Royal Borough of Windsor & Maidenhead's multi agency adults and children safeguarding arrangements and West of Berkshire Adults Safeguarding Board

An Adult Safeguarding Review and a Children's Safeguarding Practice Case Review regarding

Michelle

April 2020

Independent Reviewer – Ian Vinall

Case Review and Adults Safeguarding Review V1.4

Contents

1. Introduction to Michelle

1.1. Michelle was described by those who knew her as a funny, loving, affectionate young woman. She had a good sense of humour, was charismatic, engaging and caring with an optimistic outlook. She had a strong and loving relationship with her paternal grandparents with whom she lived under a Special Guardianship Order from the age of 2 and she continued to have some ongoing contact with her birth parents. Michelle also had long standing mental ill-health and had social work involvement from an early age after being estranged from her birth parents in 2001. Michelle's mother has had long standing mental ill health herself and Michelle's father was an alcoholic. Michelle's maternal grandparents both had admissions to psychiatric hospitals. Michelle was diagnosed with depression and paranoid schizophrenia in 2015 and spent some time in adolescent mental health units. She became a looked after child in July 2017 and was moved to semi-independent provision. Michelle died in February 2019, aged 19.

2. Introduction to the review

2.1. This review was initially commissioned following the death of Michelle and although she was over 18 years of age, she was a care leaver and still receiving services from Children's Social Care at the time of her death via the Leaving Care Team. Subsequently, the West Berkshire Safeguarding Adults Review Panel considered the case as Michelle died in their area and agreed that the situation met the criteria for a Safeguarding Adults Review (SAR) under the Care Act 2014[1]. It was agreed that the review would be combined and shared with the Adults Board for publication and learning. This review is being carried out in order to identify learning and is not about establishing blame or culpability.

3. Methodology and process

3.1. Michelle's family have contributed to this review. They have provided valuable information and insights into Michelle's history, her needs and the circumstances leading up to her death. They want agencies to learn lessons from Michelle's experience with an honest appraisal of agencies involvement in her care. Michelle's uncle facilitated contact with Michelle's birth parents and the author met with Michelle's birth parents separately. All agencies that knew Michelle have participated in the review. The Supported Care Provider

[1] The Care Act 2014 states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult known to have care and support needs dies as a result of abuse or neglect, whether known or suspected and there is a concern that care agencies could have worked more effectively to protect the adult

had not previously been involved in a Safeguarding Adults Review. A chronology was provided by the following agencies:

- Children's Social Care (Michelle's home authority)
- NHS Foundation Trust
- GP
- Adults Social Care (Michelle's host authority)[2]
- Supported Care Provider
- Ambulance Service
- Police

4. Key Practice Episodes

4.1. January 2017 – December 2017

4.2. Michelle was voluntarily admitted to an Adolescent Mental Health Unit in January 2017 and a referral was made to Children's Social Care by Michelle's care coordinator in the Children and Young People's Early Intervention in Psychosis Service[3] (CYPs EIPS). The referral indicated that Michelle's paternal grandparents felt unable to continue to care for Michelle, feeling that they could no longer offer the support and supervision that Michelle needed.

4.3. Children's Social Care recommended that Michelle would be made the subject of a child in need plan. Michelle's case was allocated to a qualified social worker and a student social worker undertook most of the work.

4.4. Children's Social Care management oversight of Michelle's case in January 2017, suggested that a foster placement would meet the same 'challenges' as the paternal grandparents and requested clarification from 'health' as to the care plan.

4.5. Michelle was ready for discharge from the Adolescent Unit in early March 2017. There is correspondence between the unit and Children's Social Care about the appropriateness of placements that would best meet her needs. A foster placement search took place with no success. Agreements for placements are ratified by the local authority resource panel and this met on the 28th March. There was a view that any future accommodation needed to be found where Michelle could develop her independent living skills. There were parameters placed on the placement search which included the need for Michelle to be near to her grandparents, uncle and aunt.

[2] Home and host authority is used to explain where Michelle originated from (home) and where she lived at the time of the review (host)

[3] The EIPS support people experiencing symptoms of psychosis for the first time, as well as people at risk of developing psychosis. The CYPs EIP Team is part of the services offered by the Child and Adolescent Mental Health Service in the NHS Foundation Trust.

4.6. During this period, Michelle was having regular overnight weekend contact with her paternal grandparents. She was not aware at this point that her grandparents had asked for alternative care.

4.7. At the end of March, a Care Programme Approach (CPA)[4] meeting was held. Placement searches by the Children's Social Care Commissioning Team had not identified any suitable care arrangements for her. Michelle's mood had improved, she was on consistent medication and she was ready for discharge.

4.8. Discussions with Michelle took place about her moving to accommodation where she could develop her independent living skills. She was observed to be quieter and more withdrawn in these discussions. It was felt that this was linked to her anxiety about the changes she was now being faced with. It was reported that Michelle had become upset and distressed as she could no longer live with her family.

4.9. In April, a supported care provider had been identified by Michelle's psychiatrist that could meet Michelle's needs. It was considered local enough to maintain Michelle's strong attachment and regular contact with her grandparents, uncle and aunt. Consideration was given to finding Michelle a transitional placement, but no appropriate resource could be found.

4.10. Michelle visited the Supported Care Provider accommodation twice, and an assessment took place[5]. Children's Social Care records indicated that Michelle was getting frustrated by the delay in securing her new accommodation. The assessment undertaken by the Supported Care Provider indicated Michelle needed considerable support and when in a low mood neglected her personal hygiene and this impacted on her ability to care for herself and her environment.

4.11. The process of securing a placement at the Supported Care Provider then took 4 months to progress at which time Michelle remained in the Adolescent Unit. During this time, Michelle completed her GCSEs.

4.12. In preparing Michelle, she was encouraged to research furniture and household goods and given budgeting advice. Her grandparents, uncle and aunt were involved in the preparation for her move. There was however limited work with Michelle regarding her daily living skills and these were assessed as poor. Michelle continued to express mixed views, both positive and negative, to professionals and her family about the move. She expressed apprehensions

[4] CPA is a holistic assessment and support planning process that is used by secondary mental health services.

[5] The supported care provider is responsible for the care function only. The housing provider is responsible for the accommodation and provides support regarding housing benefit applications, general maintenance and safety compliance and support with tenancy management.

to her social worker, particularly as the other tenants at the accommodation had learning disabilities and she felt very different to them.

4.13. There was a CPA discharge meeting on the 20th June at the Adolescent Unit. It highlighted that Michelle had made positive progress yet remained at risk of self-harm or suicide, was vulnerable to sexual exploitation and substance misuse. Michelle's social worker did not attend this meeting and therefore was not part of the discussions about her risk and vulnerabilities.

4.14. Michelle was discharged from the Adolescent Unit and moved to her new accommodation on July 3rd, 2017. On this date, she became a looked after child under Section 20 of the Children Act 1989.[6]

4.15. Michelle had her statutory initial looked after child review on the 19th July 2017 It was recorded that she had settled well and engaged with staff. She expressed some concerns about the other tenants in the accommodation, describing them as intimidating. There was a further review on the 10th October. Subsequent statutory visits by the social worker suggested that Michelle had settled well into the accommodation and she felt well supported.

4.16. Michelle's birth father told the author that Michelle did not like being at the accommodation and that she was being 'pestered' by older tenants. He reported that Michelle was upset because 'staff did nothing' to address this.

4.17. Michelle was registered with a local GP and met her for the first time on 20th July. Michelle was seen with her social worker and Michelle discussed her mood and ongoing medication and prescriptions. Michelle was taking Olanzapine[7] and Sertraline[8] to help manage her moods. It was reported that she felt emotionally well with no suicidal ideation. It was agreed that the Supported Care Provider staff would physically collect Michelle's prescription for her medication and would administer her medication as directed by the GP. Michelle's medication was in a locked cupboard at her accommodation and was only accessible by staff.

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[6] Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of (a)there being no person who has parental responsibility for him; (b)his being lost or having been abandoned; or (c)the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care. (S20 Children Act 1989)

[7] Olanzapine is an antipsychotic medication. Olanzapine is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression) in adults and children.

