Central Bedfordshire and Bedford Borough SAFEGUARDING ADULTS BOARD

Safeguarding Circle

Safeguarding Adults Review

Alex

Commissioned by Central Bedfordshire and Bedford Borough Safeguarding Adults Board

June 2025

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1. Introduction

1.1 In October 2024 Central Bedfordshire and Bedford Borough Safeguarding Adults Board ['CBBBSAB'] commissioned a safeguarding adults review in respect of Alex (aged 19 at the date of commissioning), a care experienced adult who has a diagnosis of ADHD, mild learning disabilities, Autism, mental health needs and is transgender. He has experienced periods in secure accommodation under the Children Act 1989, detention under the Mental Health Act 1983, in addition to detention through the criminal justice system. As a consequence of the harm Alex has experienced whilst cared for by statutory agencies, including self-harm, trauma linked to disrupted placements and lengthy periods of detention, CBBBSAB agreed to carry out a review to examine Alex's transition from children's to adults' services and as he has moved between agencies and across boundaries as Alex is in need of care and support, and to understand how agencies with relevant functions worked together to safeguard Alex.

2. Pen picture of Alex

1.2 Alex is a hilariously funny, inquisitive and creative person, who is very loyal to his family. A talented musician who loves rap, he regularly attends a music studio and a local gym for specialist personal training sessions designed for people who are neurodiverse. Despite the disruptions to his education, he is keen to learn, and steps are being taken to secure him a tutor. His diverse interests include history, walking, football and architecture, and he is curious about world religions. Having discovered that his grandfather is Jewish, he asked to meet with a rabbi to explore this but subsequently developed an interest in Christianity and met with a supportive priest, although his interest in this has now waned.

1.3 Alex was registered female at birth, but affirmed his male gender identity through a social transition and the Family Court authorised his name being changed in January 2022. However, this identity remains fluid and there are periods when Alex will identify with different pronouns. He experiences significant body dysmorphia, but is usually very well presented, meaning that when this deteriorates, practitioners know he is becoming unwell. Alex will be referred to as male and by his chosen pronouns throughout this document in accordance with his current wishes, including the period prior to his decision to transition. We are respectful of Alex's chosen name but are using an alternative male pseudonym in this report to maintain his anonymity.

1.4 Alex was placed in the care of Bedford Borough Council under Section 31 of the Care Act 1989, when he was 8 years old, after he and his siblings were removed due to concerns about neglect and his mother's mental health. Although he was initially placed in foster care, practitioners felt that his carers were not equipped to deal with some of his behaviours that resulted from his disordered attachment and complex trauma. By the age of 12, Alex was moved to a residential placement, but had 11 placements breakdown due to high levels of self-harm (in particular, swallowing items such as batteries) resulting in multiple moves around the UK, inconsistent care, disjointed education and fragmented Child and Adolescent Mental Health [CAMHS] support. There have been multiple incidents when he assaulted staff at his placements, including making weapons and attempting to strangle them, often in response to a perceived threat or his overriding fear due to the uncertainty around his future. Practitioners commented that at times, he would use insulting or racist language to inflame staff because he was bored or frustrated. As a person with a diagnosis of autism, Alex likes routine, but this can be very difficult in a hospital setting with other patients with competing needs. He shows some insight into his behaviour, saying to one practitioner "*I can take things too far. You can tell me [negative things] but not in a mean way.*" Clinicians are currently exploring a possible diagnosis of Dissocial Personality Disorder alongside Emotionally Unstable Personality Disorder.

1.5 Alex has a really positive relationship with some of the practitioners involved in his care, some of whom have been working with him since before he turned 18 and who spoke of him with real

fondness. Across the two learning events for health and social care practitioners, a repeated theme was of Alex's feelings of isolation, one saying "*…Alex just wants to be able to fit in somewhere, he just feels really lost*" and another "*he's very, very lost, he feels that he doesn't belong anywhere"*. ELFT specialists noted that they have approached every low-secure hospital in the country, trying to find him a suitable step-down placement, and that Alex has been calling the complex care lead for Learning Disabilities and Autism (who is leading on his placement search) frequently, seeking reassurance that the only placement that has made a tentative offer is progressing. Practitioners are concerned that a ward manager who Alex has become particularly attached to is shortly to move roles, as this is likely to further unsettle him, although it is noted that this person had been the target of several assaults by Alex. Practitioners also noted that his relationships could be fragile, and that when angry "*anything goes.*" The ongoing dedication to his care is truly admirable, despite some of these challenges and the personal impact on individual practitioners, but there is a real sense of exhaustion.

Background

1.6 In March 2021 Alex was made subject of a secure accommodation order under s25 of the Children Act 1989 and placed in a registered secure accommodation unit in Scotland (authorised by the Family Court). He was moved to an unregistered residential placement in 2022, but this placement rapidly became strained as Alex caused damage to the property and assaulted staff. Practitioners commented that the placement "*looked good on paper*" but broke down very quickly, resulting in a scramble for a new placement. He was supported by North Bedfordshire CAMHS during this period. An application was made to the Family Court for an order authorising the deprivation of Alex's liberty under the court's inherent jurisdiction, although this was initially declined as the court sought more information about the placement and nature of the restrictions and supervision he would be placed under. In mid-2022, ten months before his 18th birthday, a referral was also made to Bedford Borough's Adults with Disabilities team for a child's needs assessment under s58 of the Care Act 2014, to plan for Alex's transition to adult services.

1.7 Alex was moved to a placement in Peterborough the following month, but repeated assaults against staff resulted in him being charged with Actual Bodily Harm. In late 2022, he was remanded by the Youth Court to a secure training centre and he was subsequently sentenced to an 18-month youth referral order. Following another incident in Spring 2023 when he attempted to stab one member of staff and strangle another, Alex received a further detention and training order. Although efforts were made to find a forensic mental health unit to meet Alex's needs, this was initially refused as he was still only 17. Peterborough's ICB agreed to carry out a continuing healthcare assessment.

1.8 When Alex turned 18 in mid-2023, a referral was immediately made to EPUT to identify an adult secure placement for him, and a Gateway recommendation was made for a forensic mental health bed. He transferred from YOS to the Probation Service. Alex's violence towards professionals continued to escalate, and he was referred to Multi-Agency Public Protection Arrangements [MAPPA and accepted as a level 3 MAPPA subject] in Thames Valley, as he was reported to be the perpetrator of over 170 extremely violent incidents. At the end of May, he was sentenced to a 4-month custodial sentence.

1.9 ELFT continued to search for a forensic bed for Alex throughout the summer, but his mental health deteriorated. An assessment under s2 of the Mental Health Act 1983 [MHA] was carried out in August after he self-harmed by swallowing batteries and a self-ligature, and Alex was assessed as requiring detention. He was released from custody in Autumn 2023 and detained in ELFT's Ward A Psychiatric Intensive Care Unit [PICU], a male psychiatric unit, before being moved to Ward B (a female PICU) where he was assessed as requiring detention for treatment under s3 MHA. Alex spent short periods in seclusion due to incidents of violence, and a care co-ordinator was allotted. However, clinicians queried whether Alex's behaviour was too high

risk to manage in a psychiatric unit, and he was discharged from the MHA after an incident when Alex stabbed a staff member on the ward, believing he would be charged by police. However, he was not charged, and the professional network was not notified, nor was support put in place, and he was arrested after intimidating family members and recalled to prison before again being detained under the MHA.

1.10 In late 2023, a recommendation was made that Alex should transfer to a low secure mental health unit, and this, together with his frustration that he could not spend Christmas with his mother, triggered several violent incidents. In early 2024, ELFT planned to transfer Alex to Ward A, and he spent another two days in seclusion after assaulting staff, so he was placed on 3:1 nursing observation. He became dysregulated after accessing illicit drugs.

