Safeguarding Adult Review
‘CJ’

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Introduction

1. On 23rd December 2020, West Midlands Police visited 18-year-old CJ at his new temporary accommodation in Coventry at the request of his mother, who had been unable to reach him for some days. Police found CJ dead in his room, surrounded by drug paraphernalia. The post-mortem concluded that the cause of CJ's death was combined drugs toxicity (cocaine and morphine) and the inquest held on 20 December 2021 concluded that his death was drug related.

2. CJ was a vulnerable young White British adult with a diagnosis of ASD[1] and ADHD[2]. He was high functioning with social communication difficulties, for which he had attended specialist schools from the age of 12. CJ was the subject of a child protection plan for emotional abuse between the ages of nine and eleven. From the age of 12 he was the subject of a child in need plan and at the age of 15, he was taken into care by Warwickshire at his parents' request.

3. CJ was aware that he was treated differently because of his vulnerabilities, which frustrated him as he felt that others were more in need. He was keen to make friends and more latterly when he was in care, CJ gravitated to spending much of his time amongst the street homeless[3] where he felt more accepted. CJ frequently sought opportunities to change 'how he felt inside his head'[4] and had a history of trying to 'get high.' There were numerous occasions CJ had stockpiled his ADHD medication then taken it all at once. This increased to using alcohol and drugs to excess to seek to feel differently. Inevitably, all these methods resulted in him needing emergency medical treatment. CJ had a history of self-harm and was the subject of a safeguarding referrals as both a child and an adult.

4. As he reached 18, so responsibility for his day-to-day care and living arrangements moved from Children's Social Care to Adults Social Care, although as a previous child in care, he remained in receipt of support from the Leaving Care Service.

Acknowledgement

5. It is important to offer sincere thanks to those who have been able to take part in the review, in particular family members who despite their tragic loss of CJ, took time out to contribute in-person and in writing. Those contributions have been invaluable in helping provide knowledge and understanding of CJ's experience and of their own experience

[1] **ASD Autistic Spectrum Disorder** is a lifelong neurodevelopmental condition characterized by persistent difficulties in social interaction and communication, and stereotypic (rigid and repetitive) behaviours, resistance to change or restricted interests [National Collaborating Centre for Mental Health, 2012; SIGN, 2016; NICE, 2016]. Difficulty with cognitive and behavioural flexibility and emotional regulation difficulties may also be presenting features [NICE: National Institute for Health & Care Excellence 2016] Last revised May 2020

[2] **ADHD Attention Deficit Hyperactivity Disorder** is defined as a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. (National Institute for Health & Care Excellence]. Last revised January 2021

[3] **Street homelessness** is a much wider term than rough sleeping, taking into account the street lifestyles of some people who may not actually sleep on the streets. Street homeless people are those who routinely find themselves on the streets during the day with nowhere to go at night. Some will end up sleeping outside, or in a derelict or other building not designed for human habitation, perhaps for long periods. Others will sleep at a friends for a very short time, or stay in a hostel, night-shelter, or squat, or spend nights in prison or hospital. Link to Shelter - streethomelessnessfactsheet

[4] 'Change how he felt inside his head' is the description given by his paternal uncle.

of the array of different agencies who engaged with him. This was such an important element within the review and really helped to bring CJ's voice to the fore.

6. Frontline practitioners were open and fully engaged in the practitioner event and in individual interviews. Their obvious positive regard for CJ and deep sadness at his loss made their contributions even more valid. Agencies have responded positively to requests for information and been open to challenge and willing to engage with intensive scrutiny for which we are very grateful.

7. Last but not least, special thanks to the Safeguarding Partnership team who have ensured this review treated all participants with care and respect, ensured that all voices were heard, and kept everyone to task. This has been of enormous help to everyone who took part.

