



# Safeguarding Adults Review

‘Eddie’

Overview Report

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# 1. Introduction

- 1.1 'Eddie' was a hugely endearing, fun and energetic care experienced 18-year-old, who tragically died in 2019 from diabetic ketoacidosis. Surrey Safeguarding Adults Board [SSAB] commissioned this safeguarding adults review [SAR] due to concerns that organisational neglect contributed to his death, findings which have subsequently been made by the coroner.

## Background

- 1.2 Eddie was placed in Surrey County Council's [SSC] care at the age of 7 under an emergency protection order in 2008, a care order was subsequently granted in 2009. He was diagnosed with Type 1 diabetes in 2014, meaning that he was insulin dependent, and also had coeliac disease so was supported to follow a gluten free diet. Whilst diagnosed with attention deficit hyperactivity disorder [ADHD] as a child, his last ADHD review appointment was in 2014, as the clinical view was that he did not have ADHD. Eddie was diagnosed with a learning disability as a child and in 2015 was assessed to have an overall IQ of 42. However, within his final Educational Psychology assessment in 2018, he was assessed to have an overall IQ of 61, which meets the criteria for a mild learning disability.<sup>1</sup>
- 1.3 Eddie lived in several foster care placements before moving to an SCC Children's Home ['the Children's Home'] in 2012, and he remained in this placement until he was 17 ½ years old. The Children's Home staff were trained by health practitioners to manage Eddie's diabetes, and this was a caring and supportive placement, with a high standard of care. Eddie had supervised contact with his parents at the Children's Home three times per year, but as his family lived locally, he often saw them in the community and would have informal contact. His mother and stepfather consistently attended all reviews and meetings and had a positive relationship with staff. An Education Health and Care Plan [EHCP] was in place and Eddie was supported by SCC's Special Educational Needs and Disabilities [SEND] team.
- 1.4 SCC's Transition Service met in March 2018 to discuss whether Eddie met the criteria for support from Adults Social Care [ASC]. The Transitions Service assessment was completed in October 2018, concluding that Eddie did not have eligible care and support needs, as they recorded that he had learning needs rather than a learning disability, despite the recent Educational Psychology assessment. An independent advocate was appointed for Eddie to appeal the outcome of the assessment, but they did not write to the Transition Team until March 2019 to challenge this, 3 weeks before Eddie's 18<sup>th</sup> birthday. The reasons for this delay are unclear. The Transition Team responded, asking the advocate what parts of the assessment Eddie disagreed with, but no further correspondence was received.
- 1.5 Eddie's Independent Reviewing Officer [IRO], social worker and SEND worker strongly believed that he required a residential placement to meet his needs, and advocated powerfully to obtain funding for this, jointly through Children's Social Care (CSC) and SEND. CSC and the SEND team identified a residential school in Gloucestershire ['the Residential School'] as a suitable 52-week educational provision for Eddie. He moved there in September 2018, with his diabetic care transferring to Gloucester Royal Hospital [GRH]. As Eddie approached 18, he began to have occasional contact with his family in Surrey, without supervision, and although overnight contact was planned for Christmas 2018, this wound up being a day contact only. His first overnight contact therefore took place shortly after his 18<sup>th</sup> birthday. His family did not receive training or advice in respect of managing the risks around Eddie's diabetes and contact was not risk assessed.
- 1.6 At 18, Eddie was transferred from CSC to SCC's Leaving Care service and supported as a former looked after child by a personal advisor. Although Eddie was able to monitor his blood

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<sup>1</sup> The International Classification of Diseases 11th Revision (ICD-11) classifies mild learning disabilities as an approximate IQ range of 50-69: [WHO, 2022](#)

sugar and administer his insulin, he required support to do this consistently, and from January to September 2019, he attended GRH's emergency department on five occasions due to hyperglycaemia. Eddie's pathway plan from August 2019 confirmed that staff at the Residential School were required to coach and supervise Eddie to keep his blood sugar well managed. Although he had a Libre device fitted to monitor his blood sugar in September, Eddie had two further hospital attendances in October and November as his diabetes management was inconsistent. A risk assessment completed by the Residential School in September confirmed that staff needed to remind Eddie to check his blood sugar levels and that staff should check his readings. Eddie was assessed as able to self-administer his own insulin, but it was noted this should be under supervision by the Residential School staff

- 1.7 In late November 2019, Eddie moved to a new placement ['the College'] managed by the company that managed the Residential School, due to an ongoing safeguarding enquiry. Staff at the College received training to safely manage his diabetes and a diabetes control support plan was provided. Eddie contacted his personal advisor for support with travel warrants to spend Christmas with his family from 24 - 30 December 2019 but was instead dropped off at home by College staff. No risk assessment was completed in respect of Eddie's ability to manage his diabetes independently or in respect of contact and no advice was given to the family on managing Eddie's diabetes or how to recognise if he was becoming unwell.
- 1.8 Eddie was noted by his mother to be unwell from shortly after Christmas, when he was throwing up bile and she called the College the following day to notify the placement that his return would be delayed as he had vomited and not eaten anything, reporting that other family members had also been unwell that day. The staff member at the College was aware of Eddie's diabetes and asked if his blood sugar had been checked and if he had enough glucogel, and the mother confirmed both of these points. The staff member advised Eddie's mother to call 111 for advice if he got worse, but noted that mother seemed distracted as she was focussed on obtaining the phone number for the college's duty manager. Eddie's mother called the duty manager at the College, who notified the College's team house manager not to collect Eddie. They called Eddie's mobile phone, Eddie's mother answered and confirmed what she had said to the staff member and said that Eddie was asleep; a text message was subsequently sent to Eddie, but no reply is recorded. Eddie was last seen alive at 11pm, then his mother found him unresponsive in the middle of the night and tragically, he was later confirmed to have died. Evidence during the inquest led to the coroner's conclusion that *"If [Eddie] had been admitted to hospital at any time prior to 5 pm on the [evening of his death] he would have been successfully treated."*
- 1.9 The company who managed the Residential School and College ['the Company'] at the time was prosecuted by the Care Quality Commission for the offence of failing to discharge a duty imposed by Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They entered a guilty plea to the offence. It was accepted by the Company, as evidenced in the papers considered in relation to the CQC prosecution, that the College failed to complete a sufficient risk assessment and that a specific care plan should have been in place for Eddie's visit home including Eddie, the College and his family, with input from the Diabetic Team. The Residential School accept that the College should have been in daily contact with Eddie, and his family, to establish his glucose level readings.
- 1.10 A coroner's inquest took place in 2023, which found that Eddie died from diabetic ketoacidosis and *"...was not capable of, and had not been trained to, manage diabetes independently if he developed hyperglycemia and became unwell. His family had not been given any training to recognise a deterioration in [Eddie's] condition and when to seek emergency medical assistance."* The coroner issued a Regulation 28 Report (known as a Preventing Future Deaths report) which found that SCC's Leaving Care and Children's Social Care failed to ensure Eddie's safety when he went home for overnight contact, by obtaining information about the risks from Eddie's diabetes, risk assessing his ability to manage this independently, create and

coordinating an adequate pathway plan including an evaluation of contact with his family, or mitigating the risks of such contact. The coroner found that there were systemic failings on the part of SCC's Leaving Care to adequately to train and oversee personal advisers in relation to their legal obligations in preparing pathway plans. The Coroner also found that the Residential School failed to ensure Eddie's safety by ensuring that employees involved in pathway planning were fully informed about the extent of the risks posed by his diabetes, risk assessed the resulting risks in relation to contact, put in place a care plan informed by his diabetic specialist team, had a plan to monitor his blood sugar reading while he was away from college or responded appropriately by advising he needed immediate hospital attendance when informed that he was unwell. Consequently, the coroner found that Eddie's death was contributed to by neglect.

- 1.11 The authors wish to express their sincere condolences to all members of Eddie's family for their loss. The authors are grateful to the professionals who worked with Eddie for sharing their insight into his experiences so honestly. They shared fond memories of Eddie, and their affection for him and grief at his loss were very clear.

