# Safeguarding Adult Review

# Executive Summary

Review into the death of Natalie, who died in May 2023 in Bristol

**Review Panel Chair and Report Author:**

Althea Cribb

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**Acronyms/Abbreviations**

| | |
|---|---|
| ABE | Achieving Best Evidence interview (police) |
| ACE | Assertive Contact and Engagement Service (St Mungo's) |
| ASC | Avon and Somerset Constabulary |
| AWP | Avon and Wiltshire Mental Health Partnership NHS Trust |
| BCC | Bristol City Council |
| BCC ASC | Bristol City Council – Adult Social Care |
| BCC CFS | Bristol City Council – Children and Families Services |
| BCC HLS | Bristol City Council – Housing and Landlord Services |
| BNSSG | Bristol, North Somerset and South Gloucestershire |
| BNSSG ICB | NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board |
| BRAG | Tool to assess vulnerability, with outcomes of: Blue/Red/Amber/Green (Avon and Somerset Constabulary) |
| CPA | Care Programme Approach |
| CRG | Case Review Group (Changing Futures) |
| DAHA | Domestic Abuse Housing Alliance |
| DARA | Domestic Abuse Risk Assessment |
| DAT | Drug and Alcohol Team (North Bristol NHS Trust) |
| DHI | Developing Health and Independence |
| DNA | Did not attend (GP) |
| DSI | Death and Serious Injury (police) |
| DWP | Department for Work and Pensions |
| FAQ | Frequently Asked Questions |
| GP | General Practice |
| HMIC | His Majesty's Inspectorate of Constabulary |
| HWYNI | Help When You Need It (St Mungo's) |
| IDVA | Independent Domestic Violence Advisor |
| IOPC | Independent Office for Police Complaints |
| ISVA | Independent Sexual Violence Advisor |
| KBSP | Keeping Bristol Safe Partnership |
| KPI | Key Performance Indicator |
| MARAC | Multi-Agency Risk Assessment Conference |
| MASH | Bristol Multi-Agency Safeguarding Hub for adults |
| MHFS | Mental Health Floating Support (St Mungo's) |
| MTAM | My Team Around Me (Changing Futures) |
| NBT | North Bristol NHS Trust |
| OIC | Officer in Case (police) |
| PMAR | Panel Member Analysis Report |
| PPN | Public Protection Notice (police) |
| ROADS | Recovery Orientated Alcohol and Drugs Service |
| SAR | Safeguarding Adult Review |
| SARC, UHBW | The Bridge Sexual Assault Referral Centre, University Hospital Bristol and Weston NHS Trust |
| SARI | Stand Against Racism and Inequality |
| SARSAS | Somerset and Avon Rape and Sexual Abuse Support |
| SMART | Specific, Measurable, Achievable, Relevant, Time-bound |
| SOP | Standard Operating Procedure |
| SWAST | South Western Ambulance Service NHS Foundation Trust |
| UHBW | University Hospital Bristol and Weston NHS Trust |
| UWE | University of the West of England |
| WNBI | Was not brought in (GP) |

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| YATS | Young Adults Transition Service |

**Definitions**

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| Care Act 2014 Section 42 | Section 42 of the Care Act 2014 applies where a local authority has reasonable cause to suspect that an adult has needs for care and support; is experiencing, or is at risk of, abuse or neglect; and as a result of those needs is unable to protect themselves against the abuse/neglect. https://www.legislation.gov.uk/ukpga/2014/23/section/42 |
| Children Act 1989 Section 20 | Under Section 20 of the Children Act 1989, children may be accommodated by the local authority if they have no parent or are lost or abandoned or where their parents are not able to provide them with suitable accommodation and agree to the child being accommodated. A child who is accommodated under Section 20 becomes a Looked After Child. Section 20 agreements are not valid unless the parent giving consent has capacity to do so, the consent is properly informed and fairly obtained. Willingness to consent cannot be inferred from silence, submission or acquiescence - it is a positive action. (https://swcpp-bristol.trixonline.co.uk/) |
| Cuckooing | Crime and Policing Bill, going through Parliament at the point this SAR was completed (2025) "will make it an offence to exercise control over another person's dwelling without their consent for the purpose of enabling the dwelling to be used in connection with the commission of specified criminal activity." https://www.gov.uk/government/publications/crime-and-policing-bill-2025-factsheets/crime-and-policing-bill-child-criminal-exploitation-and-cuckooing-factsheet |
| Domestic abuse | (2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if— (a) A and B are each aged 16 or over and are "personally connected" to each other, and (b) the behaviour is abusive. (3) Behaviour is "abusive" if it consists of any of the following— (a) physical or sexual abuse; (b) violent or threatening behaviour; (c) controlling or coercive behaviour; (d) economic abuse (see subsection (4)); (e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct. (4) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to — (a) acquire, use or maintain money or other property, or (b) obtain goods or services. (5) For the purposes of this Act, A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child). (6) References in this Act to being abusive towards another person are to be read in accordance with this section. https://www.gov.uk/government/publications/domestic-abuse-act-2021 |
| Mental Health Act 1983 Section 136 | Section 136 of the Act 1983 allows police to detain someone and remove them to a place of safety if: they appear to have a mental disorder; they are in immediate need of care or control for their own welfare or the protection of others. A person can be held in the place of safety for up to 24 hours. |
| Multiple Disadvantage | "The definition of multiple disadvantage (MD) is people who are experiencing three or more combinations of the following: homelessness, substance misuse, mental ill-health, criminal justice involvement, domestic abuse, as defined in the Changing Futures2 programme." (p. 7, Bristol's Multiple Disadvantage Strategy 2023-2026. |

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| | https://democracy.bristol.gov.uk/documents/s91861/Appendix%20A1%20MD%20Strategy%20Final%20draft%202023.pdf) |
| Personality Disorder | There are several different types of personality disorder, and symptoms vary. A person with a personality disorder thinks, feels, behaves or relates to others very differently from the average person. (From: https://www.nhs.uk/mental-health/conditions/personality-disorder/) |
| Protected Characteristic | The Equality Act 2010 set out nine 'protected characteristics' protecting people from discrimination in the workplace and wider society: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. |
| 'Your Team, Your Conversation, Your Plan' | Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) approach since 2024, "adopting a new more personalised and system-based approach to care planning … aimed at enhancing the quality of care and outcomes for people." (https://www.awp.nhs.uk/patients-and-carers/your-team-your-conversation-your-plan) |

## 1. Introduction

1.1. Natalie was a white British woman aged in her twenties. Natalie died in 2023 following escalating mental health concerns in the week prior to her death. The inquest returned a conclusion of suicide, with the cause of death listed as hanging.

1.2. Under Section 44 of the Care Act 2014, Safeguarding Adult Boards are responsible for conducting Safeguarding Adult Reviews (SAR) in circumstances where somebody with care and support needs has died, and the Board knows or suspects that the death resulted from abuse or neglect, and there are concerns about how the Safeguarding Adult Board (i.e., the Keeping Bristol Safe Partnership (KBSP)) members worked together.

1.3. The KBSP received a SAR referral from Bristol City Council Children and Families Services in May 2023, shortly after Natalie's death. Following partnership discussion, it was agreed the referral met the criteria for a mandatory SAR.

1.4. The purpose of SARs, described in the statutory guidance, is to enable effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to reduce the likelihood of similar harm re-occurring.

1.5. Louise Rae was appointed as the Independent SAR Author. She has no connection to any agency in Bristol. Due to unforeseen circumstances, she was unable to complete the SAR. A new Independent SAR Author, Althea Cribb, was appointed. Althea has no connection to any agency in Bristol.

1.6. The KBSP wishes to express sincere condolences to the family of, and those who knew, Natalie. The SAR process recognised that some practitioners had worked with Natalie for a long time, and had developed trusting relationships with her, and thus had been significantly impacted by her death and the circumstances leading up to it. Following the recommencing of the SAR in 2025 they were included in the process, offered opportunities to meet with the new Independent SAR Author as well as to review the draft report and provide their feedback. The SAR Panel discussed any need for support practitioners may have during the SAR process.

## 2. Methodology

2.1. A SAR Panel was identified, comprising agencies known to have contact with Natalie. An initial meeting took place in November 2023 where the methodology and Terms of Reference were agreed. When the SAR recommenced in 2025 the Terms of Reference were reviewed and were found to only contain the key lines of enquiry, listed in the next section (3). Drafting and agreeing a new Terms of Reference would have delayed the SAR further; key missing areas (such as Natalie's protected characteristics, and the detailed methodology for the SAR) are included within this report.

2.2. The first SAR Panel meeting agreed that the SAR would be undertaken using a methodology which engages frontline staff and their managers who were involved with Natalie, avoids hindsight bias or individual blame, identifies opportunities for improvement within systems for safeguarding adults and promotes good practice.

2.3. SAR Panel membership, in addition to the KBSP and Independent SAR Author, comprised:

- Avon and Somerset Constabulary
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
- Bristol City Council – Adult Social Care (BCC ASC)
- Bristol City Council – Children and Families Services (BCC CFS)
- Bristol City Council – Housing and Landlord Services (BCC HLS)
- Changing Futures
- Gwent Police
- Next Link (incorporating Safe Link)
- NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) on behalf of the General Practice (GP)
- North Bristol NHS Trust (NBT)
- Somerset and Avon Rape and Sexual Abuse Support (SARSAS)
- St Mungo's
- Womankind

2.4. The following agencies were involved in the SAR, but were not members of the SAR Panel: Bristol Specialist Drug and Alcohol Service (delivered by AWP); Developing Health and Independence (DHI); South Western Ambulance Service NHS Foundation Trust (SWAST); and University Hospital Bristol and Weston NHS Trust (UHBW).

2.5. Chronologies were provided from agencies in addition to Panel Member Analysis Reports (PMARs), in which agencies analysed and commented on their chronologies and identified any learning for their agency. Chronologies and PMARs were received, as appropriate, from all agencies listed above (in 2.3 and 2.4).

2.6. Additionally, scoping information was provided by Avon Fire and Rescue Service, Adoption West – Birth Links, Department for Work and Pensions (DWP), The Bridge Sexual Assault Referral Centre (SARC, UHBW), which were incorporated into the chronology.

2.7. All agencies participated fully in the SAR, including once it had recommenced in 2025.

2.8. The SAR placed strong emphasis on the engagement of frontline practitioners and managers by way of a Learning Event. This took place in January 2024, attended by all agencies listed above (2.3 and 2.4) except for Next Link, SWAST, UHBW, and Womankind, who sent apologies.

2.9. Following the Practitioner Learning Event, the original Independent SAR Author was unable to complete the review. A new Independent SAR Author was appointed and from then, the following methodology was adopted: the new Author reviewed all SAR documentation; updates on PMARs were requested to identify where actions had been taken / practice had changed; the SAR report was completed and shared with SAR Panel members, and the practitioners who had attended the Learning Event. The SAR Panel met to review the report, and practitioners were requested to submit comments.

