Safeguarding Adults Review: Madeleine

Croydon Safeguarding Adult Board

Authors:
Ms Fiona Bateman
Professor Christine Cocker

October 2021

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Section 1: Introduction:

This Safeguarding Adults Review is to understand what hindered the safeguarding of a young woman, referred throughout this review as 'Madeleine'. Her name has been changed, out of respect for her family's anonymity, and the choice of name was theirs. Madeleine was of mixed ethnicity (White British/Black Nigerian). She was 18 years of age when she died. At the time of her death, she was known to a number of services and, despite having reached adulthood, coordination of her care needs remained the responsibility of the London Borough of Wandsworth's Children Social Care [hereafter referred to as 'LBW-CSC'] as she had previously been in their care.

Madeleine experienced emotional, social and behavioural difficulties from a young age. As a very young child her family noticed her mood could quickly change and she became violent. Her parents sought help, undertaking parenting classes in order to better understand how to support her and manage her behaviours. In between outbursts, she was described as a bright, charming and polite child. At 6 Madeleine was treated (hormone therapy) for precocious puberty and whilst this treatment had no long-term impact on her physical development, her parents reported it was traumatic for her to endure. Her challenging behaviours continued after completion of the hormone therapy and, following an assessment that these were unconnected to precocious puberty, she was referred (aged 7) to Child and Adolescent Mental Health Services ['CAMHS']. When she was 9, she was admitted to Bethlem and Maudsley hospital after she started exhibiting behaviours associated with Obsessive Compulsive Disorder ('OCD') and anxiety. In 2014 (aged 12) she was diagnosed with Autistic Spectrum Disorder ('ASD')/ Asperger's. Madeleine and her parents disputed the diagnosis. A second opinion in 2015 concluded that Madeleine had 'subtle features of ASD'[1], but for her this diagnosis remained problematic. Her parents and the practitioners who knew Madeleine well explained that references to this diagnosis could act as a trigger for violence, particularly if she felt 'labelled' or side-lined in decision making about her. Over the course of her involvement with CAMHS, she received family therapy (2009-10), music therapy, two courses of Cognitive Behavioural Therapy (first for anger management and then for OCD) and in 2018 mentoring through Redthread (a Youth work charity). Her parents reported long waits between each intervention during which often her behaviours became more extreme. Despite the different interventions, very little was understood about why Madeleine exhibited such violent outbursts or how best to support her to manage her emotions. Eventually her parents were told by CAMHS they had 'tried everything' and they may wish to refer themselves to social care for further help.

Madeleine was first assessed by the London Borough of Wandsworth Children Social Care ['LBW-CSC'] in 2014, at the age of 12. Later that year she was briefly accommodated under s20 Children Act ['CA '89'] by LBW-CSC following an incident where she was taken to hospital having assaulted her mother. She returned home a few days later with a package of support from LBW-CSC, CAMHS and 'educational establishments' until this was stepped down on the 12.02.15. She was again accommodated in January 2018 under section 20 CA '89. Between 12.01.18- 01.05.18 she was accommodated in 8 separate placements.[2] LBW-CSC case records suggest she exhibited exceptionally challenging behaviours both towards her mother and staff with '*numerous assaults on residential and social staff, damage to property, frequent episodes where she was reported missing from placement and mental health concerns including threats to harm herself and others. … carers and providers struggled to manage the severity of the behaviours'.*[3]

[1] People with ASD have characteristics such as poor social functioning, repetitive behaviour, anxiety, emotional lability, and eccentricities or fixed habits of behaviour that can mimic symptoms of other illnesses, including schizophrenia spectrum disorders, bipolar disorder, attention deficit hyperactivity disorder (ADHD), avoidant personality disorder, social anxiety disorder, and mood disorder.
[2] Taken from the Police IMR, pg3.15
[3] Taken from the statement prepared by LBW-CSC for the Coroner, dated 18.01.21

Between January 2018- January 2020 there were 66 occasions when police were asked to intervene, either to find Madeleine after she had absconded from her family home or placements or to respond after violent outbursts. The vast majority of alerts resulted in no further action against Madeleine as neither her family or staff wished to pursue charges, but she was arrested on 6 occasions for criminal damage and possession of cannabis, battery (of two care staff), threats to kill (against her mother), and assault and false imprisonment (against a support worker). No further action was taken in respect of those incidents, however she did receive 3 separate convictions for assault on the 21.05.19, 06.08.19 and 07.01.20 and was also cautioned for possession of cannabis in January 2019. Her final two placements were for longer periods. The first was a secure placement[4] in Scotland and, on 30th August 2019 she moved into an Independent Living placement in Croydon. This was arranged and funded by LBW-CSC. Madeleine reportedly settled well at this placement; she got on well with a number of staff. She was receiving support from LBW-CSC and had been assessed by a transitions worker based in the leaving care service as having care and support needs under s9 of the Care Act 2014. She was not known to Adult Services in Croydon. Children's Services in Croydon had been notified that Madeleine was in an Independent Living placement in their area.

Madeleine was described by those who knew her best as vibrant, eloquent, intelligent and likeable. In many ways her strengths made it harder for her to access help, because she was articulate and, like many young people, did not want to be different. She enjoyed learning and was passionate about horse-riding and working with animals. She was keen to pursue some sort of paid employment or internship working with animals. Madeleine achieved some academic success[5] which was a significant achievement given her disrupted secondary education experience. She was keen to continue with her education in London but was unable to do so because of the perceived risk she posed to others in a college environment.

On the evening of 13th August 2020, whilst in her Independent Living placement, Madeleine took Ketamine. Staff called 111 for advice. Concerned about posts she had made on social media, friends and family contacted the placement to request help. Shortly after staff found her suspended from her door. She was taken to hospital and died on the 16 August 2020.

This review has been commissioned to explore why Madeleine, as a care experienced young person with significant on-going health and social care needs, was not able to be kept safe, despite the wide-reaching legal obligations and powers available to those supporting her to assist her transition into adulthood. It is intended that lessons from this review will not only form the basis of an action plan for CSAB partners, but also inform the development of or input into Croydon's Suicide Prevention Plan.

[4] LBW-CSC having obtained a Secure Order (in lien with s25 CA) and Interim Care Order (s31 CA) during an emergency hearing on the basis of her behaviours 'demonstrated an inability to regulate her own emotions which render her a risk to herself and others. These risks were felt to be unmanageable in a non-secure setting'.

[5] In 2019 she secured GSCE grade 5 in Maths; Scottish grade 73 (GSCE equivalent grade 7) in design and technology; Scottish grade 74 (GCSE equivalent grade 8) in Practical Woodwork, Maths, Cookery, Numeracy, English; Scottish grade 75 (A Level equivalent) in Maths. Her family explained that even this success was tainted as she felt let down by the system as the move to Scotland made it harder for her to continue to study the English National Curriculum.

Section 2: Safeguarding Adult Reviews

Croydon SAB has a mandatory duty[6] to arrange a SAR where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

A Safeguarding Adults Board (SAB) has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect includes self-neglect.

Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

The referral for consideration of this case for a SAR was sent by the Transition Social Worker in the Future First Care Leavers Service (LBW-CSC) on 08.09.20. Initially it was anticipated that this would be a jointly commissioned review between Croydon SAB (because Madeleine died whilst residing in this area) and Richmond and Wandsworth LSCP or SAB (because LBW-CSC were responsible for her care). Unfortunately, agreement could not be reached, so at a SAR sub-group meeting on 05.05.21, Croydon SAB members agreed to commission the independent authors to write the SAR. The SAR commenced in June 2021 and the independent authors were given a six-month time frame for the review. The following agencies, that had commissioned or provided services to Madeleine, contributed to the review:

- GP – Grafton Medical Centre (Wandsworth)
- South London and Maudsley (SLaM) NHS Trust
- South West London and St Georges NHS Trust (response to this report only)
- Croydon Health Services
- Croydon Adult Social Care
- Phoenix Hub Housing Provider
- GP Croydon
- Lambton Road Medical Centre
- Future First Care Leavers Service (LB Wandsworth)
- Police
- CAMHS (SLaM- based within the London Borough of Wandsworth)

The authors are also grateful to the Coroner's office for their willingness to share pertinent information.

LBW-CSC offered to provide a representative from Children's Services to attend the SAR Panel. A representative attended the final SAR panel meeting where this report was presented. However, a good number of representatives from LBW-CSC did attend the practitioners learning event and the

[6] Sections 44(1)-(3), Care Act 2014.

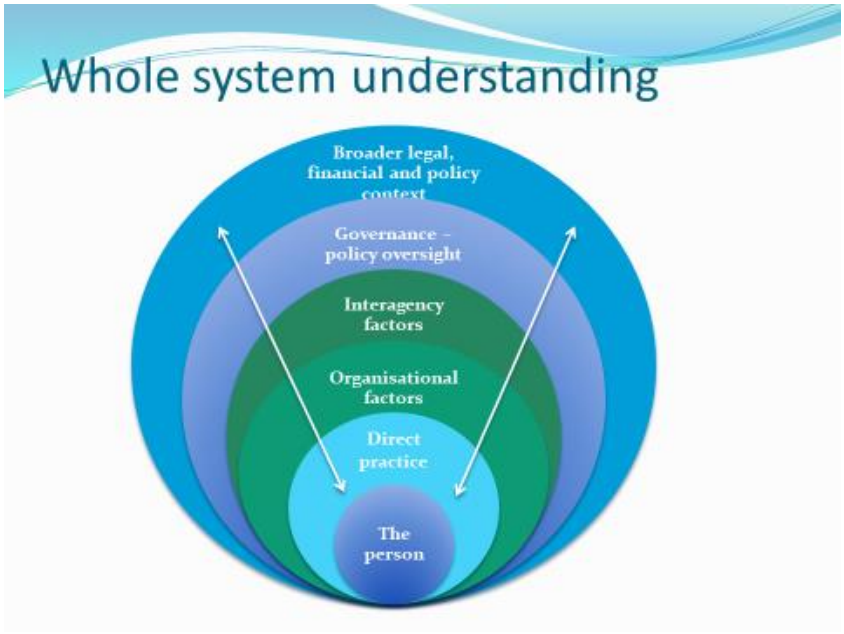
senior managers learning event. Additional information requested by the independent authors from Wandsworth was sent through promptly after these events. An IMR was also provided by LBW- CSC, but only following the practitioners and senior leader's event. This prevented the authors' ability to test the findings from that review with those who worked with Madeleine.

As this was not jointly commissioned, the main emphasis of this SAR is on the period of time Madeleine was living in Croydon. However, given the complex issues present in this case, the reviewers have constructed a chronology of Madeleine's life that includes the period of time before Madeleine was living in Croydon, as this is pertinent to the case.

Section 3: Review Process

The case has been analysed through the lens of evidence-based learning from research and the findings of other published SARs[7]. Learning from good practice has also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice.

The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram below[8]. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



The overarching purpose of the review has been to learn lessons about the way in which professionals worked in partnership to support and safeguard Madeleine. Specific lines of enquiry, or terms of reference, were identified as follows:

1. Infrastructure for Transition
2. Cross Borough Working
3. Mental Health
4. Communication between agencies/Multi Agency working
5. Development of or input into Croydon's Suicide Prevention Plan.
6. Could any additional services or interventions have been considered to have prevented/reduced the risk to Madeleine.
7. Exploring the barriers
8. Decision making around the placement

Methodology:

A traditional SAR has been selected as the methodology for conducting this SAR, though slightly adapted to allow the authors to speak directly with practitioners who worked with Madeleine and senior leaders. Details of the methodology can be found in Safeguarding Adults Reviews under the

[7] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[8] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection, 17 (1), 3-18.

Care Act: implementation support. The timeframe for the review covered the period of time Madeleine moved into Croydon in August 2019, to her death on 16.08.20. However, information from outside this timeframe has been included when significant for understanding and learning from this case.

A number of agencies provided chronologies and reflective reviews within an agreed timeframe. These chronologies detailed each agency's specific involvement with Madeleine, and so included a lot of information that was outside of the timeframe. The independent reviewers produced a composite chronology that was circulated to practitioners, senior managers and Madeleine's mother and stepfather, with questions added to the text to aid discussion and draw out potential lessons for learning.

Two learning events took place, one with practitioners and one with senior managers. Whilst most attendees were from Croydon-based services, some practitioners and senior managers from Wandsworth attended these events. The reviewers also had a separate event with workers from Phoenix Hub, the Independent Living project in Croydon where Madeleine lived. Discussions from these events have been included in subsequent analysis of this case.

Family Involvement:
Madeleine's mother and stepfather have made a significant contribution to this review. They have been in regular contact with the SAB Board manager since the decision was made by Croydon to conduct a SAR. The authors met with the family to hear about Madeleine. This was particularly important as up until this meeting, the reviewers had not managed to gain a strong view about who Madeleine was as a person, beyond the mental health labels and problematic behaviours that were described by those agencies involved with her. They also gave their perspectives about the services Madeleine had received leading up to her death. The reviewers have also read emails sent by Madeleine's mother to the South London and Maudsley ['SLaM'] NHS Trust as part of their Serious Incident Review. This has been an important part of the review process and we have included their perspectives in our commentary, analysis and recommendations.

The Independent Reviewers are very grateful to Madeleine's family for sharing information about her. Their contribution filled in some missing parts of the jigsaw about her life journey and gave a balance to the review by sharing how difficult it was for them to challenge frequent misperceptions or misreporting of events and why, they believed, this impeded attempts to keep Madeleine safe as their concerns or warnings based on her past behaviours were undervalued or ignored.

Parallel processes:

- Coroner's inquest into the death of Madeleine. The final hearing has not occurred, but the SAR independent reviewers have had sight of a number of witness statements and a Serious Incident Report completed by SLaM.

- Croydon has received a letter from Madeleine's parents' solicitor about a proposed civil claim against the local authority

Section 4: Evidence-Base:

Relevant research and legal context

Social care assessment duties are triggered on a deliberately low threshold of the appearance of need. Section 17 of the Children Act provides obligations for local authorities to support any child in their area who, because of illness or disability, may require support from education, health and social care services to achieve or maintain a reasonable standard of health and development. For some children, their ill-health or disability may require support beyond their 18th birthday so local authorities, health professionals and those working in education are expected to work together to ensure assessments of need are completed and treatment/care plans are agreed in a timely way so as to promote the young person's wellbeing into adulthood.[9]

The legal framework to assess and support children and young people's health are interwoven with duties to provide social and educational support. There are also additional obligations that were relevant in Madeleine's case because of the enduring and severe nature of her behavioural and psychological conditions. For very young children restrictive care arrangements are commonplace; they are rightly supervised throughout their waking hours. As children grow up, it is usually to reduce this to increase their skills and independence. The level of supervision is usually determined by those with parental responsibility for the child. For a cohort of older children with additional needs, including those who are at increased risk of exploitation or abuse, additional restrictive care arrangements may need to be arranged in order to provide safe, protective care. Crucially, if care arrangements are administered by public bodies[10] there are very well-established legal principles that must be applied. The rationale for any restrictive measures must record how services will balance the child's right to liberty (protected under article 5, ECHR) and the obligation to keep them safe and supported so they achieve and maintain their developmental potential. These are explored in more detail later within this report.

It is commonly understood that many care-experienced young people will require additional support from social care services, as a consequence of adverse childhood experiences and it is for this reason that the range of 'leaving care' duties and powers continue to be owed to provide support. This includes powers (if required) to extend arrangements to allow foster carers to continue to provide care under the 'staying put' arrangements[11]. Leaving Care obligations are owed to all care experienced young people aged 16 and 17 who have been looked after for at least 13 weeks after they reached the age of 14. Responsibilities for planning continuing support applies to all care leavers at least until they reach the age of 21. This includes:

- keeping in touch with them [section 23C(2) of the 1989 Act],
- regularly reviewing their pathway plan [section 23C(3)(b) of the 1989 Act; the requirements for carrying out reviews are set out in regulation 7 of the Care Leavers Regulations],
- having a personal adviser [section 23C(3)(a) of the 1989 Act; the functions of the personal adviser are set out in regulation 8 of the Care Leavers Regulations], and
- providing financial assistance by contributing to the former relevant child's expenses in living near the place where they are, or will be, employed or seeking employment [sections 23C(4)(a) and 24B(1) of the 1989 Act] if their welfare and educational and training needs

[9] Obligations owed to children with special education needs and disabilities are set out in Part 3 Children and Families Act 2014 and the accompanying Code of Practice and extend from 0-25years of age. Duties owed for children transitioning to adult social care are set out in s58-66 Care Act and chapter 16 of the Care and Support Guidance.

[10] Local authorities will usually lead on arrangements for social care and education, Clinical Commissioning Groups or NHS England/Improvement remain responsible for the provision of health services. Where there are shared responsibilities (for example, many mental health services) local arrangements should be in place for joint assessments in line with relevant Code of Practices.