[8] Sertraline is a type of antidepressant. It's often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). (NHS 2018)

4.18. The Supported Care Provider staff reported that Michelle presented with very limited independent skills on arrival and they had to provide intimate personal care for her for the first two weeks of her move to the accommodation. This progressed to her being prompted to carry out her own personal care but recording by the social worker suggests this remained an issue into 2018. It was reported that she struggled with day to day living skills and a high level of support was needed. They reported that her grandparents had offered a very warm and caring environment for Michelle and provided her with all her needs. As a result, the transition to semi-independent living was challenging for Michelle. Michelle was by far the youngest resident and it was agreed that 56 hours per week of support would be provided as part of the care package. This included a staff member 'sleeping in' in Michelle's flat in the spare bedroom as Michelle was anxious not to be left alone.

4.19. Michelle enrolled into a local college part time and started in September 2017.

4.20. December 2017 – October 2018

4.21. On the 3rd December Michelle became 18 and continued to be supported by her social worker despite her transition to becoming a care leaver. Outreach visits to Michelle continued by the Children and Young People EIPS care coordinator and in early December, Michelle was in a bright mood but her personal hygiene was described as very poor. A transition meeting was held in mid-December where there was an agreed date for a formal discharge CPA meeting from the Children and Young People EIPS in February 2018. Mental health support was to be transferred to the Adult EIPS team.

4.22. Michelle was discussed at the Adult EIPS Clinical Team Meeting on the 8th January 2018, where it was confirmed a referral was to be made to the Community Mental Health Team.

4.23. The CPA meeting took place on the 6th February 2018. A crisis and relapse prevention plan was established at this meeting. Michelle's relapse indicators were identified as; hearing negative voices, intrusive negative thoughts, loss of interest, impulsive behaviour, withdrawal from social contacts and activities, walking out of college or absconding, poor self-care, hostility, distracted, tearful and irritable. The Supported Care Provider report that this plan was not evident in their records, but they did have a copy of the CPA notes on their case files.

4.24. Michelle's psychiatric care was also transferred at this meeting and Michelle requested a medication review. There was correspondence between Michelle's Children and Young People's EIPS consultant psychiatrist,

and her new adult psychiatrist and Michelle was offered an outpatient appointment with her new psychiatrist to review her medication.

4.25. In late May, Michelle's uncle contacted the Crisis Resolution Home Treatment team (CRHTT) as Michelle was expressing suicidal thoughts and felt she should be admitted to hospital. Michelle spoke to a mental health practitioner and the admission protocol was explained to her. Strategies were offered to Michelle, but she declined further verbal support. Michelle reported that her mental health had been triggered by loneliness and isolation.

4.26. Michelle's support hours at the Supported Care Provider reduced from 56 hours to 35 hours per week. Michelle was to be supported 5 hours a day. One hour for medication and morning support/check call, two hours in the afternoon for any activity or appointment, one hour for preparation of dinner which mostly she cooked with staff and one hour for evening medication and check call.

4.27. Michelle was given her first written warning for breaching her tenancy agreement. This followed a serious altercation with another resident at the accommodation.

4.28. At an EIPS clinical team meeting on the 9th July, it was noted that as Michelle was due for discharge from the EIPS in September she could no longer continue psychological therapy. It was recorded that Michelle did not meet the criteria for transfer to the Community Mental Health Team (CMHT)[9] and Michelle's care would be discharged back to her GP. The CMHT Consultant would only oversee her medication. The Early Intervention in Psychosis Service confirmed that Michelle was due for discharge as she had received the maximum 3 years of support from both the children and young peoples and adults EIPS team combined. At this meeting, the EIPS had been advised that the Leaving Care Service within the local authority would support Michelle's care package.

4.29. Michelle's medication was further reviewed and adjusted following an outpatient's appointment with her adult psychiatrist in July and August. The GP, who was to resume care of Michelle in September, did not receive correspondence from the psychiatrist about her medication changes.

4.30. In September, Michelle's social worker conducted a 'goodbye' visit and her care was taken on by a Personal Advisor in the Leaving Care Team. At this visit, there was discussion about whether Michelle could self-medicate. This was assessed and deemed inappropriate.

[9] Supports and treats patients with severe and complex mental health difficulties

4.31. The CPA Review meeting held on the 3rd October discharged Michelle from the EIPS back to her GP. Michelle was reported as feeling much better and that she declined psychological intervention. Michelle's psychiatrist would continue to review her medication and her Personal Advisor would support Michelle's overall wellbeing. This was considered by the GP to be an unusual arrangement given Michelle was no longer receiving care via her psychiatrist. Despite the meeting being held in early October, the CPA care plan and the EIPS discharge prevention plan was written on the 31st December and uploaded to Michelle's records on the 2nd January 2019. The GP received a letter from the psychiatrist, but details of the crisis/contingency plan was not included.

4.32. October 2018 – February 2019

4.33. On the 2nd November, it was reported that Michelle had been verbally abusive to a member of staff. Michelle then went missing for two days. She had booked a hotel on the south coast near to her parents and was reported missing on the 3rd November.

4.34. Michelle's birth father reported that Michelle had informed him of her intention to visit but he did not have any contact with her during this visit.

4.35. Michelle was located at a hotel by police and reported to police that she had been raped. Michelle was collected by her uncle and returned to her grandparent's home for one night.

4.36. On the 5th November, Michelle disclosed that she had been the victim of two sexual assaults on two separate occasions. She was reported as feeling low and the Crisis Resolution Home Treatment Team (CRHTT)[10] were involved at the point of her disclosure. Michelle was assessed as not posing an immediate risk to herself and the CRHTT agreed to contact the Adult EIPS and CMHT.

4.37. On the 6th November, Michelle was referred by the team leader at the Supported Care Provider to the Safeguarding Adults Team in her host authority. It was stated that as Michelle was open to the Leaving Care Team in her home[11] local authority, they were advised to contact her Personal Advisor. Whilst a Section 42 Enquiry was opened by the Safeguarding Adults Team in Michelle's host authority, the enquiry was closed following the confirmation of a planned professionals meeting in Michelle's home authority on the 12th November in which a safety plan would be agreed. The host

[10] The CRHTT respond if people are suffering from an acute mental health problem or crisis. They provide a home assessment and treatment to avoid hospital admission.

[11] 'Home authority' refers to where Michelle originated and 'host authority' is where Michelle actually lived at the time.

authority were not part of the safeguarding meeting held on the 12th November.

4.38. The team leader also contacted the Care Quality Commission[12] to report the incident. Michelle's Personal Advisor had requested support from the EIPS and was reminded that Michelle had been discharged and was considered stable in terms of her mental health. Michelle's aunt contacted the Supported Care Provider and expressed concerns that Michelle was low in mood and she had told her aunt she was feeling suicidal.

4.39. Despite the initial response to the Personal Advisor, a visit was made by the Adult EIPS that day who assessed her level of risk to herself as being medium. EIPS referred Michelle back to the CRHTT for daily support. Michelle contacted CRHTT asking when she would be visited but terminated the phone call when told it would not be until the following day.

4.40. Michelle declined making a formal statement to the police. The information from the police suggested that Michelle gave a 'muddled account', was vague and lacking in detail. She would not consent to a medical and the police took no further action regarding the sexual assault allegations. They reported that she did not wish to return to the Supported Care Provider.

4.41. Staff at the Supported Care Provider stated that Michelle had withdrawn from support, refused her medication and was not engaging with any staff member. She was visited on the 7th November by the CRHTT and a risk assessment completed, and her care plan was updated. Michelle's uncle had also expressed worries for Michelle's mental health to the Personal Advisor.

4.42. There was then daily contact with Michelle by the CRHHT for the next 3 days and she stated she was feeling more stable.

4.43. Michelle's Personal Advisor set up the professionals meeting on the 12th November. The purpose of this meeting was to consider the recent incident and agree professional actions and support to Michelle as a result. The Leaving Care Team, the Supported Care Provider, a representative from college and Michelle's uncle were present. Michelle was not present. CRHTT and Safeguarding Adults representatives were not invited. Michelle's care coordinator from the EIPS was invited to this meeting but declined attendance as Michelle had been discharged from their service and her mental state was described as 'stable'.

[12] The independent regulator of health and social care in England.

