The death of "Ms A"

A Safeguarding Adult Review for Havering Safeguarding Adults Board

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June 2017

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1. INTRODUCTION

1.1 Havering Safeguarding Adults Board commissioned a safeguarding adult review relating to Ms A in May 2016. The terms of reference refer to Ms A's transition to adulthood and to how agencies worked together to meet her needs.

1.2 Safeguarding Adult Reviews (SARs) are commissioned where an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. They must be commissioned also where an adult has experienced or is suspected of having experienced serious abuse or neglect. Safeguarding Adults Boards (SABs) may arrange a SAR in any other situation involving an adult with needs for care and support. SARs may cover all types of safeguarding financial abuse, and sexual and physical abuse. SARs may also explore good practice outcomes (Department of Health, 2016).

1.3 The review should explore what happened and why, namely the underlying reasons that led individuals and agencies to act as they did, in order to achieve understanding of a case and embed the findings in a multi-agency organisational culture of continuous learning and improvement. It should seek to understand practice from the viewpoint of those involved at the time rather than use hindsight, recognising the complex circumstances in which professionals work together to safeguard adults. Reviews should draw on relevant research to inform the findings and recommendations, and promote good practice. Practitioners and managers should be fully involved in reviews in order to contribute their perspectives. Families should be invited to contribute to the process. SARs should therefore be transparent in the process of collecting and analysing the data (Department of Health, 2016). These principles were followed in this review.

1.4 Agencies participating in the review were:

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Clinical Commissioning Group
- Havering Council, Adult Services
- Havering Council, Children's Services, including Transition to Adulthood and Care Resources and Leaving Care Team
- Havering Council, Education Services
- Havering Council, Housing Services, including Anti-Social Behaviour Reduction Team
- London Ambulance Service NHS Trust
- Metropolitan Police Service
- North East London Foundation Trust
- WPD Havering, Service for People with Drug and Alcohol Problems

2.0 Introduction to the case – the trigger event

2.1 Ms A took her own life on 27th December 2015 by jumping from a window of her flat. She was aged 20. She had been a looked-after child and was known additionally to the police, Community MARAC, NHS Trusts providing mental health and physical health treatment, and to the adult social care safeguarding team. At the time of her death she had a Young Person's Adviser (YPA). She had a boyfriend and had experienced the loss of a baby through miscarriage[1]. The chronology from the Metropolitan Police records that shortly before she jumped her boyfriend had received a text in which Ms A expressed her desire to end her life.

2.2 The Coroner reached a narrative verdict in this case, concluding that Ms A had been under the influence of alcohol at the time of her death and that there was insufficient evidence to determine that she had intended to take her own life.

2.3 The request for a SAR was made by the adult social care safeguarding team, recommending a multi-disciplinary learning review to establish if a more robust safeguarding plan, drawing on multi-agency co-operation, would have reduced the likelihood of Ms A's death. The Havering SAB Case Review panel agreed that the circumstances met the criteria in the statutory guidance (Department of Health, 2016) whereby a SAB may commission a SAR involving an adult with care and support needs.

2.4 In this case, the Case Review panel identified that the focus of the review should be on transition processes from children's services to adult services when there are complex needs and vulnerabilities that will impact on stability and security in adulthood; eligibility criteria for services; and how to co-ordinate a service for vulnerable adults. The focus of the review would be to learn and understand how things can be delivered differently in the future to improve outcomes for vulnerable adults.

2.5 Available methodologies for reviews were considered and the panel concluded that the most appropriate type of review would draw on the significant incident learning process, which can focus on significant incidents and support the development a better way of working (Clawson and Kitson, 2013). This approach enables a systemic review of practice, with the process focusing on practitioner events where a thorough understanding of the systems within Havering can be explored.

3.0 Terms of reference

3.1 Transition

There was evidence that the assessment process was not sufficiently co-ordinated to support Ms A's transition to adulthood, namely her needs were not grasped or fully understood.

[1] The loss of Ms A's child is referred to as both stillbirth and miscarriage by those involved at the time and both terms are used to describe the event in this report.

a. How does the multi-agency system in Havering support young people, including those identified to have chaotic lifestyles, to engage with services so that an assessment of need is undertaken and transitions effective? Where are the gaps and how can these be mitigated?
b. Ms. A was noted to have capacity to consent to services or reject services. How was this assessed? Did professionals fully understand capacity and consent and was it applied correctly? How can we strengthen practice within this area?
c. Did a focus on process, eligibility, governance and referral pathways stop practitioners implementing a person centred approach when assessing Ms A's needs, inhibiting the partnership's ability to develop a bespoke package of care?

Why did Ms A not meet a threshold for adult social care (including adult mental health) at the point of transition and how flexible is the partnership when considering agency thresholds? How effective were communication pathways and when information was shared, was it understood?

d. How is the multi-agency partnership supported to work collaboratively when managing transitions in Havering?
e. What is the eligibility process for services and how can this be co-ordinated across the range of services to meet a person's needs?
f. What inhibits effective working and where are the strengths within the system?

3.2 Adulthood

1. How did the partnership work together to think about realistic ways to meet Ms A's needs and mitigate risk? Were complex and compounding vulnerabilities considered when determining threshold, need and risk?
2. How would the network decide the best person to build a relationship and bring processes together to make a difference when delivering services?
3. When is a pre-birth assessment undertaken in Havering and how does the system identify the vulnerability of the parent in order to offer a proactive and supportive response at the earliest opportunity? What is best practice and how can this be implemented within Havering?
4. How effectively do children services work with adult services to ensure continuation of care/ attention?
5. What are the best practice models nationally for working effectively across service boundaries, sharing a common language / common approach, and what actions must be undertaken in Havering to develop a framework to implement best practice locally?

4.0 Historical case background and pen picture

4.1 The following case background is taken from local authority records. It should be noted that Ms A and her family may have a different perspective from that which was recorded at the time.

4.2 Ms A and her family were known to children's social care services, initially in the London Borough of Newham (1992) and then the London Borough of Havering (from 1994). Ms A's parents were unable to appropriately parent Ms A and her siblings, with referrals regarding her welfare from January 1996. The children suffered physical and emotional abuse along with severe neglect. The house was filthy. At this time the children were placed on the child protection register under the category of physical abuse and neglect. Charges of cruelty against Ms A's mother were pursued but later (January 2000) dropped as the Crown offered no evidence.

4.3 Ms A was removed from her family with her siblings in 1998 by the London Borough of Havering and became a looked-after child (section 20, Children Act 1989). However, the removal was challenged and Ms A was returned home. Concerns for the care of Ms A and her siblings re-emerged because of chronic neglect and physical abuse, and Ms A and her siblings were received back into care. An Interim Care Order was made in June 1999 and a section 31 Care Order in February 2000. The plan was for Ms A to remain with her siblings but this was not successful, due to her behaviour, and Ms A experienced a number of placement breakdowns, one of which was a failed adoption placement. At this time, Ms A's siblings moved into a successful placement whilst Ms A was returned to her mother's care around November 2001 after a family assessment. Children's Social Care noted that the foster carer responsible for Ms A's siblings continued to be a significant person for Ms A despite the breakdown. From February 2002 there were on-going concerns at school and about the home conditions, including physical abuse and neglect. In June 2002, a recommendation was made for psychotherapy for Ms A's mother and therapy for Ms A. A Supervision Order was made in November 2002. Ms A was admitted to a pupil referral unit in January 2003 and had play therapy sessions in May 2003. She had contact with her siblings six times a year. An application to extend the Supervision Order was made in September 2003 and she remained on the child protection register for neglect. A core assessment and section 47 (Children Act 1989) investigations were completed in November 2003, noting that Ms A was unkempt and living in unhygienic conditions, with a poor diet. There were concerns of physical abuse. In December 2003, the Supervision Order was extended to November 2005. During 2004, there are multiple referrals about Ms A's welfare and Ms A was removed again in January 2005 and made subject to a Care Order (section 31, Children Act 1989) in November 2005.

4.4 Ms A disclosed physical abuse at home and also drug abuse in the family. No further action was taken after police investigation. Ms A had some play therapy in February 2006. Numerous placements followed, with foster carers struggling to maintain a safe environment for Ms A in the context of aggressive outbursts at home and at school. Ms A eventually enjoyed a period of relative stability in foster care between July 2011 and November 2012. When that placement broke down, a series of placements followed, including foster care, semi-independent and independent living arrangements, supported by the leaving care team and a wide professional network.

4.5 Ms A had additional educational needs, with a statement for speech and language. In October 2010 she is noted in education records as attending alternative provision to challenge her negative behaviour to build her confidence. She was recorded as having serious attachment issues and as struggling to learn due to her emotional state. She was also noted in PEP meetings as having poor peer relationships, especially when in contact with her siblings. *Observation: was any work attempted with Ms A about her contact with and views of her family*? She attended college erratically and was excluded on three occasions for physical assaults, racial abuse and drugs. Her behaviour was a barrier to learning. *Question: what follow-up was attempted when her attendance or behaviour at college was an issue*?

4.6 Ms A was described as exhibiting challenging and difficult behaviours and assessed to have ADHD in February 2008 and Disorganised Attachment Behaviour (DAB) at the age of seventeen. This followed several previous mental health assessments which had reached divergent diagnostic conclusions. Ms A was offered services from CAMHS, for example in April 2009 to work on peer relationships and conflictual relationships with her siblings, but her attendance was sporadic. Children with DAB will most likely have experienced maltreatment from a close attachment figure; the carer that is supposed to be in place to protect is also a source of fear. These children have experienced 'fear without solution' (Shemmings and Shemmings, 2011). When a child is exhibiting DAB and is placed with an alternative carer, the primary role of the caregiver is to help the child manage their arousal and distress. They should be helping the child to manage anxiety, as opposed to the child being overwhelmed by it (Howe, 2010).

4.7 Ms A did have support from multi-agency partners but was described to be resistant to services and likely to split professionals. These types of behaviour can be correlated to DAB, which has a causal link to loss and trauma in childhood. People presenting with DAB will likely be more at risk of suffering mental health disorders and drug and alcohol problems, and be more likely to engage in unhealthy/harmful relationships in adulthood. DAB can be resolved if a child/young person/adult has the opportunity to develop a secure attachment with a caregiver/significant other (Howe, 2010); from the available chronologies it appears that Ms A did not have this opportunity because her placements were not successful. Although the foster carer for Ms A's siblings has been noted to be 'significant', it is unclear whether the significant person was someone that Ms A had developed a healthy attachment to; the behaviour exhibited may suggest that this was not the case.

4.8 Research has identified that 80% of looked-after children have DAB; children with DAB will likely present with challenging and difficult behaviours, which is correlated to placement instability. Howe (2010) stated that these children expend significant amounts of energy trying to obtain a sense control, security and safety. Their internal model of self and others is skewed and these children find self-regulation difficult (Shemmings and Shemmings, 2011). They believe that they have the power to generate anger, fear, distress or panic in others; they also feel frightened and alone, and crave a sense of belonging and safety (Howe, 2010). A child in these circumstances is self-reliant because their internal model anticipates that a carer will not respond to need. The child expects rejection and is likely to exhibit behaviours that create situations that may cause them to be rejected. Rejection

reaffirms the internal working model that the child is unlovable (Shemmings and Shemmings, 2011; Howe, 2010).

4.9 It is this cycle of negative belief that must be rewired for the child to begin to resolve past negative attachment experiences (Howe, 2010), for example through foster placements that provide positive attachment experiences and allow the child to develop resilience and new behavioural patterns. Ms A experienced significant instability within her early years with her birth family and then as a looked-after child. The damage caused from early experiences would be less likely to be resolved because Ms A was not provided with a carer who was able to meet her needs and provide her with a secure base to support her to develop secure attachment behaviour. *Observation: participants at the first learning event recognised that children and young people in Havering still experience placement disruptions. This raises the question as to whether more could have been done to sustain Ms A's placements and those of other young people with complex needs.*

4.9.1 Recommendation: As part of the transformation of children's services in Havering, a review is considered of how children and young people with complex needs, and their carers, are supported in order to prevent where possible placement disruptions.

4.10 As a young adult, Ms A presented with some unusual behaviour and some complex health and mental health needs. She was known to have impersonated a nurse and had attended hospitals allegedly with the intention of stealing insulin. She claimed to have been injected with crack cocaine by a friend, had been admitted to hospital with suspected overdoses and was suspected of fabricating illness. She was suspected of injecting herself with insulin to bring about a termination of pregnancy. She was perceived as being very needy and as seeking attention. It appeared that agencies struggled to fully understand and respond to her situation. *Observation: participants in the learning events agreed that Ms A's case is not unique, with other care leavers also presenting with a variety of complex and fluctuating needs. This underscores the importance of learning from this case and therefore informs the recommendations in this review which are designed to enable the agencies involved to offer effective care, support and protection for young people at risk.*

4.11 Children's Services had significant concerns regarding Ms A as she approached adulthood in respect of her ability to safeguard herself and lack of proven ability to make informed choices. She did not look after herself, mirroring in terms of her presentation and hygiene what she had experienced as a child. Supported lodging placements were provided. From the age of 16 years old, referrals and requests for intervention were made by Children's Services to adult/mental health/learning disability services highlighting concerns about her lack of ability to live safely, independently in the community. She did not meet the threshold for their intervention. *Observation: this is perhaps surprising given the history. The review has learned that a recent change in mental health provision means that adult and adolescent mental health services are now within one directorate, with integrated safeguarding meetings which in the future will include LAS. Joint supervision will be offered for practitioners who are working with complex cases.*

4.11.1 Recommendation: Following the integration of adolescent and adult mental health provision, audits are considered to identify good practice in co-ordinating mental health support for young people at risk.