[11] S.98 Children and Families Act 2014. This power was used to enable LBW-CSC to continue to fund Madeleine's placement in PH after her 18th birthday when agreement could not be reached for LBW- Adult social care to take over funding for that placement.

require it, provide financial assistance to enable them to pursue education or training [sections 23C(4)(b) and 24B(2) of the 1989 Act] (DfE 2010, p12-13)

In addition, Regulations[12] and statutory guidance requires '*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. Looked-after children themselves (according to age and understanding) should also have the information they need to make informed decisions about their health needs. Staff working with looked-after children who are delivering health services should make sure their systems and processes track and focus on meeting each child's physical, emotional and mental health needs without making them feel different... Local authorities, CCGs and NHS England need to reflect the high level of mental health needs amongst looked-after children in their strategic planning of child and adolescent mental health services (CAMHS). They should also plan for effective transition and consider the needs of care leavers*.'[13] The National Framework for Continuing Healthcare ['CHC'] also requires Clinical Commissioning Groups 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. This is relevant to this case because of a specific focus within the assessment tool of challenging behaviours, psychological and emotional needs. Formal screening for CHC eligibility should occur when a young person is 16 and eligibility determined in principle when the young person is 17.[14]

Whilst the leaving care duties are hugely important, it should be noted that the Supreme Court was 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 CHC 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, it would have done so expressly*.'[15] Therefore, as a care leaver with long-term behavioural and mental ill health, Madeleine was eligible for assessment and support through all these statutory processes.

There are three principles for transition set out in the Children Act 1989 guidance for care leavers (DfE 2010, p9) which should govern practice when talking to the young person and when making any decision about them:

'*• Is this good enough for my own child?*
• Providing a second chance if things don't go as expected.
• Is this tailored to their individual needs, particularly if they are more vulnerable than other young people?'

It is the role of the Independent Reviewing Officer (IRO) to ensure that the care plan agreed for the young person considers the young person's views. This includes evaluating the quality of the

[12] The Care Planning, Placement and Case Review (England) Regulations 2010.
[13] 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.
[14] See pg331-349 of the National framework for Continuing healthcare available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf
[15] LJ Elias [pg52] in *R (Cornwall Council) v Secretary of State for health and others* [2014] EWCA Civ 12. The Supreme Court, also confirmed that duties (now under the Care Act) provide '*the exclusive statutory basis for securing the long-term care and were not displaced by provisions under the 1989 Act, which are transitional in character*.' The Supreme Court concluded s23C powers purpose is '*not to supplant the substantive regime, but to ease the transition (usually) to adult independence*.' [pg30 *R (Cornwall Council) v Secretary of State for health and others* [2015] UKSC 46

assessment of the young person's readiness and preparation for any move. Madeleine's move occurred after her accommodation in Scotland gave notice on her placement, at that time some plans were already in progress regarding Madeleine's move back to London to correspond with her 18th birthday and transition from care.

Tailoring any plan to a child's individual needs requires consideration of the specific challenges presented by their experience as a Looked After Child and additional risks or needs associated with personal characteristics and circumstances, including disability. Consideration should be given to relevant clinical guidance and quality standards published by the National Institute for Clinical Excellence ['NICE']. Of particular relevance in this case was guidance regarding transition from children to adult services.[16]

Madeleine had a diagnosis of Autistic Spectrum Disorder ['ASD'] and presentations of emotional dysregulation and OCD. Since 2010 statutory guidance strongly advised that all staff working in health and social care receive autism training and frontline staff responsible for needs assessments have demonstrable knowledge, skills and good understanding of the good practice guidelines (including NICE Quality Standards) because '*when professionals understand autism, know to make reasonable adjustments in their behaviour and communication …the positive impact on the lives of those with autism can be immense*.'[17] As such, the NICE guidance on the provision of support and management of ASD in under 19s[18] should have been applied by all practitioners (including clinicians) working to support her and her family. This guidance requires staff 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.

In addition to assessment responsibilities, there are clear duties to assess a child or young person at risk of abuse, exploitation or neglect[19], including enduring duties to assess (under s11(2) and 58(4) Care Act 2014). These apply irrespective of the person's capacity to refuse support. For this reason, even if an adult says they do not want an enquiry to be undertaken under s42 Care Act, 'making safeguarding personal' approach advises those working within partner agencies to consider wider statutory or professional responsibilities[20] and explore the person's ability to understand the risk. Safeguarding Adults Reviews and Domestic Homicide Reviews have also evidenced the importance of careful consideration of risks associated with undue influence, coercion or other external pressures that prevent a person from freely deciding to accept support.

A framework for best practice in Transitional Safeguarding

Preston Shoot (2019)[21] makes reference to research and findings from SARs that enable models of good practice to be constructed. Braye and Preston Shoot have used the same analytic approach

[16] https://pathways.nice.org.uk/pathways/transition-from-childrens-to-adults-services/transition-from-childrens-to-adults-services-overview#content=view-index
[17] Statutory Guidance for Local Authorities and NHS organisations to support the implementation of the Autism Strategy, Department of Health, 2015 available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/422338/autism-guidance.pdf
[18] NICE (2013) cg170, available at: https://www.nice.org.uk/guidance/cg170/resources/autism-spectrum-disorder-in-under-19s-support-and-management-pdf-35109745515205
[19] Under section 47 Children Act 1989. Those assessments and any subsequent plans should comply with the expectations set out in 'Working Together to safeguarding children' 2018, Department for Education. Available at: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
[20] See 'Myths and Realities' about Making Safeguarding Personal available at https://www.local.gov.uk/sites/default/files/documents/25.144%20MSP%20Myths_04%20WEB.pdf
[21] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' Journal of Adult Protection, 21 (4), 219-234.

previously (Braye et al., 2015a, b)[22], and it has been adapted from studies of Serious Case reviews (SCRs) in children's services (Brandon et al., 2011)[23].

This evidence-base is drawn from recent publications on Transitional Safeguarding[24] [25]and provides a framework for Safeguarding Adults Reviews (SAR) analysis where SARs are about young adults. The framework for analysis invites a further set of questions, namely what has enabled best practice where this is found and what have been the obstacles or barriers to best practice where these are also found. This then informs the structure and content of a SAR about a particular young person, which will have a unique set of circumstances.

The model comprises four domains. In line with 'Making Safeguarding Personal' principles, the first domain focuses on practice with the individual. The second domain focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with young people with Transitional safeguarding needs. The domains and evidence are presented here.

The material in the box below has been authored by Michael Preston-Shoot, Christine Cocker and Adi Cooper. The authors will be publishing this in due course, but because of its relevance to this SAR, it has been reproduced here in full, with permission.

A Framework for Best Practice in Transitional Safeguarding
Michael Preston-Shoot, Christine Cocker and Adi Cooper (2021)

Direct work with individuals

Personalised. Practice is characterised by a needs-led, personalised approach. Practice is person-centred and rights-based: all aspects of that individual's situation are acknowledged and taken into account in the safeguarding process, including structural inequalities. Practice is relational and participative, with young people/young adults involved in co-design and capacity building, in assessments and reviews, their wishes and preferred outcomes known and considered. Practitioners do not walk away and do not close down involvement when support is declined but are curious and tenacious in seeking ways to engage young people/young adults, particularly where there are complexities in the lives of young people (for example, mental health and substance misuse), which compound their experiences of services. This approach is not simply an aspiration; rather is necessary 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. This must also have regard to positive obligation to respect private and family life (article 8) and liberty (article 5). Preventing escalation of social care needs (a duty under s2 Care Act 2014) can be facilitated by providing advice and support before eligibility thresholds for services are crossed. Practitioners must take into account everything they can reasonably be expected to know, consider exercising all available

[22] Braye, S., Orr, D. and Preston-Shoot, M. (2015a), "Learning lessons about self-neglect? An analysis of serious case reviews", Journal of Adult Protection, Vol. 17 No. 1, pp. 3-18. Braye, S., Orr, D. and Preston-Shoot, M. (2015b), "Serious case review findings on the challenges of self-neglect: indicators for good practice", Journal of Adult Protection, Vol. 17 No. 2, pp. 75-87.
[23] Brandon, M., Sidebotham, P., Bailey, S. and Belderson, P. (2011), A Study of Recommendations Arising from Serious Case Reviews 2009-2010, Department for Education, London.
[24] Holmes, D. (2021) *Bridging the Gap: Transitional Safeguarding and the Role of Social Work with Adults*. London: DHSC.
[25] Holmes, D. (2021) Transitional Safeguarding: The Case for Change, *Practice*, DOI: 10.1080/09503153.2021.1956449

legal powers available to SAB partners and record why they believed any action or inaction legally available, necessary in the circumstances and proportionate to the risk.

Context and history. Practice considers the history and current context of the young person and their environment at all times. It takes into account extra-familial risks in young people's lives including 'place' and 'space'. It considers the strengths and challenges in the young person's social networks. Practice "thinks family" and "thinks communities", recognising the significance of meaningful and trusting relationships[26] but also the impact of family dynamics, and working in collaboration to build circles of support. Where appropriate, carer assessments are offered.

Developmental. Practice takes a developmental perspective that is not bound by age-determined boundaries. It acknowledges the emerging evidence about brain development and its effects on behaviour that show some elements of brain growth have a continued effect on regulation, social relationships and executive functioning well into young adulthood, namely early 20s[27]. It avoids reductive interpretation of these studies to define capabilities of adolescents[28]. It also recognises the inconsistencies in age in the legal, policy and service frameworks regarding young people's transitions to adult services and seeks to resolve tensions in these.[29]

Prevention, protection and recovery. Practice is clearly focused on preventing harm, protecting young people/young adults from harm, and enabling them to recover from harm and trauma where this has already occurred. The evidential basis that the impact of adverse childhood experiences, placement instability[30] and trauma has on the development of the brain and, consequently, adult mental health is now well-established. There is both a greater awareness of the prevalence of trauma in society and deeper knowledge of its long-term effects on survivors. [31] Practice therefore should be trauma-informed, strengths-based and outcomes focused, aimed at promoting safety and wellbeing[32]. Practice offers flexible and integrated support. Practice uses a risk enabling approach that can prepare and support young people with their adult lives, and so acknowledges the complex interplay of these factors as young people become adults.

Whole-person. Work with young people/young adults is characterised by a holistic view of the person rather than defining their needs, vulnerabilities or strengths according to age or service eligibility.

Equalities. Practice clearly recognises protected characteristics arising from gender, sexuality, race and disability. Practitioners work with the young person, acknowledging inequalities, recognising the impact on their lives, for example of racism, and addressing unconscious bias.

[26] Holmström, C. (2020) 'Transitions to adult social care.' In S. Braye and M. Preston-Shoot (eds) *The Care Act 2014: Wellbeing in Practice*. London: Sage/Learning Matters.
[27] Sawyer, S. Azzopardi, P. Wickremarathne, D. and Patton, G. (2018) 'The age of adolescence'. *The Lancet Child and Adolescent Health*, 2 (3), pp223-228.
[28] Moshman, D. (1999) *Adolescent psychological development: Rationality, morality, and identity*. Mahwah, NJ: Lawrence Elbaum Associates.
[29] Cocker, C., Cooper, A., Holmes, D. and Bateman, F. (2021) Transitional Safeguarding: Presenting the case for developing Making Safeguarding Personal for Young People in England. *Journal of Adult Protection*. Earlycite
[30] See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5518265/
[31] Jones & Wessely, 2007; Scottish Government, 2012; Becker-Blease, 2017
[32] Holmes, D. and Smale, E. (2018) *Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood*. Dartington: Research in Practice.

Exploitation. Practice recognises the impact on decision-making of coercion and exploitation. It challenges any assumptions about lifestyle choice[33]. Practitioners explore with young people/young adults their decision-making, offering support and advocacy.

Mental capacity. Practice is informed by a legally literate understanding of the Mental Capacity Act 2005[34].

Assessment. Assessments are timely and fulfil statutory requirements[35]. Assessments of care and support needs are incorporated into other processes, such as looked after children reviews, to minimise the need to repeat information,[36] because repeating personal details for numerous assessment processes can be frustrating or intimidating, particularly for those who have already experienced exclusion from statutory support. Assessments of care and support focus not just on eligible needs but also on wellbeing and prevention. Assessments of risk are completed.

Planning. There is evidence of early and proportionate planning[37]. Planning is not limited by a focus on eligibility criteria and thresholds[38]. Care plans are followed through and reviewed. Contingency planning for escalation and de-escalation as risk changes, is crucial. There is clear evidence of pathway planning, with key worker/personal adviser offering continuity and a sustained relationship that incorporates insight into the young person's feelings and experiences.

Meeting need. Placements and accommodation provision are suitable, including any necessary, restrictive elements of care have the correct legal authority in place to enable the provider to provide safe care. The impact of transition, of moving on, on mental health is recognised.[39] Practice is characterised by wrap-around support aimed at meeting accommodation need but also enhancing physical and mental wellbeing, and supporting young adults into training and/or employment. Options are considered, with adherence to the young person's preferences unless contraindicated.

Team around the person

Working together. Agencies work together across service and geographical boundaries rather than in silos in order to offer an integrated system of planning and support, recognising the inter-connected nature of harms and risks. This involves primary and secondary care, children's social care and adult social care, child and adolescent mental health services and adult mental health providers, housing, and substance misuse services, modelling whole system thinking[40]. Practice is characterised by collaboration, information-sharing and co-location. It is based on a shared and proper understanding of

[33] Holmes, D. and Smale, E. (2018) *Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood*. Dartington: Research in Practice.
[34] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[35] Holmström, C. (2020) 'Transitions to adult social care.' In S. Braye and M. Preston-Shoot (eds) *The Care Act 2014: Wellbeing in Practice*. London: Sage/Learning Matters.
[36] Holmström, C. (2020) 'Transitions to adult social care.' In S. Braye and M. Preston-Shoot (eds) *The Care Act 2014: Wellbeing in Practice*. London: Sage/Learning Matters.
[37] Holmström, C. (2020) 'Transitions to adult social care.' In S. Braye and M. Preston-Shoot (eds) *The Care Act 2014: Wellbeing in Practice*. London: Sage/Learning Matters.
[38] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[39] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[40] Holmes, D. and Smale, E. (2018) *Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood*. Dartington: Research in Practice.

the roles and responsibilities of everyone involved in the young person's life. There is recognition of the practical and legal constraints which could limit use of statutory powers so that imaginative, flexible solutions are explored. There is a clearly agreed lead agency and key worker to facilitate and coordinate planning and decision-making[41], this should be someone who is trusted by the young person and who is afforded time to build and maintain that trust.

Information-sharing. There is early and proportionate sharing of information about risk and regarding the range and level of support required[42]. Information is shared without consent when this is necessary to safeguard a young person or young adult at risk and/or to prevent or assist with the detection of crime.

Legal literacy. Practice is legally literate, whereby there is less focus on eligibility and more on preventative work and wellbeing. Advice and support are sought to address the inconsistencies in age in the legal, policy and service frameworks regarding young people's transitions to adult services.[43] Legal rules are used to prevent and to disrupt sources of harm. It is core to the professional standards of those working in health and social care that they understand the limitations of their statutory powers, but also the legal mechanisms available to ensure safe, protective care is in place. At its best, this will ensure that restrictions are introduced to provide therapeutic support and assist the young person and their carers to develop skills to manage new circumstances or challenges. It also provides clear boundaries regarding behaviours and the consequences of transgressing these. It enables practitioners and parents to work with the young person constructively, resisting the use of criminal sanctions to manage risk. Relevant in this case are powers under the Mental Health Act 1983, as amended in 2007 [hereafter 'MHA']. This sets out the legislative framework for assessment and treatment of mental ill-health. Accompanying the MHA powers are additional powers for a Court to authorise a placement in secure accommodation under s25 Children Act 1989 and, separately, the Mental Capacity Act 2005 affords the Court of Protection powers to authorise protective care arrangements for those 16 and over who lack capacity.[44] Finally, the Supreme Court, in agreement with the Department for Education, has recently confirmed that it has authority under their 'Inherent Jurisdiction' to authorise restrictive, protective care where this is necessary to provide a therapeutic care package.[45]

Safeguarding literacy. Adult safeguarding concerns are referred appropriately using the criteria in section 42(1) Care Act 2014, including without consent when necessary to safeguard a young person or young adult at risk, and decision-making regarding the duty to enquire is robust and lawful[46].

