Safeguarding Adults Review

“Max”

Overview Report

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1. Introduction

1.1 Bedford Borough and Central Bedfordshire Safeguarding Adult Board (the SAB) have commissioned this Safeguarding Adult Review (SAR) after "Max" was found deceased on 22 May 2020.

1.2 Max was an 18-year-old White British man who had been adopted in infancy, who was described as a mischievous, 'smashing young man', a free spirit who could be very kind. He was passionate about music and extremely talented, able to play any song by memory and generously helped other young people on his music course with their work. He was very proud of his sister's achievements, and was very pleased to attend an awards ceremony where she won a prize. The description of Max as having 'high functioning' autism may have been misleading to practitioners working with him. Although Max was not learning disabled, his full-scale IQ had been assessed 73, which placed him on the borderline of learning needs. Certainly, his autism and anxiety made it more difficult for Max to understand his place in the world and he had poor impulse control due to attention deficit hyperactivity disorder which contributed to poor decisions. Max lacked insight into the intentions and motivations of others, which made it difficult for him to make or sustain friendships, but his desperate longing to belong meant that he was very vulnerable to those who could exploit him. This was likely exacerbated by the lengthy period he was out of mainstream education from the age of 16, placed by himself in a residential unit under 2-1 supervision, without the opportunity to develop his social skills.

1.3 Max had a history of behavioural problems, including self-injurious and aggressive behaviour. He had intrusive sexual thoughts, and received multi-systemic therapy for his problematic sexual behaviour. A sexual risk assessment concluded that Max was unlikely to pose a future risk to children but was likely to engage in risky sexual relationships due to his own vulnerability, however the issue of sexual risk sat like a shadow over his files and greatly limited the available options for accommodation as he transitioned to adulthood. This, combined with the fact that he did not have a learning disability or severe mental health diagnosis meant that there was a lack of clarity about which adult service was responsible for assessing his care needs, consequently these were still not assessed by his 18th birthday. Options for supported accommodation were therefore extremely limited, although Children's Services delayed moving him from his residential unit for several months after his 18th birthday while they continued this search. During this period, he started college and initially did well, but struggled to stay focussed on his college work or retain friends because he would say things to try to impress other young people in an effort to fit in, describing college as 'lonely'. Max was adamant that he wanted to live in his own flat, but when his moved into a private tenancy in January 2020, he was wholly unprepared to live alone, had no self-care skills and no ability to weigh risk. His mental capacity to take decisions around these issues had not been adequately assessed. No care plan or safeguarding plan was in place from adult mental health or social care to support Max.

1.4 The lack of structure or supervision must have been exciting, but overwhelming and lonely for Max. He immediately started using drugs and his drug use escalated extraordinarily quickly, likely aggravated by his poor impulse control and self-medication to manage the unboundaried situation he found himself in. He was repeatedly admitted to mental health wards during periods of crisis, but was released because he was not detainable for treatment under the Mental Health Act 1983. A clinician who had worked with him as both an adolescent and after he turned 18 explained that in her view, Max's mental health had not deteriorated, rather, these crises related to his unmet care needs. During the last weeks of Max's life, practitioners and his family made strenuous efforts to protect him, desperately trying to put measures in place to mitigate the escalating risk in chaotic circumstances and under the strictures of the Covid-19 lockdown. However, delays in coordinating the multi-agency response meant that these efforts were fragmented and lacked leadership. Max was tragically found dead of an accidental overdose in his flat on 22 May 2020.

1.5 The author wishes to express her sincere condolences to all members of his family for their loss and for contributing so generously to the review. The author is also grateful to the practitioners who worked with Max for sharing their insight into his experiences so honestly. The efforts they made to support him and try to keep him safe were very clearly apparent throughout the review process and all expressed how devastated they were at his death.

2. Scope of Review

Purpose of a Safeguarding Adult Review

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

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

2.2. There is a strong focus in this report on understanding the underlying issues that informed agency and practitioners' actions and what, if anything, prevented them from being able to help and protect Max from harm.

Themes

2.3. The SAB prioritised the following themes for illumination through the SAR:

- Explore care pathways
- Was the impact of childhood trauma and loss adequately considered during his transition?
- How effectively was risk managed and how did fluctuating capacity affect risk management?
- What were the barriers and enablers to good risk reduction of exploitation and criminal exploitation?
- How is critical information held and shared between care providers?

Methodology

2.4. The SAB commissioned an independent reviewer to conduct a SAR using the Social Care Institute for Excellence Learning Together methodology and tools from the SAR In Rapid Time method. 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. Although this review has been carried out as a safeguarding adult review, the involvement of Central Bedfordshire Council's Children and Families Service with Max, and examination of transitional safeguarding has resulted in learning being identified for children's safeguarding partners.

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

- Bedford Borough Council (BBC) Department of Adult Social Services, Adult Safeguarding Team and Mental Capacity lead
- Central Bedfordshire Council (CBC) Adults Social Care including the Preparing for Adulthood Team, Deprivation of Liberty Safeguards Team and Adult Safeguarding Team
- Central Bedfordshire Council Children's Services, including Leaving 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), Young Adult and Independent Living, Learning Disability Services, and Adult Mental Health Services (AMHS) including inpatient services, Pathway to Recovery (P2R), Approved Mental Health Practitioner (AMPH) Team, Triage, Assessment and Brief Intervention Team (TABI), Community Health and Community Mental Health Team (CMHT)
- Cambridgeshire Community Services
- East of England Ambulance Service
- GPs (the De Parys Group and Barton Hills Surgery)
- Luton Borough Council
- Luton and Dunstable Hospital
- Bedford Hospital
- POhWER advocacy

2.6. Multi-agency learning events took place, both with front-line practitioners who worked with Max and the leaders who oversaw the services involved in supporting them. The engagement in these events was really positive, with staff from nearly every individual service who worked with Max contributing meaningfully. The commitment all participants showed in learning from this tragedy gave confidence that partners sought to make positive change and evidenced a healthy, well led safeguarding partnership.

Involvement of Max's family

2.7. The author met with Max's family and is very grateful to them for sharing information about his personality and life journey. Max's sister, an articulate and engaging young woman, shared valuable insight into the challenges in obtaining support as a young person on the autistic spectrum. Max's parents expressed their gratitude to the many individual practitioners who worked so hard to support Max, his mother describing an occasion when she and Max's social worker spent a desperate night searching the streets of Bedford, trying to find him. However, they spoke of a lack of coordination in the efforts made by processionals to keep Max safe, and felt that the complete systems did not 'speak' to each other. In particular, Max's parents noted that the incompatible ICT systems, not only between partner agencies but within organisations, meant that vital information was not shared when it needed to be, which hampered efforts to safeguard him. Max's father described the escalation in harm Max experienced as "*watching a train crash happening in slow motion*", helpless to stop the impending disaster.

2.8. The family had an opportunity to review and comment on this report before publication and chose the pseudonym 'Max' to reflect his exuberant personality, living life 'to the max'.

3. Narrative Chronology

3.1. Max was removed from his birth mother, who had severe learning disabilities, at birth due to concerns about interfamilial abuse and substance misuse. He was placed in foster care before being placed for adoption at 18 months of age. His adoptive parents were provided with an incomplete history in respect of the reasons Max came into care at birth, and were not told of his pre-natal exposure to substances. In Year 4, it began to become apparent that Max was developing differently to other children his age. His parents had difficulty in securing help through statutory services, so engaged a private consultant who diagnosed that he was showing autistic traits. From the point of diagnosis, Max received very good support from consultants at Child and Adolescent Mental Health Services (CAMHS). He required a lot of support in education and had therapy through Central Bedfordshire Council's (CBC) Children's Services.

3.2. However, when Max moved to middle school, the quality of the Special Educational Needs (SEN) support he received declined. At this point, Max's sister attempted to make disclosures at school about physical abuse in the home, but these were not referred to children's social care until she presented with bruising. In 2015, Max's violence sharply escalated, both towards his parents and sister and they commented that he used threats of violence to control them. This situation was managed through CBC's adoption team, rather than the child protection team, and priority was given to preventing the adoption breaking down. Max's sister was moved into foster care, because practitioners felt that there were limited options in respect of identifying an alternative placement for Max, whereas his sister would be easier to place. Although Max's sister reported that she had wanted to have contact with Max, now that he had a high level of support and was taking his medication, this was not facilitated by children's social care.

3.3. The volatile home situation continued to escalate and in March 2018, Max's parents took a decision that he should be taken into care. Care proceedings were issued, together with an application for an order authorising deprivation of Max's liberty due to his risk of self-harm. The care order was granted shortly before Max's 17th birthday and although a capacity assessment concluded that he did have capacity in respect of his daily care, a Deprivation of Liberty (DoL) order was also granted, authorising provision of 2:1 support under the inherent jurisdiction of the High Court. The DoL order subsequently expired, this was allowed to lapse as Max agreed to the level of supervision provided.