### Pen Picture of Eddie

- 1.12 Practitioners described Eddie as extremely endearing, funny, with the ability to pull people in to go the extra mile for him. He was a bundle of energy, and would take off on his bike around the local cycle paths, although he always let staff at his placements know which way he was going so they knew when to expect him home. Eddie enjoyed being the spokesperson for projects and was a confident presenter, including doing a presentation to 100 police cadets. He loved dogs and when he was younger he wanted to become a dog trainer. Although he had requested a support dog for his diabetes, practitioners were concerned that this would limit his future placement options. Eddie was starting to express his independence and talked about obtaining his driver's licence. His ambition was to become a chef.
- 1.13 Eddie's confident, chatty personality could mask his learning disability to those who did not know him well. He would learn new skills reasonably quickly, but then forget them again, and could find it difficult to stay on task or weigh the consequences of his decisions. He had challenges with his working memory and although he could carry out many of the activities of daily living such as chopping vegetables for dinner or washing his clothes, he required significant support and prompting to carry these tasks out, and practitioners were clear that he would not have been able to safely live independently. The nurturing environment of Eddie's placement masked many of his needs. The Transition Team's assessment in October 2018 described Eddie's interests as he approached 18 as "*...playing boards games as well as soft play, building dens and playing with Lego*".
- 1.14 However, as an 18-year-old, Eddie started to test his independence, and would stay out at friends' places for parties, which caused staff at his placement concerns as he needed prompting in respect of safe management of his diabetes. This contributed to the decision that his blood sugar would best be monitored by a Libra device that linked to his phone and could be remotely monitored by staff at the placement when he was in the community.
- 1.15 Although Eddie had not lived with his family since he was 7, he maintained a loving relationship with his mother, speaking to her every day by telephone. She remained committed to supporting him, consistently attending meetings and reviews to promote his welfare. Eddie's stepfather also engaged well with professionals, enthusiastically discussing Eddie's dietary needs and provided practical support to his mother.

## 2. Scope of Review

### Purpose of a Safeguarding Adult Review

- 2.1 The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:
- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
  - To review the effectiveness of procedures (both multi-agency and those of individual organisations);
  - To inform and improve local interagency practice;
  - To improve practice by acting on learning (developing best practice); and
  - To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.
- 2.2 There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Eddie from harm.

### Themes

- 2.3 The SSAB prioritised the following themes for illumination through the SAR:
- Was Eddie's transition to adulthood in line with expected standards? In particular, how well do practitioners from across health and social care understand care pathways and coordination across services for care experienced young people with co-existing neurodivergence, learning disabilities and/or physical health conditions?
  - Was the decision that Eddie did not have care and support needs appropriate? How confident are practitioners to use dispute resolution and escalation pathways in circumstances where there is disagreement between services in respect of an individual's needs or care plan?
  - How was Eddie supported to understand and manage his diabetes and coeliac disease and how was his ability to manage this independently risk assessed? Were the principles of the Mental Capacity Act 2005 applied?
  - What was understood in respect of the reasons Eddie was removed from his parents' care as a child and what assessment or risk assessment was carried out in respect of his contact at home? How were the family supported to understand and supervise Eddie's diabetes and how to recognise if medical intervention was required?

### Methodology

- 2.4 The authors are grateful to the coroner for granting leave for the bundle in the inquest to be disclosed for the purpose of this review. In addition to reviewing key documents in respect of Eddie, multi-agency learning events took place with frontline practitioners who worked directly with Eddie and his family, and senior managers responsible for overseeing the departments involved. The case has been analysed using a learning together approach, through the lens of evidence-based learning from research and the findings of other published SARs.<sup>2</sup> Learning from good practice and a discussion of the legal framework have also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice.
- 2.5 The learning produced through a SAR concerns 'systems findings', which are the underlying issues that helped or hindered in the case and are systemic rather than one-off issues. Systems

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<sup>2</sup> Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement. London: LGA/ADASS

findings identify social and organisational factors that make it harder or easier for practitioners to proactively safeguard, within and between agencies.

## Contributing Agencies

- 2.6 The following agencies provided documentation to support the SAR and/or met with the authors of the review to inform its recommendations:
- Surrey County Council Care Children's Social Care and Leaving Care team
  - Surrey County Council Transitions Service
  - The Residential School and College
  - Gloucester Royal Hospital Diabetic Clinic
  - Gloucester County Council's named GP for Safeguarding
  - Surrey Police
- 2.7 To ensure Eddie's anonymity and that of his family, the names of some of the agencies involved in his care have been anonymised, where disclosing these could potentially identify him.

## Involvement of Eddie's Family

- 2.8 The SAR Panel took a decision to wait to engage with Eddie's family until the coroner's inquest had concluded, to ensure that the overlapping processes did not overwhelm them. Although the family expressed that they were grateful to be invited to participate, they did not wish to do so.

## 3. The Legal Framework for Transition from Children's to Adult Services

- 3.1 Since 2014, substantial legislative changes have been introduced to strengthen the legal frameworks that facilitate provision of care and support for young people leaving care, with special educational needs or transitioning to adult social care, to ensure that partner agencies could work more closely to meet those needs in a holistic way. The Government recognises that a 'cliff-edge' at 18 is detrimental to this cohort of young people, and the legislative framework seeks to ease their transition into adulthood, by providing additional duties on statutory agencies to provide support up to the age of 25.

### Maintaining an Education Health and Care Plan (EHCP)

- 3.2 Part 3 of the Children and Families Act 2014 and the SEN Code of Practice place a duty on local authorities to assess the educational needs of young people with learning or other disabilities and implement an Education Health and Care Plans [EHCP] to support them, ideally in mainstream education, until the age of 25 if they remain in education. The annual review in Year 9 and any subsequent annual reviews until the young person leaves school must include preparation and review of a transition plan, drawing together information from a range of individuals within and beyond school in order to plan coherently for the young person's transition to adult life, with a particular focus on the young person's ambitions and goals post-16.
- 3.3 Statutory agencies are required to communicate and agree policies and protocols that ensure that there is a 'seamless' service, with a focus on the voice of the young person. The Special Educational Needs and Disabilities Code of Practice<sup>3</sup> describes the duty on education, health and social care to work together to plan and jointly commission services for these young people, explaining the interface between duties under the Children and Families Act 2014, the Care Act 2014 and the National Health Services Act 2006 for young people with special educational needs or disabilities with or without EHCPs. The Code of Practice sets out:

*"...local governance arrangements must be in place to ensure clear accountability for commissioning services for children and young people with SEN and disabilities from birth to*

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<sup>3</sup> [SEND Code of Practice January 2015.pdf \(publishing.service.gov.uk\)](#)



*the age of 25. There must be clear decision-making structures so that partners can agree the changes that joint commissioning will bring in the design of services. This will help ensure that joint commissioning is focused on achieving agreed outcomes. Partners must also be clear about who is responsible for delivering what, who the decision-makers are in education, health and social care, and how partners will hold each other to account in the event of a disagreement. The partners must be able to make a decision on how they will meet the needs of children and young people with SEN or disabilities in every case.” (paragraph 3.25)*

## **Care Act 2014**

- 3.5 Section 58 of the Care Act 2014 places a duty on the local authority to carry out a child’s needs assessment prior to their 18th birthday, to ensure that careful planning is in place to meet their care and support needs as they transitioned to the adult legal framework. The Care and Support Statutory guidance<sup>4</sup> sets out that an assessment should be carried out if a young person is ‘likely to have needs’, not just those needs that will be deemed eligible under the adult statute, and that this process should start when the young person reaches 14 years, to allow adequate time to assess and plan for their future care.
- 3.6 The guidance also sets out the reciprocal duty for relevant partners to cooperate for the purposes of transitions and paragraph 16.43 states: “*Local authorities should have a clear understanding of their responsibilities, including funding arrangements, for young people and carers who are moving from children to adult services. Disputes between different departments within a local authority about who is responsible can be time consuming and can sometimes result in disruption to the young person or carer.*” The ethos of the Care Act is that assessments should be needs-led and not restricted by available services. Diagnosis should not act as a barrier to support.
- 3.7 In 2015 the Care Act introduced both a statutory safeguarding duty (section 42) and an enduring duty to continue to assess<sup>5</sup> where there was ongoing risks of abuse or neglect in respect of an adult with care and support needs. Multi-agency responses to risk should be shaped by the ‘making safeguarding personal’ approach. This requires practitioners to work with the adult at risk to better understand how to reduce the risk of abuse in a way that is meaningful to them. Given the facilitative nature of the legal duties to safeguard, prevent escalation of needs and assess ongoing health and social care needs it is counterintuitive to construct ‘eligibility’ for services at too high a level.