2.1. The following month, Alex was assessed and diagnosed with attention deficit hyperactivity disorder [ADHD] and prescribed medication for this. A further referral was made to a women's low secure unit, which initially rejected Alex, resulting in a violent incident when he tried to stab and strangle two staff members. Alex was stepped down to 2:1 support in mid-2024, and at the end of that month, the low secure unit agreed to reassess him and made a provisional offer of a bed, subject to agreement to funding and "*once the ward's acuity is safer*". However, the date for this move has continued to be delayed due to the profile of other patients and staffing levels and as at the date of the learning events for this review in 2025, Alex remained on Ward A. One leader described that it is impossible to know how Alex will respond when he is moved to a more appropriate unit, but that the delay and uncertainty are causing him endless distress - he cries every day. To use Alex's words: *"I'm an abandoned dog waiting for a kennel*."

3. Scope of Review

Purpose of a Safeguarding Adult Review

3.1. 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).
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies to make recommendations for future action.

3.2. There is a strong focus on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Alex from harm. The learning produced through a SAR concerns systems findings. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

Themes

3.3. The CBBBSAB prioritised the following themes for illumination through the SAR:

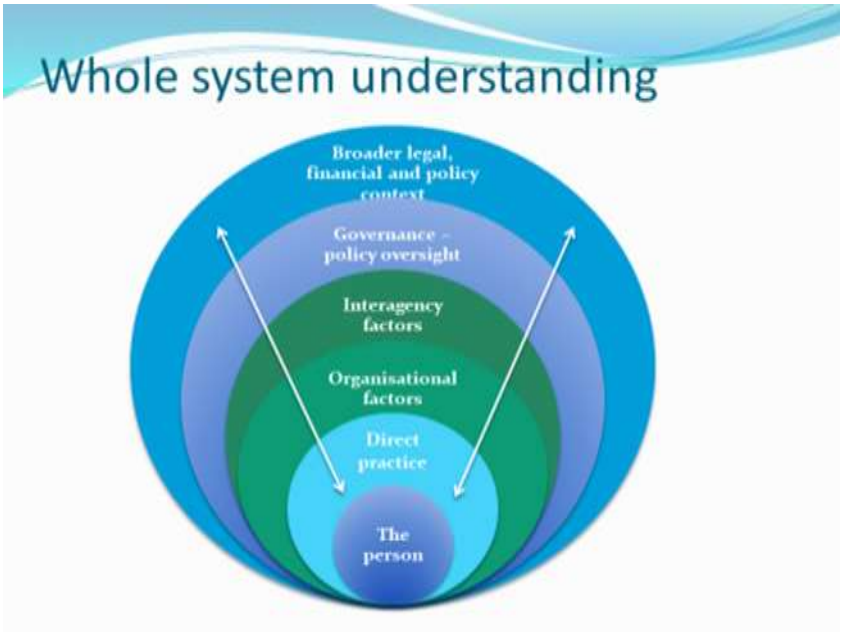
- How did diversity, disability, diverse gender and sexuality, diverse neurodiversity affect the outcomes and Alex achieving good outcomes in his life?
- How were responses and possible links between experiencing mental health crises and forensic needs considered in minimising risks?

- How are specialist services commissioned, planned, allocated and accessed and how can we further escalate to achieve the right services and therapies at the right time?
- How systemically did we institutionalise Alex and what are the barriers to achieving person centred care and positive outcomes? Did Alex experience abuse or neglect by a system that was meant to care and safeguard him from harm?

3.4. The review will cover the period from May 2022- July 2024.

Methodology

3.5. 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.[1] 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. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram below.[2] Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



3.6. The overarching purpose of the review has been to learn lessons about the way in which professionals worked in partnership to support and safeguard Alex. Agencies provided reports setting out a description of their involvement with Alex, with a chronology of key events. The author used these to draw together an Early Analysis Report, summarising the agency returns to provide a framework for multi-agency discussions at learning events with front-line practitioners who worked directly with Alex and the leaders who oversaw the services involved in supporting him.

3.7. The learning produced through a SAR concerns 'systems findings', by reviewing the underlying issues that helped or hindered in the case the report seeks to identify systemic rather than one-

[1] 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

[2] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection, 17 (1), 3-18.

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

Contributing agencies

3.8. The following agencies provided documentation to support the SAR:

- Bedford Borough Council (BBC) Adult Social Care (ASC) Teams and Children's Social Care (CSC) Teams
- Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK)
- Bedfordshire Police
- Probation Services
- MAPPA
- Group 4 Security (G4S)
- East of England Provider Collaborative
- Essex Partnership University Trust (EPUT)
- East London Foundation Trust (ELFT),
- East Midlands Ambulance Service
- Bedfordshire's Hospitals
- Autism Bedfordshire
- Advocacy Services
- Department of Work and Pensions (DWP)

Alex's involvement

3.9. Alex's clinical team have been approached to establish whether it is in his best interest to be invited to participate in this review. This will be raised again prior to publication.

4. The legal framework

Deprivation of liberty under the Children Act 1989

4.1. The family courts can authorise a deprivation of liberty under section 25 of the Children Act 1989 [CA1989] to place a child in approved secure accommodation. This will only apply if the young person has a history of absconding and is likely to abscond and suffer harm in any other type of accommodation, or if they are likely to harm themselves or others in any other type of accommodation. In urgent circumstances, the director of children's social care [CSC] can approve a placement for up to 72 hours while a court order is sought.

4.2. The Family Court can also, in exceptional circumstances, exercise the Inherent Jurisdiction of the High Court to make an order to authorise a deprivation of a young person's liberty on welfare grounds, in accommodation which is not registered secure accommodation. This will usually be made on the basis that the grounds for secure accommodation have been made out, but that a registered secure placement cannot be identified, despite an extensive search. The court will have to authorise the local authority placing a child under constant supervision and control which goes beyond the level of supervision a child of that age would normally experience (for example, a 2 year old will always be supervised by an adult in the home or community, however a 14 year old would normally be able to go out with friends after school, as long as they were home by their curfew).

Youth Detention through the criminal justice system

4.3. The conditions for detention into youth detention accommodation are set out in section 91 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012. A young person can only be remanded while awaiting trial if they are over the age of 12, there is reasonable prospect they will receive a custodial sentence, they have a history of absconding and committing imprisonable offences while on bail or remand, that it is necessary to prevent the public from death or serious injury by the child or to prevent the child committing further offences. The child must also be legally represented during the hearing. However, custodial remand should always be considered as a last resort and the Youth Court must consider of the welfare and best interests of the child when making remand decisions and there is a presumption that children should be remanded in the community unless there is no other option.

4.4. Young people aged 12 to 17 years old who are sentenced to custody in the youth court are normally given a detention and training order (DTO). This combines detention with training and will be used for young people who commit a serious offence or commit a number of offences. Half the sentence is spent in custody and the other half is supervised by the Youth Justice Service in the community, providing training, offending behaviour programmes and education to reduce the risk of young people offending when the sentence is finished. This is so fundamental to the ethos of the youth justice system that young people in these facilities are referred to as 'trainees', rather than inmates or prisoners. Children under the age of 15 years old will be held in a secure children's home (SCH) and those aged 15 years old or over will be held in either a secure training centre (STC) or, for boys only, a young offender institution (YOI) or.

4.5. The Youth Justice Service (YJS) for the local authority area where the young person is ordinarily resident (either where they live, or if they are a looked after child, the local authority in whose care they were placed at the time they were detained) is responsible for conducting regular visits and planning for release. On return to the community, the YJS provides supervision in the community until the end of the sentence, to mitigate the risk that of further offending and to protect the public. Young people can be recalled to court or the STC/YOI if they breach the conditions of their release.

Detention under the Mental Health Act 1983

4.6. There are a number of provisions under the Mental Health Act 1983 [MHA] that enable someone who presents as seriously mentally unwell to be lawfully deprived of their liberty, including children. For the purpose of this document, a 'mental health assessment' refers to a formal assessment under the MHA to determine whether someone should be detained in hospital. Two assessing doctors (one of whom must be a psychiatrist) must make a medical recommendation that the person should be detained, then an approved mental health professional [AMHP] will make the final decision, applying the principle that the least restrictive option to meet the person's needs should be followed. Other assessments of Alex's mental health needs outside the MHA will be referred to as Child and Adolescent Mental Health Services (CAMHS) assessments or forensic risk assessments.