The minutes of the meeting highlighted that the Supported Care Provider had not followed their own procedures outlined for Michelle for when she went missing. An agreed action plan was put in place to manage future episodes where Michelle went missing. The minutes reflect that Michelle had made little progress in the 18 months since moving into the accommodation, that her self-care skills remained poor and that she had not made any progress in her independent living skills. The minutes challenge the use of language to describe Michelle, implying that as she had made false allegations previously, agencies run the risk of dismissing her disclosures and therefore could fail to safeguard her. The minutes reflect Michelle's vulnerability and potential exploitation. There was also reference to the fact that the professional network did not have all the contact details for the professionals involved with Michelle and this hampered consistent information sharing.

4.44. The Supported Care Provider report that they did not receive the minutes of this meeting until April 2019. They have subsequently raised some queries about the minutes of the meeting.

4.45. On the 14th November. Michelle attended an outpatient's appointment with her adult psychiatrist. At this appointment, the psychiatrist wrongly assumed that the CRHTT would remain involved and that EIPS would resume support again. The chronology indicates confusion about who was responsible for providing mental health support to Michelle at this point.

4.46. A record on the 19th November, stated Michelle no longer wished to complete her college course and she stated that felt picked on and was unsupported particularly regarding being sexually harassed. The college view was that this was attention seeking behaviour and she was not taking responsibility for her own behaviour.

4.47. On the 3rd December, the Personal Advisor was advised by her line manager to make a referral to the Safeguarding Adults Team in her host authority. However, there is no record of a safeguarding referral being made despite evidence from the Personal Advisor to the contrary. The Personal Advisor confirmed that Michelle did not meet the threshold for assessment and no further action was taken. There are no records of this referral and subsequent advice in the Safeguarding Adults Team.

4.48. On the 5th December, Michelle attended a GP appointment with her Personal Advisor. Michelle stated she was feeling low, wanted to shut herself away and wanted to change her medication. Michelle had been excluded from college and had not enjoyed her 19th birthday. Whilst she had a medication review booked with her adult psychiatrist on the 19th December, Michelle felt she could not wait that long and requested she restart Sertraline.

The GP agreed to 50mg daily and the Personal Advisor agreed the prescription would be handed to the Supported Care Provider staff as per the agreed policy. Michelle was given a 28-day supply. It was the responsibility of the Supported Care Provider to support Michelle with medication and for GP appointments and this appointment attended with the Personal Advisor went outside of the agreed plan. These arrangements then caused confusion between the Personal Advisor and the Supported Care Provider and neither confirmed any new arrangements for the collection of the prescriptions from the GP or obtaining the medication from the pharmacy. Michelle had never previously picked up her prescription and medication independently. It would seem there was no communication between the Personal Advisor and the Supported Care Provider over this issue and the Supported Care Staff assumed that the Personal Advisor had taken an active role with the collection of the medication. Neither agency nor individual challenged those assumptions and there was no risk assessment undertaken of whether this was an appropriate course of action. Michelle began collecting her own prescription from the 11th January 2019 and records suggest she gave the medication to staff at the Supported Care Provider. The GP was not aware that Michelle was collecting her prescription.

4.49. There was correspondence between the CQC and the Supported Care Provider confirming what supportive measures had been put in place for Michelle. There is reference in this exchange regarding the Court of Protection[13] and the challenges of independence for a 19-year-old woman balanced against putting in effective boundaries to keep her safe. The outcome of this enquiry led to the view that as Michelle had capacity to make her own decisions, this intervention would not be taken forward.

4.50. Michelle was reviewed by her GP on 10th December. She was seen alone, due to the Personal Advisor not being available. Michelle's medication was reviewed, and she stated that her mood was improving. Triggers for worsening mental health and signs of relapse and her physical health were discussed. Michelle denied any alcohol or illicit drug use and described clear goals for the next 12 months. Blood tests were also completed on the same day. She was due to see her psychiatrist on 19th December for a medication review and the GP sent a letter to Michelle's psychiatrist to update him regarding the medication changes. This was the last time Michelle saw her GP.

4.51. In mid-December there was a letter exchange between Michelle's GP and her adult psychiatrist which indicated Michelle was to be transferred to

[13] The **Court of Protection** in English law is a superior court of record created under the Mental Capacity Act 2005. It has jurisdiction over the property, financial affairs and personal welfare of people who lack mental capacity to make decisions for themselves.

another psychiatrist in her locality and clarifying her current medication (quetiapine[14] and sertraline). In this correspondence, it suggested that Michelle's care package remained the responsibility of children's services.

4.52. On the 31st December a discharge letter and relapse prevention plan was written by the care coordinator in the EIPS and sent to the GP stating that Michelle had been discharged from the EIPS on the 3rd October.

4.53. On the 9th January 2019, Michelle was reported missing to the police. She subsequently stated she had been with her boyfriend. There were a series of subsequent nights where Michelle did not stay overnight in her flat. There was no evidence that the agreed protocol had been followed and the records suggest she was spending more time with her boyfriend. Michelle had posted on social media that she was in a new relationship. There was no risk assessment and no safeguarding issues were considered given this new relationship and her vulnerability.

4.54. There is a record that Michelle had a medication prescription on the 11th January.

4.55. On the 15th January there is the first reference to Michelle being spoken too by care staff about her use of cannabis.

4.56. A placement review meeting took place on the 17th January, to which Michelle did not attend and the risk assessment was updated. It stated that if Michelle had not returned to her flat by the agreed time, a call to her was to be made and if no response within 30 minutes the police were to be called. However, staff were given discretion on whether to wait before calling Michelle if required. Michelle was informed of this protocol subsequently.

4.57. There was an email exchange between the Supported Care Provider and Michelle's Personal Advisor confirming that if Michelle did go out in the evening and was not back the following day by 9am she would be reported as missing. This is not recorded in the Children's Social Care chronology and is at odds with the safety plan drawn up on the 12th November. It is reported by the Supported Care Provider that this change reflected Michelle's current circumstances.

4.58. There is a further record that Michelle collected another medication prescription on the 24th January and handed the medication to the Supported Care Provider.

[14] Quetiapine is an antipsychotic medicine that is mainly used to treat schizophrenia and bipolar disorder

4.59. On the 12th February, Michelle contacted staff at the Supported Care Provider, she was crying and very upset, stating that she didn't feel herself. The following day she was reported as being in 'a mood' and did not sleep all night.

4.60. On the 14th February, Michelle was not in her flat and her Personal Advisor informed staff that she had gone to see her mother and would return the following day. Michelle made direct contact with her Personal Advisor to inform her of this visit. Michelle returned late on the 15th February. The Personal Advisor had telephone contact with both of Michelle's parents over these two days. The Personal Advisor was advised by the Supported Care Provider to call Michelle's mother who was asking to urgently talk to her.

4.61. Michelle's birth parents gave conflicting accounts when Michelle visited in February, 4 days before she died. Michelle's birth father stated that Michelle stayed overnight at his friend's flat but was not able to give any details. Michelle then went to see her birth mother the following day. Michelle's birth mother reported that Michelle had arrived at her accommodation 'doped up with cannabis' and had to sleep. Michelle's birth mother alleged that the cannabis had been provided by her ex-husband. Michelle had asked to stay with her mother, but this could not be agreed as Michelle's birth mother also lived in a supported care arrangement. She reported that Michelle wanted to move to be near her birth parents and she made a call to her Personal Advisor that day to ask if she was being 'looked after properly'. Michelle's birth father stated Michelle spent the day with her mother and then returned to his flat later that day. On her return he described her as happy but a little 'quiet'. Michelle returned to her own flat later that evening.

4.62. Michelle was at her flat on the 16th and 17th February and whilst compliant with taking her medication, she did not engage with staff, including for support cooking meals. On the morning of the 18th February, staff attempted to see Michelle and she did not respond to banging on her door. The registered manager gave permission for staff to enter her room. Michelle's daily record states she was 'quiet, snivelling and muttering' but took her medication. Michelle was last seen by a staff member late that afternoon returning to her flat. Michelle did not engage with staff and had locked the door of her bedroom from the inside. Whilst the registered manager was contacted that evening by a staff member again, there is no record of any actions. Whilst not documented in the daily notes record, the staff member who was sleeping in that night was woken by Michelle at 1am as she was watching television. The staff member did not feel it necessary to engage with Michelle and went back to sleep.

4.63. The information from the GP indicates that Michelle signed for her prescription medication and collected this from the surgery and took this to the pharmacy on the 18th February.