4.12 The first learning event noted that young people's needs do not change significantly or automatically when a young person becomes 18. Services, however, appear to move immediately to a more contractual approach. Practitioners and managers at the event recognised that procedures and processes must be more flexible and responsive to young people's needs, and that their chronological age is only one determinant of how agencies attempt to engage. *Observation: this reflection from the first learning event informs recommendations which follow in the review concerned with strengthening the formal linkages between children's services and adult services, and with introducing flexibility into the use of thresholds and eligibility criteria*.

4.13 Those professionals attending the first learning event also recognised that the historical background could generate a negative picture of Ms A. At the second learning event, therefore, time was taken to develop a more rounded picture of Ms A, drawing from the knowledge of those who worked with her. Ms A loved music and was interested in the medical profession. She appeared to have enjoyed riding horses. She had an ability to read situations and knew what she wanted to say. She was bright and intelligent, with an ability to seek and act on information.

4.14 As her mother and step-father would also confirm (section 6), Ms A would also build identities and take on different aliases and personas, leading those who knew her to question whether she experienced reality differently or was able to show the needs of her true self. Ms A had experienced many rejections herself and was jealous of her siblings who were settled but she was not able to confide this.

5.0 The review process

5.1 Once terms of reference had been agreed for the SAR, those agencies who had worked with Ms A completed chronologies of their involvement.

5.2 From a reading of the chronologies of work with Ms A, there did not appear to be specific key episodes around which a review could focus. Rather, the chronologies traced a tragic life journey where there appeared to be repeating patterns of behaviour and interactions with services. By contrast there did appear to be a number of key themes, corresponding to the terms of reference, which a review could explore through learning events. These themes are both discrete but they also overlap. In addition some cross-cutting lines for enquiry emerged which appeared relevant to each of the discrete themes, and these included information-sharing, recognition of Ms A's needs and vulnerabilities, and multi-agency working. Accordingly, questions which addressed these cross-cutting lines of enquiry appeared in every one of the key themes below. Agencies were asked to conduct and report back upon reflective conversations with those involved with Ms A. The learning seminars then drew on these individual agency reports that critically reflected on the work that was done and on

the perspectives of the practitioners, managers and carers who worked directly with Ms A. In this way, the intention was that Ms A's own voice would find expression through those who knew her best.

5.3 The reflective conversations and the learning events were designed to gather perspectives from those who worked with Ms A on what occurred and what was happening at the time – organisational, political, service and personal influences that may have impacted on practice and its management. It is helpful to capture these influences as they potentially shed light on contextual and contributory factors that affected outcomes in this case. The starting point was the questions that agencies were asked to consider through the reflective conversations, identified below. The learning from these conversations was combined into findings that were then discussed and refined at the first learning event, to capture not just what occurred but as importantly why and with what implications for future service design and practice.

5.4 Key theme one: This theme relates to Ms A's mental health and how agencies might work effectively with young people and young adults with complex mental health needs. Questions which occur to me about work with Ms A include:

- What assessments were undertaken of Ms A's mental well-being and what treatment or intervention options were considered?
- How were her mental health needs understood?
- What stories were told about her mental health?
- How was the difficulty in engaging with Ms A understood and what would Ms A want us to learn from how services and individual practitioners engaged with her?
- When it was difficult to engage with her, what risk assessments were undertaken?
- How well was information shared between the agencies involved in respect of her mental wellbeing?
- How well were her needs and vulnerabilities recognised, included in assessments, and communicated between agencies?
- What lessons for the future can agencies learn from how they worked together in this case?

5.5 Key theme two: This theme relates to Ms A's mental capacity. From the age of sixteen the Mental Capacity Act 2005 applies. Given the decisions that Ms A made and the risks that were apparent in relation to her mental wellbeing, housing, possible substance misuse, domestic violence and relationships, what consideration was given to her decision-making capacity? Questions which arise here include:

- To what degree were the legislative requirements relating to transition understood and met in this case?
- What mental capacity assessments were undertaken and with what outcome?
- What impact did knowledge of her background have on professional on decision-making?

- What would Ms A want us to learn from her experience of decision-making in the context of fractured relationships and disrupted life events?
- How well was information shared between the agencies involved in respect of her mental capacity and decision-making?
- How well were her needs and vulnerabilities recognised, included in assessments, and communicated between agencies?
- What lessons can be learned from how agencies worked together in this case?

5.6 Key theme three: This theme relates to transition. Legislation requires that children's services, adult social care and education liaise closely with respect to transition for young people leaving care. Questions which arise here include:

- To what degree were the legislative requirements relating to transition understood and met in this case?
- What leaving care arrangements were put in place and how effective were they?
- What would Ms A want us to learn from outcomes in this case for young people approaching transition in the future?
- What attempts were made to engage with Ms A and what can be learned from what appears to have been effective engagement by some practitioners and agencies?
- What options in this case were perceived and what stories influenced practice with Ms A?
- How well was information shared between the agencies involved in respect of transition planning?
- How well were her needs and vulnerabilities recognised, included in assessments, and communicated between agencies?
- What lessons for the future can agencies learn from how they worked together in this case?

5.7 Key theme four: This theme relates to young people who are hard to engage, whose needs are complex and where the experience of working in such a context can leave practitioners and managers feeling powerless and helpless in terms of effecting beneficial change. Practice in relation to Ms A often centred on crises of different types. In such circumstances it can be challenging to attempt to work proactively and to get beyond the immediate presenting issues. Caseloads may also prevent a more person-centred approach. Questions which arise here include:

- What risk, child protection, mental capacity and mental health assessments were completed?
- How aware were those involved at this point of the historical background of this case?
- What stories were influencing practice in this case about young people of Ms A's age and presentation?
- Was practice sufficiently person-centred and co-ordinated in this case?
- Were there sufficient opportunities for practitioners, managers and agencies together to hypothesise about what might be happening in this case, to consider and then to follow through action plans with Ms A?

- What would Ms A want us to learn about working with young people and young adults in her position?
- What can be learned in terms of Ms A's different levels of engagement with different agencies and practitioners?
- How effective was intra-agency supervision in this case?
- How effective were complex case procedures in this case?
- How well was information shared between the agencies involved?
- How well were her needs and vulnerabilities recognised, included in assessments, and communicated between agencies?
- What lessons for the future can agencies learn from how they worked together in this case?
- How well were the causes of hard to reach behaviour understood and managed?
- What more can be done to support professionals who lack confidence in challenging young people and their parents?

5.8 A second learning event considered the emerging findings and refined the analysis, leading to recommendations for Havering Safeguarding Adults Board and Havering Local Safeguarding Children Board.

6.0 Family involvement

6.1 Contact was made with Ms A's siblings and their carers. They decided not to participate in this review.

6.2 Contact was made with Ms A's mother and step-father and the reviewer met them together with a staff member who knew them and who had supported YPAs working with Ms A. They understood fully the challenges that Ms A's behaviour had presented to those attempting to work with her. Much of what they said resonated with the picture offered by those who worked with Ms A. For example, they recognised that Ms A had a strong tendency to push people away and to reject the care and support they were offering.

6.3 They described some of her risk-taking behaviours as if she was oblivious to the consequences. They recalled the aliases that she had adopted, including with her boyfriend, and thought that this was at least partly because she was jealous of what her siblings had. They thought that she had been good at manipulating people, convincing professionals to prescribe methadone and insulin when she was not taking heroin and was not diabetic. They noted that she often had food for her pets but not for herself and that they had tried to help her keep her flat clean and tidy, a reference to self-neglect that professionals working with Ms A also noted (section 7).

6.4 They wondered whether opportunities to support Ms A more effectively had been missed, such as when she missed mental health appointments and her case had been closed or when she had been discharged after having been sectioned under the Mental Health Act 1983 without any apparent plan. They were also critical of the number of changes of social

worker she had experienced and of having been kept on a labour ward with her stillborn baby.

6.5 In summary they were doubtful whether there was a key that might have unlocked the complexities that their daughter presented. They remarked that, when they were working with a family assessment centre when Ms A was aged around 6, she had been described as high risk, that she had absconded from school and really tested their boundary setting and that of her teachers. Whilst they appreciated the terms of reference set for this review, their contribution reminded us all of the importance of placing the "here and now" in the context of the "there and then."

7.0 Thematic findings and analysis

7.1 **Key Theme 1** covered Ms A's mental health and how agencies might work effectively with young people and young adults with complex mental health needs. When working with young people and young adults, practitioners and managers require an understanding of mental health legislation. Drug and alcohol workers, midwives, housing officers, police officers, social workers and young people's advisers believed that they had a level of understanding of mental health law commensurate with their roles and responsibilities, such as when a person's confidentiality may be breached. However, not everyone felt sufficiently trained and equipped to manage the level of complexity in Ms A's case, complicated further by conflicting mental health diagnoses and the lack of sustained involvement from community and/or hospital specialist mental health services.

7.1.1 Recommendation: Since it is important that practitioners and managers are confident in their legal knowledge, training provision should be reviewed in relation to the law relating to young people and young adults, specifically mental health, mental capacity, leaving care and transition, and information-sharing.

7.2 Undoubtedly, Ms A had complex mental health needs. It is therefore pertinent to explore what mental health assessments were undertaken and what treatment and intervention options were considered. In November 2004, a systemic psychotherapist stated that Ms A met the criteria for Oppositional Defiant Disorder (ODD) and she was referred to Havering CAMHS. In February 2008 Ms A was diagnosed with ADHD by Kent CAMHS. She was prescribed Ritalin medication. Ms A's mental health was then regularly monitored by Havering CAMHS.

7.3 Early in 2012 Ms A began receiving specialist psychological support sessions through the 'Treasure Keepers' project (commissioned by Havering's Children in Care and Support Services), involving regular sessions (once every 3 weeks) with a Counselling Psychologist to reflect on psychological issues and strategies to help maintain and/or manage Ms A in a foster placement. She appears to have engaged positively with this work and an assessment (completed in April 2012) by a psychologist was commissioned by Children's Services to assist with the care planning and transitional arrangements for Ms A. Recommendations from this assessment focussed upon maintaining Ms A's then foster placement as a

protected single placement until Ms A was at least 18 (with no other young people being placed within the home) and that consideration be given for the placement to be extended for an additional year after she turned 18 if the placement continued to progress well. However, the placement subsequently ended suddenly and work focussed upon using a "re-parenting" approach to develop Ms A's developmental gaps and create a 'secure base' could not be pursued further. From this point onwards, the mental assessments and interventions offered to Ms A were unable to obtain any consistent "grip" in addressing her mental health needs as a result of the absence of any perceived alternative, the chaotic pattern of Ms A's lifestyle and the lack of any sustained engagement.

Observation: momentum from children's social care commissioned specialist services "Treasure Keepers" was lost when ultimately the plan based on recommendations from this specialist service could not be implemented. For this reason, recommendations appear throughout this review on systems for managing complex cases and the risks therein.

7.3.1 Recommendation: arrangements for managing complex cases concerning young people and young adults could be reviewed to ensure that active consideration is routinely given to situations where services are struggling to meet an individual's needs.

7.4 Several referrals for mental health assessments and treatment were made in relation to Ms A as a vulnerable adult but these did not proceed due to Ms A not making appointments. Ms A was referred for and attended a psychiatric assessment at Queens Hospital in June 2012, which recommended 12 sessions of therapy to address an "emotional dis-regulation", but these appointments were not attended and then the case closed. This lack of engagement and Ms A's frequent lack of availability meant that the YPA's were constantly in a position of tracing Ms A's whereabouts which usually concluded in addressing a crisis of some nature when she was located. *Observation: Ms A was sometimes accompanied to appointments and doing so more routinely might have been advisable if the pattern of non-attendance had been recognised. If she felt disinclined to attend, perhaps because of a fear of being labelled "crazy", this could have been worked with.*

7.5 Ms A was admitted to Goodmayes Hospital between the 08/05/2013 and 13/05/2013 and a referral made to Queen's Hospital Psychiatric Unit, where she was diagnosed with an emotionally unstable personality disorder and referred onto Havering's IMPART personality disorder service. This followed an allegation of rape (which was later closed by police due to lack of evidence). Ms A went to Whitechapel Haven with a support worker for her third check-up and was referred to Queens Hospital psychiatric unit for an assessment as she was deemed unsafe due to telling staff she had a knife hidden in her room. She was later transferred and admitted to Goodmayes Hospital, Hepworth Ward. However, a further assessment by a senior psychologist at IMPART disputed this diagnosis and the resulting report advised that her needs could not be met under their service. The recommendations of this report were based solely on Ms A's voiced view on her own needs and history during a one off 2 hour assessment in clinic. A view was expressed that Ms A could "perform" in assessment and was able to present well to professionals (including mental health services) for pre-arranged appointments. *Observation: this reflection underscores the importance of*

information from one source being triangulated with that from others. Is this now done? The GP practice where Ms A was registered between January and September 2013 saw her regularly and reflected that communication channels and procedures did enable review of her mental health needs. However, Ms A's changes of address also meant that some GPs may have been unsighted on her history and needs given delays in the transfer of medical records.

