Cwm Taf Safeguarding Boards

Adult Practice Review Report

Re: CTSB 1/2016

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

The Social Services and Well-being (Wales) Act 2014 guidance 'Working Together to Safeguard People, Volume 3 – Adult Practice Reviews' sets out the criteria for conducting an Adult Practice Review. It states that a Safeguarding Board must commission an Extended Adult Practice Review where an adult at risk who has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a Local Authority has determined to take action to protect them from abuse or neglect following an enquiry by a Local Authority, and has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health.

In addition, 'Volume 2 – Child Practice Reviews' sets out the criteria for conducting a Child Practice Review. It states a Safeguarding Board must undertake an Extended Child Practice Review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development;
  and
- the child was on the child protection register and/or was a looked after child (including a person who has turned 18 but was a looked after child) on any date during the 6 months preceding:
  - the date of the event referred to above; or
  - the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

In accordance with the above criteria the Cwm Taf Safeguarding Board commissioned this Adult Practice Review following the death of the young person who was previously Looked After by the Local Authority on a number of occasions. Due to the nature of the death and the level of multi-agency involvement both as a child and an adult the

Safeguarding Board's Case Review Group agreed that a review was required.

Given the extensive multi-agency involvement throughout the young person's life the decision was taken to extend the time period covered by the Review to 31 months prior to death.

The young person was born in South Wales, UK in March 1997 and lived with their mother and brother. Their father was estranged although living elsewhere in the South Wales area. In addition the young person had a loving and supportive relationship with their maternal grandparents who also lived locally.

The first child protection concerns brought to the attention of the Local Authority were when the young person was still a baby, with concerns that mother was struggling to meet the needs of the child. After this episode there was no contact with child protection until the young person was a teenager. From early teenage years school attendance became poor and then there was complete absence from education along with an increase in the use of alcohol and drugs.

Following escalating problems the young person was accommodated under Section 20 of the Children Act, 1989 on six different occasions and subject to a Child Protection Plan on four occasions with the last episode being closed whilst they were 17 years of age.

At the age of 16 the young person spent time in hospital detained under the Mental Health Act 1983 for assessment of their mental health.

The young person also had many contacts with the Criminal Justice system with a total of 325 Police contact records, including 37 arrest records, 2 anti-social behaviour referrals, 28 missing / absent reports, 6 violent offences and offences whilst on bail. All of which culminated in a period of time in prison which ended just a few weeks prior to the young person's death.

The day before the young person's death they were found collapsed on a train having consumed alcohol, Diazepam & Subutex (Buprenorphine); they were taken to hospital Emergency department, in the early hours of the morning and discharged from hospital later that day. The young person then met up with a friend and purchased a litre bottle of vodka which they drank. They arrived at another friend's flat where the young person consumed about half of another bottle of vodka.

On Sunday 4th October a friend found the young person in bed and unresponsive at around 2.00 pm.

The Assistant Coroner recorded at the Inquest the cause of death as combined toxicity of Buprenorphine, alcohol and Diazepam.

This Adult Practice Review has examined thoroughly the circumstances and issues that have arisen in this complex case. This was an unusual review given the complexity of the case and the extent of the multi-agency involvement with the young person over many years. This resulted in the decision to carry out the review over a 31 month period. The reviewers also took into consideration the historical events prior to the review period April 2013 to October 2015.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

Good Practice

During the course of the review, including the learning event, several areas of good practice were identified.

Police

- The young person was taken by the police to a place of safety where Mental Health Services appropriately used Section 2 of the Mental Health Act (MHA, 1983). This allowed for a period of stability and an opportunity to assess the young person's holistic needs.

Mental Health Services

- One hospital maintained comprehensive records of the young person's admission and arranged for a Mental Health Advocate to be involved. Records were appropriately used to provide clear and detailed information to the panel and reviewers.

- Community Mental Health Services (CMHT) provided ongoing continuity of care and support to the young person during their period of involvement. There were also good examples of multi-agency working, where the CMHT co-ordinated work in partnership with the National Probation Service, RCT Housing and other multi agency partners.

