ADULT PRACTICE REVIEW REPORT CTMSB 06/2020

Cwm Taf Morgannwg Safeguarding Board
Extended Adult Practice Review

Re: Adult N

Circumstances resulting in the Review

An extended Adult Practice Review (APR) has been undertaken in line with the Social Services and Well-being (Wales) Act 2014 "Working Together to Safeguard People Volume 3". The guidance states that an extended review will be commissioned by the safeguarding board 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.

Due to the nature of the event, it was agreed at the Cwm Taf Morgannwg Safeguarding Board's Joint Review Group on 1st July 2020 that the criteria was met for the extended Adult Practice Review. The circumstances are as follows:

On the 14th September 2019, Adult N died by suicide at aged 20 years old. Adult N, at the time of her death, was living in the Cwm Taf Morgannwg (CTM) region, however she was previously a Child Looked After by an English Local Authority, who had responsibility for her care and support up until the age of 18. Following this, Adult N would have been entitled to support under Leaving Care Arrangements, such as advice support and guidance.

Adult N moved back to the CTM area around her 16th birthday and re-connected with her birth mother. She remained living in the area following her 18th Birthday and moved into her own accommodation. Prior to her death, whilst in the CTM area, she was subjected to serious domestic abuse, abused substances to the point where she lost consciousness on at least one occasion and had ongoing suicidal thoughts and self-harmed. These circumstances form the review and will be explored further throughout.

Background and Pen Picture

Adult N was adopted. She and her birth sibling moved to a Local Authority area in England with their adoptive parents in 2011. After this move, Adult N made an allegation of rape against her adoptive father (not substantiated). By March 2012, the adoption had broken down and Adult N was accommodated by an English Local Authority under Section 20 (Children Act, 1989).

There were many incidents of her going missing from care and she was found to be at high risk of Child Sexual Exploitation. In 2012, she was detained under the Mental Health Act (Section 3) and was admitted to a medium secure hospital in London, because of serious self-harming and aggressive behaviour.

She received a diagnosis of mixed disorder of conduct and emotions, ADHD and emerging emotionally unstable personality disorder. She was discharged from hospital at the end of April 2014 to a therapeutic placement.

Adult N contacted her birth mother, and both felt that Adult N should return to her care. Adult N refused therapeutic input after her discharge from her hospital admission as a child and as an adult she continued to refuse support and intervention in respect of her mental health.

The relationship quickly broke down with her birth mother and arrangements were made for her to move into supported accommodation, which continued into adulthood. During this time, there were multiple Public Protection Notices (PPN) (19 between 07.09.2015 and 17.08.2016) which were raised following police contacts. Many of these PPNs concerned ongoing domestic abuse by Adult N's then partner (she was discussed at MARAC[1] in this time), however other PPNs reflected Adult N's emotional distress, where she was suicidal, had self-harmed or was using substances heavily.

The above PPNs are not included in the timeline of this Review, however they reflect Adult N's chaotic circumstances and difficulties at the time. As an adult and within the timeline, three PPNs were received around anti-social behavior, being under the influence of substances and as a victim of Domestic Abuse. As an adult she was deemed to have had capacity and she continued to refuse interventions from Domestic Abuse Services and a refusal for support in regard to her mental health and substance misuse issues.

As part of this Review, the reviewers met her birth mother, she described Adult N as living everyday as if it was her last. Her birth mother described her as being at her best when she was with her first boyfriend, this was the most stable that she was. This was what she

[1] Multi Agency Risk Assessment Conference

described as ‘normal family life’ for Adult N, as her boyfriend had a child, and this was what Adult N wished for herself. His untimely death had a significant impact on Adult N’s wellbeing and her ongoing mental health issues, this experience was very traumatic for her, as she not only lost her partner but also contact with his child. Adult N’s mother described this as manifesting in a further significant deterioration in her mental health, she became very frightened of being detained under the Mental Health Act and it appears that she began using illicit substances as a way of coping.

Practice and organisational learning

A Learning Event was held on the 8th July 2021. This Learning Event was conducted via Microsoft Teams, with a range of representatives from agencies who had worked with Adult N in attendance, as well as those who were able to contribute to learning and any recommendation and actions moving forward. A timeline of significant events in respect Adult N was shared with practitioners, who had the opportunity to identify areas of effective practice and areas for improvement. The timeline was split into four parts spanning from May 2017 until September 2019. Supplementary information was also provided.