3.4. In November 2018, Max was moved to a placement where he was the only young person, where again he received 2:1 support, although this was later reduced to prepare him for independence. Throughout this period, provided Max with support due to his complex diagnoses of attention deficit hyperactivity disorder, anxiety, sensory issues, difficulties with social interaction, Raynaud phenomenon apparently precipitated by methylphenidate, and a history of behavioural problems, including self-injurious and aggressive behaviour. He received multi-systemic therapy to address his inappropriate sexual behaviour, having assaulted another child. In December 2018 Max (aged 17) was introduced to his leaving care social workers and discussions were held around the need for an assessment of his care needs. A case discussion with Preparing for Adulthood (PfA) took place in January 2019, however two weeks later the team manager from PfA responded, identifying serious concerns that had been raised in a psychological report about Max's ongoing intrusive thoughts about self-harm, sexual violence and killing and expressed a view that he required a risk assessment in respect of his forensic mental health issues.

3.5. In March 2019, PfA provided further advice in respect of necessary assessments of Max's mental capacity to make decisions in relation of his residence and care. In May, Max's self-harming and sexual risk behaviours increased after his medication was changed. A complex case discussion took place with the Head of Service, practice manager and social worker and it was agreed that a specialist service would be commissioned to assess Max's sexual risk in the community and how to plan for the future. A full multi-systemic therapy problematic sexualised behaviour course had previously been completed which concluded that Max could be supported at home, but this had not assessed his ability to live independently. Ray Wyre Associates were instructed to assess Max, although this piece of work did not start until August 2019. Max was offered a college placement with 1:1 support in place to manage the sexual risks, which was arranged by the SEN service.

3.6. The PfA manager followed up to obtain the outstanding information on 2 July 2019 expressing her concern about the lack of transition planning, including the capacity assessment, risk assessment and community mental health team (CMHT) referral. At this point, CAMHS were drawing together the information to refer him to adult services, but took the view that he would not meet the criteria for a Care Education Treatment Review as Max was not then at risk of admission to hospital. On 10 July Children's Services referred Max to Shared Lives, Bedford Supported Living and the KWV Transition Service and the Registered Cluster Manager, as well

as for a mental health assessment. A referral to Bedfordshire Wellbeing Service was refused as Max was living in Luton.

3.7. The children's social worker followed this up with CAMHS on 24 July, raising concern that Max had not been referred to adult mental health services, therefore he would not be able to access CQC registered supported accommodation. On 30 July, the social worker made an application for mainstream housing for Max, and CBC's resource panel placed him on Band 1 priority for bidding for properties due to his vulnerability. This was for a tenancy in a self-contained flat, because general needs supported accommodation provided by Housing has shared facilities, so would not have been suitable given Max's history of sexually assaulting another young person. Despite the fact he clearly met the eligibility criteria for care and support under the Care Act 2014, an assessment of his needs was not completed in accordance with statutory requirements[1] by the time Max turned 18 in mid-August and no care plan was ever put in place by adult mental health or social services to support his complex needs.

3.8. Max's existing specialist children's accommodation was extended for three months while his leaving care social worker continued to search for accommodation. Children's Services considered that Max would require CQC registered supported accommodation as his self-care skills were poor, however, he did not meet the criteria for the available accommodation which were targeted at young people with learning disabilities or with more serious mental health conditions. Max was last reviewed by CAMHS on 4 September 2019 and, as it was unclear where he would be living as an adult, his consultation psychiatrist wrote a letter to Max's GP to support his transition to Adult Mental Health Services. In October 2019, concerns were noted by staff both at his accommodation and college that he was binge drinking. On 8 November, Housing refused Max's housing application on the basis that his needs were too high to manage a universal tenancy. Later that month, Max disclosed to his college that he had slept with a male prostitute.

3.9. Max moved into a private one-bed flat in Bedford on 2 January 2020, after his parents co-signed the tenancy and on the basis that CBC managed his Personal Independence Payments to support him with his finances. The Children's Social Care team sent an assessment request to the PfA team, advising that they intended to close Max's case in January. PfA responded querying what risk assessments had been carried out to manage his behaviour in the community, whether he was receiving mental health support through the Care Planning Approach and noting that as Max had moved to Bedford Borough and had not been placed by CBC, he was now the responsibility of Bedford Borough mental health services and adult social care. The Ray Wyre risk assessment was completed in January 2020, which concluded that although Max was unlikely to pose a sexual risk to children as his behaviour was more akin to a young person who had experienced abuse rather than a sexual predator, he had a propensity to casual and risky sexual relationships. The children's social worker completed an assessment of Max's mental capacity on 24 January 2020, which concluded that he had capacity to make decisions relating to finances, use of knives, computer and phone, medication and restriction of movement.

3.10. Without professional support to oversee his concordance with prescriptions, Max stopped taking his medication in accordance with instructions as it made him feel drowsy. Instead, he started to self-medicate with illicit drugs and rapidly spiralled. Safeguarding referrals were made to BBC's Safeguarding Adults team by Max's uncle on 25 January 2020 and the children's social worker on 28 January, in relation to allegations of financial and physical abuse, which were referred to ELFT to investigate. Following urgent CMHT referrals and an A&E admission, on 30 January 2020, the Mental Health Crisis Team confirmed that it would consider whether Max met the criteria for their Intensive Support Team. On 1 February 2020, police were called after Max

[1] Under s58 of the Care Act 2014

took an overdose of prescription medication and he was informally admitted to acute mental health services. The police sent a safeguarding referral stating that his unsupported accommodation was placing him at risk and that he needed support to take his medication and attending appointments in particular. Police also raised concern that Max may be experiencing exploitation through cuckooing. Max was given home leave by the ward, but was returned to hospital by the police who found him intoxicated and behaving bizarrely. He was found not to be detainable and sent home again, but was found on 15 February by his mother, having overdosed and was detained under s5(2) of the Mental Health Act 1983 (MHA) then transferred to s2 for assessment on 17 February. Emergency Department staff and a charity providing support to Max made safeguarding referrals in respect of his hospital discharge in light of the harm he subsequently experienced, although it is unclear which council received these referrals and the outcome of any resulting investigation is not known.

3.11. Max's social worker reviewed his pathway plan on 2 March and indicated that he could not live independently, however, four days later the case transferred to a personal advisor. Due to ongoing safeguarding concerns, the hospital gave a view that Max required more suitable supported accommodation and his discharge was delayed for this to be arranged. The hospital expressed concerns to the CBC that Max was being cuckooed, and an Occupational Therapy assessment concluded that without supported accommodation, Max's mental health was likely to deteriorate. The ELFT Safeguarding team agreed to carry out a care assessment, including capacity. Despite this, only an initial assessment was completed before Max was discharged and there was a multi-disciplinary team decision to refer Max to the autism service. However, an assessment on the ward concluded that Max did not have any care and support needs or a severe and enduring mental health condition. The Bedford Triage Assessment and Brief Intervention (TABI) team agreed to further assess Max.

3.12. On 23 March 2020, the Government announced that England was entering lockdown in response to the Covid-19 pandemic. All non-essential shops and services closed, and people were required to work from home unless they were key workers. As numbers of infected patients and staff sickness surged, staff in many services were redeployed to enable the NHS to cope with the increasing numbers of hospital admissions, placing extreme pressure on the NHS and social care. The national lockdown significantly limited professional oversight, as face-to-face visits were limited and some safeguarding measures were not feasible, for example there were limited opportunities for temporary alternative accommodation due to tight rules about households mixing. However, the frontline practitioners working with Max continued in the efforts to provide him with face-to-face support, carrying out regular home visits although he was rarely found at home. Throughout this period there was widespread concern about the impact that the Covid-19 pandemic and lockdown measures would have on mental health and by May 2020 there was a significant rise in patients accessing secondary mental health services needing urgent and emergency mental health care.[2]

3.13. On 24 March 2020, ELFT's records indicated that Max was still detained under s2 MHA (after 36 days), which, if correct, was unlawful as a decision should have been taken after 28 days as to whether he needed to be detained for treatment under s3 MHA. On 25 March 2020, Max's pathway advisor made a referral to the PfA team, which was declined on the basis Max's primary needs related to his mental health and advised her to liaise with mental health services, but PFA also made a referral directly to Central Bedfordshire Mental Health and Pan Bedfordshire Early Intervention Services, seeking a transfer to the CMHT for clinical input and a care assessment, so he was opened to their TABI team. The pathway advisor also made a referral to CBC's Safeguarding Adult Team, raising concern that Max had refused to return to Onyx ward after being granted home leave[3] at his parents' address. She noted Max was at risk of

[2] Nuffield Trust Quality Watch blog, published 30.11.20 available at: https://www.nuffieldtrust.org.uk/news-item/what-impact-has-covid-19-had-on-mental-health-services

[3] Under section 17 of the Mental Health Act 1983

self-harm and sexual exploitation and that he had threatened his parents with violence. The safeguarding lead recommended that Max's treating clinicians should arrange an urgent (remote) meeting to resolve this impasse, including appropriate senior members of management from CMHT, Adult Learning Disabilities and The Leaving Care Team. As a consequence, a care and treatment review (CTR) were organised by the Onyx Ward. A second safeguarding referral was then received by CBC on 31 March 2020, raising concern about Max experiencing physical abuse while at his parents' home on leave from the ward. The safeguarding lead concluded that the threshold for a s42 enquiry[4] was met and that the CMHT should take the lead on the enquiry and an urgent assessment of Max's care and support was requested. ELFT Safeguarding's response queries whether a s42 enquiry was appropriate, as Max had not wanted a safeguarding enquiry in respect of another referral received earlier that week and noting the challenges in carrying out an investigation during the lockdown period. A Care Treatment Review was convened by the Learning Disability Commissioning Manager on 2 April which recommended that a care assessment, risk assessment, capacity assessment and mental health assessment needed to be undertaken, but it does not appear that these tasks were allocated to any agency or individual.

