Safeguarding Adults Review

‘Sylvia’

Overview Report

January 2023

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Contents

1. Introduction

1.1 Croydon Safeguarding Adult Board (CSAB), in collaboration with Bromley Safeguarding Adults Board (BSAB) and Kingston Safeguarding Adult Board (KSAB), who will collectively be referred to as 'the Partnership' have commissioned this Safeguarding Adult Review (SAR) after Sylvia was tragically found dead in September 2021, of a suspected drug overdose.

1.2 Sylvia was a 19-year-old British Sri Lankan woman, who could lift a whole room with her smile and charm. She was a happy and sociable child; her family described her befriending a lonely 60-year-old woman and homeless people, offering them kindness and listening as they opened up about their lives. Her family said Sylvia could also be naïve about people. Sylvia loved dancing with the music up loud, the homely environment of her youth club, and spicy food that reminded her of her mother's cooking. Sylvia was articulate and artistic, expressing herself through her pictures, Although Sylvia had used cannabis and alcohol as a younger teenager, when she was 16 she tried Spice, a synthetic drug which looks like cannabis and is similarly smoked. What may have seemed a benign one-off experiment had catastrophic consequences for Sylvia; she became acutely psychotic and never fully recovered. The long-term impact on her mental health and cognitive function increased her vulnerability to exploitation and her substance use became entrenched. Her family expressed their grief that people had forgotten Sylvia's sweet nature and the joy she could bring, thinking of her 'just as a drug user', but Sylvia's youth worker, who continued to provide trusted support to her from the age of 11 into adulthood, described Sylvia as 'a beautiful soul'.

1.3 Sylvia had struggled to meet her developmental milestones and was later assessed as having a degree of frontal lobe impairment which could have resulted from head trauma injuries she sustained as a young child. There were long standing concerns about Sylvia being out of formal education from the age of 11, exploitation in the community including several sexual assaults as a child, 'relationships' with older men that revolved around coercive control, drug use and missing episodes. Consequently, Sylvia was made the subject of a care order to Kingston's Children's Social Care in 2016, but placements struggled to meet Sylvia's needs and she moved repeatedly, including to a specialist unit for young people at risk of child sexual exploitation.

1.4 Sylvia was detained under the Mental Health Act 1983 while placed outside London in 2018 as a result of her drug-induced psychosis and was placed in a Child and Adolescent Mental Health Services (CAMHS) bed with the South London and Maudsley (SLaM) Mental Health Trust. She was diagnosed with schizophrenia, emotionally unstable personality disorder, substance misuse and possible mild learning disability, and spent long periods of time detained in psychiatric facilities and multiple placements, including under a Community Treatment Order. Kingston continued to meet her care needs as an adult although she was placed in Croydon, and then Bromley when not detained in hospital. Several of Sylvia's placements broke down, usually due to her physically and verbally aggressive outbursts and she had many missing episodes, some of a long duration and there were ongoing concerns that she was experiencing exploitation as an adult. A Community Treatment Order was obtained to manage her medication and an application was made to the Court of Protection because she could not engage with assessments about alternative accommodation. During a hospital detention under the Mental Health Act in 2021, Sylvia went missing for a lengthy period and was eventually found trying to jump into a canal and returned to hospital. Sylvia was then granted s17 leave on the hospital grounds, escorted by two staff members, but managed to evade her escorts and went missing. She was found deceased two days later in a flat in Croydon.

1.5 The authors wish to express their sincere condolences to all members of Sylvia's family for their loss and thank Sylvia's mother, sister and brother for contributing to the review. The authors are also grateful to the professionals who worked with Sylvia for sharing their insight into her experiences so honestly.

2. Scope of Review

Purpose of a Safeguarding Adult Review

2.1. The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local interagency practice;
- To improve practice by acting on learning (developing best practice); and
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2. There is a strong focus in this report on understanding the underlying issues that informed agencies and professionals' actions and what, if anything, prevented them from being able to help and protect Sylvia from harm. Committed, caring support for Sylvia was clearly evidenced across the professional network, from social workers and personal advisers who dropped everything to try to meet Sylvia whenever she was seen, to community police officers who recognised a vulnerable young woman in an exploitation hot-spot and proactively challenged the safety of her placement with other agencies.

Themes

2.3. The Partnership prioritised the following themes for illumination through the SAR:

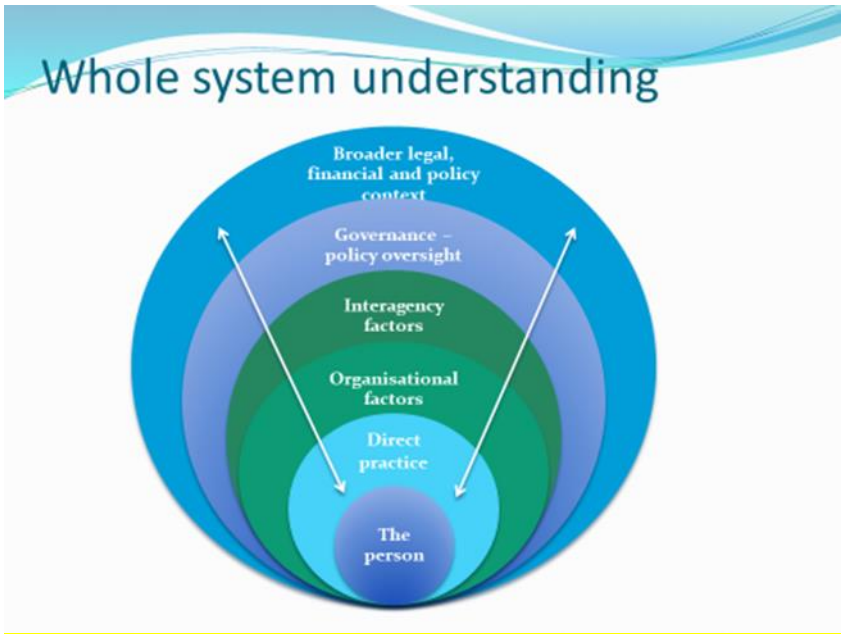
- Whether the infrastructure for transitions (between children social care and adults and between CAMHS and adult mental health services) met with the expectations and, if there were barriers to effective and preventative support, that these are identified. Good practice examples should be highlighted from any areas to support practice and system improvement;
- Whether there were any issues in respect of cross boundary working that increased the risks to Sylvia;
- Whether the support offered to Sylvia regarding her mental health met expected standards;
- Whether communication between agencies/multi agency working was effective; and whether any additional services or interventions could have been considered to have prevented or reduced the risk to Sylvia;
- How can services work together to manage very complex cases with extensive trauma history, exploitation, coercion control and multiple risk factors such as substance misuse.

Methodology

2.4. The case has been analysed using a learning together approach, through the lens of evidence-based learning from research and the findings of other published SARs.[1] Learning from good practice and a discussion of the legal framework have also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice. The review has adopted a

[1] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement. London: LGA/ADASS

whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram below.[2] Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



2.5. The overarching purpose of the review has been to learn lessons about the way in which professionals worked in partnership to support and safeguard Sylvia. Multi-agency learning events took place, both with front-line practitioners who worked with Sylvia and the leaders who oversaw the services involved in supporting them.

2.6. The following agencies provided documentation to support the SAR:

- Kingston's Achieving for Children (AfC)
- Kingston Adult Social Care (Kingston ASC)
- Bromley Adult Social Care (Bromley ASC)
- Croydon Adult Social Care (Croydon ASC) and Children's Social Care
- Croydon Clinical Care Group (now NHS South West London Integrated Care Board) (CCG)
- Croydon Health Services NHS Trust
- Metropolitan Police
- Oxleas NHS Trust
- South Est London Clinical Commissioning Group
- South London and Maudsley NHS Foundation Trust (SLaM)
- Trent Vale Medical Practice

2.7. Please note that Achieving for Children (AfC) is a not-for profit social enterprise that was established in 2014 by the Royal Borough of Kingston and London Borough of Richmond to provide their children's services including social care and education. In 2017, the Royal Borough

[2] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection, 17 (1), 3-18.

of Maidenhead and Windsor joined this social enterprise. Kingston's Adult Social Care continues to be provided directly by the council.

Involvement of Sylvia's family

2.8. We are grateful to Sylvia's mother, sister and brother, who shared their memories of Sylvia, their insight into her experiences and how the professional network worked with her. They requested that she be referred to using the pseudonym 'Sylvia' within this report. Sylvia was dearly loved by her family and their consistent efforts to protect and support her were incredibly moving. Practitioners described her mother travelling across London to search for her during missing episodes, attending every meeting and visiting daily during periods in hospital. The family spoke positively of the agencies (and individual practitioners who showed commitment to supporting and building a rapport with Sylvia, but raised concern that some agencies treated Sylvia as making 'poor lifestyle choices' rather than understanding the impact of her mental ill-health and failed to treat the family as being part of her safeguarding network, particularly after Sylvia turned 18. In particular, they noted that often Sylvia's mother's views were disregarded, and felt that because her English is strongly accented, practitioners believed that she did not understand the language, despite consistent assurances that her understanding of English was excellent and she was able to express her views very clearly to the authors. As the people who knew Sylvia best, her family should have been trusted and respected safeguarding partners.

Parallel processes

2.9. SLaM are currently undertaking an Unexpected Deaths Review in respect of this matter and the Metropolitan Police Special Investigations Unit's Local Investigation Report into Sylvia's death has been completed, and was provided to help inform this review. A Coroner's Inquest will also take place in due course.

3. Narrative Chronology

3.1. Sylvia and her two older siblings became known to Kingston's Children's Social Care in 2007 and due to child protection and housing issues within the family, they had moved 8 or 9 times throughout her childhood. Sylvia experienced physical and emotional abuse from her father and witnessed his domestic violence towards her mother. From the time she started high school, Sylvia's behaviour at school become increasingly disruptive and aggressive, and Sylvia was permanently excluded from school shortly before her 12th birthday for persistently bullying a newly qualified teacher. She joined a youth club at this time, a place where she felt comfortable and safe, and the trusting relationship she formed with her youth worker continued to be a positive support to her for the rest of her life. Tuition was provided through a Pupil Referral Unit but her family described that she was bored without friends in one-to-one tuition and while travelling independently to attend tuition, Sylvia met an older man on a bus who encouraged her to try cannabis. From that time she started going to friend's houses instead of attending tuition. A new high school was identified after a few months, but it took a further 5 months for Sylvia to begin attending the school. This did not last and Sylvia returned to personal tuition the following year after several fixed term exclusions, and her attendance and engagement remained poor.

3.2. Following an arrest for being drunk and disorderly on 17 January 2015, concerns started to be raised about risks of child sexual exploitation. Sylvia's friends at youth club would tell her family when Sylvia tried to cover that she was spending time with older men. The police were responsive to Sylvia's missing episodes, proactively searching for her and working closely with AfC and the family to try to disrupt the perpetrators. Sylvia generally responded to police officers with aggression.

3.3. In October 2015 Sylvia moved to live with parents of a friend in New Malden where she reported that her father had physically abused her. AfC made a safety plan with Sylvia's mother that the Sylvia would not be left alone with her father and that she would stay with the friend's parents when Sylvia's mother was working. The friend's parents were identified by AfC as 'private foster carers' and child in need visits took place, but a referral for a private fostering assessment was not made. Within a short period, the private foster carers reported to the police that Sylvia was being sexually abused and exploited by an adult male (Adult A) and she was arrested several times for shoplifting and burglary in the company of adult males known to pose a risk to children. After going missing from the 'private fostering' arrangement twice, Sylvia was placed in police protection and returned to her parents' care in Croydon, but had repeated missing episode and further arrests. Police issued a Child Abduction Warning Notice (CAWN) on 21 April 2016 against Adult A, and he was prosecuted for child abduction when she was again arrested in his company on 29 April 2016.

3.4. Sylvia became a child looked after on 26 April 2016 after being remanded into local authority care by the criminal courts for shoplifting and assaulting police officers; her mother then consented to section 20 on 4 May 2016. Sylvia was placed with foster carers in Milton Keynes, but routinely absconded, often returning late at night intoxicated and was arrested for robbery and possession of a knife. Following legal advice in July 2016, AfC applied and obtained Care Order on 8 March 2017. During the care proceedings, Sylvia was moved to a residential placement in Warwickshire and she was arrested several times for robbery and knife possession. However, the residential placement broke down after four assaults on staff and concerns being raised about Sylvia's mental health and she was moved to a semi-independent placement in Hounslow on 11 December 2017.

