara and the support she needed at that time.

x. When the Chair of the LSAB and the reviewer met with Kiara, she was very generous and said that she could have accessed more support from professionals, but she did not. She also said that she found it difficult to ask for help as she felt that she should be able to cope. She often said she was 'ok' although she was not.

xi. This raises the question about how professionals can move beyond accepting what an adult is saying. It also requires professionals to review the person's needs, risks, and circumstances far more broadly and beyond what the vulnerable adult tells them. Kiara could have benefited from having an advocate who could support her to voice her needs, risks, and circumstances.

xii. There was some good practice in the way that some professionals worked with Kiara, listened to her voice, and lived experience. In particular, she had a good relationship with one of the mental health workers. However, this was not consistent in work with Kiara across all professionals and agencies.

xiii. There is little evidence of professionals considering lived experience and asking questions that are beyond her surface presentation and self-reporting.

xiv. There was a long period of time when Kiara was homeless. Prior to becoming homeless, Kiara was physically assaulted by her grandmother and uncle. She

[15] Multi Agency Chronology provided for this review.

went to live with her mother, but family members found her there and abused her there.

xv. She then went to live in her car for many days. There is little evidence of acknowledging that Kiara was living in her car. There is insufficient evidence to indicate that there were assertive attempts made to find her a suitable home where she felt safe. Kiara had told professionals that she felt safe in her car but not at her family home. When she did move, she did not share her address with professionals or her family.

xvi. When the Chair of the LSAB and the reviewer met with Kiara she said that she did not have much trust of professionals. The fact that she did not share her address with professionals suggests that this was one occasion when she did not trust professionals.

xvii. This was a good opportunity for professionals to reach out to Kiara by phone, to build trust, because she found it difficult to trust them. Furthermore, when living in the flat, Kiara experienced racism and therefore moved back to the family home. It is unfortunate that she did not receive support to move somewhere that she would feel safe and where she did not face racism.

xviii. Kiara said that she was aware that authorities provide housing support, but she did not think she would be entitled to any support because she was working. When asked whether she was aware of women's refuge and other culturally appropriate safe spaces that she could have accessed, her response was the same. That is, that she did not believe that she was entitled to these services as a professional with a job. This suggests that professionals did not discuss the potential housing options or choices with her.

xix. An area of 'protective factor' was Kiara's job. She shared with professionals that it was her 'happy place'. However, Kiara had to leave the job because of the deterioration in her mental health. Prior to this, it is unclear whether any work was carried out with Kiara about what could be done to help her maintain a job she loved and was one of the few assets she had.

xx. There is little known about this as one of the most important areas for her. Kiara told the Chair of LSAB and the reviewer that she loved her job, and this reinforces how important it was to her.

xxi. At one level some may argue that professionals were working in a manner that is in keeping with Making Safeguarding Personal, but from the evidence presented at best it was only at a superficial level.

xxii. Whilst some were able to engage well, there was no evidence to suggest she was being supported to make informed choices, with clear information being provided about the potential support that could be available to her.

7.5. Issues of cultural competence: Intersectionality and multiple vulnerabilities with relevance in this finding?

i. ‘Culturally appropriate care (also called 'culturally competent care') *is being sensitive to people's cultural identity or heritage. It means being alert and responsive to beliefs or conventions that might be determined by cultural heritage’* [16]. It includes the confidence to understand practice and to respond to the needs of vulnerable adults within a culturally competence approach.

ii. In relation to Finding 1, there is little in the way of a narrative about Kiara’s cultural background, bar some knowledge about Kiara’s family’s country of origin, her religion. However, this is not integrated into the assessment of her need and how it impacted on her needs, risks, and circumstances.

iii. For example, how did she experience her cultural background? What did it mean to her, did she see her culture positively or was she uncomfortable given the backdrop of the abuse she had experienced within her family.

iv. Was faith an asset, did she see herself as part of the community, or did she feel “outcast/excluded?” To assess well, professionals needed to understand the impact of how issues of gender, faith, and community affected her. It is not enough to say, “this person is of this faith or from this community”. To assess well, one needs to consider the issues of intersectionality, which has been defined as:

v. *“The concept of intersectionality describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class, and other forms of discrimination “intersect” to create a unique dynamic and affections”*[17] To do so requires a clear capturing of the voice and what life is like for the person.

vi. This review findings indicate that a systemic approach to the voice and lived experience of global majority and cultural competence have yet to be adopted and embedded in practice.

vii. The co-learning from the practitioner event echoed the importance of ‘normalising’ cultural competence in understanding the lived experience of adults with safeguarding needs.

viii. This requires a move away from practitioners seeing cultural competence as a specialist area, to one that it is understood to be part of what is person centred practice, a concept understood, accepted, and generally applied across all disciplines.

ix. This comes out clearly in Kiara’s case in terms of how her allegations of forced marriage and sexual abuse were managed. Kiara has shared with professionals that in 2013 a man from her home country was brought to the UK for her to marry and she did not want to marry him. In reviewing Kiara’s records, forced marriage has been featured a few times as the family’s response to her

[16] The Quality Care Commission’s definition of cultural competence.

[17] NHS England.

needs and risks, without the understanding of this as a safeguarding issue, professionals could struggle to provide appropriate responses to her needs.

x. When the Chair of the LSAB and the reviewer met with Kiara, she told them that she felt the pressure of forced marriage and was mistreated by the aunt when she was a child and when she was an adult, the aunt wanted to force her into a marriage.

xi. Also in 2013, there was a Lucy Faithful report commissioned after Kiara had said that she was sexually harmed by an uncle. She later retracted this and the social worker notes that she is at low risk of sexual abuse.

xii. There are a few occasions when Kiara has reported that she is the victim of sexual abuse and on one occasion, a victim of rape. These were followed up at the time and the outcome was no further action. That is either because of evidence or because Kiara did not want to pursue it any further. However, work could have been offered and carried out with Kiara on sexual harm, abuse, and rape, and there is no evidence that there was work carried out with her in respect of sexual harm.

xiii. Considering sexual abuse and rape from Kiara's cultural lens and viewing her experience through intersectionality provides some insight into why she may have retracted her statements. This is especially true in relation to two incidents when Kiara reported she had been sexually assaulted.

xiv. One while she was in a faith school and the other when she reported that the perpetrator being a family member. The concept of honour or 'dishonour' that a disclosure brings to the family or community faith could be considered as a significant reason for Kiara in taking no further action/ retracting against anyone who had sexually abused her.

xv. Therefore, this aspect of her lived experience should be viewed with the lens of cultural competence and intersectionality. Although there is sensitivity of making allegations of sexual abuse in Kiara's cultural context, this would put pressure on her to retract her statements.

xvi. The same arguments of honour and dishonour apply to other forms of abuse. For example, the physical harm that Kiara experienced as an adult.

