Safeguarding Adults Review

Joe

Commissioned by Central Bedfordshire and Bedford Borough Safeguarding Adult Board

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Lead Reviewer: Sarah Williams

Independent Safeguarding Consultant, Safeguarding Circle

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1. Introduction

1.1 In November 2023 Central Bedfordshire and Bedford Borough Safeguarding Adults Board [CBCCSAB] commissioned a safeguarding adults review into the death of Joe, who had just turned 18. Joe was a poly-substance user from the age of 14, and had repeatedly overdosed, requiring hospital treatment on at least 8 occasions from January 2022. He was known to Central Bedfordshire Children's Social Care [CBCSC] as a child in need, Child and Adolescent Mental Health Services and Aquarius for substance misuse, as well as to Bedfordshire Police due to incidents of domestic abuse towards his parents and intelligence reports around drug use and supply. His parents believed he had undiagnosed depression. They and Joe moved to Northampton to try and remove him from the local drug dealers who they had repeatedly reported to police and social services, at the end of October 2022, shortly after his 18th birthday, although Joe declined referrals to Northampton's adult services. On 15 January 2023, Joe died of pneumonia bought on by cocaine toxicity along with trace elements of 4 other drugs, police found drugs in his possession. A coroner's inquest is being timetabled.

1.2 Although Joe died in Northamptonshire and did not receive support from adult services in either Bedfordshire or Northamptonshire, CBCCSAB agreed that a discretionary safeguarding adults review should be undertaken, as Joe was in need of care and support, and there is reasonable cause for concern about how persons with relevant functions worked together to safeguard Joe, in particular while a child in Central Bedfordshire's area.

2. Pen picture of Joe

2.1. Joe was a charming, cheeky boy, the youngest of three children, with two sisters who were significantly older than him. He was born in Lincolnshire, then the family moved to Italy until he was 4, where his grandmother and her partner lived next door. His speech was slightly delayed, as is common for bi-lingual children. On their return to the UK, the family moved to Central Bedfordshire, where they remained until shortly after Joe's 18th birthday. He attended a church school initially where his sense of humour ensured he was popular with other children and teachers but could be very sensitive to criticism. He enjoyed piano lessons, horse riding, tennis and motorcycle trial riding, he played rugby until he broke his collarbone although was not keen on team sports. His parents lovingly reported that he "*was a little bit spoiled*."

2.2. Joe fell out with his friends when he moved to middle school and developed severe acne which impacted his self-confidence, although he could be entrepreneurial doing dares for money from his peers. He really struggled with friends when he moved to upper school, and when Joe was 14, he met new friends who lived around the corner and asked his parents' permission to stay at his house. It later transpired that the boy's older brother had given them cannabis, and from this time Joe, who was always a bit of a homebody, started sneaking out to meet older friends and take drugs. This included getting caught with Xanax at school, although he was not excluded for this.

2.3. Joe passed his GCSEs in mid-2020, but because of the pandemic he decided to start a carpentry apprenticeship through Milton Keynes college rather than returning to school. After a trial period, he went on holiday with the family to Italy over the summer, before starting his apprenticeship on their return. However, he spent his wages on drugs and his parents found sheets totalling 350 tabs of LSD that he had ordered on social media from Holland with the intention of selling this. From January 2022, Joe's drug use rapidly escalated, and he was using constantly, then binging on top of this, taking any substances he could obtain including synthetic substances he purchased online, resulting in multiple hospital attendances. This was very high-risk drug use as even Joe did not know exactly what he was taking or its concentration and his parents did their best to disrupt this by intercepting packages, searching his room, and requiring Joe to take drug tests. They encouraged him to attend Narcotics Anonymous. In 2022 there

were also a series of incidents where he became abusive or violent to his parents or damaging property while under the influence of drugs, resulting in the police being called or engaged in dangerous behaviour such as throwing himself down the stairs, out of a first floor window or attempting to jump from a moving car on the motorway. His parents raised concerns that he may be suicidal, as they had found a knife and razor blades in his possession.

2.4. Joe was referred for substance misuse support to Aquarius, a specialist substance misuse service for adolescents and offered support from CBCSC, including a Child and Family assessment and regular meetings with his allocated social worker, which included family meetings with the intention of improving Joe's communication and dynamics with his parents. His GP also met with Joe regularly. However, Joe's parents felt that he minimised his drug use and risk-taking behaviour, and felt frustrated that their very serious concerns were not given appropriate weight by professionals, who believed Joe over them. The parents received very good support from Path to Recovery's [P2R] Family and Friend's service, but P2R were not included in the team around the child or invited to meetings, despite the parents requesting this. Over the summer of 2022, CAMHS also provided talking therapy remotely, as Joe spent the holiday period in Italy with his family. During this period, he was abstinent from drugs and did not display any withdrawal symptoms.

2.5. On his return to the UK, Joe enrolled in Northampton college but there were further significant incidents in September 2022 when Joe assaulted his mother, was using drugs chaotically and going missing, resulting in a s47 safeguarding investigation and further Child and Family assessment. CAMHS also offered a one-off appointment but considered it inappropriate to triage him for a service so close to his 18th birthday. This was on the basis that Joe reported that he did not consider his substance use problematic or that he was addicted, but that he enjoyed and did not intend to stop using. CBCSC noted that there was no role for children's services as he was approaching his 18th birthday and the family planned to move to Northampton to try to get Joe away from negative influences so closed the case. Information was provided to the family about local services, but no referrals were made to Northampton services as Joe had said he did not want involvement from adult services. Joe's father had made contact with Northampton substance misuse services before they moved shortly before the end of October 2022, just after Joe's 18th birthday.

2.6. Practitioners described Joe as a lovely young man who was always very polite. They explained when he did attend appointments, he was engaged, reflective and articulate. They reported feeling very worried about Joe's substance use, both in terms of the type and amounts of substances he was taking, but felt at a loss about how to tackle this, given his very clear view that he liked taking drugs and had no intention of stopping. Practitioners described the desperation of Joe's parents to help him, the stress and distress this caused them and the impact of this on their own health, wellbeing and employment. Some felt that the parents were not being listened to, but at the same time, practitioners were unable to identify what other steps could have been taken to reduce the risk to him, having regard to the legal framework and local resources. Like many teenagers, Joe felt that he was invincible and tragically, he was wrong.

2.7. The author and CBBSAB wish to express their sincere condolences to Joe's family and friends for their loss. The love Joe's parents had for him and desolation they felt at his death permeated their discussions with the author. They felt profound frustration that agencies had not been able to provide the support Joe needed to prevent his death and felt that they had not been listened to when they were very clear to professionals that Joe's life was in danger. A poignant description from one practitioner was that "*Joe's parents were mourning his loss before he died."*

3. Scope of Review

Purpose of a Safeguarding Adult Review

3.1. The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures (both multi-agency and those of individual organisations).
- To inform and improve local interagency practice.
- To improve practice by acting on learning (developing best practice).
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies to make recommendations for future action.