3.5. In early January 2018, Sylvia came to the attention of police on five occasions due to 'odd' or chaotic behaviour. On 6 January, police took her to West Middlesex Hospital after she assaulted police officers and ambulance staff. At hospital she disclosed being taken to a hotel by her boyfriend and that she 'consented to him but not to his friends', but did not clarify this comment and could not recall further details. Intelligence checks were carried out on the 'boyfriend's' name. She was found again by police the next day and returned to her placement, having walked out of the hospital before a mental health assessment could be carried out. On 13 January 2018, Sylvia was detained under s2 of the Mental Health Act 1983 (MHA) and admitted to West Middlesex Hospital, before being moved to an Adolescent Mental Health Unit at Edgeware Hospital, where she remained under s3 of the MHA. It transpired that she had drug-induced psychosis, after experimenting with Spice and when her youth worker visited, she described Sylvia as hallucinating and gurgling, unable to speak or recognise visitors. On 4 June 2018, Sylvia was moved to Brennin Ward in Wales, where she was visited by a police officer from the Child Sexual Exploitation team, before being discharged to a semi-independent, high support unit in Kingston on 30 July 2018. Sylvia went missing almost daily from 31 July-20 August 2018 which led to her placement giving notice and she moved to a new placement in Bracknell on 23 August. She was arrested twice for assaulting police officers. During a further missing episode on 8 October 2018, Sylvia was found at the home of a young man being investigated for rape, Adult B. Initially Adult B's mother, then Adult B himself were served with CAWN, although when Sylvia was found at his home on 14 March 2019 during a missing episode, Adult B was not prosecuted for child abduction as he had called the police to notify them she had turned up, so no offence was committed.

3.6. On 5 December 2018, Sylvia was detained at SLaM's Snowfields Adolescent unit (Maudsley Hospital) under Section 2 of MHA 1983. At the time of this admission, her working diagnosis was conduct disorder with anti-social personality disorder traits, previous drug induced psychosis, neuro developmental difficulties/ frontal lobe dysfunction, emotionally unstable personality disorder. Sylvia's mother and youth worker suspected that she was pregnant because she was throwing up, and supported her to take a pregnancy test, although she was so unwell that they believed she was not capable of understanding this. Hospital records

indicated that she did not acknowledge the pregnancy and resisted an examination. An assessment was carried out of her mental capacity to take decisions around her pregnancy, including an assessment of her cognition which concluded that she may have a borderline learning disability. Sylvia's mother and the local authority (as corporate parents) were also consulted to inform this assessment. The baby's father, Adult C, who was 28 years old and had met Sylvia when she was 16, was not allowed contact with her during this time and her whereabouts were kept confidential from him, although information provided to the ward indicated that he was a "protective factor" during missing episodes.

3.7. During the s2 assessment, staff recognised that an acute adolescent unit may not be appropriate due to Sylvia's aggressive behaviour and the risk of absconding so she may need a placement in a low secure unit in the future. Liaison took place with AfC, both in respect of Sylvia's needs and the child protection concerns in respect of the unborn child. Contact was made with an Independent Mental Health Advocate and although Sylvia refused to speak with them, she agreed they could instruct a solicitor to challenge her detention at a Mental Health Tribunal.

3.8. An application for detention under s3 of the MHA was made on 4 January 2019. Five days later Sylvia's pregnancy was terminated, which the hospital reported was in accordance with her decision. While on the ward, concerns were noted that Sylvia had absconded during escorted leave to the zoo; she had returned intoxicated from leave on a number of occasions and been found outside Adult C's property. On 15 February 2019, police notified the ward that Adult C had been arrested for sexual exploitation of another child. Sylvia remained under section 3 MHA until 1 July 2019, when there was a marked improvement in her mental state after her medication started to be administered by depot injection. During this period she had engaged better with education as the structured environment with peers suited her learning style. Sylvia remained in hospital voluntarily until 24 July 2019 while accommodation was sought by AfC.

3.9. Sylvia was discharged to accommodation in Croydon where she was the only resident, in a known 'hotspot' area for substance use, where Adult C was known to live. Her family opposed the move to Croydon, as they felt that living so far from home was not appropriate given the support Sylvia needed, in particular in light of her recent abortion. A referral was made to CAMHS but as Sylvia refused to engage, CAMHS asked AfC to encourage her to engage and informed her consultant psychiatrist. Arrangements were therefore made for CAMHS to engage with Sylvia at her residential placement, including medical reviews. Sylvia's family reported that the placement was initially very supportive and proactive in supporting Sylvia to take her medication. However, Sylvia's physical presentation immediately deteriorated and there was evidence she was taking hard drugs with older substance users and experiencing abuse.

3.10. On 7 August 2019, 8 weeks before Sylvia's 18th birthday, CAMHS emailed the Early Intervention Adult Service to start transition planning to Adult Mental Health Services. Concerns started to rise that Sylvia was refusing to engage with CAMHS, that adults were supplying her with cannabis and Adult C had been released from prison, although the placement was documented to have a robust safety plan in place and liaison took place between CAMHS and the Leaving Care team.

3.11. On 3 September 2019, AfC sent a Child Looked After transfer document to Croydon's ASC, but this did not mention any safeguarding or health concerns, focussing instead on the fact Sylvia had not attended school since year 7, when she would have been 11 years old. There was no further reference to her CLA or care leaver status on her records. However, it appears that this notification was 'for information only' as Kingston's ASC continued to hold case responsibility for Sylvia and carried out all assessments and care planning under the Care Act.

3.12. On 10 September, a permanency planning meeting took place after Kingston ASC's Care Act assessment was completed, taking a decision that adult services would continue to

accommodate Sylvia in the same placement post-18. Sylvia wanted to return home to live with her family – '*like any child, she just wanted to feel safe*' - but understood that this would not be safe for her mother due to Sylvia's physical aggression towards her. CSE police agreed to keep a vulnerability marker on Sylvia's file post-18.

3.13. Sylvia turned 18 on 30 September 2019, but experienced a protracted transfer of care to adult mental health services. Sylvia was placed on a waiting list for the Community Mental Health (Adult) Team (CMHT) on 23 September 2019 after she was found not to meet the criteria for the early intervention psychosis team. However, due the CMHT being over-subscribed, there was a 5 ½ month delay before Sylvia was allocated a care coordinator. CAMHS had made four attempts to telephone or email the CMHT to follow up the referral during this delay.

3.14. On 10 November 2019, Sylvia attended the Emergency Department at Croydon Health Services following a physical assault, then was arrested for assaulting hospital staff. The staff in the Emergency Department recorded that they deemed Sylvia to be 'not capacitous' to make decisions around her care and treatment, although it is unclear from the care records if a formal capacity assessment was completed. Sylvia was discharged home with advice and to be referred to psychiatry. No safeguarding referral was made to ASC in respect of Sylvia's risk of self-neglect as she was not compliant with taking her medication to maintain her mental health. As time progressed, staff at Sylvia's placement struggled to manage her increasingly erratic behaviour and her family noted that due to turnover in the cohort of staff, their response became less empathetic. As a child, when Sylvia did not take her medication, residential staff would call the ambulance to support her to take this, but as an adult she was expected to manage this herself. Rather than recognising the impact of non-concordance with medication for lengthy periods on her deteriorating mental health, her family felt that mental health professionals attributed this to Sylvia 'misbehaving'.

3.15. From January – March 2020, ongoing concerns were recorded in respect of the risk of sexual exploitation, discussion was held about whether Sylvia met the criteria for a Multi-Agency Risk Vulnerability Exploitation (MARVE) discussion, multiagency safety planning took place between AFC and Kingston ASC and Sylvia consented to a referral to substance misuse services. A safeguarding referral was made on 16 March to Croydon Adult Safeguarding because Sylvia had a bruised eye.

3.16. On 23 March 2020, England entered the first national lockdown due to the Covid 19 pandemic. All non-essential businesses closed and only essential services were able to offer face-to-face services. Sylvia's family described how difficult she found the lockdown, becoming increasingly paranoid and many of her positive supports were disrupted as professionals could not visit her. On 30 March 2020, Sylvia was referred to Multi Agency Risk Assessment Conference (MARAC) by AfC's Leaving Care Service. She was identified as being at risk of sexual exploitation and a victim of domestic abuse perpetrated by her partner (Adult C). At this point in time, she was a Care Leaver and vulnerable due to the significant health concerns she was experiencing, her history of being a child looked after and life experience prior to this. The perpetrator was referred to the Domestic Abuse Perpetrator Panel. The Independent Domestic Violence Advocate (IDVA) contacted Sylvia, but she declined to engage with the Croydon domestic violence and abuse service (Family Justice Centre).

3.17. Sylvia was allocated a care coordinator by Adult Mental Health Services on 14 April 2020. There is no record of a handover meeting where all relevant parties met to share information, risks, and ongoing plan. SLaM reports that there was little evidence of partnership working during this transition period, identifying that because the case was allocated to a care co-ordinator at the height of the Covid- 19 pandemic, all but essential workers were being asked to work from home and priority was given to people in crisis.

3.18. On 22 April 2020, emails between the residential placement, leaving care team and AMHS raised concerns that Sylvia's mental health was deteriorating and an urgent outpatient psychiatric appointment was requested, but SLaM could not find evidence that a review was carried out until 14 May, when a telephone consultation took place with placement staff, as Sylvia refused to come to the phone.

3.19. On 20 May 2020, Sylvia was brought to the Emergency Department by ambulance because she damaged a vehicle, was running into the road and 'threatening to attack people'. Her mother followed her to the hospital. Sylvia was noted to be non-compliant with antipsychotic medication and denied any alcohol or drug use. She was discharged from hospital as she was refusing any support and returned home, with a notification sent to her GP. The Leaving Care social worker contacted the modern slavery helpline for advice around exploitation and control from Sylvia's partner. There is no record of a referral to Adult Safeguarding for self-neglect or of this information being shared with her care coordinator.

3.20. On 21 May 2020, an AMHP referral was completed by Sylvia's care coordinator, with a plan for the AMHP to obtain a court warrant under s135 MHA to enter the placement and take her to be assessed under the MHA, however, it appears this was not progressed. A risk minimisation plan was updated in a multi-agency meeting on 22 May. On 29 May, Sylvia was found with Adult B drunk and in possession of cannabis. Both were arrested and she became abusive toward officers. Police took Sylvia to a place of safety under s136 MHA, she was transferred to Royal Bethlem Hospital and assessed and sectioned under s2 MHA on 30 May 2020.

3.21. Proactive steps were taken to disrupt Sylvia's primary perpetrator, Adult C, who she saw as her 'boyfriend', and his name was put on a 'dauntless list' of the highest risk domestic abuse perpetrators in the area. It was noted that a Child Abduction Warning Notice had been made against him when Sylvia was a child. Intelligence was also noted that the other adult male who had exploited Sylvia as a child, who was also subject of a CAWN, was shortly due for release from prison.

3.22. On 20 June 2020, Sylvia's social worker challenged the ward's decision to approve unescorted leave from hospital, which had been recommended by the AMHP as a trial to determine whether a community treatment order would be feasible. On 26 June Sylvia transferred to s3 MHA and she remained in hospital under a legal framework to prevent her absconding until 14 July 2020, when she was discharged to her previous placement after a community treatment order was obtained, requiring compliance with depot medication and engagement with the CMHT. The consultant concluded that Sylvia's presentation related to personality and behavioural issues as opposed to a psychosis and therefore admission to an acute ward was not appropriate. There was no evidence that an assessment was carried out under the MCA to determine whether Sylvia had the capacity to agree these conditions or understood the risks of non-compliance, although her capacity was noted to be 'limited' in respect of understanding her mental health needs. The day before she was discharged from hospital, Sylvia was sitting on her mother's lap, incoherent and dribbling because she was hallucinating that people were spitting in her mouth. Sylvia's mother vehemently opposed her discharge but a practitioner at one of the learning events reported that she was told "*we're the professionals*" and her views were disregarded. A joint Crisis Plan was implemented by Kingston's ASC, Leaving Care and the placement.

3.23. On 14 July 2020, Sylvia was presented at Croydon's MARAC due to concerns that she was a victim of domestic violence by her partner, experiencing financial and sexual abuse, extremely vulnerable as a care leaver, and not concordant with anti–psychotic medication. She declined support from Family Justice Centre, but her GP was notified and an alert put on the electronic records. Concerns that Sylvia was being financially exploited were reported to the police on 28 August 2020 as Adult C was thought to have access to her bank card and pin, which she subsequently denied; she was found to have capacity to manage her finances. Her case was

closed after a further MARAC referral on 2 September 2020, when she declined IDVA intervention. Concerns around exploitation continued to arise, and a police 'grab bag' form was completed and saved in documents to ensure essential information would be available for the police if Sylvia went missing. Collegiate working took place between Sylvia's care coordinator, adult social worker and Strengthening Families social worker to assess her capacity around finances and accommodation and develop risk minimisation plans.