7.6. What is the significance of this finding to the functioning of the safeguarding system?

(What does this review tell us about the involvement of individual agency and multi-agency practice).

i. In analysing the learning for the wider system on how Kiara's voice and lived experience, the questions are: how do processes, policies and procedures provide professionals with the framework for engagement, voice and lived experience of adults with safeguarding needs? A more systematic approach

needs to be taken to understand the voice and lived experience of women from Kiara's cultural background.

ii. Luton Safeguarding Adult Board has carried out some work on cultural competence prior to Covid for systemically implementing cultural competence across the Safeguarding partnership.

iii. This work stemmed from a previous Usman SCR/SAR where two adult women of South Asian background formed part of the review. The learning from this review (Kiara) could be amalgamated with the findings of the previous review to design a more proactive approach to system change for work with South Asian women.

iv. Professionals need to enable vulnerable adults with mental health needs to 'voice' their views wishes and feelings, however, the responses require an informed analysis which considers if there are issues of coercion, and the impact of trauma.

v. These need to be clearly reflected in the assessment, care planning and interventions. For example, when Kiara said she was 'ok' and 'fine' she was not. Use of legislation and processes could have further investigated this.

vi. Better understanding is needed about how Kiara's cultural background impacted on her being able to disclose and follow through on experiencing all forms of abuse and what part 'honour' and dishonour plays in her reporting abuse and the justification of abuse by those family members who abused her.

vii. In relation to Kiara's voice and lived experience, professionals she worked with may have provided her with improved services if there were more assertive responses when she said that "*she was fine".*

viii. In a meeting with the Chair of the LSAB and the reviewer, she said that she told professionals that she was fine because she did not know what she could ask for and it was shorthand for saying "*I don't know".* 'It is often unrealistic to expect adults who are in crisis or high level of need to articulate their needs, risks, and circumstances.

Finding 1

A lack of adequate understanding of Kiara's voice, lived experience and complexity of need: Kiara's voice and lived experience was not fully accounted for in the assessment, planning and intervention by the professionals despite her presentation.

Recommendation for the Board

The review has considered impact of monocultural practice when responding to the needs of a vulnerable young woman of South Asian background. Her voice and lived experience have been considered through a lens that may not 'see' her or understand and appreciate her lived experience.

Recommendation 1

Board partners should provide assurance to the Board about:

a) How they support staff to capture the voice of and lived experience (especially women from global majority backgrounds).

b) How they ensure it is consistently captured for all adults they are working with.

Recommendation 2

The LSAB needs to be assured that organisations are making concerted attempts to embed cultural competence as a facet of standard practice. To that end, Board partners need to provide assurance of how:

a) Cultural competence has been embedded as part of standard training for all front facing staff.

b) How issues of diversity and intersectionality are consistently addressed in assessment, care planning and interventions.

c) The Board should undertake an audit of cases annually to assess the progress on this recommendation.

7.7. Finding 2: The assessment and interventions with Kiara

The assessment and interventions with Kiara were episodic and incident-based responses. There was insufficient and disproportionate work carried out with Kiara in response to the high level of her need. That is the lack of analysis of her needs, including PTSD, depression, and suicide ideation and the acceptance of Kiara saying that she is well without any professional probing of those statements.

7.8. How did the finding manifest in the case?

i. Since 2019, when Kiara presented with high level of psychological distress, work with Kiara followed a pattern of agency involvement in the community and in hospital. In March 2020, A Section 42 was opened and there was a discussion with Kiara about her needs. When Kiara was told it is to support her with her risks, she said "*what risks*"?

ii. This indicates that she was not aware of the high level of risk that she was assessed as having at the time. When the Chair of the LSAB and the reviewer met with Kiara, she said that she was not aware of her risks because she was not in a place where she could see the risks.

iii. At all times in working with Kiara, she was assessed as having capacity and on one occasion she was reported to be 'sounding normal'. The Section 42 was

closed. Within two weeks, it was noted that Section 42 could continue, and the level of Kiara's needs, risks and circumstances was raised to 'enhanced level'.

iv. It is likely that Kiara presented as 'normal' when spoken to by professionals. She is articulate and intelligent young woman. However, in many instances, she was not well and had a high level of need. In work with Kiara professionals found that another 'incident occurred' which was high level and therefore the level of risk and intervention was upgraded.

v. In one instance, a safety plan (who to call and what to do if she suddenly experienced further psychological distress) was put in place but not shared with Kiara, or a copy left with her. Hence it was ineffective as she did not have the information to be able to contact someone if she was distressed.

vi. The episodic nature of work with Kiara is evidenced in the involvement of the school psychology work colleague who became involved when Kiara presented as particularly distressed or at risk of suicide ideation. For example, on 3rd February 2021 the school psychiatrist made contact to inform that they had concerns about Kiara.

vii. Police became involved and Kiara was found in her home with a noose around her neck. At this time, she was made subject to Section 2 of Mental Health Act 1983[18], later in the month, she was made subject of Section 3 of Mental Health Act 1983[19].

viii. Prior to this escalation, work was carried out with Kiara, but it does not appear to be proportionate to her needs and particularly her risks. It is difficult to see any professional or agency assessing her needs and having an understanding about any patterns of need.

ix. For example, mistrust of professionals, difficulty in communication her needs, fleeing from her family and afraid to ask for support to live away from them. This approach may have enabled professionals to have an overall plan for Kiara in response to her increasingly escalating mental health and suicide ideation.

x. In February 2022, the school psychology colleague raised concerns that Kiara had left work early, when contacted by her mental health worker, she said she was in her car and had a bag of tablets. Whilst mental health services were considering a mental health assessment by a doctor, the police placed Kiara under Section 136 of Mental Health Act 1983[20].