4.7. Under s136 MHA, a police officer can take a person to a place of safety (usually a hospital) if they appear to be suffering from a mental disorder and in need of immediate care and control. However, if the person is in their own accommodation (including a residential placement), a warrant must be sought from the courts by an AMHP under s135 MHA. Someone who is already an in-patient in hospital can be detained under section 5(2) MHA for up to 72 hours, to allow an assessment to be undertaken to determine whether they need to be further detained.

4.8. A person can be detained for the purpose of assessment for up to 28 days under section 2 MHA if they are suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; and ought to be detained in the interest of his or her own health or safety, or with a view to the protection of others. If they are assessed as needing to remain in hospital for medical treatment, a further application can then be made under s3 MHA.

4.9. The Mental Health Act 1983 Code of Practice[3] reinforces that when making any decision in relation to care, support of treatment under the Act, clinicians must apply five guiding principles, including using the least restrictive option that maximises independence, empowerment, respect and dignity. The MHA contains mechanisms for a patient subject to detention to be represented by an Independent Mental Health Advocate (IMHA) and request a review before the Mental Health Tribunal (although this does not apply to s5(2)[4]) and provided powers are properly used, treatment and care plans will comply with Article 5 ECHR. Planning for safe discharge should start as soon as the person is admitted to hospital, to identify the appropriate aftercare services necessary to meet their needs before they are discharged.

4.10. Section 117 of the MHA places an enforceable joint duty on the ICB and local authority to provide aftercare services to a person who has been detained under section 3 MHA on discharge from hospital. An aftercare service is a service provided to meet a need arising from or related to the individual's mental disorder, to treat and prevent a deterioration in their mental disorder and reduce the risk of the individual being returned to hospital. This will include specialist accommodation if this is necessary to meet the person's mental health needs. The duty to provide s117 aftercare services is triggered on discharge from hospital, although as noted, planning should start immediately on detention. It is important to recognise that the local authority's duties to a looked after child or under the Care Act will run alongside s117 duties and do not displace them, as this is not a substitute for expert support to prevent a relapse in mental health.

4.11. If the Responsible Clinician is considering discharge, they should consider whether the person's s117 aftercare needs have been identified and addressed. The individual must be fully involved in any decision-making process with regards to the ending of aftercare, including, if appropriate, consultation with their carers and advocate. In cases when the Responsible Clinician believes that the aftercare plan needs to be tested before the person is formally discharged from s3, they can support the move to a new placement by allowing leave from the ward under s17MHA, subject to a careful risk assessment. Although this should not be used to artificially delay discharge when the patient is no longer clinically detainable, this can facilitate a careful trial of the person's readiness for discharge. It has the benefit of ensuring that oversight of the person's mental health treatment remains with a Responsible Clinician and enables the person to be readmitted under s3 without delay if it transpires in the community that discharge would be premature. This can also give greater confidence to potential placements that they will be fully supported by an expert clinical team, and that they will not be left managing an unsafe situation because Tier 4 beds are not available.

4.12. Aftercare should be kept under review to ensure this continues to meet the person's needs and will only end if both the ICB and local authority are satisfied that the person no longer needs this. It cannot be withdrawn simply because someone has been discharged from specialist mental health services, readmitted to hospital (unless the person is detained under a fresh application of s3MHA)[5] or after an arbitrary period. If aftercare is withdrawn, services can be reinstated if it becomes obvious that was premature.

[3] Mental Health Act 1983 (publishing.service.gov.uk)
[4] There is also no legal right to an IMHA for people detained under sections 4, 135 and 136 of the Mental Health Act 1983
[5] R (oao Worcestershire County Council) v Secretary of State for Health and Social Care [2023] UKSC 31, though this would not be relevant in Alex's circumstances as his ordinary residence was determined in line with s105 Children Act 1989 as he remained subject to a care order.

Transition to adulthood

4.13. 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, and those who require mental health services, 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.

4.14. 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 Education Health and Care Plans [EHCP] to support them, ideally in mainstream education, until the age of 25 if they remain in education. 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[6] 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 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)

4.15. 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[7] 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. When a young person is in care, it is the responsibility of the Adult Social Care Service for the local authority that the young person is in the care of to carry out the transition assessment, as until the young person turns 18, they remain ordinarily resident in the area that took them into care. This avoids gaps in assessment and provision of care and support in cases when it is unclear where the young person will live, or whether their ordinary residence will change after they turn 18.

4.16. The Care and Support 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

[6] SEND_Code_of_Practice_January_2015.pdf (publishing.service.gov.uk)
[7] Care and support statutory guidance - GOV.UK (www.gov.uk), para. 16.9

assessments should be needs-led and not restricted by available services. Diagnosis should not act as a barrier to support.

4.17. The leaving care provisions in the Children Act 1989 place a duty on local authorities to act as good 'corporate parents' and provide continuous support for children and younger adults who have been accommodated under the Children Act 1989, up until the age of 25, even if they are no longer living in the same area. This includes requirements to keep in touch with them, regularly review their pathway plan, allocate a personal advisor and provide financial assistance in some circumstances. Whilst leaving care duties are clearly important, the Supreme Court has been explicit that these do not supplant the legal duties owed under the Care Act to adults with care and support needs. The Supreme Court commented that the purpose of leaving care duties is '*not to supplant the substantive regime, but to ease the transition (usually) to adult independence*.'[8]

4.18. 2013 NICE guidance[9] on children with a diagnosis of autism also advocates that transition planning should start when the young person is 14, with an updated assessment of their needs to ensure a smooth transition to adult services. This further advocates a care planning approach to transfer between services in complex cases and requires staff to receive training and know how to assess risk, provide individualised care and make adjustments or adaptations to Health and Social Care processes to enable access and that they have skills to communicate with the young person. The expectation is that those providing care will anticipate and make adjustments to prevent behaviour that challenges or offer psychosocial interventions as a first line treatment for challenging behaviours. In addition, regulations[10] 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 of looked-after children are met without delay… They should also plan for effective transition and consider the needs of care leavers*.'[11]

4.19. Integrated Care Boards are required to have systems in place with local authorities to ensure every looked after child has an up-to-date individual health plan based on a health assessment and that appropriate referrals are made so clinicians can be actively involved in transitional planning as they approach adulthood. For young people with significant and complex health needs meeting the criteria for continuing healthcare [CHC], the National Framework for Continuing Healthcare also requires formal screening for CHC eligibility when a young person is 16 and eligibility determined in principle when the young person is 17. However, Alex was not referred for the CHC assessment until after his 18th birthday.

5. Case analysis

Impact of diverse needs and equalities duties

How did diversity, disability, gender and sexuality, neurodiversity affect the outcomes and Alex achieving good outcomes in his life.

5.1. *"Autism is a lifelong developmental disability that affects how people perceive, communicate and interact with others, although it is important to recognise that there are differing opinions on this and not all autistic people see themselves as disabled."*[12] The impairments associated with autism are on a dimensional spectrum, characterised by difficulties in social communication,

[8] R (Cornwall Council) v Secretary of State for health and others [2015] UKSC 46, para. 30
[9] Recommendations | Autism spectrum disorder in under 19s: support and management | Guidance | NICE
[10] The Care Planning, Placement and Case Review (England) Regulations 2010
[11] 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) but was binding on the local authority and CCG at this time.
[12] National strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK (www.gov.uk)

restricted interests, repetitive behaviours, and sensory behaviours. In addition to these central features, up to 70% of children and young people with autism can have at least one co-occurring mental health diagnosis.[13] Alex's autism means that he takes things very literally and becomes extremely upset if things are promised and not delivered.

5.2. ADHD is a developmental disorder characterized by developmentally inappropriate and impairing symptoms of inattention, hyperactivity, and impulsivity.[14] A series of studies have shown that males are diagnosed with ADHD at higher rates than females, and are diagnosed earlier, with many women being diagnosed in adulthood. [15] This differential may be due to physicians lacking knowledge of gender differences in ADHD, leading to overlooked or missed diagnoses for girls. This may have contributed to Alex's late diagnosis in 2024, as an adult after he had transitioned to a male gender.