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

Themes

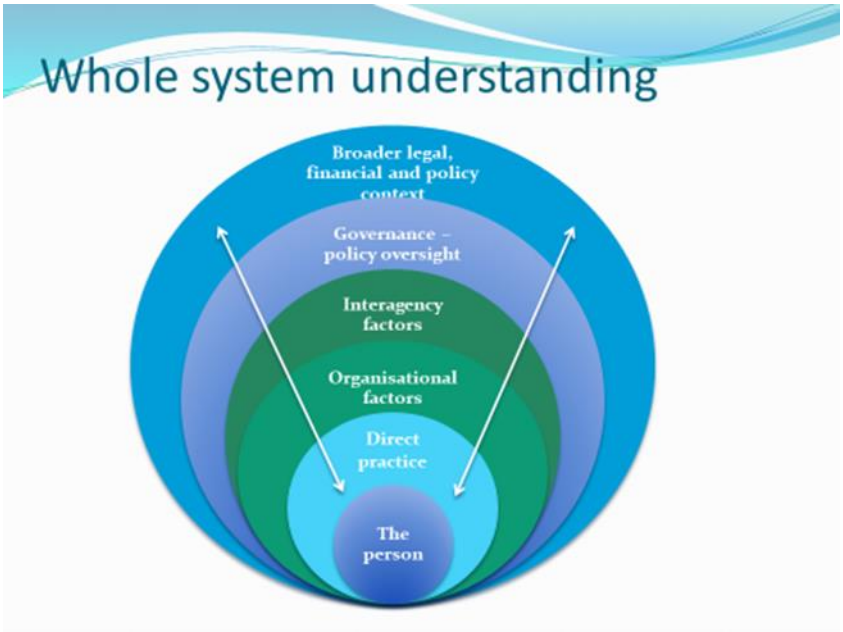
3.3. The CBBBSAB prioritised the following themes for illumination through the SAR:

1. How well do practitioners from across the health, mental health, social care and criminal justice agencies respond to the needs of young people who are experiencing harm as a consequence of high-risk substance use and self-harm?
2. How effective was the multi-agency system in recognising and then responding during this period to prevent an escalation of Joe's substance use? Is substance misuse provision in Bedfordshire adequate to meet need?
3. What were the barriers and enablers to risk reduction of grooming and criminal exploitation to mitigate the impact of contextual harm? What disruption activity took place? What disruption tools are available in respect of on-line/social media drug dealing and how are these applied locally?
4. How were the family supported as victims of domestic abuse? How are MARAC and other multi-agency processes used to disrupt abuse by a child towards their parents?
5. In light of Joe's age, how did agencies apply the principles of the Mental Capacity Act 2005 and balance these against their duties to him as a child and his parents' exercise of their parental responsibility?
    a. Was adultification a feature in the agency response?
    b. How effective was transition planning for adulthood, in the context of Transitional Safeguarding?

3.4. The review will cover the period from January 2022- January 2023.

Methodology

3.5. The case has been analysed using a learning together approach, through the lens of evidence-based learning from research and the findings of other published SARs.[1] Learning from good practice and a discussion of the legal framework have also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram below.[2] Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



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

3.7. The learning produced through a SAR concerns 'systems findings', by reviewing the underlying issues that helped or hindered in the case the report seeks to identify systemic rather than one-off issues. Systems findings identify social and organisational factors that make it harder or easier for practitioners to proactively safeguard, within and between agencies.

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

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

Contributing agencies

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

- Central Bedfordshire Council (CBC) Adult Safeguarding Team and Children's Social Care
- Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK), previously the Luton and Bedford Borough Clinical Commissioning Group
- Bedfordshire Police
- East London Foundation Trust (ELFT), including Child and Adolescent Mental Health Services (CAMHS)
- Milton Keynes College
- Luton Borough Council
- Northamptonshire police
- East Midlands Ambulance Service
- Milton Keynes Hospital
- GP surgery
- Aquarius
- Path to Recovery

Involvement of Joe's family

3.9. Joe's parents contacted CBBBSAB to raise their concerns in respect of the organisational response to Joe's needs while living in Central Bedfordshire. After CBBBSAB decided to commission a discretionary SAR, they met twice with the independent reviewer (online and in person), to share their loving memories of Joe, as well as their experiences and concerns in respect of the agencies involved in supporting him.

4. The legal and practice framework: mental capacity and the Children Act 1989

4.1. The term 'Transitional Safeguarding' describes the need for an approach to safeguarding adolescents and young adults fluidly across developmental stages[3], despite the differences between the legal frameworks for children and adults. The Chief Social Worker and Research in Practice's Transitional Safeguarding briefing[4] highlights the important contribution made by adult social work within transitional safeguarding, pointing specifically to the expectation within the Care and Support guidance, which accompanied the Care Act 2014, of adopting a human rights-based, person centred approach. All public bodies must exercise their legal powers in an ethical way that complies with duties under the Human Rights Act 1998, Mental Capacity Act 2005 [MCA] and Equality Act 2010. Personal freedoms must be weighed against duties placed on public bodies to protect lives and mitigate risks to vulnerable young people. While Article 2 of the European Convention on Human Rights [ECHR] places a duty on public bodies to prevent avoidable deaths, this must be balanced against the right to freedom from inhumane treatment (Article 3), the right to liberty (Article 5) and respect for your private and family life (Article 8).

4.2. Although the Children Act 1989 [the 1989 Act] defines anyone under the age of 18 as a 'child', the MCA and associated Code of Practice distinguishes a 'child' as being under the age of 16, and a 16 or 17 year old is defined as a 'young person'. The MCA sets out the right of a competent

[3] Holmes and Smale (2018) Mind the Gap:
[4] Bridging the gap: Transitional Safeguarding and the role of social work with adults (publishing.service.gov.uk).

person over the age of 16 to take decisions. There can be a significant tension between the principle under section 1 of the MCA, that the fact a decision may be unwise does not mean that the young person lacks the capacity to take that decision, and the safeguarding duty on a local authority and partners under section 47 of the 1989 Act. This places a duty on the local authority to make enquiries if they believe that a child under the age of 18 may be at risk of significant harm, including physical harm, and to take decision about whether any action should be taken to safeguard and promote the child's welfare.

4.3. This is further complicated by parental responsibility, which is defined under s3 of the 1989 Act as "…*all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child*…" and applies to any child under the age of 18. [5] This includes a duty to ensure that the child's basic care needs are met, including adequate nutrition and health care, and failure to do so may constitute neglect. Further, article 8 of the European Convention on Human Rights sets out "*Everyone has the right to respect for his private and family life, his home and his correspondence*"; and, as the courts have recognised,[6] the responsibility of parents to bring up their children as they see fit, within limits, is a fundamental part of respect for family life in the UK. There is a fundamental principle that the exercise of parental responsibility comes to an end, not when the child reaches a fixed age, but when they attain "Gillick capacity".[7] This means that they have sufficient understanding and intelligence to fully comprehend what is involved in the proposed decision, including the purpose, nature, likely effects, risks, chances of success and be able to weigh other options.

4.4. People with parental responsibility for a young person may only make decisions on behalf of that young person that are seen to sit within the scope of parental control, which is a legal concept describing which decisions a parent should be able to take concerning their child's welfare. Although this is not clearly explained under the 1989 Act or related guidance, the Mental Health Act 1983 Code of Practice[8] explicitly sets out that "*Parental consent should not be relied upon when the child is competent or the young person has capacity to make the particular decision*." [para. 19.39]. It further sets out that when determining whether an intervention can be undertaken on the basis of parental consent, the two key questions that must be addressed are "*First, is this a decision that a parent should reasonably be expected to make?*", having regard to the type and invasiveness of the proposed intervention, the age, maturity and understanding of the child or young person and the young person's views. "*Secondly are there any factors that might undermine the validity of parental consent?*" such as the parent's own mental capacity, whether they are able to focus on the child's best interests, conflict between the parents and the child, or two parents disagree about the proposed treatment. [para. 19.41] If either of these applies, it will not be appropriate to rely on parental consent and the proposed intervention must be lawfully authorised by other means. [para.19.42]. Although this specifically relates to application of the Mental Health Act 1983, these principles are helpful more generally when considering what actions a parent can reasonably expect or be expected to take in respect of safeguarding their child.