## **Leaving Care Duties**

- 3.7 It is commonly understood that many care-experienced young people will require additional support from social care services, as a consequence of adverse childhood experiences and it is for this reason that the range of ‘leaving care’ duties and powers continue to be owed to provide support. The leaving care provisions in the Children Act 1989 place a duty on local authorities to act as good ‘corporate parents’ and provide for continuous support from social care for young people who have been accommodated under the Children Act 1989, up until the age of 25, “*to put them on the pathway to success as they make their transition to adulthood*”.<sup>6</sup> Leaving Care obligations are owed to all care experienced young people aged 16 and 17 who have been looked after for at least 13 weeks after they reached the age of 14. Responsibilities for planning continuing support applies to all care leavers at least until they reach the age of 21. This includes:
- keeping in touch with them [section 23C(2) of the 1989 Act],
  - regularly reviewing their pathway plan [section 23C(3)(b) of the 1989 Act; the requirements for carrying out reviews are set out in regulation 7 of the Care Leavers Regulations],

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<sup>4</sup> [Care and support statutory guidance](#) - GOV.UK (www.gov.uk), para. 16.9

<sup>5</sup> S11(2) Care Act 2015

<sup>6</sup> [DfE \(publishing.service.gov.uk\)](#), paragraph 1.11



- having a personal adviser [section 23C(3)(a) of the 1989 Act; the functions of the personal adviser are set out in regulation 8 of the Care Leavers Regulations], and
  - providing financial assistance by contributing to the former relevant child's expenses in living near the place where they are, or will be, employed or seeking employment [sections 23C(4)(a) and 24B(1) of the 1989 Act] if their welfare and educational and training needs
- 3.8 In addition, Regulations<sup>7</sup> and statutory guidance require '*effective channels of communication between all local authority staff working with looked-after children, CCGs, NHS England and health service providers, as well as carers – along with clear lines of accountability – are needed to ensure that the health needs (including mental health needs) of looked-after children are met without delay. Looked-after children themselves (according to age and understanding, and capacity) should also have the information they need to make informed decisions about their health and mental health needs. Staff working with looked-after children who are delivering health services should make sure their systems and processes track and focus on meeting each child's physical, emotional and mental health needs without making them feel different... They should also plan for effective transition and consider the needs of care leavers.*'<sup>8</sup>
- 3.9 There are three principles for transition set out in the Children Act 1989 guidance for care leavers<sup>9</sup> which should govern practice when talking to the young person and when making any decision about them (p9):
- 'Is this good enough for my own child?
  - Providing a second chance if things don't go as expected.
  - Is this tailored to their individual needs, particularly if they are more vulnerable than other young people?'
- 3.10 It is the role of the Independent Reviewing Officer (IRO) to ensure that the care plan agreed for the young person considers the young person's views. This includes evaluating the quality of the assessment of the young person's readiness and preparation for any move.
- 3.11 Tailoring any plan to a child's individual needs requires consideration of the specific challenges presented by their experience as a care experienced child and additional risks or needs associated with personal characteristics and circumstances, including disability. Consideration should be given to relevant clinical guidance and quality standards published by the National Institute for Clinical Excellence (NICE). Of particular relevance in this case was guidance regarding transition from children to adult services.
- 3.12 Section 3 of the Children and Social Work Act 2017 requires local authorities to appoint a personal advisor to care experienced young adults once they turn 18; personal advisors are appointed until a person reaches 25 years old. Whilst there is no specific qualification needed to become a personal advisor, local authorities should appoint personal advisors who have an understanding of the issues their young adults are likely to encounter as they transition to adulthood.
- 3.13 It is the role of a child's social worker before their 18th birthday to devise their pathway plan including the young person's views, wishes and feelings and having consulted with their parents and their IRO. Once 18, the personal advisor's role is then to liaise with professionals to ensure the pathway plan is implemented. The pathway plan should be reviewed at least every six

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<sup>7</sup> The Care Planning, Placement and Case Review (England) Regulations 2010

<sup>8</sup> P.9 of 'Promoting the health and wellbeing of looked after children' March 2015 from the Dept. for Education and Dept. for Health (this is currently being revised).

<sup>9</sup> Department for Education (2010) The Children Act 1989 Guidance and Regulations Volume 3: planning transition to adulthood for care leavers: <https://www.gov.uk/government/publications/children-act-1989-transition-to-adulthood-for-care-leavers>

months and include information about a young adult's health needs and how these should be met as well as any support they may need to develop, or sustain, family relationships.

### **Transitional Safeguarding**

- 3.14 Transitional safeguarding goes beyond the statutory duties in respect of transition planning for young people with care and support needs who are moving from children to adult services, set out in sections 58-66 of the Care Act 2014. The term describes the need for an approach to safeguarding adolescents and young adults fluidly across developmental stages, despite the differences between the legal frameworks for children and adults. The principles of transitional safeguarding require practitioners to meet the positive obligations under the Human Rights Act 1998, Article 2 (the right to life) and Article 3 (the prohibition on torture, inhuman or degrading treatment) and respond appropriately where there is a foreseeable, real and imminent risk.
- 3.15 However, this must be balanced against the obligation to respect private and family life (Article 8) and liberty (Article 5). In circumstances where young people may not meet the statutory eligibility thresholds for services when they turn 18, this may require proactive consideration of the general duties (under s2 Care Act 2014) to prevent care needs, including mental health needs, escalating by providing advice and support. This recognises the particular impact of trauma on a young person's development.

### **Mental Capacity**

- 3.16 The fluid nature of transitional safeguarding requires practitioners who work with adolescents and younger adults to have a nuanced understanding of the Mental Capacity Act 2005 [MCA] and how to apply this in practice. The MCA sets down the right of a competent person to make decisions and applies to those over the age of 16. There can be a significant tension between the principal under section 1 of the MCA, that the fact a decision may be unwise does not mean that the person lacks the capacity to take that decision, and the duty on a local authority under section 42 of the Care Act 2014 to devise a safeguarding plan for adults with care and support needs who are experiencing abuse or neglect, where they are unable to protect themselves from that abuse. To make a competent decision, an adult must be able to understand information about the decision to be made, retain that information and apply it to the decision-making process, and communicate a decision. Practitioners must ensure they break down the information to be weighed in a manner that will best facilitate this process and consider the person's "executive capacity", which is the ability to implement decisions taken and to deal with the consequences and the impact of someone else's undue influence on the decision-making process.
- 3.17 Mental capacity assessments should explore rather than simply accept notions of lifestyle choice. This means applying understanding of executive capacity and how adverse childhood experiences, trauma and cognitive functioning can affect decision making. The executive function of the brain is a set of cognitive or understanding/processing skills that are needed to plan, order, construct and monitor information to set goals or tasks. Executive capacity is the ability to implement decisions taken, to deal with the consequences and to make adjustments to changing risks in the real world. The MCA Code of Practice (para 4.21) notes: "*For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. A person must accept the information and take it into account. A person may appear to be able to weigh facts while sitting in an interview setting but if they do not transfer those facts to real life situations in everyday life (executing the plan) they may lack mental capacity.*"
- 3.18 The Court of Protection has explored 'articulate and demonstrate' models of assessment in the 2014 case of *GW<sub>2</sub>* which parallels Eddie's ability to describe his diabetes management: "*It is not surprising that GW was able to recall some safety issues in oral evidence, or to describe the route she took into town. The question was whether in practice she had the ability to apply insight and understanding about road safety when she was out and about. Every time someone walks into town, it is a different experience, no matter how well they know the route. The*

question is whether GW has an appreciation of the risks that may arise every time she steps out of the front door.” (GW v A Local Authority [2014] EWCOP20)

- 3.19 Further, Eddie’s poorly controlled diabetes would also have led to his mental capacity fluctuating due to variations in his blood glucose. In the leading case of *RB Greenwich v CDM* [2018] EWCOP15, which involved a 63-year old woman with a diagnosis of personality disorder and poorly controlled diabetes, with fluctuating capacity to take decisions due to variations in blood glucose, the Court of Protection held that an assessment of a person’s capacity must be based on their ability to make a specific decision at the time it needs to be made and not their ability to make decisions in general, but that “*when making appropriate decisions she has capacity but when making manifestly inappropriate decisions she lacks capacity.*”
- 3.20 NICE guidance<sup>10</sup> advises assessments should take into account observations of the person’s ability to execute decisions in real life situations, highlighting the situational aspect of decision making. This should have been applied throughout the assessment, care planning and provision of support to Eddie. Where there is evidence that outside of an assessment environment the person is not able to understand or weigh up information to enact a decision, this should be thoroughly explored. The presumption of capacity under section 1 of the MCA does not override professional and statutory duties to ensure that young people or adults with care and support needs are safe from abuse, neglect or exploitation. “*There is a difference between someone who has an appreciation of risk and yet goes on to take the risk – albeit unwisely – and someone who... lacked awareness of the risk and sufficient problem-solving ability.*”<sup>11</sup>