Through the course of the Learning Event the following themes where identified:

1: Support mechanisms for those who move to a different local authority as a young person and continue to remain there as an adult.
2: The transfer of responsibility in relation to the Mental Health Act and understanding of the responsibilities relating to 117 aftercare.

3: The impact of Adverse Childhood Experiences (ACEs) in adulthood and sudden bereavement and loss
4: Transition to adulthood
5: Ensuring that decisions relating to support are backed up by evidence to include Adult N's choice to decline support and the reasons behind this

Theme One:

Support mechanisms for those placed in the local authority area from outside

Adult N moved to the Local Authority aged around 16-17, as a child previously looked after by another authority. She had contacted her birth mother and returned to live with her. The responsible authority at that time did not oppose this move and she lived with her birth mother for a period of six months (this is out of scope of the review but provides background information this arrangement was assessed by the existing authority). This was a challenging time for both Adult N and her mother (her mother also had younger children who were living with her).

When this broke down, Adult N moved into her own accommodation, the responsible authority therefore commissioned an agency to provide a supported placement for her with a high-level of support to include night-time support prior to her 18th birthday.

Following her 18th birthday, this converted to a floating support arrangement with high levels of support and Adult N held her own tenancy. At the age of 18 the responsible authority commissioned their leaving care arrangements to an external agency who became responsible for providing support and guidance and monitored the floating support.

During this time, there were significant incidents that were being reported which were not followed up on. For example, Adult N had been observed to be unconscious following alleged drug use, medical intervention does not appear to have been sought at the time. It is evident to the reviewers and identified in the Learning Event, that instances as described above were becoming increasingly difficult to manage and Adult N was becoming chaotic. However, she continued to decline support from external agencies and local services and concerns were not raised in relation to her decision-making ability around this.

There were incidences of drug usage and possible overdoses, she was a victim of domestic abuse and appeared to be suffering from a decline in her mental health. This has led the reviewers to consider the support mechanisms in place for her within the area that she lived and how she could have been encouraged to access them in a supported way, considering that she was in an area that was unfamiliar to her and what could be offered.

The support provided by her originating authority could have been difficult due to the distance and not having local knowledge of the CTM area in which she lived. The leaving care service that was commissioned, maintained contact with her, this was mostly by telephone calls and visits.

However, when Adult N was in crisis, the support given was led mostly by the commissioned provider with limited access to any multi agency support. This, in particular, was around her mental health and periods of using substances, however it is acknowledged that Adult N continued to refuse intervention. Local knowledge of provision and support was lacking (this in part due to her leaving care support being provided by the originating authority). There appeared to be a reliance on Adult N accessing her GP for support to be provided. The lack of a joined-up approach and knowledge of local provision was a potential factor in her decisions to not access support as Adult N was not aware of what could be provided.

It may have been more beneficial for the originating authority to commission a leaving care service from the area in which she lived or indeed link in with the authority in which she lived to discuss potential support options, to enable Adult N to develop local connections.

Learning Points

Cross border issues can be a challenge for local authorities, there are often significant discussions about each other's responsibilities, which can lead to young people having limited care and support and access to local services. Where responsibility lies with another authority and the person lives outside of it, then there should be discussions about the support that can be provided locally and consideration should be given to commission local services to provide ongoing support, which could continue into adulthood.

Theme Two:

The transfer of responsibility in relation to the Mental Health Act and understanding of the responsibilities relating to Section 117 aftercare.

Adult N had previously been detained under Section 2 of the Mental Health Act in England. In January 2013 she was subsequently detained under Section 3 (for treatment) and placed in a health-run adolescent unit. Whilst this event falls outside of the timeline it is relevant in terms of Section 117 aftercare.

The local authority and the health board in which she was detained in would have had a duty to continue to monitor her mental health as she had been subject to detainment under the mental health act and entitled to Section 117 aftercare. She should, at the very least, have

had an annual review of her mental health and the reviewers could find no record of this being undertaken and no record of her being discharged from Section117 aftercare.

It was evident to the reviewers and at the Learning Event, that this was of significant concern. It was apparent that her mental health was deteriorating, and her drug use was increasing, which was also having an impact upon her decline in her mental health, however at no point does it appear that health professionals and social care professionals in the area that she was placed were aware of her Section 117 status. This entitled her to care and support in relation to her mental health.

The health board in which she was detained should have transferred and notified the local health board in CTM to ensure at the very least she was having her mental health monitored, however responsibility would have still been with the local authority in which she was detained in. The reviewers cannot find notification of Adult N's status which is of concern and there is no evidence to suggest that she had been discharged from Section 117 aftercare.