5.3. Gender dysphoria is a term that describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity.[16] It is not a mental illness and is not related to sexual orientation. Research by the University of Cambridge's Autism Research Centre[17] has found that "…*transgender and gender-diverse adult individuals were between three and six times more likely to indicate that they were diagnosed as autistic compared to cisgender individuals… Transgender and gender-diverse individuals were also more likely to indicate that they had received diagnoses of mental health conditions, particularly depression, which they were more than twice as likely as their cisgender counterparts to have experienced. Transgender and gender-diverse individuals also, on average, scored higher on measures of autistic traits compared to cisgender individuals, regardless of whether they had an autism diagnosis*." [18]

5.4. Alex appears to have been well-supported in his gender transition by the practitioners who attended the learning events. Practitioners noted that he had started the process to legally change his name, then decided he wanted a middle name, then wanted to return to his birth name, before again confirming that he wanted to be known as Alex, so he does not have any identification in his own name. As a consequence of the number of moves he had around the country, he did not receive consistent CAMHS support in respect of his mental health or gender identity, and remained on the waiting list for an assessment at the Tavistock Gender Identity clinic for a lengthy period before being seen by a transgender clinic while placed in Scotland, but this was disrupted when he returned to England at the age of 17. He was still waiting to be seen by the Tavistock when the clinic was closed.

5.5. Following the Cass Review of gender-related treatment for young people, [19] the UK government banned puberty blockers for under-18s experiencing gender dysphoria, and draft guidance has been prepared for NHS gender clinics to conduct multi-disciplinary assessments of young people seeking to transition, including screening for neurodevelopmental conditions, and developing an individual plan for support. A systematic study[20] of research into gender dysphoria found that "…*children with gender dysphoria often experience a range of psychiatric comorbidities, with a high prevalence of mood and anxiety disorders, trauma, eating disorders*

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[13] Simonoff E, Pickles A, Charman T, Chandler S, Loucas T, Baird G. Psychiatric disorders in children with autism spectrum disorders: prevalence, comorbidity, and associated factors in a population-derived sample. *J Am Acad Child Adolesc Psychiatry* 2008; 47:921. https://pubmed.ncbi.nlm.nih.gov/18645422/.

[14] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

[15] E.g. Mowlem F. D., Rosenqvist M. A., Martin J., Lichtenstein P., Asherson P., Larsson H. (2018). Sex differences in predicting ADHD clinical diagnosis and pharmacological treatment. *European Child & Adolescent Psychiatry*, 28, 481–489. https://doi.org/10.1007/s00787-018-1211-3

[16] Gender dysphoria - NHS (www.nhs.uk)

[17] Warrier, V et al. *Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses and autistic traits in transgender and gender-diverse individuals.* Nat Comms; 7 Aug 2020; DOI: 10.1038/s41467-020-17794-1

[18] Transgender and gender-diverse individuals are more likely to be autistic and report higher autistic traits | University of Cambridge

[19] Final Report – Cass Review

[20] Frew, T., Watsford, C., & Walker, I. (2021). Gender dysphoria and psychiatric comorbidities in childhood: a systematic review. *Australian Journal of Psychology*, *73*(3), 255–271

and autism spectrum conditions, suicidality and self-harm", but there was no standardised approach to their assessment, treatment or clinical management. The researchers noted that it was important for these co-occurring psychiatric conditions to be carefully considered when determining the appropriate course and timing of treatment for the young person's gender dysphoria. However, social transition to the affirmed gender is a treatment model that allows a reversible means of managing the child's distress until it is known whether the gender dysphoria will persist through adolescence.[21]

5.6. Although when Alex was detained under the MHA, he was initially placed on ELFT's Ward A, which is a male PICU ward, he was subsequently moved to Ward B, which is an all-female ward. However, after a series of assaults on staff, he was moved back to Ward A. This decision was taken in part because staff on the male ward have more experience and higher staffing numbers to manage violent patients. High levels of supervision were put in place, in part to manage the risk Alex posed to staff and in part, to ensure that as a trans man, he was not at risk from other male patients. However, practitioners noted that Alex had asked to be moved to a female ward, as he found being detained on a male ward triggering.

5.7. Alex was seen by ELFTs gender identity clinic while on Ward A, but clinicians assessed that he did not have mental capacity to take decisions around his gender identity and could not prescribe him testosterone due to the potential for this to exacerbate his aggression. However, other practitioners felt that this information was poorly presented to Alex without considering his autism, leading to him becoming distressed and dysregulated, assaulting staff members. They were particularly concerned that Alex was misgendered throughout the clinic's decision letter, which he found very disrespectful. They were also concerned that the gender identity clinic had taken a decision not to work with Alex further due to his lack of capacity in respect of this issue, when those working with him felt that he still required therapeutic support to help him manage his sense of dysphoria. They noted "*He feels trapped… trapped in his body, trapped in hospital".*

5.8. Alex has reported that he was sexually assaulted as a child. Research[22] evidences that transgender adolescents, particularly those assigned female at birth, experience higher rates of psychological, physical, and sexual abuse, compared with their cisgender peers. This increases the risk of negative mental health outcomes, although research[23] demonstrates that this can be mitigated by access to trauma-informed, gender affirmative interventions. Nationally, systemic barriers have been identified for transgender survivors of sexual abuse, as many support services are only accessible for women.[24] Transgender people are likely to feel uncertain about their ability to access services or be excluded from these services following the recent Supreme Court decision which has held that the Equality Act 2010 in its "…*context and purpose, demonstrate that the words "sex", "woman" and "man"…mean (and were always intended to mean) biological sex, biological woman and biological man*."[25] This means that organisations are able to decide whether they limit access to male-only or female-only services by biological sex, and although many will chose to include trans men or women within these services, it is important that leaders have assessed the impact of this decision on service provision locally.

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[21] Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal American Academy of Child and Adolescent Psychiatry*, *52*(6), 582–590.

[22] Thoma B, Rezeppa T, Choukas-Bradley S, Salk R, Marshal M. Disparities in childhood abuse between transgender and cisgender adolescents. *Pediatrics*. 2021;148(2)

[23] Shipherd J, Berke D, Livingston N. Trauma recovery in the transgender and gender diverse community: extensions of the minority stress model for treatment planning. *Cognit Behav Pract*. 2019; 26(4): 629-646

[24] Supporting transgender survivors of sexual violence: learning from users' experiences in: Critical and Radical Social Work Volume 3 Issue 1 (2015)

[25] https://supremecourt.uk/uploads/uksc_2024_0042_judgment_aea6c48cee.pdf

Systems finding

5.9. Alex has generally been well supported in his gender transition by practitioners, and although his diagnosis of ADHD was delayed until adulthood, the intersectionality between his gender identity, neurodiversity and mental health needs is well recognised. However, delays in accessing specialist gender identity services and incidents when communicating with Alex was insensitive or disrespectful heightened Alex's frustration and were not tailored to consider his neurodiversity. Leaders should also analyse availability of local support services for transgender people who have been victims of violent or sexual assaults.

Recommendation 1: *Local gender identity services should provide an assurance report to the SAB, setting out:*

- ***i)*** *Their timescales for waiting lists for assessment and (where appropriate) treatment; and*
- ***ii)*** *the reasonable adjustments made when working or communicating with patients with neurodiversity.*

Recommendation 2: *CSC, ASC and the ICB should ensure that when children or adults who are awaiting diagnosis in respect of neurodiversity or gender dysphoria are placed or hospitalised out of area, clear multi-disciplinary plans are made in advance of those moves (or as soon as possible after an urgent move) to ensure that their assessment and/or treatment are not delayed or negatively impacted.*

Recommendation 3: *Partners should explore what support is available locally to support trans people who have experienced sexual abuse or violence.*

Mental health and risk management

How were responses and possible links between experiencing mental health crises and forensic needs considered in minimising risks.

5.10. The fact that Alex's core emotional needs were unmet in his early life has led to the emergence of maladaptive schemas. Evidence made available to this review indicate that Alex's response to external pressures or inconsistent support appears often to turn feelings of being let down or overwhelmed against himself, triggering violence to others or self-harming behaviours. Parasuicidal behaviours are behaviours involving deliberate self-harm that may or may not be intended to result in death. Often these are a way for people with emotional dysregulation to regulate their emotions when they became overwhelmed. Practitioners commented that with higher staffing levels in residential placements with deprivation of liberty orders in place, Alex became more oppositional as he "*felt free*" to become more dysregulated. He also struggled with the changes of residential staff and therapeutic supports as he moved around the country.