xi. In March 2022, Kiara was informally admitted to hospital. The use of Mental Health Act 1983 (amended 2007) on several occasions was a response to Kiara's highly escalating mental health. Once a crisis episode and the

[18] Section 2 of Mental Health Act 1983 pertains to the process of detaining individuals for assessment and potential treatment for mental health for up to 28 days.
[19] Section of Mental Health Act 1983 pertains to the process of detaining individuals for assessment and potential treatment for mental health for up to 6 months initially.
[20] Section 136 of Mental Health Act 1983 provides Police with powers to take individuals in a public place experiencing a mental health crisis to a place of safety for assessment.

immediate risk of harm appeared to have receded, she was discharged into the community.

xii. There was support put in place, however, this support did not appear to be holistic and informed by a detailed review and assessment of her needs, risks, and circumstances. Whilst there were clear responses to a crisis incident, but for obvious reasons this did not resolve any of the underlying issues.

xiii. Practice could be improved by robust risk assessments, followed through with a plan that is informed by her lived experience and is contextualised by an understanding her cultural context, family situation and relationships. In doing so there was an opportunity to have a better safety plan involving those around her who could keep her safe.

7.9. Issues of cultural competence and intersectionality with relevance in this finding

i. In reviewing the episodic and incident-based response to Kiara's needs, the cultural competence layer is crucial and significant. The questions arise about the underlying reasons why professionals did or did not have culturally informed discussions about Kiara's relationship with her family, especially her mother.

ii. The impact of the issues around shame, guilt which are sometimes linked to incidents within the family and particularly the concept of honour and dishonour needed to be understood if one was going to clearly understand Kiara's needs and how she responds to the risks.

iii. When Kiara was attacked by her family members, there was good practice in identifying the attack as honour-based violence and a police officer was assigned to her to provide her with support. Other agencies referred to Kiara's background and culture intermittently, but this was not consistent.

iv. The question is about how comfortable professionals feel able to make informed culturally appropriate decisions, act in an inclusive culturally competent manner in the moment when they are working with adults who experience multiple risks and vulnerabilities.

v. It is concerning that the responses to Kiara's needs were not escalated in the community when she was moving from family home to living away, and back to the family home. She told professionals that she was sleeping in her car in April 2022, she said she cannot go home because she does not feel safe, and she does not want her mother to know that she is sleeping in the car.

vi. How confident were professionals at being culturally curious about why she felt unsafe at home? What other options did she have? Were any assumptions made that she would be taken care of by her family?

vii. Luton Safeguarding Adult Board has previously commissioned work on cultural competence and supporting professionals to be curious about the impact of diversity in adult safeguarding work. This ties in with the work of the Bedford

Safeguarding Children Partnership which highlights the importance of knowing about and working with cultural diversity with children and families and similar principles apply to the adult safeguarding in Luton.

viii. As with issues of cultural competence in Finding 1, a question we need to ask is what lies at the heart of it. Is it a reluctance, is it a lack of confidence or is it a lack of competence?

7.10. What is the significance of this finding to the functioning of the safeguarding system?

i. Alongside the cultural competence, the management of incident raises the issue of what systems and processes are there in place in Luton for adults experiencing suicide.

ii. LSAB will want to ensure that there are effective processes and procedures in place in Luton for adults experiencing suicide ideation. Luton safeguarding partners should consider developing professional understanding and confidence in working with suicide ideation, especially in cultural competence and suicide ideation.

iii. Kiara presented with multiple needs as reviewed in Finding 4, the partners and professionals within Luton will need to review and study how patterns of self-harm, suicide ideation present in vulnerable adults to safeguard them.

iv. The Board may want to share learning so there is a common understanding across the partnership on how best to manage suicide ideation. For example, a common template for safety planning.

v. A second issue is the assessment of mental capacity. Kiara was assessed to have capacity as she was appearing to '*sound normal'*. This could be because her profession requires her to be a good communicator. Soon after it was believed that Kiara sounds normal, she was made subject to Mental Health Act 1983.

vi. Therefore, consideration could have been given to Mental Capacity Act at times when Kiara was in the community and presenting with significant mental health needs and at risk to herself.

vii. Clearly the Mental Capacity Act quite rightly requires that professionals assume capacity and should be carefully exercised. Equally, professionals should be confident to make use of it when necessary and often this can be followed up once a pattern has been established.

viii. Therefore, Luton partnership will want to promote practice where practitioners clearly make use of Mental Capacity Act to assess mental health capacity. In addition, it is important that the adult is known well, including effective culturally competent practice.

ix. Questions need to be asked about what triggers the adult at risk. Making use of thorough assessments of the needs, risks, and circumstances of adults at risk. Professionals could enhance the understanding of the cultural context '*seeing the adult at risk in their community and environment'.* This approach would enable practitioners to have a more rounded and holistic view of adults with which they are working.

x. The wider system in Luton has recognised the importance of understanding and responding to suicide ideation in completing an audit on suicide. An audit, which covered the period between 2019 and 2022, was produced by Public Health and Business Intelligence (BI) teams. This is in line with National Guidance[21].

xi. The report emphasises the importance of identifying and working with a specific demographic and the high incidence of suicide amongst males of a particular age. The audit review does not fully cover suicide ideation and cultural competence, and this is an area the service and partnership will want to explore following this SAR and what happened to Kiara. However, it is positive that the report emphasises the impact of mental health needs of suicide ideation.

xii. Further use could be made of opportunities for the system to arrange Multidisciplinary Team Meetings to discuss risk and safety planning which includes all those who are involved in supporting the vulnerable adult.

xiii. For example, her colleague in school had identified a significant risk and raised concerns at crucial times for Kiara. An MDT could have been called to discuss Kiara's vulnerabilities and what processes need to be in place to respond to her needs.

xiv. In Kiara's case, those who were closest to her, knew her well and professionals and agencies could/ should have worked with them to identify and respond to patterns of psychological distress. The psychologist in school was an important professional whose voice could have been better employed by other agencies working with Kiara with her permission.

xv. An incident in January 2022 was particularly concerning where Kiara was stockpiling medication and sleeping in the car, a Multidisciplinary Team Meeting was held.

xvi. There is no further evidence that can be gathered about an MDT meeting being held to discuss the needs, risks and circumstances Kiara was experiencing. The policy framework for calling MDT meetings needs to be better understood and implemented by agencies.

xvii. There may be a need to reinforce good practice in respect of MDT meetings, calling professional meetings and assessing and analysing patterns of risks and

[21] HM Government 2021 Suicide Guidance.

needs in respect of vulnerable adults especially in the context of equality, diversity, and inclusion.

xviii. In May 2022, Kiara's needs and risks escalated, she was found walking on train tracks with a view to taking her own life on train tracks. This was escalated and Police helicopters were called to look. When found, she had appeared to be very distressed and determined to take her own life.

xix. On the following day in May 2022, an MDT meeting was held recording that after any contact with Kiara there should be a risk assessment and safety plan to be developed and put in place.