2.10. Following the SAR Panel meeting the report was finalised and approved by the Panel. Final approval was from the Bristol Keeping Adults Safe Board.

## 3. Terms of Reference

3.1. The timeframe covered by the SAR was 2020 to the date of Natalie's death. Any significant incidents which occurred prior to this timeline were included. This time period does not form a complete history of Natalie but was recognised as being important for the SAR to understand Natalie's experiences that potentially led to the deterioration in her mental health shortly before she died.

3.2. Due to the delay in completing the SAR, it has been some time since many agencies had contact. Thus, the analysis in this report focuses on the relevant contacts and experiences of Natalie in the three months prior to her death. Her history prior to this period was reviewed by the SAR; these were essential in trying to understand Natalie.

3.3. The Terms of Reference for the SAR, which have been condensed from those originally agreed, were:

- The effectiveness of information sharing, and multi-agency working, including risk management and safety planning to safeguard Natalie within the community.
- The effectiveness of both the assessment of and intervention(s) around Natalie's mental health.
- The appropriateness in application of the legal framework and statutory duties in safeguarding Natalie.

3.4. These Terms of Reference were addressed in PMARs and at the Learning Event which provided proportionate and effective means of gathering information for the SAR. They are explored in the analysis contained in this report.

3.5. In addition to the analysis of information held by agencies, the Independent SAR Author drew on research on the key issues in the SAR and learning from previous SARs and the second National SAR Analysis, to ensure that the learning in this case was contextualised, and recommendations were appropriate.

3.6. The inquest was completed in December 2023 and did not impact on the SAR.

3.7. Avon and Somerset Constabulary made a Death and Serious Injury (DSI) referral to the Independent Office for Police Complaints (IOPC) as Natalie had (indirect) contact with police officers shortly before her death. An internal investigation was deemed to be required to consider if any action or inaction of the police caused or contributed to her death and if Natalie was adequately risk assessed and safeguarded throughout all her contact. The DSI investigation report concluded that officers' risk assessments and safeguarding was more than adequate. The DSI investigation report went to the IOPC in July 2023.

3.8. The IOPC concluded that the report from Avon and Somerset Constabulary did not indicate any officer had committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings in relation to the last (indirect) contact with Natalie following a concern for welfare call in May 2023.

## 4. Information from those who knew Natalie

4.1. Family involvement in a SAR is an important part of the process. The KBSP wrote to Natalie's grandmother and Casey's foster carers to invite them to participate in the SAR.

4.2. The first Independent SAR Author met with Casey's foster carers through a telephone call in 2024. Feedback from them is included in the section below about Natalie.

4.3. The first Independent SAR Author made an offer to meet with Natalie's grandmother through Casey's foster carers who remained in touch with the family and was informed that Natalie's grandmother did not wish to participate in this SAR.

4.4. When the SAR recommenced in 2025, the KBSP wrote to Natalie's grandmother and Casey's foster carers to update them on what had happened, and to invite them to participate in the SAR again.

4.5. The Independent SAR author updated Natalie's child's former foster carers on the learning identified by the SAR, and they supported in the identification of the pseudonym. The learning from the review was welcomed, particularly relating to increasing/embedding awareness of trauma, and its cumulative impact; improving multi-agency working and communication through the My Team Around Me model, including having a lead professional – for Natalie, continuity was essential, and 'less was more' in terms of the number of professionals she had contact with.

4.6. The former foster carers also raised the future needs of Natalie's child, Casey, both in supporting their mental health and wellbeing and their understanding of what happened to Natalie. While this is not within the remit of the SAR, this will be raised with the relevant service(s), because it is important in paying due respect to Natalie's and Casey's experiences.

## 5. About Natalie

5.1. It was important for the SAR to recognise and try to understand who Natalie was as a person. In the absence of information from Natalie's family, this was provided by the professionals who supported her, and Casey's foster carers.

5.2. Casey's foster carers spoke of Natalie's vulnerability and how she struggled to engage with those she considered to be in authority. They described how they had a good relationship with her and felt they were one of the few people that Natalie listened to. Natalie appeared to let her guard down with them and they described how Natalie didn't appear to feel threatened by them despite their role as professional carers for Casey; they weren't seen as part of the system of professionals that Natalie had such mistrust for. They knew that Natalie had experienced significant trauma both historical and in her recent past. As such she had difficulty in forming relationships with professionals and trusting them, especially when she felt that they would be short term. They saw that Natalie's biggest focus in her life was her child; she wanted Casey to be safe and said to the foster carers that she was relying on them to make sure her child got the right adoptive parents. They were hugely shocked by Natalie's death; they had known something wasn't right because Natalie had stopped responding to their messages.

They tried to raise their concerns but couldn't contact anyone as it was over the weekend.

5.3. Natalie was seen by practitioners as a mother who loved her child, they were her world. She herself had been in local authority care as a young person. She recognised that she was unable to care for them in the longer term given the difficulties she experienced with her mental health. It should not be underestimated that, despite her understanding that Casey was not returning to her care and the reasons for this, the adoption process had a significant impact on her, and she was heartbroken that the proceedings in the Family Court were reaching the conclusion that Casey should be placed for closed adoption. This left her feeling that she had nothing left; she had told professionals that Casey was her purpose and that her purpose had been taken away.

5.4. Natalie felt extremely let down by the system and isolated and that very little was achieved when she asked for help. She was extremely vulnerable and had fluctuating moods which were exacerbated at times by her use of substances. It was clear that Natalie had fluctuating and complex needs and despite challenges had periods of presenting and engaging well with services offered. Professionals who worked with her described Natalie as driven, organised, funny and caring; she loved to chat and was very sociable. She was remembered by key professionals with fondness; those practitioners spoke about how she was a great artist with her own distinctive style.

5.5. Natalie benefited from a longstanding professional relationship with her BCC CFS Through Care Service Personal Advisor. There was continuity from the start (2020) with the Personal Advisor being allocated to her. It was positive for Natalie to have a Personal Advisor who knew her and with whom she had a good relationship. The Personal Advisor was an important professional and held a vast amount of information which she had gained over many years of working with Natalie.

5.6. From July 2022, Natalie was supported by Changing Futures, and her allocated worker developed a close working relationship with Natalie and her Personal Advisor. They worked to support Natalie with the Family Court proceedings in respect of Casey, and to engage Natalie with substance misuse services and mental health support.

5.7. The SAR recognised that Natalie's mental health was impacted by her use of drugs, which she used as coping mechanisms. In the six months before her death, Natalie was using cocaine, Xanax and ketamine.

5.8. It was important to practitioners that Natalie was also recognised as a survivor of domestic abuse.

5.9. Practitioners shared their perspectives that, until the end of March 2023 when Natalie reported experiencing sexual violence (having reported the same previously in August 2022), followed by the adoption decision for Casey, Natalie had been engaging well with agencies and her close support team of her Personal Advisor and Changing Futures. She was beginning to take steps in relation to engaging with drug services and mental health support. Her Changing Futures worker described how she was enjoying the changes that she was making and the activities that she was engaged in until this time.

## 6. Summary of Natalie's History and Agency Involvement

6.1. The SAR analysed Natalie's contact with services to produce the learning. Due to the level and type of detail in that chronology, it is not included in this Executive Summary.

*Brief Summary of Natalie's History*

6.2. Natalie was known by Bristol City Council Children and Family Services (BCC CFS) as a small child. When Natalie was a teenager, she entered a foster placement and remained there until she was an adult.

6.3. Casey was born when Natalie was aged 20; she contacted services, knowing an assessment would be needed due to her history of being in care. An initial assessment was completed and there were no concerns.

6.4. Concerns around Casey were raised with BCC CFS when they were aged three; some months later, Casey moved to live with foster carers. A parenting assessment was completed and a route to permanency – adoption – for Casey's care was pursued, which occurred in 2023.

6.5. Agency records indicate Natalie experienced, at different times in her life, sexual violence, domestic abuse, and miscarriage. She continued to have challenges with her mental health throughout her time with services, alongside illicit substance use.

*Agency Involvement*

6.6. *Adoption West – Birth Links*: This is a support service for birth relatives affected by adoption, providing advice, support, information and guidance. Natalie was referred to this service in April 2023 when the decision for Casey to be adopted was made. The service was unable to contact Natalie before she died.

6.7. *Avon and Somerset Constabulary*: Multiple contacts were recorded with Natalie; in most of these Natalie was the victim of interpersonal violence or harm; in a small number Natalie was an alleged offender.

6.8. *Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)*: AWP were in contact with Natalie, albeit not consistently, from the end of 2021 up to her death. Natalie's contact was with the Single Point of Access Team, the Response Line, and the Crisis Team, during which contact was difficult to maintain with Natalie leading to comprehensive assessments not being able to be completed.

6.9. *Bristol City Council Adult Social Care (BCC ASC)*: Five safeguarding concerns were raised for Natalie in 2022 and 2023. Four were raised by Changing Futures and one by Avon and Somerset Constabulary.

6.10. *Bristol City Council Children and Families Services (BCC CFS)*: BCC CFS were involved with Natalie when she was a child, and she remained with the service due to being in care and then receiving the Care Leavers service after she turned 18. She had the same Personal Advisor for many years, up to her death. BCC CFS were also involved with Natalie due to concerns for her child.

6.11. *Bristol City Council Housing and Landlord Services (BCC HLS)*: Natalie was awarded a secure tenancy in 2018, which she gave up in 2021 when she fled domestic abuse from her then partner. She was rehoused later in 2021 with a secure tenancy. The

service worked with Natalie at times to clear rent arrears. In April 2023, Changing Futures submitted a homelessness application on Natalie's behalf, which was prioritised; the process was ongoing at the time of Natalie's death.

6.12. *Bristol Specialist Drug and Alcohol Service (BSDAS), within AWP*: The service supports individuals with specialist treatment and psychological interventions that can include detoxification treatment. Natalie was referred by Developing Health and Independence for assessment to undertake the service's 'Moving on after Trauma' intervention, in April 2023. Contact was made with Natalie who said she would like an assessment, but she died before this could take place.

6.13. *Changing Futures*: The service is central government funded, working to support adults and young people who face multiple disadvantage. Natalie's Personal Advisor referred her to this service in July 2022 due to her increased drug use and mental health difficulties following the removal of her child into care. The service is called 'My Team Around Me'[1] and aims to coordinate agencies around individuals such as Natalie who need multi-agency support. Natalie was recorded as wanting control over her life back, help with trauma, and help to regain care of her child. They worked with her consistently until her death.

6.14. *Developing Health and Independence (DHI)*: DHI provide substance misuse services. Natalie self-referred to the service in February 2022, and the service was in sporadic contact with her from then until her death.

6.15. *Gwent Police*: Seven contacts were recorded in a short time in 2021, while Natalie was living in this area with her then partner. Natalie reported domestic abuse from that partner; also recorded were concerns for her child, and drug use concerns.