3.24. A professionals meeting was held on 4 November 2020 after Sylvia assaulted her mother and sister, and her placement gave notice of eviction due to property damage and 15 missing episodes in 3 months. A Behavioural Assessment of Dysexecutive Syndrome assessment dated 20 November 2020 noted that Sylvia's frontal lobe damage adversely affected her executive functioning, leading to frustrating, maladaptive coping strategies, vulnerability and emotional disregulation. Kingston's ASC sought legal advice in respect of obtaining appointeeship to manage Sylvia's benefits, but the social worker was unable to meet with her to complete a mental capacity assessment. Sylvia was referred to MARVE and MARAC. A safeguarding referral was made on 6 January 2021 after Sylvia was attacked by a group of people in Croydon. The risk minimisation plan was therefore updated.

3.25. A placement was eventually identified for Sylvia in Bromley, and a further professionals meeting on 14 January agreed that she would be transferred to the new accommodation by ambulance, with police present, with plans made to transfer her care to the receiving CMHT. A Community Treatment Order was sought and granted by the Mental Health Tribunal on 27 January 2021. As Sylvia was refusing to leave her placement, Kingston's ASC also took legal advice on 20 January 2021, and after unsuccessful attempts to obtain an independent mental capacity assessment in the community, an application was made to the Court of Protection on 15 February 2021, for an order authorising Sylvia's placement move and deprivation of liberty.

3.26. Police brought Sylvia to Princess Royal Hospital (Oxleas) following an arrest on 23 February 2021 and she was discharged back to police custody after a full assessment by the mental health liaison team. Sylvia was brought to the Emergency Department at Croydon University Hospital by police on 1 March 2021 after she was seen using illicit drugs and drinking a litre of vodka and was diagnosed with acute alcohol intoxication. The psychiatry team made five attempts to assess her but she was not fit for assessment and was only sufficiently sober for assessment on the final attempt. After four unsuccessful attempts to assess Sylvia due to her intoxication, she was assessed to have acute intoxication and '*poor lifestyle choices*' rather than suicidality or being acutely psychotic. She was discharged to her placement with a plan for the CMHT to provide 7 days follow up, although it is unclear if safeguarding was considered. Emergency Department staff challenged the use of restraint by police officers during this incident, as they felt it was unlawful when she was not subject to detention under s136 of MHA. Staff contacted the officer's sergeant at the local police station to report concerns that the restraint was excessive. SLaM records indicate that she assaulted staff and was given intramuscular medication.

3.27. Sylvia's risk minimisation plan was updated on 12 April 2021, MARVE advised that the Metropolitan Police safeguarding team was a more appropriate avenue for a referral, which was actioned and a notification was sent to the National Referral Mechanism as a referral could not be sent when Sylvia did not consent.

3.28. Sylvia went missing on 29 April 2020 and was taken to Croydon University Hospital by the police on 1 May as she had taken crack. She was reported to be discharged to her mother's care on 2 May, but Sylvia's mother confirmed this was not her. Sylvia's mother found her in a Tesco two days later and returned her to her placement. Enquiries were made of the hospital and an ECO map completed. On 7 May 2021, a decision was taken to discharge Sylvia from the CTO as this was not changing her behaviour and instead that Kingston ASC would '*pursue DoLS via the COP*'.

3.29. On 10 May 2021, police were called after Sylvia assaulted the manager (and then the attending police officers) at her placement while suffering delusion. After being taken to the Croydon police station, Sylvia was assessed as being psychotic by an AMHP and two medical practitioners, so was detained under s2 MHA. Staff from her placement reported that Sylvia regularly went on unauthorised leave for 2-3 days at a time, associating with known drug users. Sylvia was then transported to Bethlem Royal Hospital, where she had ongoing delusional thoughts about her tonsils melting and was given depo medication. A safeguarding referral was raised after Sylvia's mother raised concerns that she may be visited by the man who introduced her to drugs. Sylvia declined to engage with a referral to the Family Justice Centre on 11 May 2021, so her case was again closed. On 1 June 2021 the Ward started planning Sylvia's discharge to her new accommodation in Bromley, using secure transport. The Court of Protection authorised Sylvia's move to this placement and the deprivation of her liberty on 3 June 2021. She absconded from the placement by going over the fence on a ladder on 4 June. A referral was made to the Home Treatment Team, but this was declined as she would be in a residential placement and was on a monthly depot. She was therefore referred to Oxleas mental health team, who requested more information. When Oxleas reviewed the referral on 17 June, Sylvia was deemed suitable for a service from ADAPT due to her diagnosis of EUPD.

3.30. Sylvia absconded from her placement again on 14 June 2021 and her sister reported that she was in Brighton. The 'grab bag' was updated on 29 June to ensure the police information was current. Police located her but did not have powers to return her, reporting that Sylvia appeared mentally stable and denied being influenced by others, which led the CMHT to downgrade the risk rating from amber to green during their risk zoning meeting. Multiple reports were received that Sylvia was attempting to obtain a bank card or withdraw money and on 9 July, Barclays' Special Relationship Team contacted police to report that Sylvia had attended 3 branches in late June accompanied by 2 men who purported to be her carers. On the last occasion, bank staff had called the police who spoke to the parties involved but no outcome was recorded. On 30 June, Sylvia was seen by police officers in the company of a known male drug user (Adult D) but was noted to be coherent and well. On 14 July Sylvia tried to withdraw money from another branch; bank staff called police who attended, but Sylvia said she was not being taken advantage of. On 22 July, Kingston ASC obtained a High Court Collection Order, empowering the police and Tipstaff to return Sylvia to her placement.

3.31. Bromley's Safeguarding Team received two Police Merlins in respect of this missing episode, which were screened as being for information purposes as Sylvia was under s117 MHA and DoLS and Bromley concluded that the responsible authority would need to review the care arrangement. The Oxleas ADAPT team held a transfer of care meeting on 22 July 2021, with a plan for an urgent psychiatric review at her placement once Sylvia was located.

3.32. On 12 August 2021, Sylvia was detained by police under s136 MHA after British Transport Police had to physically restrain her from jumping into the water near Heron Quays DLR. She was taken to Homerton Hospital then admitted to Psychiatric Intensive Care Unit at the Bethlem Royal Hospital under s2 MHA where she became increasingly agitated, expressing paranoid and delusional thoughts and was administered an anti-psychotic. As she was admitted to hospital, Oxleas' ADAPT team closed Sylvia's referral on 16 August until she was discharged.

3.33. Multi-disciplinary meetings took place regularly (attended on one occasion by Sylvia's care coordinator), where concerns were noted that her current placement was struggling to manage her. Sylvia talked about having her baby removed, although it is unclear whether staff were aware of her history of having a termination. She was also noted to have sexually disinhibited behaviour. During an MDT meeting on 23 August 2021, attended by Sylvia's leaving care social worker, it was noted that s17 leave had not been granted yet due to the high risk of absconding based on her history. In light of the cycle of instability and relapse in supported living and secure units, a specialist rehabilitation unit was discussed for consideration on discharge as Sylvia required containment in a rehab unit where there would be a high level of support from various

professional disciplines in order to holistically support her needs. This would include treatment optimization, psychological support regarding trauma, abuse, sexual assaults, activity of daily living skills, drug and alcohol therapy. An assessment was completed by the Complex Care team at South London Partnership, a specialist mental health placement service.

3.34. Because Sylvia was more settled on the ward, a decision was taken that she could be managed on an acute ward and Sylvia was transferred to Fitzmary Ward on 27 August, where she was initially uncooperative and aggressive, stating that she wanted to 'go home'. During an MDT discussion on 31 August, the Complex Care Manager confirmed that a rehab application had been completed and that a few placements had been identified, but that Sylvia would need to be on a s3 before she could be admitted to a rehab ward. Later that afternoon, Sylvia threatened staff when her requests to go out were refused as she did not have s17 leave.

3.35. The Mental Health Safeguarding Team (MHST) received a safeguarding referral on 1 September that Sylvia was an inpatient and there had been several altercations between Sylvia and another patient. Due to the high risk of recurrence a S42 enquiry was opened. An interim safeguarding plan was put in place by the team to increase Sylvia's observations to every fifteen minutes and steps were being taken to transfer Sylvia or the other patient to another ward to remove the risk of further altercations. This safeguarding case remained open at the time Sylvia died.

3.36. From 2 – 5 September, the Ward notes indicate that Sylvia was persistently requesting s17 leave. She was allowed short periods of leave, escorted by two staff members to go to the shops or go out to smoke. On 6 September, Sylvia asked for leave to go to the bank and plans were made for her to do this, but when staff spoke to her mother, she cautioned them that if Sylvia was able to obtain too much money she was likely to abscond. The AMHP was informed and an occupational therapy assessment was planned around Sylvia's capacity to manage finances, to consider whether a formal arrangement such as an appointeeship was necessary.

3.37. Over the next two days, Sylvia continued to request unescorted leave, becoming increasingly agitated on the ward. She was told that a drug rehabilitation placement was being found for her, and she stated that she wanted her own accommodation or a hostel, in Croydon. During the morning MDT meeting on 8 September, Sylvia's leave was downgraded from 2:1 to 1:1, although when she took her leave at 11.25am, two staff members escorted her. As she approached the gates arguing with staff, the staff members contacted the ward to ensure that Sylvia was allowed outside the gates and it was confirmed that she was, but she immediately ran off. Staff searched for her unsuccessfully.

3.38. Police were called at 11.55am by Bethlem Royal Hospital to report that Sylvia had absconded whilst on escorted leave on the hospital grounds, supervised by two staff members. Police were advised that Sylvia was suffering from paranoid schizophrenia and mixed anxiety disorder and classed as a vulnerable adult, who was known to smoke cannabis. The missing person's report was classified medium risk and local police units were instructed to attend her home address, but the address was incorrect. Police therefore sought clarification from the hospital, who stated Sylvia was not known to self-harm, but could sometimes be aggressive during misunderstandings with fellow patients. They described her behaviour as up and down, but had recently improved. The hospital confirmed she had no mobile phone or money and provided two further addresses as possible locations (one of which was a few doors down from the address she was eventually found) and computer aided dispatches were arranged for units to attend, although these addresses had not been visited by the time Sylvia died, due to competing priorities. The Merlin report was reviewed the following day and remained medium risk.

3.39. At 7pm on 9 September, police were called by London Ambulance Service to attend a Croydon address where Sylvia had been found dead. The resident (Adult D) at the address reported that she had turned up highly intoxicated asking for drugs and money. Adult 3 told officers he went

for a walk at 1.30pm and returned home at 4pm to find Sylvia slumped against his sofa, not breathing and bleeding from the nose. He could not find a pulse and called 999, giving CPR until the ambulance attended, but paramedics pronounced her dead. Police investigating Sylvia's death deemed that the situation was not suspicious. Adult D was identified as having vulnerabilities himself and

3.40. was believed to be being 'cuckooed' at the time of Sylvia's death.

4. Legal and practice framework

Transitional Safeguarding

4.1. The term 'Transitional Safeguarding' describes the need for an approach to safeguarding adolescents and young adults fluidly across developmental stages[3], despite the differences between the legal frameworks for children and adults. The Chief Social Worker and Research in Practice's Transitional Safeguarding briefing[4] highlights the important contribution made by adult social work within transitional safeguarding, pointing specifically to the expectation within the Care and Support guidance, which accompanied the Care Act 2014, of adopting a human rights-based, person centred approach. This requires practitioners from all relevant agencies to exercise legal powers mindful of the positive obligations under the Human Rights Act 1998 to act to prevent real and imminent risk to breaches of Article 2 (the right to life) and Article 3 (the prohibition on torture, inhuman or degrading treatment).

4.2. These duties are balanced against Article 5.1 ECHR which provides: *"Everyone has the right to liberty and security of the person. No-one shall be deprived of his liberty save in the following cases and in accordance with a procedure proscribed by law ...(e) the lawful detention of persons of unsound mind ...".* There are two primary pieces of UK legislation that provide a legal framework to deprive someone of their liberty because they are of 'unsound mind', the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA). However, any intervention must be necessary to prevent harm to the person or others and proportionate to the likelihood and seriousness of those risks – the least interventionist approach must be used.

4.3. Equally important is the obligation to support safe transition into adulthood (under s58-66 Care Act) and to prevent social care needs escalating (under s2 Care Act 2014) or homelessness (and s195 Housing Act 1996) by providing advice and support before eligibility thresholds for statutory interventions are crossed. Given the facilitative nature of the legal duties to safeguard, prevent escalation of needs and assess ongoing health and social care needs it is counterintuitive to construct 'eligibility' for services at too high a level.