5.11. NICE guidelines[26] set out that self-harm needs to be responded to, not with a risk assessment that distinguishes based on method and a statement of intent, but a comprehensive and immediate psychosocial assessment and engagement in a therapeutic relationship. This would then facilitate development of a care plan to prevent the escalation of self-harm and a risk management plan to include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail. During discussions at the learning event, practitioners explained that while in Bedfordshire, NELFT's CAMHS' Crisis team held responsibility for leading the risk management plan for Alex. However, as discussed below, when out of area, there were significant delays in accessing mental health support for Alex. This also meant that his Education Health and Social Care Plan was not consistently updated, as

[26] NICE Clinical Guidance CG113: Self-harm in the over-8s: long term management 2011

responsibility for this lies with the host local authority's Special Educational Needs team and Alex's frequent moves meant that this process constantly restarted.

5.12. There was an extensive debate about whether health or social care should be taking the lead in respect of meeting Alex's needs. Although a care assessment was completed by the Adults with Learning Disabilities Team in 2023 (after some delay, an issue that was escalated for resolution by CSC), this concluded that Alex's needs primarily related to his mental health, rather than a learning disability, and that the care he required was greater than social care could provide. Discussions in frequent multi-disciplinary team meetings between frontline practitioners had not resolved these disagreements.

5.13. A Dynamic Support Register [DSR] is a list of people with a learning disability and autistic people who need support because they are at risk of being detained in hospital under the MHA if they do not get the right care and treatment in the community. DSRs have been mandatory for people with autism and/or a learning disability, or who show or are at risk of developing behaviours that challenge or mental health conditions, and guidance was published in January 2023 to establish greater consistency, in how DSRs are managed and used, by setting minimum standards.

5.14. A Care (Education) and Treatment Review [CETR] ensures children get the right care, education and treatment and looks at how to make care and treatment better. A CETR is for children who are at risk of going into hospital or who are already in hospital, which includes: children; young people; adults with a learning disability or autism. CETRs are independent meetings about someone's care and treatment run by a CETR panel which includes people who are not involved in their everyday care to ensure independence, including experts by experience. CETRs should take place six weeks after someone goes into hospital, if someone has already had a CETR in the community, change hospital security settings, or if a clinical review shows that someone is not autistic or do not have a learning disability when they have been told before that they are autistic or have a learning disability.

5.15. Although the NHS Dynamic support register and Care (Education) and Treatment Review policy and guidance[27] was issued in 2023, the requirements were already in place, albeit not necessarily used consistently nationally from 2021. Practitioners commented that Alex was not referred for a CETR until June 2023, shortly after he turned 18, as wider partners were not aware of the pathway. The benefit of the DSR can be seen in the strengthened efforts which were then made to have him admitted to a psychiatric bed. However, use of these tools at an earlier stage may have further helped to coordinate Alex's treatment, facilitate a more proactive approach to prevent his needs from escalating and help improve planning for his transition to adult services. Practitioners noted that colleagues from the Adult DSR sit in provider services, and attend monthly Children's DSR meetings to agree the priority rating for young people on the register. This enables them to identify young people coming through the system who will require adult services on transition; however, this did not necessarily support planning for young people out of area. Practitioners felt that although Alex's different needs were recognised, ongoing debate about which of these was the 'highest need' resulted in conflict between services about which should meet those needs.

5.16. Alex was also referred for a Continuing Healthcare [CHC] assessment when he turned 18 (although this was considered premature as he was not ready for discharge from hospital), however an earlier referral for assessment under the Children's Continuing Care Framework[28] may also have provided a framework for a holistic assessment of Alex's health needs, including his psychological and emotional needs and challenging behaviour. An assessment under the Continuing Care Framework can be used to provide an evidential basis for the provision of

[27] NHS England » Dynamic support register and Care (Education) and Treatment Review policy and guide

[28] National Framework for Children and Young People's Continuing Care (publishing.service.gov.uk)

specialist accommodation, if that is identified as a need under the care plan. Again, the fact that Alex moved frequently around the UK is likely to have been a barrier to this.

5.17. Instead, the risk Alex posed to others meant that for a significant period, his behaviours were managed through the criminal justice system, and he was repeatedly arrested and charged with assault. While under the care of FCAMHS, an HCR-20 assessment was completed, which is a structured professional judgment instrument that evaluates historical, clinical, and risk management factors for violence among forensic and civil psychiatric patients. However, it was noted that this was completed under pressure and has not been subsequently updated, although the low-secure placement currently being explored has advised that they will carry this out once they have clear timescales for Alex's admission.

5.18. CSC tried hard to ensure that Alex was not criminalised, attempting to educate the Youth Court in respect of Alex's behavioural needs and as a consequence, on many occasions the court took a decision not to convict him. However, after returning to a community setting when he came out of secure accommodation, Alex received a custodial sentence shortly before his 18th birthday. Practitioners felt that this was in part because Alex was determined to keep offending until he returned to a secure setting, as that was where he felt safe. He would escalate risk, obtaining knives, metal bars and threatened a police officer with a broken bottle. Practitioners would advocate that the police needed to utilise their powers under s136 MHA to take Alex to a place of safety for an assessment of his mental health, but as Alex had often calmed down by the time police attended, officers would instead return him to his residential home where the risk to staff would continue.

5.19. Positive behaviour support is a person-centred framework for supporting people with emotional dysregulation, learning disabilities and/or autism that takes a person-centred approach to create a positive physical and social environment and develop constructive interventions that eliminate the need for aversive and restrictive practices.[29] By developing a sophisticated understanding of the individual's triggers and approaches that work for them to diffuse situations before they escalate, there is evidence that the approach significantly decreases challenging behaviour and promotes positive skills. A cohesive strategic approach designed by CAMHS/CMHT, and agreed by social care, police and other first responders and placement staff can be highly effective in deescalating situations when the individual is becoming dysregulated, and this have may have assisted in Alex's situation.

5.20. However, practitioners noted that once Alex was referred to Thames Valley MAPPA in May 2023, just after he turned 18 and having been recorded as being involved in over 170 violent incidents, this provided an effective forum for multi-agency management that was coordinated by police and facilitated better communication between agencies. This enabled a tailored risk management strategy with police, probation, providers as well as health and social care partners. Practitioners felt that regular MAPPA meetings changed the conversation from a debate about whether health or social care should be leading in respect of Alex's needs to a discussion about risk and what he needed to reduce those risks. Over 24 MAPPA meetings took place in a 12–18-month period, with the chair's role in holding the professional network together praised by practitioners.

5.21. ELFT practitioners noted that once detained under the MHA, police and the Crown Prosecution Service would not consider charging Alex for assaults on staff, some of which were extremely serious. For example, Alex attempted to stab a member of staff in the neck using a makeshift weapon, which "…*he felt was justified because the person said they were going home at the end of their shift, then didn't*". Although practitioners did not want to criminalise Alex as they recognised the extent of his trauma, they explained that this became a barrier to obtaining the type of care Alex needed, as a forensic ward has the necessary specialism in treating extremely

[29] About Positive Behaviour Support – Positive Behaviour Support

challenging, violent behaviour. They were clear that they did not believe that he should be sentenced to a custodial term, but rather, a Hospital Order, but that this was outside their control. Clinicians felt that although police consulted with them about Alex's mental capacity in respect of criminal culpability, this was then disregarded at the point charging decisions were made.

5.22. Importantly, the incident in September 2023, when Alex was discharged from s2 by Ward B without notice to the wider professional network, was described as a "*near miss*" by one leader. There was some communication that clinicians wanted to discharge Alex in the days leading up to his discharge because he was deemed to be "*too high risk to manage on a psychiatric ward*". However, the decision was taken to discharge him that day because he had stabbed a member of staff with some glass, and clinicians believed that he would be charged by police, however he was released without charge as the CPS advised that he should not be prosecuted due to his mental health. Consequently, he returned to the community with no accommodation or support in place. ASC only became aware of this after Alex's mother contacted them, and social workers had to be escorted from their offices for their safety. It is absolutely essential that when patients, who are known to pose a high risk of violence to others, are discharged from hospital or other secure settings risk management planning takes place as far in advance as is practicable, involving all relevant agencies, including MAPPA. Police also need to ensure that contingency planning is in place for patients arrested from a psychiatric ward.