7.5.1 Recommendation: information-sharing in complex cases involving young people and young adults could be the focus of an audit.

Recommendation: the transfer of medical records between GPs should be reviewed.

7.6 Havering Children's Services records show that 5 referrals were made to IMPART and other mental health services, and regular professional meetings took place. When referrals were made the response appears to have been that Ms A did not meet the necessary criteria. Ms A knew what questions would be asked and was able to perform in assessments. YPAs were not able to offer their views and assessment. Mental health assessments were carried out in isolation with Ms A. Equally, assessments did not appear to identify clear approaches as to how services could have effectively supported Ms A. Case management was not helped by the lack of a consistent mental health designated link with whom YPAs could liaise. YPAs felt that they were being "batted back and forth;" Ms A was stated not to meet the threshold for mental health services. YPAs "felt drained and powerless" and responding to crisis rather than completing any planned work. *Observation: once again, this highlights the importance of having in place a system for managing complex cases to which any practitioner or manager can escalate concerns.*

7.7 A psychiatric assessment, undertaken at Queen's Hospital on the 07/10/2013 following another crisis incident, appears to have ruled out any formal mental illness. Ms A was then discharged from Queen's on the 09/10/2013. *Observation: once again, with a pattern of disagreement about Ms A's mental health profile, an opportunity appears to have been missed for a case conference to share information and, with mental health specialists, to discuss how to respond to her mental health needs.*

7.8 In April 2014 following an ante-natal appointment the GP was contacted regarding a mental health assessment. A referral was made but Ms A did not attend her appointment. *Question: what do the LSCB and SAB expect as good practice when someone at risk does not attend for appointments?* A joint mental health assessment was undertaken on the 9/6/2014 by the Perinatal Mental Health Team, a Midwife and Home Treatment Team. Ms A was considered high risk of self-harm and the interventions included 1:1 nursing care with Registered Mental Health Nurse until a Section 2 assessment by an Approved Mental Health Professional and Section 12 Doctor was completed. *Observation: it is possible to see a start, stop, start, stop pattern with respect to Ms A's mental health needs and presentation. A case conference, as observed in the previous paragraph, might have been helpful.*

7.9 On the 10/06/2014, Ms A was discharged from hospital following the miscarriage of her daughter, after having received counselling from the bereavement team, specialist midwife and chaplain services. According to Children's Services records, a mental health assessment had initially recommended that Ms A should be hospitalised under Section 2 of the Mental Health Act but this decision was reviewed and Ms A was discharged to Havering's Mental Health Home Treatment Team where again Ms A's engagement was inconsistent and the professional response continued to be driven by responses to crisis. The plan had been for the Home Treatment Team to continue involvement for up to one month and a forensic psychiatric assessment with formal handover to the Community Mental Health Team. An initial forensic psychiatric assessment appointment was given to Ms A on the 08/07/2014, but the assessment did not proceed as she did not have identification with her despite the YPA's attendance. Ms A's referral was then closed after 2 subsequent failed appointments. A further mental health assessment was carried out in Harold Hill on the 16/12/2014. Ms A was supported to attend by a drug worker but no clear details of the outcome appear available. Ms A did not want to take any medication, and she seemed reluctant for a diagnosis and would say 'I'm not crazy'. Staff tried to frame it as 'having had the experiences you've had, that could be called trauma'. *Question: how common is this kind of scenario?* Community MARAC records note that mental health referrals were made in February and March 2015.

7.10 Approaching adulthood, Ms A's case was sent to the learning disability team via transition. On receipt of all the documents and reports they were reviewed by the psychologist who ascertained that Ms A did not meet the criteria for the team. A recommendation was made to CYPS that they should contact "adult social care" so they could undertake an assessment. CYPS say that they did this; however the database does not show evidence of a referral. Subsequently, safeguarding triaged the case but did not do any assessments, leaving the leaving care team to support Ms A or to pass onto mental health services for follow up. It is unclear how her mental health, care and support needs, and adult safeguarding risks were considered within the numerous safeguarding alerts, for example from the police and ambulance service. *Observation: perhaps this was an example of Ms A becoming someone else's problem, concerns being passed around the agencies. Was there also a failure to follow through on referrals? Might this have been one occasion when a network meeting might have been able to construct a whole-system way forward?*

7.10.1 Recommendation: with the implementation of the Care Act 2014, a review could be considered of the management of thresholds for a section 42 enquiry and a section 9 care and support assessment.

7.11 Those involved with Ms A generally felt that information was shared and discussed well regarding her mental well-being. The Community MARAC appears to have had a good understanding of Ms A's background and mental health issues. However, this was increasingly in response to crises or singular incidents, which often resulted in new referrals for mental health and/or adult services input, thresholds for which Ms A did not apparently meet. Unfortunately, it may also be that due to the complexity of the case, information-sharing had a negative impact on staff wanting to take on the case as they could envisage

how difficult and time consuming this could be. *Observation: information-sharing was good but did not appear to prompt network discussion of the underlying patterns in Ms A's behaviour. It did not translate into an action plan to seek to minimise the risks, which was then actively monitored; rather, individual agencies agreed to take forward specific actions, which were then reviewed.*

7.12 If information-sharing was generally effective, some agencies were perhaps unsighted on the history of the case. Housing staff were unaware of the assessments that had been completed prior to their involvement with Ms A. Ms A's personal educational plan does not name a social worker and from the documentation it is unclear what information was shared and how aware other professionals might have been about issues arising in Ms A's educational setting.

7.13 Information-sharing is more effective if it facilitates understanding of a person's mental health needs. There is evidence that children's services held and shared a good narrative chronology which highlighted early attachment issues and trauma. There is also evidence of practitioners speaking with Ms A openly about her behaviours relating to claiming to have diabetes, a brain tumour and allergies. The collaboration between the ante-natal/mental health clinic and perinatal mental health team and Home Treatment Team demonstrated effective working together. Knowledge of her emotional state shaped the personal educational plan in an effort to overcome her barriers to learning. 1:1 educational support was put in place for Ms A. However, understanding was made more complicated by several factors, namely:

- Disagreement amongst mental health professionals regarding diagnosis and treatment.
- The narrative surrounding Ms A – one of being "so damaged", "broken", "very manipulative", "attention-seeking" and "in her own world" – that may have raised anxieties.
- Lack of experience in dealing with, and lack of availability of expertise surrounding "fabricated illness syndrome" and her complex needs more generally.
- Ms A's resistance to what may have been seen as traumatic, and her sporadic engagement.
- Ms A's changes of address which disrupted continuity and meant the potential to lose information, despite for example hospital discharge letters being sent to GPs and one MARAC beginning a process of sending information to another MARAC.
- Insufficient support and interventions to work with Ms A on her emotional and behavioural issues. Mental health assessments reached divergent diagnoses, including an emotionally unstable personality disorder. No recommendations appear to have followed about what mental health services Ms A required.
- The leaving care practitioners held a strong view that assessments and recommendations overly reflected Ms A's voice and opinions and did not sufficiently factor in the considered opinions and experiences of the wider professional network, which was particularly apparent once Ms A reached adulthood.

7.14 So, how effective did agencies work together in understanding, assessing and meeting Ms A's mental health needs? The "Treasure Keepers" psychological assessment in April 2012

appears to have been the most comprehensive effort to identify the risks involved and provide a plan to address these concerns. Ms A was discussed at six Community MARAC meetings from December 2014 to August 2015. In April/May 2015, the Community MARAC was advised that Ms A had moved to the Hampshire area. As such, processes began to transfer Ms A on a MARAC to MARAC basis. Information was shared and multi-agency meetings were held where Ms A's mental health issues were discussed. For example, details and arrangements for the funeral for her stillborn child were shared and the anniversary date of loss of her pregnancy was known so agencies could be sensitive to her emotional needs around those times. However, there does not appear to have been a risk management plan which was kept under constant review. Therefore there was no trigger for a change of tack from a multi- agency perspective as Ms A's case evolved. Thus, little momentum seems to have come from meetings, from information-sharing and from mental health/psychiatric completed or failed assessments, with the outcome that managing her behaviour became the focus, such as reporting on drug testing, rather than seeking to tackle its underlying causes. This might have been because risk was managed by individual agencies rather than overall risk being discussed and then becoming the focus of a unified action plan to address the risks and her care and support needs. Thus, most activity remained crisis driven and those involved struggled to plan any sustained interventions and activities with Ms A. *Observation: at the first learning event it was felt that Ms A's case was not unique, which highlights again the recommendations in this SAR regarding review of complex case procedures.*

7.15 Thus, the YPA's were of a strong view that the mental health input into Ms A's case management was singular and did not take a longer term perspective. They reported considerable frustration in their attempts to work with adult mental health services and believe that information sharing could have been substantially improved but seemed to stop when she did not engage. Perhaps too engagement was not helped by the majority of services being clinic and hospital based. Integrated work did not appear so apparent once Ms A became an adult. From an adult social care perspective, decisions did not take into consideration that there will always be people that don't fit into any eligibility criteria but remain vulnerable and require support. *Observation: this may be a systemic issue, which reinforces the recommendation above concerning thresholds for implementation of the Care Act 2014, with its emphasis on wellbeing, prevention and support. It reinforces too the recommendations for strengthening further the interface between children's social care and adult social care.*

7.16 Ms A sometimes engaged well with services and individual practitioners; at other times engagement proved challenging. When she was difficult to engage, given the complexity of her needs, what risk assessments were completed and how effective were they in setting actions to be followed through? What can agencies learn from those occasions when she did engage? Those who knew Ms A felt that she was looking for, but was possibly also ambivalent about human connection. Relationships and adequate attention were important to Ms A so the availability of time, continuity and trust were important. Responding to this required flexible working, outside the constraints of eligibility. *Question: is this possible in cases of such complexity? How is this decided?* Non-engagement can prove frustrating for

practitioners. *Question: was her non-engagement, for example with specialist midwives, talked about sufficiently in multi-agency settings? Were different strategies tried to engage her when she disengaged?* Whilst challenging to engage, did Ms A have sufficient opportunity to discuss with those with whom she did, at times, engage her views about, for example, her progress in education or her contraceptive needs? One reflective conversation concluded that the assumption made was that as Ms A had capacity when choosing not to engage with services, or that non engagement was a result of her mental illness. It questioned whether in-depth thought or analysis had been given to the impact that her history had on engagement. *Question: what would happen now?*

7.17 Participants at the first learning event discussed the importance of Ms A, and other young people, being seen where they wanted to be seen; of persistence and the use of relationship. They emphasised the importance of one agency taking a lead, of seeing patterns rather than just single incidents, and of considering the triggers underlying how young people like Ms A present, for example at Accident and Emergency Departments. This reinforces the recommendations in this SAR regarding the approach to complex cases.

7.18 To conclude this theme, those who knew Ms A were asked to reflect on what she would want us to learn about how to engage with young people and young adults with mental health issues. Their reflections follow:

- Ms A would want professionals to share their concerns to ensure that she had holistic support to help her achieve and to promote her well-being;
- Although young people are classified as adults the issues that they have experienced for the past 18 years do not just disappear on their 18th birthday. They may have several diagnoses around their mental health and generally there is no clear diagnosis until they get older. Do not always focus on the label but the symptoms and presentation; their life experiences may impact on this;
- She would see the importance of establishing strong therapeutic relationships, not giving up, seeing beyond her behaviour to the person, and to take a more comprehensive, joined up and dynamic approach to the assessment and management of risk and vulnerability;
- To recognise that she was looking for human connection not just an institutional response;
- Ms A would have wanted a consistent inter-agency package of support led by a practitioner with the expertise, time and resource to engage and work with her, responding to her immediate needs whilst working to a clear plan. Relationships and adequate attention were extremely important to Ms A and she seemed to seek out care and "parenting" although she found this input difficult to work with consistently. Ms A was also inviting more control and directive input.

7.19 *Observation: it can be challenging to balance self-determination with a duty of care, and negotiated with more directive interventions. Reflective spaces are useful to enable individual practitioners and the multi-agency network to think through these challenges. If what Ms A might want us to learn are benchmarks for services, how close does Havering now appear in relation to work with young people with complex mental health needs?*

7.20 Those involved with Ms A were also asked to reflect on what they believed to have worked well when understanding, assessing and meeting Ms A's mental health needs and what lessons they felt could be learned from this case. There is evidence of effective information-sharing and of working with Ms A in a sensitive and open-ended manner, which acknowledged her struggles with her physical and mental health. She had a good therapeutic alliance with substance misuse workers and with young people's advisers. This was a protective factor. The provision of the joint ante-natal and mental health clinic and the communication within the NHS Trust's Maternity Service and Community Home Treatment Team worked well.

7.21 Lessons to be learned include the importance of sharing updates with all relevant practitioners and agencies, and of ensuring that young people feel listened to about their needs. In complex, high risk cases, such as Ms A, there is a need to see beyond the boundaries of what services are 'contracted' to deliver, and to develop a universal approach to risk assessment whereby it could be recognised that someone should receive an intensive multi agency package. When the brevity of Ms A's contact with services, such as maternity, enabled recognition of her needs and vulnerabilities, but not the implementation of an action plan, this could have been fed into network meetings. When the plan for placement stability ended suddenly and work that focussed upon using a "re-parenting" approach to tackle Ms A's developmental gaps and create a 'secure base' could not be pursued further, it is unclear what mental health assessments and action planning followed.