Multi-agency meetings. Practice is characterised by the use of multi-agency, multi-disciplinary meetings, such as MARMs, to share information, identify needs and risks, and

[41] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[42] Holmström, C. (2020) 'Transitions to adult social care.' In S. Braye and M. Preston-Shoot (eds) *The Care Act 2014: Wellbeing in Practice*. London: Sage/Learning Matters. Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[43] Cocker, C., Cooper, A., Holmes, D. and Bateman, F. (2021) Transitional Safeguarding: Presenting the case for developing Making Safeguarding Personal for Young People in England. *Journal of Adult Protection*. Earlycite.
[44] Presently, local authority powers are restricted so that they apply only to people aged 18 or over, but the Liberty Protection Safeguards are due to replace the current process in April 2022 and will apply to young people 16 and over.
[45] *In the matter of T (a child)* [2021 UKSC 35. This case also confirmed that if it was necessary to protect against a breach of article 2 or 3, it would be lawful for the Courts to authorise care arrangements that deprived a child of their liberty in an unregistered setting.
[46] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.

agree a coordinated plan, with a lead agency and key worker clearly identified. Pathways for convening multi-agency meetings are clearly stated and understood[47].

Recording. Reasons for decisions, including of mental capacity assessments and best interest decision-making, are clearly recorded[48].

Organisational support for team members

Supervision. Practitioners are offered reflective, trauma-informed supervision, to enable them to manage the emotional impact of the work, and explore any unconscious bias. Supervision enables practitioners to maintain a person-centred approach in complex cases where a young person's engagement may be ambivalent[49].

Training. Practitioners and managers are offered training to develop their knowledge of and skills for transitional safeguarding. This includes understanding the developmental needs of young people, proportionate risk-taking, legal literacy, mental capacity, trauma informed practice, and development of skills of professional curiosity and enquiry into young people's lived experiences[50].

Communication. Professional and personal relationships and organisational cultures that support joint working at all levels within and between organisations.

Specialist advice. Practitioners and managers across services have access to specialist advice and guidance, for instance from lawyers and from mental capacity, substance misuse and mental health specialists[51].

Co-production. Commissioners and providers involve young people/young adults in co-design/co-production of services for safeguarding young people.

Commissioning. Commissioners (health, housing and social care jointly), providers and young people/young adults regularly conduct needs analyses and review available services to identify any gaps in provision, ensuring that planning is responsive and evidence-informed. Commissioning recognises the importance of services that are developmental, that are not bound by rigid age-determined boundaries, and that offer flexible support. Commissioners escalate concerns about shortages of accommodation and other resources, and contribute actively to the assessment of suitability of proposed placements[52].

Management. Senior managers demonstrate leadership that spans boundaries, essentially embracing a life-course and contextual/ecological approach. The setting of a clear vision across different service areas and having 'a 'listening' senior management open to

[47] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[48] Holmström, C. (2020) 'Transitions to adult social care.' In S. Braye and M. Preston-Shoot (eds) *The Care Act 2014: Wellbeing in Practice*. London: Sage/Learning Matters. Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[49] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[50] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[51] Holmström, C. (2020) 'Transitions to adult social care.' In S. Braye and M. Preston-Shoot (eds) *The Care Act 2014: Wellbeing in Practice*. London: Sage/Learning Matters.
[52] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.

change' are managerial strengths and necessary enablers to facilitate improvement in transitional safeguarding approaches to working with young people[53].

Policies and procedures. There are agreed multi-agency procedures and practice guidance for transitional safeguarding[54]. This includes clear pathways for victims of exploitation, including access to therapeutic and mental health support.

Staffing. Caseloads allow for the development of relationship-based practice as transitional safeguarding cannot be time-limited work[55]. Staff have sufficient knowledge and experience to manage case complexity. Recruitment and retention of staff enable continuity of relationships with young people/young adults[56].

Governance

Safeguarding Adults Board (SAB). The SAB routinely exercises its statutory mandate by seeking assurance regarding how transitional safeguarding is being developed and embedded in policy and practice locally.

Strategic response. The SAB works closely with the Community Safety Partnership (CSP) and with the Local Children's Safeguarding Partnership (LCSP) to ensure system-wide, coordinated oversight of transitional safeguarding locally. This might involve shared chairing arrangements, shared work groups or shared objectives between SABs, CSPs and LCSPs [57]. It might include a cross-age strategic group to direct activity for both children and adults, with a shared vision of purpose, clear terms of reference, multi-agency membership and clearly defined responsibilities[58].

Quality assurance. Regular case audits of transitional arrangements are conducted[59].

Reviews. Safeguarding Adult Reviews and Child Safeguarding Practice Reviews are used to develop arrangements for care leavers.

This model enables exploration of the facilitators and barriers of good practice. The analysis that follows draws on information contained within the chronologies and group discussions during the learning event. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding is situated.

[53] Cocker, C., Cooper, A., and Holmes, D. (2021) Transitional safeguarding: Transforming how adolescents and young adults are safeguarded. *British Journal of Social Work*. Advance Access
[54] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[55] Holmes, D. and Smale, E. (2018) *Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood*. Dartington: Research in Practice.
[56] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[57] Walker-McAllister, S. & Cooper, A. (2021) Transitional Safeguarding: A Strategic Response, *Practice*, DOI: 10.1080/09503153.2021.1948523
[58] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[59] Holmes, D. and Smale, E. (2018) *Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood*. Dartington: Research in Practice.

The analysis begins, however, with a summarised chronology with accompanying commentary on good practice and on concerns about how practitioners responded to the needs and risks that Madeleine presented with and how services worked collaboratively to attempt to address those needs and mitigate the risks.

Section 5: Chronology and Initial Commentary

For the purposes of this SAR, the chronology and initial commentary have been broken down into three sections:

1. **2014-2017 – background information**
2. **January 2018- August 2019 (becoming a looked after child in LBW)**
3. **September 2019 – August 2020 (Moving to Croydon)**

Key Practice Episode 1, 2014-2017

By 2014 Madeleine was attending a Pupil Referral Unit (following an assault against a peer and teacher in her former school), she was reported to have settled and making good academic progress. Later that year she was very briefly accommodated under s20 Children Act by LBW-CSC for 4 days respite in residential school following an incident where she was taken to hospital having assaulted her mother. She returned home with a package of support from LBW-CSC, CAMHS and 'educational establishments' until this was stepped down on the 12.02.15. In 2015 Madeleine and her family were involved with 'Wandsworth Family Recovery Project'. This was a multi-agency programme designed to help vulnerable families in need.

Madeleine was reported missing from home on the 08.12.15, 27.01.16, 10.03.17, 26.10.17, 15.11.17.[60] LBW-CSC case notes record only two incidents on 13.03.17, 27.10.17 and confirmed they conducted a return home interviews on those occasions, concluding no further action was necessary. Police also responded in June 2016 to a request by her mother to speak to Madeleine following her expulsion from school[61] and on the 27.01.16 in response to a neighbour's concerns as Madeleine was on her bedroom window ledge, fighting with her stepfather.

Madeleine was offered a place at a specialist school for children with autism, but this appears to have triggered an escalation in Madeleine's behaviour. Her parents reported this was because it was to provide support to children whose needs were very different to Madeleine. On the 27.06.17 police were called to the school as Madeleine '*had been punching and kicking walls, letting off fire extinguishers, smashing plates and generally out of control around the school. Madeleine was located and spoken to whereupon she said that she hated everybody, including her family, but wouldn't explain why she had acted in the way that she had. Teaching staff reported that Madeleine had written a note the previous week stating she felt numb and there was no point in her being around anymore. London Ambulance Service (LAS) were called to check on her and look at an injury to her wrist. Due to concerns about her mental health, a decision was made by police in consultation with paramedics who were present to detain her under s.136 Mental Health Act 1983 in order to conduct a mental health assessment*.'[62] She was taken to hospital but assessed as not meeting the criteria for admission under s2MHA and was subsequently permanently excluded due to behaviour. She was again assessed under s17CA '89, but the case was closed to LBW-CSC on the 23.08.17. A re-referral to LBW-CSC for s17 assessment saw this completed in November 2017 and support was offered via the Child in Need team.

[60] Police IMR records 'Madeleine was found the following morning (16/11/17) by officers in Marble Arch. She was acting erratically and it appeared that she may have taken drugs. LAS were called to check her, and she was eventually returned home by police. Madeleine explained that she had been with a girlfriend and had spent the night walking around and taking buses here and there. She eventually admitted using Cannabis which her girlfriend had supplied to her. CCTV showed Madeleine walking with an adult male prior to her being found. She said she couldn't remember anything about what had occurred during the previous hours.'

[61] Police IMR reports: There was some mention by the officer of Madeleine being 'lucky' that whatever was thrown at a teacher did not hot him and the officer talking about pointed and bladed articles. The officer spent some time chatting with her about her hobbies, likes and fears. Madeleine was calm and responsive and it was suggested to her that she may want to consider writing a letter to the school apologising for her actions, which is what she subsequently did whilst the officer was present.

[62] Taken from the Police IMR

On the 12.12.17 police were called to her home address where her mother reported that Madeleine had been at a CAMHS appointment that day and after returning home she had run off. She reported Madeleine was in a 'distressed and dangerous state' adding she had tried to 'attack' people walking past her and had hit her mother having returned home. Her stepfather reported she had told her parents that she did not feel that she was part of the family and felt that her mother favoured her 'new' family. He stated that he had been in Madeleine's life since she was three years old. He and Madeleine's mother did not wish to make any allegations, they just wanted to get help for her. Eventually Madeleine was spoken to by police whereupon she disclosed that she hated all of her family and spoke of little else. It was reported that Madeleine was due to attend a CAHMS meeting the following week and she believed that she was going to be placed into care, although how that information is known is unclear from the report. Her mother then took Madeleine to stay at her maternal grandmother's home address, however it was agreed this would not be suitable as a permanent fix. The circumstances of the contact with police was referred to LBW-CSC.

Commentary:
During this period, there were a number of different agencies involved in Madeleine's life. The main support to Madeleine and her family was provided via health (CAMHS) and education services. There were a growing number of contacts with police, including 'missing from home' episodes, and a smaller number of contacts with local authority services via s.17 CA '89, usually after incidents which involved Madeleine assaulting her mother or causing damage at school, which indicated the complexity of Madeline's needs.

It is not clear from the available information what support Madeleine and her family received from CAMHS after the incident on 27.06.17, following being detained under s136 of MHA 1983, but not meeting the criteria for admission under s2MHA 1983. The local authority's involvement was via s17 CA '89, so as a support to a child deemed to be 'in need' and their family. It does not appear that any multi-agency planning meetings took place over this time, involving the parents, to bring together information known about Madeleine and plan appropriate services and support for her. It would appear that over the latter 6-month period of 2017, Madeleine's needs began being framed by the professional network as 'care needs' rather than 'mental health' needs. This then set up the way in which services engaged with Madeleine and her family from this point forward, with 'care needs' becoming the dominant framework that determined how Madeleine was viewed, particularly by CAMHS.

The authors were not made aware of any changes to practice during the discussions at learning events held as part of the SAR process. Following completion of the review, the SWLStG NHS Trust advised they now had a Community Dialectical Behavioural Therapy team which aims to support young people. However, it remains possible that current arrangements for supporting families where children exhibit similar behaviours to Madeleine remain fragmented in terms of proactive planning, in part because of the effect of limited mental health resources and funding issue pressures for local authorities.

Key practice episode 2, Jan 2018- August 2019: transitional planning for the move to Croydon
On the 08.01.18 having been expelled from a CAMHS meeting that afternoon because of her aggressive behaviours and following an assault against her mother, Madeleine again moved in temporarily with her maternal grandmother.[63] Madeleine became a looked after child on the 13.01.18, following an incident on the 12.01.18 where, angry at her grandmother for mentioning to a social worker she had Asperger's, punched the social worker and absconded. Once located she was taken into police protection and accommodated by the LBW-CSC. She was placed by LBW-CSC in semi-

[63] Taken from Police IMR, p8

independent accommodation under s20 CA but absconded on the 13.01.18. She refused to return to the s20 accommodation.

On the 15.01.2018 Madeleine returned to home address and with the assistance of the local authority a 'care contract' was created. The 'contract' was created to provide family rules intending to maintain order within the family home. However, Madeleine was arrested on the 17.01.18 from her mother's address for criminal damage and arson (having become angry at her mother's request to hand over her ipad). Madeleine (accompanied by an appropriate adult) admitted the offences, though blamed her mother for insinuating to other people that she had mental health issues. Madeleine was released from the police station under investigation pending a Youth Offending Team (YOT) referral and was taken by her social worker to stay at a new placement, her second placement address.[64]

Further missing episodes were recorded by the police on the 27.01.18, 29.01.18, 03.02.18, 05.02.18 (police called due to assault against mum, threats to kill and criminal damage to the property- Madeleine receiving a youth caution), 07.02.18 (Madeleine called police to report she's committed criminal damage, she was also arrested for possession of cannabis), 08.02.18, 09.02.18 (reported altercation between Madeleine and another resident), 10.02.18, 17.02.18 (Madeleine called police to request lift home from SE18), 23.02.18, 24.02.18, 25.02.18, 03,03,18, 04.03.18, 08.03.18, 13.03.18, 18.03.18 (police called by care workers as they need more help and thought MERLIN report by police might assist them to get this from LBW-CSC), 20.03.18, 21.03.18, 23.03.18, 29.03.18 (police called re criminal damage- Madeleine complained this was her response to the 6th move), 11.04.18, 13.04.18, 14 &15.04.18 police were called due to criminal damage), 16.04.18, 17.04.18 (reported feeling suicidal), 18.04.18, 20.04.18, 23.04.18 (police also intervened as Madeleine was holding a social worker against her will) on the same day she later went missing not returning to the placement for 4 days, 28.04.18, (staff also alleged criminal damage, police records report '*Upon arrival, staff said there was no damage and they did not wish to substantiate any allegations. Police spoke to* [M] *for over an hour. She said staff had refused to provide her weekly allowance. She said she had noticed that over the years, if she created a scene, she would generally get what she wanted*' she was found by police outside a previous placement on the 29.04.18. Later that day the police were called as Madeleine had assaulted a support worker and run off, later turning up at her mum's home.

Commentary:
It is of concern that police records indicate significantly more missing incidents that those recorded by LBW-CSC. Despite the very high number of missing incidents, LBW-CSC practitioners conducted only 2 return home interviews, possibly because at this time there was a separate service who provided outreach and return home interviews. Had this formed part of the scope of this review, the authors would have wished to explore and comment on the apparent absence of professional curiosity and analysis of risk within that service, particularly given the circumstances reported on the 16.11.17.

It is also of significant concern that the provider's rationale for police involvement on the 18.03.18 was because they hoped it would persuade LBW-CSC to provide additional, necessary support to keep Madeleine, other children in the placement and staff safe. This should prompt commissioners to reflect on whether they have sufficient mechanisms in place to enable positive, open dialogue with providers and, if not, what steps should be taken to improve practice and cooperation to meet statutory duties to provide safe care.

[64] The disposal decision recorded on the Police's CRIS electronic records is not wholly clear as it appears after a YOT referral was made, the Crown Prosecution Service (CPS) subsequently authorised charges against her. The case was listed at the South West London Magistrates Court where a not guilty verdict was recorded following the case being withdrawn by the CPS.

We understand that, subsequent to these events, Wandsworth Safeguarding Children Partnership have approved a Vulnerable Adolescents Strategy and Multi Agency Risk Vulnerability and Exploitation (MARVE) protocol. Senior leaders sought to reassure that if Madeleine was now 14 the response to an escalation in risk associated with the high number of missing incidents would be different. They explained return home interviews are now routinely conducted and the MARVE panel reviews cases of concern. This panel receive referrals from the council's MASH, Referral and Assessment, Child in Need and Child Protection teams for all children, not simply those already in local authority care. In addition, a strategic MACE panel is jointly chaired by Police and CSC in accordance with the Metropolitan Police Pan London Exploitation Protocol. LBW-CSC also reported that adolescent services and responses to contextual risk have been realigned in LBW-CSC, including the establishment of a specialist exploitation and missing team called Evolve.

Whilst outside the scope of this review, WSCP and partner agencies may wish to assure themselves implementation of these policies and protocols has or will quickly result in a change in professional culture and necessary practice improvement so that children at high risk of harm and exploitation (including those placed by LBW-CSC out of area) are quickly identified and provided with adequate levels of support to stay safe.

In April 2018 Madeleine reported she had suffered sexual abuse from the age of 6 (alleging that her mother had caused harm). This was investigated under s47 CA. Her parents explained that, despite assurances at the time from investigators that they were satisfied there was no basis for the accusation, they repeatedly had to refute the allegations when new caseworkers became aware of it. They reported it was a common occurrence for case records to be inaccurate and that they often felt portrayed negatively. When they sought to rectify this, they were viewed as being defensive and often this resulted in them feeling as if they were being blamed by professionals for any trauma Madeleine may have experienced. Consequently, when they voiced concerns about her care or highlighted risks for her safety, they felt these were not given sufficient consideration.