4.64. On the 19th February, attempts were made during the morning to contact Michelle. Staff repeatedly knocked on her door, including trying to gain access to her bedroom with a spare key, but Michelle had locked the door from the inside. The registered manager contacted the Managing Director of the Supported Care Provider who advised the police should be called. Contact was made with Michelle's uncle and her Personal Advisor. It was agreed to leave Michelle. A further attempt was made at 2.30pm which was reportedly agreed with family. There was a reported conversation between the registered manager and Michelle's Personal Advisor which appeared to suggest agreement was made with all concerned parties to call the police at 3.00pm. The registered manager also explained to the Personal Advisor that there was a risk that Michelle would lose her tenancy as her rent had not been paid. This was apparently a processing error and the Managing Director had attempted to discuss this with Michelle, but she had refused to talk to them.

4.65. Police entered her flat forcibly at 4.40pm that afternoon and Michelle was found deceased on her bed.

4.66. Following this, it came to the notice of the Personal Advisor that Michelle had posted pictures of a coffin onto social media on the weekend of the 16/17th February.

5. Emerging Practice Themes

5.1. <u>The commissioning of suitable semi-independent accommodation for young people previously looked after</u>

5.2. There was a delay in sourcing suitable supported accommodation for Michelle and whilst she was not updated regularly about the search, the records indicate that appropriate information was shared between agencies.

5.3. A resource panel within Children's Social Care had considered the accommodation and agreed the funding. The commissioning of the supported accommodation should consider any inspection reports undertaken and assess its suitability to meet the young person's needs and particularly if she was a looked after child. The only available inspection report was via the CQC and this is dated after Michelle arrived.

5.4. Michelle had expressed worries to her family and professionals about the accommodation prior to moving there and reiterated this consistently

throughout her stay. She described herself as 'different' to the other tenants who were primarily people with learning difficulties. Michelle was by far the youngest resident at the accommodation and the suitability and the appropriateness of placing Michelle in a mixed age setting does not appear to have been considered. Michelle was still a child albeit 6 months from her 18th birthday and had never lived independently of her family. Michelle had been heavily reliant on the care of her grandparents and had very limited independent skills. Michelle had stated on several occasions that she did not like the accommodation and wanted to move. She described feeling socially isolated and lonely. These comments, in the context of her mental health, should have prompted consideration as to the suitability of her placement meeting her needs. Whilst alternative options were explored with Michelle once she had moved to the Supported Care Provider, she stated that she did not wish to move again.

5.5. At the point of Michelle's move to the Supported Care Provider she was 17 years of age and was a looked after child[15]. There is some discretion on local authorities in securing placement options. Children can be placed in 'other arrangements' where it best meets their needs. The local authority has a responsibility for ensuring that the accommodation is suitable, and the placement planning arrangements reflect the needs of the young person and how those needs will be met. There must be explicit explanations of the role of the social worker and the placement provider. A Placement Plan had been completed and is dated the 3rd July 2017. It does not detail how the 8 hours per day of one-to-one support available to Michelle would be met.

5.6. Under the Care Standards Act (2000) settings that provide both care and accommodation for children under 18 are required to register with the Office for Standards in Education, Children's Services and Skills (Ofsted). Unregulated provision such as semi-independent living accommodation is not required to register with Ofsted. If a Supported Care Provider meets the definition of care in the Care Standards Act and does not register with Ofsted they are operating illegally. The evidence points to Michelle receiving a level of personal care by the Supported Care Provider and therefore the commissioning local authority should have been aware that this may have altered the placement status. In Michelle's situation, post 18, it was unclear as to whether the responsibility for commissioning oversight of the placement rested with children's or adults commissioning.

5.7. With Michelle leaving a specialist Tier 4[16] residential mental health resource with a risk of recurring mental health and at risk of self-harm or suicide, it was

[15] The Children Act 1989, Guidance and Regulations: Volume 2, Care Planning, Placement and Case Review provides guidance on the placement of looked after children and applies to children looked after under Section 20 of the Children Act 1989.

[16] Tier 4 refers to Child and Adolescent Mental Health Services inpatient care.

concerning to learn that staff working for the Supported Care Provider had not had any specialist mental health training or specific understanding of her mental health needs. This issue does not appear to have been considered in the commissioning of the accommodation. There was, however, ongoing support to Michelle from mental health services during this time and regular liaison between staff and mental health staff.

5.8. It is well evidenced that children who have experienced trauma and abuse and disrupted childhoods are more likely to find transitions challenging.[17]. Michelle experienced an abrupt change in her care givers and therefore her transition to being looked after to semi independence was swift. This period was accelerated and compressed and did not afford appropriate consideration of her needs, placement choice or indeed alternative care arrangements. A foster placement was investigated with no success yet there is no record of exploring a supported lodgings placement or indeed how the family could be supported to care for Michelle safely. This could have afforded Michelle with a more 'family orientated' care experience where the transition from being in the sole care of her grandparents, then to specialist Tier 4 accommodation in the Adolescent Unit and then to semi-independent living could have been managed more carefully. Whilst it might not have been appropriate to live with either birth parent, they were not consulted regarding Michelle's potential future care.

5.9. <u>The preparation of Michelle for semi-independent living</u>

5.10. The information available gives limited detail as to how Michelle was prepared to move into semi-independent living accommodation. There is evidence that her social worker had undertaken direct work with Michelle focusing on what skills she needed to develop but this is not well documented, and it is unclear what this work focused on.

5.11. Michelle's social worker did start a Pathway Plan document in July 2017. The Pathway Plan is comprehensive. It is clear to see that Michelle's practical, life and social skills were not well developed prior to her move to the Supported Care Provider. The Pathway Plan sets targets and identifies who is responsible for actions. This document has been completed with Michelle and the Supported Care Provider staff. Michelle did reflect in her Pathway Plan feeling socially isolated in the accommodation and she was encouraged to seek out other social activities. The Supported Care Provider staff were encouraged to support Michelle in extending her social and leisure activities, however Michelle did not fully engage with this.

[17] https://fosteringandadoption.rip.org.uk/wp-content/uploads/2014/04/Early-childhood-trauma.pdf

5.12. The Placement Plan records that 'Michelle feels she is able to look after herself however needs support in areas of independent living'. Her statement is at odds with her presentation and the Pathway Plan assessment. Whilst offering Michelle considerable support including intimate personal care, the Supported Care Provider should have triggered agencies to review the suitability of the placement and whether it was able to fully meet Michelle's needs.

5.13. The Pathway Plan indicated the Supported Care Provider would provide the necessary support to enable Michelle to live independently. The package of 8 hours support per day was agreed to ensure that Michelle was supported in many daily living tasks. Agreement from Michelle to commit to this level of support was not initially discussed with her and it is reported that she found this restrictive once in place. The arrangement for a staff member to sleep in her flat was at Michelle's request and was part of the 56 hours per week commissioned support. This was a high level of support and reflected her vulnerability and needs. The reduction of hours was at Michelle's request and was agreed despite the evidence suggesting she was not effectively utilising the support hours offered. It is evidenced that whilst Michelle accessed some support from the Supported Care Provider staff, she did not fully participate and made conscious choices to avoid staff offering this, particularly in the latter time in her placement. This is balanced against evidence that Michelle worked well at times with the support offered and that she had reported feeling supported by the staff team.

5.14. Whilst Michelle had considerable support hours in place, this did not guarantee that her independent skills would develop as expected. This was dependent on her participation with that support as well as her ability to understand what was required of her. A statutory social work assessment was undertaken by Michelle's social worker in children's services but no formal mental capacity assessment was undertaken to assess Michelle's capacity to understand what was required of her and whether she could support herself safely and confidently. There is evidence that her independent living skills did not develop at all over the period in the accommodation, but this was not the subject of much scrutiny by the social worker, the Supported Care Provider and the commissioners of the placement. This was only truly reported at the professionals meeting of the 12th November 2018, some 18 months after her move.

5.15. <u>Local authority children and adult services</u>

5.16. Michelle came into local authority care at the point of her move to the Supported Care Provider. Up to this point, she had remained a child in need under the Children Act 1989. This afforded Michelle ongoing support beyond her 18th birthday via the Leaving Care Team.