7.22 YPA's did their very best to understand and address Ms A's mental health needs but required the consistent and timely input of mental health services, and a seamless multi-agency care package to address Ms A's chaotic behaviours and difficult presentations. They frequently repeated the point that "it was hard to get a grip on what was going on" amidst the variety of mental health conclusions. Put another way, the lesson is a formal, more dynamic, joined-up and multi -agency approach to risk assessment, planning, active risk management and review. Whilst Ms A's vulnerability was recognised, there was perhaps too much focus on whether she fitted the criteria for a specific service; there needs to be a joint approach and pathway for cases that do not fit any particular team but where it is evident that person is vulnerable and has complex needs.

7.23 Recommendation: Training in relation to mental health, complex cases and legislation for all agencies involved with young people where risks are significant.

Recommendation: SAB and LSCB to review the availability of mental health professionals for immediate and regular consultation.

Recommendation: LSCB and SAB to ensure that an escalation procedure is available to senior management in order to facilitate future planning in complex cases with significant risks.

Recommendation: A lead agency to be appointed through the Community MARAC in complex cases, supported by an action plan setting out the roles and responsibilities of all the agencies involved.

Recommendation: CAMHS and Adult Mental Health Services to review their eligibility criteria and their responses to people who do not engage, and to report their conclusions in light of this case to the LSCB and SAB.

7.23 **Key Theme 2** covered Ms A's mental capacity. From the age of sixteen, the Mental Capacity Act 2005 applies. Given the decisions that Ms A made and the risks that were apparent in relation to her mental well-being, involving housing, possible substance misuse and domestic violence, what consideration was given to her decision-making capacity?

7.24 Some practitioners appeared to have a broad understanding of mental capacity principles and practice, and the relationship between capacity, decision making and risk management but not detailed knowledge of the interface between diverse pieces of legislation. Others have reflected that they had very little knowledge. Perhaps because of this, some practitioners assumed throughout that Ms A had capacity, whilst others concluded that it did not appear to have been considered within the process of supervision, care/pathway planning and professional network meetings. Specialist midwives reflected that they have received mental capacity training since involvement with Ms A and they would now have assessed her capacity given her high risk behaviours. *Observation: these findings are not specific to this case but reflect a more general (systemic) phenomenon. This forms part of the rationale for the recommendation in section 7.1.1 concerning legal literacy for all frontline practitioners and managers.*

7.25 Chronologies noted that Ms A had capacity to consent to services. In reflective conversations those involved were asked how this was assessed and whether professionals fully understood capacity and consent. Some practitioners believed that Ms A had capacity whilst sometimes being resistant to hearing information about risks. Others thought that there was an assumption within the professional network that Ms A had capacity to provide consent and make complex decisions and choices with regards to her future. They concluded that there was no clear evidence of the professional network challenging this assumption and thought that greater efforts might have been made to drill down into specific risks and areas around capacity. Discussion at the first learning event also concluded that Ms A's mental capacity was too easily presumed. Across the practitioners and agencies involved was a belief that more network discussions would have been helpful, focusing in part on mental capacity, and that assessment tools could usefully include screening about an individual's decision-making and executive capacity. One agency concluded that children services staff and the wider professional network clearly require more training with regards to working with service users with complex mental health problems and understanding where capacity issues maybe an issue and how this can be addressed in partnership. It is also important that practitioners have access to legal advice, mental capacity specialist expertise and consultation. *Research (for example, Braye et al., 2014) highlights the importance of accessibility to legal advice and consultation. Training is also important but is more effective*

when supervision, and organisational procedures and cultures more widely, ensure that knowledge and skills acquired through training are embedded in practice and the management of practice (Braye et al., 2013). Observation: the recommendations from this review include review of mental capacity training. Both the LSCB and SAB could also review how knowledge and skills acquired during training are embedded in subsequent practice.

7.26 There is evidence to suggest that Ms A's case history was shared amongst at least some of the agencies involved, such as children's social care and drug and alcohol services, GP and psychiatry, sometimes in detail and sometimes in summary form. Specialist midwives and police officers, for example, knew Ms A's history, including that involving fabricated illness. Ms A's personal education plan, however, does not appear to have contained any such information and referrals to mental health and substance misuse services could have contained more information about her history, especially her attachment issues. *Information-sharing is addressed in detail later*. What is less clear is the impact that such knowledge had upon decision making processes within individual agencies and the multi-agency network. It could be argued that Ms A needed connection and unconditional positive regard, even if she was ambivalent, understandably given her history of relationships, in which event it is unclear how much of her background and particularly her experiences of trauma would have fed into decisions for agencies to either work or not work with her. *Observation: network meetings and individual agency supervision records should routinely record decision-making – who was involved and the rationale for decisions. Additionally, if information-sharing is a systemic issue, this reinforces earlier recommendations with respect to training and the management of complex cases.*

7.27 When information-sharing was considered in reflective conversations alongside mental capacity, the assumption emerges again that "it always felt like she had capacity." However, there was recognition that maybe this was not sufficiently challenged. Concerns in relation to risk taking and chaotic choices were regularly shared via referrals and during professional network meetings; however, mental capacity was not formally raised or pursued within the network in an open and transparent manner. Some participants in the first learning event expressed frustration about Ms A's unwise decisions and felt unclear about what legal options there might have been to safeguard her wellbeing. *Observation: if Ms A was disabled from making a choice by virtue of her life experiences, might protective measures available through the High Court's inherent jurisdiction been an option to consider?*

7.28 Recommendation: Community MARAC, formal case reviews and other network meetings involving high risk cases should have available legal advice and other forms of relevant specialist expertise. Decisions should clearly record the legal options that were considered.

7.29 Those involved were asked to reflect on what worked well and what lessons might be learned from how agencies worked together in this case with respect to young people and young adults' mental capacity and decision-making. Those who knew her well have concluded that Ms A understood the significant neglect and abuse that she had experienced during her childhood and the huge loss this resulted in. Earlier effective decision-making in relation to permanence may well have been an area which Ms A would want services to

learn from and if similar outcomes were experienced by other children she would want to see the availability of a consistent therapeutic offer which is seamless and runs well into adult life. *Observation: in reflecting on what practice is like now and what more needs to be done, participants in the first learning event considered joint commissioning, for example with respect to robust clinical work for young people and young adults, with the ambition of constructing systems around individual young people rather than requiring them to slot into pre-existing provision. As this forms part of the transformation of transition provision in Havering, a process already underway, a recommendation appears later in the review for the LSCB and SAB to monitor progress.*

7.30 Regular professionals meetings meant that all agencies were aware of some relevant information. However, more emphasis could have been given to her attachment issues and communication about this may have aided better engagement with (and assertive outreach from) mental health services. Professionals across all services clearly require more training with regards to working with service users with complex mental health presentations and better understanding of mental capacity.

7.31 Young adults experiencing similar problems would benefit from access to key provision which did not rely on rigid threshold criteria but was more flexible and examined need, risk management and longer term prediction of need and support. Such gaps should be considered when commissioning specialist and targeted services. The considered assessment of the entire professional network should be given due weight in such cases and appropriately influence the allocation of resources. *Observation: threshold criteria were discussed at the first learning event and appear a system-wide issue. Participants recognised that the current approach could result in "the system losing the person" and that especially for people like Ms A, with very complex needs where the risks are highly and not easily mitigated, services should aspire to fit around the person.* In complex cases, such as Ms A, it would have been beneficial to have had a clear, coordinated case manager and for this to be the person/agency who would best meet her presenting issues. *Observation: research on SCRs and SARs has found this recommended in various cases (Braye et al., 2015). Recommendations have been made in this SAR regarding the appointment of a lead agency, escalation procedures and the involvement of senior management in complex cases.*

7.32 Young people should be part of decision making where possible and appropriate, and this should be documented and taken into consideration. Those who knew Ms A believe that she would want to be part of the decisions that were made about her, for example concerning her education, and should have had the opportunity to share her views about the support she was receiving and whether it was working for her, even if such a person-centred approach did not always mean much to her. Documentation does not routinely outline whether this happened or not. She might emphasise the importance of consideration and knowledge around trauma and how people react to trauma, to inform understanding about behaviour and non-engagement. Ms A is likely to have wanted services to help her gain control of her day to day activities in order that effective work could be undertaken and that she be helped to feel safe.

7.32.1 A small group of young people who had experienced transition and leaving care were asked for their perspectives on the issues central to this review. They had very positive comments about YPAs and some social workers, housing support staff and residential workers, finding their persistence, advocacy and accessibility helpful. Those workers who put themselves out, offered support not judgement, who checked in and made unannounced visits, were seen positively. When reviewing their experiences, they said that they would have benefited from more help with their education and job hunting, and more information on benefits. They suggested that there should be a matching process for young people with YPAs and social workers. They emphasised the importance of comforting and respect.

7.32.2 When reflecting on their experience of placement decisions, they said that they had had little or no involvement in placement decisions; moves were often unexplained or unannounced, and disrupted their education. Planning for leaving care had been good in their experience but execution poor, particularly in terms of what accommodation was offered and where it was located. They stressed that not everyone was ready for independence at 18. On counselling, looking back they could see the importance and usefulness of it but they felt that more consideration needed to be given to the timing of it and also to support to help young people to engage in conversations about why they were in care. They also emphasised that they needed to get to know someone and build a relationship before they could speak about themselves and their experiences.

7.33 Recommendation: Training on working with young adults who are difficult to engage and who have complex needs, to include content on mental capacity and adult safeguarding.

Recommendation: Senior managers involved in service planning and (joint) commissioning could explore what more can be provided to ensure person-centred planning in complex cases.

Recommendation: Supervision should routinely consider how to support frontline staff to maintain a person-centred approach in complex cases, where young people's engagement is ambivalent.

7.34 **Key Theme 3** covered transition and leaving care. Legislation requires that children's services, adult social care, health and education liaise closely with respect to transition for young people leaving care. A pertinent line of inquiry, therefore, is the degree to which the assessment and intervention process was sufficiently co-ordinated to support Ms A's transition to adult.

7.35 The legislative requirements relating to transition and young people leaving care appear to have been broadly understood by most practitioners and managers involved in Ms A's case. However, there were shortcomings in how the legislative requirements were implemented. There were early meetings between children's social care and young people's services as a 'handover of case' to provide continuity and to highlight risks and behaviour patterns. However, the involvement of all relevant agencies in developing and pursuing the transition plan was mixed. For example, the pathway plan was not shared with housing services and

the risk assessment provided did not reflect the breadth or depth of issues faced by Ms A. This meant that, at the point at which permanent housing was being offered, there was not a clear line of sight on her needs. When information about young people is known in advance the housing system is equipped to support young people who have chaotic lifestyles through direct work, positive requirements and signposting. A change in the way leaving care and housing services work together to manage the transition of a young person from care provision into independent housing would contribute to achieving better outcomes for care leavers. *Observation: this is not unique to Ms A's case but reflects a wider systemic issue that is being addressed as part of the transformation process now being undertaken with respect to young people leaving care in Havering. The review recommends elsewhere that the LSCB and SAB monitor progress, including the development of partnership working between children's social care, adult social care and housing, and the availability of different types of housing provision for young people whose needs are complex.*

7.36 Reflecting on the leaving care arrangements that were put in place with Ms A and how effective they were, communication between leaving care and housing services could have begun prior to Ms A moving into her property in order to consider its appropriateness. Essential things for health and wellbeing like being registered with a GP were not in place. Drug and alcohol workers might have been involved in assessments that specifically focused on transition. However, it was not a question that her needs and vulnerabilities were not recognised in assessment and support plans but rather agencies did not fully pull together, that threshold criteria were obstacles, and that communication between agencies may have dropped off once Ms A reached 18. When she did not engage, some agencies withdrew. *Observation: other Safeguarding Adult Reviews have reported and criticised the same phenomenon (Braye et al, 2015)*.

7.37 Recommendation: Complex cases involving young people with significant risks to their wellbeing should not be closed without a multi-agency professionals' meeting to consider how best to manage the risks involved.

7.38 Adult social care did not engage with Ms A, or complete a risk assessment, since it believed that it was more appropriate for mental health services to be involved. On reflection, adult social care concluded that it would have been appropriate for it to conduct a joint assessment with children's social care, who knew Ms A well, to inform decision-making. *Observation: for this reason the SAR has already recommended that thresholds for section 42 duty to enquire and section 9 duty to assess needs for care and support be reviewed. This might help to strengthen the co-operation between children's social care and adult social care.*

7.39 The transition and pathway planning process in Ms A's case may have benefitted from an earlier starting point at 14 as opposed to 16 years. Additional assessment and support was identified via the "Treasure Keepers" project which provided comprehensive recommendations in terms of transition planning for Ms A. The pathway plan was very clear that Ms A was not ready for independent living but a foster placement breakdown appears to have resulted in Ms A being moved to semi-independent provision somewhat

prematurely and outside the recommendation from a psychological assessment that she remain in her foster placement at the time for an additional year after her 18th birthday.