## 4. Analysis of Agencies’ Actions

### Pathway Planning

- 4.1 Eddie was very well supported when looked after by Surrey CSC at his placement at the Children’s Home. Eddie was diagnosed with Type 1 diabetes in September 2014 when at the Children’s Home and it is clear that his staff had developed a close, supportive relationship with Eddie over a number of years and that his needs in relation to his diabetes diagnosis was well understood. Eddie’s first EHCP plan was put in place in July 2016.
- 4.2 Eddie’s social work team, SEND and his independent reviewing officer [IRO] were of the clear view that Eddie would need support beyond the standard provision of semi-independent accommodation to most care experienced children when he turned 18. There is evidence that the social work team had been working towards ensuring this was possible as early as October 2016, when Eddie was 16 years old. His social work team made a referral to SCC’s Transitions Team to seek support from the service in order to identify an appropriate placement for Eddie, however this was confirmed to be outside the remit of the Transitions Team. Thereafter, a specialist residential college, the Residential School was identified as the most suitable placement for Eddie to support his growing independence. Eddie’s social worker and his IRO were pursuing all possible funding streams to ensure that Eddie could move to a suitable provision, this is understood to have taken some time. Eddie then moved to the Residential School in September 2018, aged 17.
- 4.3 In line with good practice, a further referral for an assessment of Eddie’s care and support needs was made to the Transitions Team in February 2018, the referral was accepted and the process of assessment took a number of months. In October 2018 when it was confirmed that the Transition Team had assessed Eddie as not having eligible care needs the outcome of the assessment was not formally challenged by the professionals working with Eddie, an independent children’s advocate was appointed by Children’s Social Care but the advocate did not proactively challenge the outcome of the assessment outcome was not progressed; this is

<sup>10</sup> NICE (2018) Decision Making and Mental Capacity. London: [Overview | Decision-making and mental capacity | Guidance | NICE](#).

<sup>11</sup> Baker J, GW v A Local Authority [2014] EWCOP20, para. 45

discussed further below. Instead, Eddie's IRO worked collaboratively with his social worker and SEND worker to advocate on Eddie's behalf to ensure funding for his placement at the Residential School was agreed, presenting to multiple panels and escalating to director level when required. Their determination to ensure that Eddie was placed in provision that they believed would meet his needs was laudable and a real credit to the council.

- 4.4 Eddie's initial pathway plan was completed in September 2018, shortly after he moved to the Residential School. It was noted within the initial pathway plan that Eddie would require ongoing support to manage his diabetes and contact with his family when turned 18. The Children's Home shared helpful information with the Residential School before Eddie's move in September 2018, including meetings with key workers and staff who had worked with Eddie for a number of years as part of a handover, this is good practice.
- 4.5 Between September 2018 and March 2019, when Eddie's pathway plan was next updated, he was appointed a personal advisor. In relation to contact with his family, Eddie's contact is recorded to have increased from three times per year to six times per year; the pathway plan records that Eddie would need support when he visited his family but does not set out what that support should look like.
- 4.6 The statutory role of the IRO ends when a young person reaches 18 years old. Eddie's IRO, who had supported him for many years and had a lovely relationship with him, chaired the final child looked after review meeting on 8 March 2019. Responsibility for Eddie's pathway plan was then handed over to his personal advisor. Despite clearly expressing her views in respect of Eddie's future care and advocating for funding for a residential placement, the input of Eddie's IRO was not recorded by the allocated social worker or personal advisor in the two pathway plans completed before he turned 18, nor is it clear whether his family had any input into the plan or received copies of the plans to consider when Eddie spent time with them. It is understood that since Eddie's death the IRO service has undergone some changes which include that IROs have a lower-case load and that the minutes of all child in care review meetings are incorporated in the pathway plan, in accordance with good practice.
- 4.7 Eddie's pathway plan was last updated in August 2019, between March and August 2019 there was a change in personal advisors for Eddie, the August 2019 plan does not detail any further support in relation to the support Eddie needed when spending time with his family; the plan does confirm that the Residential School staff will need to "*coach and supervise Eddie to keep his blood sugar levels as constant as possible as to ensure the correct dosage.*"<sup>12</sup> In respect of the requirement to support contact with the young person's parents and wider family, the pathway plan noted "*Eddie will continue to have contact with his family. This has now moved towards unsupervised since Christmas. Eddie will be supported with travel warrants and staff will take him to and from the station and ensure Eddie knows travel times*". The pathway plan does not consider the interaction between these two domains or address who will support Eddie to manage his diabetes during periods of unsupervised contact. It is not clear if Eddie's pathway plans were shared with his family or whether they were consulted before the plans were completed.
- 4.8 The statutory guidance '*The Children Act 1989 guidance and regulations Volume 3: planning transition to adulthood for care leavers*'<sup>13</sup> [the Planning Transition guidance] includes a single paragraph in respect of family contact:

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<sup>12</sup> Eddie's Pathway Plan dated August 2019, page 14

<sup>13</sup> [DfE \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

*“The pathway plan must address in particular: ...Contact with the young person’s parents, wider family including siblings and friends and the capacity of this network to encourage the young person and enable them to make a positive transition to adulthood” [paragraph 3.7]*

- 4.8 This gives little guidance in respect of the nuances of supporting contact for a young person who has turned 18, no longer subject of a care order which would provide a framework for the local authority to make decisions around contact, and who is entitled to exercise their autonomy to make decisions about what contact they will have. The only exception to this would be if there is evidence that the young person lacks capacity to take decisions in respect of contact, and it is in their best interest that these decisions are taken on their behalf by the local authority or placement. Deprivation of Liberty Safeguards [DoLS] is the procedure prescribed in law<sup>14</sup> that enables a local authority to authorise a detention of a resident of a residential home, hospital or supported living accommodation who lacks capacity to consent to their care and treatment, in order to keep them safe from harm. Where the person (or their family) continues to object to the proposed course of action, their advocate or representative should initiate a review or, if necessary, apply to the Court of Protection [CoP] to challenge the decision. However, even when a young person does have capacity to take their own decisions in respect of contact, this will not obviate the local authority’s safeguarding duties under s42 Care Act 2014 or the positive obligations under the Human Rights Act 1998, Article 2 (the right to life) and Article 3 (the prohibition on torture, inhuman or degrading treatment) and respond appropriately where there is a foreseeable, real and imminent risk.
- 4.9 Although the Planning Transition guidance does not prescribe specific qualifications for personal advisors, it advocates that they will “ *need to have a working knowledge of the range of issues that care leavers might expect to face as they make their transition to adulthood and the legal framework affecting care leavers (in particular the 1989 Act and Children (Leaving Care) Act 2000 and related Regulations)... and would benefit from training in how to promote both physical and mental health.*” However, this does not reference the importance of personal advisors understanding the principles and application of the Mental Capacity Act 2005 or the Care Act 2014, despite the importance of these to transitional safeguarding in respect of the vulnerable cohort of care leavers. In fact, despite being most recently updated in January 2022, the guidance makes no reference to the Care Act 2014, instead referencing [at paragraphs 6.14 to 6.19] the legislation it replaced 10 years ago.<sup>15</sup> The only reference to the MCA is in relation to determining the young person’s ordinary residence when they turn 18.
- 4.10 While it may be difficult to influence the Department for Education to update the Planning Transitions guidance to reflect best practice and legal literacy in respect of transitional safeguarding, it is essential that policy and practice across Surrey supports practitioners to understand both the children’s and adults’ frameworks and identify pathways to secure the best outcomes for care experienced young people.

## Systems Finding

- 4.11 There was clear evidence that Children’s Social Care, SEND and Eddie’s IRO gave careful consideration to his transition to adulthood, and passionately advocated in respect of his need for a residential placement where he would be fully supported in respect of his daily care needs, educational needs and development of his independent living skills. However, vague requirements within the statutory guidance and a narrow view of pathway planning for care leavers resulted in a superficial pathway plan that complied with procedural requirements in respect of timing of reviews and content, but did not consider the interaction between his different and at times competing needs.

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<sup>14</sup> Mental Capacity Act 2005, Schedule AA1

<sup>15</sup> *Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care - guidance on eligibility criteria for adult social care* (2010)



**Recommendation 1:**

Legal literacy training for children's practitioners working with over-14s (including personal advisers) should include a module on transition to adulthood, including assessments and safeguarding under the Care Act 2014, the Mental Capacity Act 2005 and transitional safeguarding.