Madeleine was taken into police protection again on the 15.04.18 and handed into the care of LBW-CSC, but again absconded on the 16.04.18. On the 17.04.18 the police returned Madeleine to her placement. On the 29.04.18 Madeleine was arrested and charged with assault- the matter was discontinued at Magistrates Court on the 06.06.18. Further reports of Madeleine absconding from placement/ missing are recorded on the 01.05.18, 02.05.18 and on the 07.05.18.

Commentary:
Throughout this period, as Madeleine's behaviours escalated, those providing her care appeared to rely heavily on an emergency police response to locate and return her to placements. There appears to have been no consideration as to whether alternative legal mechanisms could have been applied to enable Madeleine to be placed within restrictive, therapeutic care. At the learning events, LBW-CSC staff explained that it had proven very difficult to secure input from their CCG to support Madeleine through her Education, Health Care Plan. Senior leaders also accepted that communication and multi-agency working with CAMHS required improvement. They spoke about initiatives intended to improve multi-agency working and transitional planning, particularly the Intensive Intervention Team who are attached to LBW-CSC. They believed this team were working with Madeleine, but also commented many frontline practitioners (including personal advisers coordinating leaving care support) are unaware or underuse the support available.

In discussions with the reviewers, practitioners and senior leaders expressed frustrations at the limitations of existing legal remedies, specifically they felt the high thresholds applied by the

Family Court for s25 Children Act 1989 orders meant they had little choice but to 'set children up to fail'. This highlights the importance of legal literacy within the workforce. As set out in section 4 of this report, s25 Children Act powers is only one of many powers that enable public bodies to put in place restrictive, protective care for a young person. Madeleine had previously received in-patient support as a child and was known to CAMHS, though support was fragmented as each specialism appeared to reach the conclusion that they were unable to address her significant needs so referred her, via waiting lists, to alternative services.

The reviewers believe she could have benefitted from earlier consideration of whether it was necessary to provide her with a therapeutic placement, albeit one that restricted her movements, in order to provide her with safe care. If so, and if Madeline were unwilling to consent, the local authority could have explored whether powers under the MHA, MCA or the High Court's Inherent Jurisdiction would have been a less intrusive, less damaging way to provide the necessary care. There is no evidence within the documents submitted to the review that this was considered, there is also very little evidence of strategic planning of assessments or care planning between the CCG, Local Authority and CAMHS.

The relevant public bodies within Wandsworth may wish to consider whether it would be prudent, to prevent similar harm for other young people in their care, to review their current case files and ascertain how many young people might benefit from strategic joint assessment between CCG, local authority and mental health services. They may also wish to consider offering additional training to staff in respect of the combined duties to assess and plan care for those transitioning to adult services to ensure those most at risk are not left solely reliant on the 'leaving care' support which were only ever intended to complement the full range of community care responsibilities to provide time for young people to acquire 'life skills'. What Madeleine needed was therapeutic care to address her mental health needs.

She was again arrested for assault and false imprisonment on the 08.05.18.[65] In response to this further incident, LBW-CSC believed they had sufficient evidence to justify an emergency application under s25 Children Act. On the 10.05.18 LBW-CSC obtained a Secure Order and Interim Care Order for Madeleine on the basis that her behaviours '*demonstrated an inability to regulate her own emotions which render her a risk to herself and others. These risks were felt to be unmanageable in a non-secure setting*'[66] She was transferred to a Secure Unit in Scotland for a period of assessment. She remained on a Secure Order at that address until 01.09.2019. The Court granted a full care order to LBW-CSC on the 19.11.18 and appointed a Guardian to represent her throughout this period.[67]

On the 30.11.18, when Madeleine was 16, she was allocated a personal advisor from the leaving care service. Madeleine was referred (aged 17.5) for an assessment to ascertain her likely care and support needs following her 18th birthday, in line with duties under s58 Care Act 2014. However, she was not referred at this time for consideration as to whether she might be eligible for NHS CHC support after she turned 18. Reports regarding the frequency, severity, unpredictability and complexity of her psychological and emotional needs are such that they could be described as high (as defined by the CHC decision support tool), similarly the reported behaviours corresponded with

[65] In response to this incident Madeleine was subsequently convicted on the 06.08.19 of assault and being a 'child aggravator' at Forfar Sheriff's Court. She was sentenced to 9 months community payback order and 9 months supervision/probation period, both deferred to 07/08/19.
[66] Taken from the statement prepared by LBW-CSC for the Coroner, dated 18.01.21
[67] In August 2018, as Madeleine had moved away from London, SWLStG NHS Trust ceased involvement. They have subsequently advised the reviewers that on closing the case they provided copies of her assessment to LBW-CSC, her GP and the placement in Scotland.

the severe category of need described within the tool.[68] The social care assessment confirmed she would need assistance with maintaining a habitable home, maintaining family and other relationships and engaging with employment or training. Whilst she was at the Secure Unit, LBW-CSC kept her pathway plan under review. This was overseen by Independent Reviewing Officers. There is evidence from correspondence and reports at the practitioner/senior leader events that Madeleine's social worker at this time took time to listen to Madeleine and worked to develop a relationship of trust with her. There is also evidence that the transitions worker worked hard to establish a rapport with Madeleine. Unfortunately, it is questionable whether the importance of the relationship with her children's social worker was understood at organisational level, as there was no flexibility offered to enable her social worker to continue to work with her for a period of time after her 18th birthday. This is of particular concern given that Madeleine had spent most of the previous 18 months prior to turning 18 living in Scotland, which limited the opportunity for any worker from the leaving care service to get to know Madeleine.

Madeleine was allocated an advisory teacher from the Virtual School in Wandsworth. She was also under the care of Tayside CAMHS and received a number of therapeutic assessments and interventions focused on stabilising her behaviours, supporting her mental health and emotional regulation as well as preparing her for eventual step-down and independence. Despite that input and close monitoring from staff at the secure unit, Madeleine continued to exhibit exceptionally challenging behaviours. Staff at the placement reported 14 serious incidents of her self-harming (scratching herself, hitting her head on floors/walls) or assaulting others between May 2018-October 2018. There were also reports of her experiencing periods of heightened serious mental distress. None of her injuries were considered by staff to be life threatening or placed her at serious risk.

On the 16.07.19 she moved from the Secure Unit to a 'step down' facility run by the same provider, in order to prepare her for more independence as it was anticipated she would move to Phoenix Hub in Croydon [hereafter referred to as 'PH']. It is understood that Madeleine requested the move to the step-down facility was for the minimum time possible as she had, by this time, had numerous placements and had found this to be detrimental to her wellbeing. Her behaviours escalated at the time of this move; there were two assaults on members of staff during a visit to view the step-down facility, she was also found to be in possession of items that were contraband within the facility (broken glass, razor, cigarettes and papers). Whilst this was noted as an 'incident' there isn't any evidence that staff within the unit or those responsible for planning her move back to London considered what this suggested in respect of risks of her self-harming once the close supervision and structured activity available within the secure setting was removed or if she had the skills and insight to her needs to manage in semi-independent supported accommodation.

On the 25.07.18 two clinical psychologists from the Adolescent at risk and forensic service within the South London and Maudsley NHS Foundation Trust [hereafter referred to as 'SLaM'] completed an assessment to 'inform future risk management and placement/ therapy options'. During the assessment Madeleine reported she '*felt her views were not taken into account when considering future placements. That her placements this far had been negative experiences, but she 'struggles to know what a 'good' placement would look like*.'[69] The assessment concluded OCD as a diagnosis may not quite capture Madeleine's difficulties. Problems with emotional regulation (and ASD) were more important to a better understanding of the mental health problems that relate to her behaviours and risk. For emotional dysregulation, they suggested a treatment such as Dialectical Behavioural Therapy (DBT), but because this behavioural and psychological approach required consent and

[68]The NHS CHC Decision Support Tool is available at: https://www.gov.uk/government/publications/nhs-continuing-healthcare-decision-support-tool
[69] Taken from the SLaM Serious Incident report

commitment from her and she had already been clear she did not wish to have any mental health input, their report had limited practical application to her future care plan. In effect, it could only make recommendations for management of her difficulties and risks in the future. It does not appear that the purpose of the assessment was explained to her parents, they understood that this was undertaken to inform the support that would be provided by SLaM once Madeleine returned to London.

The recommendations made were mainly in relation to adaptations to environmental factors that should be taken into account to minimise behaviours associated with her ASD and emotional dysregulation. They advised any future placement decisions should provide her with some agency in deciding where to live. This posed further complexities, because their ideal would have been an ASD specialist setting but recognised her strong disagreement with her ASD diagnosis meant there was a likelihood that she would reject this, causing a breakdown of any such placement. Madeleine's preference was generally for a semi-independent setting. The assessment also recommended consistent boundary-setting by staff and having a comprehensive activity programme. Again, Madeleine had already stated she did not want any support such as mentoring, key working or specific work on emotional regulation.

It is reported, inaccurately[70], within this assessment '*there was no evidence of self-harm while at the secure accommodation despite peers self-harming and though she expressed some hopelessness about her future, she denied any thoughts to end her life. It was also noted that there had been no recent self-harm in the community before her admission to the secure unit, with the most recent incident she could remember occurring approximately 3 years beforehand*.' They therefore assessed the risk of deliberate self-harm as low, though accepted a risk of 'inadvertent' harm to herself. This report was not incorporated into the SLaM risk assessment, nor did SLaM staff subsequently assessing Madeleine's needs properly review the historic notes on her records or consider the '*impact of her life experiences on how she may receive services, meaning that a trauma informed approach was not applied*.'[71]

A further serious assault on the 21.08.19 resulted in the Secure Accommodation provider serving notice and requesting her move to PH be expedited. Despite the unplanned timing, the process of her transition back to London was coordinated with members of staff from PH and the secure unit involved. However, there is no evidence that Wandsworth CCG were involved in planning for her move. This is contrary to expectations in statutory guidance[72] which requires CCGs and NHS England must cooperate with local authorities, agree mechanisms to ensure they comply with NHS England's guidance in relation to secondary health care when making placement decisions for looked-after children and that if (as in Madeleine case) '*a looked-after child or child leaving care moves out of the CCG area, arrangements should be made through discussion between the "originating CCG", those currently providing the child's healthcare and the new providers to ensure continuity of healthcare. CCGs should ensure that any changes in healthcare providers do not disrupt the objective of providing high quality, timely care for the child*.' Instead, SLWStG's NHS Trust confirmed they received a referral from the residential unit notifying them Madeleine was returning to the area and providing a summary of her care.[73] SWLStG NHS Trust have subsequently explained to the reviewers

[70] Reports from the secure placement had raised self-harm as an ongoing concern.
[71] Taken from the SLaM IMR prepared for this review, p5
[72] 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.
[73] Previously her Consultant Psychiatrist in Scotland raised concerns regarding her anxiety, self-harm and behavioural disturbance, detailing ongoing issues re anxiety and OCD symptoms, over-arousal states, shouting and pacing, tapping and taking clothes off, crying hysterically and pulling hair as well as scratching her face, cutting her legs when distressed. She also was obsessively brushing her teeth, and she was concerned about contamination. She also got angry when she felt that she had been treated unfairly. She was started on fluoxetine at 10 mg once daily for two weeks and increased to 20 mg once daily. The conclusion was OCD with behavioural disturbances, also linked to ASD. The summary provided to Wandsworth CAMHS was by letter (dated 19.08.19) detailing a diagnoses of ASD, OCD, emotional dysregulation and self-harm. It confirmed

that a duty worker from the Wandsworth CAMHS contacted the residential unit on the 28th and 30th August 2019 to ask her new address and advised the unit they should get back in touch when her address was known, but until then the case would remain closed. The summary of information was also subsequently passed to her GP in Croydon. SWLStG Trust explained, whilst it is usual practice for recipient teams to request information from previous teams and that they often share information with SLaM, no such request was received in respect of Madeleine's case. Whilst handover information was forwarded this was not done correctly, it appears LBW-CSC relied on placement staff in Scotland to carry out this task. As a result, there was insufficient follow up or accountability across partner organisations. It remains unclear who led on assessing and planning her health provision. Given her status as a looked after child and widespread agreement she had complex health and behavioural needs, consideration should be given to how partners could offer assurance that there are sufficient resources to meet statutory expectations for collaborative planning in respect of health needs, particularly as this issue is not unique to this case.[74]

A risk assessment safety plan dated the 30.08.19 detailed all the triggers to self-harm and mentioned that she continued to self-harm and had been using ligatures around her neck to harm herself. It also detailed concerns about her risk of harm to others and additional concerns regarding her behaviour of stripping naked when distressed. As regards the suicide risk, she was assessed as having escalated risk contradicting the previous assessment which had considered her of low risk, as staff within the secure setting reported numerous incidents of her self-harming on 22nd, 23rd and 28th August 2019. She had started using clothing and items to create ligatures. Whilst this was received by LBW-CSC and uploaded onto their electronic records, again this document and the safeguarding risks were not noted in later assessments or included in care planning. Madeleine's parents recognised that for new practitioners allocated to provide support Madeleine, the task of sifting through her case records must have been daunting, but they felt more should have been done to ensure key information was more easily accessible, particularly information about known risks, triggers for escalation of her behaviours and what worked well to engage her with support. Understandably, the LBW-CSC's IMR identified a lack of comprehensive risk assessment within this case.

Madeleine moved to Phoenix Hub in Croydon at the end of August 2019.

Commentary: Whilst it is positive that SLaM became involved in supporting staff planning for Madeleine's move back to London, it is of concern that the assessment undertaken did not feed into any subsequent planning from both CAMHS or adult mental health services in London, including any risk assessments. This is a major oversight and omission. The findings of this risk assessment should have prompted a multi-agency meeting involving health, adult and children's social care commissioners and secondary mental health providers. Again, in common with previous practice for transitional assessment and care planning, where there was an absence of multi-agency holistic understanding of her likely needs, the responsibility fell predominantly on the leaving care framework. This resulted in an overreliance by the CCG on LBW-CSC to manage all her needs and a relegation of the secondary mental health providers' role to provide advice to LBW-CSC on placement decisions. If services are striving to achieve good practice in transitional safeguarding it would be worth reflecting on why the CCG were not invited to contribute to her care plan by detailing her health needs or consider eligibility for CHC when Madeleine turned 16. They should also explore why the CCG was not involved in discussions with SLWStG NHS Trust when they withdrew specialist support, despite her ongoing behavioural and psychological needs,

Madeleine was on fluoxetine 40 mg once daily and risperidone 0.5 mg once daily. Both Madeleine and her care worker reported that since starting on the risperidone in July 2019, she was much calmer and there was only one incidence of self-harm when she broke an IPad and cut her hand. This was two weeks prior to the appointment, and the staff reported that there had not been any self-harm since. She still had compulsions around contamination, but this was less intrusive.

[74] There are similarities regarding the incomplete analysis of global health needs and a lack of holistic planning in this case and the 'Jasmine' SAR published by Richmond &Wandsworth SAB in 2020 (available at: https://www.sabrichmondandwandsworth.org.uk/media/1475/safeguarding-_adults_review_jasmine.pdf)

because they had reportedly offered all the support that they had available. From a governance perspective, any gaps in services to meet complex behavioural needs should be escalated to health commissioners so that these are included within Joint Strategic Needs Analysis.[75] Following completion of this review, SWLStG Trust confirmed that whenever a child is detained in a health based place of safety for more than 24hours this is now escalated as a Serious Incident to CQC and the CCG. They also drew attention to recommendations made by SWL CDOP for 2021 and the Child T SCR for Sutton, advocating for the commissioning of a local specialist ASD 24/7 crisis team so support could be offered in appropriate tier-2 Mental Health facility, rather than relying on the s.136 Suite at Springfield Hospital, paediatric wards or police station holding facilities. In light of the findings in *Re (T)* [2021] UKSC35 and *Nottingham CC v LH* [2021] EWHC2584 the authors of this review would strongly add their support for this recommendation to be actioned urgently.

This approach, namely for the specialists to provide guidance to commissioners, was also not fully understood by the team around Madeleine, most notably her parents. They explained that, had they realised the limitations of SLaM's Forensic Team's future involvement, they would likely have pushed much harder to have secondary mental health services directly involved in delivering Madeleine's care and support.

The lack of strategic multi-agency transitional planning also encouraged poor practice in respect of consultation and collaboration with Madeleine. Madeleine's resistance to ongoing involvement with mental health services appears to have been a barrier for all professionals, but there is very limited evidence (save for a conversation between the leaving care worker and another one with a police officer) that practitioners explored her views or gave weight to her wishes. There were no examples of mental health professionals talking to her about her previous treatment experiences and any trauma that multiple exclusions from school, placements and services may have caused. Madeleine's parents explained to the reviewers that her level of intellect was such that she fully understood that she had been failed by 'the system' and this left her feeling hopeless for her future.