4.4. In 2015 the Care Act introduced both a statutory safeguarding duty and an enduring duty to continue to assess[5] where there was ongoing risks of abuse or neglect. Multi-agency responses to risk should be shaped by the 'making safeguarding personal' approach. This requires practitioners to work with the adult at risk to better understand how to reduce the risk of abuse in a way that is meaningful to them. Misperceptions about how these principles and the obligations under the Mental Capacity Act 2005 should be applied, however, persist. Subsequent briefings[6] have made clear that neither the Mental Capacity Act or making safeguarding personal principles absolve practitioners of statutory or professional responsibilities if an adult says they do not want an enquiry to be undertaken. Rather, careful

[3] Holmes and Smale (2018) Mind the Gap:
[4] Bridging the gap: Transitional Safeguarding and the role of social work with adults (publishing.service.gov.uk).
[5] S11(2) Care Act 2015
[6] See 'Myths and Realities' about Making Safeguarding Personal available at **https://www.local.gov.uk/sites/default/files/documents/25.144%20MSP%20Myths_04%20WEB.pdf** and LGA/ADASS 'Making decision on the duty to carry out safeguarding adults enquiries' advice note [July 2019] available at: https://www.adass.org.uk/media/7326/adass-advice-note.pdf

consideration is needed of the circumstances and any inability or coercion that impacts on the person's ability to understand the risk or freely decide to refuse support must be acted on.

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

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

4.6. In addition, Regulations[7] and statutory guidance requires '*effective channels of communication between all local authority staff working with looked-after children, CCGs, NHS England and health service providers, as well as carers – along with clear lines of accountability – are needed to ensure that the health needs (including mental health needs) of looked-after children are met without delay. Looked-after children themselves (according to age and understanding, and capcity) should also have the information they need to make informed decisions about their health and mental health needs. Staff working with looked-after children who are delivering health services should make sure their systems and processes track and focus on meeting each child's physical, emotional and mental health needs without making them feel different... Local authorities, CCGs and NHS England need to reflect the high level of mental health needs amongst looked-after children in their strategic planning of child and adolescent mental health services (CAMHS). They should also plan for effective transition and consider the needs of care leavers.*' [8]

4.7. Whilst the leaving care duties are hugely important, it should be noted that the Supreme Court was explicit that the legal powers afforded local authorities under s23C to provide ongoing support to care leavers do not supplant the legal duties owed under the National Framework for CHC and Care Act to provide ongoing care and support to those reaching 18 with eligible needs. Leaving care powers are *'a far cry from a power to provide the full range of community care services … section 23C(4)(c) is an extremely slender thread on which to hang such extensive and burdensome duties. In my judgment, if Parliament had intended to confer a power of this scope, it would have done so expressly.*'[9] Therefore, as a care leaver with long-term behavioural and mental ill health, Sylvia was eligible for assessment and support through all these statutory processes.

[7] The Care Planning, Placement and Case Review (England) Regulations 2010

[8] P.9 of 'Promoting the health and wellbeing of looked after children' March 2015 from the Dept. for Education and Dept. for Health (this is currently being revised).

[9] 15 LJ Elias [pg52] in R (Cornwall Council) v Secretary of State for health and others [2014] EWCA Civ 12. The Supreme Court, also confirmed that duties (now under the Care Act) provide 'the exclusive statutory basis for securing the long-term care and were not displaced by provisions under the 1989 Act, which are transitional in character.' The Supreme Court concluded s23C powers purpose is 'not to supplant the substantive regime, but to ease the transition (usually) to adult independence.' [pg30 R (Cornwall Council) v Secretary of State for health and others [2015] UKSC 46

4.8. There are three principles for transition set out in the Children Act 1989 guidance for care leavers[10] which should govern practice when talking to the young person and when making any decision about them (p9):

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

4.9. It is the role of the Independent Reviewing Officer (IRO) to ensure that the care plan agreed for the young person considers the young person's views. This includes evaluating the quality of the assessment of the young person's readiness and preparation for any move. Many of Sylvia's moves occurred after her placements gave notice, which compounded agencies' abilities to plan with Sylvia, particularly regarding her transition from care.

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

4.11. An evidence base for Transitional Safeguarding and Safeguarding Adult Reviews has been published[11]. This evidence-base is drawn from recent publications on Transitional Safeguarding[12] [13] and provides a framework for Safeguarding Adults Reviews (SAR) analysis where SARs are about young adults. The framework for analysis invites a further set of questions, namely what has enabled best practice where this is found and what have been the obstacles or barriers to best practice where these are also found. This then informs the structure and content of a SAR about a particular young person, which will have a unique set of circumstances.

4.12. The model comprises four domains. In line with 'Making Safeguarding Personal' principles, the first domain focuses on practice with the individual. The second domain focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with young people with Transitional Safeguarding needs. This model enables exploration of the facilitators and barriers of good practice. The analysis that follows draws on information contained within the chronologies and group discussions during the learning event. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding is situated.

Mental capacity

4.13. The Mental Capacity Act 2005 (MCA) sets out the right of a competent adult to take decisions, and applies to those over the age of 16. There can be a significant tension between the principle under section 1 of the MCA, that the fact a decision may be unwise does not mean that the person lacks the capacity to take that decision, and the duty on a local authority and partners

[10] Department for Education (2010) The Children Act 1989 Guidance and Regulations Volume 3: planning transition to adulthood for care leavers: https://www.gov.uk/government/publications/children-act-1989-transition-to-adulthood-for-care-leavers

[11] Preston-Shoot, M., Cocker, C. and Cooper, A. (2022), "Learning from safeguarding adult reviews about Transitional Safeguarding: building an evidence base", The Journal of Adult Protection, Vol. 24 No. 2, pp. 90-101. https://doi.org/10.1108/JAP-01-2022-0001

[12] Office for the Chief Social Worker and Research in Practice (2021) Bridging the Gap: Transitional Safeguarding and the Role of Social Work with Adults. London: DHSC.

[13] Holmes, D. (2021) Transitional Safeguarding: The Case for Change, Practice, DOI: 10.1080/09503153.2021.1956449

under section 42 of the Care Act 2014 to devise a safeguarding plan for adults with care and support needs who are experiencing abuse or neglect, where they are unable to protect themselves from that abuse. To take a competent decision, an adult must be able to understand information about the decision to be made, retain that information and apply it to the decision-making process, and communicate a decision. Practitioners must ensure they break down the information to be weighed in a manner that will best facilitate this process and consider the person's "executive capacity", which is the ability to implement decisions taken and to deal with the consequences and the impact of someone else's undue influence on the decision-making process.

4.14. Mental capacity assessments should explore rather than simply accept notions of 'lifestyle choice'. This means applying understanding of executive capacity and how adverse childhood experiences, trauma and 'enmeshed' situations can affect decision making. NICE guidance[14] advises assessments should take into account observations of the person's ability to execute decisions in real life situations, highlighting the situational aspect of decision making. This should have been applied throughout the assessment, care planning and provision of support and healthcare to Sylvia. Where there is evidence that outside of an assessment environment the person is not able to understand or weigh up information to enact a decision, this should be thoroughly explored. The presumption of capacity under section 1 of the MCA does not override professional and statutory duties to ensure that young people or adults with care and support needs are safe from abuse, neglect or exploitation. "*There is a difference between someone who has an appreciation of risk and yet goes on to take the risk – albeit unwisely – and someone who… lacked awareness of the risk and sufficient problem-solving ability*." [15]

4.15. Outside of treatment under the MHA, the provision of care and treatment is only lawful if the person receiving the care/treatment has either given capacitated consent or, if the person lacks capacity, acts are done in accordance with the legal obligations under the Mental Capacity Act 2005 and the Human Rights Act 1998. The courts have held:

"*Every adult capable of making decisions has an absolute right to accept or refuse medical treatment, regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. Without consent any invasion of the body, however well-meaning or therapeutic, will be a criminal assault*"[16]

4.16. The principles embedded in s4 MCA require that any decision taken on behalf of a person who lacks capacity to make it, follows the least interventionist approach, and is taken in the person's best interest. This is not just the person's medical best interest, but rather their welfare in the widest possible sense, considering the individual's broader wishes and feelings, values and beliefs. All decisions should follow careful consideration of the individual circumstances of the person and focus on reaching the decision that is right for that person – not what is best for those around them, or what the "reasonable person" would want. The person who lacks capacity to make a decision should still be involved in the decision-making process as far as is possible, and those who know them best should be consulted.

4.17. Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed under the MCA that enables a local authority to authorise a detention of a resident of a care home or patient, who lacks capacity to consent to their care and treatment, in order to keep them safe from harm. Where the person continues to object to the proposed course of action, their advocate or representative should initiate a review or, if necessary, apply to the Court of Protection (CoP) to challenge the decision. However, if this does not happen, the onus will fall on the Best Interests assessor or agencies imposing the deprivation of liberty to seek legal advice with a view to making an application to the CoP for determination of the matter.

[14] NICE (2018) Decision Making and Mental Capacity. London: Overview | Decision-making and mental capacity | Guidance | NICE.
[15] Baker J, *GW v A Local Authority* [2014] EWCOP20, para. 45
[16] Aintree University Hospitals NHS Trust v James [2014] AC 591

Section 117 aftercare, mental health support and transitions

4.18. There are a number of provisions under the Mental Health Act 1983 that enable someone who presents as seriously mentally unwell to be lawfully deprived of their liberty. Of relevance to Sylvia's case, a patient who is already in hospital can be detained under section 5(2) MHA for up to 72 hours, to allow an assessment to be undertaken to determine whether they need to be further detained. A person can be detained for the purpose of assessment for up to 28 days under section 2 MHA if they are suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; and ought to be detained in the interest of his or her own health or safety, or with a view to the protection of others. If they are assessed as needing to remain in hospital for medical treatment, a further application can then be made under s3 MHA. Finally, under s136MHA, a police officer can take a person to a place of safety if they appear to be suffering from a mental disorder and in need of immediate care and control (unless the person is in their own accommodation in which case a warrant must be sought by an AMHP).

4.19. The Mental Health Act 1983 Code of Practice[17] reinforces that when making any decision in relation to care, support of treatment under the Act, clinicians must apply five guiding principles, including using the least restrictive option that maximises independence, empowerment, respect and dignity. The MHA contains mechanisms for a patient subject to detention to be represented by an Independent Mental Health Advocate (IMHA) and request a review before the Mental Health Tribunal (although this does not apply to s5(2)[18]) and provided powers are properly used, treatment and care plans will comply with Article 5 ECHR. Importantly, planning for safe discharge should start as so as the person is admitted to hospital.

4.20. Section 117 of the MHA places an enforceable duty on the ICB and local authority to provide aftercare services to a person who has been detained under sections 3, 37, 45A, 47 or 48 of the MHA on discharge from hospital. An aftercare service is a service provided to meet a need arising from or related to the individual's mental disorder, to treat and prevent a deterioration in their mental disorder, and reduce the risk of the individual being returned to hospital. This can be provided for a broad range of needs arising from the mental disorder, including immediate health and social care needs as well as, for example, employment support, or development of independent living skills. This will include specialist accommodation if this is necessary to meet the person's mental health needs. The ultimate aim is to maintain patients in the community, with as few restrictions as are necessary, wherever possible. It is important to recognise that leaving care duties, where applicable, will run alongside s117 duties and do not displace them – again the '*slender thread'* of leaving care duties is not a substitute for expert support to prevent a relapse in mental health.

4.21. The duty to provide s117 aftercare services is triggered on discharge from hospital, however, discharge planning should begin as soon as the person is detained under section 3, to identify the appropriate aftercare services necessary to meet their needs before they are discharged. If the Responsible Clinician is considering discharge, they should consider whether the person's aftercare needs have been identified and addressed. The individual must be fully involved in any decision-making process with regards to the ending of aftercare, including, if appropriate consultation with their carers and advocate.

4.22. Aftercare should be kept under review to ensure this continues to meet the person's needs and will only end if both the ICB and local authority are satisfied that the person no longer needs this. It cannot be withdrawn simply because someone has been discharged from specialist

[17] Mental Health Act 1983 (publishing.service.gov.uk)
[18] There is also no legal right to an IMHA for people detained under sections 4, 135 and 136 of the Mental Health Act 1983

mental health services, readmitted to hospital or after an arbitrary period. If aftercare is withdrawn, services can be reinstated if it becomes obvious that was premature.

4.23. Adolescence is a period associated with increased rates of psychiatric morbidity, substance misuse and risk-taking behaviours, however, healthcare transition is often inadequately planned and executed. There is a risk of disengagement at this crucial time as a result. 2016 NICE guidance[19] for children also advocates that for all young people in receipt of mental health services, transition planning should start when the young person is 14, with an updated assessment of their needs to ensure a smooth transition to adult services. This further advocates a care planning approach to transfer between services in complex cases. This guidance also requires staff to receive training and know how to assess risk, provide individualised care and make adjustments or adaptations to Health and Social Care processes to enable access and that they have skills to communicate with the young person. The expectation is that those providing care will anticipate and make adjustments to prevent behaviour that challenges or offer psychosocial interventions as a first line treatment for challenging behaviours.