Systems finding

5.23. Practitioners demonstrated a nuanced understanding of Alex's personality, wishes and needs, as well as the impact his adverse childhood experiences had on his mental health and emotional dysregulation. However, professional disagreement about which services were best placed to meet those needs created a 'stale mate' and became an obstacle to holistic care and tools (such as the Dynamic Support Register and Continuing Care Framework) designed to draw together this holistic analysis were not used at an early stage, delaying care and transition planning. It is vital that governance structures in children's and adults' services across Bedfordshire provide effective leadership oversight of the efficacy of transition planning, in particular to support practitioners trying to progress complex cases.

5.24. At times, poor communication between agencies at points of transfer or discharge created serious risks, as multi-agency risk management strategies were not in place, and too much reliance was placed on the criminal justice system to manage risk. Further, a more strategic multi-agency approach to risk management involving the wider professional network at an early stage may have better supported the therapeutic approach to reduce the frequency of Alex's dysregulation. Assessments and formulations provided should be used to identify triggers and develop a positive behaviour support plan, using a strategic partnership approach to implement these.

Recommendation 4: *CBBBSAB, BBSCP and CBSCP should develop a joint Transitional Safeguarding subgroup for all three safeguarding partnerships, to provide leadership and oversight in respect of the efficacy of all agencies' arrangements for transitions to adulthood.*

Recommendation 5: *CBBBSAB should carry out an analysis of whether its Cooperation Protocol is being used to resolve interagency disagreement in complex cases.*

Recommendation 6: *Guidance should be prepared for practitioners supporting young people with severely dysregulated behaviours and mental health needs, to set out the various best practice pathways available (including the DSR and Continuing Care/Healthcare), to support a holistic formulation of needs and facilitate effective care and transition planning at an early stage.*

Recommendation 7: *Where people are displaying severely dysregulated behaviours, detailed risk management and positive behavioural support plans should be developed at an early stage, and these strategies should be agreed between agencies, including residential staff, police and ambulance services.*

Commissioning of services

How are specialist services commissioned, planned, allocated and accessed and how can we further escalate to achieve the right services and therapies at the right time?

5.25. Practitioners and managers spoke of the need for a range of alternative provision designed specifically for children and adults with severe emotional dysregulation to minimise the need for hospital admission and provide a route for discharge from secure provision, with comprehensive mental health and therapeutic input built into the offer. All agencies involved in supporting Alex recognised his high level of need and serious risk to others and himself due to his self-harming behaviour and worked collaboratively to mitigate those risks. All agreed that he needed to be deprived of his liberty to enable him to keep him and others safe and to access treatment for his severe emotional dysregulation.

5.26. Practitioners discussed the challenges in trying to identify residential placements for Alex that could meet his needs, as many placements were unwilling to accept a young person who was extremely violent to staff members and displaying highly dysregulated behaviour. There was a lack of clarity as to whether placements had neurodiverse support embedded, and practitioners felt that residential providers would overstate their capability to meet Alex's needs. As there are only 13-14 secure placements nationally, options are very limited, resulting in Alex being placed in Scotland, a huge distance from his support networks. CSC managers were clear that money was never an object when trying to meet a young person's needs and that although they would fund high levels of supervision with a deprivation of liberty order in place, that did not replicate secure accommodation or specialist mental health beds. The ongoing national shortage of appropriate secure accommodation and registered children's homes has resulted in some High Court judges refusing to authorise wholly inappropriate deprivations of liberty and both judges and the Children's Commissioner have highlighted the paucity of appropriate beds nationally, and the impact on young people of being placed at a distance.[30]

5.27. These challenges continued when Alex was ready to be stepped down from secure accommodation. Placements can usually only accept one young person who self-harm, as their needs can conflict, and may increase the risk to, other young people. As a consequence of these difficulties, Alex was frequently placed out of area both before and after his secure accommodation, in placements that rapidly destabilised. Alex was separated from his family and the Bedford Borough practitioners who he relied on for emotional and practical support. When Alex moved from a residential placement in Bedfordshire to one in Peterborough, despite being supervised on a 4:1 staffing level, he frequently went missing and was found staying with the homeless community and accessing drugs.

5.28. This also presented a significant challenge in respect of securing mental health support. When young people are placed in out of borough placements, CSC must refer to local CAMHS, and although some have a designated LAC team there are different criteria and waiting lists all over country. Although Alex's access to Forensic CAMHS services was good during periods that he was in secure accommodation, when in community residential placements his access to CAMHS services was disrupted, as services in the host area would not accept Alex onto their waiting list until he had arrived in a placement. Practitioners described having to "*constantly push the reset button*" which meant that at the time when Alex was most distressed and dysregulated as a consequence of another move, no therapeutic support was available to him

[30] cco-who-are-they-where-are-they-technical-report-2020.pdf (childrenscommissioner.gov.uk)

and the frequency of his moves meant that he never had an opportunity to establish a therapeutic relationship.

5.29. The challenges in obtaining timely CAMHS support for children in care who are placed out of area is a serious problem, which is identified time and time again in safeguarding reviews. The history of trauma young people have experienced greatly increases the likelihood of dysregulated behaviour and placement breakdown, and as the pool of providers that will offer a placement dwindles, children are moved around the country. The educational needs of children in care are prioritised by law. This is through the legal requirement under 22(3A) of the Children Act 1989 for local authorities to promote the educational achievement of their children in care and to have a Virtual School Head, who is responsible for ensuring that arrangements are in place to improve the educational experiences and outcomes for its care-experienced children, including those placed out-of-area. Importantly, admissions authorities of all mainstream schools must give the highest priority in their oversubscription criteria care-children, as defined in the School Admission Code, whether those children are in the care of their own local authority or another local authority. However, there is no equivalent statutory requirement for CAMHS services, meaning that social workers have to go "*cap in hand*" to the host area, as one practitioner commented.

5.30. The Children's Commissioner published a report, *Pass the parcel: children posted around the care system* in 2019, which set out that 52% of children placed out of area have special educational needs and 24% have social, emotional and mental health needs, but that despite their need for routine and consistency, they experienced "*chronic instability at the hands of the care system*." The report noted nationally, it was common for young people to lose their places on CAMHS waiting lists when they were moved into new areas, resulting in the most vulnerable children missing out on the mental health support they needed. The Commissioner recommended that the Department for Education should:

> "*Together with the NHS publish a protocol focusing on the mental health of children in care. This should include plans for a targeted programme of CAMHS support for children in care and plans to ensure that automatic transfer of children on CAMHS and other health-related waiting lists is implemented so that moving to a new home does not affect access to support*." (page 18)

5.31. However, this does not avoid the problem of children in care who have moved areas, having to restart assessment processes or being placed on the bottom of the waiting list for support in the receiving area. While this is a national issue, it is vital that Bedfordshire partners, in particular the Integrated Care Board, take steps to ensure the mental health and other needs of this vulnerable cohort are urgently addressed when they move placement, to avoid a vicious cycle of placement breakdown, as was evident in Alex's case.

5.32. It is enormously positive that Bedford Borough CSC has developed a strategic plan for a care home for children with complex needs relating to trauma, similar provision for young people aged 16-17 years, an 18+ provision, and a parenting unit for care experienced young parents. This will have an attached hub for care experienced people, including housing provision and a drop-in centre. It is vitally important that the ICB engages with this project, to ensure that CAMHS/CMHT support is embedded in the strategic plan.