Safeguarding Adult Review Purpose

8. Warwickshire Safeguarding Adult Reviews Protocol and Guidance[5] notes the purpose of SARs to be:
   - Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively and additionally
   - Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables the Safeguarding.
   - Adult's Partnership in Warwickshire to improve its services and prevent abuse and neglect in the future
   - Agree how this learning will be acted on, and what is expected to change as a result
   - Identify any issues for multi or single agency policies and procedures; and
   - Publish a summary report, which is available to the public

Safeguarding Adult Review Process

9. Warwickshire Safeguarding Adults Partnership conducted a Rapid Review into CJ's death and concluded that the circumstances reached the requirements for a Safeguarding Adults Review (SAR) as set out in the Care Act 2014.[6]

10. As CJ reached adulthood only a few months before his death, the review is undertaken additionally, in accordance with Child Safeguarding Practice Review Guidance.[7]

11. Two independent reviewers were commissioned to complete this review and a panel was formed representing the agencies involved during the period under review. Terms of Reference and Key Lines of Enquiry were agreed. Single agency reports and a chronology were submitted, and a practitioner learning event was held. Please see Appendix One for detailed account of the methodology.

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[5] **Warwickshire Safeguarding Adult Reviews Protocol and Guidance** Link to guidance

[6] **The Care Act 2014 Statutory Guidance, s.44** Safeguarding adults' reviews
(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult has died,

[7] **Child Safeguarding Practice Review Panel:** Practice Guidance April 2019 Link to Guidance

Pen-picture of CJ

12. Three members of CJ's family were able to engage in the review process: his mother, his father, and his paternal uncle. The following includes some of their comments.

13. Each parent provided us with a photograph of CJ smiling. He was a tall, just shy of six feet, with brown curly hair with a warm engaging smile. The photographs reflected a considerable change in his weight. His mother explained that the photograph of them together, taken just a week before his death, showed CJ's significant weight loss over the previous months. He appeared thin, which was very different to the photo of CJ from his father, which showed a robust-looking teenager. CJ's mother explained that previously he was much more solid.

14. CJ liked spending time with his sibling, and he kept a photograph of them together in Blackpool on display in his placement bedroom. CJ enjoyed watching YouTube as well as being outdoors and could walk for miles. He loved to play on his Nintendo DS and was a big fan of Minecraft. CJ had favourite soft toys and cushions which he kept with him during his various moves. He loved animals.

15. His mother described CJ as softly spoken, very intelligent and funny. He was good at doing impressions and had no filter which often made people laugh. CJ gave the best hugs. His mother said that CJ was loving, he enjoyed spending time with her and cooking his favourite meals together (such as spaghetti Bolognese).

16. His father said CJ was an intelligent, curious, and caring child, with an infectious laugh and a keen sense of humour, which he said were characteristics that remained with him throughout his life. But his father felt that CJ was emotionally immature due to a combination of his disabilities and the abuse and neglect he suffered.

17. His uncle said CJ was a caring, sensitive, and loving person who always wanted a friend. He enjoyed making people laugh and would test jokes out on him to see if they were funny. He was intelligent and had a phenomenal ability to read online and retain and process that information. At age 9 CJ had a reading ability of age 11, but CJ struggled with concrete life experiences, he would keep repeating the same things not learning from them. Uncle gave an example of CJ's struggle to learn to cross the road safely (which he finally did master of late by going through the process aloud when he was beside the road, akin to that of a much younger child).

18. His mother explained that CJ was easily influenced and would repeat without thinking, things others had said. He was aware of his 'differences' and felt very uncomfortable when other people made fun of him. His uncle said that CJ told him that inside his head was a horrible place, and his aim was to make his head feel better.

Background

19. CJ was the eldest of his parent's two children. He lived with both parents until age seven when they separated, and his father left the family home. They divorced some seven years later. It is understood that the marriage breakdown was acrimonious. CJ and his sibling remained living with their mother and had regular contact with their father. CJ's father remarried and he has three stepchildren. CJ's sibling moved to live with their father in November 2020 and the relationship between their parents has since ceased.