Transition planning: Assessment of need for care and support, SEND duties and Continuing Healthcare

4.24. Section 58 of the Care Act 2014 places a duty on the local authority to carry out a child's needs assessment prior to their 18th birthday, to ensure that careful planning is in place to meet their care and support needs as they transition to the adult legal framework. The Care and Support Statutory guidance[20] sets out that an assessment should be carried out if a young person is 'likely to have needs', not just those needs that will be deemed eligible under the adult statute. This includes care and support that arise from or are related to a physical or mental impairment or illness (including a condition as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury), but not needs caused by other circumstantial factors.

4.25. The guidance also sets out the reciprocal duty for relevant partners to cooperate for the purposes of transitions and paragraph 16.43 states: "*Local authorities should have a clear understanding of their responsibilities, including funding arrangements, for young people and carers who are moving from children's to adult services. Disputes between different departments within a local authority about who is responsible can be time consuming and can sometimes result in disruption to the young person or carer*." The ethos of the Care Act 2014 is that assessments should be needs-led and not restricted by available services. Diagnosis should not act as a barrier to support.

4.26. The National Framework for Continuing Healthcare (CHC) also requires ICBs to have systems in place with local authorities to ensure clinicians are actively involved in transitional planning for anyone with significant health needs who may be eligible for CHC post their 18th birthday. This is relevant to this case because of a specific focus within the CHC Decision Support Tool on challenging behaviours, psychological and emotional needs. Formal screening for CHC eligibility should occur when a young person is 16 and eligibility determined in principle when the young person is 17.[21]

4.27. The Children and Families Act 2014 places duties on the local authority to start planning for young people with Education Health and Care plans (EHCPs) to prepare for adulthood from Year 9, with a particular focus on the young person's ambitions and goals post-16. These duties

[19] Recommendations | Transition from children's to adults' services for young people using health or social care services | Guidance | NICE
[20] Care and support statutory guidance - GOV.UK (www.gov.uk), para. 16.9
[21] See pg331-349 of the National framework for Continuing healthcare available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf

include young people with EHCPs up to the age of 25 if they remain in education. The Special Educational Needs and Disabilities Code of Practice[22] describes the duty on education, health and social care to work together to plan and jointly commission services for these young people, explaining the interface between duties under the Children and Families Act 2014, the Care Act 2014 and the National Health Services Act 2006 for young people with special educational needs or disabilities with or without EHCPs. The Code of Practice sets out:

> *"…local governance arrangements must be in place to ensure clear accountability for commissioning services for children and young people with SEN and disabilities from birth to the age of 25. There must be clear decision-making structures so that partners can agree the changes that joint commissioning will bring in the design of services. This will help ensure that joint commissioning is focused on achieving agreed outcomes. Partners must also be clear about who is responsible for delivering what, who the decision-makers are in education, health and social care, and how partners will hold each other to account in the event of a disagreement. The partners must be able to make a decision on how they will meet the needs of children and young people with SEN or disabilities in every case*." (paragraph 3.25)

Responsibility across boundaries

4.28. At times, the fact that Sylvia moved across local authority boundaries created confusion in respect of who was responsible for taking action to safeguarding or support her. There are two key tests that will apply to different duties for health and social care. Ordinary residence is the area that a person "…*has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration*."[23] However, if the person goes into hospital or NHS accommodation, or is placed by a local authority in specified accommodation (including a care or residential home, supported accommodation or a shared lived scheme), they will be 'deemed' to remain ordinarily resident in the area they were ordinarily resident prior to moving into these placements.[24] Where the person lacks capacity to take a decision where they will live, the 'voluntary' aspect of the test should be disregarded, and instead the facts should be weighed to establish whether "…*the purpose of the residence has a sufficient degree of continuity to be described as settled.*"[25]

4.29. The second relevant test is that of 'physical presence', which means that responsibility will rest with whichever area the person is physically located at the time of an incident or admission.

4.30. Periods when a child is accommodated by the local authority under its duties under the Children Act 1989, the person is in hospital or placed in 'specified accommodation', which will include a specialist residential unit provided under the Care Act 2014 or as part of a package of s117 aftercare, are excluded for the purpose of determining ordinary residence. Although she moved repeatedly to residential units and hospitals in different local authority areas both as a child and an adult, Sylvia remained ordinarily resident in Kingston through the period relevant to this review as the 'deeming' provisions applied to these placements. Whilst some of her missing episodes were lengthy, her specified accommodation always remained open for her return and there was no indication that Sylvia had a clear intention not to return on a permanent basis.

4.31. For clarity:

4.31.1. The local authority which looks after a child or young person will remain responsible for their care wherever they are placed under the Children Act 1989, as well as providing leaving care support until the care leaving turns 25. Consequently Kingston's AfC

[22] SEND_Code_of_Practice_January_2015.pdf (publishing.service.gov.uk)
[23] *Shah v London Borough of Barnet* [1983] 1 All ER 226 (HL)
[24] Section 39 Care Act 2014, the Care and Support (Ordinary Residence) (Specified Accommodation)Regulations 2014 and the Care and Support Statutory Guidance, Chapter 19
[25] Care and Support Statutory Guidance, Chapter 19, para. 19.32

remained responsible for meeting Sylvia's needs as a child as well as ongoing leaving care duties after she turned 18.

4.31.2. The local authority responsible for meeting a person's needs under the Care Act 2014 is where the person is ordinarily resident, unless they have no settled residence, when the test is physical presence, and the local authority carrying out the assessment is responsible for arranging a Care Act advocate to support the individual if they need this to engage with the assessment. Kingston's Adult Social Care were responsible for meeting Sylvia's care and support needs.

4.31.3. The local authority responsible for meeting the person's needs under s117 of the MHA is where the person was ordinarily resident at the time they were detained under the MHA, even if they have subsequently moved to a new area after discharge, so again, Kingston continued to responsible for Sylvia's s117 aftercare. The responsible ICB (or CCG prior to July 2022) will be where the person is registered with a GP practice prior to their detention, and their responsibility will continue until the person is formally discharged from s117 aftercare. Although Sylvia was not provided with a s117 aftercare plan at any time, she was also not discharged from s117. Consequently it appears, presuming that she was registered with a GP near her placement at the time, the North West London CCG in Hounslow is likely to have been responsible for meeting her aftercare duties, although there is no indication they were put on notice of this.

4.31.4. The local authority where the individual is physically present is responsible for organising an Approved Mental Health Practitioner (AMHP) to assess whether to make an application to detain the person under s2 or s3 of the MHA, although in limited circumstances, the AMHP can suggest that another area should do this if they consider this more appropriate. During each of her detentions under the MHA, this will have been the local authority where the hospital was located.

4.31.5. The local authority where the individual is physically present (including temporarily) when an incident that needs to be investigated takes place is responsible for carrying out any safeguarding inquiry under s47 of the Children Act 1989 or safeguarding enquiry under s42 Care Act 2014 and will be responsible for arranging a Care Act advocate to support the individual if they need this to engage with the investigation. Croydon Children's Social Care then Croydon's Safeguarding Adults team, and Bromley's Safeguarding Adults team were responsible for safeguarding enquiries while Sylvia was in their respective areas.

4.31.6. Under the Mental Health Act (s130D) the registered establishment or hospital managers where the individual is detained is responsible for organising an advocate. Where a person is subject to a conditional discharge it is their responsible clinician who must arrange this. Where a person is subject to guardianship the local authority.

4.31.7. The local authority where the individual is ordinarily resident (Kingston) will be responsible for carrying out a Best Interest assessment and authorising a DoLS application under the MCA. Independent Mental Capacity Advocates, appointed in line with legal duties under s35 Mental Capacity Act 2005, can only work with an individual once they have been instructed by an appropriate person/ body. For accommodation decisions and care reviews this is likely to be the local authority responsible for the arrangements. For serious medical treatment decisions this will be a medical practitioner who has responsibility for the person's treatment. For adult protection cases this will be the local authority coordinating the adult protection proceedings. For the IMCA roles in DOLS this will be the Supervisory Body.

5. Analysis of Agencies' Actions

Education and early intervention

5.1. From 2007, the serious concerns about violence within Sylvia's family home were known to professionals and although some steps were taken to address this including moving with her mother and siblings to YMCA accommodation, her parents resumed their relationship. The long-term impact of ongoing exposure to violence in childhood cannot be underestimated and it is not clear what CAMHS support was offered to Sylvia, particularly as her school attendance started to become inconsistent and concerns about her volatility increased. This appears to have been perceived as a behavioural issue as a consequence of boundaries within the home, rather than recognising the early signs of an emerging mental health condition. It may be that earlier therapeutic intervention to meet Sylvia's emotional needs, targeted at the time of the traumas and instability she experienced, could have gone a significant way to mitigate her escalating needs.

5.2. Sylvia was globally delayed and struggled in school. She had been accidentally dropped on her head as a baby and her family speculated that this may have caused a traumatic brain injury, a concern later confirmed through a Behavioural Assessment of Dysexecutive Syndrome when Sylvia was an adult. However, because she refused to attend assessments that were arranged during her childhood, for example for Attention Deficit Hyperactivity Disorder, she was never formally diagnosed with any learning needs at the time. Although the professional and educational response to children's needs should be needs-led rather than diagnosis-led, a formal diagnosis would have ensured that Sylvia had a statement of special educational needs (now replaced by an Education Health and Care Plan) to ensure that the educational support she required was provided from an early age. Leaders in Kingston were confident that systems were now in place to ensure that similar organic issues were assessed at an early age so that any necessary support could be provided.

5.3. Certainly at the time Sylvia was first permanently excluded from school, intensive, proactive therapeutic support was needed, not only to address her educational needs, but to address the underlying emotional and psychological difficulties she was experiencing, which underlay the behaviours she was exhibiting. During this period the family was experiencing considerable instability, with the children moving multiple times both to flee domestic violence and due to an eviction. Despite the fact Sylvia was already struggling to engage in education, she was expected to travel independently at the age of 12 to attend tuition sessions. It is now recognised that a lack of a safe and stable home environment, past experience of abuse, disengagement from education and social isolation are all key vulnerabilities and risk factors in respect of child sexual and criminal exploitation.[26] Had an escort been arranged to support Sylvia's travel from her family's temporary accommodation across the borough to the location of her tuition service, she may not have been exposed to the adult man she met on a bus, who introduced her to cannabis. Further, a positive friendship group is developmentally very important and in the isolation of one-to-one tuition, Sylvia sought friendships where she could.

5.4. From this time, Sylvia was rarely meaningfully engaged in education. There were considerable delays noted in the timeline once decisions were made within the professional network for alternative educational provision, and it then being available. An example of this is a school was identified for Sylvia to attend in May 2014 but she did not begin until October 2014. This rapidly broke down with a series of fixed term exclusions. The school complied with its duties under the Education Act 1996 by arranging tuition from May 2015, but the family was evicted from their tenancy during this period and Sylvia's attendance at tuition was minimal. This improved while she was staying with her friend's family in a so called 'private fostering' arrangement, but the

[26] Characteristics of group-based child sexual exploitation in the community: literature review (accessible version) - GOV.UK (www.gov.uk)

exploitation risks to Sylvia sharply increased at the same time. Once she was subject of a care order, Sylviah's educational needs were met through her placements with the oversight of the Virtual School, however by this time Sylvia had been out of mainstream school provision for some time and the established patterns in her behaviours around schooling and education were then difficult to change.

5.5. Leaders at AfC noted that since [date?], they have established an Emotional Health Service for young people across Kingston and their partner boroughs, linked to early family systemic practitioners, clinical psychologists and CAMHS. A young person with Sylvia's complex needs would now be referred to this service at an early stage and may have provided additional support she needed.

5.6. Central to the early response to Sylvia's escalating needs was her youth club worker, who was identified repeatedly by different practitioners during learning events as being an anchor, offering outstanding, proactive, consistent support to Sylvia from the age of 11. Sylvia's family also spoke in glowing terms about the youth worker, who they felt knew Sylvia best. When Sylvia first went into care they lost touch for a short period, as the worker had moved to a new job. However, Sylvia asked her social worker to find the youth worker and from that time, she always bent over backwards to be present at meetings, including when Sylvia was later placed out of area, even while she was in Birmingham or Wales. Her commitment, and the difference her kindness made to Sylvia's experience of professionals was truly inspirational and was exceptional practice.

5.7. The value of this relationship was clearly recognised by the wider professional network, who engaged with Sylvia's identified 'trusted professional' as a valued member. Relational social work engages with the individual's existing support networks to enhance their resilience and problem-solving capacity, and can promote social inclusion.[27] This model of developing a more effective team around the person needed to be used more consistently as Sylvia moved between different settings and in particular, when she was detained in hospital.