There is also evidence of contradictory assessments of the levels of risk posed by Madeleine's self-harming. This does not appear to have been discussed at senior or operational level. Given the pro-active duty of public bodies to act to protect life (Article 2, ECHR) LBW-CSC may wish to assure themselves that such clear contradictions are now routinely picked up and trigger multi-agency strategic discussion (in line with obligations under s47 Children Act) with suitable, specialist input from mental health professionals.

Key Practice Episode 3: Croydon

Following Madeleine's move to Phoenix Hub in Croydon,[76] she saw her family more frequently. She had a 2:1 staff ratio and was reported to be engaging well with her psychologist and semi-structured interventions; these included group and single activities, sensory room and meditation classes and key work sessions. She had also volunteered weekly at a stable and received responses from two other stables inviting her for an interview in relation to apprenticeships. She also had applied for three part-time jobs and during her key work sessions she had been practising interview skills and techniques.

[75] Again this is requirement under Promoting the health and wellbeing of looked after children' March 2015.
[76] This placement was staffed 24/7. Madeleine was expected also to participate in weekly key work sessions to assist her with learning skills to live independently.

When Madeleine saw the GP in September 2019, she reported no further incidents of self-harm. Her family reported to the reviewers they were not surprised by how well she appeared to settle as it was not unusual for her to manage behaviours for short 'honeymoon periods' in new placements. They expressed concerns that staff within the placement were dismissive of their warnings regarding her lack of structure, increased use of cannabis or when they asked about incidents of self-harming. Her parents raised doubts as to whether record keeping was sufficient as there appeared to be no details of an incident when Madeleine cut into her face and forehead. They were left with the impression that PH staff believed they had 'cracked it'. Her parents believed she was likely to always require support. Some days would be better than others.

Police records note Madeleine was reported missing from her placement, she was subsequently arrested on the 14.09.19 for possession of cannabis and was referred to YOTS for a disposal decision to be made given she had previously been warned over cannabis possession and so she was not eligible for a further warning. On 26.09.19, Madeleine attended Wimbledon Police Station where she was interviewed under caution and admitted the offence of possessing cannabis.

On 14.10.19 Madeleine was reported missing from her placement and returned on the 15.10.19 having 'stayed with friends'. On the 18.10.19 Croydon CAMHS[77] confirmed they had received a referral. Despite Madeleine now being only within three months of turning 18, there is no evidence that a referral was made to adult mental health services in accordance with NICE guidelines.[78] Instead PH staff were advised CAMHS couldn't confirm a next available appointment but anticipated it would be within the next 3 months. A senior manager within CAMHS subsequently reviewed the case and an appointment was made for the 27.11.19.

In early November 2019, following Madeleine's return from a trip to visit staff and residents of her former secure placement, a transitional planning care meeting discussed with Madeleine how to support her into further education or training. PH staff reported during discussions with the reviewers, that Madeleine had been accepted by a college to restart her education. This was following an interview and she had started classes, but her place was later withdrawn by the college until they could secure additional support for her. Her suggestion that PH staff support her was rejected. This was particularly upsetting for Madeleine as it was another exclusion, based on an assumption of her needs arising from past presentations. Subsequent attempts to identify tutors failed as Madeleine felt they underestimated her abilities and always placed her in lower sets based on her diagnosis.

Madeleine attended the session with a SLaM psychiatrist on the 27.11.19, accompanied by a PH support worker who reported she started to disengage when she was asked by the psychiatrist to revisit past incidents and emotions, at this point she '*stated she did not wish to attend… did not want to discuss her past and felt she was in a better space*'.[79] SLaM records state she report that she was complaint with her OCD medication, in stable mood (though bored in her current placement), and was using cannabis on a daily basis to cope. This did not trigger any further action by SLaM despite NICE guidance. Her risk of self-harm and harm to others was incorrectly recorded as low, because they had not had sight of pertinent risk assessments (although these should have been made available either via the GP or from SLWSG Trust). She was advised to contact adult mental health services if she had concerns. Feedback of this assessment clinic was delayed until 10.01.20 when it was decided to liaise with her social worker and support the transition to adult mental health services. In fact her GP made the referral to adult mental health services, but this did not occur until 27.04.20, following fresh concerns raised by her keyworker in Phoenix Hub.

[77] This service was managed by the SLaM NHS Trust
[78] NICE (2016) Transition from children's to adults' services for young people using health or social care services. London: National Institute for Health and Clinical Excellence
[79] Taken from the PH IMR [p11] prepared for this review.

Staff from PH explained to the reviewers that they were not present in the session when she disclosed daily cannabis use, though they would have been aware of her use. Her parents reported Madeleine did frequently use drugs within the placement. PH confirmed they were surprised that SLaM closed the referral as quickly as they did without first seeking the views of PH staff providing daily support. Given her complex history they were surprised decisions were made purely on her presentation on that day and felt further attempts should have been made to work with them to support her engagement.

On 18.12.19 (one month before Madeleine's 18th birthday) LBW-CSC and Adult Services discussed her future support at a transitional panel meeting. Whilst panel discussions are recommended as good practice, it is notable that representatives from SLaM and the CCG were not in attendance which was an omission, given the complexity and longevity of her mental health needs.

LBW-CSC's transitions worker from the Future First service made a referral for a CHC assessment some time in February 2020, following a rejection from LBW Adult Services to accept responsibility for meeting her ongoing care costs. He later chased for information on the referral in April 2020. No outcome for this assessment is recorded so it looks as though it had not started at the time of her death in August 2020. [80] In terms of other placement options, there are records of the transitions worker making plans for Madeleine's future placement moves in June 2020, but she was not part of this conversation and her views were not sought until very late. On the 05.08.20 Madeleine was told about plans to move her to a training flat for 6 months and rejected this plan, because she had been previously told she would be moving to a permanent flat and this is what she wanted.

On the 07.01.20 Madeleine was convicted of two counts of assault which had occurred during her placement in the secure unit. She received a deferred sentience (9 months community payback order, 9 months supervision period, 30 hours unpaid work order within 9 months.) She was again found in possession of cannabis on the 26.02.20 and received a community resolution disposal.

On the 03.02.20 Madeleine was brought into Croydon University Hospital's Emergency Dept ['ED'] by London Ambulance Services (LAS), accompanied by PH staff. She was experiencing "*a gritty feeling to the eye and painful swallowing, which prevented her regular medication*" (including medication for her mental health condition). During this admission, Madeleine locked herself in one of the treatment rooms (with an internal lock). PH staff explained to the review that they had prepared Madeleine for a long wait, but she became increasingly more agitated as the advertised waiting time grew. They reported that her reaction, whilst extreme, was amplified by the way in which hospital staff responded. They reported having to ask nursing and security staff to stop shouting at her as this was placing her in a heightened state. Conversely the hospital's IMR reported this as a missed opportunity as staff had not viewed her reaction as significant[81] so focused on the safety breach of Madeleine locking herself in the room rather than exploring the reasons and/or any potential link to her mental state at the time. During this episode of care consideration was not given to reasonable adjustments that could have assisted Madeleine to access emergency treatment or for a referral to the Mental Health Liaison Service (MHLS) for an assessment of her mental state despite her distressed behaviour and given that Madeleine had reported that she was not compliant with her mental health medication regime. Madeleine was subsequently prioritised for immediate treatment, prescribed with antibiotics for conjunctivitis and later discharged. The incident was not mentioned in the discharge letter for her GP; this focused on the physical presentations and failed to mention any

[80] As Madeleine was by then 18 the NHS CHC national framework sets out expectations that 'the whole process should usually be completed within 28 calendar days' [p122]

[81] Though the IMR reported 'the traumatic impact of placement instability for CLA as well as the impact of being detained in secure accommodation is well documented and raised questions about how agencies share information about this cohort of vulnerable care leavers so that they are well supported.

concerns about not taking her medication. It should also be noted that at that time, staff did not follow Croydon Health Services NHS Trust (CHS) risk assessment guidance and report the incident as a risk for further investigation and possible preventative actions.[82]

On the 11.03.20 PH staff raised concerns with CAMHS that Madeleine was not engaging with mental health support, specifically that she had decided to stop taking her medication. They were advised it was her *'choice should she no longer wish to take her medication, however he advised Madeleine not to come off the medication all at once, due to her possibly experiencing withdrawal symptoms. He stated he could reduce the dosage of the Risperidone to one tablet*.' This interaction appeared to trigger a decision to discharge Madeleine from CAMHS. The SLaM IMR report commented '*there are several concerns which arise from this action. The transition support required was not rendered to [Madeleine], her family or the multi- agency team. Given [her] history and the level of support required during her adolescence it would have been helpful for the CAMHS team to discuss with Adult CMHT about what support, if any, could be offered to [her]. Unfortunately, it is clear in this instance that the trust transitions policy was not followed. [Madeleine] had relatively recently moved to a new placement which was a long distance from her previous one. It must be considered what the impact of this would have been upon her in terms of the severing of well-established relationships both personal and professional. This was a period for [Madeleine] where the way transitions were managed would have been particularly important to set the scene for how professionals were able to work with [her] moving into her adult life and what [she] could expect from adult services. It must also be considered what the impact of having no contact with the service following an initial assessment and then just receiving a letter some months later would have had on [Madeleine] and her perception of mental health services. This is particularly pertinent when considering a trauma informed model of care*.'[83]

PH staff supported Madeleine to review medication with her GP as she was refusing to take this because of concerns about weight gain. On the 16.03.20 they requested a face-to-face appointment, but this was refused due to Covid restrictions. The GP, in line with the CAMHS doctor, stated 'as she was 18 this was her choice', but advised her against it as she may experience withdrawal. They provided reassurance her medication wouldn't cause weight gain, but there was little exploration with her about alternative treatments that she might accept. On reflection, during this review, they recognised a face-to-face appointment would have been an opportunity to ascertain if her mental health had deteriorated. On the 09.04.20 her keyworker contacted Madeleine's GP to advise that she had stopped taking her medication and to ask for advice about how this may impact her behaviours in the medium term. This triggered the GP to make a referral to SLaM though SLaM reported this was only received, by email, on the 27.04.20. The GP reported in their response to this review they felt that risks posed by her coming off her medication were mitigated by referral to Mental Health Adult Services and ongoing key worker support as they could liaise with mental health specialists. There was no explanation for the delay in making the referral, or for the lack of advice to PH staff about how to manage her mental health in the interim.

The referral was discussed at the SLaM Assessment and Liaison ['A&L'] team's multi-disciplinary team ['MDT'] meeting[84] on the 28.04.20, where she was allocated a Nurse Practitioner and the psychiatrist agreed to liaise with SLaM's ASD/ADHD workshop panel for advice. When the Nurse

[82] Taken from Croydon Health Services IMR [p5] prepared for this review.
[83] Taken from the SLaM IMR [p4] prepared for this review.
[84] The Croydon SLaM's Assessment & Liaison service acts as a referral gateway or pathway into secondary mental health services. The team provides a comprehensive health and social care assessment service to eligible service users between the ages of 18-65 who are experiencing moderate to severe mental health problems, as well as social issues that may be having a detrimental effect on mental health. In addition to providing assessment, stabilisation and liaison functions, the team works closely with the Council's adult social care reablement service. The aim of the service is to ensure service users seen are provided with up to twelve weeks of assessment and stabilisation care interventions before people are either discharged back to primary care / general practitioners or signposted to other services such as the treatment by secondary community mental health teams [CMHT'].

Practitioner called Madeleine on the 07.05.20 she was distressed by the referral and was reported to 'rain insults on mental health services' before ending the call. Her keyworker subsequently contacted her GP on the 11.05.20 and the Nurse Practitioners to request that they make contact through PH staff, rather than Madeleine directly. The following day the ASD specialist instructed A&L team to provide more details of her previous history and medication response, obtain further details of her presentation and conduct a mental state examination and thereafter return, if necessary, for further advice to the ASD/ADHD panel. Those actions were not followed up and the panel later rejected a referral, mistakenly believing that she had no formal diagnosis of ASD.

By mid-June her PH keyworker reported to her GP that Madeleine was still not taking her full dose of medication and that she was becoming more aggressive. Her GP re-sent a letter to SLaM's adult mental health services. Her GP advised '*there is nothing he or the placement can do in relation to Madeleine no longer taking her medication and that the police should be called if [she] displayed aggressive or concerning behaviour to herself or others*.'[85] This does not accord with expectations set out in the NICE guidelines regarding the management of ASD (summarised at p11 of this report).

There is no mention of receiving the subsequent letter in SLaM's case records, but they do confirm that PH staff contacted the allocated worker on the 01.07.20 to agree a plan to communicate through PH so that SLaM could carry out the medication review. Around this time practitioners working to secure training or employment opportunities for Madeleine noted '*she doesn't want any help. She's very pessimistic still and thinks that everything will have a bad outcome*.'[86]

In subsequent MDT meetings SLaM A&L's Nurse Practitioner reported Madeleine to be 'very settled' though it should be noted that PH staff had not used that term, rather they had explained her past history of challenging behaviour, stated she was 'settled' but they were now concerned as she had stopped taking medication. The A&L team, unclear what effect stopping her medication had for Madeleine's care, focused on securing an assessment of her capacity and whether any incidents had occurred over the last 6 months. The Nurse Practitioner resigned shortly afterwards from the team and during a subsequent caseload review it was determined that, unless there was further contact from PH, the case could be considered for discharge. This was despite the previous identified actions remaining outstanding. A new worker reviewed the case (though the steps requested at the most recent MDT hadn't been taken before the Nurse Practitioner resigned) and, without regard to the earlier representations made by PH, wrote on the 11.08.20 to Madeleine advising she had been referred and asking her to contact the service.

On 13th August 2020, Madeleine returned to the placement after spending the night with at her mother's home. Her mother had informed keyworkers, before Madeleine had arrived back to the placement, that Madeleine was distressed. Upon return to the placement, keyworkers briefly spoke with her and she informed the keyworkers that she was OK and wanted to go to her room. They reported welfare checks were carried out throughout the evening and on one occasion a keyworker believed she had taken class A drugs. Madeleine confirmed this when questioned further. The keyworker informed the safeguarding officer who advised the keyworker to ensure there were no more drugs in Madeleine's possession and to call 111 to inform them of the incident and seek further advice. When the keyworker contacted 111, the operator stated they wished to speak with Madeleine and carry out an assessment. When the keyworker returned to her room with the phone for the assessment, they discovered Madeleine had hung herself. The keyworker performed first aid, whilst emergency services attended the placement to assist. She was bought by ambulance to

[85] Taken from the PH IMR [p15] prepared for this review.
[86] Taken from the LBW-CSC chronology [p47] prepared for this review.

Croydon University Hospital's emergency department and subsequently passed away on the 16.08.20.

Section 6: Revisiting the Terms of Reference

This section will review practice during the final practice episode, with reference to the best practice framework set out in section 4 of this report and the specific areas of inquiry:

1. **Did the infrastructure for transitions (between children social care and adults and between CAMHS and adult mental health services) meet with the expectations? If there were barriers to effective, preventative support, identify these and provide good practice examples from other areas to support practice and system improvement.**

Direct practice with Madeleine

Personalised practice*:* Practitioners responsible for assessment and care planning functions must take steps to ascertain the child's wishes and clearly record what weight was given to their wishes when deciding the care plan. Aside from this being a statutory responsibility[87] and integral to international legal obligations[88] in a very practical sense, recording their wishes and carefully considering the weight to apply to those wishes, taking into account the child's level of understanding, enables practitioners an opportunity to reflect on longer-term strategies to support a young person come to terms with their circumstances. Put simply, this is a duty for a very practical reason- being heard and understood helps us all to develop skills necessary for our independence.

Madeleine's parents commented that it often felt to them that decisions were made about her, without her and without regard to who she was or what she had experienced. Concerns regarding poor needs-led, person-centred and rights-based practice in respect of her early care are detailed earlier within this report. In respect of the period whilst Madeleine was living in Croydon, the impact of that poor practice continued to be felt by Madeleine, but there are also further examples where practice should be improved. This section provides important reflections regarding necessary practice and system change for Croydon SAB and partners. Appendix 1 provides examples of good practice in the area of Transitional Safeguarding.

Firstly, throughout this time period there is limited evidence that her voice was heard, or her views sought, or evidence she was supported to make safe decisions.