3.14. On 14 April 2020, Max was discharged from Onyx Ward to his parents' address as he was not detainable under the MHA because he did not suffer from a functional mental disorder and was assessed to have the capacity to make "*unwise decisions such as drinking or selling his body for sex* (sic)". No care assessment had been carried out. A referral was made to CMHT for support. Max's POhWER advocate immediately raised a safeguarding alert with BBC in respect of Max being discharged without any support in place.

3.15. From 14 April 2020 onwards, ELFT and BBC received a series of contacts and safeguarding referrals from Max, his family, his personal advisor, police, A&E, CBC's Safeguarding team and Sexual Health Services, evidencing a serious deterioration in Max's presentation. For example, on 16 April, a CMHT case manager was allocated and immediately received a call from Max, saying he was going to A&E, and he had considered taking a knife to his throat. The case manager ensured that he knew to go through Psychiatric Liaison Services in A&E, noting that Max was very familiar with the hospital. The following day, Max called again to say he was walking on the A421 towards Cambridge and the case manager called the police to bring him to safety. He was seen by the Mental Health Hub and given medication, which he immediately took in one go. Police were called by the CRHT on 17 April after Max stated he was going to 'kill children' and considered hanging himself with a noose. BBC's Safeguarding team spoke to the TABI team about the referrals being received, who advised that Max had been assessed as having no mental health needs and that a referral to the Learning Disabilities team was being considered. Although it was acknowledged that the threshold for a s42 enquiry was met and a referral to VARAC[5], practitioners felt that Max's consent to these interventions was needed and as he refused this, the s42 enquiry was closed. A multi-disciplinary team discussion on 23 April agreed that a care assessment should be carried out with ELFT taking case responsibility and PfA supporting, but Max would not cooperate with this and further efforts to assess him were unsuccessful as he was under the influence of drugs. A referral to the Early Intervention Service was declined and a further professionals meeting took place, where the Recovery Team and TABI agreed to informally assist.

3.16. At a further professionals meeting on 1 May, a decision was taken to look further into alternative accommodation, including the location and support and what had worked well for Max in the past. Leaving Care were clear that this would need to be provided through mental health services as they did not have the remit or funding to provide this.

[4] Under section 42 of the Care Act 2014

[5] Vulnerable Adult Risk Assessment Conference, a multi-agency risk management forum

3.17. Further safeguarding referrals were made to BBC by Leaving Care and Max's family in respect of a 'new man' staying with Max and a Complex Case discussion was convened by Children's Services on 12 May, which decided to flag Max 'high red' due to the increased risks and a further referral was made for an assessment under the Mental Capacity Act 2005 (MCA). The case manager and team manager attended Max's home to try to assess him that day when he missed his appointment. Because Max presented as unkempt and a risk of harm to himself and others, the Approved Mental Health Professional (AMHP) team was asked to visit. Max also alleged to the police that he had been raped and was working as an escort for drugs. Police recorded that he might be being cuckooed by 'John' (a pseudonym), who had his flat keys.

3.18. Police detained Max under s136 MHA, and his personal advisor and the TABI team manager believed that he would be detained in hospital, but instead he was released to be managed by the Crisis/CMHT teams, with a plan to visit twice daily. An emergency professionals' meeting was convened on 14 May. Mental capacity assessments were completed in respect of Max's ability to take decisions around sexual activity, drug use, finances and accommodation and he was found to lack the ability to retain the depth of information to make decisions in each area, with particular concern expressed in respect of being able to weigh the dangers of being cuckooed. During a home visit on 14 May, a man in his 50's was seen in Max's flat, under the influence of drugs.

3.19. On 18 May 2020, Max was found unconscious in Trafalgar Square following a Spice overdose. He was transferred to Crystal Ward in Luton and the Crisis team assessed that it was unsafe for him to return home in light of the identified safeguarding concerns around cuckooing and the risk of him being injected with drugs. Max's case manager was not contacted. He was assessed as not being detainable under the MHA and the treating psychiatrist considered that he had the capacity to make a decision about being discharged from treatment. In the early hours of 20 May, the AMHP team raised concerns about plans to discharge Max home with the ward manager, however, these were not relayed to the treating psychiatrist. Although RIO notes indicated a plan for Max to be discharged to supported accommodation/respite, Max refused this, wanting to return to his flat. By way of compromise, Max agreed that his mother could be contacted to bring his keys and take him home. Max referred to working for 'John', this was likely to be the individual previously identified by police as cuckooing Max.

3.20. On arriving home on 20 May 2020, it appears that Max met John and went to another associate's home. He had a telephone conversation with his aunt that evening, but failed to respond to any subsequent phone calls or messages. At the request of the Crisis team, his mother attended his home with keys on 22 May, when Max was tragically found dead. Toxicology tests found that he overdosed on morphine and cocaine, with other drugs in his system, suffering acute cardiorespiratory failure, to which bronchopneumonia contributed.

3.21. Following the Coroner's Inquest, ELFT and NHS England were directed to submit Preventing Future Death reports, on the basis that "*Transition arrangements within ELFT for individuals with high functioning autism were inadequate when Max turned 18 and, as a result, he was not transferred to the appropriate adult mental health team for continued treatment and to enable provision of an appropriate adult social care package, including suitable accommodation for him*."

4. Analysis of Agencies' Actions

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

4.1. Since 2014, substantial legislative changes have been introduced to strengthen the legal frameworks that facilitate provision of care and support for young people leaving care, with special educational needs or transitioning to adult social care, to ensure that partner agencies could work more closely to meet those needs in a holistic way. The Government recognises that

a ‘cliff-edge’ at 18 is detrimental to this cohort of young people, and the legislative framework seeks to ease their transition into the adulthood, by providing additional duties on statutory agencies to provide support up to the age of 25. However, the tension between safeguarding duties and the rights of adults to take capacious decisions in respect of their private lives, even where those decisions are unwise or harmful, and the restricted legal framework for intervention results in a marked inconsistency between the approach to safeguarding as children with care and support needs reach adulthood.

4.2. Cohesive, multi-disciplinary planning should have taken place to ensure that mental health, safeguarding, care and accommodation planning was coordinated for Max well in advance of his transition to adult services, given the very clear risks he posed and likely difficulties in commissioning a suitable placement. There were a number of pathways that placed a duty on safeguarding partners to assess and plan for Max’s transition to adulthood and all require practitioners from all relevant agencies exercise their powers and fulfil their legal duties in a manner that complies with overarching principles set out within associated guidance and the positive obligations under the Equality Act 2010 and Human Rights Act 1998. Article 2 (the right to life) and Article 3 (the prohibition on torture, inhuman or degrading treatment) of the Human Rights Act require public bodies to respond appropriately where there is a real and imminent risk, but this must be balanced against Article 5 (the right not to be deprived of liberty save in accordance with the law) and Article 8 (the right to a private and family life).

4.3. Importantly, these duties are intended to complement each other and provide a seamless framework for agencies to meet the needs of the individual, not to create barriers or disputes between or within organisations about where responsibilities lie. Whilst in some situations, regulations or guidance explicitly state that agencies must not allow the existence of the dispute to prevent, delay, interrupt or otherwise adversely affect the meeting of the needs of the adult[6], this ethos should apply irrespective of specific legislative requirements, in particular in circumstances where the individual’s Article 2 or 3 rights may otherwise be breached.

Maintaining an Education Health and Care Plan (EHCP)

4.4. Part 3 of the Children and Families Act 2014 and the SEN Code of Practice place a duty on local authorities to assess the educational needs of young people with learning or other disabilities and implement an EHCP to support them, ideally in mainstream education, until the age of 25. The annual review in Year 9 and any subsequent annual reviews until the young person leaves school must include preparation and review of a transition plan, drawing together information from a range of individuals within and beyond school in order to plan coherently for the young person’s transition to adult life. Statutory agencies are required to communicate and agree policies and protocols that ensure that there is a ‘seamless’ service, with a focus on the voice of the young person.