Finding 2

The assessment and interventions with Kiara were episodic and incident-based responses. There was insufficient and disproportionate work carried out with Kiara in response to the high level of her need. That is the lack of analysis her needs including PTSD, depression, and suicide ideation and the acceptance of Kiara saying that she is well without any professional probing of those statements.

Recommendations and questions for the Board

Recommendation 3

The review has highlighted a need for the local system to develop relevant processes and procedures in response to the needs of adults with multiple vulnerabilities. The partnership will want to consider taking a more joined up and embedded approach to Suicide ideation and prevention across the partnership.

Recommendation 4

Adult Social Care and Health agencies will want to review current training, policy, and procedures in relation to suicide ideation, PTSD, Forced Marriage, and Honour Based Violence and guidance on the appropriate use mental health capacity assessment.

Recommendation 5

Adult Social Care and Health Agencies to review how advocates can be employed when working with adults who are experiencing high level of risk and mental health episodes. Advocates should represent their circumstances, risks, needs, wishes and feelings.

7.11. Finding 3: Professionals were aware of the level of suicide ideation.

Professionals were aware of the level of suicide ideation and the level of risk Kiara was in, but there were episodic responses to suicide ideation. There is insufficient evidence that services were confident and assertive in their understanding of and response to suicide ideation and self-harm throughout the timescale and scope of this review.

7.12. Level of Suicide Ideation and Research

"[22]*Suicide ideation often called suicide thoughts or ideas, is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide. There is no universally accepted consistent definition of suicide ideation*". Suicide and attempt to take one's life is a complex issue that can only be considered and understood in the context of the person's circumstances.

i. Research and practice on suicide ideation suggests that it is difficult to plan work on suicide ideation because [23]"*It is evident that suicide ideation present in a 'waxing and waning manner', so the magnitude and characteristics fluctuate dramatically. It is critically important that professionals recognise that it is a heterogeneous phenomenon".*

ii. For Kiara, suicide ideation was significantly complex with self-neglect, not eating, sleeping and at times sleeping in her car (effectively homeless). Kiara had difficulties with her family and was physically assaulted by family members as an adult. When talking with professionals, Kiara described her feelings of guilt and shame, these are often associated with abuse, especially sexual abuse. Some of their emotions are likely to have been impacted by Kiara's cultural background. Studies have shown that:

iii. "*Cultural risk factors were discussed in most of the studies, including gender inequality, unrealistic expectations set for women, the community grapevine, family honour, forced marriage and being controlled by family members"*[24]

iv. Kiara had experienced childhood abuse and neglect and was reported as a resilient and intelligent young woman. She had achieved a university degree and worked in a school. In 2016, Kiara's mental health began to deteriorate, and in 2019, her mental health needs were severe. The care leaver service professionals noted that they were shocked when they became aware about what had happened to Kiara after leaving care.

v. The Ambulance service reported that in March 2020, she had taken an overdose and was being forced to eat. At this time, she was screaming, crying, and presenting as very distressed. The ambulance service completed a safeguarding referral to Adult Social Care.

vi. In April 2020, the outcome of the MASH enquiry was provision of advice and guidance because Kiara did not want to pursue the matter with her family and moved out instead.

vii. Adults who have experienced abuse and neglect as children, are more likely to experience suicide ideation as adults. A thorough study of suicide ideation

[22] National Library of Medicine. Suicide Ideation B Harmer, S Lee, T Duong, A Saadabadi Jan 2023.

[23] National Library of Medicine. Suicide Ideation B Harmer, S Lee, T Duong, A Saadabadi Jan 2023.

[24] Childhood maltreatment and adult suicidality: a comprehensive systematic review with meta-analysis Ioannis Kiarakis, Emma Gillesie and Maria Panagioti. Cambridge press Jan 2019.

concludes that the risk of suicide ideation increases two/threefold if the adult has experienced childhood abuse or neglect.

viii. *"The most comprehensive systematic review and meta-analysis to date demonstrated that suicidality is a major concern in adults who have experienced core types of childhood maltreatment (e.g. abuse, neglect). A two- to three-fold increased risk for suicide attempts and suicidal ideation was identified in adults who experienced sexual, physical, or emotional abuse as children compared with adults who have not experienced maltreatment during childhood. Adults exposed to sexual abuse and complex abuse in childhood were particularly vulnerable to suicidality.*[25]

ix. At a crucial moment in Kiara's deteriorating mental health, in September 2019, she was not taking her medication, her mother attempted to source the medication and was not successful on several occasions.

x. Kiara's mother raised this issue with many professionals but only managed to get the prescription and medication after significant persistence. It is concerning that this is at a time when she too will be under pressure due to Kiara's poor mental health. Carers should be supported to care for their family members in the community and accessing medication simply and efficiently is an important element in their care.