**Recommendation 2:**

Surrey CSC should extend the role of IRO beyond a child's 18th birthday, including attendance at (at least) one pathway planning / EHCP review meetings post 18 to bridge the gap in transition.

**Recommendation 3:**

All child in care, EHCP and pathway planning review meetings should have an agenda and have detailed notes recorded of key discussions; each meeting should include an agenda item to include parental / extended family contact including any risks that might arise due to the child and/or family's circumstances.

**Recommendation 4:**

SSAB should write to the Department for Education, drawing their attention to the obsolete references to the Eligibility Criteria for Adult Social Care (2010) guidance within the Planning Transitions guidance and advocating for clear advice to be included in respect of the transition planning under the Care Act 2014 and Mental Capacity Act 2005, to improve national practice.

## Assessment of Care and Support Needs

4.12 In many ways, the quality of the child's needs assessment under s58 of the Care Act 2014 completed by the Transitions Team in October 2019 was good. The assessor took time to visit Eddie on four occasions, building an understanding of his needs over time. As an apparent gap was identified in respect of an assessment of Eddie's learning needs, an assessment was requested from an educational psychologist, commissioned by SCC. The assessment was also strengths based, focusing on what Eddie was able to do independently. However, having sought an assessment of Eddie's cognitive functioning, somewhat perplexingly, the child's needs assessment concluded that Eddie had learning needs, rather than a learning disability. An IQ below 70 meets NICE's criteria for a diagnosed learning disability, where this has an onset in childhood and results in a significant impairment of social and adaptive functioning<sup>16</sup>. The updated Educational Psychology assessment dated May 2018 found that Eddie's overall IQ was assessed as 61. Three years earlier in September 2015 Eddie's IQ had been assessed by another SCC Educational Psychologist, their findings were distinctly different, Eddie's overall IQ at that time was assessed as 42. It is unclear why this report was not available on Eddie's file to inform the child's needs assessment.

4.13 The difference in the assessment of Eddie's needs between the two assessments is significant as a learning disability is considered to be mild for a person with an IQ of between 50–69 and moderate for an IQ of between 35–49. NICE guidance informs us that a person's IQ can change over time and that 'mild' and 'moderate' learning disabilities/difficulties have different meanings in education services and in health services.<sup>17</sup> However, Eddie clearly met the NICE criteria for a learning disability in both the 2015 and 2018 educational psychology assessments.

4.14 Leaders noted that an educational psychologist assessing the child's IQ cannot make a diagnosis of a learning disability as this is a medical diagnosis, but that there was a lack of clarity as to who was responsible for making a formal diagnosis. Some GPs or paediatricians, particularly those with an interest in paediatric neurology, are comfortable making a diagnosis, but others are reluctant to label children early, as some children's developmental delay can resolve over time. However, a diagnosis of a learning disability must be made before the child

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<sup>16</sup> [Context | Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges | Guidance | NICE](#)

<sup>17</sup> [Clinical guideline scope \(nice.org.uk\)](#)

turns 18, otherwise they will be diagnosed with a cognitive deficit, and it is good practice for this diagnosis to be made by Year 9.

4.15 In Eddie's case it is unclear why this was not picked up through his annual Looked After Child health assessments or SEN reviews. The educational psychologist who completed the initial assessment in 2015 for Eddie's EHCP was also unable to access a clinician to give the diagnosis. Despite obtaining the second educational psychologist's assessment when he was still 17, social workers also struggled to identify a pathway through health partners to secure a formal diagnosis, and the Escalation processes were not used to challenge this. Consequently, both ASC and the Leaving Care team understood that Eddie had a learning difficulty rather than a learning disability, and it is likely that this contributed to the assessment that he did not have eligible care needs. It is possible that the fact he did not have a formal diagnosis led practitioners to believe that he did not have a learning disability. However, the Care and Support Statutory Guidance<sup>18</sup> sets out that although to be eligible, the adult's needs must arise from or be related to a physical or mental impairment or illness, "*the authority should base their judgment on the assessment of the adult and a formal diagnosis of the condition should not be required.*" (at paragraph 6.104).

4.16 It is understood from those who supported Eddie closely that he could often present as being more adept than he was, he would need repeated instructions to complete a task successfully independently and even when able would seek reassurance from staff he trusted in his placements regularly. Eddie may have been able to tell professionals that he was fairly independent but that was in the context of the continual support of the Children's Home and then the Residential School staff. Those caring for him were clear that he could not live independently safely and that he needed a lot of support to safely manage his diabetes. It is likely that the high level of support Eddie received at the Children's Home and the Residential School inadvertently masked his high level of need. Consequently, the child's needs assessment did not include Eddie's eligible care needs that were being met by his placement.

4.17 However, the Care and Support Guidance sets out:

*"During the assessment, local authorities must consider all of the adult's care and support needs, regardless of any support being provided by a carer... After the eligibility determination has been reached, if the needs are eligible or the local authority otherwise intends to meet them, the care which a carer is providing can be taken into account during the care and support planning stage... This ensures that the entirety of the adult's needs are identified, and the local authority can respond appropriately if the carer feels unable or unwilling to carry out some or all of the caring they were previously providing."* [paragraph 6.15]

4.18 Whilst the social work team and Eddie's independent reviewing officer did not agree with the outcome of Transition Team assessment, they did not challenge or escalate the outcome of the assessment directly. Instead, a children's advocate was appointed under section 26A of the 1989 Act, which imposes duties on local authorities to provide advocacy services to enable children to challenge decisions made in respect of the duties owed to them under the 1989 Act.

4.19 However, there is a separate duty under s67 of the Care Act 2014 for the local authority to arrange for an advocate to be available to represent and support the individual's involvement in functions under the Care Act, including a child's needs assessment under s59 of the Care Act. It is unclear whether practitioners recognised the distinction between these two advocacy duties and in particular, recognised that the skill set and expertise for Care Act advocates and Children Act advocates differs. The decision to delegate responsibility for challenging ASC's decision that Eddie was not eligible for Care Act support to the advocate will only have been appropriate

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<sup>18</sup> [Care and support statutory guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67222/care-and-support-statutory-guidance.pdf)



if that advocate was qualified as a Care Act advocate. Further, effective pathway planning required Eddie's children's social worker to monitor and ensure that this was being progressed robustly and in a timely way.

- 4.20 Records indicate that although Eddie's advocate emailed the ASC team to challenge the outcome of the child's need assessment, this was only sent three weeks before Eddie turned 18. The advocate did not respond when the adult social worker enquired what aspects of the assessment were disputed. The fact this had not been properly actioned was not fed back to the children's social care team by either the advocate or the adult social worker. Each service is jointly responsible for this oversight, which meant that the gaps in the assessment, in particular the fact that although Eddie's care and support needs were being met by his nurturing placement, these were still eligible needs and that the duty to meet these needs therefore fell to ASC, not the Leaving Care service. Although it was good practice that SEN and CSC took a decision to jointly fund a specialist residential college for Eddie that met his needs rather than allow him to fall through the gaps by placing him in mainstream accommodation for care leavers, this did not resolve the underlying dispute between departments in respect of his care and support needs.
- 4.21 Whilst leaving care duties are clearly important, the Supreme Court has been explicit that the legal powers afforded local authorities under s23C to provide ongoing support to care leavers do not supplant the legal duties owed under the Care Act to provide ongoing care and support to those reaching 18 with eligible needs. Leaving care powers are *'a far cry from a power to provide the full range of community care services ... section 23C(4)(c) is an extremely slender thread on which to hang such extensive and burdensome duties. In my judgment, if Parliament had intended to confer a power of this scope, it would have done so expressly.'*<sup>19</sup> The Supreme Court further commented that the purpose of power under s23C of the Children Act is *'not to supplant the substantive regime, but to ease the transition (usually) to adult independence.'*<sup>20</sup>
- 4.22 During the course of discussions at the learning events, it appears that there was a perception that this primarily related to a funding issue, in respect of which local authority department would be responsible for paying for Eddie's residential college. This needed to be reframed into consideration of Eddie's rights, needs and the duties owed to him.
- 4.23 All practitioners involved in supporting Eddie were very clear that he would not be capable of caring for himself in the community without a high level of support and that if not for the supportive placement provided by the SEND and Leaving Care teams, he would have been unable to achieve the outcomes specified in the Care Act and come to immediate harm. They felt it was very unlikely, even with substantial work to develop Eddie's independent living skills, that he would be able to live independently when he turned 25 and the duties owed to him under SEND and leaving care provisions fell away. The fact that a care and support plan was not prepared meant that his wider care and support needs were not assessed and met. Funding for the Residential School was only agreed for two years, something the Residential School noted was common but unsettling for young people, particularly those with learning needs. Eddie's anxiety as to the uncertainty regarding the plans for his support into adulthood is documented within his pathway plan.
- 4.24 SCC's specialist ASC Transition Team only carry out child's needs assessments of young people with a diagnosed learning disability and young people with other care and support needs are assessed by its ASC Locality Teams, which are generic teams that primarily undertake assessments of adults' care and support needs. Consequently, when Eddie was supported to self-refer for a further assessment of his care and support needs in September 2019, the Transitions Team told the SEND and Leaving Care as Eddie has 'learning difficulties' rather