6.16. *Next Link and Safe Link*: Next Link and Safe Link are separate interventions within the same voluntary sector service. Next Link provides domestic abuse support; Safe Link provides support in relation to sexual violence; they are delivered separately, due to the nature of the Safe Link work connecting with ongoing criminal cases, however there is regular communication between the two. Next Link supported Natalie in relation to domestic abuse in 2021 and 2022, including refuge provision, community-based support and attendance at the Freedom Programme. Natalie received support from a Safe Link Independent Sexual Violence Advisor (ISVA) from 2020 to the end of 2022 relating to historic and recent sexual violence, and an ongoing criminal justice process. The ISVA maintained contact with Natalie and with the Avon and Somerset Constabulary Officer in Case (OIC), to keep Natalie informed of the progress of the criminal case. Their last contact with Natalie was in December 2022 when Natalie confirmed she wanted to engage with the criminal justice process. Despite multiple attempts the ISVA was unable to reach Natalie again; her case was closed at the end of March 2023; the OIC was informed.

6.17. *NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) / General Practice (GP)*: The General Practice received communications from the other health services involved with Natalie, which was recorded, and had regular contact with Natalie throughout 2021 and 2022, usually on the telephone, concerning her mental health and drug use.

[1] https://www.changingfuturesbristol.co.uk/my-team-around-me

6.18. *North Bristol Trust (NBT)*: The Trust midwifery service had contact with Natalie during her pregnancy and birth. Subsequent contacts in 2022 involved Emergency Department attendances due to mental health concerns and alcohol use, the last of which was in May 2023, shortly before she died.

6.19. *Somerset and Avon Rape and Sexual Abuse Support (SARSAS)*: Natalie was referred to this voluntary sector service in August 2022 by The Bridge SARC (see below). SARSAS agreed with Womankind (see below) a pathway for support, and then tried to contact Natalie. She was closed to the service after three unsuccessful attempts at contact, in line with policy.

6.20. *South Western Ambulance Service NHS Foundation Trust (SWAST)*: The ambulance service had multiple contacts from and about Natalie from the end of 2021 onwards. She was included in the 'frequent caller management system' from early 2022 onwards due to the high number of calls in short timeframes, meaning Natalie was responded to via 'hear and treat'[2].

6.21. *St Mungo's*: Voluntary sector service to which Natalie was referred by Changing Futures to two teams: the Mental Health Floating Support (MHFS) and the Assertive Contact and Engagement Service (ACE).

6.22. *The Bridge Sexual Assault Referral Centre (SARC), within UHBW*: A SARC[3] provides medical care, emotional and psychological support and practical help to anyone who has been raped or sexually assaulted; Natalie attended in August 2022.

6.23. *University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)*: The Acute Trust had three contacts with Natalie in 2021 when she attended/was brought to hospital in relation to her mental health.

6.24. *Womankind*: Voluntary sector service supporting women with their mental health (see also SARSAS above), they provided specialist sexual violence counselling to Natalie in 2021-22.

*Summary of abuse experienced by Natalie*

6.25. With reference to the Department of Health and Social Care Statutory Guidance for the Care Act 2014[4], Natalie experienced domestic abuse and sexual abuse.

6.26. The Second SAR National Review[5] found that SARs focusing on domestic abuse had increased from 10% to 16%. Those focused on sexual abuse comprised 6% of SARs. The Review further found that SARs exploring "modern slavery, sexual abuse, and sexual exploitation occurred more often in younger individuals" (p. 5, Executive Summary). 33% of SARs in the National Review involved substance dependency; mental health was also a significant feature.

## 7. Key Findings and Lessons to be Learnt

[2] Hear and treat' generally refers to the scenario when 999 calls are provided with a response that does not involve dispatch of an ambulance vehicle.
[3] https://www.thebridgecanhelp.org.uk/
[4] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[5] https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

7.1. This section presents the findings produced through the analysis of information provided to the SAR.

7.2. While not covered in the original Terms of Reference for this SAR, the analysis includes Natalie's protected characteristics; the most pertinent were Natalie's sex/gender identity (female/woman), her mental health condition, and her age. Women face significant risks of being subject to sexual violence[6] and/or domestic abuse, and, when intersecting with Natalie's age, risk increases: young women face the highest risk of domestic abuse[7].

7.3. Under the Equality Act 2010[8], a mental health condition is considered a disability if it has a long-term effect on an individual's normal day-to-day activity; despite not having a formal mental health diagnosis, this was evidently the case for Natalie and, intersecting with her sex/gender and age, further increased her risk of violence and abuse[9].

7.4. Findings and lessons are presented with reference to the six principles of safeguarding where appropriate, which are: empowerment, prevention, proportionality, protection, partnership, accountability[10]. The section also addresses the 'why' of the findings and the Terms of Reference, which were:

- The effectiveness of information sharing, and multi-agency working, including risk management and safety planning to safeguard Natalie within the community.
- The effectiveness of both the assessment of, and intervention(s) around, Natalie's mental health.
- The appropriateness in application of the legal framework and statutory duties in safeguarding Natalie.

7.5. This section outlines how practice or systems have changed, and/or makes recommendations where required to address the learning identified.

*Understanding of, and responses to, Natalie's trauma history*

7.6. Natalie had experienced repeated, complex and ongoing trauma during her life. There was good practice evident in the way many practitioners showed a high level of awareness of Natalie's history, and how it may have impacted her and her interactions with agencies. This was also found in the Second SAR National Review[11], with good practice identified similar to that evidenced here. The National Review also found learning here, particularly in relation to a lack of recognition of how past trauma continues to impact people in the present, and a tendency to focus on present issues in isolation from a person's history (p. 39, Stage 2 Analysis).

[6] https://rapecrisis.org.uk/get-informed/statistics-sexual-violence/; https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/sexualoffencesinenglandandwalesoverview/march2022

[7] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2024#age

[8] https://www.legislation.gov.uk/ukpga/2010/15/section/6

[9] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/latest

[10] https://bristolsafeguarding.org/professional-resources/safeguarding-adults-regional-policy

[11] https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

7.7. Being traumatised means it can be hard for someone to trust others, particularly practitioners and those in positions of power[12]. It also creates feelings of shame about the experiences and the impact they have, such as the need to use drugs/alcohol to cope[13], which often creates barriers to building relationships with practitioners.

7.8. Natalie's history shows there were long periods of time in which she was keen to work with agencies, to seek help and support for her experiences and the impact they had on her mental health, physical health and her drug/alcohol use. Natalie had preferred means of contact, which were based on face-to-face meetings and home visits, rather than telephone (except for with Womankind) or letters. Yet when these were adopted, they didn't always lead to successful engagement of Natalie; this required further exploration: specifically, why some agencies were more able to engage Natalie than others (this is analysed below). Understandably, Natalie's involvement with agencies fluctuated over time depending on what was happening for her. It is also to be expected that her ability to work consistently with agencies declined over time, with new experiences of trauma layering on top of earlier experiences.

7.9. Research shows that when people seek help when they are "frightened, in pain or facing threat to their lives", they can adopt help-seeking stances that make it challenging for agencies to respond, including patterns seen for Natalie: only seeking help when absolutely necessary; seeking help and then withdrawing; seeking help but without a clear idea of what is wrong, or what would help that[14]. Agencies often saw Natalie as 'choosing' not to engage, but in the context of trauma, and the impact this has on help-seeking, this may have been because the barriers to accessing support were too significant. Importantly, this was not the case for Natalie's Personal Advisor who always saw Natalie as someone who wanted support but struggled to meet agencies' demands. Natalie's circumstances meant that visiting agency offices for appointments was not always possible; agencies needed to assertively try to reach Natalie through visiting her including allowing time for her to answer the door. The Personal Advisor was also aware that in the months leading to her death, Natalie felt unable to open letters, and hence would have been unaware of any agency contacts made in that way.

7.10. In the lead up to her death, Natalie experienced further trauma, which appeared to lead to the deterioration of her mental health, an increase in her drug/alcohol use, and fluctuating engagement with agencies.

7.11. This SAR does not challenge the decision-making in this area; but it is important that child removal, while a necessary course of action, is rightly recognised as traumatising for parents, particularly mothers[15], including increasing the risk of suicide[16]. Experience

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[12] Robbins, R. and Cook, K. (2018) 'Don't Even Get Us Started on Social Workers': Domestic Violence, Social Work and Trust – An Anecdote from Research, *The British Journal of Social Work*, 48(6), pp. 1664–1681, https://doi.org/10.1093/bjsw/bcx125

[13] Taylor, T. F. (2015) 'The influence of shame on posttrauma disorders: have we failed to see the obvious?', *European Journal of Psychotraumatology*, 6(1). https://doi.org/10.3402/ejpt.v6.28847

[14] McCluskey, Una. *To Be Met As a Person: The Dynamics of Attachment in Professional Encounters*, Taylor & Francis Group, 2005. p.16. *ProQuest Ebook Central*, http://ebookcentral.proquest.com/lib/uclan-ebooks/detail.action?docID=764902

[15] Morriss, L., & Broadhurst, K. (2022). Understanding the mental health needs of mothers who have had children removed through the family court: A call for action. *Qualitative Social Work*, *21*(5), 803-808. https://doi.org/10.1177/14733250221120470; Broadhurst, K. and Mason, C. (2020) 'Child removal as the gateway to further adversity: Birth mother accounts of the immediate and enduring collateral consequences of child removal'. *Qualitative Social Work*, *19*(1), pp. 15–37. https://doi.org/10.1177/1473325019893412

[16] Thumath, M. et al. (2021) 'Overdose among mothers: The association between child removal and unintentional drug overdose in a longitudinal cohort of marginalised women in Canada. International Journal of Drug Policy, 91. https://doi.org/10.1016/j.drugpo.2020.102977

locally demonstrates that the risk of deteriorating mental health, and suicide, is exacerbated by the intersection of gender and being a care leaver. Research indicates that child removal is more common for mothers experiencing multiple disadvantage, including experiences of abuse and violence[17]. Practitioners recognised that Casey's removal into foster care impacted on her mental health, but it wasn't consistently seen in the same way that other trauma experiences were, perhaps because the process took a long time (starting in February 2022 and ending with the decision for adoption in April 2023). The referral to a specialist service relating to child removal came following the decision for Casey to be permanently adopted. Natalie may have benefited from specialist support in relation to child removal at a much earlier date. Considering she had said repeatedly that her child represented her 'purpose' in life, Casey's permanent removal from her care (ending her hopes that she could maintain contact), should have been seen as a risk factor in relation to Natalie's deteriorating mental health.

7.12. The SAR heard that discussions with parents about the potential for closed adoption, and referrals to Birth Links, are discussed as early in the care proceedings process as possible, while being careful that these discussions/referrals do not pre-judge the final decision. It is likely that Natalie's child's social worker had discussed a referral to Birth Links earlier with Natalie.

7.13. A service delivered by One25 was previously in place in Bristol, named Pause[18] – a programme delivered across England that therapeutically supports parents (usually mothers) who have had multiple children removed from their care. The SAR noted that, as this was her first child, Natalie would not have met the criteria for this service even if it had still been in place, or if it were to start again.

