Surrey Safeguarding Adults Board

The death of Mrs A

A Serious Case Review

Professor Hilary Brown

EXECUTIVE SUMMARY

Serious Case Review into the care and support offered to Mrs. A

Executive Summary

Date of birth 22/02/1964
Date of death 24/01/2013

About this review

1. Mrs A. was a talented musician who committed suicide after giving evidence in a historic sexual abuse trial in which a teacher and his wife were convicted of offences against her. This review was commissioned by Surrey Safeguarding Adults Board to address issues that came to their attention about the care and support that partner agencies had been able to offer to Mrs A as she struggled to deal with this.
2. The review panel was chaired by Helen Blunden, Designated Nurse for Safeguarding Vulnerable Adults in Surrey, hosted by Surrey Downs Clinical Commissioning Group and the report written by Prof Hilary Brown, Emeritus Professor of Social Care, Canterbury Christ Church University, working under the auspices of, and with the support of, Vic Citarella from CPEA. Partner agencies also contributed to the Panel's deliberations and their representatives helped to shape the final report; all are thanked for their work.

Background to the review

Abuse suffered by Mrs A in childhood

3. Allegations of sexual abuse focused on a music school which Mrs A attended in the late 70's and early 80's. It was not within the Panel's remit to examine the extent to which the schoolworked within local child protection procedures but it seemed as if they had not taken adequate precautions to prevent exploitative sexual relationships between the school's teachers and their pupils. The account Mrs A gave, in the trial of her abusers, has all the hallmarks of a vulnerable, already abused, young person, who was singled out because she did not have reference points or supportive adults around her. She had no-one who could have helped her to resist the process of grooming to which she was subjected.
4. It seemed to be "common knowledge" in Manchester music circles that not all teachers were observing proper professional boundaries but although some teachers did try to warn those responsible, their concerns were set aside. The hot-house atmosphere of special talent and the promise of glittering careers may have obscured what were, in reality, highly asymmetric relationships and breaches of trust.

Disclosure of the extent of this abuse in adulthood

5. In the summer of 2011, Mrs A disclosed the extent of the abuse she had suffered to a friend who, knowing that the man who had abused her continued to have privileged access to young musicians, reported this to the Surrey Police. In collaboration with Greater Manchester Police, they took matters forward to a prosecution. This division of labour between the two forces created gaps, as well as appropriate boundaries, in the sharing of information between the two forces.

Stress leading up to the court case

6. Mrs A was not a reluctant witness, but she had been somewhat bounced into taking action and the trial, when it occurred, coincided with a very stressful period in her life - a time when she had been dealing with a number of family difficulties and illnesses. She oscillated between presenting in a confident manner demonstrating her determination to get justice but then falling into a state of hopelessness and seeking help in quite erratic and desperate ways.

Assessing risk

7. Competent mental health professionals should have understood the way that people traumatised in childhood shift between states in order to cope and, had they done so, it might have prevented mental health professionals from colluding with Mrs A's pattern of distancing herself from their support as soon as she felt back in charge but then rapidly falling back down into a place where suicide seemed the only way out. Their failure to do so undermined their judgment at a time when they should have been anticipating the fact that she needed more help in the lead up to the trial and also after she had given her evidence.

Providing pre-trial support

8. Throughout the trial Mrs A was given practical support from the Manchester Witness Support Service and also from her GP surgery but the mental health services who supported her during the latter half of 2012 were in disarray and they did not factor the trial and its fallout into their assessments of Mrs A's mental ill-health.
9. We could find no evidence that she had been told *not* to have counselling, but she seemed to believe that, if she did, it would weaken her testimony, so she steadfastly refused help until she could not cope. There is guidance to mental health professionals who offer pre-trial counselling and there were, in fact, no **official** barriers to Mrs A's receiving timely and appropriate help. Professionals from several agencies assumed that she had capacity to make this decision even in the stressful lead up to the court case and even when she seemed not to have been acting on accurate information. There was no reason why Mrs A could not have been supported to be more open about the legacy of the abuse she had suffered, in ways that would not have jeopardised her credibility in front of the jury[1].