Practitioners from her supported housing placement Phoenix Hub [PH] knew Madeleine best and there is evidence to show that they worked hard to ensure they had a good and positive working relationship with her. They acted as a conduit for her with many other agencies, most notably her GP; mental health services; A&E staff; and education during the time she was placed with them. The placement was a very different one from the secure unit Madeleine had been in before, and it is to the credit of staff that they established a strong supportive relationship with her. But there were also limitations in the way they 'managed' Madeleine's complex presentations by avoiding conflict or any situations that might trigger aggressive outbursts. For example, whilst there were strict rules regarding illegal substance use, staff interpreted this to require input from them only if Madeleine was found in possession or using illegal substances on the property. It was also reported that, even when Madeleine was using cannabis in the setting she wasn't consistently challenged by PH staff. Whilst staff may have discussed her drug use with her during key working sessions, they did not have access to advice from health professionals regarding the impact that daily drug use could have on her wellbeing (important given this is an indicator of increased risk of suicide) or the efficacy of her mental health medication. Nor were they able to engage her with substance misuse support. Given their commissioned role, it is perhaps not surprising that they prioritised developing a trusted

[87] See for example s1(3)a, s17(4)a and s47(5)a of Children Act 1989
[88] This is protected under article 8, ECHR and article 12, UN Convention on the rights of the Child

relationship with her and her acquisition of skills for eventual independence over addressing longer-term risks to her wellbeing, but this left a noticeable gap in her care plan and, given other risk factors, an elevated risk to her mental health. For this reason, this is addressed directly in the recommendations arising from this review.

The allocated social worker from LBW-CSC was also in regular contact with Madeleine following her move to PH, leading up to Madeleine's 18th birthday. Prior to this, staff from Future First (Wandsworth's Leaving Care service) had been introduced to Madeleine. The transitions worker attached to the team understood obligations to complete social care assessments. There is an email in the chronology that recounts this clearly (pp38-41). He had undertaken a Care Act 2014 assessment prior to Madeleine turning 18 and identified that she did have care and support needs as defined by the Act. Having a transitions worker located in the leaving care service is an example of good practice. In addition, the worker demonstrated good practice in respect of his role to complete social care assessments to inform transitional planning. However, opportunities were missed to involve clinicians from the CCG with expertise in CHC responsibilities and specialist mental health practitioners, but as set out above this is likely to be as a result of insufficient strategic organisational arrangements for collaborative assessment and care planning rather than an oversight by the worker.

Following her 18th birthday, there are records of Madeleine having regular contact with the transitions worker and her personal advisor. She also reached out to her previous social worker for support. Despite this, case records demonstrate that future placement issues dominated discussions after January 2020 and deflected from consideration of actual care delivery to her at a crucial stage of her transition. Within those discussions there was very little direct discussion with her about her own wishes, so much so that she pro-actively raised fears that her views would be ignored or misrepresented to the 'panel' deciding her future care arrangements.

Case records also indicate that Madeleine was fearful of further placement change. She had asked for her social worker to represent her wishes to panel, stating '*I am very worried that I am going to be moved very suddenly to somewhere that I might not have even seen before and I don't want things to go wrong. I do realise that I can't stay in this placement forever, but I like the idea of my next placement being linked to this one in some way with the staff here*.'[89] LBW-CSC's IMR raised concerns that there was '*a change to the level of Local Authority involvement in* [Madeleine's] *life, personal freedoms, and decision-making. The reduction in contact and drive for independent living was significant and occurred over a short period of time. Over a period of six months [she] moved from a secure unit where she was subject to high levels of control and supervision to a semi-independent placement with a view to another move to a training flat and her own independent tenancy. Less emphasis was placed upon engagement [e.g. it was noted she could refuse input from Adult Services] and the focus shifted;* [Madeleine] *was seen as more capable, and expectations of independence increased. The difference in perception manifested in the assessment of care needs – from 5 hours per day, to 1-2 hours per day. There was a notable change in the narrative of her placement from an acceptance that a high level of support was needed to manage risks of violence and aggression and to support independence, to a view that the placement provider may be "over-providing" and nurturing dependence*.'[90] This change in perception was not based on any objective assessment of the reduction in Madeleine's risk or need, rather the conflict between LBW-CSC and Adult Services focused on the cost of Madeleine's support within PH. It is laudable that LBW-CSC decided to delay the transition to LBW Adult Services so that she could continue to receive support at PH for up to 12 months '*to ensure that* [Madeleine] *experienced stability and was supported to develop sufficient independence skills before move to independent accommodation*'.

[89] Taken from LBW-CSC's Chronology (p27) prepared for this review.
[90] Taken from LBW-CSC's IMR (p4) prepared for this review.

There are a number of other concerns and issues. Firstly, there was limited consideration of Madeleine's views when planning for her care and support under the adult legal framework. Language used within practitioners' communications (for example "*Ok, so what does that mean for M as she is currently stuck in a children's placement and needs to move on but will not likely accept an adult social care placement due to not accepting her additional needs*"[91]) indicates the justifiable frustration felt by frontline practitioners concerned in trying to navigate transition arrangements for Madeleine and the funding difficulties for placements and support raised at the Panel meeting with Adult Services. This inability to resolve the many tensions between the legal, policy and service frameworks that apply to young people in transition, is an issue that is bigger than just this case.

Secondly, there may also be broader issues within the service regarding a lack of providing effective, supportive challenge to young people regarding obligations to meet need. Madeleine hated the labels that she had been given, specifically the way professionals used these to pigeon-hole and thereby underestimate her abilities. Her experiences meant that she had lost faith that any mental health service would offer her meaningful support to understand the causes behind her behaviours. The authors did not get an opportunity to explore this last point with services who offered her therapeutic treatment for her OCD and behaviours. By way of an example of the practical implications of insufficient supportive challenge, Madeleine was offered semi-independent accommodation in line with her preference. However, perhaps because she did not have a comprehensive shared care plan, this seemingly provided false reassurance to some practitioners of her abilities. For example, her GP felt the risks posed by her coming off her mental health medication was mitigated by the placement, despite unambiguous requests from PH staff for clinician support to manage this risk.

There was little consideration of adopting a developmental approach to support her to gain better insight into her own needs to support her to understand how to address immediate concerns and future aspirations. Nor was there a focus on prevention, protection and recovery (as recommended in the best practice framework), because her needs were constantly viewed through a 'care' lens and not a 'mental health' lens.

There is a distinct lack of evidence that practitioners working with her in preparation for placement moves or for becoming an adult demonstrated knowledge, skills and good understanding of the good practice guidelines in respect of Autism or implemented the relevant NICE Quality Standards. Whilst Madeleine remained resistant to her ASD diagnosis, she had insight into some triggers and impact of her aggressive presentations. She accepted support to reduce this risk when the support was tailored to take into account her previous experiences and views; [92] she also had long periods of complicity with medication. Practitioners working to prepare her plans were aware of the diagnosis, some of the associated triggers and her history of multiple exclusions from educational and residential placements. In light of the NICE guidelines, this context required detailed consideration of the heightened risks that those factors could present for her longer-term wellbeing. However, instead there was a rapid shift in the interpretation of risks and her ability to manage without support which did not take into account Madeleine's mental health diagnoses, her drug use or the impact of multiple exclusions as factors that might affect future placement options or indicate increase her risk of self-harm and suicide.

This was also evident in day-to-day issues, for example, during her attendance at A&E in Croydon University Hospital.

[91] Taken from the LBW-CSC chronology [p48] prepared for this review.
[92] For example, she agreed with her transitional social worker that rather than refer to the ASD diagnosis, he refer to her mental ill health and presentations as 'Bob'. She also worked with her PH keywork in preparation for meetings with doctors and mental health practitioners so she could use distraction techniques to prevent outbursts.

Of utmost concern were transition arrangements within SLaM and a lack of clarity regarding her ability to understand risk and make informed choices. This will be covered in more detail within the fourth specific area of inquiry below, but an example of the lack of clarity of her abilities to make informed choices was the reaction to her decision to book a trip in November 2019 to visit staff and residents from her previous secure accommodation placement. The LBW-CSC chronology contains details of correspondence between PH, her social worker and mother. The social worker was not in support of the trip stating '*I am very unhappy as to the situation that this would place myself and Phoenix House staff team in; if senior management or [Madeleine's] mother stated they are not in agreement with this. Within such a limited time frame, I hope that we can come to resolution that would suit all. It would have been much better if we had worked together to explore her wishes more effectively.'* On the day she was due to travel, her social worker wrote by email to her mother stating '*I wanted to clarify that with your parental responsibility, you have confirmed with me that you give your consent for [Madeleine] to travel … for two overnights and you expect [her] to return to London on Monday, 04/11/2019. I have confirmed that both myself and Phoenix hub placement have only been aware that [she] booked this trip at the end of the day on 30/10/2019 and that the Local Authority are not positioned to authorise the trip due to risk assessment, vulnerability and therefore have no part in the arrangements. ….Please be clear that the Local Authority have not had any part in the arrangements or responsibilities for [her] visit. In addition, you have been clear that you give your permission for this trip, have paid part of [Madeleine's] fares and therefore, do not want the Local Authority to report [her] as missing from care as this may put her off and cause her distress. You confirm that she will be absolutely fine! Please confirm that this reflects the discussion we both have had.'*

This is included within the review (and within LBW-CSC's IMR) as an example of limited risk management, limited understanding of relevant safeguarding processes and an apparent focus on reputational risks to the local authority. It also demonstrates how infrequently practitioners thought to include Madeleine in risk management discussions. As noted by the LBW-CSC IMR author, the Mental Capacity Act 2005 would have applied, notably the presumption that at 17 years of age, Madeleine had capacity to decide to travel. Equally, reliance on her mother's written agreement would not have overridden statutory duties to assess her capacity if staff had concerns about her ability to make this decision. Likewise, if there were concerns about her safety, her mother's agreement would not override LBW-CSC's duty of care (she was still a looked after child under s31 CA).[93] In all scenarios, aged 17, any refusal to allow her to travel (and by implication infringe on her right to liberty), could not have been authorised by her parent.[94] Madeleine was asked to stay in contact with staff from PH throughout the trip, which she did. On her return, following attempts to stay in contact with friendships she had formed with residents and staff, she was advised that all contact was blocked, and she would have to communicate via the manager. Understandably, this upset her and appears to be a disproportionate response to possible risks that had not been investigated.

Meeting Madeleine's therapeutic and educational needs: One of the key factors in this case is the lack of consistent therapeutic support from either CAMHS or Adult mental health services for Madeleine after her return to London from Scotland, up until she died. Being the responsibility of one local authority but living in another appears to have played a major part in Madeleine's experience of mental health services. These are not new issues and there is clear guidance available[95] around how local authorities/CCGs should resolve such issues.

[93] By Volume 2 and Volume 3 Children Act Statutory Guidance
[94] In the matter of D (a Child) [2019] UKSC 42
[95] https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

Additionally, once Madeleine turned 18, there was some confusion about which SLaM service should work with her, given her ASD diagnosis. The practitioner learning event highlighted this as a continuing issue for young people with any sort of ASD diagnosis, who also have ongoing mental health needs.

In terms of education, given Madeleine's capabilities and the impact that multiple exclusions and placement moves had on her academic attainment, it was crucial for those supporting her to re-enter college when she moved to Croydon, to have a clear understanding of her wishes and work with her and the colleges to ensure there was a shared understanding of expectations. Again, however, this task seemed to have been delegated to PH staff with minimal oversight by the local authority, who did not intervene to advocate on her behalf to secure reasonable adjustments by the college who withdrew her place despite agreement from her that she would accept support from her trusted keyworker within PH.

Team around Madeleine

Good practice in this area is characterised by consistent examples of agencies working together across service and geographical boundaries with the young person and those who form part of their wider support network. This was not Madeleine's experience.

Madeleine's family: On Madeleine's return to London, she was able to more easily see her family regularly and this was important to her. Despite this there were numerous examples, cited above, of poor communication with her parents. They reported to this review that they felt side-lined or worse, viewed as perpetrators or the cause of her behaviours, particularly by LBW-CSC staff. They explained there appeared to be an unconscious bias that Madeleine's trauma must have arisen in an intra-familial context rather than from an organic disorder and/or the multiple exclusions from school, CAMHS services and placements. They explained that when Madeleine was 16, they had turned to social care on advice from CAMHS practitioners after she had exhausted their 'usual offers', but when they did, they had to address professional prejudice and perceivable shock that they needed help despite their socio-economic background. They felt they were always having to defend themselves or correct inaccuracies in records. They reported a practical consequence was that this left them exhausted, including at the idea of more conflict if they were to try to get the right support for her. This appears to have continued, tainting their relationship with PH staff who were seemingly unwilling to act on their concerns regarding Madeleine's lack of structured activities and increased drug use.

In conversations with the reviewers Madeleine's parents stated they understood the need to respect the voice of the young person, but explained there needed to be balance too, particularly, if that child is unwell and the diagnosis is not well understood. In those circumstances, parents should be part of conversations because they have knowledge of the context and history. They explained that, because under the legal framework she was deemed to have capacity, from the age of 16 she was treated as responsible for her mental health and treatment. They expressed concerns that insufficient consideration was given to her maturity and ability to articulate her needs. Despite their concerns, they felt practitioners were assured by her assertions (sometimes in the face of obvious distress) that she was fine. They did not feel this was safe practice, but instead practitioners should also look at how a young person is presenting. They questioned how, given her sustained history of significant mental health and social care interventions she was still able to slip between gaps in support.

Communication between CSC and ASC in LBW: There is evidence of some inter-departmental communication regarding planning for her transition, but arrangements for a transition of funding responsibility could not be agreed. LBW-CSC continued to accept responsibility because they felt it unsafe to move Madeleine away from PH support. LBW-CSC IMR stated her '*care and support needs*

in relation to OCD and issues with self-care and hygiene were well-known, as was a disputed diagnosis of Autistic Spectrum Disorder. The Local Authority record does not contain evidence of proactive support for mental health needs or a risk response to self-neglect.' It concludes '*transition points were not managed as well as they could have been… An assumption appears to have been made that since she was in a placement where she could live until she was 19 years old that her transition to adult social care would simply involve Adult Services taking on the funding burden of [Madeleine's] care and placement. This is a scenario that the Care and Support Guidance cautions against. Adult Social Care had not been involved in the transition* from [the secure accommodation placement to PH] *leading to a situation where there remained uncertainty about funding and about the continuity of her placement. An Adult Services funding panel for [her] placement was refused with advice to seek Continuing Healthcare funding or to seek alternative placements. The focus on the funding gap appears to take prime focus in the transition planning and* [Madeleine's] *wishes and involvement becomes less and less*.' [96]

Because Madeleine initially came into care aged 16, transitions planning should have been part of her review process[97]. This is undertaken in order that Madeleine and all agencies who worked with her could begin to think about her likely adult care needs (including accommodation) as she approached adulthood. Pathway planning starts at 16 for all young people where it is envisaged they will remain in care until they turn 18. In addition, the duties to assess and have in place support under the Care Act or NHS CHC framework also arise and should have been activated once she was 16. This is not to suggest that all solutions are agreed at this point. Madeleine's needs were complex, but her transition plan to adulthood should have been revisited and discussed at every review.

Mental health: There were examples of PH staff pro-actively seeking to support Madeleine's access to GP support and specialist secondary mental health services. As noted above, PH expressed concern when speaking with reviewers about the way in which CAMHS discharged Madeleine in March 2020. Their concern was mirrored within SLaM's IMR which stated '*managing high risk cases in the community communication across agencies is key. It is clear from the SLaM notes that this is certainly something that was missing within this case. It would have been helpful for all services to have been supporting each other and utilising each one's expertise and knowledge about* [Madeleine] *as an individual. Each agency in this case would have had a part to play in terms of ensuring that [Madeleine] was appropriately risk assessed and getting the support she needed. Whilst [Madeleine] was sent the details for the crisis line and what to do if she herself felt she was in crisis, there was no thought around what the teams working with her may have needed to look for or consider as part of a crisis plan around* [Madeleine's] *mental health. Similarly, it is not clear that in any of the discussions with the accommodation provider that a detailed conversation was held about any concerns that they had regarding [Madeleine's] presentation*.'[98]

Organisations around the Team

There appeared to be a lack of supervision and training for all staff in the local authority, CCG, hospital services, PH and education services about Transitional Safeguarding issues for young people moving from Children's Services to Adult services.

The authors were told in the senior managers event that the adult transitions worker had specialist knowledge of autism and acted as a resource for the service. This is one model for ensuring that

[96] Taken from LBW-CSC's IMR (p6) prepared for this review.
[97] Department for Education (2015) The Children Act 1989 guidance and regulations Volume 3: planning transition to adulthood for care leavers
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/397649/CA1989_Transitions_guidance.pdf

[98] Taken from the SLaM IMR [p6] prepared for this review.

expertise exists within a team, however it does place considerable responsibility on one person for a particular area of practice. The services would be more resilient in their ability to support young people moving into adulthood if a wider group of staff and managers were better trained about the risks during this time period of young people with complex needs. There was no evidence that staff were supported by their organisations to make reasonable adjustments, given Madeleine's diagnosis, resistance to support and later non-compliance with her mental health treatment plan.