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<sup>19</sup> R (Cornwall Council) v Secretary of State for health and others [2014] EWCA Civ 12, para 52

<sup>20</sup> R (Cornwall Council) v Secretary of State for health and others [2015] UKSC 46, para. 30

than a learning disability he did not meet their criteria, so the referral should be made to the Adult Social Care team. The team also advised that they would not accept a challenge to the original assessment as it should have been challenged at the time. Although Eddie's personal adviser continued to liaise with ASC to progress this, Eddie's care and support needs had not been reassessed at the time of his death, and the fact he had a diagnosed learning disability had not been clarified.

- 4.25 Practitioners felt that the narrow service criteria for the Transitions Team often meant that children without a learning disability or those who were open to the Looked After Children teams as opposed to the Children with Disabilities [CWD] team were disadvantaged. In addition to the CWD team having more experience in framing referrals for assessments and knowing who to contact, the evidence base for the young person's eligibility was already collated. Whilst SCC's Transition Team have tracking meetings with the CWD Team to consider post-18 support, there is no pathway within SCC to consider the transition into adulthood for looked after children who are not in the CWD Team but are likely to require ongoing support and services. Finally, the ASC Localities teams had less experience in assessing young people, whose needs may present quite differently from older adults with care and support needs.
- 4.26 Practitioners from the Looked After Children team commented that they lacked legal literacy and confidence in respect of the legal framework for support for adults. They felt that a better understanding of the assessment process under the Care Act would support them to identify when a referral should be made and what information should be included to ensure that adult social care could target their assessment appropriately. Practitioners also noted that they often experienced pushback from adult social care in respect of referrals for care assessments, on the basis that the young person was already open to children's services or were excluded by narrow criteria for the involvement of specific teams. This was evident when Eddie's personal adviser attempted to re-refer him to the Transitions Team for an assessment of his care and support needs in August 2019, but was told he would have to be assessed by one of the Locality Teams.
- 4.27 Since Eddie's death the Surrey Safeguarding Children Partnership's (SSCP) FaST Resolution Process of escalation has been rolled out; the "*primary aim of the Surrey FaST resolution process is that professional disagreements are resolved at the lowest possible level, by those working directly with children and families.*"<sup>21</sup> This process would have provided a pathway for the IRO and social worker to challenge the decision by ASC that Eddie did not have eligible care and support needs.

### Systems Finding

- 4.28 The lack of a clear diagnosis pathway for children with learning disabilities meant that Eddie's learning disability was not diagnosed before he turned 18, which influenced the assessment that he did not have eligible care and support needs. Eddie's self confidence and the nurturing care provided by his residential placement masked his care and support needs and a lack of robust advocacy or confidence by children's services to use escalation processes meant that the outcome of the assessment was not challenged. Although the decision by children's social care and SEND to fund the placement was person-centred, this meant Eddie's wider care and support needs were not addressed through the appropriate legal and practice framework and created uncertainty for him. Transitions pathways and referral processes for young people with differing needs are opaque to children's services, with inappropriate application of service criteria, resulting in delays in assessment and inconsistent outcomes for young people with care and support needs.

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<sup>21</sup> [7.2 The Surrey FaST Resolution Process | Surrey Safeguarding Children Partnership \(procedures.org.uk\)](#)

**Recommendation 5:**

Surrey Heartlands Health and Care Partnership and Frimley Health and Care should develop a diagnosis pathway for children with learning disabilities and ensure that referral and escalation processes are communicated to the wider partnership.

**Recommendation 6:**

Surrey Children and Adults Social Care should establish a transitions panel to consider all young adults who are likely to have care and support needs or transitional safeguarding needs when they turn 18, including representatives from social care, SEND, IRO, health and mental health services for children and adults. This should be supported by a transitions pathway guidance, to provide guidance for practitioners in respect of the various pathways for young people with different needs.

**Recommendation 7:**

Surrey Children and Adults Social Care should ensure that the upcoming redesign of its Transitions Service incorporates the principles of transitional safeguarding in accordance with the 'Bridging the Gap' guidance.<sup>22</sup> Consideration should be given to ensuring that all child's needs assessment under s58 of the Care Act are completed by social workers with experience assessing children and younger adults, with an understanding of the impact of trauma on the executive functioning of care experienced young people.

**Recommendation 8:**

SSCP should review how the FaST resolution process is being used, including by front-line staff, and whether this is resulting in timely resolution on areas of dispute between agencies.

**Recommendation 9:**

Surrey Children and Adults Social Care should appoint advocates with an understanding of the Care Act 2014 to support young people who require support to engage with or to challenge their child's needs assessment(s).

## Mental Capacity and Diabetes and Coeliac Disease Management

4.29 Eddie is described by professionals working with him to be enthusiastic about sharing his understanding of his diabetes and coeliac disease with professionals and staff at the Residential School, he supported the delivery of diabetes training at the Residential School on more than one occasion. His dietary needs relating to his diabetes were complicated by his coeliac disease as many low-gluten foods are higher in sugars. His love of cooking meant that he enjoyed devising healthy menus and making healthy meals, but like many teenagers he could make poor food choices and was easily influenced by his peers, for example, starting a keto diet that was unsafe for him.

4.30 As noted, while at the Children's Home, Eddie had few hospital attendances in relation to his diabetes management, likely because staff took responsibility for managing his diabetes. When Eddie moved to the Residential School at the beginning of 2019, he was on the verge of turning 18 and it was important that the placement helped to develop his independent living skills, including management of his diabetes, although he continued to require supervision. The diabetes clinic noted that although Eddie required medical attention for high blood sugar on a number of occasion, this was not uncommon for young people his age, with or without a learning disability. The key difference was that he was reliant on support from his placement to communicate with the clinic or identify that he needed medical attention.

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<sup>22</sup> [Bridging the gap: Transitional Safeguarding and the role of social work with adults \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814447/Bridging_the_gap_Transitional_Safeguarding_and_the_role_of_social_work_with_adults.pdf)

- 4.31 In February 2019 Eddie was taken to GRH's emergency department by his key worker and a manager from the Residential School and it was identified that Eddie's blood sugar levels had been regularly elevated for the last two months, ranging between 18-29. The doctor queried why this was not raised with health staff earlier and advised that he should be seen urgently by the Diabetes clinic, but a child safeguarding referral was not made by the hospital to Gloucestershire CSC and Surrey CSC was not informed of this issue by the Residential School. This was a significant gap as, although Eddie was learning to manage his blood sugar independently, he still required close oversight by staff at his placement and consideration should have been given to whether this was not being provided, or there was a training gap at the placement given that Eddie had only recently moved. The appropriate framework for this to be considered was s47 of the Children Act 1989, as this placed Eddie at risk of significant harm.
- 4.32 Eddie turned 18 at the Residential School in March 2019 and it is clear that Eddie continued to rely on trusted staff for support in managing his diabetes. In particular, Eddie could be very inconsistent in recording his blood sugar levels, but with support recorded his readings regularly in Summer 2019 as he was motivated to be eligible for his Libre device to be fitted.
- 4.33 In May 2019 a 'mental capacity profile form' was completed by one of Eddie's key workers at the Residential School. The form noted that Eddie's capacity could be affected if his blood sugar level readings were too high or too low and noted that Eddie would sometimes make deliberately poor food choices that would impact on his diabetes and coeliac diagnoses. However, it does not appear that this was shared with children's social care or GRH's diabetes clinic.
- 4.34 Professionals working with Eddie noted that although he could talk about how to manage his diabetes, his understanding was limited and impacted by his learning disability. In particular, he struggled to consistently maintain his blood sugar testing and recording regimes, often taking his tests after he had eaten instead of beforehand. Work was also being carried out to develop Eddie's understanding of different units of food – he would view one packet of biscuits as having the same amount of sugar as one biscuit, which mean that he would take the wrong dose of insulin. The RA1 risk assessment completed by the Residential School in September 2019 confirmed that Eddie needed to be reminded to check his blood sugar levels and that staff should check and supervise the checking of his blood sugar levels. The Residential School's specific diabetes control support plan for Eddie instructed staff to ensure Eddie read his blood sugar levels back to them, as he could sometimes read numbers backwards.
- 4.35 The Section 42 enquiry in September 2022 explored Eddie's capacity and identified that a mental capacity assessment was not completed by health professionals responsible for Eddie's diabetic care and treatment at any time; an MCA was also not considered by Eddie's social work team at the time his pathway plan was devised in September 2018 or by the Residential School staff following his move. Although practitioners agreed that Eddie would require prompting to manage his diabetes safely, this appears to have been predicated on a presumption that Eddie did not have capacity manage his diabetes independently. This is contrary to the first key principle of the Mental Capacity Act; that a person is assumed to have capacity unless it is established that they do not.
- 4.36 The Mental Capacity Act provides a framework for methodical analysis of the individual's ability to take a decision in respect of a specific matter, when this is broken down in a manner they can understand. If the assessor concludes that they do not have capacity, the next step is to complete a best interests analysis, weighing the merits and risks of each reasonable option in respect of the decision in the context of their welfare in the widest possible sense, including their broader wishes, feelings, values and beliefs. All decisions should follow careful consideration of the individual circumstances of the person and focus on reaching the decision that is right for that person – not what is best for those around them, or what the "reasonable person" would want. The person who lacks capacity to make a decision should still be involved in the decision-making process as far as is possible and those involved in caring for the person,