When Adult N did access primary mental health care services, this information was not available to the assessor at the time. Had it been, this would have alerted them to her previous detainment and entitlement, and arrangements could have been made to request her history, in order for a full assessment to be undertaken and any support provided and offered.

Whilst Adult N was described by her mother as being frightened of any further detainment, (it is doubtful that Adult N would have disclosed this information), this information in respect of her status was a missed opportunity to provide the appropriate mental health care by agencies in the area in which she lived and could have formed a different approach and access to secondary mental health care services and any further interventions.

The reviewers have identified this as an area for learning, in particular relating to young people who are detained and professionals' understanding of the legislative requirements relating to ongoing care and support, specifically to mental health

Learning points:

Those supporting young people who have been subject to detainment under the Mental Health Act should familiarise themselves with the legal parameters of the Act and there should be appropriate training and guidance issued in respect of children and young people who are subject to detainment under the Act.

Theme Three:

The impact of ACEs in adulthood, sudden bereavement and loss

Adult N had significant ACEs, which the reviewers and attendees at the Learning Event believe to have impacted her in adulthood, coupled with her mental health issues and her diagnoses, this potentially led to behaviours which were becoming very chaotic and harmful to her.

Adult N's resilience and experiences meant that she may not have had the coping mechanisms or indeed appropriate support to deal with the sudden impact of bereavement and loss. Her partner died in tragic circumstances, and she lost a significant connection to his child, coupled with her experiences and ACEs and her limited support mechanisms, the support provided to her should have taken into consideration all of these factors.

Adult N entered a new relationship that was described as toxic by her birth mother, she began using substances and her behaviour changed considerably. She was also a victim of

domestic violence and control by her then partner which resulted in ongoing contact with the police. At this time, the support provided to her began to decrease, she also declined support in adulthood, refusing a referral to adult services and she was described as not engaging with support offered to her. During this time, those who were supporting her did not question her decision-making ability.

Providing support and guidance by an out of county leaving care provision was a challenge. The provider that was commissioned appeared to be supporting Adult N with her emotional wellbeing and support needs with no access to local services, albeit that Adult N declined this provision, this could have been a contributory factor to her deterioration.

The lack of information-sharing, in particular, relating to her historical mental health status when she was seen by mental health services, could have been a missed opportunity to provide professional mental health support relating to trauma, loss, bereavement and impact of ACEs. If this information had been provided and her status known, the assessor could have requested Adult N's records and a full history would have been provided.

Adult N was described by her mother as being extremely frightened of being detained under the Mental Health Act, it is doubtful that Adult N would have disclosed this information voluntarily. However, her history would have been known and a potential different approach adopted.

<u>Learning Points:</u>

Where a young person moves into a different area and they are subject to Section 117, the health board and the local authority should ensure that all appropriate information is shared within the authority in which the young person has moved to. Connections should be made with the local authority to determine what services are available in order to be able to discuss with the young person to help inform their decision making.

When commissioning a support provider, the commissioner should use preferred providers where the young person lives. This would enable the young person to develop local connections and the provider should have a knowledge of local provision. .

The impact of the sudden bereavement and loss and Adult N's ACEs could have been considered via a formulation meeting and planning to consider the appropriate support to be provided, had she been supported by a multi-agency partners.

Theme Four:

4: Transition to Adulthood

Adult N was a young person approaching adulthood when she moved into the CTM area. She was living in an area that was not only unfamiliar to her, but also to those supporting her as previously mentioned. Adult N as a child who was previously looked after, meant that the local authority has statutory duties to provide ongoing care and support to prepare young people for adulthood. Whilst these duties were discharged in the support provided and commissioned, there were some areas of planning regarding her mental health that which could have been improved

As Adult N was subject to Section 117 aftercare arrangement under the Mental Health Act, appropriate referrals should have been made to the Community Mental Health Team in the area in which she lived, and transfer of mental health care could have been undertaken. Adult N would have been entitled to a yearly review under Section 117, this does not appear to have taken place. The authority in which she was detained would still retain this responsibility and along with health should have monitored this, and if there were no concerns would have discharged Adult N from Section 117. At the Learning Event, this was

identified as a missed opportunity to provide support to Adult N in adulthood, in particular around her mental health.

Learning Points:

Transition arrangements should be considered at key points within a young person's journey, where there are clear indicators that support is required in adulthood.

Practitioners should familiarise themselves with transition arrangements within the local area and adopt the Regional Safeguarding Board's Principles of Transition as good practice within their forward planning.