4.5. Life-saving medical treatment sits within the scope of parental responsibility. Every person 16 or older capable of making decisions has a right to accept or decline medical treatment,[9] and a parent cannot use their parental responsibility to refuse medical treatment recommended by a doctor that a 16-17 year old has consented to. However, the courts have held that no child under 18 has an absolute right to refuse treatment, in circumstances where that would probably lead

[5] Parental responsibility will be held by the mother, the father if he is married to the mother or named on the birth certificate, people granted PR through an order of the court, such as adopters, special guardians, child arrangements order, a parental responsibility agreement or order, or testamentary guardians.

[6] *Christian Institute v Lord Advocate* [2016] UKSC 51; 2017 SC (UKSC) 29, paras 71 to 74
[7] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112
[8] Mental Health Act 1983 (publishing.service.gov.uk)
[9] Section 8 Family Law Reform Act 1969

to their death or serious harm, and although due regard will be given to their wishes, the paramount consideration will be the welfare of the child.[10]

4.6. Outside of treatment under the Mental Health Act 1983 (MHA), the provision of care and treatment is only lawful if the person receiving the care/treatment has either given capacitated consent or, if the person lacks capacity, acts are done in accordance with the legal obligations under the MCA and ECHR. The Mental Capacity Act 2005 ['MCA'] and associated code of practice is predicated on an assumption of capacity (unless there is evidence to the contrary). Capacity must also be determined in an issue and time specific manner. Practitioners should not judge someone to be incapacitated because their decisions appear unwise and should make any necessary adjustments to assessment processes to enable a person to understand information pertinent to the issue. The MCA applies across private and public frameworks for the delivery of any care and treatment, it is intended to strengthen system wide rights-based approaches and protect against unnecessary interference in our autonomy.

4.7. The MCA sets out that a person 16 or older lacks capacity in relation to a matter if at the material time they are unable to make a decision for themself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. A person is unable to make a decision for themself if they are unable to understand, retain, and weigh the information relevant to that decision, or to communicate this. The fact that a person is only able to retain the information for a short period does not prevent them from being able to make the decision and capacity may fluctuate over time. There is a presumption of capacity unless otherwise evidenced and a person cannot be treated as lacking capacity, merely because someone else considers their decision to be unwise.

4.8. The executive function of the brain is a set of cognitive or understanding/processing skills that are needed to plan, order, construct and monitor information to set goals or tasks. Executive capacity is the ability to implement decisions taken, to deal with the consequences and to make adjustments to changing risks in the real world. The MCA Code of Practice (para 4.21) notes: "*For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. A person must accept the information and take it into account. A person may appear to be able to weigh facts while sitting in an interview setting but if they do not transfer those facts to real life situations in everyday life (executing the plan) they may lack mental capacity*."

4.9. Mental capacity assessments should therefore explore rather than simply accept notions of 'lifestyle choice'. This means applying understanding of executive capacity and how adverse childhood experiences, trauma and 'enmeshed' situations and conditions such as neurodiversity can affect decision making. The presumption of capacity under section 1 of the MCA does not override professional and statutory duties to ensure that young people or adults with care and support needs are safe from abuse, neglect or exploitation. "*There is a difference between someone who has an appreciation of risk and yet goes on to take the risk – albeit unwisely – and someone who… lacked awareness of the risk and sufficient problem-solving ability*." [11]

[10] Re X (a child) (No 2) An NHS Trust v X [2021] EWHC 65 (Fam)
[11] Baker J, *GW v A Local Authority* [2014] EWCOP20, para. 45

5. Analysis of Agencies' Actions

Balancing mental capacity, child safeguarding and working with families

5.1. The complex legal framework set out above, presenting different and at times opposing duties on statutory partners in terms of their response to Joe's needs, resulted in very significant challenges to reducing the risks to him. Practitioners described Joe as very mature and articulate, and when exploring his mental capacity, his GP commented that his executive function exceeded that of most adults. They report he would present as calm, very rational and thoughtful during regular appointments. Several practitioners commented that Joe's presentation could change in the presence of his parents, paradoxically behaving in a more childlike way, but finding being corrected or infantilised by them or other practitioners '*like a red rag to a bull'.* This was perceived to be the source of significant conflict within the family dynamic.

5.2. Consideration also needed to be given to whether Joe's substance misuse could have led to his mental capacity fluctuating, and clearly this was likely to be impacted during periods when he was heavily intoxicated. However, caselaw[12] has set out that the fact someone misusing substances may seriously overestimate their ability to keep their substance use under control is not enough to establish a lack of capacity. Further, the judge warned, not every addict in some degree of denial can be regarded as incapacitous; and the requirement to be able to understand the "reasonably foreseeable consequences" of a particular decision does not mean that the person must accept the professionals' view that they will not be able to control their substance use.

5.3. Although no formal mental capacity assessment was carried out in respect of Joe's ability to safely manage his substance use, there was no evidence to override the presumption of capacity. Joe may have been overconfident in his substance use, but all practitioners were clear that he understood the advice he was being given in respect of the dangers. He was explicit that he chose to disregard this because he wished to continue to use the drugs he enjoyed. However, this meant that the powers under the MCA were not available to the professionals involved, because it is only lawful to take decisions in the individual's best interest if they lack capacity and Joe did not.

5.4. Joe consented to engage with the recommended drug treatment programme through Aquarius, although there are indications that his engagement was often based on disguised compliance, and he continued to misuse drugs. During discussions, professionals explained that they did not consider that a residential rehabilitation programme would have been suitable for Joe, as he was not committed to abstinence. While there were periods that he would stop using or say that he wished to stop, he would then resume drug use, and would often tell professionals that he enjoyed using and did not want to become abstinent. Has there been a clear medical view that compulsory residential rehabilitation was clinically necessary to save Joe's life, his parents or the courts (on application of his clinicians) could, in theory, have overridden his decision to withhold his consent to this. However, unlike medical treatment through medication or surgery, therapeutic interventions require the active engagement of the patient. There is little evidence that compulsory drug treatments are effective, to the contrary, there is some evidence that the

[12] Mr Justice Hayden in *London Borough of Tower Hamlets v PB* [2020] EWCOP 34

coercive nature of such programmes can have an adverse impact on risk of relapse.[13] Further, no clinician can be ordered to provide a medical intervention which, in their view, is not appropriate, even if this is sought by the individual, their parents or the courts.[14]

5.5. Despite the duty on the local authority to investigate and, if appropriate take a decision about what action to take to safeguard a child at risk of significant harm,[15] its safeguarding powers were very limited. There was no indication that it would be appropriate or in Joe's best interests for him to come into the care of the local authority, which would need to be at the request of Joe himself or his parents[16] as a care order cannot be made in respect of a 17 year old.[17] In any event, coming into care would not prevent Joe from using drugs unless the courts authorised him being deprived of his liberty through a secure accommodation order[18] or under the inherent jurisdiction of the High Court. The thresholds for such orders are high and based on the welfare of the child and, even if such a placement could be identified given the national shortage of appropriate placements,[19] it is unlikely that the courts would grant such an order in Joe's circumstances. In the experience of the author, the courts would likely take the view that such an order this would not have been in Joe's best interest, due to the limited evidence of the benefits of compulsory rehabilitation and the fact he had consented to attend a community-based programme. Further, this would have been a short-term intervention (due to his age), which would likely exposed him to other young people with significantly more dysregulated behaviour or more entrenched drug use and removed him from the protective environment of his family home.

5.6. Joe's parents took their own responsibility to safeguard him deeply seriously, indeed, they were desperate to keep him safe. They described feeling undermined by some of the practitioners working with Joe, in particular when CBCSC told Joe that the fact the parents were requiring him to undertake regular drug testing and search his room and remove drugs, when found was a 'breach of his human rights'. This was incorrect – the Human Rights Act 1998 governs the actions of public bodies in their interactions with private citizens, it does not govern relationships between private individuals. It is unfortunate that this discussion took place at the start of the direct work with the Family Support Service as although it was intended to build trust with Joe, it simultaneously alienated and undermined the parents.