Leaving Care duties

4.5. The leaving care provisions in the Children Act 1989 places a duty on local authorities to act as good ‘corporate parents’ and provide for continuous support from social care for young people who have been accommodated under the Children Act 1989, up until the age of 25. Whilst these leaving care duties are clearly important, the Supreme Court has been explicit that the legal powers afforded local authorities under s23C to provide ongoing support to care leavers do not supplant the legal duties owed under the National Framework for Continuing Healthcare and Care Act to provide ongoing care and support to those reaching 18 with eligible needs. Leaving care powers are ‘*a far cry from a power to provide the full range of community care services … section 23C(4)(c) is an extremely slender thread on which to hang such extensive and burdensome duties. In my judgment, if Parliament had intended to confer a power of this scope,*

[6] e.g. regulation 2 of the Care and Support (Disputes between Local Authorities) Regulations 2014

it would have done so expressly.'[7] The Supreme Court further commented that the purpose of power under s23C of the Children Act is '*not to supplant the substantive regime, but to ease the transition (usually) to adult independence*.'[8]

Assessment of need for care and support

4.6. Section 58 of the Care Act 2014 places a duty on the local authority to carry out a child's needs assessment prior to their 18th birthday, to ensure that careful planning is in place to meet their care and support needs as they transitioned to the adult legal framework. The Care and Support Statutory guidance[9] sets out that an assessment should be carried out if a young person is 'likely to have needs', not just those needs that will be deemed eligible under the adult statute. The guidance also sets out the reciprocal duty for relevant partners to cooperate for the purposes of transitions and paragraph 16.43 states: "*Local authorities should have a clear understanding of their responsibilities, including funding arrangements, for young people and carers who are moving from children to adult services. Disputes between different departments within a local authority about who is responsible can be time consuming and can sometimes result in disruption to the young person or carer*." The ethos of the Care Act is that assessments should be needs-led and not restricted by available services. Diagnosis should not act as a barrier to support. Further, although the local authority can authorise other services, including BLMK or ELFT (through a section 75 agreement), to carry out assessments and provide care plans on their behalf, the statutory responsibility for safeguarding enquiries remains with the local authority.

Mental Health support and transitions

4.7. 2013 NICE guidance[10] on children with a diagnosis of autism also advocates that transition planning should start when the young person is 14, with an updated assessment of their needs to ensure a smooth transition to adult services. This further advocates a care planning approach to transfer between services in complex cases, which would have been appropriate in light of Max's sexualised behaviour. Although regular references are made in the chronology to CAMHS' intention to refer to adult services, this did not happen, resulting in further delay when he turned 18 due to the uncertainty around where he would be living. This guidance also requires staff to receive training and know how to assess risk, provide individualised care and make adjustments or adaptations to Health and Social Care processes to enable access and that they have skills to communicate with the young person. The expectation is that those providing care will anticipate and make adjustments to prevent behaviour that challenges or offer psychosocial interventions as a first line treatment for challenging behaviours.

4.8. In addition, regulations[11] and statutory guidance require '*effective channels of communication between all local authority staff working with looked-after children, CCGs, NHS England and health service providers, as well as carers – along with clear lines of accountability – are needed to ensure that the health needs of looked-after children are met without delay… They should also plan for effective transition and consider the needs of care leavers*.'[12] The National Framework for Continuing Healthcare ['CHC'] also requires Integrated Care Boards to have systems in place with local authorities to ensure every looked after child has an up-to-date individual health plan based on the written report of the health assessment and appropriate referrals are made so clinicians can be actively involved in transitional planning for anyone with significant health needs who may be eligible. Formal screening for CHC eligibility should occur when a young person is 16 and eligibility determined in principle when the young person is 17.

[7] R (Cornwall Council) v Secretary of State for health and others [2014] EWCA Civ 12, para 52
[8] R (Cornwall Council) v Secretary of State for health and others [2015] UKSC 46, para. 30
[9] Care and support statutory guidance - GOV.UK (www.gov.uk), para. 16.9
[10] Recommendations | Autism spectrum disorder in under 19s: support and management | Guidance | NICE
[11] The Care Planning, Placement and Case Review (England) Regulations 2010
[12] P.9 of 'Promoting the health and wellbeing of looked after children' March 2015 from the Dept. for Education and Dept. for Health (this is currently being revised) but was binding on the local authority and CCG at this time.

This is relevant to Max's case because of a specific focus within the CHC assessment tool on challenging behaviours, psychological and emotional needs.

4.9. ELFT's transitions policy[13] acknowledges that "*Adolescence… is a period associated with increased rates of psychiatric morbidity, substance misuse and risk-taking behaviours*" and that "…*healthcare transition is often inadequately planned, inefficiently executed and poorly experienced. There is a risk of disengagement at this crucial time as a result*". The policy (which was last refreshed in 2019) requires effective planning to begin 6 months prior to the patient's 18th birthday with a written referral to AMHS, and if assessed as eligible for an adult service (including determining whether they meet the criteria for the Care Programme Approach), for the young person to be seen jointly by CAMHS and AMHS during this period to familiarise the young person with the new service. The CAMHS consultant remains responsible for the young person's care until a formal transfer meeting takes place around the time of the young person's birthday.

Housing duties for care experienced young people

4.10. Section 23 of the Care Act 2014 and supporting statutory guidance seek to clarify the boundary between care and support and housing legislation. Suitable accommodation is one way of meeting a person's care and support needs, as the lack of suitable accommodation puts health and wellbeing at risk, although where a local authority is required to meet a person's accommodation needs under the Housing Act 1996, it must do so. Where housing is part of the solution to meet a person's care and support needs, or prevent them, then the care and support plan may include this, even though the housing element is provided under housing legislation. Any care and support required to supplement housing is covered by the Care Act 2014.

4.11. The Housing Act 1996 requires the local authority to secure accommodation for the applicant's occupation. This is owed to those who are homeless and eligible for assistance, have a priority need, and did not become homeless intentionally. Priority need includes vulnerability arising from disability. The Homelessness Code of Guidance 2018[14] for Local Authorities requires authorities in both unitary and two-tier areas to prepare joint protocols that establish arrangements to meet the accommodation needs of care leavers, including pathway planning systems that anticipate accommodation needs. They should engage each young person, their personal advisor and housing services staff regarding suitable housing options and any additional support needed including substance misuse services, so that the necessary arrangements are in place at the point where the young person is ready to move on from their care placement, with contingency plans in place.[15] However, a local authority cannot accept an application for homelessness assistance from a person who lacks the mental capacity to make it, the onus being on the local authority to assess the applicant's capacity.[16]

Transitional Safeguarding

4.12. Transitional safeguarding goes beyond the statutory duties in respect of transition planning for young people with care and support needs who are moving from children to adult services, set out in sections 58-66 of the Care Act 2014. The term describes the need for an approach to safeguarding adolescents and young adults fluidly across developmental stages, despite the differences between the legal frameworks for children and adults. The principles of transitional safeguarding require practitioners to meet the positive obligations under the Human Rights Act 1998, Article 2 (the right to life) and Article 3 (the prohibition on torture, inhuman or degrading treatment) and respond appropriately where there is a foreseeable, real and imminent risk. However, this must be balanced against the obligation to respect private and family life (Article 8) and liberty (Article 5). In circumstances where young people may not meet the statutory

[13] Microsoft Word - Policy for Transition from CAMHS to AMHS (elft.nhs.uk)
[14] Chapter 22: Care leavers - Homelessness code of guidance for local authorities - Guidance - GOV.UK (www.gov.uk)
[15] DfE (publishing.service.gov.uk)
[16] R v Tower Hamlets LBC ex parte Ferdous Begum (1993) 25 HLR 3019, HL; R (Uddin) v Southwark LBC (2019) EQHC 180

eligibility thresholds for services when they turn 18, this may require proactive consideration of the general duties (under s2 Care Act 2014) to prevent care needs, including mental health needs, escalating by providing advice and support. This recognises the particular impact of trauma on a young person's development. In June 2021, the Government published a briefing on Transitional Safeguarding to support best practice, with a particular focus on young people experiencing exploitation.[17]

Mental capacity

4.13. The Mental Capacity Act 2005 (MCA) sets down the right of a competent adult to take decisions, and applies to those over the age of 16. There can be a significant tension between the principal under section 1 of the MCA, that the fact a decision may be unwise does not mean that the person lacks the capacity to take that decision, and the duty on a local authority under section 42 of the Care Act 2014 to devise a safeguarding plan for adults with care and support needs who are experiencing abuse or neglect, where they are unable to protect themselves from that abuse. To take a competent decision, an adult must be able to understand information about the decision to be made, retain that information and apply it to the decision-making process, and communicate a decision. Practitioners must ensure they break down the information to be weighed in a manner that will best facilitate this process and consider the person's "executive capacity", which is the ability to implement decisions taken and to deal with the consequences and the impact of someone else's undue influence on the decision-making process.

4.14. Mental capacity assessments should explore rather than simply accept notions of lifestyle choice. This means applying understanding of executive capacity and how adverse childhood experiences, trauma and 'enmeshed' situations can affect decision making. NICE guidance[18] advises assessments should take into account observations of the person's ability to execute decisions in real life situations, highlighting the situational aspect of decision making. This should have been applied throughout the assessment, care planning and provision of support to Max. Where there is evidence that outside of an assessment environment the person is not able to understand or weigh up information to enact a decision, this should be thoroughly explored. The presumption of capacity under section 1 of the MCA does not override professional and statutory duties to ensure that young people or adults with care and support needs are safe from abuse, neglect or exploitation. "*There is a difference between someone who has an appreciation of risk and yet goes on to take the risk – albeit unwisely – and someone who… lacked awareness of the risk and sufficient problem-solving ability*." [19]

Transition from Children's to Adult Services and care pathways for neurodiverse young people

4.15. After coming into care at 16, Max was very carefully supervised and supported at all times due to the serious concerns around his self-harm, resulting in suicidal gestures such as walking into a canal and intrusive thoughts of sexual harm, which included making comments about wanting to sexually abuse or kill children. Max's family's view, which is consistent with the subsequent Ray Wyre assessment, was that Max would not have posed a sexual risk to other people and that many of the sexually explicit comments he made were designed to shock and gain attention, rather than being a statement of intent. However, practitioners could not ignore these statements and this issue presented a significant challenge in respect of identifying resources that could meet Max's already complex needs.