5: The importance of evidence practice supporting step down from care delivery

Evidenced based practice involves a wide range of approaches and interventions provided by professionals across health and social care. It is important that there is timely access to professional assessments and interventions as predicated by an individual's assessed needs and risks.

At the Learning Event, it was noted that Adult N's support needs and provision of support changed on a regular basis, without what appears to have been informed by appropriate assessments and regular reviews to support step downs from care delivery. Whilst Adult N may have declined this ongoing support, this is not clear throughout the timeline, however the reviewers understand that Adult N regularly declined ongoing support.

This in part could be contributed to the limited involvement from other professionals and her access to mental health support. There appeared to be an over reliance upon the provider sharing information without following up via appropriate assessments. The responsible

service providing the statutory leaving care arrangements would inform the responsible authority of the provision of direct care and support and the services would be stepped down. It does not appear to the reviewers or at the Learning Event that this was informed by evidence and appropriate assessments. Had a multi-disciplinary approach been adopted, and Adult N consented, appropriate formulations and evidence would have been undertaken and supported an informed approach to Adult N's support and appropriate mental health interventions.

Learning points:

Evidenced based practice and intervention should always be adopted to ensure a consistent approach and provide the appropriate evidence to support step downs from care delivery. This approach will also support the individual and support to manage and minimise any areas of risk.

Improving Systems and Practice

Recommendations:

1. When young people move into another local authority area, having been a child looked after, and support is provided via leaving care arrangements by the originating authority, good practice for the originating authority would be to notify the local authority in which they move to.

There is a requirement for children who are placed in out of county placements that the authority in which they are placed in are notified, but as this was not a regulated placement there was no requirements, however as there was a young person who was living in the CTM area who may have required support and services this would have alerted the local authority when issues were raised, possible signposting could have taken place.

2. Originating authorities when commissioning support, should make enquires within the local authority that the young person moves to, in order to commission a support provider within the local area who is familiar to the services and support that can be provided and build connection for the young person.

   The reviewers noted that it can be a challenge when managing and supporting people who are living outside of their originating authority, local knowledge of the area and services could be limited and this could have impacted upon support provided, by doing this, Adult N may have been able to access third sector opportunities and community support.

3. When children are detained under the mental health act and are subsequently entitled to Section 117 aftercare, professionals within children's social care should familiarise themselves with the requirements under the Mental Health Act and Section 117 aftercare, and a policy should be developed for those young people approaching adult hood who are subject to the Mental Health Act and notification given to the Health Board and the local authority of their status.

   The reviewers noted that understanding of requirements under the mental health act were misunderstood in relation to young people who have been detained. It is important that those working with young people who are subject to detainment are

fully aware of the responsibilities placed upon the health board and the local authority in which they were detained in

4. For young people who are approaching adulthood, transition arrangements should be considered at key points within their journey, in particular for those who are living away from their originating area.

   Practitioners should familiarise themselves with transition arrangements within the local area and adopt the Principles of Transition relating to Cwm Taf Morgannwg as good practice within their forward planning.

5. Evidenced based practice and intervention should always be adopted to ensure a consistent approach when planning any support arrangements.

   Practitioners should ensure that when support arrangements are being reduced that appropriate assessments and plans are reflective of discussions with partners and young people.

Statement by Reviewers			
REVIEWER 1	Alex Beckham	**REVIEWER 2**	Steph Webber

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)*	A Beckham	**Reviewer 2** *(Signature)*	S Webber
Name *(Print)*	Alex Beckham	**Name** *(Print)*	Steph Webber
Date	02/02/2022	**Date**	02/02/2022

Chair of Review Panel *(Signature)*	L Curtis-Jones
Name *(Print)*	Lisa Curtis Jones
Date	02/02/2022

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Adult Practice Review process

The circumstances of this case were considered by the Cwm Taf Safeguarding Board's Joint Review Group in July 2020 where it was agreed that it met the criteria for an Extended Adult Practice Review.

The review was carried out in accordance with the Social Services and Well-being (Wales) Act 2014 “Working Together to Safeguard People Volume 3" guidance and a Panel was convened attended by the following services/agencies:

- RCT Adult Services
- South Wales Police
- Keys Care
- English Children Services
- OASIS, Domestic Violence Service

A learning event was held on the 8th July 2021 attended by the following services/agencies:

- Keys Care
- OASIS Domestic Violence Service
- RCT Adult Services
- RCT Adult Mental Health
- English Children Services

Adult N's Birth Mother has been kept informed and her views sought and represented throughout this review.

☐ Family declined involvement

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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	☐	☐	