Rhondda Cynon Taf County Borough Council Community and Children's Services

- There was good record keeping which evidenced that relevant policies and procedures had been complied with, including the All Wales Child Protection Procedures 2008 and the Protocol for Young Persons at Risk of Sexual Exploitation.

- It was evident that the Children's Services case holding social worker acted in a supportive and professional manner and indeed escalated the ongoing difficulties in achieving the goals of the young person's protection plan which resulted in the Head of Assessment and Care Planning chairing the Sexual Exploitation Strategy meeting on the 28th August 2013.

- The Local Authority considered whether there were grounds for Care Proceedings and applying for a Secure Order. However it was their view that the threshold for both were not met.

Residential Care

- There was evidence of the young person receiving good support from staff at one particular care home

- Another care home provided evidence of good documentation to the panel and reviewers.

Youth Offending Service and Probation Service

- Transition arrangements between the Youth Offending Service and the National Probation Service were well co-ordinated, resulting in the smooth transition of care.

Family Involvement

- There was evidence that the young person's mother did raise concerns with regards to the young person's mental wellbeing.
- The young person's grandparents and brother endeavoured to support the young person as much as possible and attended a number of the Child Protection Case Conferences and Core Group meetings.
- One hospital actively promoted this ongoing relationship between the young person and their family when they were an inpatient in 2013.

Key Learning Themes

Child

- **The importance of stable placements**

The young person was accommodated under Section 20 (Children Act, 1989), on three separate occasions (23/11/12 to 19/04/13, 19/08/13 to 30/08/13 and 04/09/13 to 05/08/14) during the period of this review, however there were a further three occasions prior to the review period where the young person was looked after. The young person was regularly reported missing from care, often returning late at night or early hours of the morning, intoxicated, under the influence of other substances and on occasion returning with injuries. During these times the young person was also frequently found at their mother's address and escorted back by police or care home staff.

- **The importance of good Discharge Planning**

This was highlighted by the recurring requests from the young person's social worker to Mental Health Services for a Mental Health Assessment Report to assist in identifying a suitable placement post discharge from the Child and Adolescent Mental Health In-Patient Unit (summer 2013). This followed a recommendation from the young person's Child and Adolescent Mental Health Psychiatrist that they should not return to their mother's care and recommended the following support: "*specialist therapeutic residential placement, psychological intervention, CBT, specialist working in Attachment Disorder, Single Occupancy Placement".(taken from case recording)*

During the young person's admission to the Child and Adolescent Mental Health Unit, two specialist therapeutic placements were identified; one in North Wales and one in Manchester both of which the young person considered unacceptable as they were too far away from home. This had been highlighted by the young person at an early stage

and prior to the search for placements. At the learning event it was noted that there is a lack of suitable local residential provision for vulnerable young people with significant mental health needs.

There was significant concern raised at the learning event in respect of the decision to discharge the young person on the 16 June 2013 back into their mother's care. It was noted that the young person had an unstable relationship with their mother who had her own mental health and dependency problems which impacted on her ability to parent the young person. However, another Locum Consultant Psychiatrist within CAMHS, reviewed the young person and took the decision to discharge back to their mother's care and recorded that there was no evidence of mental health problems which seems to contradict previous records from that period of hospital admission. These concerns were raised at the time by the Emergency Duty Team and Social Worker however, it is not evident from the information supplied that these concerns were escalated.

- **Difficulty in engaging with the young person**

The reviewers felt it is worthy of note that it was recorded in the minutes of the Review Child Protection Conference of 15th October 2013 that the "Risks include (the young person's) vulnerability to sexual exploitation; (their) offending which if it persists could result in a custodial sentence; (their) limited engagement with agencies on anything but (their) own terms which is likely to stymie the Child Protection Plan".

- **The need for good Transition arrangements**

As noted previously there were good transition arrangements between YOS and National Probation Service which was discussed and planned with the young person.