5.17. Michelle's social worker remained involved in her care post 18. This arrangement was put in place as the Leaving Care Service was being restructured and provided consistency for Michelle. Michelle was about to be transferred to the Adult EIPS and a new care coordinator and it was felt too many changes of personnel involved in her care in a short time would be disruptive. The social worker's role reverted to that of a Personal Advisor. The implications of this change of role included the regularity of visiting and support to Michelle. The level of support recorded in the Children's Social Care chronology appeared to indicate a reduction in visiting and support to Michelle from beyond her 18th birthday.

5.18. An appropriate safeguarding referral was made to Michelle's host authority Adults Social Care Safeguarding Team in November 2018 following the alleged sexual assault and rape disclosed by Michelle. The Care Act 2014 states in Section 42 that "if there is reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) is experiencing or is at risk of abuse and has care and support needs, regardless of whether the authority is meeting those needs, and that as a result of those needs is unable to protect themselves, a safeguarding enquiry should be initiated". A Section 42 Enquiry was appropriately opened. There was agreement as to who was best placed to undertake the safety planning for Michelle and the Section 42 was subsequently closed with no further action. However, the Multi-Agency Risk Framework[18] within Adults Safeguarding was not used in Michelle's case. This was an ideal opportunity to provide support and guidance to the multi-agency network where there was a high level of risk for an adult. The Leaving Care Service had felt that they were left holding the risk for Michelle given the risks had escalated. Michelle's Personal Advisor was left feeling particularly vulnerable. This led to the professionals meeting on the 12th November which was facilitated by the Leaving Care Service but had no statutory framework, yet it developed a coherent safety plan. Unfortunately, Adults Social Care were not invited to this meeting and did not have any further involvement with Michelle.

5.19. Michelle's situation has highlighted the need for local authority children and adults' services safeguarding arrangements to address the accountability and responsibility for safeguarding adults who are care leavers aged 18 plus and/or are vulnerable. The issues of accountability and responsibility for safeguarding Michelle become blurred when she reached the age of 18. Assumptions have been made that as Michelle was a care leaver and that she had a Personal Advisor, responsibility for safeguarding rested with the Leaving Care Team. There was no sense of a shared accountability for

[18] Windsor & Maidenhead Safeguarding Adult Board multi-agency risk framework has been developed to provide support and guidance on how to manage cases relating to adults where there is a high level of risk but where the circumstances sit outside the statutory adult safeguarding framework. The risk framework offers a multi-agency method to support the management of these risks in an effective way.

managing and mitigating the risk. The host Adult Services view that as a safety plan had been developed there was no requirement for them to remain involved. The available process and procedures within Adults Social Care were not effectively followed. The Leaving Care Team were not made aware of the Multi-Agency Risk Framework and this was a missed opportunity to share and mitigate risk for a vulnerable adult.

5.20. There is a careful balance to be achieved between support and protection for a person aged over 18. The Care Act 2014 aims to identify actions that need to be taken to stop or prevent abuse in the context of wellbeing. This is based on the premise that those over 18 have individual rights and freedoms with choice and control. There are procedural differences between adults and children's safeguarding arrangements which presents an immediate barrier to managing young people who may be at risk of harm. There are no escalation arrangements in place to mitigate this risk and therefore no place for professionals to go in the event of disagreement.

5.21. Cross boundary issues require resolution to ensure that when children or adults are moved to neighbouring authorities, there are clear arrangements in place to ensure they are appropriately safeguarded and supported. There is no requirement to inform neighbouring local authorities of care leavers placed in their authority. However, good practice would suggest the opposite.[19]

5.22. We know that Michelle's birth parents were not involved in her assessments and care planning yet were updated by professionals. On meeting them, they expressed regret that they were not more fully involved in decision making for their daughter. Both indicated Michelle's wish to live with or near them. Michelle continued to have a relationship with them both albeit at times very strained and had referred to her wish of being part of a 'normal' family. This option does not appear to have been explored, regardless of its suitability.

5.23. It is not clear what happened to Michelle when she went to visit her parents in February 2019, 4 days before her death. There is a suggestion that Michelle had been smoking cannabis and Michelle's mother had requested urgent conversations with her Personal Advisor about Michelle's care. On the 17th February, Michelle had posted pictures of coffins on social media, but we have no context for these posts. There can be no inferences made about this visit and whether it impacted on Michelle more than previous visits.

[19] Advice Note for Directors of Adult Social Services from the Local Government Association entitled; 'Arrangements and recommended ways of working for local authorities that are responsible for commissioning services (placing authorities) for adults with social care needs who are in out of area care and support services'.

5.24. Children and adult mental health services

5.25. Mental health support to Michelle had been in place prior to the time parameters set by this review and she had received consistent support from the children and young people's (CYPs) EIPS. This service had provided good support to Michelle since 2015. Michelle had developed a positive relationship with her care coordinator, and she understood Michelle's needs. There was evidence that the CYPs EIPS had liaised well with agencies. Michelle had an awareness of her own mental health and when to seek support. She had been reliant on medication to manage her mental health for some years and had a good understanding of what medication worked well for her. She reported as emotionally well for periods of this review.

5.26. Her voluntary admission to the Adolescent Unit had worked well for Michelle and she had stabilised enough to be ready for discharge in March 2017. Despite Michelle's wish to move on, it was commendable that Michelle was offered the chance to remain in the Adolescent Unit for a further 4 months. This offered her some consistency and stability, but she remained frustrated at not moving more quickly. Despite pressure for her to move owing to available bed space, she did not suffer the challenges of having to move accommodation before her move to the Supported Care Provider.

5.27. The process of transition to the Adults EIPS had been well considered and planned. The EIPS clinical team made a referral to the Community Mental Health Team (CMHT) so she could be added to the waiting list for transfer to the Sector Team. This was subsequently rejected as the CMHT stated she did not meet their criteria. [20]At the point of Michelle's 18th birthday, she went through a period of instability. Her CYPs EIPS care coordinator was transferring care to a new adult care coordinator, she was no longer a looked after child, social work visits had reduced, and she was due to transfer to a new psychiatrist. Michelle's risk level assessed by her care coordinators had remained at medium throughout this period. This risk level was not overtly clear to other professionals and what this meant in terms of supporting her mental health. The transition meeting highlighted clear and defined relapse indicators for Michelle but the information was not fully recorded in Michelle's behaviour support plan held by the Supported Care Provider.

5.28. Whilst the process of transition to Adult EIPS appeared to run relatively smoothly and there was communication between Michelle's psychiatrists, there was poor communication by the Adult EIPS with Michelle's GP. The communication channels between the Adult EIPS and other agencies involved with Michelle were not clear. Michelle's GP reported confusion as to which mental health service provision was involved with Michelle and often, the GP received no communication or late communication about changes to Michelle's medication and psychiatric care despite being accountable for

[20] CMHTs support people living in the community who have complex or serious mental health problems.

her care. Michelle's social worker reported that she failed to receive the plan from the Adult EIPS despite requesting documentation. Staff at the Practitioner Event accepted that communication and understanding about Michelle's care post 18 had not been well communicated.

5.29. There were periods when Michelle's mental health deteriorated and both she and her family had requested more intensive interventions, including a request from Michelle to be voluntarily admitted to hospital. The incidents in November 2018, saw a decline in her mental health. This was just one month after her discharge from the Adult EIPS. Her Personal Advisor had felt particularly isolated in this period with a limited knowledge of Michelle's mental health history, together with a need to safeguard her. The Adults EIPS did agree to visit Michelle and assess her mental health which showed a level of flexibility not initially shown when the Personal Advisor originally asked for support. There was a good response from the Crisis Resolution Home Treatment Team (CRHTT) during this period.

5.30. The records indicate that, as Michelle was not presenting with signs of psychosis, she would be discharged from the CRHTT and Adult EIPS and her care would revert to her GP. Michelle had presented as emotionally well and assessments had indicated that, whilst she remained at medium risk, no further interventions were required by mental health services. This however did leave the Personal Advisor feeling vulnerable with a level of risk and understanding that she found challenging. Whilst there was good liaison between the CRHTT and the Personal Advisor, given Michelle's history and mental health services' knowledge of her mental health needs, a more flexible approach to offering guidance and support may have assisted in managing professional anxiety.

5.31. There was evidence indicating that there was poor recording on the RIO systems by the Adults EIPS and information related to Michelle's presentation and care had not been fully recorded.