There is a further issue to explore which is about how to enable staff to develop strategies for engaging with young people where they reject services and are assumed to have mental capacity. With Madeleine, mental health staff in particular walked away when she expressed resistance. Her past experience of exclusion from services, possible underlying trauma or reasons for her resistance was not explored by clinicians despite well understood safeguarding risks. The commissioners of PH had 'outsourced' meeting her needs to PH without active monitoring arrangements to ensure that PH had access to specialist support for her drug use and mental health. In practice this meant that the least qualified workers in PH were left shouldering responsibility for risks (particularly regarding her withdrawal from medication and increased drug use) without necessary support or guidance from other services. There was no clear guidance for PH about how they could escalate concerns if additional support (for physical / mental health, drug use, training opportunities etc) was not forthcoming from other services. This is particularly important given that this was during the covid pandemic when there were significant restrictions in availability of structured activity. Within PH, there appeared to be unclear expectations within their policy about young people using drugs on the premises, which saw staff turning a blind eye to this. There were no targeted interventions provided to minimise drug misuse either on or off the premises with Madeleine, apart from this being raised in key worker sessions. Again, this is specifically addressed within the recommendations below both in terms of local processes for escalating concerns and regarding commissioner's mechanisms to ensure staff in unregulated supported placements have sufficient knowledge and skills to manage complex care needs.

In terms of staffing issues, SLaM's A&L Nurse Practitioner, who was allocated to Madeleine, was new to the service in 2019. In April 2020 she had 15 patients on her caseload, but the time of her resignation on 16.07.20 she had over 40 patients. Three or four members of the team were carrying caseloads of over 50 due to staffing issues. The manager also recognised that covid restrictions regarding face-to-face meetings had an impact on patient outcomes and that he was not happy about this. The SLaM IMR reports '*Finally, support should be given to staff to encourage professional curiosity. It is recognised that staff often have large caseloads and are very busy, however, they should be given the space when receiving a new referral to gather information and consider old documentation as part of the assessment process. Staff should be encouraged to query a person's behaviour and consider what this may be trying to communicate. They should also be supported in order to make reasonable adjustments for those who may be in need*.' [p7 IMR]

The Trust's transitions policy stipulates that if a patient is within 6 months of their 18th birthday then the service they were referred to should process the referral. CAMHS referred Madeleine to CMHT. However, it also says joint assessment input should be agreed with CMHT and agreement about who will take responsibility for the patient would be made following the assessment. It is clear in this case that the policy was not followed. It could also be suggested that further thought should be given to handovers from staff who are leaving the Trust, particularly around who manages this workload whilst service users await re-allocation of a care co-ordinator. Twice in Madeleine's case an allocated worker left leaving her without follow up, the agreed plans were not enacted and letters were sent out to her without attempts made to contact her to discuss the content. A clear handover procedure would help to prevent service users from "falling though the gaps" in a similar situation.

There were particular issues for the mental health services about the most appropriate pathway for Madeleine given her mental health diagnoses, because of her resistance to the ASD diagnosis (this was never really explored). What emerges from the information the authors have had access to is a young person who did not wish to be underestimated because of a label she had been given. Madeleine had said this explicitly on more than one occasion, yet faced countless examples of this happening. There was widespread ignorance and a lack of understanding about autism and how it affected Madeleine. The recommendations set out below seek to enable more detailed knowledge across the workforce of Autism and strategic ownership so that equality duties owed by all service providers are taken seriously in service design and delivery. For Madeleine the lack of knowledge had practical implications, for example, [on p7 SLaM IMR] Madeleine was described as struggling to manage her diagnosis around ASD and her mental health generally, and it was mentioned that this could be a trigger for her self-harm. There were no opportunities provided by SLaM for any behaviour management support and inadequate safety planning around this as a potential trigger for her. Madeleine's placement (PH) would have jumped at any offer.

LBW's IMR and chronology contains details of incidents of self-harm and of risk to self, including an incident where she may have jumped in front of a car, and another incident where she may have impulsively self-harmed through scratching at her head (the authors saw photos of this provided by Madeleine's parents that were taken from social media). However, this was not contemporaneously recorded or followed up. Risk assessment practices were one-dimensional, relying on the recording of individual incidents in case notes without an analysis of the implications of events. For example, following the report of an incident of aggression at the secure placement, she was noted to have contraband (broken glass, a razor, and cigarettes) in her possession. There was a lack of exploration or analysis of the type of risks to self, to others, level of risk or likelihood of harm. Within the secure placement the response was swift and robust, Madeleine was kept under circumstances close to seclusion, only allowed out of her bedroom for 5 – 15 minutes at a time. The details of this incident and associated risk implications are later lost from a risk summary that includes risks to others, and of public nakedness, but not of self-harm or access to weapons, or smoking paraphernalia.

There appears to be little infrastructure within SLaM to support effective record keeping or enable newly allocated clinicians to quickly ascertain important information. As noted (p.26) in this report, the extent of her interactions with different mental health services throughout her childhood may have meant it would be difficult for practitioners to have comprehensive knowledge of the interventions history, but it is objectionable that her parents were left to inform the Adult Mental Health practitioner that she was not a 'new case'. The authors concur with her parent's view that it is very difficult to understand how someone with Madeleine's sustained history could have possibly 'slipped under the radar'.

2. Were there any issues in respect of cross boundary working that increased the risks to Madeleine?

It offers no comfort that Madeleine's experience was not unique. Many of her experiences have been previously reported in Safeguarding Adults Reviews and Safeguarding Children Practice/ Serious Case Reviews, including in a recent report undertaken by SCIE[99], where many of the system findings resonant with this case.

Madeleine's numerous placements between 2018-19 meant that she was often placed out of area from the local authority responsible for her care arrangements. Her later move in 2019 to secure

[99] Hammersmith and Fulham LSCP Serious Case Review 'David' 2021, (p30 provides an overview of the findings) available at: https://www.rbkc.gov.uk/lscp/sites/default/files/atoms/files/David%20Serious%20Case%20Review%20-%20April%202021.pdf

accommodation required a significant distance and meant changes in the legal, social care and educational systems. Whilst giving her a period of stability of care, her parents view is that this was ultimately damaging for Madeleine, because it increased the disconnects for her education and contact with social workers responsible for long-term plans. Her parents reported that LBW-CSC staff appeared unaware how to navigate the Scottish social care system, in terms of mental health and youth justice provision. Given these issues, there was an understandable desire for her to return to support closer to her home. However, a shortage of specialist placements meant that again she required an arrangement where she was accommodated in unregulated accommodation outside of her responsible borough. During the learning events senior leaders spoke of the complexity of cross boundary working, particularly if this requires cooperation across disciplines, as was the case for Madeleine. It is typical to see embargos on accepting handovers to community mental health teams in host boroughs until there has been a six-month period of stability for the young person. This so often results in a catch-22 as the young person requires input from local services and to develop a trusted relationship before their mental health or challenging behaviours stabilise.

There is a further issue concerning the lack of involvement of the CCG in the assessment and support planning for Madeleine, as is required under the EHC plan. If they had been involved much earlier, this may have meant that instead of secure accommodation arrangements being made for Madeleine, the need for specialist residential psychological and behavioural management could have been identified much earlier. Practitioners at the learning event equally spoke of confusing service pathways for young people with autism and mental health needs. This was a significant feature in this case with a lack of understanding across the workforce but felt most acutely within the SLaM workforce. Good practice regarding transitional planning also requires a strategic response to ensure a system wide, coordinated oversight of Transitional Safeguarding issues.

LBW-CSC staff appeared to have limited understanding of their legal duties or had a particular view of Madeleine that was so engrained and not open to challenge even with other evidence. They appeared to 'fire-fight' each crisis rather than work constructively with Madeleine, PH and her family to reduce risks (e.g. the trip she planned in November to visit her former placement in Scotland). The IMR submitted in respect of LBW-CSC for this review also queried why actions were not taken by the department to consider whether there was cause for concern in respect of professional boundaries and, if so, why these were not further investigated and acted on in line with LADO advice and safeguarding policies.

3. Did the support offered to Madeleine regarding her mental health meet expected standards?

The short answer to this question is that support did not meet expected standards. During the review Madeleine's parents spoke of their disbelief that mental health practitioners within SLaM appeared unaware of Madeleine's previous extensive history of support. This, they felt, reflected the fragmented approach taken by the Trust to the assessment of her needs and care provision following her return to London. They explained throughout her life they had got used to hearing Madeleine was a 'hot potato', meaning that no-one quite knew what service she could fit into. Instead, they reported professionals seemed to refer her to services that, they felt, might be the nearest fit. This invariably meant a long wait for that service and when she was offered an appointment she was often met by confusion, as other professionals within the new service did not think she met their service criteria.

We know it is crucial for health and social care professionals to take into account a young person's adverse experiences during childhood and understand the impact that trauma can have on how a person perceives and responds to risk. During the review, Madeleine's parents also spoke about how for Madeleine and those around her, the high levels of violence and risk throughout her childhood

had almost become normalised. The impact of trauma and adverse childhood experiences on the development of the brain and a person's mental health into adulthood is well understood. NICE guidance[100] 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 too therefore should have been applied throughout the assessment, care planning and provision of support to Madeleine. NICE advises where there is evidence (e.g. from previous case history) 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,[101] does not override professional and statutory duties to ensure children, young people or adults with care and support needs are safe from abuse, neglect or exploitation. NHS England and NHS Improvement ['NHSE/I'] published guidance on commissioning effective trauma informed care for women, which includes examples of commissioned services,[102] recommend that services are commissioned to enable flexibility for practitioners, so they adapt their 'usual offer' to take into account the prevalence of trauma and likely long-term effects on survivors. In particular, services should be aware that survivors of childhood trauma and multiple adversities are at greatly increased risk of substance misuse and poor mental health (including self-harming and suicide).[103] Within SLaM's IMR there is acceptance that their adult community mental health teams [CMHT] '*would benefit from further learning about young adults who have been looked after children. Further information about the statutory support provided and who may be in the professional network would be helpful for the service to ensure appropriate professionals are being consulted as part of the multi-agency team. As part of this it would also be helpful for the teams to have further understanding of the experience of looked after children and the care system to promote trauma informed practice*.'[104]

Across the workforce, there was poor understanding of ASD. Madeleine's parents explained that use of this label would make Madeleine furious because of the assumptions people made about her capabilities. '*It was pervasive, even in the hospital shortly before her death the nurse commented it must have been hard for us having to manage her personal care!*'[105] Every member of the health and social care workforce should know how to adapt their services to enable access for those with ASD because this is a legal duty under the Equality Act 2010. Practitioners and senior leaders within the learning events raised concerns about how increased specialisation within clinical pathways created gaps, especially if clinicians did not have sufficient breath of understanding to address co-morbidities (e.g. autism and/ or substance misuse and mental health). Madeleine's experiences of mental health services shows stark gaps in its provision which were made more acute because practitioners generally lacked basic knowledge of how Autism may present or how to better engage with young people who may not be 'neuro-typical'. Madeleine's parents also questioned the rationale for refusing to diagnose certain mental health conditions until a young person became 18. Practice should take a developmental perspective and not be bound by age-determined boundaries, so this may be an area that CSAB may wish to work with the CCG and SLaM to ensure there are actions in place to improve practice.

The decision by CAMHS to close a referral despite significant ongoing risks and unmet need was not informed by the comprehensive risk assessments completed by SLaM's forensic psychologist earlier that summer or her case history. She had also disclosed to a SLaM psychiatrist on the 27.11.19, she was using cannabis on a daily basis to cope. As noted above, there was no exploration of the issues

[100] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.
[101] A key principle, set out in section 1of the Mental Capacity Act 2005
[102] See 'Engaging with Complexity: Providing effective trauma-informed care for women' by the Centre for Mental Health available at: https://www.mentalhealth.org.uk/sites/default/files/Engaging_With_Complexity..pdf
[103] Lewis, S.J.; Arseneault, L.; Caspi, A.; Fisher, H.L.; Matthews, T.; Mo_tt, T.E.; Odgers, C.L.; Stahl, D.; Teng, J.Y.; Danese, A. The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. Lancet Psychiatry 2019, 6, 247–256.
[104] Taken from SLaM IMR [p8] prepared for this review.
[105] Taken from conversations with the reviewers as part of the SAR process.

she was self-medicating to cope with or consideration of how daily use of cannabis might impact on her current medication regime despite NICE guidance about substance misuse. She was not offered any harm reduction advice. Whilst PH had a policy of zero-tolerance for substance misuse, this was only if this was on their premises. As such there was no clear leadership on risks associated with drug use, despite links to increased risks of suicide. It was reported that SLaM do not have a dual diagnosis service. This is run by Turning Point so would have required an additional interface if Madeleine had agreed to access this. As part of any referral there is a requirement that the person has insight into the harm and wants to change. The alternative, for those without the insight or desire for abstinence, is to depend on Youth Justice compulsory orders. An additional barrier for access in this case was that the dual diagnosis service in Croydon is focused on 'traditional' mental health risk presentation concerning psychosis and drug misuse, so there remains a gap where the underlying issues are behaviours associated with ASD and drug misuse. To access that support would require Adult Mental Health services to accept a referral, then for those professionals to secure specialist input from an ASD panel. In Madeleine's case, following PH staff request, SLaM's A&L team deferred an assessment of need in order to seek further advice. That referral was rejected by the specialist Autism panel on mistaken understanding of Madeleine's needs. There was also a lack of follow up from the A&L team. These all demonstrate a disregard to basic care management responsibilities. It is not surprising therefore that the SLaM IMR accept it '*would be helpful for staff is around the use of the Mental Capacity Act. As discussed above in this case it was used as a reason not to intervene. It may be helpful as part of Safeguarding Adult Training that consideration is given to discussing how the MCA is used appropriately in these cases and how this should be documented. It would be also useful if consideration was given to what staff can do to support if someone is to have capacity in order to support with risk management*.'

Madeleine's risk of self-harm and harm to others was misreported to be low, despite very recent risk assessments that were available to Adult Mental Health services. No regard was given to her history, including that only two years previously CAHMS had advised Madeleine's parents they had no more service options left to treat her complex behaviours and mental health needs or that she had only recently been discharged from secure accommodation. Instead, she was she was advised to contact adult mental health services if she had concerns. This was poor practice.

The impact of this poor practice was to delegate responsibility for the management of her complex mental health presentations to PH staff. In response to this review, PH staff reported they had policies in place and training for keyworkers in respect of safeguarding obligations, mental health (including self-harm), physical de-escalation and first aid. They were able to demonstrate reporting of concerns to her social worker and activity to support her to engage with her GP and mental health services, but this is not evidence of 'working together' as it does not demonstrate consistent support around the team that provided day to day care for Madeleine.

4. Was the involvement of police and criminal justice, taking into account Home Office policy that this shouldn't be used to access services or keep vulnerable women safe, used effectively in Madeleine's case?

The authors also wish to highlight the good practice exhibited by the police officers responding to an incident on 13.03.18. Their MERLIN report contained considerable information about Madeleine and her views about her life. It is clear they spent some time talking with her about her thoughts and feelings. This is one of a very few accounts in all the documents submitted for this review of Madeleine's views being recorded clearly.

The police had considerable involvement with Madeleine, frequently responding to emergency requests for assistance to manage the risk her behaviours posed. Her parents felt the advice they

were given, that if they need help call police or take her to A&E, was totally inadequate and the wrong response for her as this wouldn't aid her mental health recovery.

The Police IMR report concluded '*officers dealt with each interaction with [Madeleine] professionally, appropriately and displayed empathy and compassion, alerting the local authority on each occasion that [she] came into contact via an appropriately graded MERLIN report*.'[106] There is also evidence of officers offering appropriate critical challenge to social care colleagues, e.g. in April 2018 a police supervisor expressed their view in a MERLIN report that there was a need for intervention due to the frequency of contact with the police and concern about her entering the criminal justice system and considering using other multi-agency risk management forums (such as MARAC).

Whilst it is, of course, true that safeguarding is fundamental to the police's public protection obligations, overreliance often results in criminal sanctions being applied where what is needed is therapeutic interventions based on an agreed behaviour management plan. Within their IMR the police considered whether progressing the three criminal charges that were made, but later dropped on advice from the CPS, '*may have opened up pathways for access to additional services*.' The recognition within that IMR that whilst criminal justice processes might in some instances prove necessary for public protection the '*use of the criminal justice system should not be used simply as a vehicle for individuals with complex needs to access mental health and other services*' mirrors key recommendations within Baroness Corston's 2007 report that "*the practice of sending a woman to prison as a 'place of safety' or 'for her own good' is appalling and must stop. Nor should sentencers use prison as a means of accessing services such as detoxification, for women. Provision must be made more readily available in the community.*"[107]

5. Was the communication between agencies/multi-agency working effective? Could any additional services or interventions have been considered to have prevented or reduced the risk to Madeleine?