5.33. This national crisis in suitable accommodation has been commented on extensively by the Family Courts, the court of Protection and the Children's Commissioner, as well as being identified as an issue which has contributed to young people suffering or causing very serious harm in multiple safeguarding reviews. There are close parallels between this case and the Serious Case Review (SCR) published in respect of 'David' by the Hammersmith and Fulham, Kensington and Chelsea and Westminster Local Children Safeguarding Partnership, which was

triggered by the high-profile attempted murder of a child at a public building in central London.[31]. David had a diagnosis of autism with an associated conduct disorder, with escalating incidents of serious violence which were attributed to his diagnosis of autism without exploration of whether this could be explained by other aspects of his conduct disorder, requiring different interventions and risk management. Like Alex, his behaviour deteriorated to the point he could not be safely cared for at home, but nationally, regulatory disincentives to commissioning specialist provision for this cohort limited placement options. A key difference in that case was the fact that 'David' was detained as a child under s2, then s3 of the MHA. However, the lack of 'autism-friendly' psychiatric units meant that his distressed behaviour increased in a non-adapted psychiatric hospital. After he was discharged from hospital, responsibility for identifying placements was pushed onto the local authority, without sufficient support from the CCG (the antecedent of the ICB) who held joint responsibility for after care under s117 of the MHA, resulting in multiple breakdowns of unsuitable residential placements. The SCR authors made a finding:

"Clinical governance arrangements and regulatory processes militate against the development of facilities that could provide therapeutic treatment for the small number of young people with autism spectrum condition and distressed behaviours of concern. The resultant lack of suitable facilities means that legal frameworks available provide extremely limited options and support for these young people is either provided by social care, via ad hoc commissioning and precarious risk management in the community with limited clinical oversight, or, results in inappropriate admission to psychiatric hospital or prison as the only alternatives available."

Systems finding

5.34. Limited options in respect of specialist residential provision meant that CSC struggled to identify alternative placements when existing placements were unable to manage escalating risks. Consequently, young people with mental health needs are frequently placed at distance, resulting in fragmented mental health support and disrupting their positive support networks and can have significantly delayed admissions during periods of crisis or delayed discharges. Responsible agencies need to ensure that flexible joint commissioning arrangements are in place to meet these needs whilst this provision is developed and on an ongoing basis to meet the spectrum and volume of need locally. Consideration is also needed to how flexible joint commissioning arrangements will continue to meet needs throughout adolescence and younger adulthood. This is a theme which has been identified in other safeguarding reviews nationally, and requires urgent attention from corporate directors and budget holders.

Recommendation 8: *The ICB and CSC should commission support/provision for young people (including those in transition to adulthood) with severe emotional dysregulation, neurodiversity and complex behavioural or mental health needs, to meet the need of young people. This should include bespoke support packages and forensic mental health support to target the needs of individuals whether in residential placements or in the community, to avoid them being moved out of area.*

Recommendation 9: *BBC should provide assurance to CBBBSAB that effective contingency planning is taking place for all residential placements, and that in circumstances where a provider has given notice that they are unable to manage a situation with escalating risks, proactive and timely arrangements are made for alternative provision, using escalation routes promptly if a placement cannot be identified, and detailed care plans to support the new placements or arrangements, including plans for mental health support.*

Recommendation 10: *ELFT should explore whether the allocated CAMHS/CMHT workers for individuals detained out of area under S2 or s3 MHA can remain allocated to attend CPA reviews*

[31] https://www.lbhf.gov.uk/sites/default/files/section_attachments/david_serious_case_review_-_april_2021.pdf

and discharge planning meetings. Consideration should also be given to appointing a 'Virtual CAMHS lead', mirroring the role of the Virtual School Head in respect of the local authority's education responsibilities to children in care.

***Recommendation 11:** Bedford Borough Safeguarding Children Partnership should write to the Secretary of State for Health and Social Care, raising the issue of the need to prioritise continuity of CAMHS services for children in care who are placed out of area.*

Barriers to person centred care

How systemically did we institutionalise Alex and what are the barriers to achieving person centred care and positive outcomes?

5.35. Difficulties have also arisen when Alex was ready for step-down from Ward A in February 2024. As noted above, practitioners noted that if Alex had been prosecuted for some of the most serious assault on staff members, he would have been able to access a forensic mental health bed, where they believed his needs could best be met. Instead, Alex was referred through the NHS gatekeeping service, who recommended that a bed should be sought in a low-secure specialist learning disability unit. However, no such unit exists in Bedfordshire and despite approaching every hospital available nationally, only one low-secure provider has offered Alex a placement, an offer which is subject to funding being provided for additional staffing and other current patients moving on.

5.36. Consequently, Alex has now been waiting for this move for over a year. Practitioners expressed their concerns in respect of the impact of the delay on Alex, as not only is remaining in the PICU no longer beneficial for him, but it is also heightening his frustration, resulting in him lashing out, and creating a dependency on the highly structured treatment environment. Practitioners noted that he believes "*Nobody wants me, I'm too difficult*", and that they shared his feeling of being "*stuck*". They were very conscious that Alex's needs were not being met on Ward A and that in particular, the therapeutic intervention that may help Alex to learn to better manage his emotions and dysregulation is difficult in an acute setting when this is not a long-term placement. They noted that presently, there is difficulty recruiting to the vacant psychologist post on the ward. ELFT had considered funding an outside psychologist to support Alex as an interim measure, this was felt to be unhelpful when the plan was to move him on.

5.37. Practitioners described the very extensive efforts made to support Alex as a multi-agency network, looking at his diverse needs and how to safely manage risk in the community. Concerningly, at the time of the learning events, the low secure unit had advised that as so much time had passed since their original offer, they would now need to reassess Alex. There is no parallel plan. One commented "*If [the low secure hospital] rescind the offer, I don't know what we'll do.*" Another said "*[Ward A] might not be an ideal placement, but there are lots of staff and the ability to medicate – what would a community discharge look like? I couldn't fathom a place that could keep him or staff safe."*

5.38. Research has highlighted that although there is a legal requirement for health and social care to adequately meet the needs of people with autism,[32] "*there is little real-world evidence of implementation of these measures across the different in-patient psychiatric settings in the UK that admit people with autism*"[33] People with autism often face heightened distress when admitted to inpatient psychiatric facilities due to sudden environmental changes, unfamiliar social demands, and disruptions to their routines and coping mechanisms. Research also evidences that individuals with autism tend to have longer hospital stays, higher levels of

[32] Autism Act 2009

[33] Jones K, Gangadharan S, Brigham P, Smith E, Shankar R. Current practice and adaptations being made for people with autism admitted to in-patient psychiatric services across the UK. BJPsych Open. 2021 May 14;7(3):e102. doi: 10.1192/bjo.2021.58. PMID: 33988120; PMCID: PMC8161595.

agitation, increased use of restrictive interventions such as long-term segregation and seclusion[34] and a disproportionate use of restrictive measures.[35]

5.39. The previous Government's consultation on their proposed review of the Mental Health Act recognised that necessary changes to legislation and practice improvement regarding safety should not be at the expense of maintaining therapeutic environments that support people to recover. The consultation paper acknowledged a priority should be to shift the focus from reactive care to preventative measures.[36] Their proposal to embed principles of choice and autonomy, least restriction, therapeutic benefit and person-centred care reflects findings of earlier research by Felton et al. which identified the '*dominance of risk of harm to self or others* (within the current MHA) *serves to more readily justify interventions that may restrict enjoyable activities or remove choice from patients, while intensive risk-monitoring can perpetuate stigma and isolation*'[37] felt by individuals with poor mental health.

5.40. An ambitious vision for a modern mental health service should include development of Tier 4 beds that are designed to meet the specific needs of people with autism or experiencing severe emotional dysregulation and who need to be detained in the interest of their health or safety due to high levels of violence or self-harm. Its aim should be to promote safety and recovery in the long term and support the person to develop skills in safer decision-making. Forensic beds should be available through the NHS Provider Collaborative, to prevent the need to criminalise patients in order to obtain the right type of treatment for them.

Systems finding

5.41. Mental health services recognise that Alex meets the criteria for detention under the Mental Health Act 1983, however, the non-availability of forensic beds outside the criminal justice system and paucity of low-secure beds nationally has hindered efforts to enable him to move from the intensely restrictive environment on a PICU. This is causing him ongoing harm. While a structured national approach is required to address this crisis in care, in the interim, greater flexibility is needed from Bedfordshire and NELFT to use powers under National Health Service Act 2006[38], Mental Health Act 1983, Care Act 2014 and Children Act 1989 to provide bespoke accommodation-based support and step-down mental health beds. Existing intelligence in respect of both the current cohort of adults and those transitioning from children's services should be used to devise a strategical plan to meet local need.