5.32. The Practitioners Event highlighted considerable confusion by the agency network regarding the roles and interventions of mental health professionals when Michelle became an adult, including significantly the GP and Michelle's psychiatrist. Michelle's journey through mental health services indicated some misunderstandings from partner agencies about mental health services responsibilities and accountabilities. The fact that Michelle's care had been discharged back to her GP, but her psychiatrist remained overseeing her medication led to more confusion.

5.33. Evidence presented by the CQC in a national review of children and young people's mental health services in 201721, found that transitions between adults and children's services was particularly challenging as

[21] CQC Review of children and young people's mental health services – October 2017

children and adults services care planning frameworks are different. There was a good transition for Michelle between children's and adult's mental health services, yet once she became an adult there were gaps in the continuity of her care. This issue is particularly significant for care leavers who may have mental ill health as their care arrangements maybe more complex and require additional support. Supporting the multi-agency approach to planning and support is needed regardless as to whether the young person has a Personal Advisor in place. There were several references in documents about Michelle having a social worker and a care plan, which seemed to absolve the responsibility of others to continue to offer to support to her.

There was a gap in understanding by non-mental health professionals about Michelle's mental ill health and her potential relapse triggers. There was no shared understanding of what might constitute an apparent decline in her mental health or indeed what actions, or contingency plans the agency network should take if that decline had been noticed. There was a failure in communicating the crises and relapse prevention plan to all partner agencies. When mental health services withdrew, it left a gap in understanding about how to support Michelle with her mental health needs.

5.34. <u>The role of the lead professional</u>

5.35. Throughout the period of this review, Michelle had been the subject of a voluntary admission to an inpatient unit, subject to support from CAMHs through the provision of CYPs EIPS, a child in need under Section 17 of the Children Act 1989, a child looked after child, a care leaver and an adult service user.

5.36. Michelle was the subject of CPA meetings, child in need meetings, looked after child reviews, placement meetings and regular meetings with her psychiatrist. The chronology indicates a wealth of contact with agencies over the period of this review.

5.37. It is not clear from the chronology and from the Practitioners Event, who had overall responsibility for Michelle's care during the period of this review. Michelle's social worker had considered herself as the lead professional however she did not attend or was not invited to every meeting with health. Similarly, the Personal Advisor took a proactive role in relation to Michelle's care plan that then conflicted with the expectations of the staff at the Supported Care Provider. This issue became more pronounced when Michelle reached 18. The mental health service records indicate that as she was a care leaver, Michelle would receive ongoing support from her 'social worker'. This lack of clarity as to who holds all of Michelle's care plan led to a lack of communication, a lack of consistency and disjointed care, particularly when she reached 18 and beyond.

5.38. The use of risk assessments, support, trigger and safety plans

5.39. From the point of Michelle's admission to the Adolescent Unit, Michelle was the subject of several assessments, meetings and plans.

5.40. There are some significant issues regarding the recording and sharing of these documents amongst the professional network. Not all agencies had copies of meeting notes and some were significantly delayed, including receipt after Michelle's death. Assessments were not readily shared amongst the professional network. It is evident from the beginning of her placement at the Supported Care Provider that staff had not fully understood her needs and that she required a far higher level of support than the assessment evidenced. Michelle's Pathway Plan was probably more realistic about her needs, but this also had an element of self-assessment by Michelle, which may have over inflated her ability to look after herself independently.

5.41. Significantly however was the application of the plans put in place to support and safeguard Michelle. The CPA transition meeting held in February 2018 established a crisis and relapse prevention plan and listed the potential relapse indicators for Michelle. It has already been highlighted that these were not detailed in the Supported Care Provider behaviour support plan and it's unclear how widely this information was then known to the professionals working with Michelle.

5.42. There are a number of occasions that highlight evidence that Michelle was displaying behaviours that could suggest she was mentally unwell, but this was challenged in the Practitioners Event with a view that this followed a normal pattern of mental ill health and responses to her needs were appropriate. It is important to note that those professionals without significant experience and knowledge of mental ill health may find some of Michelle's behaviour considerably more concerning and anxiety provoking.

5.43. The professionals meeting held in November produced a clear action plan should Michelle go missing again and it was recorded that the Supported Care Provider had accepted it had not followed the previously agreed arrangement for when she went missing. The existing protocol stated the police should be notified within 24 hours when not aware of Michelle's whereabouts and when unable to get in touch with Michelle. It is not clear why the Supported Care Provider did not receive those minutes until April 2019. Michelle was not present at this meeting and therefore was not party to the agreements made about her ongoing safety. Subsequently, the Supported Care Provider reported that Michelle was reluctant to engage with the plan as agreed and wanted confirmation from the Leaving Care Service as to next steps. There is a level of flexibility in the plan which allows for the fact that it may be reasonable for an 18-year-old young woman to remain out overnight. This must be balanced against her vulnerability and without Michelle's cooperation there was little any agency could do to prevent her from exercising her personal independence. The imposing of restrictions to

Michelle's free time challenged both her and the professionals working with her.

5.44. It is understood that the plan agreed at the meeting of the 12th November did not cover situations when Michelle was in residence at the Supported Care Provider. The tenancy agreements in place indicate that as Michelle is a resident of the Supported Care Provider, she has individual rights and choice. The registered manager of the Supported Care Provider has confirmed that if Michelle refused to answer her door or not take her medication, they had no right to force her. The approach of the Supported Care Provider is to develop trust and confidence with their tenants and with that, honest discussions.

5.45. There are recorded times where Michelle refused to take her medication but there are no occurrences of Michelle refusing access to her bedroom or the flat. There are no risk assessments or trigger plans in place if Michelle refused to take her medication.

5.46. The day before she died, with the agreement of the registered manager, staff at the Supported Care Provider did enter her flat without permission as despite banging on her door, she had not responded. Her recorded presentation was concerning. Given her history this presentation did not trigger a discussion with mental health services or her Personal Advisor. As Michelle's moods were described as 'unpredictable', this presentation was not considered to be out of the norm. Reports from staff prior to her withdrawal that day contradict this presentation. She was reported as being happy following her visit to her mother, was looking forward to starting work and was in a relationship with a new boyfriend. This contradicted the reports from Michelle's mother. Either way, staff did not have access to the crisis and relapse indicators that might have prompted more proactive intervention. Michelle's continued refusal to interact with anyone that day, including locking her door from the inside, did prompt conversations with the registered manager but no further plan was evidenced. Given Michelle's withdrawal, her presentation and refusal to take her medication, it is unclear as to why the member of staff sleeping in the spare room of her flat did not talk to Michelle when she was apparently out of her bedroom, laughing and watching television early in the morning.

5.47. The Supported Care Provider appropriately communicated with Michelle's family and her Personal Advisor the following day. The registered manager did not follow the advice of the Supported Care Provider's managing director to call the police and with agreement from family, delayed this call until later that afternoon.

5.48. Regardless of how Michelle presented to practitioners or how practitioners viewed her presentation, she continued to be assessed as at medium risk of self-harm or suicide up to and beyond her formal discharge from mental health services. This ongoing assessment does not appear to have been widely shared. It is not clear whether agencies knew what it meant or how to react to it. There was a lack of understanding from the partner agencies as to how to respond to a medium risk assessment.

5.49. Balancing risk, safety and independence

5.50. The issue of individuals' rights and responsibilities has been raised in Michelle's situation. Michelle's right to privacy and independence as a 19-year-old woman has been commented on and is reflected in documents. Equally, the agency network has been anxious to ensure she was appropriately safeguarded by imposing restrictions on her movements and alerting the police if she became a missing person. Michelle found these restrictions frustrating and occasionally did not comply with those arrangements.

5.51. There are references to applications to the Court of Protection. The Mental Capacity Act 2005 explicitly acknowledges that people with capacity may make what some people would consider to be 'unwise decisions', but that does not mean that they do not have the capacity to make those decisions, even if practitioners and carers' views are at odds with them. In Michelle's case a balance had to be struck between risk and the preservation of her rights. Risk assessments and safety plans were in place for Michelle outside of her placement, but they did not consider the circumstances within her own home environment. Michelle's history of self-harm should have been a feature in those risk assessments. Together with the relapse and prevention plans, this could have detailed an agreed strategy if Michelle were to withdraw significantly from support. An escalation process was not evident in the risk assessments.

5.52. Michelle was not present at meetings where her safety plan was being discussed. She either refused to attend or was not invited. Her subsequent cooperation and agreement to those arrangements was important to help her understand why professionals were concerned and how working together, they could keep her safe.