4.16. Within 3 months of the final care order being made, and more than 6 months before his 18th birthday, efforts were made to start planning for Max to transition to the adult framework and he was introduced to a leaving care personal advisor so that pathway planning could commence.

[17] Bridging the gap: Transitional Safeguarding and the role of social work with adults (publishing.service.gov.uk)
[18] NICE (2018) Decision Making and Mental Capacity. London: Overview | Decision-making and mental capacity | Guidance | NICE.
[19] Baker J, *GW v A Local Authority* [2014] EWCOP20, para. 45

However, the allocated social worker struggled to find the right adult pathway to obtain the support Max clearly needed. Although he had ADHD, anxiety and was on the autistic spectrum, his IQ was low without a diagnosis of a learning disability, and he was assessed as having mental capacity to take decisions around his care during the care proceedings. Max's consultant psychiatrist commented about the misunderstanding that arose through the description of Max having 'high functioning' autism, which he did not. However, the consultant said that Max's functional IQ was actually between 69-71, the borderline for a diagnosis of a learning disability[20]. In any event, Max had poor impulse control which seriously impacted his ability make decisions, and his functioning was further impacted by his medication, then later his substance misuse.

4.17. The referral made by the Children's Social Care's social worker to the Preparing for Adulthood Team (PfA) for an assessment of Max's care needs post-18 was drafted in strength-based terms, focussing on Max's abilities and talents. This approach is common in both Children's and Adults' Services and aims to empower and build the confidence of the individual, particularly as young people move towards adulthood. However, this made it more difficult for the PfA team to identify where Max's care needs lay and, as the immediate risks in terms of sexual risk and suicidal ideation were identified, these became the focus of the response, advising that a formal sexual risk assessment was required. The PfA manager also considered that Max's needs primarily presented as relating to his mental health, so advised that those needs should be properly assessed through a forensic mental health assessment, to enable Max to be supported by the appropriate mental health service. This advice was presented in a collegiate and helpful way, with the clear intention of supporting the children's social worker to navigate the required processes. A Section 75 agreement[21] between ELFT and Central Bedfordshire Adult Social Care sets out that when a case is open to a mental health team, that team will carry out the care assessment, as they are best placed to assess and meet the individual's needs. PfA offered to jointly carry out the care assessment, however, this offer was declined by ELFT.

4.18. Max was adamant that he did not want to move GPs, so remained registered with the surgery near his parents' home. At that time, Adult Mental Health Services would only accept referrals from people registered to local GPs, which meant that Max's CAMHS consultant was unclear which AMHS to refer Max to, so wrote a transition letter to his GP, to be forwarded once Max was rehoused. It appears that a 'chicken and egg' situation developed where accommodation could not be identified for Max because his mental health and care needs had not been adequately assessed, but referrals to adult mental health services could not be progressed because it was not known where he would be living. It is unclear why a Care Programme Approach was not followed by CAMHS or CMHT in accordance with NICE guidelines, given the complexity of Max's needs. Max's children's social worker also wrote to Bedford and Luton Adult Social Care, but both services said that they would not offer support or an assessment until it was known where Max would be living. This meant that Max's care and support needs were not assessed in advance of his 18th birthday, so no care plan was in place to support his needs post-18. Consequently, Max's needs were being managed by Children's Social Care through their leaving care duties, which was an inadequate framework to meet Max's highly complex care and support needs.

4.19. During this period, a number of meetings took place between different services in an effort to progress the case, including escalation to senior managers. However, this did not result in resolution of the stalemate in terms of which organisation should be leading on an assessment of Max's care needs and no care plan was ever put in place for him. The well-intentioned emphasis on trying to find the 'right' care and support for Max actually resulted in him receiving no care and support from adult mental health or social services during this critically important transitional period. In effect, his diagnoses became a barrier to Max obtaining support, as a service-led rather than needs-led approach was taken. Effective and timely leadership was

[20] A learning disability is usually defined as an IQ below 70 Learning disabilities | Health topics A to Z | CKS | NICE
[21] An agreement made under section 75 of National Health Services Act 2006 between a local authority and an NHS body in England

needed to resolve this impasse, and escalation needed to translate into decisive action. The statutory framework is clear that in the absence of resolution, ultimate responsibility for assessing and meeting Max's eligible care and support needs while he remained in his children's placement sat with Central Bedfordshire Adult Social Care, and if they considered that ELFT was not complying with the section 75 agreement, they needed to hold ELFT to account.

What has changed?

4.20. Since Max's death, ELFT has introduced a 'residence-based' practice in terms of taking a decision as to which mental health services should meet an individual's needs within Bedfordshire, so that these cases will be allocated where the person is physically residing, as opposed to where they are registered with a GP. Where it is not yet known where a young person will move to when they turn 18, their current CAMHS area will remain responsible for transition planning. Although this may result in some challenges in circumstances where patients move out of the Trust's catchment area without changing GPs, as other NHS Trusts generally still follow the government guidance that places the duty on the area of the person's GP, this presents as good practice, ensuring that the individual's needs are met in their local area and preventing situations such as Max's from arising, where he could not register with a new GP he had moved to his new address.

4.21. ELFT's Preventing Future Deaths response to The Coroner set out that their transitions protocols have been strengthened since Max's death, including appointment of two full-time transitions workers in the Neurodevelopmental team to ensure a smooth transition from the age of 17½ until they are embedded in adult mental health and social care. This is supported with a strategic transitions lead to work across the Trust and local authorities to embed robust transitions pathways, with practice quality assured through regular audits.

4.22. Managers advised that the introduction of a Transitions Panel for Central Bedfordshire has improved transition planning for young people locally, although this is an overview panel and does not provide a mechanism to resolve 'stuck' cases. Children's Social Care practitioners noted that as a consequence of this case, their understanding of care planning pathways had been strengthened. They felt that they better understood how to progress key elements of planning such as the need to incorporate risk and capacity assessments within the referral process to secure a holistic assessment of needs. They also had greater confidence to escalate and challenge decisions or obstacles where necessary.

4.23. Both local authority and health leaders and practitioners noted that there had been some improvement in communication between services in complex cases, likely in part due to the increased use of videoconferencing to convene meetings, making these more straightforward to organise. Channels of communication at director level in particular was noted to have improved.

Systems finding

4.24. Gaps in collaborative assessment and planning for Max's transition and rigid application of 'eligibility' criteria for individual services meant that no adult services were in place at the point Max turned 18 despite his unquestionably complex needs. Pathways to secure a timely assessment of Max's care and supports needs were opaque and overreliance on services designed to provide 'life skills' support impeded preventative work to stop risks from escalating. A clear pathway is needed for young people with autism transitioning to adulthood across Bedfordshire, irrespective of their level of functioning, across Children and Adults' mental health and social care, with specialist services that can meet the assessed needs.

Recommendation 1: *ELFT, Central Bedfordshire Council and Bedford Borough Council should review existing mechanisms for dispute resolution and escalation in cases where either there is*

delay, a disagreement in respect of whether Health or Social Care should take the lead on carrying out a care assessment or review (including interdepartmental disputes), or where any agency (or the individual or their family) holds concern that the assessment or care plan are inadequate to meet a person's needs, to ensure disputes are promptly and decisively resolved and that all agencies are held to account for meeting the individual's needs during this process. The SAB should promote awareness of these pathways and dispute resolution mechanisms across the partnership.

***Recommendation 2:** The SAB to seek an assurance report from ELFT in respect of the effectiveness of its strengthened transitions policy and audit process, and from Central Bedfordshire in respect of the introduction of a Transitions Panel. Subject to an evidence-based assessment of the benefits of this panel, Bedford Borough should consider adopting a mirror process, to ensure a seamless service provision across Bedfordshire for all young people transitioning to adulthood, irrespective of where they live in the county. The SAB Quality Assurance Sub-group should include audits on the timeliness and quality of transition referrals from CAMHS and Children's Social Care, and the quality of the response from adult services in its annual audit cycle.*

***Recommendation 3:** Improvements to ELFT's practice, such as the move to residence-based allocations for the adult mental health teams and introduction of transition specialists within the Neurodiversity teams, should be captured within policies so that these are transparent to patients and other practitioners. The SAB should promote awareness of these policies across the wider partnership and seek assurance from partners in respect of current workstreams to improve access to specialist Neurodiversity pathways, in accordance with duties under the Autism Act 2009 and Equalities Act 2010.*

Housing options for young people transitioning to adult services

4.25. Bespoke and flexible rather than standardised responses are often needed for addressing the complex needs of young people beyond housing to include physical health, mental health and care and support. However, nationally there is a shortage of specialist housing to meet the need of individuals who have complex needs. Therefore, to achieve that bespoke response requires a collaborative and collegiate culture across the partnership that endorses challenge, values information-sharing and discussion, appreciates the value of integrated approaches towards prevention and of sharing expertise, and supports practitioners[22]. Additionally, the Care and Support Guidance, which accompanied the Care Act 2014, underlines the importance of adopting a right based, person centred approach, requiring practitioners from all 'relevant agencies' to exercise their powers and fulfil their legal duties in a manner that complies with the positive obligations under the Human Rights Act 1998 and respond appropriately where there is a real and imminent risk.