7.13. How did the finding manifest in the case?

i. In March 2020, Kiara reported to professionals that she was having thoughts about jumping to end her life. Nearly a year later in February 2021, police attended Kiara's home where she was found to have taken an overdose, she was conscious but not communicating. She had a noose around her neck, and she had clearly attempted to take her own life.

ii. Also in February 2021, she was rated as at 'high risk' by medical professionals. She was admitted to ITU, her condition improved over time, and she was discharged to mental health services. She was placed on Section 2 of the Mental Health Act 1983 (as amended in 2007) However, the underlying mental health needs, suicide ideation and self-harm needs were prevalent while in hospital. There was a concern for her life at this time.

iii. Kiara went missing from the inpatient ward via the kitchen. Following an admission to the Emergency ward. A month later, in March 2021, the 28 days of Section 2 Mental Health Act had lapsed. Kiara was reported to have taken another overdose. Kiara was then placed in a psychiatric ward as a Section 3 of Mental Health Act 1983 (as Amended 2007) patient in a secure unit for her safety.

iv. In July 2021, Kiara presented to the emergency department with self-harm and lacerations and was discharged to the mental health ward. In August 2021, Kiara had taken another overdose of medication while in the psychiatric ward.

[25] **Childhood maltreatment and adult suicidality: a comprehensive systematic review with meta-analysis**
Ioannis Kiarakis, Emma Louise Gillespie and Maria Panagioti Cambridge press Jan 2019.

During this period, Kiara was presenting with suicide ideation and there were concerns about her missing away from home.

v. In February 2022, Kiara told her friend that she had taken an overdose in a supermarket car park. The Police Mental Health Street triage team attended, and Kiara was detained under Section 136.[26] At this time, she had told her friend that she was planning to jump off a train. In March 2022, Kiara presented to Emergency Department with lacerations to her forearms, she was discharged to a mental health nurse.

vi. Between May 2022 – June 2002, Kiara was very vulnerable to suicide ideation. All records pertaining to Kiara's needs, highlight aspects of her vulnerabilities, and potential risks to herself.

vii. Also in May 2022, Kiara had an appointment with her consultant psychiatrist where she was displaying some elective mutism. She presented as anxious; she was not speaking but nodding and shaking her head to questions. Kiara told the psychiatrist that she was having suicidal and self-harm thoughts at this time but could not discuss them with her mother.

viii. In early May 2022, Kiara was observed to have a cut parallel to her vein, but she said: "*she is fine".* There was another incident in May 2022, where Kiara had gone near a rail track with an intention to jump. In early June 2022, Kiara was reported to have not eaten for three weeks and her mother told professionals that she was not sleeping during this period.

ix. The ELFT report for this review recognises that Kiara's mother's views about Kiara's suicide ideation and self-harm could not be relied upon as Kiara did not share this key information with her.

x. Between May and June 2022 there was signification escalation in the risks that Kiara presented with. Also in June 2022, Kiara accepted weekend support, she was vulnerable and had self-harmed on both thighs. In mid-June 2022, a brief risk assessment was completed, but there is no consideration of a Mental Capacity Assessment. She had indicated wanting to take her own life and this would have warranted consideration about exploring intent.

xi. In mid-June 2022, Kiara said that she would like to go back to work in the school if she is "[27]*still here".* [28]*"thoroughly assessing and monitoring the pattern, intensity, nature and impact of suicide ideation of the individual and documenting this is important".* The Crisis team reported that Kiara was missing, and she had seen 250 empty blister packs of paracetamol and 30 nytoll and she was unsure whether Kiara had taken the tablets.

xii. At this time police found Kiara. She was found to have made a serious attempt to take her own life. Police were in attendance but were not able to stop her taking serious action to take her own life. Having considered the actions taken

[26] Section 136 Allows Police to take someone to keep them in a place of safety.

[27] From chronology information.

[28] National Library of Medicine. Suicide Ideation B Harmer, S Lee, T Duong, A Saadabadi Jan 2023.

by police, there was little that could have been done on their part to have prevented the incident.

xiii. The professionals offered support to Kiara, and she had appointments and treatment plans, but do not appear to have recognised the high level of latent and underlying risk with which she was presenting.

xiv. Kiara's mental health needs, risks and circumstances were increasing, and the severity and urgency of her needs were becoming apparent.

xv. There could have been further focus on risk and there was insufficient consideration on how and when to escalate concerns and at what point multi-agency safeguarding approach would have been appropriate to safeguard Kiara.

7.14. Issues of cultural competence and intersectionality with relevance in this finding

I. In response to suicide ideation, one needs to understand the context, history, and the environment of the person. For someone such as Kiara, this requires staff to be culturally competent and have a good understanding of intersectionality to come to a strong assessment and plan.

II. The absence of cultural competence may lead professionals to a less than appropriate intervention which can potentially overlook some key safeguarding issues. Assessments should always be undertaken using a variety of sources of information to support decision-making, including the family, other practitioner perspectives and historical information"[29].

III. In addition, there should be a more dynamic understanding about the cultural, religious, and family background of the adult at risk and how this plays out in their lives in order that professionals are better able to identify the risks for the person and how their needs can be addressed within the context of their circumstances.

7.15. What is the significance of this finding to the functioning of the safeguarding system?

i. *"Exposure to violence represented all kinds of experiences of racist, sexist, and abusive behaviours exacerbating mental well-being, which were reported in the studies. Racism was reported as an external pressure by South Asian women".*[30] Cambridge.

[30] Understanding self-harm and suicidal behaviours in South Asian communities in the UK: systematic review and meta-synthesis Published online by Cambridge University Press: 15 May 2023 Büşra Özen-Dursun, Safa Kemal Kaptan, Sally Giles. Nusrat Husain.

ii. Kiara's worker had attempted to keep in touch with her and continue to have dialogue and assess Kiara's mental health state and suicide ideation. However, this was not sufficient nor proportionate to the high level of suicide ideation and mental health needs she presented with at the time.

iii. In April 2022, when the crisis team was offered to Kiara, she had declined, when her needs and risks escalated, and she was refused the support of the crisis team as she had not engaged previously. At this time, given the high level of need, consideration of Mental Capacity Act may have provided a safeguard for Kiara in terms of determining her capacity to make that decision.

iv. This issue reinforces the wider message about a vulnerable adult who reports being 'fine' and yet have a very high level of need. If the support of the crisis team were not appropriate, how could the wider partnership provide the much needed support.

v. For example, a professionals meeting, discussions with family, having a plan of interventions that navigates the medical, social and community needs that Kiara presented with at the time. Kiara was offered treatments in response to suicide ideation as the severity of the risk became apparent to professionals.

vi. However, what is not evidenced is whether this support took account of the impact of discrimination on suicide ideation. The Samaritans *Racism and discrimination can cause some of the feelings that can come before suicidal thoughts like feeling like you are a burden, feeling you do not belong or feeling trapped"* Samaritans ethnicity and suicide".

