7 minute briefing

Madeleine

Safeguarding Adult Review

Background

Madeleine was of mixed ethnicity (White British/Black Nigerian), she was 18 years old when she died and was well known to many services. She had a long history of mental health (CAMHS) support from a very young age, including being an inpatient when she was 9. At 16 her parents were told that CAMHS had 'tried everything' so they should ask for help from social care. Madeleine had a diagnosis of Autistic Spectrum Disorder, 'emotional dysregulation' and Obsessive-Compulsive Disorder. She had an education, Health and Care Plan but despite this had been excluded from schools because of her behaviour which was challenging. She was first assessed by social care services when she was 12 and at 16 she was taken into care. She experienced 8 different placements in 5 months and was then placed in secure accommodation in Scotland. Shortly before her 18th birthday she moved from there to an Independent Living placement in Croydon. Despite having reached adulthood, coordination of her care needs remained the responsibility of LB Wandsworth's Children's Social Care.

On the evening of the 13 August 2020, whilst at her placement, Madeleine took Ketamine. Staff called 111 for advice. A short time later, staff found her suspended from her door. She was taken to hospital and died on 16 August 2020.

Transitions and Transitional Safeguarding

Multi-agency support was not robust in either transition planning or in mitigating Transitional Safeguarding issues. In complex cases, transition planning requires careful multi-agency working and this was lacking with Madeleine, particularly around mental health and placement provision. The Transitional Safeguarding issues across the children's and adults divide were not fully understood for her. In situations like this, practitioners should not walk away and close down involvement when support is declined which is what happened here, but should remain curious and tenacious in seeking ways to engage young people particularly where there are complexities, eg. mental health and substance misuse, which compound their experience of services. Unfortunately there were many gaps in the service that Madeleine received.

Listening to the voice of those receiving services

Madeleine's voice was not heard by many of the people working with her: care planning was done about her, without her. This increased her anxiety and feelings of hopelessness. Neither were her family supported to understand her diagnosis or offered effective support to address behaviours and complex needs.

Multi-agency management

Support for Madeleine's mental health was fragmented from a young age. Health partners were not adequately engaged with multi-agency assessment processes so gaps in the therapeutic services to meet her identified behavioural needs were not met or reported to commissioners. Risk identification and multi-agency management were also poor. Little consideration was given to indications of high risk factors for self-harm and suicide. The lack of escalation processes for partners or commissioned services meant that those working directly with her had little organisational support.

Understanding of the legal & policy frameworks and police intervention

Poor understanding of Transitional Safeguarding issues as well as the legal and policy framework to support transition and young people with autism, together with poor multi-agency communication, created unrealistic expectations that social care would manage her needs independently of health input. This resulted in an over-reliance on police to respond when Madeleine was in crisis. Between January 2018 and January 2020 there were 66 occasions when police were asked to intervene; either to find her after she had absconded from her family home or placement or to respond after violent outbursts.

Recommendations

- To review case files of young people with complex needs who require robust transition planning to protect them against harm. This must include information about how the voices of young people have been included within the care plans.
- To support practitioners in improving their legal literacy, particularly in relation to mental capacity for young people and knowledge about autism and how practitioners can make reasonable adjustments to services and care plans, in accordance with guidance and legislation.
- To improve multi-agency care planning for young people who transition into adult services and involve young people at every stage.
- To review protocols of oversight of young people with care and safety needs who are the responsibility of one local authority but placed in another.
- To provide more extensive information and guidance about the Transitional Safeguarding needs of care experienced by young people.