4.26. Leading up to Max's 18th birthday, frequent meetings took place to attempt to progress Max's transition and find suitable accommodation, these included discussion of risk and capacity. Extensive referrals were made to specialist placements for young people with additional support needs, but Max did not meet their criteria, either because he did not have a learning disability, the perception of sexual risk excluded him from placements with more vulnerable young people, and referrals to specialist mental health provision would have needed to be led by Adult Mental Health Services.

4.27. Central Bedfordshire noted that no semi-independent accommodation was available in the local area and that supported accommodation through mainstream housing provision primarily targeted people with substance misuse problems or who were at risk of street homelessness, but Max's needs would have been too high. Supported living accommodation was clinically led in terms of care needs and was only available to adults who were open to the Learning

[22] Adult Safeguarding and Homelessness: a briefing on positive practice; ADASS and the Local Government Association.

Disabilities team. Max did not 'fit' in a specific adult team, so fell through a gap. Consideration was given to Shared Lives or approaching carers who would be open to a Staying Put arrangement, but Max did not want to live in a family environment. Because of the risks posed by Max, Children's Services were clear that a placement with children could not be considered.

4.28. Children's Services showed good practice by extended his supervised children's residential unit for several months while efforts were made to progress a care assessment or identify an alternative placement, but this could not continue indefinitely. Max himself was adamant that he wanted to live independently in his own tenancy and although an assessment by housing concluded that he would be unable to manage a council tenancy independently, Max's parents agreed to co-sign the tenancy and Children's Services paid the difference between Max's independence fund payments and the rent, to minimise the risk he could be evicted for rent arrears. An assessment of Max's mental capacity to manage a tenancy was not completed before he signed this tenancy, despite the view from housing that Max's needs were too high.

4.29. It is likely that the professional view of Max's capacity was influenced by the formal assessment during the care proceedings that Max did have capacity to take decisions in respect of his placement and supervision. However, the very close supervision he was placed under through the Deprivation of Liberty order made by the Family Court and careful care and support during his placement may well have masked his very limited abilities in respect of recognising and weighing the risks of living independently. This was exacerbated by the poor impulse control linked to his ADHD and lack of insight into the motivations of others arising from his autism. His CAMHS consultant psychiatrist stated that had he been asked whether Max had the capacity to live on his own without support, his response would unequivocally have been 'no'. Children's Social Care noted that the psychiatrist had been present throughout child in care reviews where, in the absence of a specialist placement being identified, plans were made for Max to move into a private tenancy. However, given the extent of Max's needs, it seems reasonable that an assumption would be made that a care plan for Max would include ongoing support in managing the activities of daily living.

4.30. Max's social worker commented that Max needed a more specialised and nuanced assessment of his capacity in respect of specific areas of independent living and keeping himself safe. However, he felt this would not have assisted in terms of identifying alternative accommodation, as this came down to a lack of specialist provision that would offer Max a placement. In particular, the absence of accommodation to meet the needs of young people diagnosed with Autistic Spectrum Disorder was an enormous gap, as other types of accommodation available were unsuitable for Max's specific needs. Managers from PfA have noted that alternative supported accommodation is available locally that may not have been considered, and it appears that had Max's care and support needs been assessed, a broader suite of placements could have been available.

4.31. There was evidence of careful planning to meet Max's educational needs in accordance with SEN duties, prioritising his wish attend a music course in a mainstream college. Due to Max's behavioural needs, 1:1 support was provided to him in the classroom by the local authority's Special Educational Needs Service. His educational needs were also carefully weighed when making decisions about his accommodation, recognising that for Max, it would be important that his accommodation was close to his college so that he could travel independently. Once Max moved to independent accommodation, his attendance started slipping and, having been out of mainstream education for over a year, he found it more difficult to comply with boundaries and assignment requirements.

4.32. This focus on Max's educational needs may have overshadowed decision-making around his accommodation needs. When seeking to identify a tenancy for Max, Children's Social Care prioritised identifying accommodation near his college, so that Max could travel to college independently. However, several practitioners involved in the review commented on the

unsuitability of the location for someone with Max's vulnerability, as this was known to be an area with a high number of rough sleepers and adults with long-standing substance misuse problems. Associating with older adults with entrenched addictions is a recognised risk in respect of a young person's substance misuse escalating, as this can normalise heavier use of harder drugs. Additionally, this accommodation was in Bedford Borough Council, meaning that a different local authority became responsible for meeting Max's care and support needs, further complicating the pathways to obtain support for Max.

4.33. Both Bedford Borough Council and Central Bedfordshire have Risk Enablement Panels, to provide strategic support for cases where individuals with co-morbidities such as substance misuse, mental health or autism are at risk of multi-exclusion homeless. This provides creative advice from a multi-disciplinary panel and is chaired by an associate director who is a budget holder. Although not typically used for young people transitioning to adult services, this may have provided a useful forum to explore alternative options or to remove the barriers to support for Max.

Systems finding

4.34. Limited options for specialist accommodation resulted in Max moving to private accommodation that could not meet his needs in the absence of an effective care plan. There is a clear need for specialist placements or, in the interim, greater flexibility from commissioners locally to use powers under National Health Service Act 2006[23], Mental Health Act 1983 and Care Act 2014 to provide accommodation-based support that is needs-led rather than diagnosis-led.

Recommendation 4: *A housing/accommodation pathway and protocol for vulnerable adolescents and young adults, including care experienced young people, should be co-produced by Central Bedfordshire and Bedford Borough councils, ELFT and BLMK to ensure that young people and young adults already at risk are not placed at an even greater risk as a result of being placed in unsuitable housing. The protocol and pathway should allow for more bespoke commissioned placements or support packages to target the needs of individuals, involving joint commissioning with Health to ensure that there is a seamless spectrum of provision from individuals with pure social care needs to those with neurodiversity, continuing healthcare needs or who are being discharged from mental health wards.*

Recommendation 5: *In any cases where individuals are placed, including temporarily, in accommodation which is unsuitable for their vulnerabilities or mental health needs, a multi-agency strategy meeting should be promptly convened by the lead agency and the resulting safeguarding plan kept under review to ensure that risk is continuously re-assessed and managed. Any care and support, pathway or aftercare plan in place must be reviewed to ensure that the holistic individual's health, care and/or support needs are met in this accommodation.*

Mental health, mental capacity and risk management

4.35. Having missed the opportunity to assess Max's care and support needs or carry out nuanced capacity assessment prior to his move to his own tenancy in January 2020, Max's drug use escalated shocking quickly and his presentation rapidly deteriorated. Max had moved from a residential unit where he was the only young person with 2:1 support, to living entirely alone on 'one of the most dangerous streets in the borough', with no package of support to help him manage the activities of daily living or oversee his concordance with medication prescribed to support his mental health. In the sudden absence of any boundaries at all, Max had no ability to cope or self-regulate. By the time Max's case transferred to the Leaving Care team in March, the flat was in an appalling state, filthy, with no running water or electricity. Max had stopped showering, and his personal advisor noted that he even needed to be prompted to drink water.

[23] Consistent with the obligations set out in National Framework for Continuing Healthcare

This harm was foreseeable, and with an adequate multi-agency care plan, potentially preventable.

4.36. Max's chaotic presentation resulted in police taking him to hospital twice in February 2020, initially following an overdose, after which he was informally admitted as an inpatient. He had been living independently for just one month. Section 136 of the Mental Health Act 1983 (MHA) empowers a police officer to remove any person appearing to be suffering from mental disorder and in immediate need of care and control from a public place to a place of safety. Mental health practitioners are required to assess the person within 4 hours to determine whether they need to be detained for assessment under section 2 of the MHA or informally admitted to hospital with consent, which creates a time pressure in respect of efforts to gather background information and liaise with the team around the person. In mid-February, police returned Max to hospital after finding his intoxicated and behaving bizarrely while on leave from the ward. Consequently, Max was detained under section 2, and he remained an in-patient on a mental health ward for 2 months, albeit voluntarily after the first 28 days and with periods of leave. Max was RAG-rated 'red' by ELFT throughout this period; however, this did not translate into risk management through BBC's High-Risk Panel for Adult Social Care, which may have helped to crystalise multi-agency co-ordination more quickly.