vii. In supporting Kiara to manage her mental health in the community, her prescription and medication was an important element of her treatment.

viii. In April 2022, the CMHT had not sent an updated prescription to her GP and no script was issued. Kiara's mother had made considerable attempts to source the medication for her but could not do so.

ix. The overall process of sourcing medication may require some system oversight. This is especially the case when the prescription has not been sent to the GP.

x. It should not be down to the patient or their families having to navigate this while managing a crisis situation. When Kiara's mental health deteriorated in May 2022, she still had not received her prescription.

xi. This may require some oversight within the partnership. Support needs to be provided to families attempting to care for their family member by sourcing medication and providing support for administering medication.

xii. "People from different ethnic groups do not always receive the same level of support from mental health services when they need it.

xiii. *For example, young people from minoritised ethnicity backgrounds are less likely to receive specialist assessment following self-harm, compared to White young people". Samaritans* [31]

xiv. Systemic approaches to managing difference and institutional and often unconscious bias is important for services to consider.

xv. There is action-based research and commentary from leading agencies in the suicide ideation arena about the services received by people from global majority background. For example, the Samaritans[32].

xvi. Individual professionals supported Kiara, however, further work could have been carried out to understand her background and where there was little understanding of this, to source appropriate knowledge base to work more effectively with her.

xvii. Even where the staff are of a global majority background it is important that there is understanding of and response to the nuances of individual family's values and lifestyles to provide culturally appropriate needs.

Finding 3

Professionals were aware of the level of suicide ideation and risk she was at, but there were episodic responses to suicide ideation. There is insufficient evidence that the services were confident and assertive in their response to suicide ideation and self-harm throughout the timescale and scope of this review.

Recommendations and questions for the Board

Recommendation 7

The LSAB should review how professionals can assess risk of suicide ideation and self-harm which goes beyond emergency and episodic responses to how adults can be better safeguarded by greater understanding of their vulnerabilities between episodes of high risk and need.

Recommendation 8

The LSAB needs to be assured that agencies create and develop opportunities to share information about young women with multiple vulnerabilities, its impact on the young women's behaviours and risks they present with. The partnership could utilise the cultural competence work initiated following a previous SCR/SAR (Usman Review in 2019).

[31] Samaritans – Ethnic minorities and suicide 2024.
[32] Samaritans Suicide and BAME communities.

7.16. Finding 4: There was insufficient evidence of a coordinated and determined response.

There was insufficient evidence of a coordinated and determined response to the multiple vulnerabilities, forced marriage, honour-based violence, physical assault, breach of non-molestation order, care experience young person, childhood trauma and homelessness.

7.17. How did the finding manifest in the case?

i. Kiara experienced abuse and neglect as a child, and later as an adult, she was physically assaulted. In September 2019, Kiara was assaulted by her grandmother and aunt at her home. The Ambulance service reported that in March 2020, she had taken an overdose and was being forced to eat. At this time, she was screaming, crying, and presenting as very distressed.

ii. The ambulance service completed a safeguarding referral to Adult Social Care. In April 2020, the outcome of the MASH enquiry was provision of advice and guidance. Kiara did not want to pursue the matter with her family and moved out instead. Referrals were responded to and as individual decisions, they were primarily appropriate. The curiosity about what other actions can be taken to support Kiara were not always evidenced.

iii. Therefore, Kiara would be closed to that service until another incident occurred where agencies worked with her in the immediate and emergency basis. If she had said that she did not want to receive a service, she would be closed to that service. In February 2021, Kiara was reported as a missing person. Also in February 2021, Kiara took an overdose, she was admitted to ITU, her condition improved overtime and she was discharged to mental health services.

iv. The responses to Kiara's needs at this time were based on the most recent 'episode' and ensuring her immediate safety. This is a strength in practice, however, given the multiple vulnerabilities she presented with, she needed an in-depth assessment which demonstrated an understanding of the range of incidents across services and grasped the complexities of her multiple vulnerabilities and their impact on her.

v. When Kiara was admitted to the Emergency ward and was placed in a psychiatric ward as a Section 3 patient in a secure unit. The discharge from hospital could have been more informed by the multiple vulnerabilities.

vi. The practitioner event went into more detail about the responses to these episodes and incidents and discussed how practitioners could take a more holistic partnership approach in responding to Kiara's needs, risks, and circumstances.

vii. The partnership could consider how professionals can develop opportunities to discuss more nuanced, in depth and thorough assessment of the needs of vulnerable adults.

viii. Kiara was diagnosed with PTSD[33] and this was Complex Post Traumatic Stress disorder, EYPD – Emotional Unstable Personality Disorder reported to be because of trauma in her life.

ix. An agreed definition of complex PTSD is that a person has symptoms of PTSD and have problems with managing your emotions and having relationships.

x. "*The symptoms of complex PTSD are similar to symptoms of PTSD, but may also include: feelings of worthlessness, shame and guilt; problems controlling your emotions; finding it hard to feel connected with other people; relationship problems, like having trouble keeping friends and partner".*

xi. As mentioned above, the likely causes of PTSD are experiencing recurring or long-term traumatic events, as was the case for Kiara. Complex PTSD is more likely if the people you trust harm you, as were the case for Kiara and resulted in her coming into care as a child and as an adult being harmed by close members of her family.

xii. Kiara's PTSD symptoms were exacerbated by her hearing voices that were telling her to harm herself. There were seven attempts of Kiara taking her own life. Some of these were serious attempts at throwing herself off a train and involved British transport police alerts.

xiii. The records available for this review have included conversations held with Kiara, her response to questions and next steps. While the professional discussions with Kiara demonstrate a response to individual incidents, for example, a rationale for understanding the level of need and risk, it is not **proportionate to the level of risk she was presenting with.**

7.18. Issues of cultural competence and intersectionality with relevance in this finding

i. Kiara's complex multi-faceted needs were layered with abuse within her family home. There were several occasions when Kiara was harmed by her family. Following the attack on her by her aunt and grandmother in March 2020, a non-molestation order was placed on the perpetrators. This was breached in June 2020. Her uncle who was restricted to no less than 50 miles from her, attended her home.