Systems finding

5.8. Knowledge across partner agencies of the multiple traumas Sylvia had experienced in childhood including a head injury, exposure to physical and emotional abuse, insecure accommodation should have resulted in proactive early intervention and practical support to ensure that she was able to engage in education. Better understanding of trauma-informed care and development of a specialist Emotional Health Service are likely to have provided better support to Sylvia and embedding use of relational practice across partner agencies would have created greater resilience across support networks.

Private fostering arrangements

5.9. Sylvia's family noted that the period she spent living with a friend's parents marked a significant increase in the level of exploitation she experienced, as the limited boundaries in the home meant that Sylvia was able to spend lengthy periods with older men. The friend's parents were identified by AfC as 'private foster carers', and child in need visits were carried out, but AfC records noted that one of the carers had received a custodial sentence for violent offences in 2008 and a legal planning meeting was convened, which noted that it was unlikely that the carers would 'pass a viability assessment' to become full-time carers. Although advised that after 28 days this would meet the definition of a private fostering arrangement, a referral was not made for a private fostering assessment in accordance with legal requirements.[28] AfC

[27] Folgheraiter, F. (2007). Relational Social Work: Principles and Practices. *Social Policy and Society, 6(2),* 265-274

[28] Section 66 of the Children Act 1989 and the Children (Private Arrangements for Fostering) Regulations 2005

recorded that Sylvia's mother agreed to this arrangement, however she reports that she was not in agreement, as a member of the household had recently been released from prison and Sylvia's mother and siblings reported that the family were harassing them for money.

5.10. In any event, the fact that a private fostering assessment was not completed in circumstances where it was known that one of the private foster carers had a recent conviction for violence was a serious oversight. The legal duty on a local authority to carry out a private fostering assessment reflects the significant vulnerability of children in such arrangements, and requires a specific regime of home visits by a social worker, who must see the child alone. Further, the circumstances of this arrangement indicate that it was actually a fostering arrangement made by the local authority, in light of the significant pressure on Sylvia's mother to accept the arrangement, as a consequence of the allegations of physical abuse against her father. The carer's criminal past and child protection concerns identified in respect of their own child may have meant that the couple were unlikely to be approved as temporary local authority foster carers ,[29] but equally should not have been allowed to continue as private foster carers.

5.11. In 2012, Kingston's Children's Social Care's child protection arrangements were found to be 'inadequate' during an Ofsted inspection, although arrangements for responding to domestic violence within the borough, such as the multi-agency risk assessment conference (MARAC) were found to be generally strong.[30] However, following the restructure of Kingston's children's services through the establishment of Achieving for Children, the subsequent Ofsted inspection in 2015 found that there had been a significant improvement in services for children in Kingston, rating it 'good' overall.[31] Inspectors identified a small number of unassessed private fostering arrangements, primarily due to an overreliance on those carers seeking court orders, but did not identify any children at risk as a consequence of this.

5.12. In Sylvia's case, the decision to allow this arrangement to continue as an unregulated placement may have been well-intentioned in the context of the safeguarding concerns in respect of her father, but the absence of a clear framework of assessment and visiting limited opportunities to mitigate some of the identified risks and, in the absence of boundaries, Sylvia's exploitation and substance use continued to escalate.

Systems finding

5.13. Although AfC practitioners were able to identify a private fostering arrangement, the rationale for compliance with the legislative framework was not clearly understood, limiting the opportunities to mitigate the resulting risks.

Response to exploitation

5.14. Nationally and locally, knowledge of how to recognise and respond to child sexual and criminal exploitation has evolved enormously since 2013. Although the Government had published statutory guidance on children missing from care and an action plan in respect of child sexual exploitation (CSE) in 2009, recognition of the scale and seriousness of this insidious form of abuse grew through a series of well-publicised cases across areas including Oldham, Rochdale, Manchester and Derby, culminating in the Rotherham scandal and resulting public inquiry in 2014.[32] The changing national recognition of CSE is reflected in the emphasis placed on this during Ofsted inspections over this period – in 2012 Kingston's Ofsted inspection only once mentioned CSE, but its 2015 inspection detailed the good practice AfC had developed in this

[29] Regulation 24, The Care Planning, Placement and Case Review (England) Regulations 2010 (legislation.gov.uk)

[30] Template Report template (ofsted.gov.uk)

[31] Kingston Upon Thames - draft report (ofsted.gov.uk)

[32] independent-inquiry-into-child-sexual-exploitation-in-rotherham

area, including comprehensive training for staff, direct work with young people at risk and the introduction of an effective Multi-Agency Sexual Exploitation Panel in 2014.

5.15. Recognition of the need to tackle criminal exploitation and the exploitation of vulnerable adults have also gained national impetus in recent years, albeit lagging behind CSE. Progress in this area has been supported by the strengthening of adult safeguarding duties under the Care Act 2014, together with developments in case law under the inherent jurisdiction of the High Court, which has been utilised to safeguard vulnerable adults in exceptional circumstances. However, the tension between safeguarding duties and the rights of adults to take decisions in respect of their private lives, even where those decisions are harmful, and the complex legal framework for intervention results in a marked inconsistency between the approach to safeguarding as exploited children reach adulthood.

5.16. By 2015, these developments translated into clear and strategic multi-agency responses to the escalating harm Sylvia was experiencing through CSE. AfC, the police and the wider professionals network worked closely and collaboratively in respect of the increasing length and duration of Sylvia's missing episodes. Both Sylvia's family and the practitioners at the learning events commented positively on the strong teamwork between agencies. Child Abduction Warning Notices (CAWN) are an intervention tool used by police and local authorities to inform the subject of the CAWN that if they continue to associate with a young person, they may commit an offence. Too often, the purpose of such notices is undermined when no action is taken as a consequence of further offences, however police showed good practice in prosecuting Adult A when he breached the CAWN. Likewise, when Sylvia turned up at the address of Adult C after he and his mother had been served with CAWNs, they called the police to notify them she was there, demonstrating the effectiveness of this disruption tool.

5.17. A CSE protocol had been launched to frontline officers which improved their response to young people in custody, seeing them as a child first. Constables were therefore consistent in ensuring that specialist CSE officers were notified when Sylvia was located. However, Sylvia's violence towards police officers during her interactions with them resulted in her being arrested on several occasions and this toxic situation limited the opportunities for specialist CSE officers to build a relationship of trust with her to facilitate further investigations.

5.18. Practice standards for young people with substance misuse problems,[33] require that *'substance misuse services, youth offending, mental health and children's services must all work together to ensure* (specialist support that tackles drug and alcohol misuse) *is in place*.' Due to the limited scope of this review, it is not clear what services were offered to address Sylvia's emerging substance use as this began to become known to practitioners, but this should have been a key element of any plan to disrupt the exploitation Sylvia was experiencing.

5.19. Officers acknowledged that at the time they were involved with Sylvia, understanding of the coercive nature of criminal exploitation was not well embedded across the Metropolitan police, and consideration of the issue was generally limited to county lines. Sylvia was involved in shoplifting and burglary with older men, but this was not seen through the prism of criminal exploitation. Consequently, Sylvia was charged with these offences. Further improvements have since been introduced, including a triaging process for young people who are arrested, to ensure that any vulnerabilities are identified and appropriate adults made available to support them. The Youth Diversion Service is used when young people first start coming to police attention, in an effort to ensure they do not become entrenched in the criminal justice system and can access the support or substance misuse services they need.

[33] Devised by the Royal College of General Practitioners, Alcohol Concern, DrugScope and Royal College of Psychiatrists Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/child-and-adolescent-community-teams-cahms/practice-standards-for-young-people-with-substance-misuse-problems.pdf?sfvrsn=1f333692_2

5.20. Leaders raised concern that when new officers joined the police force, there was no consistent induction or robust training around safeguarding, exploitation or coercion beyond very basic safeguarding, which did not include advice around how to process a young person in custody. While recruits learned on the job, this could result in inconsistencies across teams and Borough Command Units.

5.21. After Sylvia came into care, practitioners noted that the police response to exploitation became more inconsistent, depending on which area she was placed. Limited specialist placements within the vicinity of Kingston meant that Sylvia had to be placed at a distance in order to meet her complex needs. Unfortunately, this had the consequence of disrupting Sylvia's existing support networks and made effective co-working with police to disrupt exploitation more difficult, as her social workers did not have an established relationship with the police in the area of her placement. In total, Sylvia came to the attention of Metropolitan police on 127 occasions, including 75 missing episodes, but further indicants may have occurred when she was placed outside London that were not referred to the Met.

Systems finding

5.22. The multi-agency response to child sexual exploitation was proactive and appropriate steps were taken to disrupt the perpetrators of abuse. However, knowledge of criminal exploitation was less well embedded and partners acknowledge that safeguarding training for some agencies does not fully equip staff for the challenges of this complex issue.

Discharge planning and s117 aftercare

5.23. Although Sylvia's presentation leading to and during her time in care indicated that she required significant therapeutic input to address her traumatic childhood experiences and may have had emerging mental health needs, her detention under the Mental Health Act as a consequence of drug-induced psychosis when she was 16 came as a shock to her family and all those working with her. She never fully recovered from this catastrophic incident and in addition to the changes to her personality and cognitive abilities, her ongoing detentions under the MHA were both frequent and lengthy, particularly for one so young. She was detained under section 3 MHA for 6 months when she was 16 years old, 7 months when she was 17, 6 weeks at 18, then when she was 19 was detained for 3 weeks under section 2 in May, before her final 3 week detention before she died in September. Despite these frequent relapses, Sylvia was not provided with a s117 aftercare plan by the local authority or CCG at any stage. This resulted in 'system responses' that were heavily reliant on short-term crisis provision with little scope for innovation or flexibility to plan to preventatively manage Sylvia's mental health needs.

5.24. There was no evidence of a s117 aftercare plan being produced when Sylvia was discharged from her original detention in 2018. Her youth worker reported that she had presented as being quite well during this discharge and she moved to a high support semi-independent unit in Kingston's area on discharge. It may be that the 'rule of optimism' meant that professionals took the view that this had been a one-off reaction to Spice and that she was unlikely to relapse, so an aftercare plan was not considered necessary. However she immediately started having a very high level of missing episodes, so the placement gave notice and she moved to a placement in Bracknell, before being detained again under the MHA in December 2018.

5.25. Planning for Sylvia's discharge started in January 2019 and there was good communication between SLaM and AfC at this time. Sylvia was referred to the Bracknell Early Intervention for Psychosis team as this was local to her placement prior to detention, but in April Sylvia's previous placement gave notice. A presumption was made by staff at SLaM that as Sylvia was subject of a care order, AfC would be solely responsible for identifying and funding her placement, without co-production by the CCG. SLaM records indicate that the Responsible Clinician, who is responsible for ensuring safe discharge arrangements were in place, "*reminded*

the local authority of their duty under s117 to provide a supported placement", advising that she would need a high level of support. Only the hospital, AfC and Sylvia's mother attended the discharge meeting, no representative from CAMHS or CMHT was present. Practitioners from AfC at the learning event commented that at that time, their knowledge of the MHA and s117 were quite limited and it would not have occurred to them to challenge clinicians from a Tier 4 CAMHS unit on this issue.

5.26. Unsurprisingly, due to the paucity of specialist accommodation that can meet the needs of young people with a mental health diagnosis, history of physical aggression to staff and risk involving exploitation, AfC struggled to find a placement for Sylvia. Given that Sylvia had relapsed to the extent she had to be detained again under the MHA within 6 months of her previous discharge, it seems quite clear that a more specialist provision was required to prevent further relapse, and one which would need to be jointly commissioned by the ICB and local authority. This would actually have simplified the issue of which ICB was responsible for meeting Sylvia's aftercare needs, as this would be the CCG where she had been registered with a GP prior to her admission, regardless of where she was placed.

5.27. The national pressures on availability of Tier 4 CAMHS beds, together with SLaM's perception that AfC were delaying Sylvia's discharge by failing to find a placement meant that they discharged Sylvia from s3 without consultation with AFC as her corporate parents, but she agreed to remain in hospital voluntarily until 24 July 2019 while AfC scrambled to find an available placement that would accept a young person with such complex needs. However, this was in an area of Croydon where her 'boyfriend', Adult C lived.

5.28. Partners recognised that the impact of austerity locally had resulted in a lack of investment in community substance misuse and mental health services, particularly those that enable early intervention or preventative approaches. Further, a national shortage of specialist residential placements placed enormous pressure on agencies trying to identify placements and this had worsened significantly since 2019. Practitioners at the learning event expressed that the requirement for all residential placements to go through a brokerage system, regardless of the complexity of the young person's needs could be a serious hindrance to identifying a placement with the capacity to meet those needs. Children's social care expressed frustration at a lack of CAMHS advice around the type of placement that should be sought; CAMHS staff expressed frustration at not being permitted to interfere with formal brokerage systems by providing advice.