7.14. *Recommendation:* BCC CFS to undertake a review or audit concerning cases involving parents going through care proceedings to ensure that: (a) discussions about referrals to Birth Links take place as early as possible; (b) that the right person has had the discussion with those parents covering what support is available from Birth Links; and (c) that when referrals are accepted by parents, they are made as soon as possible in the process. The outcomes of the review or audit should inform future actions to improve practice as required. The outcomes will also be reported to the KBSP.

7.15. While BCC CFS social care practitioners were appropriately focused on Casey's wellbeing, this meant that a trauma experience, Natalie's miscarriage, was only seen in the context of her behaviour towards Casey, and she wasn't offered specialist support. Additionally, BCC CFS Through Care service didn't share the information about Natalie's miscarriage with other agencies. This lack of information sharing was unusual in response to Natalie, as analysed in the next section.

7.16. Existing mental health needs were considered during Natalie's Mental Health Act assessment with a recommendation for community-based support via the AWP recovery team and other professionals to meet a range of needs. AWP recovery team input involves assessment, detailed medical reviews, considerations on symptoms and behaviour and regular reviews by practitioner(s), informing the clinical team. Recovery support can only take place if the service user is part of the process and Natalie's experiences meant she was unable to fully access the support on offer at this time.

[17] McGrath J, et al. (2023) "They Tarred Me with the Same Brush": Navigating Stigma in the Context of Child Removal. *International Journal of Environmental Research and Public Health*. 20(12). https://doi.org/10.3390/ijerph20126162
[18] https://one25.org.uk/our-news/upcoming-changes-to-pause-at-one25/

Over the history covered by this SAR, Natalie didn't receive specialist trauma treatment or support that could have enabled her to recover from her multiple experiences and grow beyond the trauma. Rather, she remained vulnerable, leading to new traumatising experiences.

7.17. The issue of 'engagement' is a recurring theme in Bristol reviews; the SAR discussed this and agreed that the issue is one of relationships between practitioners and those using services, and between practitioners within and across agencies. When the emphasis of agencies is on building relationships, rather than on assessing engagement, focus is more likely to remain on the individual, rather than on the demands of the system. Effective practitioner relationships can also prevent situations in which individuals 'bounce' between different services.

7.18. The SAR discussed that the key area for learning here is that for those in situations such as Natalie, who are care experienced and having children removed from their care, there is a need for all practitioners to recognise the way in which these intersecting experiences increase their risk of negative impacts on their mental health, including the increased risk of suicide.

7.19. *Recommendation*: BCC CFS to ensure that when a child is removed from an adult into local authority care, they notify the adult's named GP.

7.20. *Recommendation:* ICB to promote GP surgeries to routinely enquire during their registration processes to gain consent from a *Care Leaver* for an alert to be placed on their health record.

7.21. *Recommendation:* The ICB Safeguarding Team to continue to provide education to GP's regarding the increased risk of suicide following child removal in training sessions.

7.22. *Recommendation*: KBSP Keeping Adults Safe Board to share the following reflective questions prompted by the learning in this section:

- How do agencies support their practitioners to prioritise building relationships with practitioners in partner agencies?
- How do agencies support their practitioners when there are multi-agency disagreements, for example relating to actions, non-acceptance of referrals, or thresholds?
- How do agencies support their practitioners to manage situations in which there is complexity, in relation to the individual they are working with, and the multi-agency response?

*Information sharing and multi-agency working*

7.23. The chronology and PMARs demonstrated the extent to which agencies shared information, and worked, with each other around Natalie, her history, her needs, and her interactions with practitioners. Partnership is a core principle of safeguarding and was in evidence here.

7.24. Despite this good practice, there was a lack of coordination to the multi-agency working, which limited the effectiveness of the partnership approach. Agencies were working together and sharing information between each other, but each agency had its own structures, frameworks and demands with which Natalie was expected to engage.

Several agencies fed back to the SAR that there was a lack of clarity over the roles of different agencies/practitioners in Natalie's life. These themes were all identified in the Second SAR National Review[19].

7.25. Natalie was referred to two interventions, both delivered by St Mungo's, almost at the same time. The manager of the MHFS Team (Mental Health Floating Support, delivering the intervention Help When You Need it) informed the SAR that they were very aware of the prior referral (to the Assertive Contact and Engagement service), and didn't complete a full new assessment. They highlighted their awareness at the time that to have required Natalie to complete a new assessment would not have been trauma informed; they met Natalie alongside the Changing Futures worker. A core principle of a trauma informed approach is to be alert to the potential for re-traumatisation in interactions with service users and seek to avoid them wherever possible[20]. Awareness of this was evident in the response of St Mungo's MHFS Team in not asking Natalie to start anew but drawing on information already held by the agency. Nevertheless, each time Natalie was referred to a new service, she would have had to get to know that worker and that agency. There was a wealth of information about her held by other agencies; that information could (with Natalie's consent) have been shared, but with each service having its own triage/intake, assessment and planning processes, she may still have had to repeat herself. As Natalie's Personal Advisor informed the SAR (see above), Natalie was keen to engage in support, but what has been described here could have created barriers, despite her willingness.

7.26. It is also likely that, due to her trauma experiences and the impact these had, Natalie may have been overwhelmed by the multiple agencies she was in contact with, and/or felt unable to meet agencies' demands. Each agency has their own processes, structures, thresholds/criteria and ways of working. Casey's foster carers shared that Natalie found it particularly hard to trust agencies when it appeared their involvement would be short term.

7.27. Additionally, each agency asked Natalie to focus on one of her needs/issues, e.g., drug/alcohol use / sexual violence / mental health. This separation is driven both by commissioning according to issue, and the specialisms practitioners and agencies bring to those issues. It was helpful in some instances, for example, when Natalie accessed specialist sexual violence counselling. It also meant that Natalie wasn't always seen holistically, for example, there was a lack of communication between AWP and DHI, and the ways in which Natalie's drug/alcohol use impacted her mental health, while superficially recognised, were not explored.

7.28. Those that were able to work with Natalie holistically – BCC CFS Through Care and Changing Futures – were also those that built the most consistent and trusting working relationships with her. This was empowering for Natalie. Yet, they didn't hold the remit to address each of her needs/issues, requiring referrals to other services. These were also the agencies that were least constrained by working frameworks/structures that demanded regular, consistent contact, identifiable goals and outcomes within specific timeframes. With less flexible agencies Natalie entered cycles of referral, acceptance and initial assessment, followed by being deemed not to be 'engaging', and case closure – only for new referrals to be made. This was most evident with AWP mental

[19] https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023
[20] https://library.samhsa.gov/sites/default/files/pep23-06-05-005.pdf

health services; Natalie was repeatedly referred, assessed and accepted support, after which she withdrew. Good practice was noted here in practitioners attempting different ways to engage Natalie; however, this did not appear to involve working alongside the Personal Advisor/Changing Futures team, with recognition that they had successfully engaged Natalie. An internal referral was made, appropriately, to the Assertive Outreach Team that sits within the Recovery Team; she remained on the waiting list when she died. As outlined in AWP's update, this team remains overstretched, with long waiting lists. Assertive Outreach is located within the Recovery Teams, and the latter adopted assertive outreach in trying to work with Natalie after she was discharged from hospital, visiting twice to try to speak with her.

7.29. A system-wide dataset is being developed by the Integrated Care Board, Changing Futures, criminal justice agencies and BCC ASC. The work aims to proactively identify those with multiple and intersecting needs in the area, to enable greater understanding of the level of need and what resource is required.

7.30. Changing Futures intervention, named 'My Team Around Me' (MTAM), aims to coordinate agencies around individuals such as Natalie who need multi-agency support. This would have been an appropriate intervention for Natalie in light of her intersecting protected characteristics, experiences of trauma, and difficulties with mental health and drugs/alcohol. The SAR heard that at the time Natalie was involved with services in 2022/23, Changing Futures did not have a remit for multi-agency coordination in the way that they do now, albeit they worked collaboratively with other agencies including in relation to safeguarding concerns. The history of the service was that it was established without a defined service specification, and the MTAM approach was to be developed. This took place alongside workers delivering assertive outreach and relationship building with those referred. Since Natalie's death, the MTAM approach was established and is being delivered. The nature of the approach is that Changing Futures do not take on the coordination; they have worked in partnership with agencies to co-develop the approach, and the aim is for ownership of MTAM to be shared. MTAM is a systemic approach: it is not only about bringing practitioners together around an individual with multiple and intersecting needs; it also focuses on addressing the systemic issues that can create barriers to those needs being met.

7.31. The MTAM approach aims to build a coordinated response around an individual prior to – and ideally to prevent – any crisis occurring. Agencies start by establishing the remit and context of their service, including any limitations such as capacity and workloads. This enables appropriate and actionable decisions to be made, remove duplication, and the most appropriate lead professional to be identified, in partnership with the person. The lead professional is not expected to take on all responsibility for that person, but to coordinate partner agencies who remain involved. This approach can require flexibility from working processes within agencies, for example keeping someone 'open' on a system so that the practitioner can remain involved with MTAM even while they may not be working directly with the person. As such, leadership, and supportive management, are essential to the success of MTAM in creating organisational cultures that hold ownership of working in partnership around individuals with multiple and intersecting needs.

7.32. With the support of the now-established Bristol City Council Multiple Disadvantage Transformation Board[21], Changing Futures have developed templates and guidance for the delivery of MTAM, including multi-agency care plans, and a manual that will soon be available. Multi-agency care plans enable clear documentation of the roles and responsibilities of all involved agencies, supporting practitioners in understanding each other's roles.

7.33. *Recommendation*: Agencies involved in this SAR to ensure that continued internal communication takes place with all their staff, to inform them of Changing Futures' work and the development of the MTAM model.

7.34. *Recommendation*: Representatives on the Multiple Disadvantage Transformation Board to inform the KBSP Keeping Adults Safe Board what actions they take to cascade information internally with colleagues from their respective organisations and update them on the work of the Board and the development of the MTAM process.

7.35. Changing Futures have worked with many agencies to support the implementation of the MTAM approach; they do not 'own' or deliver the approach but co-produce it with partners. For example, they have worked with AWP to align MTAM and the new AWP 'Your Team, Your Conversation, Your Plan' approach[22], which aims to enable individuals to work collaboratively with mental health practitioners to develop a personal wellbeing plan to support engagement and recovery for all identified needs (this is outlined in the section on individual agency learning below).

7.36. The Bristol Multi-Agency Safeguarding Hub for adults (MASH) started operating in October 2024. Coordinated by BCC ASC, it aims to ensure effective multi-agency working and timely information sharing to improve the safeguarding outcomes for individuals.

7.37. The MASH is attended by health partners and Avon and Somerset Constabulary; relevant agencies including (but not limited to) SWAST, Avon Fire and Rescue Service, BCC HLS and Next Link, attend when appropriate to the individual being discussed. Three virtual meetings are held every week, with two to five individuals discussed at each meeting.