ii. When the Chair of the LSAB and the reviewer met with Kiara, she told them that when she was a child and in the care of the Local Authority, she was mistreated by family members that professionals had entrusted her with. She said that she was not seen alone and therefore, she was not able to share how she was feeling with workers.

iii. This childhood experience has had considerable impact on her and when asked about the one area she would like to share with professionals she said that they should speak to children alone and support them to be taken out of risky

[33] PTSD Definition.

environments even where those environments have been assessed as safe by professionals.

iv. As an adult when Kiara was assaulted by her grandmother, the investigation was not taken further and the outcome of this was no further action as Kiara did not want to take the matter any further. Although many women victims of abuse do not act against their perpetrators, in Kiara's case, there is an additional layer of cultural pressure of shame, honour and her perception about her part in this.

v. There is no evidence of work carried out with her or 'courageous conversations' with her about her rights to take legal action, be away from harm and to be safe. There is little understood about the family structures and living arrangements other than the information that Kiara was attacked by her grandmother and aunt.

vi. At the same time, the family had planned to contest the non- molestation order. What was known is that in childhood, Kiara was at risk of abuse and therefore taken into the care of the Local Authority and when she returned to the family home after university, she experienced further abuse and experienced significant difficulties with her mental health and had PTSD.

vii. There is little known about the nature of Kiara's relationship with her mother. When she was assaulted by her wider family, she went to live with her mother, but it was not known whether she would be safe there because she reported that she felt unsafe, and her family found her at her mother's home.

viii. There were further indications that the family was not a protective factor as at times, she had slept in her car rather that with relatives who would have harmed her.

ix. Kiara had previously reported that when she had told her family that she had been raped, they told her that she should get married to 'cure' the impact of rape. Sexual abuse and rape would have presented as particularly 'taboo', with shame and honour in her cultural context. Disclosure would bring shame not only on the victim but to her family and community.

x. Kiara would therefore be reluctant to act because as well as managing her severe mental health, she would have had to consider the impact of any disclosure as an added burden. Therefore, Kiara needed a more proactive approach to support her.

xi. At the practitioner event there was a discussion about the importance of gathering intelligence from other professionals about the needs of a vulnerable adult and to piece this information together to consider the immediate, medium- and long-term risk that vulnerable adults present with.

xii. The practitioners were keen to support each other in having courageous conversations about understanding and responding to multiple needs, risks, and circumstances of vulnerable adults and how they can support each other to arrive at more nuanced responses.

xiii. These opportunities to review work with an individual is rarely open to professionals and practitioners are very keen to create these opportunities both while working with individuals and in learning from reviews.

xiv. This may be an approach that the LSAB provides, particularly where there are issues of multiple vulnerabilities, hidden needs, cultural competence, and intersectionality involved.

7.19. What is the significance of this finding to the functioning of the safeguarding system?

i. Kiara presented with multiple and complex needs which were not overtly visible to each set of professionals working with her. The practitioner event and other panel discussions have highlighted the importance of supervision and management oversight in addressing issues when working with adults who have a wide range of needs, risks, and complex circumstances.

ii. Kiara had made what was believed to be a good transition as a child in care into university. There is research that highlights the vulnerabilities of care experienced young people.

iii. The review highlights the importance of providing services informed by a thorough understanding of the needs, risks, and circumstances that vulnerable adults present with.

iv. In addition, it is important that services are more culturally competent, and supervision and management oversight reflect this practice.

v. Where professionals agree that there is insufficient understanding of cultural competence then attempts should be made to source and fund the gaps in specialist knowledge.

vi. Kiara was referred to a global majority agency where it was agreed that they would have the expertise to provide her with support.

vii. These organisations are very knowledgeable about their client group, but often lack resources and are considerably stretched because of the high level of needs.

"*Minoritised community-led micro-organisations typically exist because the client groups they serve are not adequately served by mainstream organisations (Butt, 2001).* Therefore, it is important that mainstream organisations provide the services that minoritised groups need. They are often: *operate at the grassroots and are run by members of the same community that they serve. They therefore share an understanding of the exclusion and discrimination faced by their clients".*[34] (Murray, 2020). This is an area that the LSAB will want to explore with commissioning services.

[34] Funding black-led micro-organisations in England. Adwoa Manful and Rosalind Willis. Bristol University Digital. October 2022.

viii. Referrals to these agencies are not in themselves sufficient and that agencies themselves need to review their own practices and provide development opportunities whenever possible.

ix. Good Culturally competent supervision would provide the challenge of whether these issues have been addressed and whether they are underpinned by policy and processes that are curious about the impact of equality, diversity and inclusion when working with vulnerable adults.

x. There are other issues to consider when referrals are made to agencies from the same cultural background would compound the shame and dishonour associated with abuse, mental health needs and difficult family relationships.

xi. The vulnerable adult may not feel safe and confident to share their needs. Therefore, sensitivity and due diligence is required in making referrals to relevant organisations. The individual may not feel comfortable or maybe even fearful of sharing their needs, risks, and circumstances with those from their own community.

xii. Secondly culture is dynamic and as often professionals tend to have static and erroneous assumptions about cultures. The process of migration alongside acculturation means cultural norms change in terms of values and lifestyles.

xiii. A thorough multi agency approach to supporting adults with complex needs requires the systems providing services to review how this way of working can be afforded to professionals.

Therefore, an effective system would provide:

- Support so staff are confident in undertaken thorough assessments and interventions.

- Culturally competent reflective supervisors who are systemic in their thinking and practice.

- Regular opportunities for professionals across services to work and collaborate together.

- At a strategic level, partners have a clear grasp of intersectionality and an understanding of how that plays out in terms of health inequalities, access to services and interventions which are homogenous and monocultural.

Finding 4

There was insufficient evidence of a coordinated and determined response to the multiple vulnerabilities, forced marriage, honour-based violence, physical assault, breach of non-molestation order, care experience young person, childhood trauma and homelessness.