The transition from CAMHS to CMHT occurred approximately a month after the young person's 18th birthday with no evidence of pre-planning prior to the young person becoming an adult. Arrangements were made for a period of joint working; evidence from the notes reflects that this process took approximately a month. Best practice dictates that transition between Children and Adult services for Children Looked After should be properly planned and ideally begins when the child is 14 years old or in year nine at school.

There is a lack of documentary evidence showing the planning for the young person's transition from Children to Adult Services. However, at the Review Child Protection Conference on 25th March 2014 in the Chair's Summary it states the young person needs to work with the "Independent Living Programme and work constructively with Aftercare to prepare for leaving Local Authority Care on (their) 18th birthday".

There was recognition by many professionals involved in the young person's care that they required supportive accommodation as they transitioned from childhood to adulthood and that they were not ready for independent living. At the learning event professionals felt that the young person was not appropriately placed in suitable accommodation for a vulnerable 18 year old with their needs.

- **The importance of recognising that Young People's needs do not change overnight when they become an Adult**

During the time at a supported housing provision there were several reports of the young person being vulnerable and being assaulted by other residents however there is no record that an Adult Protection Referral was considered or made at any time for the young person.

Within the first month of their tenancy in the flat there is strong evidence that the young person was not coping. The young person told their Adult Mental Health Worker that they were taking heroin, were concerned about their finances and tenancy and they were not taking their prescribed medication. During this period there was a noticeable increase in the young person's risk taking behaviour which they had disclosed to staff at the hospital, Social Worker and the Police. RCT Homes alerted the Community Mental Health Team to concerns raised by fellow residents regarding the young person. They also reported poor conditions at the flat and general concerns about the young person's behaviour including an assault on a police officer.

In late July 2015 a multi-disciplinary meeting was held where it was noted that *"the young person was at extreme risk of accidental death or harm should they return to the property".* It was accepted that the area was totally unsuitable for a young person of this vulnerability, however, it was accepted that the young person would probably want to return to the property'. An extended period of adult in-patient admission was requested to achieve stability & structured planning for discharge. However this did not take place as the young person received a custodial sentence for physically assaulting a police officer.

Information requested from the Secure Estate regarding the young person's sentence (01/09/2015 to 21/09/2015) has been provided, however this is very limited and adds nothing to our understanding of the young person's time in prison or any plans for release.

The young person was released on 21st September 2015. The recordings made by the CPN reflect that the young person appeared stable, calm, positive and focussing on short term goals regarding benefits and medication, in contrast to their previous presentation.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SAB and its member agencies and anticipated improvement outcomes:-

Escalation Processes for Complex ("stuck") Cases

The young person's circumstances and behaviours at times proved challenging for those who knew them. This included close family and the agencies the young person came in contact with. It appears to the Reviewers there were occasions when agencies charged with the young person's protection were frustrated by their inability to effect positive change, and that all agencies appeared to lose sight of the fact the young person was a child.

The reviewers recommend that the Cwm Taf Safeguarding Board review the processes for the escalation of difficult cases, this should include both children and adults.

Transition from Children to Adult Services

The Reviewers were conscious from the outset of the significance of transition into adulthood, this remained a theme throughout the review and was reflected in the outcomes of the learning event. Although there was evidence that the relationship between the young person and professionals was perceived to be good there was little evidence that transition planning was effective.

The reviewers recommend that the Cwm Taf Safeguarding Boards review the arrangements for transition planning for Children Looked After or who have previously been Looked After.

Availability of Appropriate Placements for Vulnerable People

There is some evidence to show that when the young person was placed where their needs were largely being met the young person engaged with and completed programmes of work and had good relationships with professionals. On the occasions when appropriate placements were not available i.e. post hospital discharge, the adult mental health unit and at the supported housing, the young person was not able to safeguard themselves and limit their risk taking behaviour.

It appears to the reviewers that too much emphasis was placed on obtaining a formal (Mental Health) diagnosis when action to meet the young person's obvious support needs may have been more effective.