4.37. Throughout this period safeguarding referrals continued to be raised due to concerns around intra-familial physical abuse and exploitation. However, the primary concern continuously raised (both through safeguarding referrals and of multi-agency contacts) was the fact that no care and support plan was in place for Max and practitioners disagreed about the underlying cause of his disordered presentation. This included multiple referrals from Max's personal advisor, who clearly recognised that his needs could not be safely managed through leaving care duties alone and was proactive in her efforts to secure a multi-agency response. The CBC safeguarding lead's response to the safeguarding referral on 25 March 2020 noted that:

> *'…there seems to be a difference of opinion about the support Max should receive, on one hand the Central Bedfordshire Council Learning Disabilities team believes Max is 'mentally unwell and should be managed by CMHT' whilst his clinical team on the ward consider that 'his behaviour is not due to a mental health problem, it's more of a learned behaviour.'*

4.38. At the recommendation of the safeguarding lead, a multi-disciplinary care treatment review was arranged. A second safeguarding referral was then received on 31 March 2020, and having determined that the threshold for a s42 enquiry was met, the CMHT was allocated to take the lead on the enquiry. The safeguarding lead gave clear and appropriate advice on further steps around multi-agency risk assessment/management and a Care Act compliant assessment of Max's care and support was urgently requested, including consideration of whether he required specialist accommodation. Despite this, no care plan or risk management/safeguarding plan was in place when Max was discharged from the ward in mid-April, resulting in a complaint from his advocate. A series of safeguarding referrals to BBC in mid-April were not progressed as a s42 enquiry despite the threshold being met, because Max did not consent to this, but insufficient consideration appears to have been given to whether Max had the capacity to take decisions in respect of keeping himself safe.

4.39. Practitioners commented that Max was able to present in a calm and rational manner when mental capacity assessments were being carried out in an institutional setting such as the mental health ward. He was particularly persuasive with people who did not know him well. However, he was wholly unable to recognise or weigh risks in real life. Likewise, he could verbalise how to meet the needs of daily living in a controlled environment but had no ability to put this into practice in the community. Consequently, there was a sharp contrast in the views of practitioners trying to assess Max's mental capacity and the 'light touch' care assessment undertaken on the ward in March concluded that he did not have care and support needs, although it was immediately agreed that this should be reassessed in the community.

4.40. As the number of hospital admissions, safeguarding referrals and level of harm Max was experiencing continued to escalate in April and May, the response from the professional network strengthened, with a number of multi-disciplinary meetings convened in an effort to manage the escalating risk. By coincidence, when Max was allocated to the TABI team on discharge from hospital, the allocated worker had previously worked with Max while he was with CAMHS and was utterly shocked by the change in his behaviour. She was clear that the deterioration in his presentation related to unmet care needs, rather than an escalation in his mental health.

4.41. Efforts to carry out care and capacity assessments in the community were unsuccessful, as Max was not willing, or possibly unable, to meet with practitioners. By this stage Max was rarely seen sober and although both the TABI and Leaving Care workers attempted home visits on a daily basis despite the strictures of lockdown, Max was almost never found at home. Following a further hospital admission on 14 May when Max alleged that he had been raped and was sex-working, the multi-disciplinary team convened an emergency professionals meeting assessed that Max lacked capacity to take decisions in four key areas, sexual activity, drug use, finances and accommodation. However, decisions had not yet been taken around the funding for what was likely to be an expensive placement, nor had a placement been identified. A decision was taken to seek legal advice in respect of the process of applying to the Court of Protection as this arrangement could not be authorised through a standard Deprivation of Liberty Safeguards authorisation when Max was clear that he wanted to live independently. However, Max's capacity to understand the risks of non-concordance with his prescription medication does not appear to have been assessed. Max's father advocated for the administration of depo medication to help stabilise his mental health and it is unclear what consideration was given to this view as a way forward.

4.42. During Max's final admission to hospital on 18 May, he was assessed as not being detainable under the MHA and the treating psychiatrist considered that he had the capacity to make a decision about being discharged from treatment. In the early hours of 20 May, the AMHP team raised concerns about plans to discharge Max home with the ward manager given the risks to Max, however, these were not relayed to the treating psychiatrist. This presents as a simple human error in a pressured situation, but one that may have been a tragic missed opportunity. When discussed during the review, the clinicians stated that it was likely that even had they been informed of the concerns raised by the AMPH, they would likely have made the same decision, as Max was not detainable under the MHA and their assessment, as decision makers under the MCA, was that he had the capacity to take a decision about whether to remain in hospital.

4.43. It is fair to say that practitioners became over reliant on mental health admissions to manage the risks to Max, which was not appropriate. The MHA cannot be used to manage substance misuse as this is explicitly excluded from the definition of a mental disorder in section 1 of the Act. The Code of Practice that accompanies the MHA[24] underlines the importance of adopting a human rights and person-centred approach. It also reiterates the importance of compliance with related legislation including Mental Capacity Act 2005 and Care Act 2014 duties. Furthermore, statutory guidance for local authorities and NHS organisations[25] requires agencies to work in partnership to substantially reduce in reliance on inpatient care for people with autism. "*This requires personalised care planning, discharge planning, the provision of alternative community-based settings for treatment and care and support provision and crisis intervention and support*."

4.44. However, more effective, direct communication between the clinicians and either the AMHP or the TABI team may have enabled the clinicians to assess Max's capacity in respect of broader issues: whether he had the capacity to weigh and retain information in relation to the risks in relation to his drug use, non-concordance with prescriptions, sexual activity and accommodation while the professional network urgently sourced alternative accommodation. As set out in the

[24]Full details of the guiding principles under the MHA are given in Chapter 1 of the MHA Code of Practice available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

[25] Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy (publishing.service.gov.uk)

NICE Decision Making and Mental Capacity Guidance, assessments should take into account observations of the person's ability to execute decisions in real life situations, so the number of recent admissions and safeguarding referrals provided a strong body of evidence that Max did not have capacity in respect of these risks. Section 4B of the MCA permits someone to be deprived of their liberty in an emergency, if there is reasonable belief that a 'vital act' is necessary to prevent a serious deterioration in the person's condition. Here, a 'vital act' of depriving Max of his liberty for a short period under the MCA while an application was made to the Court of Protection would have been a necessary and proportionate response. Ideally, clinicians or staff from the ward would have been invited to attend the emergency professionals meeting, so that they could participate fully in the safeguarding planning.

4.45. Given the relatively narrow time period covered by this review, the number of agencies and practitioners working with Max across the county was enormous and extremely complex to unpick, even for practitioners. Several commented on how difficult they had found it to navigate communication with all of the agencies involved. In light of Max's relatively low cognitive functioning and autistic spectrum diagnosis, the number of agencies must have been very confusing and at times, overwhelming for him.

Systems finding

4.46. Siloed working between mental health and social care resulted in practitioners taking entrenched positions in respect of each agencies' analysis of Max's needs, functioning and mental capacity. This was exacerbated by the sheer number of agencies involved, without any taking a leadership or coordinating role and incompatible ICT systems hindering information sharing. Although agencies eventually resolved this and started to work in a collaborative and strategic way to care plan and manage risk, this delay had allowed Max's needs to spiral dangerously. The bureaucracy of arranging complex care plans further hindered efforts to provide an agile response to the escalating crisis. This fragmented approach also meant that clinicians from the mental health ward were not integrated in safeguarding planning.

Recommendation 6: *The SAB should consider whether any existing risk forums can be utilised, expanded, merged or a new panel established to provide clear strategic oversight, a cohesive multi-agency response across Bedfordshire and contemporaneous problem-solving by budget-holders in complex, urgent and high-risk cases.*

Recommendation 7: *In situations where a person has frequent mental health admissions, clinical staff on keys wards should be invited, and commit to attending multi-agency professional and strategy meetings, to strengthen an integrated approach between hospital mental health teams and the wider professional network, with an aim to reducing reliance on mental health admissions and identify effective crisis plans.*

Recommendation 8: *ELFT should consider how the role of the care coordinator can be strengthened in complex cases, in particular when multiple agencies are involved in supporting the individual. The SAB should agree a protocol to enable a clear lead professional to be identified to coordinate agencies in complex cases where a care coordinator is not allocated.*

Recommendation 9: *CBC's Children's Social Care should strengthen training programmes for children's social workers and personal advisors in respect of mental capacity, including the concepts of executive and fluctuating capacity, to improve transition planning and bolster the confidence of their staff in challenging decisions on capacity by adult services, seeking legal advice if necessary. This is of particular importance in light of the upcoming legislative changes in respect of Liberty Protection Safeguards. Consideration of mental capacity in respect of key aspects of independent living needs to be embedded in referrals from Children's to Adult Social Care and considered fully in transition and pathway planning meetings and SEN reviews.*

Recommendation 10: *Partners should consider how to strengthen ICT systems to parse key safeguarding information between agencies and departments.*

Response to exploitation

4.47. Section 42 of the Care Act 2014 requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. An early response to emerging harm is essential to stop risks from escalating. In circumstances where multiple agencies or individuals are making safeguarding referrals to ACS, a s42 enquiry should be undertaken, even if individually each concern would not meet the threshold for further investigation.

4.48. Financial abuse of adults with care and support needs features in 13% of SARs and is identified as a contributory factor in other forms of abuse, particularly physical abuse, discriminatory, psychological and emotional abuse and domestic abuse.[26] Too often this results in people with care and support needs being left without financial security and unable to meet their basic needs, including people specifically targeted for financial/ material abuse because of their disabilities or social isolation (often referred to as 'mate crime'). Having been isolated in his placement for 18 months, Max then struggled socially at college, alienating his classmates by trying too hard to impress them. He was eager to make new friends, and indiscriminate in these friendships, possibly drawn to adults significantly older than him after an extended period of 2:1 supervision by adults.