7.38. Individuals to be discussed are identified by the BCC ASC Safeguarding Adults Triage Team, where they believe there is a potential need for Section 42 enquiries. Other agencies can request for an individual to be discussed through raising a safeguarding adults concern. Information is sought about the individual from a wide range of agencies, followed by the discussion meeting in which an immediate safeguarding plan, and any other relevant actions, are agreed.

7.39. Had the MASH been in place when agencies were raising safeguarding concerns for Natalie, this could have been a forum through which a multi-agency discussion could have taken place (if the concerns had been considered as potential Section 42 enquiries). In particular, it would have been a means of discussing the various risks to Natalie in March and April 2023 (see paragraph 7.5). Changing Futures' concerns were raised to BCC ASC in the context of sexual violence and abuse, however they should

[21] Strategy: https://democracy.bristol.gov.uk/documents/s91861/Appendix%20A1%20MD%20Strategy%20Final%20draft%202023.pdf

[22] https://www.awp.nhs.uk/patients-and-carers/your-team-your-conversation-your-plan

also have been raised in relation to potential cuckooing, given that the individuals involved were alleged to be dealing drugs from Natalie's flat and this could have indicated a risk of home takeover. While Natalie did not disclose all this information when she reported to the police, the 'BRAG' tool, shared with BCC ASC, raised cuckooing and multiple other concerns. Natalie's Personal Advisor raised cuckooing concerns with their manager but nothing progressed from this, and indicators for exploitation or cuckooing were not reported to or recorded by other agencies. A local cuckooing partnership protocol[23] is in place with clear pathways for practitioners.

7.40. Under the BCC ASC triage process, implemented in June 2023, officers are required to review information systems to consider all the contacts and previous incidents, taking these into account. Following an incident, the triage team utilise three decision-making support tools, which provide guidance around layers of risk and risks associated with people who transition between the support of multiple systems and agencies. This was implemented to support a more holistic assessment of risk for people. The decision support tools also provide guidance on the importance of holding partners to account.

7.41. *Recommendation*: BCC ASC should update its Standard Operating Procedure (SOP) as part of the upcoming review to formally embed the decision support tools developed following the death of Natalie. These tools should become a core element of the triage process, strengthening the assessment of layered risks, including those associated with individuals who are frequently referred. The revised SOP should clearly define escalation pathways, such as progressing repeat referrals to MASH where appropriate. Update to be provided to the KBSP on the actions and outcomes.

7.42. Several agencies referred to high caseloads and lack of capacity impacting on timely and effective responses to Natalie. This is a national issue: the Second SAR National Review[24] found a key theme across SARs was organisational support: "effective safeguarding might be undermined by workloads, increasing demand, lack of management oversight through supervision, challenges of staff retention, and gaps in commissioned service provision" (p. 10, Executive Summary). The SAR Panel discussed this issue in relation to Natalie. It was noted that Natalie's BCC CFS Through Care Personal Advisor would likely have had a caseload of around 20 young people. Their regular contact with Natalie and their efforts to involve other agencies didn't reflect more capacity or time, rather that they were focused on Natalie due to their concerns, which may have meant they had less capacity with others on their caseload. In recognition of this, the MTAM approach described above incorporates understanding of practitioners' caseloads, capacity and other contexts that impact on their work with individuals, to ensure planned activities are realistic and achievable.

*Multi-agency management of risk*

7.43. The previous sections outlined agency understanding of and responses to Natalie's history of trauma, and the impact this had including challenges, good practice and findings in relation to information sharing and multi-agency working. These themes are also relevant within this section, focusing on agency responses to risk, and the legal

[23] local cuckooing partnership protocol
[24] https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

frameworks and statutory duties that frame this. The focus is largely on May 2023, following Natalie's suicide attempt.

7.44. Again, the Personal Advisor and Changing Futures were prominent in this period in raising concerns and highlighting risks relating to Natalie.

7.45. Good practice was noted in the SAR in BCC ASC's decision to close the safeguarding concern in early May 2023 based on Natalie receiving mental health support from AWP. When Natalie was then closed to AWP, a safeguarding enquiry was proportionate and could have supported protection of Natalie. This decision also recognised the multiple safeguarding concerns raised for Natalie: professionals were seeing the bigger picture that these presented. In addition to the good practice, learning is identified here in that the multiple safeguarding concerns could have been responded to earlier, had there been recognition of the remit and limits of the services supporting Natalie. While they have safeguarding responsibilities and took appropriate actions to raise concerns, Natalie's Personal Advisor and Changing Futures remained involved with Natalie throughout; but they were – and are – not adult safeguarding specialists, resulting in a gap remaining in the support and care provided to Natalie.

7.46. Information shared with the SAR demonstrated that AWP, in assessing Natalie's risk following her discharge from hospital, was informed by the full Mental Health Act assessment completed with Natalie the evening before. That assessment had concluded there was no evidence Natalie needed to be detained for her own safety. Within the assessment, Natalie had indicated she wished to stay involved with AWP and pursue a more in-depth assessment of her mental health needs.

7.47. AWP also on this day referred to the perceived 'public' nature of her previous suicide attempt. The Personal Advisor and Changing Futures attempted to share their concerns with AWP but felt their knowledge of Natalie was not taken on board. It is also unclear how agencies collectively considered Natalie's trauma history, particularly the very recent traumas[25], in relation to her intersecting protected characteristics (sex/gender, age and care leaver status); and how these interacted with her risk for mental health deterioration and suicide. These would have been fully considered by AWP had a full psychiatric assessment been completed with Natalie, which she had indicated she would be interested in engaging with during the Mental Health Act assessment. However, when Changing Futures attempted to refer Natalie to BCC ASC at that time, they felt their request for support was denied due to BCC ASC not accounting for her trauma history and presentations. Changing Futures felt that BCC ASC's decision was influenced by BCC ASC's perspective that Natalie may have had a personality disorder, not by her trauma history and presentations – albeit this had not been diagnosed, as AWP had not had the opportunity to fully explore this with Natalie.

7.48. Contributors to the SAR expressed frustration around the lack of multi-agency safety planning for Natalie just before she died; considering the concerns from multiple agencies, this was not a proportionate response. NHS 'Staying safe from suicide' best practice guidance for safety assessment, formulation and management was published in April 2025[26]. The guidance is for all mental health practitioners in England, across community and inpatient settings. It builds on the National Institute for Health and Care

[25] https://uktraumacouncil.org/trauma/ptsd-and-complex-ptsd
[26] https://www.england.nhs.uk/long-read/staying-safe-from-suicide/

Excellence guidance 'Self-harm: assessment, management and preventing recurrence (NG225)'[27] , which "*emphasises replacing risk prediction methods with a psychosocial approach*". The guidance states:

"*The 'low-risk paradox' – that most people in contact with mental health services who die by suicide have been assessed as being at low or no risk of suicide – shows that suicide prediction tools, scales, and stratification (for example, into low, medium, or high risk) don't work. This has been well established by research[28].*"

7.49. The guidance recommends that practitioners "explore risks collaboratively, understand changeable safety factors, and co-produce safety plans". While it is not possible to say whether it would have changed the outcome for Natalie, this approach would have significantly changed the response to Natalie. During prior episodes of mental health deterioration and concerns relating to Natalie taking her own life, safety plans were in place in the form of, for example, a friend staying with her, and agencies checking in. Instead, there was an absence of safety planning in the days before she died – this was despite the best efforts of Natalie's Personal Advisor and Changing Futures worker, who contacted many agencies in the days before Natalie's death, but felt their concerns were not taken seriously. The SAR recognised that, in the days between her discharge from the mental health inpatient unit and her death, multiple agencies were involved, and this included an emergency response (ambulance and police) due to the level of those concerns.

7.50. The SAR discussed what more, or different, support could have been provided in that short period. The emphasis for the learning identified in the SAR was the need for a shared understanding of how and why Natalie's risk of suicide had increased at that point: many factors were known including Natalie being a care leaver, her child being removed, and her extensive trauma history. What had changed at this point was that Natalie was no longer contacting services for help or support. Those closest to Natalie – her child's foster carers, the BCC CFS Through Care Personal Advisor, and the Changing Futures worker – were clear that this change meant Natalie's risk of suicide was significantly increased, but the two workers felt this wasn't consistently taken on board by other practitioners.

7.51. *Recommendation*: The ICB Designated Children in Care Team will incorporate learning from this SAR into the current mental health development workstream. This workstream is to align with initiatives from the Multiple Disadvantage Transformation Board. Intended Outcome: To achieve a comprehensive understanding of emotional and mental health service provision for Children in Care and Care Leavers, including data collection and identification of service gaps. Additional Requirement: The workstream will involve expert input from psychologists, psychiatrists, and other mental health professionals experienced in supporting Children in Care and Care Leavers.

7.52. One element of the response to Natalie at this time was that she was deemed to have capacity to make the decision to not engage with mental health practitioners. The first principle of the Mental Capacity Act 2005 Code of Practice[29] is that "*a person must be assumed to have capacity unless it is established that they lack capacity*", which

[27] https://www.nice.org.uk/guidance/ng225
[28] https://pubmed.ncbi.nlm.nih.gov/28302700/
[29] https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

alongside the third principle, that "*a person is not to be treated as unable to make a decision merely because he makes an unwise decision*", means practitioners must act proportionately when an individual declines to engage with their service.

7.53. The second principle of the Act Code of Practice is that "a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success". Communication between practitioners and individuals is crucial to understanding an individual's capacity in that moment, and in relation to specific decisions. The inability of practitioners to see, or engage in discussion with, Natalie in the days prior to her death, meant that these practicable steps to support could not be taken. Yet a great deal of background information was available that indicated Natalie's mental health had deteriorated in large part due to the accumulation of trauma experiences, including the news that her child would be adopted: these factors did not change in the days leading up to Natalie's death, regardless of her statements that she would not hurt herself.

7.54. The SAR heard that local organisations, and people with lived experiences of trauma and adversity, across Bristol, North Somerset and South Gloucestershire co-developed an accessible 'Trauma Informed Practice Framework' resource and self-assessment questionnaire and action plan[30] to support local agencies in reviewing, developing and enhancing their trauma informed approach. The tool is not service-specific and aims to ensure responses are systemic, and that agencies remain accountable to themselves and each other in continuing to learn and grow.

7.55. *Recommendation:* Agencies involved in this SAR to feedback to the KBSP Keeping Adults Safe Board on their use of the BNSSG Trauma Informed Practice Framework and self-assessment tool, or similar tool that may have been developed for their service type, to continue to develop a universal and systemic trauma informed approach.

7.56. As described above, some practitioners felt their perspectives of Natalie's situation, and their knowledge of her gained through long-term trusting relationships, were not taken on board by other agencies such as AWP. The SAR found a lack of accountability between agencies, which impaired the partnership response.

7.57. A KBSP Escalation Protocol[31] is in place and has been for some time. The protocol is clear, providing a framework of stages for escalation depending on the concern and situation. Feedback to the SAR nevertheless highlighted that escalation often required knowing colleagues in partner agencies, and having existing working relationships with them, to enable professional challenge. Additionally, practitioners must be supported by their managers in escalating concerns, and this was not consistently the case for some practitioners involved with Natalie. This is crucial for practitioners supporting those such as Natalie, which is complex, intense and can be overwhelming.