The reviewers recommend that the Cwm Taf Safeguarding Board satisfy itself that there are appropriate safeguards in place when commissioning specialist placements for vulnerable people. This could include suggested sample inclusions in the Service Specifications at the point of commissioning that are outcome focussed and not diagnosis dependent.

Adverse Childhood Experiences (ACE)

It was clear to the reviewers that the young person had developed a pattern of behaviour and coping mechanism early in life that persisted throughout. As the young person matured, these behaviours increased in intensity resulting in a cycle of events that resulted in multiple offences, substance misuse, periods of hospitalisation, relationship difficulties and incarceration. The reviewers are aware that the importance of ACEs has been recognised more recently and are clearly evident in this case and that there is ongoing work in this area.

The reviewers recommend that the Cwm Taf Safeguarding Board review the Joint Training Programme to ensure that training reflects the learning in this case and others with regard to ACEs.

Child and Adult Protection Procedures

The Reviewers recognised that professionals gave considerable thought to protecting the

young person and considered a variety of options available to them. However, towards the end of childhood there were occasions where agencies appeared to lose sight of the fact that the young person was still a child. Also there was little evidence that when the young person became an adult that consideration was given to the use of adult safeguarding procedures.

The reviewers recommend that Cwm Taf Safeguarding Board use their position to influence the need for the All Wales Safeguarding Procedures to include a process for escalation of challenging cases when all possibilities have been have exhausted. This could include an External Peer Review or an Extraordinary Executive Panel Meeting.

Hospital Discharge Planning

The reviewers recognised that plans for safe discharge from hospital are critical. In this case however the decision to discharge the young person from the Child and Adolescent Mental Health Unit by the locum Doctor appeared to be arbitrary and was not consistent with previous multi-agency decisions regarding the young person's discharge planning.

The reviewers recommend that the Cwm Taf Safeguarding Board conduct a review of relevant hospital discharge policies in light of the issues raised by the circumstances of this particular Adult Case Review and identify any improvements that could be made.

Statement by Reviewer(s)	
REVIEWER 1	**REVIEWER 2 (as appropriate)**
Statement of independence from the case *Quality Assurance statement of qualification*	**Statement of independence from the case** *Quality Assurance statement of qualification*
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference
Reviewer 1 *(Signature)*	**Reviewer 2** *(Signature)* ...
Name *(print)* ....Mark Anderton.....	**Name** *(print)* .....Linda Davies.....
Date .....23.10.17.....	**Date** .....23.10.17.....

Chair of Review Panel *(Signature)*	....
Name *(Print)*	.....Alexandra Beckham.....
Date	.....23.10.17.....

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Adult Practice Review process

To include here in brief:

- *The process followed by the SAB and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

The process followed in carrying out this review was in line with the Welsh Government guidance on Adult Practice Reviews.

An independent chair was appointed from a neighbouring local authority and two independent reviewers (one from another local authority and the other from an agency not involved in the case) were appointed.

The Panel comprised of the following services:

- Police
- Children Services
- Adult Services
- Health
- Education
- Youth Offending
- Local authority legal dept
- TEDS

A learning event was held and attended by representatives from the above services.

The Chair of the Adult Practice Review Panel met with the young person's mother on the 5th December 2016 to advise her of the process of the Adult Practice Review. The Panel Chair ensured that her views were shared with practitioners at the learning event. The young person's mother was complimentary of the services that the young person had received in particular the social work intervention that was received from the 16+ team. This has been shared with the team and the allocated social worker.

The Panel chair further met with the young person's mother and the young person's friend on the 4th August 2017 to share the outcome of the learning event and the recommendations of the reviewers. The young person's mother agreed with the recommendations and shared that she hoped that other young people would benefit from the learning in the review and that this would be what the young person would want as well.

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Date information received .....

Date acknowledgment letter sent to SAB Chair .....

Date circulated to relevant inspectorates/Policy Leads .....

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	