5.7. Likewise, some practitioners held legitimate concerns that the parents' strict approach to monitoring Joe's substance use was increasing the family conflict and that decisions taken with good intentions (for example, contacting Joe's friends' parents so that they could keep their own children safe; making a referral to his college because they believed there was a drug dealer in Joe's class; and speaking to his employers due to the dangers of substance use when he was using power tools) were undermining Joe's trust in them, disrupting the positives in his life and impacting his self-esteem. Joe himself had said this could be a trigger for his substance use. The short-term nature of the intervention proposed by CBCSC's Family Support Service (as Joe was approaching 18, when his eligibility for this service would end) meant that these discussions happened during the first meeting. Had practitioners had an opportunity, those discussions should have waited until they could develop a more nuanced understanding of the family dynamic or built a professional relationship of trust with the parents. Instead, rather than decreasing the family conflict, it increased it and in the parents' view, removed some of the few tools they had to reduce the risks to Joe. Although the social worker then held a series of family meetings intended to mediate and improve communication within the family in accordance with good practice, his parents reported they understood that professionals perceived them to be the cause of the problems. This, understandably, adversely impacted their ability to engage with

[13] THE EFFECTIVENESS OF COMPULSORY DRUG TREATMENT: A SYSTEMATIC REVIEW - PMC (nih.gov)
[14] R (Burke) v General Medical Council - Case Law - VLEX 793927149
[15] Section 47 Children Act 1989
[16] Section 20 Children Act 1989
[17] Section 31 (3) Children Act 1989
[18] Section 25 Children Act 1989
[19] "*[T]he prospects of a place in secure accommodation being found ... are "vanishingly small".* Re J (Deprivation of Liberty: Hospital) [2022] EWHC 2687 (Fam), para 13

professional advice. Further, because the parents would attempt to correct the narrative that Joe had given to the social worker, these meetings frequently triggered arguments. Despite this, when the social worker took a decision to close the case in in July 2022 on the basis that they '*no longer see a role for children's services; the tasks on CIN plan had now all been completed'* the parents asked the social worker not to close Joe's case, as they believed that the level of risk had not reduced.

5.8. Other professionals reported that on occasions when Joe reported that his parents were overreacting to his drug use, they took time to explain to him that the parents' response was a result of their high level of concerns. Joe's response to this was inconsistent, sometimes he was so angry that he could not rationalise their actions, on other occasions he acknowledged that their fears came from a place of love, and would agree to engage with services to placate them.

5.9. During discussions with the author, the parents expressed their frustration that practitioners working with Joe would not listen to them when they corrected the information he had told them, as they were worried this masked the extent of his problem. Again, the parents felt that this hindered their ability to act to protect him, and practitioners' ability to effectively help him. However, as Joe had capacity to take decisions about his treatment and information sharing, practitioners were concerned that having separate conversations with the parents would have undermined his therapeutic relationship with them, and would therefore made it much less likely that the efforts those agencies were making to mitigate the risks in an age-appropriate manner would succeed.

5.10. In this context, Joe's GP's approach was commendable. He initially offered Joe an appointment with his parents at their request, to explore whether a referral to CAMHS would be appropriate. However, having observed the complex dynamic, the GP said that he would continue to see Joe and that the parents should see another GP from the surgery for their own health needs. He offered regular appointments at the end of the working day, both to fit Joe's work schedule and so that he was not restricted by the 10-minute appointment time, which meant that he often spoke to Joe for over half an hour, exploring risk, triggers and protective factors in relation to his drug use, and felt that he was making real progress. This flexible, person-centred approach was excellent practice.

5.11. Likewise, Aquarius were very clear that their primary role as a child-led service was to build a trusting relationship with Joe. They explained to the parents verbally and by email that Joe needed to feel confident that they would maintain his confidentiality. They explained that they did not consider it appropriate to have private meetings or communication with the parents without Joe present as this was likely to break down his trust of them and lead to his disengagement from the service. The explanation they gave the parents was clear, reasonable and consistent with good practice.

5.12. However, at times it appears that some practitioners became frustrated with Joe's parents, perceiving that they were not following advice, escalating conflict with Joe or being very demanding in their contacts with professionals. There was a sense that some saw them as 'difficult parents'. The term 'malignant alienation' describes a process patients may experience which is "*characterised by a progressive deterioration in their relationship with others, including loss of sympathy and support from members of staff, who tended to construe these patients' behaviour as provocative, unreasonable, or overdependent."*.[20] Although this term has been developed in relation to psychiatric patients, the mechanisms and impact could equally apply to any individual with chronic needs, or their family members. While mental health practitioners will often receive specific training or reflective supervision to mitigate these risks, it is equally important for other partner agencies to ensure that staff understand how malignant alienation can develop, how to recognise desensitisation and provide generous support to avoid this impacting on the professional response.

[20] Watts, D., & Morgan, H. G. (1994). Malignant alienation: Dangers for patients who are hard to like. *The British Journal of Psychiatry, 164*, 11–15. https://doi.org/10.1192/bjp.164.1.11

Systems finding

5.13. Practitioners appropriately applied the principles of the Mental Capacity Act 2005 in respect of their support offer to Joe and information sharing with the parents, however, this then resulted in limited options for interventions to compel Joe to accept support that might keep him safe. Instead practitioners were required to work with Joe, at his pace, to address risks through offers of advice for harm minimisation. Whilst this could not eliminate the risks, practitioners carefully balanced their conflicting obligations in line with caselaw to proportionately reduce known risks. A clear explanation of the limits of parental responsibility and safeguarding powers for a young person who is over the age of 16 and has capacity to take the relevant decisions may have helped the parents to understand the professional approach to the support being offered. Had this been done, this may have reduced his parents' frustration with individual agencies and facilitate a more collaborative safeguarding approach. Leaders should consider how to support staff to mitigate the risk of malignant alienation with respect to the young person they are supporting or their families, when dealing with cases involving chronic high-risk.

Recommendation 1: *Practitioners should be prompted, through organisational support mechanisms (e.g. guidance, reflective supervision and access to specialist advice) to see family members as valued partners in the safeguarding process for young people.*

Recommendation 2: *Partner agencies should provide assurance to CBBBSAB that they have accessible information available for family members, to help them understand confidentiality, consent and mental capacity, and the limits that may be placed on professionals in respect of support and information sharing.*

Recommendation 3: *Health and social care partners should confirm to CBBBSAB the steps they have taken to monitor use by staff of reflective clinical supervision to support trauma-informed practice, avoid burn out or desensitisation in cases involving chronic high-risk, and to minimise the risk of malignant alienation.*

Disruption of contextual harm in the digital age

5.14. Contextual harm is harm which happens outside the family home, often in relation to adolescents, where the source of risk may be in the young person's peer group, school or wider community. As the focus of the Children Act 1989 is on the relationship between the child and their parents, effective contextual safeguarding requires a modern, multi-agency response involving a relational approach with the young person, combined with strategic disruption of the sources of harm.[21] However, as digital technology has developed, new sources of contextual harm have evolved, which pose serious challenges for safeguarding partners.

5.15. Joe had been misusing substances from the age of 14, but this escalated significantly during the pandemic as he started to experiment with a variety of drugs, including, Xanax, Oxycodeine, Cocaine, Ketamin and synthetic drugs, often alone in his room. Although he bought some drugs from other people in the community, sometimes in large volumes purportedly to that he could sell some of these on to fund his own substance use, there was little evidence that he was

[21] Contextual Safeguarding and Child Protection: Rewriting the Rules - 1s (routledge.com)

actually dealing himself, but rather, appears to have been using at a very high level. Most concerningly, he often ordered drugs from social media platforms, which meant he had no real idea exactly what he was taking or how concentrated the substances were. The only common feature of Joe's drug use was his preference for tablets or cannabis, he was not known to inject, but otherwise his substance use was very impulsive.