7.40 However, the foster placement came to an abrupt end just prior to Ms A's 18th birthday and from this point there is significant evidence that the professional network and leaving care key workers started to respond to a series of crisis situations. *Observation: the SAR has already commented that, when this disruption occurred, it is unclear what attempts were made to find alternative (therapeutic) placements. A recommendation on placement finding appears in section 4.8.1.* Transitional planning for Ms A may have been significantly improved also by earlier and closer working between Adult and Children's Services within Havering, but the focus of planning seemed to fall down upon attempts to meet the threshold criteria for adult services as Ms A clearly did not demonstrate the skills to live independently. *Observation: participants in the first learning event expressed the view that the approach to transition was improving, partly triggered by the Care Act 2014 and the Children and Families Act 2014.This should be kept under close review.*

7.41 The reflective conversations covered what worked well in supporting Ms A through transition and what can be learned from this? It focused also on the gaps and how can these be mitigated in the future. YPAs appear to have driven the multi-agency planning and associated meetings and delivery. They reported consistent input from drug and alcohol services and education providers but experienced difficulty in accessing appropriate adult services (including mental health services) as Ms A did not meet the prescribed thresholds or simply failed to engage with the aforementioned services. The first learning event also heard about apparent disconnects at the time between children's and adult social care, and between adolescent and adult mental health provision.

7.42 As a young person moves into transitional arrangements it is crucial that their needs assessment and care and support plan benefit from an increasingly integrated service delivery, with close partnership working also offering timely access to specialist services. Such 'specialist' input should be of a consistent nature and involve named professionals. To have had a professional lead overseeing the system-wide approach to Ms A's care, who had an understanding of borderline personality disorder or other relevant diagnoses such attachment disorder would have been helpful. *Observation: for this reason the SAR has already made recommendations concerning the availability of specialist expertise to those working with complex cases, the appointment of a lead agency in such cases and the oversight of a senior manager.*

7.43 Information-sharing amongst Community MARAC partners was good. In Ms A's case, reflections were also offered that an earlier establishment of multi- agency meetings would have been better, with mental health, housing and MARAC involved. Gaps in information-sharing could then have been rectified, such as relevant history and readiness for independent living in advance of being offered permanent independent housing. Such meetings could also have considered the quality and content of risk assessments. The "Treasure Keepers" psychological assessment in April 2012 appears to have been the most comprehensive effort to identify the risks involved and provide a plan to address these

concerns. In addition, there is evidence of work to identify and manage risks during the course of numerous professional meetings, which eventually ceased once Ms A became an adult. Risks are identified and covered with care and pathway plans to a limited degree. However, there is no evidence of a formal risk assessment being undertaken, including of suicidal ideation and risk. Instead, consideration of risk was sought via mental health assessment and the involvement of agencies such as the police and drug and alcohol services. Routine multi-agency meetings, both before and after Ms A was 18, could have considered a strategy going forward, especially when YPA's and other practitioners were becoming caught in crisis-driven activity, struggling to plan any sustained interventions and activities with Ms A. As it was, the conclusions of risk assessment within pathway plans and following incidents of concern invariably led to professionals seeking further mental health input and assessment.

7.44 In response to a question about whether a focus on process, eligibility and thresholds stopped practitioners implementing a person-centred approach when assessing Ms A's needs and vulnerabilities, those responsible for the Community MARAC felt that a range of options had been discussed, although it was also noted that Ms A had been assessed as not meeting the threshold for adult safeguarding. However, there was recognition that it can be difficult to work with people in an open ended way, especially with diminishing resources. Some practitioners felt that eligibility and threshold preoccupations had impacted considerably. Adult social care concluded that a person-centred approach was less evident than a preoccupation with eligibility, observing that in future assessment should be done not by paper but by meeting and engaging with vulnerable young people. *Observation: recommendations have already been made about the management of complex cases and co-operation between children's services and adult services to avoid any semblance of buck-passing in the future. This responds to the conclusion of the first learning event that, with Ms A, it was challenging to determine overall case ownership and leadership on case planning. The Care Act 2014 and the Children and Families Act 2014 should make a difference to planning for meeting the complex needs of young people like Ms A, providing that all agencies are engaged in assessment and that planning responds not to single incidents but to the pattern of an individual's presentation.*

7.45 Drug and alcohol service staff, for example, had referred people who are presenting in crisis to mental health services and were often informed that they did not meet the criteria, although it was also recognised that such referrals seemed to be a 'go-to' referral option for complex/high risk people. *Observation: the review has already observed that mental health expertise might have proved useful when Ms A was being discussed. Participants in the first learning event felt that agencies had been too narrow in focus in looking at the situation from an eligibility standpoint rather than considering joint working. There was also acknowledgement of current and planned change, for example a preparation for adulthood team, transition meetings, and closer working between adult mental health and CAMHS.* Drug and alcohol service staff and Ms A's young people's advisers had, however, continued to work with her, the former even when there were questions about her actual misuse of substances. This seemed to engender a positive relationship, such that they felt that if they had kept the case open for longer, this too might have had a positive impact on her life and

stability. *Observation: participants in the first learning event identified the need for such organisational flexibility.* The focus upon process, eligibility and thresholds was to a high degree further intensified by anxiety experienced by professionals in relation to presenting risk factors which it was believed should be addressed by appropriately specialised services. This may to a degree have been compensated for by her young people advisers who had good working relationships with Ms A but the focus of their activity and engagement was driven by concerns relating to Ms A's vulnerable state and risk taking behaviours. This, in turn, led the key workers to become responders to crisis, whether in the form of urgent hospital admissions, homelessness, and criminal justice issues and self-harm. There was a view that every piece of transition/leaving care planning should be a multi-agency event that utilises comprehensive background information. It was also suggested that there should be a dedicated, multi -disciplinary service for young people/young adults of transitional age that addresses/understands attachment issues. *Observation: this forms part of the innovation work currently underway in Havering, the outcome of which should be monitored and where necessary consideration given to commissioning services for specific needs presented by individual young people.*

7.46 It appears that Ms A did not meet the threshold for adult social care services and adult mental health services at the point of transition. A question was asked about how flexible is the multi-agency partnership when considering agency thresholds? How effectively did and do children's services work with adult services, and adolescent mental health services work with adult mental health services? Those involved felt that either partnership working could have been improved or that what was lacking was sufficient flexibility for a young person with an extremely complex presentation. Provision for 'exceptional' cases and circumstances remains a gap in provision and threshold criteria can still impede progress for young people with complex presentations. When assessments were available and/or she met the criteria for treatment, input ended prematurely due to her lack of engagement. *Observation: the obstacles to services persisting with young people at risk were acknowledged at the first learning event. Once the innovation project in Havering is complete, a review using the circumstances of the Ms A case would be advisable to assess whether there remains a transition gap for young people with complex needs who do not fit neatly into the criteria for specific (specialist) services.*

7.47 It would appear that two key plans were considered for Ms A. The first centred upon maintaining Ms A, in what was her final foster placement for a longer period than usual to enable work focussed upon using a "re-parenting" approach to tackle Ms A's developmental gaps and create a 'secure base'. The latter, once Ms A entered semi-independent and independent living arrangements, focused upon crisis management and accessing specialist mental health and adult services. *Observation: when neither plan materialised, the multi-agency network does not appear to have reconvened to discuss options. This review has already commented that a lead agency and key worker would have been helpful in escalating concerns and bringing agencies together at these key points.*

7.48 A review of IRO records confirms that Ms A's needs and the risks involved in her case were known. Agencies shared information but what was known was not drawn together into action plans with outcomes. Moreover, her patterns of behaviour were perhaps not appreciated by those involved with her and therefore did not inform risk assessments and a review of decision-making about what interventions to attempt. The IROs responsible for Ms A's case have now left the local authority but they knew her well and were supportive of her. However, changes in social workers and IROs did not help continuity. From the records it would appear that drift and delay was not challenged, that there was no clear plan for post 18 support and that disagreements on mental health diagnosis were not explored. Greater professional curiosity would have helped risk assessment and planning, such as when she self-harmed or was reported as having fallen through a window. Taking time to develop a more profound understanding of her mental health needs, derived from consideration of trauma and her behavioural presentation, and insight into her lived experience, which included disrupted attachments and loss, might have informed assessment and decision-making. Arguably, perhaps greater challenge to the professionals and agencies involved from the IRO was desirable to ensure reflection on the approach being adopted. Equally, it is unclear whether Ms A understood the risks to which she had been and was exposed. Her voice is missing. The focus appears to have been on separate incidents or episodes. It is unclear how well she was understood.

7.49 In terms of what Ms A would want us to learn from outcomes in her case for young people approaching transition in the future, those involved stressed the importance of young people's involvement in decision-making, sharing all relevant information when making decisions around transition, and a joint, co-ordinated approach to interventions and services, such as when considering what housing options would be suitable. It was felt that Ms A would have wanted a consistent inter-agency package of transitional intervention led by a practitioner with the expertise, time and resource to engage and work with her. Relationships and adequate attention were extremely important to Ms A and she seemed to seek out care and "parenting" although she found this input difficult to work with consistently. Ms A required a seamless service which responded to her immediate needs whilst working to a clear plan owned by the whole professional network and Ms A herself. It was felt that she would emphasise an understanding that leaving care may have the impact of reigniting past traumas and bring heightened risk. Working on the assumption that someone is vulnerable at this point would be sensible, reconvening all professional agencies which have had a role in the past, however fleeting their involvement. *Observation: this picture resembles the strategic innovation developments in hand.* When commenting on what they felt needed to change in relation to supporting young people through transition and beyond, staff built on these perspectives, as follows:

- The development of a care leavers champion within each agency. The Champion would critically analyse the quality of service their agency provides to care leavers, be responsible for monitoring outcomes for care leavers and ensure they are treated as a priority group within their respective service area. They would compare outcomes for care leavers against outcomes for other young people with the same issues and report to management any gaps in service provision.

- Approaching such work from the perspective that people will be vulnerable at this juncture and referring to previous assessments to inform planning.

- Involving the voluntary sector more in transition planning and taking a 'wrap around' approach.

- A wider range of care leaver services with a particular emphasis on "drop in" and flexible support type provision.

- More joined up working with assessment, planning, delivery and review of young people with such needs, including flexibility in the use of eligibility criteria, the appointment of a lead agency and close senior management oversight.

- Consideration of how to track the movements between local authorities of young people with itinerant lifestyles.

- Training on adult social care and safeguarding legislation and its application in practice with young adults.

- Increased training for working with young people with complex needs involving mental health and self-neglect, and a continuation of the focus upon early transitional work, with sufficient resources to enable key workers to build and maintain relationships with young people.

- Involving and listening to keyworkers, such as young people's advisers, in assessments in the same way that family members might act for young people.

- The availability of mental health staff for regular consultation on assessments, plans and interventions.

- Availability of a simplified procedure for escalating concerns.

7.50 Recommendation: the LSCB and SAB should review the development of transition services and should use this case to audit how the new arrangements that are being put in place will respond to young people with complex needs.

7.51 **Key Theme 4** covered young people who are hard to engage, who have chaotic attachments, whose needs are complex and where the experience of working in such a context can leave practitioners and managers feeling powerless and helpless in effecting beneficial change. Practice with Ms A often centred on crises of different types. In such circumstances it can be challenging to attempt to work proactively and to get beyond immediate presenting issues. Caseloads and thresholds may also prevent a more person-centred approach.

7.52 The reflective conversations focused on how the multi-agency system in Havering supports young people who have chaotic lifestyles, ambivalent attitudes towards attachments and engagement, and mental health needs. It asked what system changes appear to be indicated, learning from work with Ms A. The first learning event considered the emotional impact of working with Ms A and her engagement with staff and services.

7.53 Some attempts to engage Ms A were relatively successful, for example from a housing perspective engagement with Ms A on tenancy matters. She engaged well with drug and alcohol workers, who worked on a programme of group work and 1:1 key working. She maintained regular contact on the whole. What worked well was seeing 'her' rather than the behaviour, and not being too concerned with eligibility. YPAs provided Ms A with far more support than would normally be offered; they were often out visiting her. Her rent arrears were cleared. The time commitment was incredibly high.

7.54 Participants at the first learning event thought that Ms A was seeking a "connection" – provoking a response – feeling anxious, testing strength of relationship by maintaining contact and attending some appointments but also sabotaging relationships or acting outside boundaries. Perhaps she wanted a friend and engaged better with young people. There was some difficulty "getting through", with those who knew her feeling that she lacked insight into the circumstances and impact of her behaviours. It is not altogether clear why she engaged with some agencies better than others. The impact on staff was considerable, with those who knew her carrying anxiety all the time – frightened she would do something, uncertain about how they would work with her. She had a nice character but she could be difficult and challenging. The work was frustrating and emotionally draining and the impact is still felt. *Observation: it is for this reason that the review has recommended training to enable staff to develop their expertise in exploring challenging behaviour, having difficult conversations, and managing the emotional impact of the work. Supervision, including of the "whole team together around the person" is also important in enabling staff to explore and manage the complexity of a person's presentation.*

7.55 There was some sense that a focus on process, eligibility and thresholds stopped practitioners and agencies from taking a person-centred approach when assessing and seeking to meet Ms A's needs and to mitigate risks, for example in respect of mental health. There was a strong sense also that there was a service commissioning gap in respect of young people with complex needs around mental health and attachment and that a focus on eligibility and thresholds was further intensified by anxiety experienced by professionals in relation to presenting risk factors, which it was believed should be addressed by appropriately specialised services. *Observation: accordingly, as this review has recommended, once the innovation work being led by children's social care has been completed and implemented, this case might be used as a benchmark to evaluate provision available for young people with a constellation of needs and risks similar to those presented by Ms A.* It should be acknowledged, however, that work had been planned for using a "re-parenting" approach to address Ms A's developmental gaps and create a 'secure base' but that this could not be pursued given the lack of stability in Ms A's life and the breakdown of fostering provision in late 2012.