Recommendation 12: *CBBBSAB should discuss this review at regional level and (if regional leads are in agreement), escalate to national SAB chairs network the risks that emerged in this review due to gaps in a national plan from the Department of Health and Social Care, NHS England and the Provider Collaborative to improve access to low secure and forensic beds that meet the needs of those with severely dysregulated behaviour and high levels of harm to others/self-harm that are local to them, to reduce reliance on acute admissions, avoid delays in people obtaining the treatment they need and improve their experience of mental health services.*

Recommendation 13: *The ICB and ASC should jointly commission support/provision for adults with severe emotional dysregulation, neurodiversity and complex behavioural or mental health needs. This should include bespoke support packages to target the needs of individuals whether*

[34] Sourander A, Ellilä H, Välimäki M, Piha J. Use of holding, restraints, seclusion and time-out in child and adolescent psychiatric in-patient treatment. Eur Child Adolesc Psychiatry 2002; 11: 162–7.
[35] Alexander RT, Langdon PE, O'Hara J, Howell A, Lane T, Tharian R, et al. Psychiatry and neurodevelopmental disorders: experts by experience, clinical care and research. Br J Psychiatry 2021; 218(1): 1–3.
[36] Available at: https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-2-reforming-policy-and-practice-around-the-new-act-to-improve-patient-experience
[37] Felton, A., Wright, N., & Stacey, G. (2017). Therapeutic risk-taking: A justifiable choice. *BJPsych Advances,23*(2), 81-88. doi:10.1192/apt.bp.115.015701
[38] Consistent with the obligations set out in National Framework for Continuing Healthcare

in residential placements or in the community, to avoid them being admitted to or remaining in hospital for lengthy periods.

Systemic harm

Did Alex experience abuse or neglect by a system that was meant to care and safeguard him from harm?

5.42. Alex has exhibited severe emotional dysregulation since childhood, which is common for people who have experienced acute and chronic stress and cumulative adverse childhood experiences. Unfortunately, as Alex's needs escalated and de-escalated, he moved from residential care to a children's secure placement, to unregulated placements and PICUs. The frequent moves were disruptive for Alex and made it more difficult to make therapeutic progress. Relational care is an approach to caregiving that emphasises building and maintaining meaningful relationships between carers and care recipients, by attending to emotional, social, and psychological well-being. The importance of relational care for Alex could be seen in respect of the residential care staff at various placements, who often supervised Alex on a three-to-one ratio with the authorisation of a court order. They did not necessarily have the experience and understanding of supporting children with high levels of trauma that were expressed through violence or self-harm, and did not understand Alex's needs specifically. Residential staff then felt anxious and intimidated about caring for him. This can manifest itself as ambivalence from those staff members towards the particular young person, who then is at risk of malignant alienation,[39] which was observed in Alex's case.

5.43. This was a particular issue for Alex prior to his detention under s3 as, due to his fluctuating needs, his placements rarely lasted more than a few weeks or months. It was difficult to build relational security when Alex constantly had to reestablish new relationships with new staffing cohorts and even while in placements or hospital, he did not know where he was going to be living next. This caused him significant anxiety and due to his attachment driven behaviour, this could result in him pushing people away. However, feeling rejected is also very triggering for Alex, so a callous approach from carers may result in an escalation in dysregulation, violence and self-harm.

5.44. As in Alex's case, teams working with people with mental health needs, particularly those with high risk violent or self-harming behaviours sometimes find themselves feeling 'stuck' in clinical dilemmas and uncertain about how best to proceed. This can manifest as *"malignant alienation",* which is an extreme ambivalence from clinicians towards the individual.[40] This commonly happens during inpatient admissions, during which time the individual can present with an intense and confusing paradox of emotions: feeling contained by being in a supportive environment and not wanting to be discharged, whilst simultaneously feeling claustrophobic and agitated about the restrictive environment on the ward and expressing a wish to leave. This can lead to an escalating spiral of threats, acts of self-harm and violence, with the mental distress within the service user becoming translated into anxiety within the care system.

5.45. To overcome this, NICE has produced a list of quality standards[41] and advise the use of structured clinical assessment, clinicians prioritising psychological therapies and group-based cognitive and behavioural therapies which the patient is involved in choosing the duration and intensity of any interventions. Continuity of care, care plans that incorporate and focus on the person's long-term education goals and tailored, skilled supervision of staff to address the

[39] Watts, D., & Morgan, H. G. (1994). Malignant alienation: Dangers for patients who are hard to like. *The British Journal of Psychiatry, 164,* 11–15. https://doi.org/10.1192/bjp.164.1.11
[40] Watts, D., & Morgan, H. G. (1994). Malignant alienation: Dangers for patients who are hard to like. *The British Journal of Psychiatry, 164,* 11–15. https://doi.org/10.1192/bjp.164.1.11
[41] Published in 2015 and available at: https://www.nice.org.uk/guidance/qs88

significant challenges staff face when positively supporting people are all key components of safe, effective care.

5.46. Of fundamental importance to this recovery concept model is to create safe places for professionals to hold uncertainty. '*Regular, inclusive and open* (multi-disciplinary) *discussion can promote shared responsibility, flexibility and creative decision-making…. Guidance from the Royal College of Psychiatrists (2016), Department of Health*[42] *(2007) and Implementing Recovery through Organisational Change*[43] *promotes therapeutic risk-taking and recognises that some of the current problems with risk assessment and management undermine autonomy and restrict opportunities for recovery. Recognising these values within policy and professional guidelines provides a framework to help justify therapeutic risk-taking*.' This is a framework that is being applied by clinicians to meet Alex's needs. Practitioners from Ward A noted that they were trying to reduce the levels of supervision for Alex, taking a positive risk to manage his behaviours.

5.47. More generally, it is important to recognise the impact on practitioners of working closely with someone who is either violent towards staff or at chronic high risk of serious harm. Staff on the ward discussed the impact on them of multiple assaults, and the constant watchfulness that was required to keep themselves safe from harm. Alex often targeted those he had the strongest relationships with, perhaps because his emotions are engaged, perhaps because he trusts them not to reject him. Vicarious trauma refers to the emotional, psychological and sometimes physical distress experienced by practitioners who are exposed to the traumatic experiences of others during their professional roles and can result in trauma-related symptoms. Managers commented that it was not uncommon for practitioners working directly with Alex to have high levels of sick leave, noting the injuries they could sustain and the stress that came from constantly worrying about him.

5.48. Using models developed to support practitioners working with people with personality disorders, it is well recognised the intensive nature of the support the individual requires can leave the professionals and teams involved with strong feelings (both positive and negative). For example, commonly staff can find themselves feeling powerfully protective/caring or rejecting/critical in relation to service users with mental health needs or neurodiversity. Processing these feelings in a professional manner is important in maintaining appropriate professional interactions. This both protects service users from harm but also ensures that the "caring system" does not become hopeless, pessimistic and risk averse.

5.49. Hospital practitioners noted that although they were offered clinical supervision, due to the intense pressures on the ward, this did not always happen monthly. Generous leadership is required to ensure that staff have the time and emotional space to take up the support that is available to them in theory. However, they spoke positively of the debrief sessions that consistently took place after serious incidents, and the mutual support between staff members.

Systems finding

5.50. The multiple rejections caused by placement breakdowns and a lengthy hospital admission because a low secure bed cannot be found have been traumatising for Alex, and the fact the placements were not equipped to meet his needs has contributed to the harm he has experienced. It is vitally important that all practitioners, including residential staff are carefully supported through reflective clinical supervision to avoid burn out or desensitisation in complex

[42] Department of Health (2007) Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services. Department of Health.
[43]Boardman, G, Roberts, G (2014) Risk, Safety and Recovery: A Briefing. Centre for Mental Health and Mental Health Network, NHS Confederation

cases involving chronic high-risk, to support their trauma and to minimise the risk of secondary trauma.

Recommendation 14: *Health and social care partners should provide assurance to CBBBSAB that they provide their staff with reflective clinical supervision to support trauma-informed practice, avoid burn out or desensitisation in complex cases involving chronic high-risk, and to minimise the risk of vicarious trauma. This should include assurance from commissioners in respect of requirements for providers (including those commissioned out of area) to provide reflective supervision for residential staff.*