5.29. Although a referral was made for CAMHS to support Sylvia on discharge from hospital, she was initially unwilling to engage with this and although the team around the person collaborated to overcome this, during this period of delay, Sylvia was not receiving mental health support and the harm she was experiencing rapidly escalated. SLaM staff acknowledged that given the proximity of her 18th birthday, a direct referral should have been made to the CMHT rather than leaving this for CAMHS to progress once Sylvia was in the community.

5.30. Once Sylvia had moved to her placement in Croydon, local police quickly identified that Sylvia, who looked very young, was regularly being seen speaking to street drinkers and raised concern with both AfC and the placement that the location was not suitable for a young person with a known vulnerability in respect of substance misuse, as the area was known to be a hotspot for hard drug use. Sylvia became fixated on obtaining drugs and started begging, telling her family that she was frightened of people in the local area as she was regularly being threatened about being beaten up over money. Her physical presentation started to deteriorate, becoming unkempt and unhygienic and she noticeably lost weight.

5.31. Sylvia wanted to move into semi-independent accommodation and opposed living anywhere more restrictive, but it does not appear that prior to her discharge in July 2019, assessments were carried out of her mental capacity to make the decisions necessary to manage her medication, sustain semi-independent accommodation or keep herself safe for risks in the

community. Nor was a community treatment order considered, which could have provided arrangements to support Sylvia's concordance with prescriptions. Although Sylvia experienced several mental health relapses over the following two years, it also does not appear that Kingston's adult mental health team or the CCG revisited the issue of s117 aftercare.

Systems finding

5.32. Section 117 aftercare duties were poorly understood by both Health and Social Care partners, resulting in an overreliance on Children Act, then Care Act duties to meet Sylvia's increasingly complex mental health needs, which failed to mitigate her risk of relapse. Pressures on mental health beds resulted in a pressure to discharge Sylvia without a sufficiently detailed or coherent discharge plan and other legal options, such as community treatment orders and/or options under the Mental Capacity Act were not considered prior to discharge, or in a timely way once it became clear that the placement was not able to safely manage Sylvia's needs.

Transition to adulthood

5.33. The intensely supportive framework governing the professional response to safeguarding risks to a child, predicated on prevention of harm, differs from the adult framework which starts from a presumption of capacity and focusses on mitigating risk of abuse or neglect in a way that empowers the individual. This legal transition occurs instantaneously, on the day a young person turns 18. However, emotional maturity and life skills do not develop overnight and for young people such as Sylvia, who have experienced multiple childhood traumas in addition to underlying learning disabilities and/or mental health conditions, their development may be very significantly delayed. The legal framework is therefore designed to ensure that careful forward planning takes place across relevant statutory partners in anticipation of this obvious deadline, with a variety of additional duties and powers that facilitate a more fluid approach to meet the needs of people with additional needs and vulnerabilities. Despite this, misunderstandings in respect of mental capacity and a rigid application of eligibility criteria for individual services can results in a very dangerous 'cliff-edge' in respect of how their needs are met as an adult.

5.34. Despite the complexity of Sylvia's case, transition planning for adulthood took place very late. AfC's Child Looked After team referred her case to the Leaving Care team to start pathway planning in May 2019, 4 months before her 18th birthday, when pathway planning should start from the age of 16. However, there were good reasons for this, Sylvia's risk profile, her detention under the MHA and the difficulties in identifying a placement for her on discharge meant that this was an extremely complex case that needed to be managed by a social worker, and most personal advisers, though highly skilled, are not qualified social workers. Further, given Sylvia's fluctuating mental health, maintaining a trusted relationship with her allocated social worker was important, and good practice. Once allocated, the pathway adviser co-worked the case with the social worker for a period of time, providing an opportunity for her to build a relationship with Sylvia over time with the support of the social worker, which again was good, relational practice.

5.35. Kingston Adult Mental Health Social Care team started co-working the case with AfC in July 2019, 2 months before Sylvia turned 18, and an assessment of Sylvia's care and support needs was only completed a week before her birthday. While her long-term needs may not have been wholly clear while she was continuing to undergo treatment for her psychosis, given that this was her second detention under the MHA, it was very clear that she would have eligible needs that would be complex to plan for. Although ASC agreed to continue to fund Sylvia's placement so that she would have continuity of care post-18, this assessment process should have started at a much earlier stage and may have facilitated consideration of a much broader range of potential placements to meet Sylvia's needs.

5.36. Finally, Sylvia was only referred to Adult Mental Health Services 8 weeks before her 18th birthday, despite her unquestionably complex mental health needs which clearly required a service. As a consequence of the lengthy waiting list for AMHS, this meant that Sylvia was not allocated a care co-ordinator for over 6 months and while her medication continued to be provided by CAMHS, she did not receive a proactive mental health service during this period. This was particularly detrimental as she did not have an opportunity to build a relationship with her care coordinator before the first Covid-19 lockdown, a situation which Sylvia's mother reported to have had a very serious impact on her mental health.

5.37. Given that Sylvia had a diagnosis of schizophrenia and already had two lengthy periods of detention under s3 of the MHA for psychosis before turning 18, this was a very significant failure. It is critically important that young people in high-risk cohorts are able to access a quality community mental health service without delay when they turn 18. The fact that Sylvia's placement was only identified in July and ASC confirmed in September that they would continue to fund this post-18 may have contributed to this. Because it was not recognised that Sylvia was entitled to s117 aftercare, the ICB where Sylvia was resident on her 18th birthday would be responsible for arranging adult community mental health services. This situation seriously disadvantages care experienced young people, who are often required to move placement frequently in their late adolescence and for whom there can be real uncertainty about where they will live post-18, particularly if their needs are escalating during this period. Given the intense vulnerability of this cohort, who are likely to have experienced significant childhood traumas, it is vital that the ICB has a protocol in place to ensure that care experienced young people are not further prejudiced.

5.38. Guidance recommends integrated commissioning between children's and adult mental health services that provides a quality transitions service to the cohort of young people up to the age of 25 who have risk factors with multiple poor outcomes, symptoms which do not meet a diagnostic threshold but are at risk of developing a mental disorder, and those with undiagnosed and unmet needs, particularly those whose needs become more acute as family, educational and other supports diminish.[34] This recognises that "*intervening early at the onset of mental illness improves prognosis, reduces future demand on mental health services and leads to better outcomes for patients*."

5.39. Practitioners discussed the difference in the approaches by the respective SAB areas in ensuring that robust planning took place in a timely way to assess and meet the spectrum of needs for young people transitioning to adulthood. Croydon had introduced a separate transitions team to meet the needs of all young people with care and support needs, to replace the previous specialist learning disability service. Efforts were underway to establish a mental health protocol to ensure a clear transition pathway was available to ensure young people with mental health needs received specialist assessments. Kingston had a multi-disciplinary Transitions Panel coordinated by its Adult Social care department, and each young person who was likely to have care and support needs was referred to this between the age of 16-17, to ensure they have a clear pathway to adulthood.

5.40. One challenge that both areas identified was a problem in securing an adult mental health care coordinator for young people who are discharged from a Tier 4 CAMHS unit shortly before their 18th birthday. The requirement to transfer from a CAMHS to a CMHT care coordinator resulted in serious delays in securing any proactive or therapeutic provision for this vulnerable cohort of young people. These difficulties were exacerbated when cross-border placements were involved. Practitioners reported a marked improvement in the mental health support Sylvia received once her care coordinator was allocated. In every case where a young person is subject of the Care Programme Approach, a named adults' care coordinator should be allocated

[34] Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services - February 2013

prior to their 18th birthday – this date does not come as a surprise to the professional network and there should be no excuse for being unable to plan for this, when a care coordinator would always be allocated before someone over the age of 18 is discharged from s3.

5.41. It is very positive that in the past 6 months, in response to another SAR,[35] the ICB has introduced a transitions' lead for Croydon's CAMHS and two transitions leads for Southwark to improve transition planning for young people who are likely to require an adult mental health service post-18. However, this presents as an enormous task for a single practitioner in Croydon, however experienced, given the increasing numbers of young people with very complex mental health diagnoses across the UK and locally, requiring transition planning to start at an earlier stage to ensure each young person receives a continuous mental health service as they turn 18. Ideally, the ICB would consider expansion of existing transitional mental health services, such as the early intervention service that has been introduced for young people with a dual diagnosis up to the age of 25. This would recognise the continuum of maturity, capacity and support needs to bridge the gap into adulthood and could reduce future need by mitigating escalating needs during this sensitive developmental period.

Systems finding

5.42. Achieving for Children provided good quality, person-centred support to Sylvia both as a child and a young adult, in accordance with their duties under the Children Act 1989. However, transition planning across the spectrum of duties owed to Sylvia by different agencies was not robust or timely and lacked the necessary detail to effectively plan to meet Sylvia's complex needs post-18, particularly in respect of her mental health needs. Due to a combination of service pressures and an assumption that AfC would fill the gap, mental health services failed to prioritise Sylvia's case or provide a proactive service, waiting for crisis or relapse into psychosis before offering a service. Agencies did not robustly challenge poor planning or decisions by other organisations not to offer a service, or hold each other sufficiently to account.

Managing multiple risks

5.43. As set out above, it was immediately obvious that the exploitation and harm Sylvia was experiencing in the placement in Croydon rapidly escalated from July 2019, due to the location and lack of enforceable boundaries in the absence of orders authorising the deprivation of her liberty. Legal advice should have been urgently sought in respect of what legal options were available to protect her. Although practitioners reported making enquiries about alternative options, it was not always clear who should be taking a lead and responses were often not received. Consideration was given to a referral to the National Referral Mechanism, but Sylvia refused to consent to this, so only a notification could be sent. She was referred to MARAC and MARVE panels to secure a multi-agency approach to this abuse, however, partner agencies struggled to address the ongoing harm that Sylvia was experiencing through substance misuse and exploitation. AfC staff described the struggle to engage with Sylvia during this period, jumping in the car to drive across London to meet her if family or other professionals spotted her.

5.44. This was doubtless exacerbated by the challenges of national lockdown in March 2020 as a consequence of the Covid-19 pandemic. The national lockdown significantly limited professional oversight, as national guidance prevented face-to-face contact and talking therapies. Existing challenges in sourcing specialist placements were greatly heightened, as households could not mix and the laudable 'Everyone In' policy placed further pressure on beds. Throughout this period there was widespread concern about the impact that the Covid-19 pandemic and lockdown measures would have on mental health and by May 2020 there was a significant rise

[35] Madeleine Final Report (croydonsab.co.uk)

in patients accessing secondary mental health services needing urgent and emergency mental health care.[36]

5.45. There were two significant 'breakthroughs' that enabled practitioners to strengthen their safeguarding response for Sylvia. Firstly, in November 2020 a Behavioural Assessment of Dysexecutive Syndrome assessment found that Sylvia's frontal lobe damage adversely affected her executive functioning, supporting a more nuanced approach to assessing Sylvia's capacity in respect of decisions around her accommodation and risk management. Secondly, a placement was finally identified for Sylvia in Bromley, months after her existing placement had given notice. However, Sylvia refused to move so a professionals meeting was convened in January 2021 and legal advice sought in respect of legal options to compel this move. This resulted in an application being made to the Court of Protection on 15 February 2021, for an order authorising Sylvia's placement move and deprivation of liberty. Once these options were identified, there was real urgency on the part of all agencies to seize on these opportunities to positively intervene to protect Sylvia, with a collaborative approach to building the evidence base to secure the orders sought and making detailed arrangements to satisfy the court that these measures were necessary and proportionate to the risks she faced.

5.46. The NWG Network's comprehensive briefing on disruption of exploitation[37] sets out the legal options available to all safeguarding partner agencies. This could form the basis of any induction programme for practitioners most likely to come into contact with adults at risk of exploitation, e.g. police, social care, A&E staff, safeguarding leads in health etc. Any training programme would need to be supported with a clear policy framework for multi-agency decision making which encourages contingency planning and escalation. Above all, practitioners need time and, if necessary, access to additional resources to explore available legal options to disrupt abuse and provide support.

5.47. There was excellent practice by bank staff on two occasions in June and July 2021 when Sylvia was accompanied by men to withdraw money: staff identified that Sylvia may have been at risk of financial exploitation, spoke with her alone and contacted the police. This reflects work that has been undertaken by UK Finance to develop a voluntary Financial Abuse Code of Practice[38] that has been adopted by a number of leading high street banks and building societies to improve recognition of and response to signs of financial exploitation or abuse for their customers. However, the police officers who spoke with Sylvia at the bank assessed that she was presenting calmly without obvious signs of mental illness or distress and was clear that she was withdrawing the funds of her own volition. Consequently, they did not consider that she needed to be taken to a place of safety under s136 MHA and were not able to return her to hospital despite having been reported missing. Kingston's ASC responded appropriately, promptly seeking a collection order from the High Court to empower the police to search for Sylvia and return her to hospital when located.