7.56 Some practitioners established good working relationships with Ms A, following a person-centred approach. *Observation: participants at the first learning event emphasised the importance of flexibility across organisations when working with young people and young adults at risk, to underpin a more person-centred approach*. However, the focus of their activity and engagement was often driven by concerns relating to Ms A's vulnerable state and risk taking behaviours. This, in turn, led the key workers to become responders to crisis, whether in the form of urgent hospital admissions, homelessness, and criminal justice issues and self-harm. YPAs appear to have made contact with the wider professional network on a regular basis but often felt that many agencies offered information if Ms A had presented with high risk behaviours or in response to a specific request from Children's Services.

7.57 Reflective conversations also considered how (well) the multi-agency partnership worked together to think about realistic ways of engaging and meeting Ms A's needs, and to what degree complex case procedures and supervision were utilised and working well. There was clearly a commitment to working in partnership across the agencies. For example, the case was considered by the Community MARAC. There were regular multi-agency meetings. The complex case procedure was used. However, those involved reflected that more agencies could have been involved and they could have done more to dynamically assess and manage risk, and to ensure that the most appropriate agencies were working with and supporting Ms A. The discussions might have gone into more depth with regard to underlying reasons and patterns behind her presentation and behaviours, and have developed an overarching multi agency plan, especially when use of the complex case procedures did not result in a reduction in safeguarding concerns. Perhaps the multi-agency network became somewhat "stuck" with regard to addressing Ms A's needs and a highly process driven and eligibility approach was employed as a means of addressing frequent crisis situations. *Observation: it is especially important to identify and address patterns in action plans to address on-going risks*. *Participants at the first learning event and members of the SAR panel have also acknowledged that the person referring a case to Community MARAC should attend meetings. Consideration could also be given to how information is gathered so that what is available to Community MARAC is comprehensive.*

7.58 In complex cases, practice is enhanced when there is a senior manager in one of the agencies involved that oversees the effectiveness of multi-agency working, and where one practitioner acts as the lead case co-ordinator. The network in Ms A's case appears not to have decided who would be best person to build and maintain a relationship with Ms A. This was not explicitly discussed. There may have been a built-in assumption within the professional network that the leaving care team was the appropriate service to coordinate provision for Ms A and build and maintain the key professional relationships. A process and protocol for selecting the lead agency/lead professional in this regard would be helpful. *Observation: the review has already made a recommendation for review of the governance approach to complex cases.*

7.59 This also impacted upon the supervision process. Those who commented on supervision felt that it focused on the service-based response to Ms A's needs with some discussion about

the role of different services, such as social work and mental health. Supervision did not bring much insight or direction with regard to the issues of attachment. *Observation: in addition to training on supervision, the review has already commented on the importance of practitioners and managers being able to access specialist mental health and legal expertise.* With regard to expertise, some agencies concluded that it remains necessary to remove barriers to key specialist provision and provide more supported foster placements which can nurture and support young people well into adulthood. The leaving care team could be enhanced by recruitment of an AMHP or mental health social worker to manage young people with complex needs and risks leaving care since the management of such individuals may fall outside of the breadth of experience and knowledge of a YPA. The availability of such a resource might facilitate the challenging of mental health assessment outcomes and prescription decisions (Ms A was prescribed methadone at times), and could have provided psychological support to Ms A around loss and bereavement as opposed to making a referral to such a service which was then closed due to her 'non engagement'.

7.60 Recently, complex case procedures have been strengthened within the Leaving Care Service through a strengthening of agency contacts and panel processes which use a "signs of safety" approach. Work in this area is also being supported via the provision of training in systemic practice for all practitioners and improved access to clinical case consultation. *Question: how far within the multi-agency network does this change extend and how is its effectiveness being monitored? Motivational interviewing training may also be useful in supporting person-centred approaches and enabling young people to co-produce their care and build trustful relationships.*

7.61 Recommendation: staff should be offered training in motivational interviewing.

7.62 At various times, Ms A was disengaging or unengaged. When this was apparent it is pertinent to consider what risk, child protection, adult safeguarding, mental capacity and mental health assessments were completed. A key challenge at such times with young people and young adults is how (well) autonomy was balanced with a duty of care and what can be learned from how this tension was managed. In order not to abandon young people and young adults who appear to have capacity and therefore the right to private and family life, but who also have the right to life and to live free of inhuman and degrading treatment, it is important that practitioners feel confident in exploring behaviour, engagement and needs. Was training and support for practitioners sufficient in relation to the skills of assertive outreach, concerned curiosity questioning, and authoritative challenge? *Observation: the SAB could take the lead here in establishing a culture in relation to the balance between autonomy and a duty of care in relation to (young) adults at risk who have capacity. It should also be a focus within training on law, self-neglect and other presentations of significant risks.*

7.63 On reflection, insufficient consideration was given to safeguarding referrals. For example, the 'shrine' dedicated to her lost baby in her flat was possibly evidence of mental distress/ anguish. The discovery of a pushchair in her flat with an object wrapped up in a baby blanket and arranged so as to look like a baby sleeping showed that Ms A was mentally struggling

with the loss of her baby. This could have resulted in a referral to mental health services as well as to adult social care.

7.64 The incident of self-insertion of a cannula was interpreted as attention seeking rather than self-harming; alongside incidents involving the wearing of medical foot brace and of a nurse uniform, and the alleged theft of medical supplies whilst on a hospital ward, indicates an issue that warranted thorough exploration but didn't appear to result in a safeguarding or mental health referral.

7.65 It does not appear that any significant formal safeguarding and/or risk assessments were undertaken in relation to Ms A once she became an adult. The professional network appeared to be "stuck" within an eligibility and threshold approach to accessing specialist services as she was an independent adult. Insufficient consideration was given to Ms A's behaviours and presentation over longer periods of time. Instead, snapshots of fixed points in time influenced assessment outcomes. There was no triangulation of significant events that happened or where Ms A was engaging with different agencies on the same day, something on which network meetings might have focused. In terms of drawing on expertise, it is noteworthy that legal services were not consulted with regard to concerns about Ms A. There appeared to be difficulty accessing consistent consultation with clinical services for advice and guidance. *Observation: this review has already recommended review of the thresholds under the Care Act 2014 for section 42 inquiries and section 9 assessments.*

7.66 There were however times when Ms A did engage, for example with drug and alcohol service staff and with young people's advisers. Internal agency meetings provided a space in which safeguarding concerns and risks could be reviewed. *Question: would this now transfer into a multi-agency forum?* Some staff accompanied Ms A to assessments, for example mental health, and encouraged her to self-refer to women's aid. On reflection, some staff felt that they could have explored the issue of domestic violence more assertively and might have made an earlier referral to MARAC.

7.67 Some practitioners who knew Ms A felt relatively confident in expressing concerned curiosity and exploring sensitive subjects and behaviour issues. However, practice in this area does not appear to have been consistent and YPA's reported the need for additional training and support. Participants at the first learning event concluded that there was insufficient focus with Ms A on self-neglect (the state of her property and her lack of self-care), and on the impact on her of life events. Practitioners might not have felt sufficiently skilled in exploring suicidal ideation. For example, shortly before she died Ms A told housing staff she wanted to settle her rent account and that she would be 'leaving soon'. A housing officer who had knowledge of the concerned curiosity questioning approach may possibly have asked 'okay, what do you mean by leaving soon? ' Was an opportunity missed to pick up on her mental state?

7.68 Recommendation: additional training in the areas of assertive outreach, concerned curiosity questioning and authoritative challenge would be most useful for all frontline staff.

7.69 Knowing what to be concerned about requires agencies and practitioners to have a clear line of sight on a person's history. Evidence suggests that Ms A's history was shared, in detail with some agencies, more summarised with others. Some information was not transferred at all, or in a timely manner, such as when Ms A moved between GP practices. Not all documentation held in individual agencies, however, records the complexity arising from her background, which lends substance to the conclusion reached in some reflective conversations that there could have been a more robust multi-agency approach and that the quality of shared information might have been enhanced with more detail and analysis of events. This, however, requires the space to think and reflect, which has been noted in other SCRs as often difficult to obtain (Carmi and Ibbetson, 2015), but is so important when the behaviours referred to in information-sharing are so bizarre as to be almost overwhelming. However, knowledge of case complexity in other agencies, such as Housing, led to intensive service provision, weekly supervision and supportive practice, whilst the detail behind her engagement with drug and alcohol workers was routinely shared. *Question: is space available for practitioners and managers to reflect on complex cases?* Concerns have also been expressed that routine sharing of information declined once Ms A reached adulthood, which coincided with her living more independently. *Observation: this concern may be evidence of a broader systems issue, which is why the review has recommended review of practitioners' and managers' understanding of when information may be shared relating to an adult at risk.*

7.70 Information-sharing is germane to how well Ms A's needs and vulnerabilities were recognised, included in assessment and support plans, and communicated between agencies. The support that Ms A received, for example when in school and when engaged with drug and alcohol services, was a result of recognition of her vulnerabilities. However, the appreciation of service gaps also emerges. In the view of the YPA's the transition period from 16 to 18 was not as well structured as it could have been and could have benefited from a wider range of care leaver services with a particular emphasis on "drop in" type provision. Equally challenging, perhaps, was balancing a person-centred approach with one that responded to her vulnerabilities and complexities by setting clear and firm boundaries. This requires very skilled practice and, throughout, her needs and vulnerabilities were such that she did not consistently engage with services. Also challenging appears to have been maintaining strong, co-ordinated inter-agency work once Ms A was 18, when the issue of thresholds may have emerged more strongly and communication between agencies became less systematic. *Observation: this is a systemic issue that is being addressed through the innovation work in Havering on transitions for young people leaving care.*

7.71 What lessons, then, for the future can agencies learn from how they worked together in this case, especially regarding complex case procedures, understanding and managing the causes of hard to reach behaviour, and coming together to hypothesise about what might be happening in a case and devising and following through action plans? In addition, what would Ms A want practitioners and managers to learn about how to work with young people and young adults who are hard to engage?

7.72 One key message is that relevant information must be shared with appropriate agencies and that this might be facilitated in complex cases where there is a lead agency/professional responsible for case co-ordination. In very complex cases, where it is difficult to secure agency involvement and the level of risk is high, the involvement of senior managers may be helpful. *Observation: a recommendation to this effect appears earlier.* A second is that complex case criteria and procedures must be widely understood by partner agencies, with agency involvement not restricted by narrow eligibility and threshold concerns.

7.73 In this case, it may also have been helpful to have had more consultation and advice opportunities with mental health professionals who specialise in working with attachment disorders. Professional network meetings may have benefited from a more reflective approach supported by such clinical input. Given her known behaviour patterns, such meetings could also have devised and kept under continuous review action planning that sought to address Ms A's challenging behaviour and boundary pushing. *Observation: the review has already recommended the accessibility of specialist mental health and legal expertise to practitioners and managers. When Community MARAC, high risk panels, and other network meetings convene, work is more likely to be effective if underpinned by a co-ordinated risk management plan.*

7.74 Finally, professionals across the entire network might benefit from effective training on working with young adults with complex presentations and who may be hard to engage. This should include the provisions of practical techniques to engage and build productive relationships with children and young people.

7.75 Those who knew Ms A also offered useful suggestions for future practice which they believed she would point us towards. These were:

- Professionals should be supported and trained on how to engage with young people that are disengaged with education and other services, and who have behavioural and emotional needs;
- Practitioners should be persistent in their efforts to engage, should not close a case when someone does not respond to offered appointments, and might offer options about venues for meetings outside of clinic and office settings;
- Be mindful of the importance of effective therapeutic alliances and that they should be prioritised above specific organisational processes;
- Reframe "failure to engage" as "practitioners have not found the right way to engage";
- Ask concerned caring questions and use your senses to indicate what young people may be neglecting;
- Discuss a young person's support needs in advance of them leaving care, think about what type of housing might be right, and identify what things are not in place so that young people are not left alone to deal with managing their own homes;
- Recognise that young people might require a seamless service which responds to their immediate needs whilst working to a clear plan owned by the whole professional network and the individual themselves;

- Regular crisis presentation may indicate that a young person is also inviting more control and directive input to be applied in relation to work with them.

7.76 Current strategic development work in Havering is focused on achieving this.

8.0 Additional observations from analysis of the chronology

8.1 An integrated chronology covering the period that Ms A approached adulthood and continued until she died was compiled to inform the review. This chronology covers the terms of reference for the review and indicates what the agencies involved at the time knew. Reading the integrated chronology raises a number of questions for partner agencies, which the following sections here outline.