5.16. New psychoactive substances, often misleadingly called 'legal highs' can be generalised into four classes: synthetic stimulants, synthetic cannabinoids, synthetic hallucinogens and synthetic depressants, which are unlawful to produce, supply or import, but not to possess for personal use.[22] They can vary in toxicity, the onset of their action or length of half-life, which can lead to users taking more doses than is safe.[23] There has been widespread media attention in respect of the epidemic of deaths (exceeding 100,000 annually) in the USA resulting from use of fentanyl,[24] a synthetic opioid often taken in conjunction with stimulants. However, in the past 12 months the UK has seen over 100 deaths from new synthetic opioids called nitazenes,[25] which can be hundreds of times stronger than morphine and are often mixed with other drugs without the knowledge of consumers. This is because they are relatively cheap to manufacture and easy to traffic because their very high concentration means that small amounts can be profitably shipped. New psychoactive substances can be ordered through online platforms and delivered by Royal Mail or other delivery services, which means that existing police strategies to catch and prosecute drug traffickers and dealers are often ineffective. Although Border Force intercepts a small proportion of the illegal drugs entering the country, the volume of legitimate traffic and number of routes into the country make this extremely difficult.[26]

5.17. Joe's father reported that on one occasion he had become aware that Joe was having a package of drugs delivered through Royal Mail and went to the post office to ask them to give the package to police instead. However, he was told that they were legally required to deliver the package unless police obtained a warrant for the item. Whilst Post Office staff applied compassion by agreeing to delay delivery for several days to facilitate this, when the father spoke to police, no action was taken. Joe's father also repeatedly attended the police station to give officers the names and contact details of people he suspected were dealing drugs to Joe and other children. Joe's father expressed his frustration that no action appeared to have been taken as a consequence of this intelligence, and reported that an officer at the local police hub in Leighton Buzzard had told him on one occasion that they had been instructed to "*prioritise graffiti*" over prosecuting drug dealers. During the learning events, police acknowledged that they faced significant challenges in respect of capacity to respond to intelligence received on a 'one-off' basis, but sought to reassure the review, this was used to develop an intelligence picture to determine when a tactical response would be appropriate.

5.18. While Joe was known to use the social media site Telegram to access dealers, a recent BBC investigation[27] identified many platforms are utilised in this way, with over 3000 posts offering drugs on the platform SoundCloud and 700 posts on X (formerly known as Twitter). During the learning event, practitioners noted that in some areas dealers also put QR code stickers on lampposts, which when scanned, automatically direct you to a site with a menu of drugs. The Online Safety Act 2023 places new duties on social media companies and search services, making them more responsible for their users' safety on their platforms, in particular for children. Online providers will be required to implement systems and processes to reduce risks their services are used for illegal activity, and to take down illegal content when it does appear.[28] The government's intention is for platforms to proactively consider how to design their sites in a way

[22] The Psychoactive Substances Act 2016

[23] New psychoactive substances: a review and updates - PMC (nih.gov)

[24] How the fentanyl crisis' fourth wave has hit every corner of the US - BBC News

[25] UK too slow to act on lethal drug threat - doctors - BBC News

[26] ttps://www.gov.uk/government/publications/review-of-drugs-phase-one-report/review-of-drugs-summary

[27] Deadly opioids smuggled into UK in dog food, BBC learns - BBC News

[28] Online Safety Act: explainer - GOV.UK (www.gov.uk)

that mitigates the risk they will be used for criminal activity. While some campaign groups hope that this will result in social media and other websites being designed with greater parental controls, some research indicates that this may result in worst safety outcomes, as this may reduce trust between parents and children, and make it less likely for children to disclose harm they experience online.[29]

5.19. Dame Carole Black's landmark independent review of drugs[30] in 2020 noted that although community treatment for substance use was the responsibility of local authorities, years of austerity had resulted in some areas reducing expenditure by up to 40%, often meaning that providers have had to prioritise long-term heroin use to the detriment of investment in services for other drug users. Likewise, the review noted that drug enforcement had "*fallen down the priority list for nearly all police forces.*"

5.20. The independent review of drugs set out the importance of developing and improving local collaboration, with joint assessments of local need and planning for delivery. This led to the government issuing guidance[31] in 2022 requiring Combating Drugs Partnerships in each locality to develop local strategies to break supply, support treatment and recovery, and reduce the demand for drugs. It is vitally important that local substance misuse strategies and commissioning are reviewed to ensure that services are planned to meet the changing face of substance use towards new psychoactive substances and supply lines, particularly for young people who are often more sophisticated in their use of social media than their parents.

5.21. Much of the recent focus by children's services in respect of adolescent substance misuse has focussed on children experiencing criminal exploitation by organised gangs, often in the context of county lines, but there was little evidence Joe was experiencing exploitation. Joe was offered a Child Exploitation assessment but refused, he was clear that he did not consider himself to be experiencing exploitation, and while this is not uncommon even for young people who are experiencing coercive control, professionals did not consider this to be a significant feature of this case. However, it is equally important that there is an effective response, including practical disruption plans for young people who are 'end users' for the drug trade, rather than just for those being coerced into criminal activity.

5.22. Undoubtedly Joe was experiencing serious harm and at times physical abuse as a result of his involvement with substance use, including a serious assault with a weapon on an occasion when he was purchasing drugs. Information with respect to this assault was not shared across the professional network, which may have hindered agencies' ability to implement safeguarding measures and to provide the necessary response to his trauma from this incident. In response to this assault, his parents passed the name of another student at Joe's college to college staff, and the name of an adult they believed was dealing drugs to Joe to the police. After Joe's death, his father provided further details to Northamptonshire police after finding evidence on Joe's phone that these individuals had been dealing him drugs. Bedfordshire police advised the review that Northamptonshire had passed father's intelligence to them to check from a welfare perspective whether the young person had consumed the same drugs as Joe. After attending addresses and checking with Joe's college, it was not possible to identify and locate the person named by father.

5.23. Since the period of the review, Joe's college reported that they have strengthened their safeguarding processes, with improved intelligence forms which will trigger police engagement. The college has introduced a Behaviour Team since September 2023, and when there are concerns about a student's behaviour, meetings will be held with them to agree a behaviour plan, setting out the consequences. They have a new Safeguarding Panel, providing a forum

[29] For children to be safe online, it's not they who need to change – it's the tech companies | Ian Russell | The Guardian
[30] Review of drugs: phase one report - GOV.UK (www.gov.uk)

for staff to discuss emerging concerns and decide how to progress them. A mobile screening arch also enables the college to screen for knives or weapons, which they report has been an effective deterrent.

Systems finding

5.24. There is currently little evidence of a strategic multi-agency or local police approach to disrupting drug dealing through social media sites. Although the local drugs strategy is the responsibility of the Combatting Drugs Partnership, CBBBSAB should liaise with the Partnership to ensure that this includes a strategic approach to tackling modern contextual harm noted within this review. Further, proactive disruption plans are not currently used to mitigate contextual harm to young people misusing substances outside the arena of child criminal or sexual exploitation.