4.49. A person's additional support needs or vulnerabilities often mask the true extent of exploitation and abuse. People diagnosed with autistic spectrum disorder are twice as likely to have problematic substance use and this risk increases if the person has comorbid attention deficit hyperactivity disorder, as in Max's case.[27] People with mental health needs or autism and problematic drug alcohol are often in highly vulnerable situations with fewer supportive social networks and have greater exposure to manipulative and violent individuals. Their mental health needs and problematic drug and alcohol use may increase dependency, impair decision making and make the person more susceptible to coercive control.[28]

4.50. Practitioners were unclear whether statements Max made about having sex in exchange for money or drugs were accurate or related to Max's intrusive sexual thoughts and desire to shock. The Ray Wyre sexual risk assessment had concluded that Max had a propensity to casual and risky sexual relationships and could be vulnerable to abuse, evidenced by Max's disclosure on 12 May 2020 of being raped. The courts are appropriately wary of intervening in a person's Article 8 rights in respect of intimate relationships, concluding that the test should be set at a 'relatively low level' of understanding the nature, character and consequences of sexual intercourse and their right to consent or withhold consent. As noted by Hayden J in a 2019 judgment: "*depriving an individual of a sexual life in circumstances where they may be able to consent to it with a particular partner, is not 'wrapping them up in cotton wool'. Rather, it is depriving them of a fundamental human right.*"[29] However, shortly before his death, a capacity assessment concluded that Max was not able to weigh the risks around sexual activity and it is likely that a programme of sex education in a controlled environment would have been needed to determine whether Max's understanding in this regard could be improved.

4.51. A number of safeguarding referrals raised concerns about the people that Max was spending time with and that older adults were often seen around his flat. Max's mother and sister described that Max had told them about being forced to withdraw money from his bank account at knife point on one occasion and his possessions had started to go missing, including his

[26] National SAR Analysis [2020] LGA.
[27] Butwicka A et al; Increased Risk for Substance Use-Related Problems in Autism Spectrum Disorders: A Population-Based Cohort Study. J Autism Dev Disord. 2017 Jan;47(1):80-89
[28] Finding from Lincolnshire SAB's thematic review into financial exploitation, available at: https://www.lincolnshire.gov.uk/downloads/file/5075/lsab-executive-summary-sar-thematic-review-financial-exploitation
[29] ***London Borough of Tower Hamlets v NB (consent to sex)*** [2019] EWCOP 27 on BAILII, para. 41

mobile on more than one occasion and the musical equipment that Max had once taken such pride in. Police officers noted that although Max may have been experiencing mate crime, the allegations he made could be inconsistent or he would not provide a witness statement, so criminal investigations could not be progressed. Sometimes his stories appeared confabulated, for example he told officers that he was a cannibal. Although Max had invited 'friends' to stay with him, there was limited evidence that he was being cuckooed as it did not appear that his flat had been taken over for the purpose of criminal exploitation.

4.52. Interestingly, on two occasions, safeguarding referrals were made by older substance users who had been spending time with Max and were very worried at how dangerous his substance use was. Again, Max's naivety, poor impulse control and inability to weigh risks meant that he was using a large volume and variety of substances and had not learnt techniques to reduce the dangers associated with his drug use. Given the source of these referrals as experts by experience in harmful substance misuse and the reluctance of most drug users to report other users, very significant weight should have been attached to these concerns and an urgent response provided.

4.53. The safeguarding concerns in respect of exploitation were embedded within the wider concerns around Max's substance use and the risks associated with his unmet care and support needs. It was in accordance with good practice that the s42 enquiry was delegated to the mental health teams working with Max, as they knew him and were best placed to assess and respond to the wider concerns. However, it is unclear whether those services had significant experience in providing a safeguarding response to criminal or financial exploitation.

4.54. Although regular multi-disciplinary meetings were taking place to manage the global risks to Max, in particular to consider whether he had capacity to understand the risks around his substance use, specific focus on the issue of exploitation may have facilitated more effective disruption strategies. Central Bedfordshire's Cuckooing Policy and Procedure advises that the Safer Communities Partnership officer should be invited to any strategy meetings and sets out some of the contextual safeguarding measures that can be used to attempt to disrupt exploitation, for example by increasing high visibility patrols by Safer Neighbourhoods officers in the area. Practitioners commented that the all-ages exploitation tool kit (which is of good quality), and training were well established for children's services, but less well known in respect of adult services.

Systems finding

4.55. The overwhelming urgency of resolving Max's needs for specialist care and support drew focus from the issue of exploitation, resulting in a limited multi-agency safeguarding response. An all-ages approach to exploitation should be developed ensure that pathways, tools and training are available to all practitioners working with people experiencing exploitation, with a particular focus on embedding knowledge for practitioners working with younger adults who have transitioned from children's to adults' services. This requires legal literacy in respect of frameworks for intervention and an effective multi-disciplinary strategic approach.

Recommendation 11: *The Safeguarding Children Partnership and members of the Safeguarding Adult Board should more widely publicise the multi-agency exploitation strategy, training and tools to facilitate an all-ages approach to tackling exploitation.*

Recommendation 12: *The SAB should consider providing more extensive information and guidance about the Transitional Safeguarding needs of care experienced young people, drawing on the recently published briefing document 'Bridging the Gap' from the Chief Social Worker for Adults.*

5. Recommendations Emerging from this Review

Recommendation 1: ELFT, Central Bedfordshire Council and Bedford Borough Council should review existing mechanisms for dispute resolution and escalation in cases where either there is delay, a disagreement in respect of whether Health or Social Care should take the lead on carrying out a care assessment or review (including interdepartmental disputes), or where any agency (or the individual or their family) holds concern that the assessment or care plan are inadequate to meet a person's needs, to ensure disputes are promptly and decisively resolved and that all agencies are held to account for meeting the individual's needs during this process. The SAB should promote awareness of these pathways and dispute resolution mechanisms across the partnership.

Recommendation 2: The SAB to seek an assurance report from ELFT in respect of the effectiveness of its strengthened transitions policy and audit process, and from Central Bedfordshire in respect of the introduction of a Transitions Panel. Subject to an evidence-based assessment of the benefits of this panel, Bedford Borough should consider adopting a mirror process, to ensure a seamless service provision across Bedfordshire for all young people transitioning to adulthood, irrespective of where they live in the county. The SAB Quality Assurance Sub-group should include audits on the timeliness and quality of transition referrals from CAMHS and Children's Social Care, and the quality of the response from adult services in its annual audit cycle.

Recommendation 3: Improvements to ELFT's practice, such as the move to residence-based allocations for the adult mental health teams and introduction of transition specialists within the Neurodiversity teams, should be captured within policies so that these are transparent to patients and other practitioners. The SAB should promote awareness of these policies across the wider partnership and seek assurance from partners in respect of current workstreams to improve access to specialist Neurodiversity pathways, in accordance with duties under the Autism Act 2009 and Equalities Act 2010.

Recommendation 4: A housing/accommodation pathway and protocol for vulnerable adolescents and young adults, including care experienced young people, should be co-produced by Central Bedfordshire and Bedford Borough councils, ELFT and BLMK to ensure that young people and young adults already at risk are not placed at an even greater risk as a result of being placed in unsuitable housing. The protocol and pathway should allow for more bespoke commissioned placements or support packages to target the needs of individuals, involving joint commissioning with Health to ensure that there is a seamless spectrum of provision from individuals with pure social care needs to those with neurodiversity, continuing healthcare needs or who are being discharged from mental health wards.

Recommendation 5: In any cases where individuals are placed, including temporarily, in accommodation which is unsuitable for their vulnerabilities or mental health needs, a multi-agency strategy meeting should be promptly convened by the lead agency and the resulting safeguarding plan kept under review to ensure that risk is continuously re-assessed and managed. Any care and support, pathway or aftercare plan in place must be reviewed to ensure that the holistic individual's health, care and/or support needs are met in this accommodation.

Recommendation 6: The SAB should consider whether any existing risk forums can be utilised, expanded, merged or a new panel established to provide clear strategic oversight, a cohesive multi-agency response across Bedfordshire and contemporaneous problem-solving by budget-holders in complex, urgent and high-risk cases.

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6. Glossary

ADASS	Association of Directors of Adult Social Services
BBC	Bedford Borough Council
BLMK	Bedfordshire, Luton and Milton Keynes Integrated Care System
CBC	Central Bedfordshire Council
BBCBSAB	City and Bedfordshire Safeguarding Adults Board
CMHT	Community Mental Health Team
ECHR	European Convention on Human Rights
ELFT	East London Foundation Trust
GDPR	General Data Protection Regulation
ICS	Integrated Care System
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
NICE	National Institute for Health and Care Excellence
P2R	Pathway to Recovery, ELFT
PfA	Preparing for Adulthood, CBC
SAR	Safeguarding Adult Review
TABI	Triage, Assessment and Brief Intervention Team, ELFT