5.53. Michelle's mental ill health did dominate the discussions regarding her safety; however, there were other risk factors for Michelle which were as significant. Michelle repeated that she was feeling lonely and isolated in her accommodation. She told professionals around her that she did not like being there and wanted to move. She had several unknown relationships and her

vulnerability to being exploited had not been fully explored. The apparent inference by some that Michelle was attention seeking and 'dramatic' may have underplayed those vulnerabilities. There was some evidence that she had been using cannabis and it is unclear how this would have reacted with her medication.

5.54. The administration of medication

5.55. There was a clearly agreed protocol in place that the Supported Care Provider staff would administer Michelle's medication twice daily. The records indicate that this was a routine task and was recorded well. Michelle occasionally either refused to take her medication or was not in residence to take her medication and this is recorded. There was no process in place to escalate this issue within the hierarchy structures of the Supported Care Provider and no mechanism to inform her GP or psychiatrist and no understanding of the implications for Michelle of her not taking her medication.

5.56. There was a lack of clarity about who was accountable for supporting Michelle with her medical needs. The Supported Care Provider staff understood it was their responsibility to support Michelle with all visits to health appointments including her GP and that their role was outlined in agreed plans. It caused confusion when Michelle's Personal Advisor attended with Michelle for GP appointments following the incident in November. This led to Michelle receiving an additional prescription for anti-depressants to which the Supported Care Provider staff only became aware after the event.

5.57. The Supported Care Provider staff have a recording book at the GP surgery where requests for Michelle's medication were recorded. The staff then collected the prescriptions and took them to the pharmacy. The tenants of the Supported Care Provider have a range of prescriptions, some are electronically produced, others as in Michelle's case, were paper prescriptions. This arrangement appeared to change after the professionals meeting in November 2018, whereby Michelle visited her GP with her Personal Advisor to collect her prescription and medication. The medication would then be handed in to the Supported Care Provider staff by Michelle. The staff at the Supported Care Provider were not involved in the decision to change the arrangement for obtaining Michelle's medication, nor was the rationale for the change explained, recorded or risk assessed. This decision, if indeed correct, is not in the notes of the meeting of the 12th November and there is no record relating to it. The GP confirmed that there had been no over prescribing or accumulation of medication at the pharmacy or the surgery.

5.58. On the 11th and 24th January and on the 18th February 2019, Michelle had signed for the prescription and took this to the pharmacy. The pharmacy has not confirmed whether she collected her medication but it is assumed this was the case. The different systems of paper and electronic prescriptions for

tenants at the Supported Care Provider would likely to have caused confusion for both the Supported Care Provider and GP surgery staff and this may have been the reason why Michelle could have signed for and collected her own prescription. Given the prior arrangements in place between the Supported Care Provider and the GP surgery for the collection of the medication, together with the arrangements in place for administering Michelle's medication day and night, it is unclear how no agency questioned the fact that Michelle was now obtaining medication herself and that no agency had risk assessed whether this was appropriate given her assessed risk of self-harm.

5.59. There had been ongoing discussions recorded about the safety and appropriateness of Michelle taking her own medication, but this was never resolved. She was party to those discussions and was always of the view that this was appropriate.

5.60. There are references to Michelle taking drugs and alcohol in her teenage years. Michelle's birth mother reported her presenting as 'doped up on cannabis' 4 days before she died. The post-mortem report does not indicate any other substances were detected in her blood samples. Therefore, it remains unknown whether her presentation to her mother was as a result of cannabis use or how Michelle was generally feeling. It is understood that cannabis can interact with antidepressants and can cause an abnormally fast heartbeat and high blood pressure. There is also a risk of other side effects such as confusion, restlessness, mood swings and hallucinations[22]. The author was able to confirm that Michelle had no access to her birth mother's anti-depressant medication when she visited.

6. Examples of good practice

- It was positive that the Adolescent Unit agreed to keep Michelle beyond her expected discharge date and avoided considerable disruption and placement changes for Michelle before her move to the Supported Care Provider.
- Michelle was supported to obtain 5 GSCE's.
- There was good multi agency working evidenced prior to Michelle's move to the Supported Care Provider.
- The CYPS EIPS maintained a positive presence in Michelle's life and she developed a strong relationship with her care coordinator.
- Michelle becoming a looked after child aged 17 ensured that she received ongoing support beyond her 18th birthday.
- Michelle's social worker remaining involved for a further 10 months after Michelle's 18th birthday is good practice and offered consistency of support and was a person-centred decision.

[22] NHS March 2017

- The transition between CYPS EIPS and Adults EIPS was well managed, with good evidence of early communication, planning and joint visits.
- Some of the Supported Care Provider staff had good working relationships with Michelle.
- There was a responsiveness to Michelle's requests for medication changes.
- The Leaving Care Team took a proactive approach to safeguard Michelle after the incident in November 2018.
- Links were maintained throughout the review period with Michelle's family.

7. Conclusions

7.1. Michelle was described as a complex yet likeable young woman who had considerable needs. Michelle demonstrated some positive behaviours yet those behaviours hid the deep-rooted impact of her experiences as a young child and whilst she received attuned care from her wider family, Michelle remained a vulnerable young woman who presented with mental ill health for several years. Her vulnerability was sometimes overlooked because of her positive presentation and outlook.

7.2. There was an opportunity missed to assess and develop Michelle's independence skills whilst she was placed at the Adolescent Unit. This would have indicated that she was not ready for semi-independent living and alternative care options should have been considered. The significant step of moving from her grandparents' sole care to semi-independent living was misplaced and did not take into consideration her lack of ability to fully care for herself, her vulnerabilities or the impact of her mental ill health.

7.3. The 'rush' to semi-independent living did not take into account Michelle's history and ability. This natural step needs long and careful consideration and care leavers themselves have reported the need for local authorities to plan these transitions well in advance. Alternative care options should have been considered and whilst Michelle may have welcomed the chance to live independently, a more considered transition would have been more appropriate.

7.4. The commissioning of the accommodation and the move to semi-independence was misplaced. Subsequent monitoring arrangements of the accommodation and whether it continued to meet Michelle's needs were poor. Michelle's needs and presentation should have prompted actions to consider the appropriateness of the placement continuing.

7.5. The Supported Care Provider, whilst offering a positive opportunity for Michelle, were not well prepared to meet her complex needs. Offering services to children transitioning from Children to Adults Social Care without formal mental health training is a significant gap in knowledge and skills.

7.6. Post 18, Michelle became caught between several agencies procedures and protocols which did not afford her person-centred care. Cross border issues of accountability and responsibility of agencies both in and between children's and adults' services acerbated this position. She had to manage a number of transitions without clear planning and consideration of her needs.

7.7. Young people leaving care require consistent and well-planned support. Whilst young people aged 18 years of age are legally adults, services available to them should have more flexibility in their approach to transitions and avoid the 'cliff edge' of all agencies removing themselves from young people's lives.

7.8. Adult safeguarding processes were not followed, and the local authority's involved were not clear who had overall responsibility for safeguarding Michelle. Adult and children's safeguarding arrangements were inflexible, and children and adults' services debated who was accountable for Michelle's situation without clear resolution. There was no escalation process in place, leading to frustration and anxiety amongst frontline professionals. There was no shared understanding from children or adults' services about respective safeguarding roles and responsibilities.

7.9. All age mental health services are currently confusing to understand from partner agencies perspective and include those within health. Whilst transition between children and adult's mental health services worked well for Michelle, post 18 there was confusion and a lack of communication between adult mental health and partner agencies. Michelle was assessed as medium risk of self-harm for most of the review period, yet crisis and relapse plans were not widely shared or understood by agencies involved in her care. The 3-year imposed removal of support by the EIPS led to a gap in service provision at a point when Michelle may have needed ongoing mental health support. The Leaving Care Team did not have the full understanding of her mental health needs and at times felt unsupported, particularly when services withdrew, and care was transferred to her GP.

7.10. Assessments and plans did not have SMART (specific, measurable, achievable, relevant and timebound) actions, rarely were they signed and dated and were not shared amongst the professional network.

7.11. The communication between professionals post 18 was not well evidenced on case files. There was a lack of understanding as to who held ultimate accountability for Michelle's care post 18. Agencies appeared to work in isolation and times when risks escalated for Michelle there were not appropriate escalations.