7.58. *Recommendation*: KBSP Policy and Projects Officer to amend the Partnership Escalation Protocol to include, when escalation concerns relate to a child in care or a care leaver, that escalation processes involve the relevant designated professionals for these groups. Also, to review with member agencies whether generic email addresses could be included in the Escalation Protocol (supported by internal agency processes for receiving these emails) to support agencies in escalating concerns when

[30] Trauma Informed Practice Framework - BNSSG Healthier Together
[31] https://bristolsafeguarding.org/professional-resources/escalation-of-professional-disagreements-safeguarding-adults

a specific point of contact is not held/known. Additionally, the Designated Nurse for Children in Care and Care Leavers to be added to the KBSP Escalation and Professional Disagreement Policy for any cases involving this cohort.

## 8. Individual Agencies' Good Practice, Learning and Actions

8.1. Within agency PMARs, many identified good practice as well as areas for learning. Some made recommendations or identified specific actions to be taken forward.

8.2. When the SAR recommenced in 2025, agencies were requested to provide updates in relation to the learning identified, recommendations and/or actions, and these are outlined in this section.

8.3. The SAR notes that analysis submitted by agencies to the SAR through the PMARs were comprehensive and reflective. This included analysis concerning the whole timeframe originally considered by the SAR (2020-2023), not just what has been covered in the report (2023 only). The Independent SAR Author thanks the agencies for their thorough engagement with the SAR, and their willingness to explore and analyse their contacts with Natalie to identify good practice and areas of learning.

*Avon and Somerset Constabulary*

8.4. Good practice was noted by the Constabulary in relation to communication and information sharing with partner agencies; safeguarding considerations for Natalie, which were reviewed when situations changed; collaboration with BCC HLS to explore alternative accommodation for Natalie; and consultation with the Mental Health Triage and Crisis Teams.

8.5. Learning was recognised in relation to the completion of the 'BRAG' tool, which is used by attending officers to assess vulnerability. Six were completed, one was not completed appropriately due to existing support being in place. Eight were not completed due to no vulnerabilities being identified; while deemed appropriate at the time, on reflection through the SAR process, officers should have considered what was known about Natalie's situation and her drug use. Had these been done, more information could have then been provided to BCC ASC when the safeguarding concern was raised in April 2023.

8.6. A BRAG was not completed when the Section 136 was completed for Natalie in May 2023 because care was in place; the learning here related to a lack of specific guidance requiring officers to complete a BRAG when people are detained under Section 136. A recommendation was made in a South Gloucestershire SAR for Avon and Somerset Constabulary to '*amend mental health procedural guidance to make clear the requirement to complete a BRAG for all incidents, particularly when detaining people under Section 136*', and the Constabulary made an additional recommendation to supplement this relating to this SAR to ensure all areas of vulnerability are included.

8.7. *Update*: BRAG guidance has been updated and specifically mentions mental health and Section 136. The review of the guidance encompassed the social care strengths and needs assessment and is designed to support with the identification of vulnerability (adults and children). This will be further supported by a full BRAG training schedule

including a video based on barriers to completion that has been identified by officers themselves. Large scale improvement plan sits in Force for BRAG and is being governed through different groups with a His Majesty's Inspectorate of Constabulary (HMIC) focus. The domestic abuse theme lead has also commissioned an update to mental health guidance to include the necessity for BRAG to cross reference the need.

8.8. Learning was identified in relation to officers not checking the spelling of Natalie's name, leading to two occasions when this was recorded incorrectly; those records were then not linked to the others concerning Natalie. Officers are regularly reminded to check for alternative spellings.

*Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)*

8.9. AWP identified areas of learning and good practice. The good practice related to liaison with Avon and Somerset Constabulary, the General Practice and Changing Futures. Risk information was shared, and discharge planning recorded in May 2023 involved contact with Changing Futures and BCC ASC Safeguarding Team advising them of the closure and that Natalie could be re-referred to the Triage Service.

8.10. Good practice was noted in that Natalie had been referred for assertive outreach in early March 2023; however, she remained on the waiting list for that service and had not been seen when she died. AWP highlight this is a small team, based in each Recovery Team. There continues to be a high demand for the service and those with a serious mental illness are prioritised to maximise their opportunity for engagement and minimise risk whilst in the community. All patients within the assertive outreach pathway have been under the care of the Recovery Team, who have identified a need for a more intensive way of working. They continue to use this model to support identified individuals within Bristol mental health services.

8.11. An area of learning highlighted by AWP was the lack of clarification of Natalie's family details; with Natalie's consent, practitioners could have spoken with them to support the work with Natalie.

8.12. *Update*: AWP has recognised that data collection for next of kin has been an area requiring improvement. Therefore, a key performance indicator (KPI) target has been set for improvement across all services. Bristol mental health services have a monthly assurance governance meeting where all KPI's are reviewed; improvement has been noted for family or friend contact details, and AWP continue to strive for compliance. AWP are committed to family engagement and complete the national triangle of care audit for each team on an annual basis to ensure practitioners 'think family' as a priority to support and engage service users referred for care.

8.13. AWP also identified that practitioners could have understood Natalie's involvement with DHI better.

8.14. *Update*: AWP are committed to individualised care and have made a recent transition from Care Programme Approach[32] (CPA) to 'Your team, Your conversation, Your

[32] https://www.nhs.uk/social-care-and-support/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

plan'[33]. The aim of this is to enable service users to work collaboratively with a personal wellbeing plan to support engagement and recovery for all identified needs.

*Bristol City Council – Adult Social Care (BCC ASC)*

8.15. The original PMAR from BCC ASC reported that changes had taken place to the approach to the management of mental health (including serious self-harm) cases: where previously these were closed by the team, they are now all triaged with a view to progressing and acting where partners are not managing risk and there may be a risk of neglect by omission. A clear process is in place with the expectation that there is challenge of mental health services to ensure protection, and clear protection plans where this is warranted. A Single Operating Procedure was established which gives guidance on the process around initial protection planning actions and the triage process, and clear guidance around escalation to senior management where actions may be needed.

8.16. Following their internal review after Natalie's death, BCC ASC issued follow up guidance for the Safeguarding Team related to the triage processes; guidance was reissued and followed up with team reflective discussions. Actions were implemented in June 2023, as follows. The strategic escalation process was re-circulated to the Safeguarding Team. A pilot of new risk assessment tools to support robust and consistent risk assessment in triage began in June 2023; the tools also explore intersectionality and how this impacts risk. A review was completed for the Safeguarding Team and individual performance in relation to compliance with policy and procedure in practice. A peer audit process was implemented for the Safeguarding Team to provide oversight of decision making at team level and to encourage a continuous learning cycle and practice improvements. These changes are being reviewed as part of ongoing improvement and review work in safeguarding practice and pathways.

8.17. BCC ASC provided an updated PMAR which stated all recommendations had been completed, with the outcomes described as follows.

8.18. The new critical incident process has been updated, agreed as per internal governance structure and is now in regular use in health and social care.

8.19. The quality assurance framework for safeguarding is now implemented and supports regular case audits, which includes scrutiny of safeguarding cases with mental health themes and repeat referrals, undertaken in line with an ongoing audit plan.

8.20. AWP and ASC have regular meetings to discuss safeguarding issues where this is required, these are regular or ad-hoc as needed.

8.21. The risk assessment tools, now called decision support tools were implemented to wider role out in 2024 and the KBSP has been updated in Keeping Adults Safe meetings.

*Bristol City Council – Children and Families Services (BCC CFS)*

[33] https://www.awp.nhs.uk/patients-and-carers/your-team-your-conversation-your-plan

8.22. Good practice was noted by BCC CFS in relation to the dedicated, consistent, and trauma informed response of the Through Care service Personal Advisor. They maintained a non-judgemental, flexible approach to working with Natalie, and worked to involve relevant partner agencies, share information and made referrals.

8.23. Learning was identified in relation to the responses of BCC CFS to the referrals raising concerns for Natalie's child. It was positive that they recognised Natalie's good working relationship with the Personal Advisor in passing the concerns onto them for discussion with Natalie, and they subsequently referred for family support. However, the First Assessment Service could have demonstrated professional curiosity in their response and recordings, in particular around Natalie's mental health, which could have prompted the initiation of a Child and Family Assessment sooner.

8.24. *Update*: Work in the First Assessment Service has continued in relation to the effective and timely response. The previous system of rating contacts as Red, Amber or Green (RAG rating) has recently been reviewed, and actions are underway to further improve the timeliness of response, and to support agencies in improving the quality of referrals made to First Response.

8.25. Since the original BCC CFS analysis report for the SAR, being a care leaver has been made a 'protected characteristic' in Bristol, which is a positive step in highlighting and responding to some of the disadvantage care leavers often experience as a result of their complex life stories and experiences. Multi-agency work in relation to Transitional Safeguarding has also continued since this initial report was completed, which has involved BCC CFS, BCC ASC, BCC HLS, 1625 Independent People, the Young Adults Transition Service (YATS) and other relevant agencies, with the view to these agencies working together more effectively to support young people in navigating the different services they may need in young adulthood. Whilst Natalie may not have fallen into this age group/cohort, this multi-agency approach still provides benefits in strengthening relationships and joint working between these agencies and will therefore benefit other young adults through more effective partnership working.

*Bristol City Council – Housing and Landlord Services (BCC HLS)*

8.26. Good practice from BCC HLS was identified in the prompt response to the emergency accommodation request for Natalie in 2023. Her application for a move was prioritised due to the service's understanding of her vulnerability. Practitioners also worked with Natalie to make referrals for debt and money advice, benefit, and tenancy support.

8.27. BCC HLS identified that the response to domestic abuse, reported by Natalie in 2022, could have been better. Contact attempts failed, and the case closed without full notes. A lock change was completed but other security and safety measures were not sought due to being unable to contact Natalie at that time. Further, the case was recorded as an anti-social behaviour nuisance case, not domestic abuse, as it should have been.

8.28. *Update*: BCC HLS now have a Housing Independent Domestic Violence Advisor (IDVA) in post and have recruited a Domestic Abuse Housing Alliance (DAHA) accreditation[34] lead; this continues to improve the response to domestic abuse.

[34] https://www.dahalliance.org.uk/membership-accreditation/what-is-daha-accreditation/

8.29. Bristol Sanctuary Scheme is now in place for victims of domestic abuse, who want to remain in their homes, to be referred for assessment and provision of additional security measures. This is provided collaboratively with Next Link and BCC Repairs to keep victims safer and reduce their risk of experiencing harm.

*Changing Futures*

8.30. The original PMAR submitted to the SAR stated an internal audit had been completed. The audit made organisational recommendations around system processes (incident reports), as well as finding a good standard of note writing, relationships and collaborative work with professionals.

8.31. The lack of a clear internal escalation process was highlighted in the PMAR, also noting that the KBSP Escalation Policy had not been followed.