5.48. Despite her very complex needs and chaotic presentation, her family, youth worker and staff from AfC commented that when agencies recognised that Sylvia needed time and adjustments to usual practice, she could develop positive relationships with individual practitioners, although this would not necessarily transfer to a new staff member allocated. There is an urgent need for greater flexibility from services so that support could be more holistic, an approach that requires generous leadership and, in some cases, additional resource. It is likely that Sylvia could have been supported to make safer decisions, but because of the longitudinal nature of the abuse she suffered and because her experience of statutory interventions to date could be predicated on control, she needed time to understand information about the complex nature of the risks

[36] Nuffield Trust Quality Watch blog, published 30.11.20 available at: https://www.nuffieldtrust.org.uk/news-item/what-impact-has-covid-19-had-on-mental-health-services
[37] Available at: https://nwgnetwork.org/wp-content/uploads/2019/10/NWG-Disruption-Toolkit-3.pdf
[38] Financial-Abuse-Code-of-Practice.pdf (ukfinance.org.uk)

associated with her survival strategy of addiction. It is a fundamental principle of the Mental Capacity Act 2005 that, when assessing whether someone has capacity, they are given time and information in a manner they can understand. For some, including Sylvia, this will likely require they first address the 'normalisation' of abuse and the impact of trauma. NHS England and NHS Improvement published guidance on commissioning effective trauma informed care for women, which includes examples of commissioned services,[39] recommending services are commissioned to enable flexibility for practitioners, so they adapt their 'usual offer' to take into account the prevalence of trauma and likely long-term effects on survivors.

Systems finding

5.49. There were gaps in legal literacy across the safeguarding partnership, in particular in respect of options available to other agencies, impacting on the range and timeliness of the options that were considered in respect of safeguarding Sylvia. These need addressing.

S17 leave and risk management

5.50. When Sylvia was detained under section 2 of the MHA in August 2021, she was not allowed to leave the ward due to the identified risk that she was likely to abscond again. She was constantly agitated, asking staff to be allowed to go out to smoke or get money for cigarettes. There is a balance to be struck when taking a decision to grant section 17 leave to a patient detained under the MHA. Patients cannot be detained ad infinitum, and as their mental health condition starts to improve, it is necessary for clinicians to test how they will cope with periods of leave in anticipation of eventual discharge. Hospital staff showed good practice by consulting with AfC and Kingston ASC before granting leave and although AfC had previously expressed concern about the risk of Sylvia absconding and that any risk management plan would need to be very thorough, no response was received to the ward's email on this occasion. ASC agreed in an email to leave being granted. However, Sylvia's mother was explicit in her warnings that Sylvia's fixation on accessing her bank account was due to her determination to obtain drugs and that if she was able to access money or contact her associates, she would abscond at the first opportunity. This was evidenced by her very recent, lengthy missing episode. The fact that ASC's agreement to a trial of s17 leave was given greater weight that the concerns raised by her mother of the social worker from AfC demonstrated a lack of parity of esteem.

5.51. In the context of a stuffy ward with locked windows in the height of summer, doctors considered that on balance, the impact on Sylvia's mental state of not getting any fresh air was disproportionate. Sylvia was initially allowed leave within the hospital grounds escorted by two staff members, but because she was compliant for the first few days, her consultant decided that her escort could be reduced to one member of staff. However, hospital policy sets out that although decisions to allow s17 leave are taken by the responsible clinician in accordance with the statutory requirements, nursing staff are able to override this based on the individual's presentation at the point they are due to take leave, either by cancelling the leave or increasing the level of supervision. In Sylvia's case, the ward matron took a decision that she should remain under double escort on hospital grounds as she appeared agitated on the day. This policy, and the matron's decision, were good practice.

5.52. However, there was a fundamental flaw in the risk management plan for this leave, which was well known to ward staff. Although there is a wall around the hospital grounds, the gates at the entrances are not locked, to allow staff and visitors to come and go freely. Hospital staff are able to restrain a patient who is attempting to abscond while on hospital grounds, but as soon as they exit the grounds, staff are unable to restrain them and must rely on police to return the person. Most missing person reports are made through 101, and waiting times for calls to be

[39] See 'Engaging with Complexity: Providing effective trauma-informed care for women' by the Centre for Mental Health available at: https://www.mentalhealth.org.uk/sites/default/files/Engaging_With_Complexity..pdf

answered can exceed an hour. Even when a 999 call is made and police grade this as high risk, the police response may not be immediate as it is dependent on the availability of officers.

5.53. More critically, given the circumstances of Sylvia leaving the grounds, police were very unlikely to grade her as a high-risk missing person. There had been one incident where practitioners had held concerns Sylvia may be attempting suicide when she tried to jump in the canal, but she had not self-harmed while in hospital or expressed any intention of doing so. The identified risks for Sylvia at this point related to the likelihood she would take drugs or experience abuse, which are undoubtedly serious given her vulnerability, but would not warrant a blue light response.

5.54. Although the hospital's safeguarding lead expressed concern that ward staff had not followed their internal protocol by contacting 999 when Sylvia absconded, the ward's response was predicated on their knowledge of the police response, as it is relatively common for detained patients to abscond from the ward. It is essential that both senior leaders and responsible clinicians have a shared understanding of the realistic police response, so that their own risk management plans are also based in reality.

5.55. Senior police officers expressed concern that the mental health patients were allowed s17 leave without adequate risk management plans in place, creating a high-risk situation in circumstances that could have been reasonably foreseen. They reported frequent calls from health or social care partners asking them to manage the risk because partners were not complying with their own legal duties in respect of safeguarding and safety planning. This was placing an enormous strain on limited police resources.

5.56. Shared understanding of the criteria the police will apply when grading missing episodes can manage clinicians' expectations of the police response, so that proportionate risk management plans can be implemented by the agency/s best placed to action these. As an example, the Affinity Protocol is a protocol developed in partnership between the Metropolitan Police, NHS trusts and hospitals to achieve a clearer mutual understanding of each other's responsibilities and ensure a sustainable joint responsibility in respect to people missing from mental health services. The Protocol seeks to address reoccurring missing episodes, problematic volume and reporting approaches through effective partnership working and problem solving. This will ensure that police resources are available to provide an urgent response in cases that are assessed as high risk.

Systems finding

5.57. Too much reliance was placed on the police to manage the identified risks in respect of Sylvia absconding from hospital, without adequate understanding of how information was held and decisions would be weighed in order to identify the response. Where s17 leave is being considered, NHS Trusts must ensure that realistic risk management plans are used to mitigate risk.

6. Recommendations Emerging from this Review

Direct work with young people

Recommendation 1: The Children's and Adult Social Care departments for each partner SAB should introduce contextual risk assessments when placing children or adults with care and support needs who are known to be at risk of sexual or criminal exploitation or substance misuse. Proactive risk management arrangements should be used for cases where individuals with multi-agency involvement are placed, including temporarily, in accommodation which is unsuitable for their specific needs.

Recommendation 2: Each SAB should take steps to raise the profile of advocacy services across partner agencies to ensure provision of advocates to support individuals' involvement in the decision-making process and enable timely challenge, including through the courts where appropriate.

Recommendation 3: The Metropolitan Police should investigate the allegation of inappropriate restraint during the incident on 1 March 2021 and feed back to Croydon's Safeguarding Adults Board in respect of its findings.

Team around the person

Recommendation 4: The examples of good practice identified within the review should be used to develop understanding of how to use relational social work practice to build resilience within the individual's own support network. Front line staff should be prompted to see family members as a valued partners in the safeguarding process and their participation should be sought, recorded and monitored (reviewed via case file audit), when it is safe to do so.

Recommendation 5: Supervision processes and messaging from leaders, supported by policy and procedures, need to give staff more confidence to make referrals, or re-referrals, for community mental health services, including s117 aftercare, where they believe this would be beneficial, rather than assuming that a service will be refused due to co-existing substance misuse, or because referrals have previously been refused.

Organisational support for team members

Recommendation 6: Senior leaders should ensure that transitions pathways and interagency escalation policies for situations where real and imminent harm persists are sufficiently robust, well publicised across all agencies and that generous leadership supports staff to hold partners to account when coherent, robust and timely transition plans are not devised and implemented for young people. Such pathways should be audited and reviewed.

Recommendation 7: The Metropolitan Police should expand its training offer in respect of exploitation of children and adults with care and support needs to ensure new recruits have the necessary skills to identify issues of coercion and control and can investigate and effectively gather evidence to disrupt perpetrators of exploitation.

Recommendation 8: All partners should ensure that legal literacy training, regarding safeguarding, mental health services including s117 duties, transitions planning and mental capacity, is embedded in training programmes, including an understanding of legal options that may be available to other partner agencies. This should be supported by access to quality legal advice on 'hard to resolve' cases. In particular, Children's Social Care and CAMHS for each of the local authorities involved in this review should ensure that their training offer for staff working with young people aged 14+ incorporates the Mental Capacity Act 2005, including concepts of executive and fluctuating capacity and the impact of high levels of childhood trauma, as well as the Mental Health Act 1983 including s117 duties, transitions under the Care Act 2014 and Continuing Healthcare, to ensure that practitioners are able to articulately advocate for the rights of young people transitioning to adult services. Assessment tools should be reviewed to ensure that these explicitly require consideration of these issues and timely referrals where appropriate. Private fostering arrangement training should also be refreshed for CSC, to ensure this is consistently embedded.

Recommendation 9: The SABs and safeguarding partners should consider how to raise the profile of missing episodes as a safeguarding issue across the wider partnership and how to embed understanding of the police response to missing episodes amongst frontline staff, to support effective discussions with police about people with mental health conditions who cannot be contacted, and promote sustainable joint responsibility for managing risk

Governance

Recommendation 10: The Partnership should seek assurance from NHS England in respect of its plans to improve access to Tier 4 beds and NHS intensive therapeutic placement for young people up to the age of 25 that are local to them, to reduce reliance on acute admissions, avoid delays in young people obtaining the treatment they need and improve their experience of mental health services. Clarity should also be sought on how NHS England holds commissioned Tier 4 CAMHS providers to account for effective discharge and transition planning.

Recommendation 11: The Partnership should utilise the national escalation pathway established between the National SAB Chair's Network and Department for Health and Social Care to advocate for the proposed changes to the Mental Health Act to include statutory duties for NHS England and providers of children's and adults' mental health services to improve transition planning so that young people do not experience a gap in service when they turn 18.

Recommendation 12: Partner agencies should consider how they design or commission services to bridge the transition from children's to adult support services, either by designing bespoke services for young people 16+, by allowing young people to continue with a children's service they have recently been referred to post-18, or by allowing young people to be assessed and then join the waiting lists for adult support services prior to their 18th birthday.

Recommendation 13: To facilitate transition planning in health, partners should agree a joined-up approach across the wider partnership to provide clarity in cases where it is not yet known where a young person will move to when they turn 18. To ensure continuity in transition planning, agencies need to identify a lead practitioner to coordinate the professional network, to enable the young person's needs and choices to be met during and post-transition.

Recommendation 14: The SABs' Improvement and Assurance Subgroups should seek assurance that effective, timely transition planning is undertaken by all partners and that the appropriate adults' services are provided in a seamless manner post-18, including for care-experienced young people.

Recommendation 15: Each SAB should seek assurance from partner agencies that effective arrangements are in place for ensuring that s117 aftercare planning is robust and kept under regular review, including when people are being placed or detained across local authority borders and that mental health professionals in the CMHT and CAMHS are robustly trained in carrying out sophisticated mental capacity assessments in respect of patients' ability to take decisions about their treatment in the community.

Recommendation 16: For placements across local authority borders, policies and protocol at regional and/or national level should be produced to reinforce the need for robust s117 aftercare planning.

7. Glossary

ADASS	Association of Directors of Adult Social Services
AfC	Achieving for Children (provider of Kingston's Children's Social Care service)
AMHP	Approved Mental Health Professional
ASC	Adult Social Care
BCU	Basic Command Unit of the Metropolitan Police
CAMHS	Child and Adolescent Mental Health Service
CAWN	Child Abduction Warning Notice
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CSE	Child Sexual Exploitation
ECHR	European Convention on Human Rights
GDPR	General Data Protection Regulation
ICS	Integrated Care System
IDVA	Independent Domestic Violence Advocate
MARAC	Multi Agency Risk Assessment Conference
MARVE	Multi-Agency Risk Vulnerability Exploitation
MCA	Mental Capacity Act 2005
MDT	Multi-disciplinary Team
MHA	Mental Health Act 1983
NICE	National Institute for Clinical Excellence
SAB	Safeguarding Adults Boards
SAR	Safeguarding Adult Review
SLaM	South London and Maudsley NHS Foundation Trust
The Partnership	Croydon, Bromley and Kingston Safeguarding Adults Boards