or interested in his or her welfare, must be consulted about their views on the person's best interests, and the person's past and present wishes, feelings, beliefs and values. What will be required of a best interests assessment process will depend upon what is reasonable, practical, and appropriate in each case.

- 4.37 In Eddie's case, a mental capacity assessment would have been an opportunity to identify all of the relevant options in respect of the management of his diabetes, including his ability to manage this without support or during contact with his family and explore his understanding and ability to manage the risks in relation to this with him in a structured way. A Best Interest meeting, involving clinicians, family, other professionals involved and carers to explore the evidence would have required the team around the person to identify the realistic options, including any options to mitigate risks. It would have engaged his mother and stepfather, providing a forum to explore their understanding of risks and identify any training needs, to determine whether unsupervised/unsupported contact was a safe and realistic option.
- 4.38 It is vitally important that practitioners recognise that in addition to being a legal requirement when they believe that it is likely that someone lacks capacity to take a decision, this process is a powerful tool to support a reflective, holistic and empowering approach to ensure someone's needs are safely met, without subjecting them to misguided paternalism.
- 4.39 It is likely that poor communication across the professional network contributed to the failure to identify the need to consider Eddie's capacity to take decisions in relation to his diabetes management. Eddie attended GRH's emergency department a number of times before his death however these attendances were not shared with the GRH Diabetic Clinic. Discharge letters would be sent to Eddie's GP in line with standard practice, but Eddie's treating clinicians did not receive any updates and therefore did not have an accurate understanding of Eddie's difficulties in safely managing his diabetes. Professionals working with young people are often not aware of the contact details for other professionals involved; this information should be contained as a directory as part of the young person's pathway plan and (with the young person's consent) their pathway plan should be shared with all relevant professionals, including the child's GP. In addition to supporting attendance at statutory reviews, effective communication and information sharing when appropriate, this will facilitate consultation with the professional network in circumstances when a best interest analysis needs to be conducted.
- 4.40 Clinicians noted that NICE guidance<sup>23</sup> recommended that specialist diabetes services should have access to an in-house psychologist, as there were often psychological or cognitive factors that contributed to an individual's difficulties in managing their diabetes. Access to a psychologist would enable risks to be more effectively explored with patients and support a more nuanced approach to assessment of the individual's mental capacity.

### Systems Finding

- 4.41 Poor knowledge and application of the principles of the Mental Capacity Act 2005 hindered professional analysis of Eddie's capacity to manage the risks associated with his diabetes and coeliac disease, and exploration of the realistic options to support him to manage these risks in accordance with his best interest. Further, a more nuanced understanding of the impact of trauma and co-occurring needs such as diabetes on executive functioning will better support practitioners when assessing a young person's capacity to take decisions in respect of risks and medical treatment.

### Recommendation 10:

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<sup>23</sup> [Quality statement 6: Access to mental health professionals with an understanding of type 1 or type 2 diabetes | Diabetes in children and young people | Quality standards | NICE](#)

Surrey Safeguarding Partnership to seek assurance about the robustness of the training, competency and accountability framework for mental capacity in use across children's services, including the Leaving Care service.

**Recommendation 11:**

In complex cases, practitioners from key partner agencies working with the individual should collaborate to formulate a shared analysis of how the individual's cognition function is impacted in different circumstances, to support frontline practitioners in undertaking mental capacity assessments that are decision and time specific.

**Recommendation 12:**

SCC's Leaving Care Service to implement a team around the person approach to review of a young person's pathway plan; with a directory of all professionals working with the young person to be included within the pathway plan to ensure that all relevant professionals including treating clinicians are invited to statutory reviews and consulted with when necessary to inform risk assessments or mental capacity assessments.

**Recommendation 13:**

GRH should consider how to ensure that the diabetes clinic has access to an in-house psychologist, as recommended within NICE guidance.

**Recommendation 14:**

GRH's diabetes clinic should ensure that guidance is available to emergency department colleagues in respect of diabetes management at all times and that any particularly unstable patients are given a patient management plan.

## Risk Assessments and Contact

- 4.42 Section 34 of the Children Act 1989 places a duty on local authorities to allow reasonable contact between children in care and their parents. There is no clarification within the legislation to define what contact should look like i.e. direct or indirect, or what amounts to being considered 'reasonable', there is therefore room for interpretation as to what can amount to sufficient contact, but fundamentally this is intended to preserve the child and family's right to a private and family life under Article 8 of the ECHR. Before Eddie was placed at the Residential School he was having formal supervised contact three times per year for two hours with his mother and stepfather, though it is understood that when living in Surrey he would see his mother and stepfather on an ad-hoc basis when out in the community with the Children's Home staff.
- 4.43 During discussions at the learning events, practitioners advised that there were no concerns in respect of this informal contact, Eddie's family were loving and consistently engaged with meetings about Eddie, such as child looked after reviews. The reasons for Eddie being removed from the care of his mother and stepfather were understood to be due to neglect, and professionals were aware that Eddie's mother had some learning needs herself. What is clear from discussions with professionals is that professionals supporting Eddie as a child did not consider that contact between Eddie and his family presented any acute risk of harm.
- 4.44 The rationale for the low level of formal contact was therefore unclear, particularly as Eddie approached 18, an age at which he would take his own decisions about contact with his family unless a court order or DoLS authorisation were in place to empower the local authority or residential college to restrict this. An important part of preparing a care experienced young person to transition to adulthood is to promote contact with their family if it is safe to do so, to ensure that these relationships are positive and enduring. It is natural for young people to gravitate home once they are entitled to do so.