Given the concerns raised in other sections above, there are areas where the authors think that communication between agencies was not as effective as it should have been. Examples have already been given above and this is not repeated below. Instead, further points relevant to communication between agencies are identified.

There are historical mental health diagnoses and circumstances for Madeleine, including previous inpatient stays and lengthy involvement with mental health services, which would indicate possible organic impairments to her decision making which was not linked to the quality of care she received as a child from her parents. If this historic information had been reviewed, it would also have been clear that distress around her mental health diagnosis and challenges coming to accept this were triggers for Madeleine. Could it have been that her distress in this area eclipsed her ability to make a capacious decision as she was not able to understand or weigh information? Given her difficulties with emotional regulation it is also probably that she would have fluctuating capacity, particularly in respect of periods of heightened distress or anxiety. This should have been assessed with specialist input so that practitioners could make adjustments for her executive capacity.

It should also be noted that services should be cautious about using the Mental Capacity Act as a reason not to intervene, particularly in a case like Madeleine's. Madeleine was known to and receptive to the support offered by a number of services. Her experiences of mental health support were not positive, but this should not have prevented specialist mental health practitioners from

[106] Taken from the Police IMR prepared for this review (p.g.6.9).
[107] The Corston Report-A review of women with particular vulnerabilities in the criminal justice system (2007) Home Office

working with colleagues to put in place effective engagement, harm reduction and crisis intervention plans.

Aside from possible overreliance on the assumption of capacity there is also a lack of professional curiosity about why Madeleine was not able to engage with services. Madeleine had a complex history in terms of inpatient stays, mental health assessments and a secure placement in a unit hundreds of miles from her family home. It is possible that more curiosity about Madeleine's situation and how this may have impacted on her may have enabled the team to consider reasonable adjustments they could have made to support Madeleine to work with the team. There are times where Madeleine was clearly able to articulate her views. These are recorded but often not acted upon (e.g. Madeleine expressed a clear view about what she wanted for her next placement after leaving PH. Instead, she was offered another short-term bridging placement which she did not want).

PH (within their IMR report) suggests that there should be procedures in place that allow other persons to liaise with the mental health team on behalf of anyone aged 18 or over [p6]. Her parents also felt a balance was needed to understand their experiences of parents/carers supporting young people with complex mental health conditions. The review authors would go further. The duty of care remains with commissioning authority to ensure that any care plan meets the identified needs of the individual. There should be one care plan with clear details of what works well to engage someone who has experienced multiple exclusions or has emotional dysregulation. The prevention duty (s.2 Care Act 2014) should be interpreted more widely, particularly given the restructuring of NHS commissioning into Integrated Care Systems (ICS) offering an opportunity for CSAB partners to reflect and design systems that facilitate multi-agency risk management and care delivery based on a recovery model. This was not the model adopted by those services working with Madeleine.

There also needs to be operational processes for unregulated accommodation providers to escalate concerns, either via the s42 Care Act 2014 safeguarding process or care management pathways. There were times where the risks to Madeleine were underestimated because she had been placed in Independent Living so the assumption was made that she couldn't need that much help, rather than this being a stepping stone to secure her engagement because she had refused or not been offered alternatives. An example of this was the (re)framing and adoption of a strengths-based model of practice by adult social care to 'encourage independent living' rather than 'dependency', which did not take into account the risk assessments that had been completed.

Finally, from once Madeleine turned 18, input from LBW-CSC seems to have been limited to funding support arrangements for care, accommodation and ongoing education. There was no real plan to support Madeleine explore or come to terms with all her options regarding education and housing and setting clear expectations of her regarding her drug use and other behaviours.

6. Do any local systems regarding the notifications of suspected suicides to safeguarding reporting points within LBC and SLaM need clarification?

The PH IMR acknowledged that even though Madeleine participated in many of the group activities that the project ran and even though staff had a good relationship with Madeleine, the behaviour of young people can be challenging and unpredictable. '*We have learned that although Madeleine may have not displayed or expressed any concerns in relation to suicidal thoughts, … We have learned that anyone can have suicidal thoughts, and this can be unpredictable and undetected…any young person who has spent a considerable amount of time in secure accommodation and receiving medication, should be engaging regularly with the mental health team when living back in the community. Madeleine was willing to participate in all key work sessions within the PH placement,*

including therapeutic sessions, meditation session, creative arts and one to one wellbeing sessions. Moving forward, should a resident no longer wish to engage with the mental health team, we will consider including and collaborating any persons from the mental health team to participate in the key work sessions at the placement, to prevent any resident feeling overwhelmed or concerned about the stigma of engaging with mental health professionals.'[108]

It is commendable they have amended their internal processes to ensure *'all managers and other professionals discuss, agree and continue to document the aims of longer-term treatment in the support plan with the person who self-harms or has suicidal idealisation, to help reduce and prevent escalation of self-harm or suicidal isolation*.'[109] However, support plans should be multidisciplinary and developed collaboratively with the person the plan relates to, with their family and carers. Support plans should identify realistic and optimistic long-term goals and short-term treatment goals. They should identify the roles and responsibilities of any team members and the person who self-harms, include a jointly prepared risk management plan and for this to be shared with the person's GP and any person considered to be important to them. Above all, those designing local systems should have regard to research findings (and ensure practitioners are made aware of) all indicators of elevated risk particularly for care experienced young people, those with ASD or Autism and those misusing substances. Any system design should reflect NICE guidance and quality standards detailed within this report. Again this is addressed directly within the recommendations.

7. What impact did the change in services and restrictions in place to address risks from Covid-19 have? Is there any good practice taken to mitigate those risks?

There were impacts from Covid-19 in this case. PH IMR p5 comments that: '*Madeleine did not display or discuss any matters in relation to suicidal idealisation. We strongly believe the impact of COVID19 and the lockdown had a negative impact on Madeleine feeling she would be unable to manage her day-to-day life and she felt the conditions reminded her of when she was in a secure unit and her access to the community was limited.'* This is a clear indication that Madeleine struggled with the impact that Covid had on her ability to live her life.

The SI report from SLaM prepared for the Coroner also detailed the effect of Covid on caseloads for the adult mental health community teams and on the service received by Madeleine as a result. Similarly, as part of risk mitigation in response to Covid-19 lockdown arrangements, LBW-CSC suggested she should access the counselling service provided by Future First if she needed support. This was a generic offer to all care leavers, it did not take into account the additional risk factors already identified in her case or the duty to have an individual plan. It is indicative of a lack of understanding about the seriousness of the mental health issues affecting Madeleine.

Whilst it is accepted that there were exceptional pressures on services during the initial lockdown, earlier failures to properly understand at a strategic level the nature and level of need for care leavers and particularly for those placed out of area must have made effective business continuity planning and risk mitigation even more challenging. The important question now is what systems are in place in each agency at this moment to embed learning and improved practice in the recovery from Covid 19, and how will these be monitored? Both CSAB and the safeguarding partnerships working in Wandsworth may want to explore this further with their partners.

[108] Taken from the PH IMR prepared for this review (p7)
[109] Taken from the PH IMR prepared for this review (p6)

Section 8: Recommendations

The decision to commission this SAR in the absence of agreement for a joint review demonstrates the commitment of strategic leaders with CSAB to learn from Madeleine's experiences and prevent future harm. From a Children's social services perspective, the authors are satisfied that Croydon had no statutory duties and responsibilities for Madeleine's care as LBW-CSC remained the lead agency whilst they negotiated the transfer of her care with LBW- Adult social care and/or the CCG. Whilst a few practitioners attending the learning events questioned whether for Croydon social services this case was 'academic' as lead responsibility lay with LBW-CSC, they did accept there may be young people within their own caseloads who had similar experiences to Madeleine. It is, however, also important to highlight that many of the system issues identified within this report will require action across agencies and providers working in Croydon. CSAB has a wider reach and an important role to support practice improvement across all services, including those commissioned by the three statutory SAB partners. It is therefore crucial that CSAB engages with partners in a continuing conversation about how the learning from this case is used to improve policies, procedures, service development, training and practice. CSAB's own strategic business plan should also be informed by an analysis of learning from this SAR. We have collated recommendations to reflect the framework for good practice in Transitional Safeguarding.

A. Direct work with young people

I. CSAB partners should undertake a multi-agency case file audit across Adults and Children's Social Care, Education, CAMHS, Health and Youth Offending Services to capture the cohort of young people with complex needs who require transition planning to protect them against harm. This is important, given the gaps in collaborative assessment and planning from an early stage in Madeleine's transition and because transitional responsibilities may apply to anyone aged between 14-25 (not only looked after children). The audit should review compliance with statutory duties for collaborative assessments and evaluate the degree to which practice corresponds with the best practice framework. CSAB should coordinate the audit to ensure representation from all relevant agencies, including social care, health commissioners, mental health specialist providers, specialist (regulated and non-regulated) providers, family carers and care experienced young people.

II. CSAB partners should provide assurance on steps taken to support practitioners to improve knowledge and understanding in the following areas, given the lack of awareness among practitioners working with Madeleine, regarding:
    a. recognising the features of possible autism, understanding their legal duties (under the Autism Act, health and social care legislation and the Equality Act) to make reasonable adjustments to services and apply the NICE Guidance and Pathways[110] in care delivery;
    b. legal literacy in respect of options to provide protective or restrictive care to young people, particularly where this is required to provide therapeutic behavioural management;
    c. Understanding the impact of trauma, adverse childhood experiences or multiple exclusion has on young people, in order to improve practice in assessment of risk, needs, executive functioning and mental capacity and how application of the Mental Capacity Act relates to a clinician's/ practitioner's duty of care.
    d. Essential record keeping and care management tasks, including how to hold partners to account where collaborative care delivery is required.

[110] Available at: https://pathways.nice.org.uk/pathways/autism-spectrum-disorder

B. Team around the young person

III. CSAB partners should develop mechanisms to ensure multi-agency transition planning results in a robust, clear coordinated care plan, developed in consultation with the young person in a timely manner. These need to draw together all partners in the professional network as well as those within the young person's wider support network (e.g. parents). Reviews of the plan should take place regularly, analysing which interventions are effective and setting out clear contingency plans so that all those involved, particularly the adult at risk, understands what to do if the risk is not reduced. Where young people or adults are placed out of borough multi-agency health and social care plans need to be put in place to ensure that the necessary supports are robust and available on arrival at the placement.

IV. CSAB partners should seek assurance that there is a clear pathway for:

a. Access to preventative support for young people regarding substance misuse, based on the NICE quality standards;
b. Access to specialist preventative advice where there is a risk of self-harm or suicide;
c. Escalation of professional disagreement across the partnership, so that a decision by a service to refuse an assessment, discontinue support or dispute the level or type of risks that would trigger safeguarding responsibilities can be challenged in a timely manner. This should include mechanisms to report high level disputes directly to CSAB.[111]

V. The CSAB should ensure that referral forms and 'panel' decision records should be amended to include a 'pen picture' of the individual, to ensure they are personalised. This should include details of the current risks and needs assessments, the plans (including contingency) to manage needs and mitigate risks, an analysis of the extent to which interventions that have been trialled with the person have been successful, how the person prefers to work with practitioners to improve the likelihood of successful engagement and any triggers that could adversely impact engagement. This should 'travel' with the individual, to build professional understanding and truncate the timescale for developing a positive relationship as each new worker/service is introduced.

C. Organisational support for team members

VI. The CSAB should seek assurance that partners (including health professionals with clinical responsibilities for mental health) have mechanisms in place for monitoring caseloads and use of supervision. This case demonstrates the importance of affording practitioners time to understand complex presentations. Equally, senior leaders should be confident systems identify if practice falls below expected standards, for example professionals meeting with young people at high risk without fully exploring their case history. This should Include, as would have been available in this instance, speaking with family members who have taken an active role in providing care.

VII. The CSAB should seek assurance from CCG, LA, SLaM and CUH that they have action plans in place to implement the revised Autism Strategy, including a focus on specific risks to care experienced young people preparing for adulthood. This should also include staff working in customer service or those responsible for triage so that they are aware of the need to (and flexibility within policy framework) make reasonable adjustments to improve access to care and treatment for young people presenting with ASD.

[111] Thereby reducing the current reliance on s44 mechanism, but ensuring CSAB and strategic leaders still has oversight.

D. Governance

VIII. The CSAB should review protocols of oversight of young people with care and safety needs who are the responsibility of one local authority but placed in another. Particular consideration should be given to safeguarding responsibilities and contract monitoring arrangements owed by both the host and placing authority to young people moving from secure accommodation or other restrictive care regimes into unregulated supported accommodation.

IX. CSAB 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[112]' from the office of the Chief Social Worker for Adults at DHSC.

X. CSAB may wish to highlight this case review to the London Safeguarding Adults Board as a further example of where insufficient accommodation options for those with ASD/Autism and poor safeguarding responses to risks associated with poor mental health and substance use has resulted in tragic consequences. This may support a case for escalating enquiries to the Department of Health and Social Care on the steps being taken nationally to scope the strategic level of need for specialist placements at a regional level, so that young people are not moved around the country, which increases the likelihood of disruption to positive ties with family, wider social networks and professionals. This may also add weight to calls for national guidance on professional standards, or a regulatory/competency framework for supported accommodation providers working with complex care needs.

[112] https://www.gov.uk/government/publications/bridging-the-gap-transitional-safeguarding-and-the-role-of-social-work-with-adults

Appendix 1: Documents and resources that identify or promote good practice in Transitional Safeguarding

There are a number of resources which identify and present information about best practice for Transitional Safeguarding. Because this list will quickly date as other research and service evaluations become available, we have included this list as an appendix, so it will not be published with the SAR.

Specific resources:

1. Holmes, D. (2021) Bridging the Gap: Transitional Safeguarding and the role of social work with adults. London, Chief Social Work Office for Adults/DHSC. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990426/dhsc_transitional_safeguarding_report_bridging_the_gap_web.pdf There are a number of case studies and local area examples included in this document as well as some general information about how practitioners, managers, commissioners and strategic leaders
2. Special Issue of the journal Practice: Social Work in Action, Issue 34 Vol 1 (2022). This contains a number of articles, including 4 examples from Practice about how Transitional Safeguarding has been embedded into practice.
    a. London Borough of Hackney – Adolescent Safeguarding Service
    b. London Borough of Havering – development of the Cocoon service, following the death of Ms A, a care-experienced young person
    c. Norfolk County Council – development of the Preparing For Adult Life service
    d. Barnes and North East Somerset – developing a strategic response to Transitional Safeguarding. B&NES have combined their Safeguarding Adult Board, Children's Safeguarding Partnership and Community Safety Partnership arrangements.

    The journal homepage is: https://www.tandfonline.com/toc/cpra20/current
3. Dez Holmes, the Director of Research in Practice, is the person responsible for coining the term 'Transitional Safeguarding'. The Research in Practice website https://www.researchinpractice.org.uk/ has information about Transitional Safeguarding.
4. Research in Practice has set up a 'Community of Practice' for practitioners and managers interested in Transitional Safeguarding. Please email Mary Robson Mary.Robson@researchinpractice.org.uk if you are interested in joining this.
5. NWG network is an organisation specialising in child exploitation. There are tools and information available on their website: www.nwgnetwork.org
6. No Wrong Door is a service based in North Yorkshire that works with young people in care. https://www.local.gov.uk/case-studies/no-wrong-door-services-young-adolescents-care-north-yorkshire It received Innovation funding from the DfE, and the service has been evaluated by Loughborough University, which showed a number of strengths to this approach of working with young people. The evaluation report is available here: https://www.gov.uk/government/publications/no-wrong-door-innovation-programme-evaluation

Further reading:

Cocker, C., Cooper, A., and Holmes, D. (2021) Transitional Safeguarding: Transforming how adolescents and young adults are safeguarded. British Journal of Social Work. https://academic.oup.com/bjsw/advance-

article/doi/10.1093/bjsw/bcaa238/6102523?guestAccessKey=78b38361-28be-48b8-b591-9f2edff7fff4

Cocker, C., Cooper, A, Holmes D, and Bateman F. (2021a) Transitional Safeguarding: Presenting the case for developing Making Safeguarding Personal for Young People in England. Journal of Adult Protection

Firmin, C, Horan, J. Holmes, D and Hopper, G. (2019) Safeguarding during adolescence– the relationship between Contextual Safeguarding, Complex Safeguarding and Transitional Safeguarding. Dartington, Research in Practice

Holmes, D. and Smale, E. (2018) Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood. Dartington, Research in Practice