8.32. Since producing the original PMAR, Changing Futures informed the SAR, the service has developed, and many actions have been taken forward. Changing Futures have incorporated the learning from the SAR and their own desktop review into the service redesign for 2025-26, which is being used to further embed the MTAM approach (which assumes a shared safety planning approach) across Bristol services that work with people experiencing multiple disadvantage.

8.33. Rather than being a case holding service, senior MTAM practitioners have been recruited to work alongside multi-agency case discussion spaces: MASH, Multi-agency Risk Assessment Conference (MARAC), Case Review Group (CRG) (escalation meeting for people in the homelessness pathway) and Eastwood Park Prison Release Board to identify individuals. Therefore, practitioners work alongside and support them in developing this multi-agency approach for those individuals. A senior practitioner (Social Worker) has been recruited to work alongside the senior MTAM practitioners to support with specialist Care Act and mental health assessment knowledge. They will also work with the BCC ASC teams to develop assessment processes through a 'multiple disadvantage' lens.

8.34. Changing Futures have embedded this approach into the processes within those spaces (albeit they highlight, with some variation in process and progress) and are working collaboratively with colleagues in those spaces to identify individuals who could most benefit from this pre-emptive, shared safety planning approach. This aims to support more people in the system to have the opportunity for 'real life' practice and begin to problem solve how MTAM (best practice multi-agency working) can work in their own organisational context. Through the identification of individuals, Changing Futures have met specific teams in organisations in Bristol that they had not worked directly with previously; Changing Futures are using these opportunities to share (duty to share) information, training and collaborative learning spaces more widely.

8.35. Changing Futures have supported a piece of work by AWP in developing 'Your Team, Your Conversation, Your Plan', which is taken broadly from MTAM, however, Changing Futures see this as still internally focused. Where Changing Futures are supporting MTAM's to be led by other services or organisations, it is challenging to bring mental health services to the table to fully participate in multi-agency support planning and shared risk holding within an MTAM.

8.36. The MTAM approach has been formalised, co-produced with partners across the city as well as people with lived and living experience. MTAM is characterised by pre-emptive shared safety planning which aims to mitigate or reduce the impact on the individual when they spiral or begin to escalate towards crisis. Services within an MTAM are asked to maintain connection and updates in between joint safety planning meetings to enable ongoing coordinated support.

8.37. Training has been created and delivered freely available to partners, with further dates scheduled throughout 2025.

8.38. The approach has been evidenced by University of the West of England (UWE) and Bristol University as being trauma informed, and by SARI (Stand Against Racism and Inequality) as considering people's equality and diversity needs.

8.39. A manual has been written, which will be shared with everyone attending training and made available on the Changing Futures website by the end of July 2025.

8.40. The MTAM Exchange (human learning system), a communication and learning system, has been developed. This is where problem solving takes place on systemic issues with partners across multiple service domains. The Exchange includes the Multiple Disadvantage Transformation Board, Multiple Disadvantage Commissioners Network, service leads, practitioners and representatives from the lived experience community. In one cycle the Exchange specifically looked at information sharing (duty to share) and developed a Frequently Asked Questions (FAQ) document which has been shared and is available on the Changing Futures website. The learning has also been included in the MTAM training and manual.

8.41. Annually, the Changing Futures host organisation, Second Step, completes a thematic review of the learning from incident reviews completed during the year. This case raised several learning points which were identified as key areas for development by the thematic review of the incidents from 2023/24, including:

- A comprehensive review of the assessment and management of client risk across Second Step services. The work is informed by both local and national practice improvement, including 'Your Team, Your Conversation, Your Plan' (AWP), and the joint safety planning approach developed by Changing Futures and its partners.
- Improvements to the guidance and training covering case note recording and file keeping standards.
- The redesign of service quality and compliance audits, designed to ensure greater oversight by operational managers.

*Developing Health and Independence (DHI)*

8.42. The original PMAR submitted to the SAR highlighted a lack of escalation from the practitioner to their line manager when Natalie's situation changed or risk increased. Increased safeguarding and risk training has taken place since Natalie's death.

8.43. A task and finish group was in place at the time of the PMAR being completed in 2024 (across Recovery Orientated Alcohol & Drugs Service (ROADS), a partnership between four organisations (including DHI) in Bristol then responding to drug and alcohol use) looking at numbers of referrals to adult and child safeguarding, successful

outcomes, and quality of referrals. Child and adult safeguarding were added as two separate headings to all staff supervisions.

8.44. A ROADS wide audit was completed in 2023, with the BCC CFS Front Door. Data was being evaluated with a review planned in November 2023. DHI safeguarding policies and procedures were in the process of being reviewed so that they are in plain English. The Care Plan Audit Group looked at how people are safeguarded through clear care planning and how the purpose of the plan is to safeguard and promote the interests of the person.

8.45. DHI no longer provide substance use treatment in Bristol. A new service was commissioned, with Bristol Horizons[35] (a partnership of nine community organisations, with Turning Point leading) launching in April 2025. The commissioners (BCC Public Health) informed the SAR that over the two years prior to the writing of this report (2025), scrutiny of safeguarding practice has been strengthened, forming a core reporting requirement within contract management.

8.46. The tender of the contract for Bristol Horizons had clear expectations regarding safeguarding expertise and practice. As the lead partner, the national safeguarding leadership and policy/practice of Turning Point is being embedded into Bristol Horizons, and they have secured local leadership. BCC Public Health will continue to measure safeguarding as a performance indicator throughout the contract.

*Gwent Police*

8.47. Gwent Police noted good practice in relation to the recorded contacts with Natalie in 2021, in relation to information sharing with partner agencies, and internally with the Domestic Abuse and Safeguarding Team. A clear safety plan was documented by the attending officer.

8.48. Areas for learning identified by Gwent Police were as follows: Public Protection Notices (PPNs) should have been completed on every incident for the safeguarding of Natalie's child, even if the officers believed the call to be malicious (this was the case on one occasion when someone called stating Natalie stored drugs within reach of her child). The victim statement concentrated on one incident only. It did not cover the relationship therefore it missed the potential coercive control. If the victim is being supported by a specialist, a request can be made for them to support the victim whilst they provide a statement.

8.49. *Update*: Gwent Police has now embedded Domestic Abuse Matters training into the force[36], which includes coercive control, stalking, safeguarding, and voice of the child. To date 1,004 front line officers and staff have been trained. Officers will also receive training over the next months on the Domestic Abuse Risk Assessment (DARA)[37]. The Detective Inspector within safeguarding has confirmed that PPNs are submitted on domestic abuse cases. The investigation support officers review all domestic abuse cases and ensure that the relevant support services are updated.

[35] Home | Horizons Bristol
[36] https://www.college.police.uk/career-learning/licensed-products/domestic-abuse-da-matters-change-programme
[37] https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-Rationale-2022.pdf

*NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) on behalf of the General Practice (GP)*

8.50. Several actions were identified by the BNSSG ICB/General Practice; these are listed below, with updates provided.

8.51. The GP to have a robust policy to review records following non-attendance or failed contacts. *Update*: Since the death of Natalie, the General Practice now has a care coordinator assigned to working with their identified vulnerable and complex patients. The General Practice continue to have monthly internal safeguarding meetings with attendance from the Health Visitor and the care coordinator to discuss vulnerable families/patients. The ICB Safeguarding team have met with the General Practice who have given assurance there is a process in place for reviewing their safeguarding policies on a yearly basis and this includes the review of Did Not Attend (DNA) policy.

8.52. For the GP Practice to review their adult safeguarding practice policies, including their DNA policy. *Update*: BNSSG ICB Safeguarding team in January 2025 updated the adult and children DNA and Was Not Brought In (WNBI) policy. These have been shared with all General Practices in BNSSG and is available to all health care professionals with access to the Remedy website. This policy has been incorporated into the in-house General Practice DNA policy when it was reviewed. The ICB Safeguarding team have had assurance from the GP practice there is a process in place for reviewing all their safeguarding policies on a yearly basis.

8.53. The GP should consider regular face-to-face reviews, especially when dealing with complex cases, care experienced adults and young people. *Update*: The General Practice care coordinator liaises and works with GPs to ensure all vulnerable patients are considered for face-to-face appointments/visits and any reasonable adjustments are noted on their medical records. The General Practice shared they prioritise face-to-face reviews for all patients and now have only a few telephone slots on offer each day. In July 2025, the BNSSG ICB Designate and Deputy Designate Nurse for Children in Care and Care Leavers delivered a webinar to update all General Practices of the complexities and vulnerabilities for children in care, care leavers and care experienced patients. The update included services available and the role of the Personal Advisor to their patients. The update also reinforced that the GP is the lead health professional for care leavers and their duty of care.

8.54. For the General Practice to review their safeguarding policies and practices and how their high-risk vulnerable adults are identified and reviewed. *Update*: The General Practice is in the process of reviewing and standardising their coding. They plan to utilise the risk stratification requirement in the new GP contract to evaluate practice capacity and to review their vulnerable patients registers for each GP as patients progress through episodes of care and how they can both come on and off the vulnerability registers. Their safeguarding link GP will work with the care coordinator to progress and to standardise coding on records of vulnerable patients.

8.55. A learning event to be convened around Adverse Childhood Experiences (ACEs) and health related issues and the application of trauma-informed care approach to consultations. *Update*: The BNSSG ICB Primary Care team in June 2024 arranged the delivery of a specialist trauma informed seminar update at the annual Primary Care

Conference, and attendance was recorded for over 180 clinicians from across BNSSG GP Practices. The safeguarding link GP from Natalie's General Practice attended the Primary Care conference in 2024 where ACEs and trauma-informed care approaches to practice update was provided. The General Practice also report they access training through the women's health hub initiative and the ICB lunchtime learning sessions.

8.56. For the General Practice to review the management of repeated short-term prescriptions to high-risk adults. The GP Practice to review their adult safeguarding policies and practices that includes risks of exploitation. *Update*: Since the initiation of the SAR the General Practice completed an in-house audit on Opioids usage and Diazepam. They now have two in-house pharmacists and a prescribing hub in place who review and support GPs in the prescribing of short-term prescriptions.

*North Bristol NHS Trust (NBT)*

8.57. NBT noted evidence of person-centred multi-agency working around Natalie. The learning for NBT was that at the time, only an alcohol support pathway was in place internally, not a substance misuse support pathway.

8.58. *Update*: The NBT Drug Team have been in place since November 2023. All referrals for patients identified with drug and/or alcohol problems are made to the single point of contact for the Drug and Alcohol Team (DAT). Each referral is triaged and allocated accordingly. Patients with local authority care experience and those under 25 years of age are prioritised and seen by senior professionals within the team.