- 4.45 The level of involvement that Eddie's family had with his pathway plan appears to be limited, despite the requirement under the Planning Transition guidance [paragraph 3.12] to consult with the young person's parents when preparing or reviewing the pathway plan. Eddie's mother and stepfather did attend a number of child in care review meetings and other meetings at the Residential School when his health needs, including his diabetes and dietary needs were discussed. However, their understanding of this was not explored and they were not provided with any training to understand and supervise Eddie's diabetes or how to recognise if medical intervention was required should Eddie present as unwell when with them. This may in part have been because Eddie's diabetes was closely managed by staff when he was a child at the Children's Home and as a result, he had not required regular hospital attendances.
- 4.46 A decision was taken to allow Eddie to have unsupervised staying contact at the family home for Christmas, from 25-28 December 2018 when he was still 17 years old, although travel warrants were issued, in the end Eddie only visited for the day. Regulation 17 of The Care Planning, Placement and Case Review (England) Regulations 2010 confirms that before a decision is made to place a child in care with their parent (including temporarily) that the suitability of the placement should be considered, as well as consideration being given to a Schedule 3<sup>24</sup> assessment being completed before a decision to place a child into their parents' care. The assessment includes consideration of the parents' capacity to care for the child including their capacity to provide for the child's physical needs and appropriate medical care and their capacity to protect the children adequately from harm or danger.
- 4.47 Unquestionably, the care provided to Eddie by the Children's Home was very high quality, and children's social care explained that the Children's Home closely supported any contact with took place with the family. However, no risk assessment by his social work team took place before the planned staying contact and it does not appear that consideration was given to providing the family with training in supporting Eddie to manage his diabetes or to recognise if he needed medical treatment. The fact that the contact was uneventful may have given professionals a false sense of security about Eddie's ability to manage his diabetes independently, and his family's ability to oversee this safely. Further, it appears that practitioners on the case may not have been aware that Eddie only visited for Christmas day, rather than the three-day contact planned. Shortly after this contact, he moved from the Children's Home to the Residential School.
- 4.48 There are some inconsistencies in the information provided by the Residential School and the Leaving Care team in respect of the dates of Eddie's subsequent contacts with his family, which may indicate that these arrangements were not clearly defined between the two agencies. The Residential School recorded that Eddie had his first planned overnight stay with his family immediately after his 18<sup>th</sup> birthday, from 30-31 March 2019 (although Leaving Care's records indicate this was a single day on 29 March). Although significant concerns had been raised in February by the diabetes specialist at GRH that Eddie's blood sugar had been poorly managed for months, including two hospital attendances for hyperglycaemic episodes in January and February, this did not prompt a risk assessment before staying contact took place. Professionals were aware that having just turned 18, Eddie was entitled to take his own decisions in respect of contact unless a Court of Protection order or DoLS authorisation were in place. However, there is no record that any discussion took place with Eddie or his parents about how this would be managed, nor is there any indication, given the positive relationship Eddie had with the practitioners working with him, that he would have objected to any measures put in place to mitigate the attendant risks.
- 4.49 Leaving Care recorded that Eddie had contact overnight on 13-14 July 2019, although this was not recorded by the Residential School. Eddie's next planned home visit was from 1 to 3

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<sup>24</sup> [The Care Planning, Placement and Case Review \(England\) Regulations 2010 \(legislation.gov.uk\)](https://www.legislation.gov.uk)



November 2019. In preparation for this visit Eddie's personal advisor arranged his travel warrant, on the morning of 1 November 2019 the Residential School staff checked that Eddie had the medication he needed before he set off by train to Surrey, a call was made to Eddie later that day by his keyworker to confirm he had arrived safely. Despite the high level of need identified within the Residential School's risk assessment (RA1 dated September 2019) regarding the need to ensure that Eddie's blood sugar levels were monitored and that his diabetes management was to be supervised by staff, a risk assessment was not completed in advance of this planned visit and there is no record of requests by the Residential School staff for Eddie's blood sugar level readings, or that these were reviewed on the Libre app during this visit.

- 4.50 The staying contact planned for 24-30 December 2019 was significantly longer than any previous contact between Eddie and his family since he was taken into care at the age of 7. The fact this was over the holiday period increased the risk to Eddie as a diabetic, as Christmas is typically celebrated with a large meal, often alcohol, and consumed at times outside the person's usual routine. Again, Children's Social Care, the Residential School and the College did not complete a risk assessment in respect of the contact, or make arrangements to ensure that Eddie's blood sugar levels were monitored remotely.
- 4.51 During discussions with the review authors, Eddie's treating clinician at GRH's Diabetic Clinic noted that if they been consulted to feed into a risk assessment, they would have raised their concerns about Eddie being at home for an extended period of time without support from the Residential School staff. However, all discussions that had taken place with the clinician had been predicated on Eddie being provided with support in managing his diabetes by the Residential School staff, who had received appropriate training.
- 4.52 Although the College's team house manager was in contact with Eddie from 24 – 26 and on 28 December 2019, information was not sought about Eddie's blood glucose readings. The first aid trained staff member who first spoke with Eddie's mother on 30 December identified that his presentation and the fact he had not eaten all day were risks due to his diabetes, checked whether his blood glucose levels had been taken and that he had enough glucogel. The staff member reported that although she told Eddie's mother to call 111 for advice if he got worse, mother seemed distracted as she was focussed on obtaining the phone number for the college's duty manager. However, the staff member did not contact the duty manager directly or record the conversation until the following day. Neither of the managers who spoke to mother that day discussed Eddie's diabetes or gave her advice to seek medical attention. Again, a comprehensive risk assessment recorded on Eddie's file may have supported the managers to recognise and respond to the immediate risk to Eddie's life.
- 4.53 The section 42 enquiry found Eddie experienced neglect from the Residential School due to there not being a risk assessment in place, *"it is likely that, among other things, a plan would have been put in place for staff to monitor Eddie's blood sugar levels through his Libre device and the associated app. This appears to be a missed opportunity to use the equipment that was prescribed and in place for Eddie. The risk assessment would have also resulted in the staff having to explore Eddie's ability to manage his diabetes. Staff at the Residential School also did not respond to the information provided by Eddie's mother or consider that his mother did not have the experience of supporting Eddie with his diabetes (as she clearly stated to the Residential School staff when they dropped him off)."*<sup>25</sup>
- 4.54 The Residential School completed an internal investigation and learning review following Eddie's death, recognising the need to urgently review their safeguarding processes in the wake of this tragedy, and implemented the resulting learning without delay. This included replacing the education learning coordinator role with an education, care and health manager, who has

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<sup>25</sup> Section 42 Enquiry dated September 2022, page 23

more expertise to support young people placed within the Residential School placements. The Residential School has also introduced a requirement for each young person's education, care and health manager to complete an overnight stay risk assessment when planning for any overnight family contact. The overnight stay risk assessments include agreed intervals for keeping in touch with young people and sharing details of named workers for the period of time it is agreed a young person when away from placement.

- 4.55 However, as identified by the coroner, Surrey's Leaving Care and Children's Social Care equally held responsibility, both statutorily and as good corporate parents for ensuring there was an up-to-date assessment of Eddie's needs, including his health and contact needs, addressed through his pathway plan. This duty included a duty to consult Eddie, and support him to understand the risks of going home unsupported. Although it appears that the Leaving Care team were not informed about all of the occasions when medical intervention was required as a result of Eddie's inconsistent diabetes management, the professional concerns about his management in general was discussed during EHCP and pathway review meetings. While supporting contact for a young adult care leaver might generally require a 'light touch' by providing travel warrants, Eddie's health needs evidenced a foreseeable risk, so the local authority should have completed a risk assessment to comply with its positive obligations to Eddie under Article 2 (the right to life) of the Human Rights Act 1998 and to take steps to mitigate the risks identified. In the event Eddie wished to disregard the mitigation measures identified in the risk assessment, a mental capacity assessment should have been completed to ascertain whether he was able to take the relevant decision, and if appropriate, step taken to safeguard him.
- 4.56 While in some circumstances, it may be more appropriate for the provider to complete the risk assessment, it is essential that there is clear agreement recorded in respect of who is responsible for this, when and how it will be reviewed. This may need to be incorporated into the contractual arrangements with providers by the commissioning service.

### Systems Finding

- 4.57 The decision by Surrey Children's Social Care to restrict Eddie's contact with his family to occasional, supervised contact at his placement meant that the family had not developed an understanding of how to recognise or respond to his health needs relating to his diabetes. Neither the placement nor the local authority undertook an assessment of the family's ability to meet those needs before unsupervised contact took place, and there was no clear agreement about whose responsibility this was. A lack of professional curiosity or governance structure around risk assessments allowed this situation to continue as the length of unsupervised contact progressively increased, despite frequent concerns being raised by clinicians during this period in respect of Eddie's inability to safely manage his diabetes without support.

#### **Recommendation 15:**

Surrey Children's Social Care and IROs should review contact plans as looked after young people approach 18, to ensure these are age-appropriate and safely prepare the young person to take their own decisions around contact as an adult.

#### **Recommendation 16:**

For all young people placed in care or residential colleges with serious medical conditions, a risk assessment regarding contact with family must be completed by the child's social work team before they reach 18 and feature in their EHCP and pathway plan. The risk assessment should be provided to any placement arranged by the leaving care service, SEND or adult social care to ensure that the assessment is kept up-to-date and used to devise safely plans for contact.

**Recommendation 17:**

SCC's Leaving Care Service, in consultation with health partners, should develop practice standards for risk assessments in relation to care leavers, including guidance on the circumstances in which these should be completed and who is responsible for this.

**Recommendation 18:**

The Residential School should provide assurance to SSAB in respect of how it monitors that overnight stay risk assessments are consistently completed for all young people before any planned trips away from placement.