Recommendation 4: *CBBBSAB should liaise with the Combatting Drugs Partnership to ensure that the findings from this review are used to inform the local drugs strategy, in particular the need to take a strategic approach to tackling synthetic drug use and drug dealing through online platforms.*

Recommendation 5: *Existing forums and tools for addressing child criminal exploitation should be used to develop disruption plans to reduce contextual harm for young people exposed to drug dealers, even if there is no evidence they are being criminally exploited.*

Multi-agency response to substance misuse

5.25. The primary resource to support young people misusing substances in the area of Bedfordshire where Joe and his parents lived was Aquarius, which offered Joe a programme of structured one-to-one sessions. Although he was initially referred to the service in early 2021, a combination of workforce difficulties for the service and Joe not attending some sessions meant that limited face to face sessions with Joe took place. However, CAMHS re-referred Joe in January 2022 after his parents took him to Milton Keynes University Hospital due to their concerns about his excessive drug use and mental health. While CAMHS' assessment did not indicate a mental health need, Joe acknowledged that he was misusing substances and asked for help with this. A referral was also made to CBCSC, who initiated a Children and Family assessment.

5.26. Aquarius uses a harm reduction approach when working with adolescents, rather than advocating abstinence. Sessions focussed on ensuring that Joe understood the risks of taking different substances and had strategies he could employ to mitigate these risks. Key to this method in a relational approach, building trust with the young person so that they feel confident to be honest with workers. Aquarius staff reported that they tried hard to work collaboratively with the parents and support them to understand this approach, including a number of joint family sessions with Joe present. However, the parents felt frustrated that professionals did not share their views on abstinence as the best approach to addressing Joe's substance misuse, or the steps they took to disrupt his drug use.

5.27. There is a substantial body of research that evidences that the 'Just Say No' campaign from the 1980s was ineffective in reducing substance misuse in young people. "*There are real and perceived benefits to using drugs, as well as risks, such as coping with stress or liking the 'high.'*

If we only talk about the negatives, we lose our credibility."[32] Instead, research suggests that modern prevention and treatment programs should empower young people to make their own decisions around substance use in a developmentally appropriate way which is a holistic, non-stigmatising approach that incorporates principles of harm reduction. This aims to reduce the risk of accidental overdoses and other consequences of substance use, including addiction, criminal justice involvement, and problems at school. This is consistent with the ethos of transitional safeguarding, as young people approaching adulthood it is important they learn how to weigh the consequences of their actions (including around substance use) and make healthy choices about their future. Aquarius's approach was therefore consistent with current best practice. However, as noted above with respect to CBCSC's relationship with Joe's parents, again they reported felt undermined by the messaging being given to Joe, despite Aquarius having explained their (appropriate) position. Consequently, Aquarius decided that although there was a risk that this might further alienate his parents, they would need to limit their private interactions with Joe's parents and prioritise building trust with Joe to avoid undermining their therapeutic relationship with him.

5.28. The parents reported that the quality of support they received from Path to Recovery's [P2R] Family and Friends service (after self-referring in 2021) was excellent, and the practitioner was very impressive during the learning event, with thoughtful insight into Joe's substance use and the parents' support needs. However, P2R was not invited to professionals or CIN meetings and the practitioner described feeling isolated and left to carry a huge amount of risk and stress as a consequence. CBCSC asserted that the parents did not disclose that they were working with P2R, however, P2R had made the initial referral to CBCSC in early 2022 because they felt that Joe's drug use and the domestic abuse he was subjecting the parents to had reached the level of significant harm, requiring a statutory response. Further, a contemporaneous email from the parents from this period, complained that CBCSC had refused to allow P2R to attend a professionals meeting. While the details of the service may not have been passed on when Joe transferred between departments, this appears to have been due to CBCSC's record keeping, rather than information being withheld by the parents.

5.29. This resulted in a significant gap in the team around the child and a missed opportunity to mediate the conflict between the parents and CBCSC or Aquarius. P2R would have been the ideal intermediary to support the parents to understand the harm reduction approach being utilised and it was clear during the practitioner event that P2R understood the value of this approach. CAMHS, Joe's college and his employers were also not included in CIN or professionals meetings and again, this was a missed opportunity to share information, explore the wider family concerns (including the issue of domestic abuse discussed below), exercise professional curiosity in respect of the discrepancies between Joe's self-reporting and the parents' concerns and consider alternative options to better support Joe and his family holistically.

5.30. Joe's parents believed that his substance use was linked to undiagnosed depression and questioned why he was not assessed as having a dual diagnosis. NICE guidance defines dual diagnosis as co-existing mental health and substance misuse difficulties, where the person has a clinical diagnosis of a severe mental illness of schizophrenia, bipolar disorder or severe depressive episodes.[33] It can be difficult to diagnose dual diagnosis because drug and alcohol intoxication or withdrawal can make it difficult to assess mental illness and whether drug and alcohol use is a cause, or an effect, of mental health issues. Joe could become highly emotionally dysregulated while under the influence of drugs or 'coming down' from them, and during some periods his parents reported that he was almost constantly high or detoxing. During learning events, the health partners noted that due to the location of the family home, Joe

[32] More teens than ever are overdosing. Psychologists are leading new approaches to combat youth substance misuse (apa.org)

[33] Overview | Coexisting severe mental illness and substance misuse: community health and social care services | Guidance | NICE

sometimes presented to hospitals from different NHS Trusts, which may have masked the number of hospital attendances and harm Joe was experiencing.

5.31. In early 2022 Joe's parents had repeatedly raised concerns during hospital attendances and meetings with CBCSC that Joe was suicidal, that he was found with a knife, razor blades and that some of his overdoses may have been intentional. Joe's parents raised concern during the review that the response of hospital staff to Joe during these attendances lacked empathy and they felt that this related to a stigma against substances users as 'having brought this on themselves'. It is extremely important that, even within the pressured environment of an emergency department, staff are mindful that a judgmental response to a young person in crisis may mean that they will be less likely to seek help from professionals in the future. Recommendation 3 (above) addresses this issue. However, Joe's parents were reassured when advised that the hospital had taken Joe's needs seriously during this attendance, and made referrals to CBCSC's MASH and to CAMHS.

5.32. Joe was allocated to CAMHS Emotional Behavioural Team who completed a screening assessment which indicated that Joe's mental health needs were not severe. However, Joe also reported that he struggled with sadness, anxiety, emotional dysregulation and anger management. CAMHS concluded that Joe's primary need related to his substance misuse rather than mental health, and recommended that he should be referred to Aquarius. There was a delay of several weeks before this referral was made, though this did not materially impact on the outcome of this case, as by that time Aquarius was already working with Joe. The mental health practitioner also recommended that Joe should be offered therapy sessions around social anxiety and although Joe initially missed his in-person therapy sessions, he began to attend in person after much encouragement from his parents. Following a self-harming incident whereby he slashed his arms with razor blades his allocated practitioner offered further sessions remotely while Joe was in Italy on holiday with his family. It is telling that this was during a period when Joe was abstinent from drugs. Importantly, this provided a forum for Joe to process his trauma resulting from the incident when he was assaulted by an associate.

5.33. Unfortunately, on his return to the UK, Joe resumed his substance use and his emotional dysregulation escalated again. The clear link between his substance misuse and emotional dysregulation indicates that he would be unlikely to meet the criteria for a dual diagnosis, as it strongly suggests this was an effect of drug misuse rather than an underlying condition. Despite the fact that this might not have been the right diagnosis for Joe, during discussions with practitioners, they felt that the fact there is no dual diagnosis service for adolescents in Bedfordshire was a gap in the resources for this cohort. Further, they felt that this would provide a valuable resource for practitioners working with young people with emerging needs, to seek support and guidance for the appropriate multi-agency response. Practitioners noted that options for services that would meet the needs of young people who required a different therapeutic response or with different co-occurring conditions were limited and that while rehabilitation may not have been suitable for Joe, the fact that this was not available locally was also a significant gap in service.