[1] Achieving Best Evidence in Criminal Proceedings Guidance March 2011 refers to Therapeutic help for child

Assessing and managing risk

10. By October 2012, she felt she had to have psychological help and the indicators suggest that she should have been prioritised as being at high risk. She took at least nine overdoses during those months but was variously assessed as at low or medium risk. Despite the fact that these attempts on her life were growing more frequent and escalating in severity, their seriousness was not being properly calibrated. The Panel thought that the assessments that were carried out were like separate snapshots rather than a linked-up story.
11. Mrs A attended A&E on seven occasions and after each episode she was seen by the Psychiatric Liaison Team and then discharged home even following one occasion when she explicitly stated that she intended to try to kill herself again. The assessments did not take Mrs A's shocking history of sexual abuse, as a girl and young woman, sufficiently into account nor did they pay adequate attention to the impact of having her traumatic memories reactivated by coming face-to-face with her abusers, and giving her testimony, in court.
12. Her suicide risk was therefore not properly assessed in the months leading up to the trial despite these strong indicators of Mrs A's distress and despite the fact that the court case presented a unique and very powerful reminder to her, of a time in her life when she was helpless and without support. The Home Treatment Team, and the Community Mental Health Recovery service both attended to her, but she was not allocated to a care coordinator until January 2013. This person almost immediately went off sick and no replacement was designated. There was a lack of continuity seen within, and across, these teams. The CMHRS was later formally identified to be "at-risk" in its performance targets, with sickness, low morale and vacancies exacerbating other resource and skill shortages.
13. A significant proportion of people using mental health services are people who have been traumatised by early childhood abuse and sexual exploitation, which is a matter of record and should feature in the training of all mental health professionals. All the mental health services should have been clear that Mrs A's recent ordeal in giving evidence was bound to trigger intense feelings in her and moreover they should have related her escalating suicide attempts to the trial and its impact on her mental health. There should have been tight case coordination to support Mrs A throughout this period, and much clearer communication between the different mental health teams, the acute hospital and her primary care team.

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or vulnerable adult and intimidated witnesses.

The stress of the courtroom experience

14. The trial took place in late 2012 and early 2013, and Mrs A had to travel to Manchester to give her evidence. She had been identified as a "vulnerable" witness and had been offered, but refused, "special measures" such as screens or video-link facilities that would have enabled her to give evidence without facing her abusers in court. She was deemed to have capacity under the Mental Capacity Act 2005 to make such decisions for herself, but the Panel wondered whether, at some points, her distress cut across her ability to make an informed decision and/or to act in her own best-interests.

The aftermath of the court case

15. Unsurprisingly Mrs A found the whole courtroom experience very traumatic and when she returned home, she was exhausted and upset. She re-engaged with mental health services (HTT), who visited on alternate days and arranged for medication to be delivered to her. She followed the course of the trial from a distance, reliant on press reports and no longer being given support from the Witness Support Officer or the Officer-in-Charge who had been alongside her throughout the process of preparing for the trial.
16. Some charges had to be dropped towards the end of the trial because important matters about the timing of the offences could not be proved, so the judge asked for them to be removed from the charge sheet. This was reported in the Press and Mrs A took from those accounts that she read, that she had not been believed. But Mrs A *had* been believed on the other matters and the jury brought in guilty verdicts on a number of other charges that resulted in a prison sentence. By then Mrs A had already died, having taken her own life believing that she had failed to bring her abusers to justice.

Linking abuse in childhood to suicide risk

17. The National Suicide Prevention Strategy does not make the link between childhood sexual abuse and suicide explicit, but it does make clear that self-harming behaviour is a prime indicator of suicide risk, especially where there has been a non-fatal suicide attempt. A previous strategy document issued in 2008[2] argued that a person's history of violence and abuse should be made explicit in clinical assessment as a way to combat victim-blaming and compassion fatigue. The National Suicide Strategy also argues for better services when people have been hospitalised on account of, and/or are known to be at high risk of, suicide and current NICE Guidelines state that a full psycho-social assessment should take place when a person is admitted to an Accident and Emergency Department as a result of self-harm or attempted suicide.

[2] http://www.nhsconfed.org/Publications/Documents/Implementing%20national%20policy%20on%20violence%20and%20abuse.pdf

The need for reflection

18. Mrs A's death was widely reported in the media after her death. The Home Secretary announced a probe into the police involvement in the case and particularly the issue of whether someone waiting to give evidence in this situation should have been offered counselling. Questions were subsequently asked of the Attorney General about the support that Mrs A had been given throughout the trial.
19. Interim guidelines have recently been issued by the Director of Public Prosecutions (DPP) asking for a change in emphasis in the way cases of sexual abuse and exploitation are prosecuted requiring prosecutors to: **look at the allegation actually being made, rather than focusing too intently on the perceived weaknesses and vulnerabilities of victims.** These guidelines call for better collaboration between forces and for evidence to be brought that dispels myths and stereotypes about victims of sexual abuse and exploitation. Its focus is on young witnesses but the ethos on which it rests is equally relevant to adult victims/survivors of abuse.