8.2 The Safeguarding Adults Team appears simply to have referred on information it received about Ms A. *Question: subsequent to the introduction of section 42, Care Act 2014, duty to enquire, with multiple referrals, what would now trigger this duty and why was it not triggered then?*

8.3 When the Metropolitan Police Service and the London Ambulance Service sent notifications to the Safeguarding Adults team, *what did they expect would happen next*? Feedback on referrals helps to inform the multi-agency system going forward with complex cases.

8.4 Ms A was often the subject of call-outs by the London Ambulance Service. There was a repeating pattern of falls, suspected drug overdoses, left-sided pain, assaults and possible injuries to her left hand/leg. There were at least ten admissions to hospital from November 2012 to December 2015. Ms A was also regularly involved with the Metropolitan Police Service, again with a similar repeating pattern. Similarly, Ms A was a repeat attender at Emergency Departments, with the same pattern of concerns/injuries. *It is arguable that insufficient focus was given to this repeating pattern and an action plan was not put in place to attempt to tackle it*. *The multi-agency network did not have a shared hypothesis about the meaning of this repeating pattern*.

8.5 The integrated chronology demonstrates that information was shared, so partnership working is evident. *However, did healthcare practitioners come to a view and develop an action plan based on her presentations? Was there an agreed view on whether or not she had diabetes, on what was and was not fabricated illness*?

8.6 There was the possibility across a number of months that Ms A might be prosecuted for procuring an abortion. She had support from the bereavement team, specialist midwife and chaplain services after the miscarriage. *How effective was the support that was offered to her after the miscarriage and what were the outcomes*?

8.7 Housing and CYPS staff attempt to engage adult mental health services. *What was the rationale that Ms A was not eligible for mental health interventions*? When a young person has mental health and care and support needs, demonstrates lack of self-care, and

expresses suicidal and self-harm ideas, *were sufficient and diverse attempts made to engage with Ms A*?

8.8 Community MARAC did not discuss Ms A's case after August 2015. Given the on-going risk, this decision is questionable in the absence of routine multi-agency discussions and effective work underpinned by an action plan designed to mitigate the risks.

9.0 Wider available learning

9.1 There is no national repository of SARs which makes it difficult to learn from their findings and recommendations, although some regions are beginning to develop repositories for SARs conducted in their localities. Research into SARs where young people's self-neglect, suicidal ideation or transition has featured has identified some useful available learning. One (West Berkshire SAB, 2014) noted that young people who are assertive are less likely to be seen as vulnerable, even when there are known risk factors. Consequently, crises may be missed. Amongst this SAR's recommendations are three that are pertinent to this review. The SAR recommends that professionals should be inquisitive about a young person's experience of their living circumstances; that assessment should focus not just on the young person but on interdependencies and co-dependency needs of those relating to those with whom they are living or connected with; and that young people should be engaged in developing self-protection strategies when living in chaotic or unstable situations. *Observation: these recommendations are relevant when reviewing work undertaken or attempted with Ms A.*

9.2 Another (Sunderland SAB, 2014) centred on a young person whose history included sexual abuse and neglect. The review found a lack of knowledge and clarity about adult safeguarding processes, including a failure to consider historical information in depth and to use this to complete a comprehensive analysis of the on-going, unfolding situation amongst adult services. Indicators of concern were not prioritised and records did not show what information had been shared or the rationale for decisions. It was unclear who was responsible for specific actions and by when tasks were to have been completed. There was insufficient use of professional challenge and a lack of clarity about mental capacity assessments and best interests decision-making. The young person had not benefited from a transition process as the case was closed to children's services, and information was limited on their views, circumstances and needs. The review recommends consideration of a lifespan service, clear protocols for use when young people disclose suicidal ideation, and training regarding the Mental Capacity Act 2005. Pertinent for this SAR are the recommendations:

- Review the commissioning of children's mental health and adult mental health services and the interface between them;
- Embed transition in SAB procedures through a multi-agency procedure that follows young people at risk into adulthood;

- Establish a transition management group to ensure discussion of vulnerable young people and the completion of holistic assessments and plans across education, health and social care needs.

Observation: changes have been noted in this review regarding the organisation of mental health provision and the interface between children's mental health services and adult mental health services. Also noted has been the proposed development of a multi-agency approach to transition, involving adult social care. Recommendations in this review are designed to support strategically and operationally this direction of travel.

9.3 Within the adult safeguarding literature, there is some guidance relating to people who are hard to engage. Brown (2011) observes that a person's history and experience of disappointment and abuse might result in their being fearful, negative and/or uncertain about engaging with services. They might lack internal coherence or stability, and act on the basis of memories. They might be restricted in the options they perceive for themselves, unable to escape patterns of behaviour. Consequently, emotion and past experience will be significant in their decision-making, and their engagement will be characterised by ambivalence – fragmented self-seeking (neediness) but pushing support away (fearfulness).

9.4 There are clear parallels within the children's safeguarding literature. For example, both Rose and Barnes (2008) and Brandon et al (2008) highlight the importance of attending to the emotional impact of working with people who are resistant or hostile to engagement. When practitioners are left unsupported there is a danger that refuge is taken in eligibility criteria and of missed opportunities to take safeguarding action. Sheehan (2016) and Brandon et al (2008) conclude that young people affected by the legacies of abuse and neglect will be vulnerable to self-harm, exploitation, anti-social behaviour and suicide. In particular Brandon et al (2008) note the following:

- The risk of suicide when young people after a long history of high-level involvement, and with a childhood of rejection, loss and maltreatment, experience help slipping to lower levels of intervention once they turn 18;
- The importance of having clear transition from children's services to adult services, with provision being responsive with tailored services that seek to address the root causes rather than just the symptoms of distress;
- The importance of effective supervision to help staff to think critically, understand cases holistically, complete analytical assessments, and weigh up risk and protective factors.

9.5 SCRs commissioned by Local Safeguarding Children Board are more readily available. For the purposes of this review, individual SCRs, reviews of reviews, and thematic inquiries have been accessed. In one SCR (Cumbria LSCB, 2013) agencies failed to recognise the full extent of a young woman's difficulties and to take protective action. It concluded that practitioners had difficulty recognising and responding to the young person's vulnerabilities and distinguishing between risky self-harming behaviour and life-threatening suicidal ideation and planning. A fuller appreciation of her inner world and a greater appreciation of the impact of sexual abuse on her emotional well-being would have informed assessment.

However, practitioners appeared ill-equipped for this complex work and experienced difficulty also in balancing a duty of care with the right of young people to be self-determining.

9.6 In one thematic review of SCRs involving young people aged over 14, OFSTED (2011) found that agencies tended to focus on young people's challenging behaviour, seeing them as hard to reach and/or rebellious, rather than trying to understand the causes of the behaviour and to meet their need for sustained support. A co-ordinated approach to young people's needs was often lacking, including the challenge of the application of thresholds, although individual agencies worked hard. This review noted the complexity and range of risk factors facing young people, including alienation from family, education difficulties and accommodation instability, abuse by adults and misuse of drugs/alcohol, and emotional or mental health difficulties. Too often the response by agencies included lack of persistence, inadequate needs assessment and care planning, lack of assertive approach to formulating plans to safeguard, insufficient consideration of statutory powers to provide protection, and failure to assess the individual's capacity to make informed choices.

9.7 A second thematic review of SCRs (Vincent and Petch, 2012) contains similar useful material about cases involving young people. Key messages include the following:

- Seek to understand the causes of hard to reach behaviour;
- Parental lifestyles can play a part in young people's risk-taking behaviour;
- Young people are treated as adults and not children due to confusion about their age and legal status;
- Professionals lack confidence in challenging young people and their parents;
- Consideration should be given to use of statutory powers (Children Act 1989 and Mental Capacity Act 2005 is relevant for young people aged between 16 and 18);
- A good working knowledge of adolescent development and risk is needed, including mental health (we know, for example, that depression can cause increased social withdrawal and self-neglect in adolescence);
- A coordinated and assertive approach towards young people is often lacking; a failure to work collaboratively;
- A reflective, questioning practice culture is necessary;
- Adolescent mental health services are often criticised for failing to meet young people's mental health needs;
- Decision-making should include risk assessments.

9.8 There have also been thematic learning reviews (Somerset Safeguarding Children Board and Safeguarding Adults Board, 2014) and inquiries (IRISS, 2013) into suicide of young adults. Their findings provide a benchmark that prompts questions, here in italics, for local services to answer.

Young people's adverse background and continuing stress increases risk	*To what degree did practitioners acknowledge this with Ms A and try to work through it?*
Pull of birth family, unresolved emotions, fear, sadness, hope, anger, excitement	*Before and during transition, were attempts made to explore with and help Ms A make sense of her own history?*
Each person's motivation will be different	*How well did local services know Ms A?*
Services must respond to the underlying distress	*How focused were practitioners on this distress? How responsive were services?*
Behaviour, such as self-harm (and fabricated illness) can be a search for relief from intense feelings and/or for control when they have not previously been able to exercise control over their lives and bodies	*How was Ms A's behaviour understood? How were Ms A's different ways of presenting and engaging understood and was this recognition acknowledged with her?*
Mental distress increases as young people approach leaving care	*Was this appreciated? The move towards independence can involve loss of connectedness.*
With complex needs young people can be left poorly supported in accommodation, with those with the greatest number of life changes having the poorest outcomes	*Were there safety nets? Who was attempting to work on developing Ms A's resilience to succeed? How good was transition planning and post-transition work then? Now?*
Assessment is essential and should focus on any protective factors and needs as well as current levels of risk	*How thorough and co-ordinated were assessments? How routinely were they reviewed? How well did the team around Ms A collaborate?*
Young people have a constellation of needs that require collaborative, flexible and responsive services which recognise and meet their needs	*When IRO involvement ceases, who holds the agencies together and to account? Do thresholds miss this constellation of needs by focusing on eligibility rather than overall vulnerability?*
Mental health services should help staff around the young person understand and manage their behaviour	*Was this available to practitioners and managers working with Ms A? Did those involved know what support to provide?*
Be alert to suicidal thinking and planning; vulnerability is not always taken seriously	*To what degree was this held in mind?*
Multi-agency policies, guidance and recording are essential	*Were these available and used?*
Work should balance support with protection	*How was this balance thought through with Ms A?*
Care-giving has been frightening and therefore engagement may be avoidant or controlling, despite their need for stable and consistent relationships	*Was intervention superficial or persistent and resilient? Did it attempt to help Ms A build healthy, safe relationships? Being with, building supports, appraising risk, monitoring and communicating with others are all important.*
Supervision in such complex cases is essential; training is helpful too in building staff expertise and resourcefulness	*What was the quality of the supervision available? Was there sufficient expertise available?*
The impact of the work on staff needs consideration	*What emotional containment was available for those working with Ms A?*

9.9 Finally, analyses of social policy towards young people leaving care and the associated legal rules (NCAS, 2013; National Audit Office, 2015) have argued that corporate parenting should not end when a young person reaches 18 and that they should have the statutory right to

support, to the assessment and meeting of their needs to 25. They note that young people can be catapulted into "instant adulthood" without support and necessary life skills, with poor preparation and inadequate planning, with the result that the period after leaving care can prove extremely problematic for many young people. Rather than support falling away, the reports emphasise the importance of secure attachments, paced transition and involvement in preparation, and the value of specialist schemes. They recommend that adult social care should prioritise their needs for support. The Children and Families Act 2014 enacted staying put provision for young people in foster care. The Children and Social Work Bill 2016, if enacted, is expected to address the issue of corporate parenting, support to the age of 25, improved access to mental health support and prevention of homelessness, and may extend the staying put/close arrangements beyond foster care to residential care. *Question: How involved was Ms A in transition planning? Did she feel that she left care too early? How comprehensive was the personal support that was offered? Was there an attempt to meet her more deep-seated needs? Are young people routinely asked about their feelings and perspectives as they work through transition?*

9.10 Research on effective work with adults who self-neglect (Braye et al., 2014) uncovered two approaches with respect to practice with complex cases which the Havering SAB might wish to consider. The first, developed particularly in Sheffield, is an "adult at risk management system." This SAB endorsed policy enables an agency, concerned about the risks involved in a case and about multi-agency working, to request a case conference, the purpose of which is to share information and to construct an action plan. Subsequent network meetings monitor progress with respect to the action plan and continue until multi-agency working is secure and the risks have been mitigated.

9.11 The second approach is the availability of scheduled case discussions, where any practitioner or manager, concerned about a complex case, can present that case to senior staff with particular expertise, for example in law, fire risk, mental capacity and mental health.

9.12 This section has summarised wider learning that is available, from which various recommendations for policy and practice emerge for consideration, namely:

9.12.1 Developing staff skills and confidence to express concerned curiosity, to inquire into young people's lived experiences, to recognise and explore the impact of past experience on current engagement, and to assess the impact on on-going actual or hoped-for contact with family members.

9.12.2 Using knowledge of case history to inform risk assessment and to work with young people to develop self-protection strategies.

9.12.3 Supporting frontline staff to manage the emotional impact of the work through debriefing after critical incidents, peer support and supervision.

9.12.4 Developing a protocol for the management of suicidal ideation and risk.

9.12.5 Reviewing guidance, including available legal options, with respect to the tension between self-determination and a duty of care in relation to young people and young adults who appear to have capacity to make particular decisions.

9.12.6 Embedding transition in SAB procedures to ensure that a multi-agency approach, including communication and co-operation between children's social care and adult social care, and children's mental health services and adult mental health services, underpins work with young people at risk as they move into adulthood.