20. CJ was diagnosed with Autistic Spectrum Disorder (ASD) at the age of five and was supported with a Statement of Special Educational Needs (SEN), this provided him with support in school and he was educated within a mainstream primary school. The identified needs were in relation to his:

'Significant difficulties with social interaction and communication skills.'[8]
Arrangements worked well. His parents were happy with the support provided by the school and CJ's progress there.

21. From 2009 onwards CJ attended various specialist autism play schemes on and off and received respite from Take a Break[9].

22. In April 2010 whilst staying with his father, CJ age 7 sustained a cut to his ear and bruising to his face said to have been caused accidentally. Children's Social Care (CSC) conducted an Initial Assessment, although subsequently the explanation was accepted by them and by other involved agencies.

23. CJ's father said that he was told by CSC that he was not allowed to have any contact with either of his children while the investigation was conducted. He understood this to be a Police investigation. He said that this was an extremely difficult time; he was left waiting for information as to when he could resume seeing his children. The children's experience was that he disappeared from their lives with no explanation from him for six weeks. In the meantime, it had been accepted that this was an accidental injury, and no police investigation was to be undertaken. Father complained to CSC about the way this matter had been conducted, for which he said he received an apology. There is acknowledgement from CSC that communication could have been improved and that the process did take in the region of six weeks. Father felt that CSC records from this matter had an impact on decisions made later in respect of CJ's care.

24. In September 2011, CJ aged 9, was made the subject of a Child Protection Plan (CPP) under the category of Emotional Abuse. This followed CJ sustaining scratch marks to his face, which were said to be caused by his mother who had intervened in an argument between the children. The CPP was in place until November 2012. A package of support was provided, which included childcare, activities, and provision of a Family Support Worker. The support was deemed to be helpful, but it is understood family felt more was needed. CJ's mother advised that CJ did not enjoy the activities as he did not like being with other children who were Learning Disabled.

25. CJ's father advised that at this time, he applied to the Family Court to become the children's main carer. It is understood that the subsequent Section 7[10] report completed by CSC stated that both parents were equally able to look after the children. His father's application was unsuccessful and both children remained in the care of their mother.

26. In September 2013, aged 11, CJ moved to a local mainstream secondary school again with a package of SEN support, but this support was said to have lasted only a few days. It is understood that he did not have direct support in class and was overwhelmed with his experience. His uncle said that he had rushed out of school straight into the road with no regard for his safety.

[8] First Statement of Educational Needs issued 31.03.08

[9] Take a Break Coventry, Warwickshire and Solihull | Coventry Information Directory

[10] Section 7 Welfare reports. (1)A court considering any question with respect to a child under this Act may—
(b)ask a local authority to arrange for—(i)an officer of the authority; to report to the court on such matters relating to the welfare of that child as are required to be dealt with in the report. Children Act 1989 (legislation.gov.uk)

27. CJ was said not to have returned to that school thereafter, which meant he was without schooling for five months. His mother advised that she had to enlist the help of her local MP to gain support for suitable educational provision for CJ.

28. In February 2014, his SEN statement notes provision of a special school out of county approximately thirty minutes' drive away to which he was transported daily by taxi. CJ's mother explained that he developed a good relationship with the regular taxi driver whose mother acted as escort to CJ, accompanying him each day.

29. In 2017 at the age of 14 CJ was arrested for assaulting his mother, he admitted the offence and received a Police caution. Mother advised that on one occasion CJ had pushed her unaware of his own strength, and she went flying across the room. She went to calm CJ down; he was in the kitchen very distressed about what he had just done and was holding a knife to his chest asking her to kill him.

30. Within a few months, CJ came to the notice of Warwickshire Police a number of times, incidents included; offering tablets to young children in the park, which resulted in a parent becoming very irate with him and CJ making a false allegation about sexual assault. During a police interview about this allegation, CJ became distressed and refused to engage, his mother was present as an appropriate adult. On his return home, CJ took an overdose of his ADHD medication. As a result, he was hospitalised and when ready for discharge was assessed by CAMHS[11].