Concluding remarks

20. Based on the information available to us, the Panel believes that Mrs A's abuse as a young woman reflected major weaknesses in child protection practice at that time. Schools that cater for "special" pupils should conscientiously work within the child safeguarding process. We also believe that, as an adult survivor, Mrs A was failed by mental health services who did not appreciate how vulnerable she was throughout the process of bringing her abuser to justice and who did not put in place proper case coordination arrangements or adequately assess her increasingly serious suicide attempts against the backdrop of the trial.
21. The Panel considers that this was a suicide that could and should have been prevented. Mrs A had reasons to live and she continued to ask for help throughout this period. We therefore invite all the agencies concerned to take real and concrete steps towards improving their practice. When historic cases of sexual abuse come to court, we ask former victims to stand up and lay bare details about their lives that are painful and intimate. Criminal justice and mental health services should be able to provide a comprehensive and seamless support service to them throughout this process because, as this case demonstrates, *historic* abuse is always a *present* source of difficulty and distress to those who have been victimised.
22. Specifically, we ask that
    - **Criminal justice agencies** improve their practice in supporting survivors of sexual abuse, in recognising the vulnerability of witness/victims as they give evidence against alleged abusers in court, and in acknowledging when victim/survivors might lack capacity to make decisions about special measures that would be in their own best

interests. The police and CPS should *promote*, (not merely not dissuade), victims from seeking, timely counselling and they should stand alongside vulnerable witnesses in court, underlining their veracity to jurors by introducing expert witness testimony when they give their evidence. The media also has an important role to play in educating the public about the effects of childhood abuse so that its consequences for a person's mental health, are understood by all and so that jurors will take on their responsibilities from an informed position.

- **Mental health services** increase their alertness to the consequences of sexual exploitation and to the risks of suicidality and other forms of self-harming behaviour that are linked to it; they should work sensitively to make such histories explicit and to dignify a person's coping strategies. Commissioners and service managers should be much more informed and sensitised to the needs of people who have emotionally intense but unstable mental states[3] and to the skills required for proper assessment and containment of risk in these cases. They should recalibrate their application of the Mental Health Act to ensure that someone making repeated suicide attempts is appropriately assessed and reviewed.
- **The Press** play its role responsibly both during a trial and in relation to its broader remit of public education. Journalists, broadcasters and editors should be mindful of the way a person's credibility is discussed throughout court proceedings not only because they are obliged to avoid influencing a jury or affecting the outcome of the legal process but out of respect for individual witnesses (who are not the ones on trial) and for their families. Public education about the effects of childhood abuse on adult survivors may go some way towards de-stigmatising symptoms and behaviours such as self-harm that are otherwise used to blame and marginalise victims. This will, in turn, serve justice because juries are drawn from the general public and will be in a better position to evaluate abused victims and witnesses.

Taking action

23. Mrs A deserved support as a troubled teenager, and she most certainly deserved support again when, as a mature woman concerned for the safety of others, she stood up and faced her abusers in court. The Panel commend her bravery for taking a stand in this way. Those services, who held responsibility for her care, were found wanting in number of ways, and we hope that Mrs A's death will galvanise them into providing more coordinated and skilled care to other victims of historic sexual abuse. Perhaps then, Mrs A's wish to protect other young people, can belatedly become a reality.

[3] These conditions might previously have been referred to as Borderline Personality Disorder

Recommendations

1. This review did not have a mandate to comment on issues of child protection but urges children's safeguarding boards and the Independent Schools Inspectorate to pay attention to all schools especially but not exclusively, boarding schools, including those concerned with "special" pupils or those that have elite status. This includes so called "free" schools that exist to some extent outside of local networks.

2. The Home Secretary and the College of Policing will be asked to initiate the development of guidelines on how to share information across Police Forces with specific regard to historic abuse cases

3. Both police forces and CPS units, in association with the College of Policing, should work to implement the change in emphasis outlined in recent guidance from the CPS, testing the allegation rather than challenging the credibility of survivor witnesses of childhood sexual abuse

4. Managing fragmented and sometimes un-boundaried behaviours should be seen as a core task across all professional groups dealing with victims of historical sexual abuse. National bodies such as the College of Policing, the GMC (General Medical Council), RCN (Royal College of Nursing), Teaching and Social Work bodies, and other national organisations should be advised to include these issues in their curricula so that their members are trained to recognise and manage these symptoms in unstigmatising ways.

5. Appropriate managerial oversight and professional supervision of cases involving people abused in childhood should be provide to practitioners in the police force, the medical profession and mental health services.

6. All agencies should have guidelines in place that help staff to manage inappropriate and/or sexualised behaviours when they arise in the context of their work: these should allow practitioners to escalate concerns about inappropriate and/or unboundaried behaviour on the part of patients or clients and offer a route for case reassignment and/or redeployment as a matter to be managed on behalf of the agency as a whole and not left as something for the individual practitioner to manage alone.

7. Safeguarding procedures across other local authorities and across Surrey's partner agencies, should state provisions for victims of historic abuse and/or contain information about how to signpost alleged victims to services that can advise and help them.