5.34. One area of outstanding practice was the proactive efforts of P2R to obtain a prescription for Joe of a Naloxone injection pen, which can be administered in an emergency to people who are suspected to have overdosed on opioid drugs. At the time, this was not prescribed for under-18s, but in light of the chaotic and impulsive nature of Joe's substance use, P2R fought hard to secure this for him. Naloxone and a similar product, Nyxoid spray (which is easier to administer) are now widely available and safe to administer and attendees at the learning events discussed their value in reducing drug fatalities. Many first responders are now issued these, and leaders advocated that this should be promoted across the partnership. However, it was identified that there was a need for education to ensure that people are aware that it is necessary to administer multiple sprays in cases of suspected synthetic opioid overdose, due to the unpredictable strength of these substances.

Systems finding

5.35. Substance misuse services followed current best practice in using a harm reduction model of intervention and education, although the limited range of service options available locally for young people misusing substances means that targeted support is not available for those who may respond better to a different therapeutic model. Further, the exclusion of some partner agencies from the team around the child hindered information sharing, professional curiosity, and conflict resolution with the family.

Recommendation 6: *CBCSC should promote understanding of the importance of including agencies providing support to parents and family members as part of the team around the child to strengthen the multi-agency response and information sharing.*

Recommendation 7*: Local authority leaders should consider how to expand the range of resources available to young people with different needs who are misusing substances across Bedfordshire, including dual diagnosis and rehabilitation options, to increase the engagement of young people in drug treatment.*

Child on parent domestic abuse

5.36. Child to parent abuse is defined as: '*a pattern of behaviour…which involves using verbal, financial, physical and/or emotional means to practise power and exert control over a parent...such that a* parent *unhealthily adapts his/her own behaviour to accommodate the child. Commonly reported abusive behaviours include name-calling, threats to harm self or others, attempts at humiliation, damage to property, theft and physical violence'*[34]

5.37. Although the definition of domestic abuse under the Domestic Abuse Act 2021 includes child to parent abuse when the child is over the age of 16, this is often poorly recognised across the professional network and, even when identified, relatively few resources are available nationally or locally to address this. Parents are often reluctant to disclose this abuse, due to stigma and shame, fear of being blamed, or fears the child may be removed by children's social care or criminalised. As such, they may attempt to ignore or placate the behaviour instead of seeking support. A 'victim/perpetrator paradigm' - the narrative that portrays victims and perpetrators as separate, distinct and mutually exclusive – may mean that when professionals believe parents to have been neglectful or abusive (whether currently or in the past), they are then unable to recognise that they may also be the victims of abuse from their child.[35]

5.38. Child to parent abuse has been found to be more common when the child has experienced abuse perpetrated by a parent, either directly or by witnessing this, likely as a consequence of internalising the use of abuse and control within relationships. Research has shown that boys are more likely to be perpetrators than girls, and that mothers/female carers are 80% more likely to be the victims of abuse, in common with gendered dynamics of many forms of domestic abuse.[36] Other risk factors include drug use and social maladjustment, including difficulties at

[34] Holt, A. (2016). Working with adolescent violence and abuse towards parents: Approaches and contexts for intervention. London, Routledge.
[35] Borer TA (2003) A Taxonomy of Victims and Perpetrators: Human Rights and Reconciliation in South Africa. Human Rights Quarterly 25(4): 1088-1116.
[36] Child to Parent Abuse - Dr Amanda Holt (justiceinspectorates.gov.uk)

school and with peer groups. Research also indicates that parenting styles, such as authoritarian parenting or overly permissive parenting may contribute to abuse by children.[37]

5.39. Although police had completed eight Domestic Abuse Risk Assessments [DARAs] in the 12-month period that is the focus of the review, following incidents when Joe had been aggressive or at times violent towards his parents, this issue was poorly recognised by the professional network. Although officers offered referrals to support services during call-outs, this was declined by the parents and it is not clear whether they were clearly advised that this could include domestic abuse support services for them. Officers did make appropriate referrals to CBCSC, to ensure that appropriate assessments and support would be available to the family. However, the perception by CBCSC and Aquarius that Joe's behaviour was a response to controlling and critical behaviour by the parents meant that they were seen as the source of risk rather than the victims. They were not referred to Non-Violent Resistance or Parental Education Growth Support training, although P2R reported that other parents in similar circumstances who had attended PEGS had found this unhelpful and minimised the abuse they were experiencing.

5.40. While it must be acknowledged that the family dynamics were complex, and required a nuanced response, one of the agencies accessed by the parents to obtain support described that "*my whole experience was of demonising the parents, it's their fault we're in this situation*". Not only was this alienating and distressing for the parents, but they felt that the messaging that some professionals gave to Joe during this period increased his conflict with them and the abuse they experienced as a result. Without oversimplifying the complexity of the circumstances, it is difficult to imagine another situation involving domestic abuse where professionals' advice to the victim would focus on ways in which they could be less provocative to their abuser.

5.41. A multi-agency risk assessment conference [MARAC] is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors [IDVAs] and other specialists from the statutory and voluntary sectors, with a view to identifying measure to mitigate the risk of further incidents. Leaders noted that a referral to MARAC will be made in respect of a high-risk incident if there have been three incidents in a 12-month period where there is an escalation in incidents or if the case has been heard at MARAC in the past 2 months.

5.42. It was clear that the parents were reluctant to criminalise Joe, and there are indications that the abuse had been escalating before incidents started to be reported to police, albeit the parents would then decline to support a prosecution. Some practitioners commented that part of the reason Joe may have felt able to treat his parents badly was that he knew that because they loved him, they would always be there for him, no matter what he did. Most of the DARAs were rated low or medium risk, but the 7th DARA was rated high risk on the basis of the number of previous police contacts and the fact Joe had used a splitting maul to damage the family home. The police MARAC team reviewed the high-risk DARA and took a view that the incident did not warrant a referral to MARAC as the parents had not been directly threatened during the incident. They also took the view that although there had been repeated incidents of domestic abuse within the 12 month period, there was no indication that these were escalating.

5.43. During the learning event, leaders commented that safeguarding training for frontline police officers was very limited and that understanding how processes such as CIN meetings, child protection and MARAC work would help emergency responders to develop the 'big picture' rather than viewing callouts as one-off incidents. However, as Bedfordshire police have an internal system that reviews the one-off incidents reported by emergency responders to ascertain if safeguarding or MARAC referrals need to be made, focussing training in respect of

[37] Child to parent abuse: what social workers do and don't know (communitycare.co.uk)

child on parent domestic abuse on staff carrying out the reviews is likely to have more impact than trying to upskill the entire cohort of frontline officers.

5.44. Leaders also noted that any of the professionals involved could have referred the case to MARAC, rather than relying on the police to lead on this. There appeared to be a perception that this was a 'poor family dynamic' rather than a pattern of domestic abuse and this minimisation meant that no clear plan was in place to address this. Although CBCSC and Aquarius had joint family meetings with both Joe and his parents in attendance with the intention of improving communication and mediating this dynamic, records of these meetings indicate that this often resulted in an escalation, rather than de-escalation in conflict. It may be that having practitioners whose primary role was the protection of children taking the lead in such meetings meant that insufficient consideration was given to the safety and emotional needs of the parents. At the very least, inviting practitioners whose role it was to support the parents directly, such as P2R may have helped them feel more supported and ensured a more balanced safeguarding approach.

5.45. As a consequence of the early learning on this case, CBBBSAB has identified child on parent domestic abuse as a key strategic priority and are planning a multi-agency audit across the three local authority areas it covers (Bedford Borough, Central Bedfordshire and Luton children and adults services) to understand the effectiveness of the current partnership approach. An experts by experience workshop is being arranged with parents, facilitated by the CBBBSAB independent chair, to understand their experiences and needs, and ensure these inform the audit findings. A multi-agency workshop is then planned for September 2024 to discuss national best practice, the findings of the audit, any barriers and enablers to good practice and systems findings, to help develop the local approach to tackling child on parent domestic abuse.