31. This is standard practice for the CAMHS team following an overdose, their purpose being to assess the child's mental health at that point and determine the best course of action: '*are they at significant risk to themselves that they require an inpatient stay in a mental health unit, or do they require follow up with community mental health or are they fit to be discharged with or without follow up?'*
CJ was deemed well enough to be discharged, he was already in receipt of a CAMHS service, he attended a weekly clinic with a psychotherapist.

32. CJ experimented with stockpiling his medication, or mixing it with other substances, in his attempts to 'feel different.' He also admitted using his mother's medication. It is understood, that on at least one further occasion this resulted in him being hospitalised. CAMHS noted these as self-harm attempts and explained that CJ had expressed feelings of hopelessness in relation to his future given his diagnosis of ASD. CAMHS reported that:
'He did not like to feel "sober" as he feels helpless.'
CJ would openly ask clinicians or strangers when out on his own for something that could change the state of his mind, often referring to wanting to get "high", this could be drugs or alcohol. CAMHS advised this indicated that CJ struggled with the impact that ASD had on his ability to cope with life and looked to substances to escape and/or manage his feelings.

33. CJ was receiving prescribed ADHD medication[12]:

- Atomoxetine (to help with concentration, feel calmer and be less impulsive),
- Risperidone (to help with aggression and self-injurious behaviour),
- Fluoxetine (this has been shown to significantly improve inattentiveness and hyperactivity and to treat depression)
- Melatonin (to improve sleep).

[11] CAMHS - Child and Adolescent Mental Health service
[12] Medication and reasons for it supplied by CAMHS

34. In July 2017, after one such hospitalisation when CJ was ready for discharge, neither of his parents felt able to care for him.

35. They decided to ask the local authority for him to be taken into care, and mother advised that she reluctantly signed the required section 20[13] agreement.

36. Records are not entirely clear from this time, but it would appear that CJ was moved from hospital to an emergency foster carer for a few days. (Placement 1), His mother advised that he liked the placement, in particular the foster carer's cat, but the carer did not feel able to keep him safe. It is understood there were few good placement options available, and CJ was moved to an unregulated placement (2). The organisation was a regulated adult provider[14], which used a set team of staff to stay with the child using hotels. Whilst the hotels changed with some frequency, it is understood that there was consistency with the staff team.

37. CJ's father disputes that there was a consistent staff team. He and his second wife were so concerned at the frequent changes of staff and accommodation that they offered to have CJ and his carers stay with them towards the end of the summer holidays. That offer was taken up for a week before CJ moved. His father advised that whilst staying in the hotels, CJ had been fed with take-away meals. His mother advised that CJ was fed junk food and not involved in any activities, that staff had only taken him around various car boot sales.

38. These are not acceptable placements for children. In February 2021, the government gave notice that all unregulated placements for children under the age of 16 would be banned from September 2021[15]. Furthermore, there is a drive from the Children's Commissioner to extend the ban to all children, therefore including 16 and 17-year-olds.[16]

39. In August 2017, CJ again came to Warwickshire Police attention, he had absconded from what was referred to as supported accommodation (3), although it is not known if this was the hotel accommodation or something else. He had been self-harming and matters escalated when he held a broken bottle to his neck threatening to harm himself. He ran out into traffic, with the intention to kill himself.

40. CJ was detained under Section 136 of the Mental Health Act 1983[17] by Police and taken to hospital. CJ told Police that he wanted to kill himself and felt suicidal because, they recorded: '*He was being passed from pillar to post'* by the care agencies.
The s136 assessment determined that CJ did not need inpatient mental health treatment.

41. This must have been an extremely scary time for CJ. He had been removed from home and had been moved multiple times with no understanding of what was planned for him. CJ found all change extremely difficult and as much as possible, all change needed to

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[13] Section 20 Children Act 1989 Provision of accommodation for children: general.
(1) Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of—(c)the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.

[14] The organisation is regulated with the Care Quality Commission which regulates adult placements, rather than with Ofsted which regulates children's placements.