10.0 Looking forward in Havering

10.1 The experiences and outcomes for care leavers in Havering have been broadly reflective of national trends. Havering's adolescents in care and care leavers have disproportionately poor mental health, exhibit offending behaviour, and have higher levels of not being in education, employment, or training. This group also experiences high rates of placement disruption, changes of social workers, and a multitude of professionals coming in and out of their lives. The lived experiences of these young people are often shaped by disrupted relationships, isolation, and a distrust of professionals. A particular concern is the perception of a "cliff edge" that care leavers face. The transition to adulthood sees many young people fall between the cracks due to ineligibility and barriers to accessing services.

10.2 The ambition of Children's Services is to work with the multi-agency partnership to produce a significant change in the outcomes for care leavers, by developing more purposeful practice and effective interventions across the wider system of care. A successful transition to adulthood begins as soon as a young person comes into care. Services are in the process of exploring a new form of delivering for looked-after children and care leavers aged 11-24 years. Training in systemic practice and motivational interviewing will also support a multi-disciplinary team to deliver person-centred practice, enabling young people to co-produce their care and build consistent relationships at every step of their journey. This approach will inform every interaction a child or young adult in care experiences and will be extended to the role of foster carers. Carers will be involved before, after, as well as during care episodes, providing consistent and lasting relationships with young people. Through re-shaping partnerships across the Council, statutory sector, and third sector, the pathway will form an innovative passported-network, removing barriers and allowing improved access to services. By moving away from the traditional approach of provision based on eligibility or threshold, the pathway will allow young people access to support at the time when this is most likely to add value. The intention is that this pathway will provide a more engaged and empowered group of looked-after children and care leavers, who are more equipped to cope with the transition to adulthood.

Recommendation: Both the Havering LSCB and Havering SAB will need to keep service development under close review.

Recommendation: the findings of this review are used as the basis for a review of learning and service development after one year to address what has changed in the provision of

services for young people with complex needs and what remains to be done. An audit of similar complex cases would enable dissemination of good practice.

10.3 Staff attending the second learning event recognised that changes were needed in organisational systems with respect to children, young people and young adults presenting with complex needs. This included developing or reviewing protocols that set clear expectations for joint working, for example between children's services and adult services, and for escalation and challenge within and between agencies. It embraced introducing greater flexibility into thresholds and eligibility criteria when working with complex cases, and considering whether there is a commissioning gap with respect to young people and young adults who have longstanding and complex vulnerabilities and care and support needs, to provide them with on-going, person-centred contact. They reiterated the importance of building resilience in foster care provision, in an attempt to reduce placement breakdowns, and of investing in transition services. Once again it was recognised that people's behaviour needs to be understood rather than agencies simply reacting to behaviour.

10.4 Staff attending the second learning event believed that the change process had begun, partly as a result of Ms A's case. Although recognising that young people had not always been listened to, efforts were being taken to make the system more person-centred, such as in the allocation of housing accommodation when leaving care, strengthening linkages between child and adolescent and adult mental health services, or attendance of frontline staff at Community MARAC meetings. Ms A's case and this review have acted to the impetus for change.

11.0 Examples of good practice

11.1 Examples of good practice were identified through the reflective conversations, learning events and SAR panel discussions.

11.2 All partners were aware of the difficulties in gaining meaningful engagement from Ms A. Some agencies and individual practitioners persevered and met with reasonable, though not always positive success. Engagement with Ms A by YPAs and staff from the drug and alcohol service in particular offered continuity, advocacy and support. Frontline workers showed compassion, concern and persistence in working with Ms A, "going the extra mile" and offering the service asked for even when this lay outside their eligibility criteria.

11.3 Welfare visits were undertaken by police officers and housing staff in an attempt to engage and protect Ms A.

11.4 CYPS offered services, such as supported lodgings, in an effort to engage and protect Ms A.

11.5 Community MARAC took an active interest in the case, with individual agencies taking forward and then reporting back on agreed action points.

11.6 There was some good sharing of information and joint working, for example between leaving care, housing and drug and alcohol service practitioners.

12.0 Conclusions

12.1 All agencies have engaged positively in this review through the SAR panel, reflective conversations and learning events. The SAR process has been managed effectively.

12.2 Strategic development work on transition and broader provision for looked-after children and young people in Havering is well underway. There is a clear intention amongst senior managers across the agencies that learning from the review will inform that development work.

12.3 This was a challenging case and the emotional impact of the work and of the case outcome is understandably still being felt. The involvement by those staff who worked closely with Ms A was essential to the learning available from this review and without exception their engagement has been open, positive, constructive and reflective. However, their experience of this case also reminds everyone of the importance of managing anxiety, frustration, fear and helplessness in the face of rejection of the relationship and support they are offering. Professionals do not always have answers and they too must be "looked after."

12.4 The ambition is that services for young people and young adults at risk in Havering should be person-centred, with the multi-agency network sufficiently flexible, responsive and co-ordinated to safeguard and promote their wellbeing. It will be important to review operationally how the strategic development work is implemented and experienced by those involved so that, where necessary, further refinements can be made.

13.0 Recommendations

13.1 The reflective conversation template enabled practitioners and managers to offer recommendations based on their experience of working with Ms A. Themes have been extracted from these recommendations, as follows. The review advises that the members of the Havering Safeguarding Adults Board and Local Safeguarding Children Board consider how best to take these recommendations forward.

13.1.1 *Training*

- In working with hard to reach young people, disengaged pupils, and young people with attachment issues and with behavioural and emotional needs.
- In mental capacity with respect to young people aged between 16 and 18.
- Carer training to improve placement options for young people.
- In systemic practice and motivational interviewing to support multi-agency, multi-disciplinary team working to deliver person-centred practice, enabling young people to co-produce their care and build consistent relationships.

13.1.2 *Support*

- Strengthened carer support to maximise placement stability.
- Formal structures for multi-agency risk sharing in complex cases.
- Availability of consultation and sharing of expertise in relation to young people with complex needs and specific “disorders”.
- Recognition from managers that complex cases are challenging and time consuming.

13.1.3 *Involvement*

- Young people’s views on their educational experience should always be taken into consideration.

13.1.4 *Records*

- PEP documentation should outline a young person’s needs both in and out of the classroom to ensure appropriate support and interventions are in place. Documentation should be thorough and quality assured to ensure relevant information is recorded and shared between education and children’s social care via the young person’s social worker.

13.1.5 *Transition*

- Each agency should have a care leaver’s champion.
- Housing services should consider the type of property offered to care leavers to ensure it represents a good opportunity for care leavers to settle into independent living (this requires comprehensive information-sharing, for example about suicidal risk).
- Each young person leaving care, especially those with complex needs, should have a profession-led overarching care and support plan.
- Mandatory multi-agency planning meeting regarding every transition, with mental health input, a multi-agency plan with integral risk management and frequent review time frames.
- Expand staying put options.
- Service redesign and reshaping to promote purposeful practice and effective interventions, with carers providing consistent and lasting relationships with young people and access to required services on the basis of need.

13.1.6 *Thresholds*

- Consider how agencies respond to young people with complex needs where they do not appear to meet thresholds.
- An approach which enables agencies and services to work jointly and flexibly with young people who do not necessarily meet traditional thresholds and eligibility criteria, and

who present as challenging for staff and multi-agency systems but also remain vulnerable and at risk in the community.

- A clearer process for repeat Merlin's, referrals that come into the Safeguarding Team so that there is clarity about the point at which an assessment (either section 42 or section 9, Care Act 2014) is triggered.

13.1.7 Non-engagement

- Agencies to review case closure procedures (to ensure someone stays in touch and a young person does not become someone "nobody owns").
- Consider ways in which agencies respond when young people do not respond to letters or attend scheduled appointments. Consider home visits and not insist on appointments in professional venues such as clinics.
- Provide procedures, training and advice through panels on how to approach vulnerability and risk in the context of non-engagement, safeguarding adults and mental capacity.

13.1.8 *Mental health*

- CAMHS assessment should follow people leaving care.
- A co-ordinated multi-agency response for working with personality disorder and people with complex needs.

13.1.9 *Mental capacity*

- Embedding of capacity-related questions in all screening and assessment tools for young people.

13.1.10 *Complex cases*

- All agencies to maintain and review an effective and shared complex case procedure, including how to escalate concerns (overseen by the Havering LSCB and SAB jointly).
- A joint approach and pathway for complex cases involving young people at risk that does not focus on eligibility.
- Robust inter-agency communication when there are safeguarding concerns.

13.1.11 *Assessment*

- Regularly updated risk assessment to reflect the nature and severity of the situation.

13.1.12 *Information-sharing and communication*

- Robust interagency communication regarding safeguarding concerns.

- Information-sharing should be pulled together into action plans, the implementation of which is then closely monitored.

13.2 Recommendations in the body of the review are listed again here. The review advises that the SAB and the LSCB should consider which partner agencies should lead on taking each recommendation forward, constructing an action plan that can then be regularly monitored to capture progress on implementation.

13.2.1 As part of the transformation of children's services in Havering, a review is considered of how children and young people with complex needs, and their carers, are supported in order to prevent where possible placement disruptions.

13.2.2 Alongside steps to further integrate adolescent and adult mental health provision, audits are considered to identify good practice in co-ordinating mental health support for young people at risk.

13.2.3 Since it is important that practitioners and managers are confident in their legal knowledge, training provision should be reviewed in relation to the law relating to young people and young adults, specifically mental health, mental capacity, leaving care and transition, and information-sharing.

13.2.4 Arrangements for managing complex cases concerning young people and young adults could be reviewed to ensure that active consideration is routinely given to situations where services are struggling to meet an individual's needs.

13.2.5 Information-sharing in complex cases involving young people and young adults could be the focus of an audit.

13.2.6 The transfer of medical records between GPs should be reviewed.

13.2.7 With the implementation of the Care Act 2014, a review could be considered of the management of thresholds for a section 42 enquiry and a section 9 care and support assessment.

13.2.8 Training in relation to mental health, complex cases and legislation for all agencies involved with young people where risks are significant.

13.2.9 Mental health professionals should be available to frontline staff and their supervisors for immediate and regular consultation in complex cases involving children, young people and young adults.

13.2.10 A review to ensure that an escalation procedure is available to senior management in order to facilitate future planning in complex cases with significant risks.

13.2.11 A lead agency to be appointed through the Community MARAC in complex cases, supported by an action plan setting out the roles and responsibilities of all the agencies involved.

13.2.12 CAMHS and Adult Mental Health Services to review their eligibility criteria and their responses to people who do not engage, and to report their conclusions in light of this case to the LSCB and SAB.

13.2.13 Community MARAC, formal case reviews and other network meetings involving high risk cases should have available legal advice and other forms of relevant specialist expertise. Decisions should clearly record the legal options that were considered.

13.2.14 Training on working with young adults who are difficult to engage and who have complex needs, to include content on mental capacity and adult safeguarding.

13.2.15 Complex cases involving young people with significant risks to their wellbeing should not be closed without a multi-agency professionals' meeting to consider how best to manage the risks involved.

13.2.16 The development of a protocol for transition planning with respect to young people with complex needs.

13.2.17 Staff should be offered training in motivational interviewing.

13.2.18 Additional training in the areas of assertive outreach, concerned curiosity questioning and authoritative challenge would be most useful for all frontline staff.

13.2.19 Senior managers involved in service planning and (joint) commissioning could explore what more can be provided to ensure person-centred planning in complex cases.

13.2.20 Supervision should routinely consider how to support frontline staff to maintain a person-centred approach in complex cases, where young people's engagement is ambivalent.

13.2.21 The LSCB and SAB should review the development of transition services and should use this case to audit how the new arrangements that are being put in place will respond to young people with complex needs.

13.2.22 Developing staff skills and confidence to express concerned curiosity, to inquire into young people's lived experiences, to recognise and explore the impact of past experience on current engagement, and to assess the impact on on-going actual or hoped-for contact with family members.

13.2.23 Using knowledge of case history to inform risk assessment and to work with young people to develop self-protection strategies.

13.2 24 Supporting frontline staff to manage the emotional impact of the work through debriefing after critical incidents, peer support and supervision.

13.2.25 Developing a protocol for the management of suicidal ideation and risk.

13.2 26 Reviewing guidance, including available legal options, with respect to the tension between self-determination and a duty of care in relation to young people and young adults who appear to have capacity to make particular decisions.

13.2.27 Embedding transition in SAB procedures to ensure that a multi-agency approach, including communication and co-operation between children's social care and adult social care, and children's mental health services and adult mental health services, underpins work with young people at risk as they move into adulthood.

13.2.28 The findings of this review are used as the basis for a learning and service development after one year to address what has changed in the provision of services for young people with complex needs and what remains to be done. An audit of similar complex cases would enable dissemination of good practice.

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15.0 List of abbreviations

CAMHS – Child and Adolescent Mental Health Services
CPR – Child Protection Register
CRT – Community Rehabilitation Team
CYPS – Children and Young People's Services
LAS – London Ambulance Service
MARAC – Multi-Agency Risk Assessment Conference
NPT – Neighbourhood Policing Team
PEP – Personal Education Plan
SAB – Safeguarding Adults Board
SAR – Safeguarding Adult Review
SAT – Safeguarding Adults Team
YPA – Young Person's Advisor