8.59. The DAT work closely with other speciality professionals within NBT, including the Mental Health Liaison Team, promoting a multi-disciplinary assessment of patients with dual diagnosis. DAT also work closely with community services, again as part of a multi-agency response to patient care, particularly aimed at patients presenting with significant risks associated with substance dependency and use. DAT assess dependent and problematic recreational drug and alcohol use, complete detox management plans for in-patients, make referrals to community drug and alcohol services, provide psycho-education on the risks associated with drug and alcohol use, provide follow up and support for recovery, relapse prevention and abstinence, with Specific, Measurable, Achievable, Relevant, Time-bound (SMART) meetings being held in the hospital every Wednesday. Currently DAT provide specialist input across the whole hospital-covering both the Emergency Department and in-patient wards. Whilst the team was commissioned to provide Emergency Department cover between 8-4pm Monday-Friday, weekend cover is currently being trialled with the long-term plan for this to be made permanent. DAT work closely with NBT Safeguarding Team for both child and adult safeguarding considerations.

*South Western Ambulance Service NHS Foundation Trust (SWAST)*

8.60. Good practice was noted by SWAST in relation to practitioners meeting their practice standards for medical management, and ensuring signed refusals were gained from Natalie when she declined to be taken to hospital against their advice.

8.61. SWAST identified learning in relation to practitioners consistently assessing mental capacity and gaining consent from patients. They provided the following updates:

8.62. Training and Education: SWAST completed a review of safeguarding training in 2023. As a result of the review, safeguarding training was increased and the annual education day for 2024/2025 included 4.5 hours of safeguarding training. Included in the training was a learning outcome on professional curiosity, 'state the importance of using professional curiosity to recognise safeguarding concerns' and is taught to all front-line staff and clinicians working within the ambulance control room. There was also a focus on referrals – when and what to refer and how to write a good quality referral. This has resulted in a significant improvement in the quality and appropriateness of referrals. SWAST safeguarding duty line went live in 2024. Ambulance crews and control room staff are now able to call for real time advice from a safeguarding specialist or an advanced clinician.

8.63. Mental Capacity Assessments: The electronic patient clinical record was reviewed in July 2024 and changes were made to the mental capacity section. Ambulance crews are now prompted to complete the functional stage of the test first, consequently they will need to record the functional part of the test prior to being asked to record if the patient has an impairment, this should help to put more emphasis on the patient's ability to understand, retain, weigh up and communicate their decision. Mental Capacity Act training has been reviewed and was included in the development day 2024/2025. The training is scenario based, and the learning outcomes state the importance of accurate and detailed record keeping when mental capacity is diminished. The Safeguarding Education Specialist is designing a Mental Capacity Act two-hour session for advanced clinical practitioners and specialist paramedics who provide duty advice out of hours on the safeguarding duty line.

8.64. Safeguarding Supervision and Referral Feedback: SWAST safeguarding specialists are offering supervision to ambulance crews in relation to incidents that involve safeguarding, this will help to promote reflection and future learning. SWAST safeguarding specialists can provide feedback to ambulance crews regarding safeguarding referrals resulting in improvement to practice.

*Womankind*

8.65. Womankind identified in their PMAR that the only information they had recorded had been provided by Natalie herself, or through the referral form from The Bridge. They had no contact with any other agencies working with Natalie.

8.66. Since the PMAR was first written, Womankind have worked to improve communication, and a more coordinated approach, seen as essential when working with vulnerable individuals who have complex histories and interactions with different services. Womankind aims to ensure more consistent contact with other agencies working with the most vulnerable clients, making it a priority to promptly share any new information regarding vulnerable clients with relevant agencies. If Womankind become aware a risk has changed or increased, this will also be communicated to the appropriate agencies/contacts.

8.67. Womankind identified that when a client is working with multiple agencies, it can sometimes be unclear who is responsible for leading safeguarding efforts. When a client is involved with another service such as social care, it is beneficial for supporting agencies such as Womankind to have a designated contact person for any safeguarding concerns. Womankind has therefore acted to ensure that when there is contact with a client who has a history of contact with social care or other relevant agencies, they seek the client's permission to make contact.

8.68. Womankind has created and appointed a new Head of Operations role to provide additional capacity; their responsibilities include management of clinical risk and safeguarding.

8.69. The Womankind safeguarding policies and procedures have been reviewed and updated, providing updates to the clinical teams. The number of trained Designated Safeguarding Leads has been increased from two to three within the organisation. A rota of out of hours Designated Safeguarding Leads cover is in place.

8.70. Critical incident training was delivered in March 2025 to the clinical team to increase skills, confidence, knowledge and application of risk management policies and procedures. This will be repeated annually.

## 9. Conclusion

9.1. Natalie had multiple and complex needs which endured throughout the time that agencies were involved with her. It is clear to the SAR that the agencies involved had worked hard to consider these needs, and, led by Natalie's Personal Advisor and Changing Futures, had made multiple attempts to meet Natalie's needs.

9.2. In their referral for the SAR, BCC CFS raised the following: 'There is significant research on how women's mental health needs are conceptualised within statutory services and how complex trauma is understood and responded to[38]. Did Natalie experience unconscious bias or structural discrimination as a female care leaver with a history of complex trauma trying to access mental health services?' This was discussed by the SAR Panel.

9.3. It is impossible for the SAR to state with certainty whether Natalie experienced this type of bias from practitioners at that time. However, the SAR Panel heard from those that work with care leavers that they do experience bias including assumptions and perceptions that they're 'too complex'.

9.4. In January 2025, Bristol City Council councillors unanimously approved a recommendation to formally recognise care experience as a protected characteristic. It was felt that – while recognising this change is for Bristol City Council only – the impact of being care experienced may not be consistently recognised across all agencies; although agencies did highlight receiving training in this area, such as AWP. Importantly for this SAR, it was felt that agencies needed to recognise their roles in the context of Corporate Parenting for Natalie, who had no family to turn to and thus relied on agencies for support.

[38] https://www.bma.org.uk/media/2115/bma-womens-mental-health-report-aug-2018.pdf; https://assets.publishing.service.gov.uk/media/5c18e0f0ed915d0b8a31a424/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf

9.5. The following actions have taken place since:

- Human Resources: data collection points have been updated to ensure care experience status is captured both at application stage and for staff already in post. All job applicants who are care-experienced and meet essential criteria will be automatically offered an interview.
- Data collection: an audit is taking place of care experience as a metric in data collection across the local authority to address any gaps.
- Equalities: Equality Impact assessments have been updated to ensure that due regard has been given to impact on care-experienced people before decisions are made. Care experience is now included on all council equality monitoring forms to ensure we better understand the representation of care-experienced citizens.
- Procurement: contracts now have a specific pathway via social value for promoting equality of opportunity for care-experienced children and young people.
- Raising awareness: significant work has been undertaken with senior officers and political leaders, as well as key partners, to promote care experience as a new locally protected characteristic and to support implementation.

9.6. *Recommendation*: Agencies involved in this SAR to provide information on what actions they have taken, or plan to take, to make adaptations to their systems for those who are care experienced, as they may have in place for other protected characteristics.

9.7. *Recommendation*: BCC CFS, BCC ASC and BNSSG Population Health teams to collaborate to gather and share a comprehensive dataset regarding care leavers.

## 10. Recommendations

10.1. In response to the learning identified within the report, the SAR makes the following recommendations.

10.2. BCC CFS to undertake a review or audit concerning cases involving parents going through care proceedings to ensure that: (a) discussions about referrals to Birth Links take place as early as possible; (b) that the right person has had the discussion with those parents covering what support is available from Birth Links; and (c) that when referrals are accepted by parents, they are made as soon as possible in the process. The outcomes of the review or audit should inform future actions to improve practice as required. The outcomes will also be reported to the KBSP. (*See paragraph 7.14*)

10.3. BCC CFS to ensure that when a child is removed from an adult into local authority care, they notify the adult's named GP. (*See paragraph 7.19*)

10.4. ICB to promote GP surgeries to routinely enquire during their registration processes to gain consent from a Care Leaver for an alert to be placed on their health record. (*See paragraph 7.20)*

10.5. ICB Safeguarding Team to continue to provide education to GP's regarding the increased risk of suicide following child removal in training sessions. (*See paragraph 7.21*)

10.6. KBSP Keeping Adults Safe Board to share the following reflective questions prompted by the learning in this section (*see paragraph 7.22*):

- How do agencies support their practitioners to prioritise building relationships with practitioners in partner agencies?
- How do agencies support their practitioners when there are multi-agency disagreements, for example relating to actions, non-acceptance of referrals, or thresholds?
- How do agencies support their practitioners to manage situations in which there is complexity, in relation to the individual they are working with, and the multi-agency response?

10.7. Agencies involved in this SAR to ensure that continued internal communication takes place with all their staff, to inform them of Changing Futures' work and the development of the MTAM model. (*See paragraph 7.33*)

10.8. Representatives on the Multiple Disadvantage Transformation Board to inform the KBSP Keeping Adults Safe Board what actions they take to cascade information internally with colleagues from their respective organisations and update them on the work of the Board and the development of the MTAM process. (*See paragraph 7.34*)

10.9. BCC ASC should update its Standard Operating Procedure (SOP) as part of the upcoming review to formally embed the decision support tools developed following the death of Natalie. These tools should become a core element of the triage process, strengthening the assessment of layered risks, including those associated with individuals who are frequently referred. The revised SOP should clearly define escalation pathways, such as progressing repeat referrals to MASH where appropriate. Update to be provided to the KBSP on the actions and outcomes. (*See paragraph 7.41*)

10.10. ICB Designated Children in Care Team will incorporate learning from this SAR into the current mental health development workstream. This workstream is to align with initiatives from the Multiple Disadvantage Transformation Board. Intended Outcome: To achieve a comprehensive understanding of emotional and mental health service provision for Children in Care and Care Leavers, including data collection and identification of service gaps. Additional Requirement: The workstream will involve expert input from psychologists, psychiatrists, and other mental health professionals experienced in supporting Children in Care and Care Leavers. (*See paragraph 7.51*)

10.11. Agencies involved in this SAR to feedback to the KBSP Keeping Adults Safe Board on their use of the BNSSG Trauma Informed Practice Framework and self-assessment tool, or similar tool that may have been developed for their service type, to continue to develop a universal and systemic trauma informed approach. (*See paragraph 7.55*)

10.12. KBSP Policy and Projects Officer to amend the Partnership Escalation Protocol to include, when escalation concerns relate to a child in care or a care leaver, that escalation processes involve the relevant designated professionals for these groups. Also, to review with member agencies whether generic email addresses could be included in the Escalation Protocol (supported by internal agency processes for receiving these emails) to support agencies in escalating concerns when a specific point of contact is not held/known. Additionally, the Designated Nurse for Children in

Care and Care Leavers to be added to the KBSP Escalation and Professional Disagreement Policy for any cases involving this cohort. (*See paragraph 7.58*)

10.13. Agencies involved in this SAR to provide information on what actions they have taken, or plan to take, to make adaptations to their systems for those who are care experienced, as they may have in place for other protected characteristics. (*See paragraph 9.6*)

10.14. BCC CFS, BCC ASC and BNSSG Population Health teams to collaborate to gather and share a comprehensive dataset regarding care leavers. (*See paragraph 9.7*)