Systems finding

5.46. Child to parent domestic abuse is not well understood in Bedfordshire and the ethos under the Children Act 1989 of the paramountcy of the welfare of the child, while important, hindered the ability of the professional network to recognise and respond to this issue. Local resources to support parents who are victims are limited, and there were no local resources identified to address concerns directly with child perpetrators of domestic abuse. CBBBSAB's proactive approach in progressing the planned audit and workshops to develop its strategic response to this issue is commendable.

Recommendation 8: *CBBBSAB should, in conjunction with their local Domestic Abuse Partnership Board, explore what further steps it should take to highlight the recent changes introduced in the Domestic Abuse Act 2021 to ensure abuse between all 'connected persons' is better understood and improves the professional response. This might include reviewing current MARAC referral forms or local risk assessment tools to ensure these reflect the changes introduced by the 2021 Act.*

Recommendation 9: *Partners should consider how to broaden the available local resources to address child to parent abuse, including therapeutic provision for children and parents and IDVA support, using the outcome of the planned audit and workshops to inform its strategic and commissioning approach.*

Transition planning and transitional safeguarding

5.47. There are significant differences in the statutory safeguarding criteria for children and adults. Section 47 of the Children Act 1989 places a duty on local authorities, with the cooperation of safeguarding partners, to make enquiries to enable them to decide whether they should take any action to safeguard or promote the child's welfare if there is reasonable cause to suspect that a child in their area is suffering, or is likely to suffer, significant harm. This is also underpinned by the United Nations Convention on the Rights of the Child 1989 which, among other rights and freedoms, requires signatory governments such as the UK to protect children from the illegal use of drugs and from being involved in the production or distribution of drugs (Article 33).

5.48. By contrast, section 42 of the Care Act 2014 places a duty on local authorities, with the cooperation of safeguarding partners, to make enquiries when there is reasonable cause to suspect that an adult in its area has needs for care and support (whether or not these are being met) which prevents the adult from protecting themselves against abuse or neglect they are experiencing or at risk of. If these criteria are made out, the local authority must make any necessary enquiries to decide whether any action should be taken and, if so, what and by whom.

5.49. This distinguishes between the relatively low threshold of a child suffering any kind of harm, which could include self-harm or substance use, and an adult, where the safeguarding duty will only be triggered if they are experiencing abuse or neglect (including self-neglect). Self-harm, suicidal ideation and substance misuse will not, by themselves, meet the criteria for an adult safeguarding enquiry, although there may be other concerns that, combined with those risks, mean the matter will meet the s42 criteria. These different thresholds for safeguarding referrals can present a real challenge for partner agencies, in particular those working across age-groups, such as 6th Form colleges, who may be trying to support a number of young people of various ages with exploitation, substance use, suicidal ideation or self-harm.

5.50. However, the fact that the statutory criteria for a s42 enquiry are not met in a specific case does not mean that the local authority or safeguarding partners are prevented from taking action to support an adult (with or without care needs) who is at risk of harm. On the contrary, effective transitional safeguarding, using a preventative, rights-based approach advocates a proactive multi-agency response based on the understanding that powers (e.g under s2 Care Act to prevent needs escalating) and duties to protect life enable partners to act. As the young person approaches adulthood, they can be assessed for care and support needs, or signposted to other services such as substance misuse services or risk management forums such as a Multi-Agency Risk Assessment Conference (for high-risk domestic abuse cases), or Multi-Agency Risk Management panel (for high-risk cases where practitioners are struggling to identify services to mitigate risks). Legal literacy across partner agencies is needed to ensure that referrals are appropriately targeted to secure the necessary support to mitigate the identified risks.

5.51. Although passing mention is made to Joe transitioning to adult services and that a 'robust package' of support should be provided, the fact that Joe did not agree to any referrals to adult services meant that in reality, no support was provided to him post-18. This included a discussion with CAMHS in September 2022 about being referred to adult mental health services, which Joe declined as he reported that he had found his therapy sessions beneficial

and did not consider an onward referral for continued support into adulthood necessary. He asked instead to be discharged from the CAMHS service.

5.52. While it is correct that such referrals can only be made for an adult who has capacity to take such decisions with their consent, this withdrawal of support based on age criteria while the recognised high risks persisted indicates that a more holistic and developmentally appropriate systemic approach to transitional safeguarding was still in its nascency in Central Bedfordshire at the time. There was a distinct sense in the papers provided for the review that Joe's 18th birthday was seen as a 'deadline' when services would stop. This message was reinforced to Joe and his parents. CBCSC records repeatedly referenced his approaching birthday as a reason that there was '*no further role for children's social care'*. This may in part be because professionals themselves believe that it is more difficult to access services for adults or that lengthy waiting lists are likely and are therefore trying to ensure that young people have realistic expectations of the adult services they will receive.

5.53. In 2022, when Joe was transitioning to adult services, most services had a 'cut-off' at 18, which requires young people to self-refer or actively consent to referrals to adult services, with a new cohort of professionals supporting them in an unfamiliar system. Significant steps have since been taken to improve transitions locally, as learning about transitional safeguarding from CBBBSAB's safeguarding adult review in respect of 'Max'[38] has become embedded. Central Bedfordshire has reviewed the terms of reference for its transition panel, with a supporting joint transitions policy between agencies, and there is now a presumption of a care package for young people with the appearance of care and support needs from adult social care unless it is established that this is not required. Both NELFT and Aquarius reported that they had introduced specialist transitions services since 2022, which they felt could have better supported Joe's transition to adulthood. Aquarius has introduced a transitions worker, whose role is to support young people aged 16-25, and NELFT has introduced a mental health transitions team, who work with young people from the age of 16 who are likely to require adult mental health services. This avoids an artificial cut off at 18, and provides continuity of care at this critical age, so that young people can continue to work with a familiar practitioner or team and don't have to join a waiting list for adult services. However, Aquarius acknowledged that a single worker provided a limited resource, and practitioners were unable to identify other substance misuse services for young people that were commissioned to provide a transitional service locally.

5.54. In Joe's case, this 'cliff edge' was further complicated by the fact that his family were planning to move to Northamptonshire around the date of his 18th birthday. Information was provided to the family about Northamptonshire services by the professional network and Joe's father was proactive in approaching local substance misuse services. Despite his substance misuse, Joe was able to manage the activities of daily living (albeit supported by his parents) and therefore it is highly unlikely that Joe would have been found to have an eligible need for care and support under the Care Act 2014 by either local authority's adult social care department. However, Joe would clearly have benefitted from ongoing support for his substance misuse. Promoting his understanding of the benefits of longitudinal support should have been a key focus of the work by all of the agencies involved with him throughout this time, so that he would view a referral to adult substance misuse as a positive choice rather than an unwelcome imposition.

Systems finding

5.55. During the period relevant to this review, Bedfordshire was still developing its approach to transitional safeguarding, leading professionals to view Joe's 18th birthday as a deadline for support ending. While significant progress has since been made locally in terms of more flexible services with supporting governance structures, this needs to be developed further in respect of ensuring a range of services are available for young people misusing substances. Further, a

[38] Safeguarding Adults Review - Max (bedford.gov.uk)

culture shift is needed to enable practitioners to think of how to ensure a continuum of support for young people from early adolescence to adulthood, including developmentally appropriate messaging for young people and their families to promote this concept.

Recommendation 10: *The local authority and ICB should consider how to strengthen commissioning of substance misuse services that support 16-25 year olds.*

Recommendation 11: *Partners need to consider how to embed planning for safe transition to adulthood into the culture of children's services working with adolescents.*