Recommendations and questions for the Board
In addition, there is a need for professionals to confidently respond to patterns of risk, suicide ideation and safeguarding rather than responding to individual incidents and immediate emergency responses. In doing so, health and social care practitioners should become more comfortable in exercising culturally competent practice in their assessment and intervention of risk and need. ***Recommendation 9*** There is a need for professionals to confidently respond to patterns of risk, suicide ideation and safeguarding rather than responding to individual incidents and immediate emergency responses. It is recommended that LSAB has a process in place to review whether any changes have been made following the findings of this review: Health and social care agencies should advise the LSAB how they will progress with the learning from this review and to carry out multi agency audits to test their impact on adults with multiple vulnerabilities.

8. Conclusion

8.1. Kiara had multiple and complex needs which were responded to particularly at times of crisis. She presented as articulate to professionals and this could at times be inaccurately interpreted as being competent and she was therefore perceived as needing less support. The intersectionality of her needs, risks and circumstances was not fully understood or assessed.

8.2. She felt comfortable with some professionals. At times, she was so distressed with suicide ideation that professionals made use of Mental Health Act 1983 (as amended in 2007) to keep her safe. Even when this was used, and she was in hospital there were incidents of self-harm, missing and harm in the community.

8.3. There was some understanding of and response to the needs she presented with, however, this was intermittent and episodic. Many agencies visited Kiara; the crisis team was involved in working with her, mental health professionals in hospital settings as well as the community, police, transport police, consultant doctors and many others.

8.4. Responses to crisis were immediate, however, the underlying pattern of suicide ideation, self-harm, and other vulnerabilities she presented with was not always considered (as there was no evidence to suggest they were).

8.5. Lead agencies could have improved work with her with by having a multi-agency understanding of her history, the risks her family presented, the impact of her PTSD and the cultural context which informed her decision making and patterns of behaviour. The family environment that Kiara attempted to navigate

was complex, fragile and members of her family were abusive towards her. Although Kiara was known to services since childhood, the family dynamics, and their impact on her were not well known and included in work carried out with her as part of trauma informed work.

8.6. Kiara's need to feel safe was fulfilled by feeling safer sleeping in her car, than with her family. There is some understanding of cultural competence in that honour-based violence was identified and support provided for forced marriage and professionals attempted to work with Kiara to support her.

8.7. As set out in the findings in each section, working confidentially and competently with cultural competence and intersectionality is essential for partners and professionals to respond to safeguarding adults from a global majority background. Further work should be considered to enhance policies, procedures, and training as part of the learning from this review.

8.8. The author of this review has been assured that many of the issues raised in this report have already been understood and agencies separately and together have acted upon some of the issues raised in this report. Once the report is finalised, an action plan will be completed to respond to the findings and lessons learnt from this review.

8.9. The reviewer and chair of the Luton Adult Safeguarding Partnership visited Kiara who is now recovering and looking forward to her future. The key findings of the review were shared with her. She said she liked having her poem at the start of the review and wants the learning from this review to help others who are like her.

9. The Review Recommendations

These are areas for the board to consider with partners and it is suggested that an action plan in put in place for the implementation of the recommendations. The reviewer will work with the LSAB to complete the action plan based on current work and any initiatives already in place in the Luton Safeguarding Adults Board. The recommendations are based on learning from this review and an action plan will need to be devised in order to develop multi-agency SMART plans and an oversight process and systems for monitoring.

Recommendations	Who should lead on the action?
Recommendation 1 The LSAB should assure itself that there is a multi-agency forum and/or training to press upon professionals, the importance of analysing patterns and working with persistence to support adults at risk of self-harm and suicide ideation. The LSAB needs to be assured that agencies create and develop opportunities to share information about young women with multiple vulnerabilities, its impact on the young women's	LSAB

Recommendations	Who should lead on the action?
behaviours and risks they present with. The partnership could utilise the cultural competence work initiated following a previous SCR/SAR (Usman Review in 2019). a) How they support staff to capture the voice of and lived experience (especially women from global majority backgrounds). b) How they ensure it is consistently captured for all adults they are working with.	
Recommendation 2 The LSAB needs to be assured that organisations are making concerted attempts to embed cultural competence as a facet of standard practice. To that end, Board partners need to provide assurance of how: c) Cultural competence has been embedded as part of standard training for all front facing staff. d) How issues of diversity and intersectionality are consistently addressed in assessment, care planning and interventions.	LSAB
Recommendation 3 The review has highlighted a need for the local system to develop relevant processes and procedures in response to the needs of adults with multiple vulnerabilities. The partnership will want to consider taking a more joined up and embedded approach to Suicide ideation and prevention across the partnership. LSAB to work as a partnership to implement mechanisms such as CASPA, ensuring that strength based early prevention and intervention is offered to adults with mental health needs and severe suicide ideation.	LSAB
Recommendation 4 Adult Social Care and Health agencies will want to review current training, policy, and procedures in relation to suicide ideation, PTSD, Forced Marriage, and Honour Based Violence and guidance on the appropriate use mental health capacity assessment.	ASC & H
Recommendation 5 Adult Social Care and Health Agencies to review how advocates can be employed when working with adults who are experiencing high level of risk and mental health episodes. Advocates should represent their circumstances, risks, needs, wishes and feelings.	ASC & H
Recommendation 6 The LSAB should review how professionals can assess risk of suicide ideation and self-harm which goes beyond emergency and episodic responses to how adults can be better safeguarded by greater understanding of their vulnerabilities between episodes of high risk and need.	LSA, ASC & H
Recommendation 7 Health and social care agencies should advise the LSAB how they will progress with the learning from this review and to carry out multi agency audits to test impact.	LSAB and ASC & H
Recommendation 8 The LSAB needs to be assured that agencies create and develop opportunities to share information about young women with multiple vulnerabilities, its impact on the young women's behaviours and risks they present with. The partnership could utilise the cultural competence work initiated following a previous SCR/SAR (Usman Review in 2019).	LSAB
Recommendation 9	LSAB and ASC & H

Recommendations	Who should lead on the action?
There is a need for professionals to confidently respond to patterns of risk, suicide ideation and safeguarding rather than responding to individual incidents and immediate emergency responses. It is recommended that LSAB has a process in place to review whether any changes have been made following the findings of this review: Health and social care agencies should advise the LSAB how they will progress with the learning from this review and to carry out multi agency audits to test their impact on adults with multiple vulnerabilities.	

Kanchan Jadeja

Independent Reviewer