7.12. Michelle had not been invited or was not part of significant meetings about her care. Her cooperation and understanding of the risks that agencies were worried about was not fully explained to her and therefore she 'kicked back' at the imposition of rules that she was not able to agree with.

7.13. The balance of rights and responsibilities versus safety and protection can only be based on the development of trusting relationships. There was no one consistent professional post 18 that offered this for Michelle and there was no consideration of Michelle having an advocate. Whilst her family strongly advocated for Michelle, she may have benefitted from this input.

7.14. The crisis and relapse prevention plan had clearly highlighted indicators that would suggest Michelle's mental health was deteriorating. These were not shared fully with the professional network and should have provided professionals with a clear understanding of her changes in behaviour and what actions should be taken in response.

7.15. Assessments of risk or safety plans need to fully consider any risks whilst the tenant is in the accommodation as well as external risks.

8. Summary of learning from this review

- Children and young people must be at the centre of care planning, and they must be fully involved in all aspects of their care plan. They must be listened too and heard, and changes made in response to their feedback if safe and appropriate to do so.
- Isolation and loneliness are key issues for care leavers.
- Children leaving care need appropriate time and preparation for semi-independent living. It should not always be the only natural next step for those children who can no longer live at home and moving on in their late teenage years.
- Children leaving care should have detailed and clear plans to develop their independent skills, with targets and regular review.
- Joint commissioning of semi-independent living accommodation should be robust, with regular reviews in place to ensure it continues to meet young people's needs. Commissioners should be reassured as to the efficacy of the provision including reassuring themselves through a range of checks and balances that it will provide the best possible care and support. This responsibility should not be left with practitioners alone.
- Additional support as part of commissioned services should be detailed and clear. There should be clarity as to who reviews the provision of support and when this should be appropriately adjusted.
- Adults aged 18, may need more flexible transition arrangements in place that are person centred and not based on chronological age.

- At all times, children and adults should have a named lead professional who coordinates all their care irrespective of the number of agencies involved and the primacy of the need.
- Cross borough protocols should be in place for care leavers aged 18 or over including who has responsibility for ongoing support and safety.
- Children's safeguarding arrangements and adult safeguarding arrangements present barriers to effective safety for individuals aged 18 or over.
- Children and Adults Social Care should develop more effective pathways for young people reaching 18. Chronological age should not be the precursor to support.
- Not all agencies understand the complexity of mental health services and with a limited understanding of mental ill-health comes a level of professional anxiety that must be supported and understood. Greater understanding of mental ill-health should be a priority for all agencies. Specific training should be provided to those who care for people with mental ill-health.
- Assessments and plans must be widely shared, understood and reviewed to consider changes in circumstances. Information sharing amongst professionals should not be fragmented.
- Risks and responsibilities need constant review and balance based on the changing circumstances of the individual. Whilst people's right to privacy is paramount, this must be balanced again known assessed risks.

9. Recommendations

9.1. Royal Borough of Windsor & Maidenhead's multi agency adults and children safeguarding arrangements and the West of Berkshire Adults Safeguarding Board

9.2. With the introduction of the Windsor and Maidenhead's multi agency adults and children safeguarding arrangements, there is an opportunity to work alongside the Safeguarding Adults Board to consider how transitional safeguarding for young people aged over 18 could be better managed. This could include the development and design of more fluid safeguarding arrangements for vulnerable young people.

9.3. Partnerships and Boards should consider the introduction of multi-agency family safeguarding training which encompasses an understanding across adults and children's services about safeguarding arrangements for children and adults post 18.

9.4. The Windsor and Maidenhead multi agency adults and children safeguarding arrangements in conjunction with the Corporate Parenting Board, should consider undertaking a multi-agency audit into support arrangements for children leaving care and moving to semi-independent living arrangements.

It should review the efficacy of the plans for young people and make recommendations to the partnership for future scrutiny.

9.5. The Windsor and Maidenhead multi agency adults and children safeguarding arrangements and the Safeguarding Adults Board should jointly review the information sharing protocols and reassure themselves that they are being used effectively across adults and children's services.

9.6. There should be the introduction of a jointly agreed and owned escalation policy across the children's safeguarding partnership and the adults safeguarding board.

9.7. <u>The NHS Foundation Trust</u>

9.8. The NHS Foundation Trust should offer awareness raising sessions across the partnership as to the range and provision of mental health services to children and adults.

9.9. The NHS Foundation Trust should ensure that all crisis and relapse prevention plans are shared with partner agencies and agreed with the service user. There should be clear escalation arrangements in place for partner agencies.

9.10. The NHS Foundation Trust should ensure that they are involved in provision planning for adults with mental ill health and with commissioners be reassured that supported living arrangements for young adults have suitably trained staff in providing care for people with mental ill health.

9.11. The NHS Foundation Trust should reassure the Windsor and Maidenhead Safeguarding Children's Partnership and the Safeguarding Adults Board through audit and quality assurance processes, that young people leaving care with identified mental health needs are well-supported post 18 and do not experience a loss of appropriate support.

9.12. The NHS Foundation Trust should reassure themselves, through audit, that health professionals are recording on the RIO system in a timely way and the recording is of good quality.

9.13. The NHS Foundation Trust should ensure that risk assessments are shared, understood and have effective mechanisms in place to escalate should risks increase.

9.14. <u>Local Authority Children's Social Care and Adults Social Care</u>

9.15. Children's Social Care should review their arrangements for commissioning external placements for care leavers. There should be

reassurance to the Windsor and Maidenhead multi agency adults and children safeguarding arrangements and the Safeguarding Adults Board that commissioning of placements and support is robust for care leavers and that monitoring of placements is well documented.

9.16. Children's Social Care alongside Adults Services should review cross border arrangements for care leavers, particularly with regard to commissioning out of area placements. There should be agreed protocols developed to ensure care leavers are adequately safeguarded and supported in their placements out of area. Commissioning of placements should include a formal review process for care leavers undertaken by the commissioning team jointly by adults and children's services.

9.17. Children's Social Care and Adults Social Care should identify a professional lead for transitions for care leavers who do not have Education, Health and Care Plans but are considered vulnerable.

9.18. Training should be offered to the Leaving Care Team on the Multi-Agency Risk Framework to raise awareness of the existing mechanisms to mitigate and manage risks for care leavers who are now adults, including the use of multi-agency risk panels.

9.19. Children's Social Care and Adults Social care should develop protocols together to address the safeguarding needs of young people aged 18 or over who are assessed as vulnerable or at risk. Particularly at transition and specifically for care leavers and ensure that social work staff have a clear escalation process if there are disagreements between children's and adults' services about safeguarding young people and adults.

9.20. Children Social Care and Adults Social Care need to introduce a jointly agreed escalation process for ensuring safeguarding arrangements for vulnerable young people, including care leavers are robust, with accountabilities and responsibilities clearly set out.

9.21. Significant changes made to care plans for care leavers should be risk assessed and shared with the agency network as appropriate with permission from the care leaver.

9.22. Children's Social Care and Adults Social Care should assess the efficacy of extending the remit of the existing Transitions Panel for young people reaching 18 with Education, Health and Care Plans to encompass care leavers and vulnerable young people aged 18 and over.

9.23. <u>The Supported Care Provider</u>

9.24. The Supported Care Provider needs to fully review their care arrangements for young people and adults with diagnosed mental health issues. They should ensure that risk assessments fully consider the risks to the person whilst in residence as well as out in the community.

9.25. The Supported Care Provider should urgently review all current arrangements for children under 18 placed in their establishments and reassure their statutory regulator that those placements are appropriate, and risk assessed.

9.26. The Supported Care Provider needs to offer their staff at the very least Level 2 training in mental health.

9.27. The Supported Care Provider need ensure that their staff receive appropriate training in the administration of medicines. There should be formal arrangements with GP surgeries and community pharmacists in place that avoid paper prescriptions having to be collected.

9.28. The Supported Care Provider is advised that internal doors in their establishments should allow appropriate access to staff members whilst maintaining confidentiality and personal space.

9.29. The Supported Care Provider should ensure in their contractual agreements with local authorities that there are appropriate escalation processes identified for adults considered to be at risk of harm.

9.30. The Supported Care Provider should ensure that their senior staff are fully cognisant with the expectations of Safeguarding Adults Boards and Children's Safeguarding Partnerships in any review of cases where they are a partner in the review process.