8. Expert witness testimony as to a person's credibility should routinely be offered in court to explain to jurors how childhood sexual abuse affects individuals because this is germane to the way they assess the truthfulness of a victim/ witness's account in the light of their traumatic experiences; this recommendation will be conveyed to The Home Office, The Director of Public Prosecutions and to the College of Policing .

9. Police forces and mental health practitioners should be provided with additional training on how to assess mental capacity and support assisted decision making; they should understand the role of mental health difficulties and emotional distress in sometimes over-riding the cognitive processes necessary for sound decision-making.

10. Where a judge is of the considered opinion that a witness is vulnerable, even in circumstances where that witness has refused special measures, the judge should be proactive by introducing special measures that both protect the person deemed to be at risk of psychological or physical harm and the quality of evidence put before the court.

11. Steps should be taken to ensure that mental ill-health is not seen as a barrier to participating in and/or receiving, justice including following CPS guidelines on pre-trial counselling.

12. Workers within the HTT and CMHRS should be offered training on the sequelae of sexual abuse and on managing presentations marked by intense and unstable mental states

13. Workers within the HTT and CMHRS should have access to a range of specialist services to whom they can onwardly refer survivors of personal or sexual violence; a directory of such resources should be compiled

14. NHS Commissioners should ensure that there are adequate specialist services within their catchment area to meet the needs of people who are survivors of childhood trauma and abuse

15. Recognition and intervention in teams that are failing should be timely and well managed

16. SABP should revise their contingency planning to provide staffing cover in such circumstances in future

17. Designating a care coordinator should be seen as a priority within the CMHRS team and should be effective for urgent referrals within 5 working days of the receipt of that referral

18. The internal critical incident reporting form used for reflection by the team should be subject to review with a view to producing a more in-depth initial analysis which will inform the Serious Incident investigation reporting process

19. Training and supervision should be offered to all staff responsible for completing internal management reviews (IMR) that are comprehensive, coherent and that demonstrate genuine reflection and consideration of the implications of serious cases for organisational and individual learning

20. Practice in assessment of suicide risk must be strengthened in this Trust and broadened out to include

- understanding of the contribution of childhood abuse and trauma
- evidence about para-suicide as a precursor to fatal suicide attempts
- longitudinal assessment of risk including changes in frequency or seriousness of suicide attempts
- how to investigate and assess the degree of pre-planning of suicide attempts
- how to manage medication in the context of repeated overdoses
- these considerations should be added to documentation that is used to guide clinicians in the assessment process

21. Training and supervision should be offered to medical staff completing Serious Incident reports following suicide so that a realistic assessment of failures to prevent such events is compiled and fed into service improvement plans

22. Risk management structures and practices should be overhauled to ensure that zoning decisions (that is the risk assessment decisions taken in mental health care) are taken appropriately over time, revisited on a regular basis, and properly recorded

23. Thresholds for application of the MHA should be reviewed within Surrey mental health services and monitored against national figures

24. Commissioners should ensure that all voluntary agencies receiving money from public funds are bound by their local Safeguarding Adults and Safeguarding Children procedures

25. Commissioners should ensure that all voluntary agencies receiving money from public funds actively support and enable professionals working in their service to abide by their professional codes of conduct

26 Voluntary agencies working with survivors of abuse should be required to sign up to safeguarding protocols and information/risk management processes: where they are commissioned locally and/or receive some of their funding from local statutory agencies this obligation should be written into service level agreements

27. Mental health services should implement the government's abuse policy, making a history of abuse explicit in clinical assessment and ensuring that clinicians are able to address symptoms appropriately

28. The National Suicide Strategy should be taken as a driver for training and service improvement across all mental health services and NICE Guidelines on assessment of patients reporting to A&E after suicide attempts should be adhered to.

29. ASSIST and/or another evidence-based suicide prevention training programme should be rolled out across the SABP Trust

30. As part of the preparation for a trial a timeline should be constructed using various sources as corroboration so that an abused witness does not have to present details about times and dates in order to come across as a credible witness

31. Mental health workers should be supported to develop their ability to make nuanced and well considered assessments of mental capacity in relation to specific decisions, including a decision to disengage from services or to refuse special measures, where a person's cognitive functioning is temporarily or indefinitely affected by mental ill-health or distress

32. The Crown Prosecution Service (CPS) and Police Witness Care Units (WCU's) should maintain contact with potentially vulnerable victims/witnesses throughout the whole course of a trial, beyond their own testimony, and right through the process of obtaining a verdict and sentencing, explaining to the victim/witness on what basis decisions have been made and helping them to manage their reactions to the Court's decisions.

33. All victims of rape or serious sexual assault, including historic cases, should receive a daily call from the OiC even after they have finished giving evidence so that, within the legal constraints of the judicial process, reassurance can be provided and any concerns identified and addressed, and if appropriate referred on to other services.