[15] Unregulated accommodation banned for vulnerable children under 16 - GOV.UK (www.gov.uk)

[16] cco-unregulated-children-in-care-living-in-semi-independent-accommodation.pdf (childrenscommissioner.gov.uk)

[17] **Section 136 Mental Health Act 1983** allows a police officer to remove a person from a public place (a place where the public has access to, including by payment). That person must "appear[s] to a police officer to be suffering from mental disorder and to be in immediate need of care or control." (DH 2008, page 74). The removal is in order that the person in question can be assessed under the conditions laid out in the Mental Health Act. No warrant is required., the maximum period a person may be detained is 72 hours and moving between more than one place of safety is permissible within this time period.
Centre for Mental Health Report: Review of Sections 135 & 136. 2014 Link to report

be planned, prepared for, and repeatedly explained to him. His mother advised that she did not have any contact with him during this period, he did not have a mobile phone and she did not have contact details for the workers who were with him. The uncertainty would have been a difficult experience for any child, however for CJ, is likely to have felt overwhelming.

42. CSC were struggling to provide CJ with a suitable placement. The CAMHS Consultant Psychiatrist recommended that CJ needed a residential placement due to the nature of his behaviours and identified risks.

Special Educational Needs – Autism & ADHD

43. In seeking to find a suitable placement to care for CJ, CSC had to pay particular attention to CJ's specific learning needs, relating to his Autism and ADHD. Whilst seemingly intelligent and articulate he had significant difficulties with his communication skills. He was unable to problem solve and his thinking was very literal. CJ had little appreciation of the impact of his behaviour on others, nor could feel empathy towards them.

44. CJ's last available Education Health and Care Plan (EHCP) was issued in August 2017. This related to his special day school which he had attended until July 2017, whilst living at home with his mother. At the time in accordance with the new guidelines,[18] SEN statements were being replaced with EHCPs and this was part of that replacement process.

45. Comments on his behaviour in the EHCP included:
'CJ's behaviour can be erratic, unpredictable, antagonising, and uncooperative at times. He can also be very considerate and helpful. At times he can be immature and become emotional about his life when feeling insecure'
The focus of the plan was:

- *Social interaction and communication skills*
- *Reduce anxiety and improve self-esteem*
- *Increase concentration, develop independent learning & generalise learning*
- *Age-appropriate gross & fine motor skills*
- *Therapy sessions to reflect on behaviour*
- *Gain understanding of thought processes & feelings, his own and others.*

46. In September 2017 CJ was moved to a residential school (4), specifically for children with ASD. This was a considerable distance from his mother, but near to his father. Initially, he struggled with the change. He set fire to his bedroom curtains and sprayed himself with deodorant and tried to set it alight.

47. Whilst he would react spontaneously to situations, he also would plan or manipulate situations or people to achieve what he desired, for example he encouraged others to break windows; with the intention to use the broken glass to cut himself.
In this residential school, again he stockpiled his medication with the intention to use it to 'get high.'

48. In a psychological assessment undertaken by the school and completed in February 2018. CJ had said that negative attention was better than no attention and that he would use bad behaviour to make sure he got attention. Also, that he would sabotage positive situations to get a reaction and attention. The assessment recorded:

[18] From 1 September 2014, Education Health, and Care Plans (EHCPs) replaced Statements of Special Educational Need (SEN). Existing Statements remained valid until gradually converted into EHC Plans. The deadline for statements to be replaced by EHC Plans was March 2018. Conversions would usually take place at key transition points. Special Educational Needs and Disability Regulations 2014

'It is our strong view that CJ does not yet have the ability to implement internal management strategies and that he is heavily reliant on external management support…CJ requires full supervision across all settings until he develops the skills to interact safely with others.'

49. Formal testing was undertaken as part of the assessment and the findings were: -

- *Cognitive ability - Average (WISC 4)*[19]
- *Independent functioning - Extremely low*
- *Resilience – Low*
- *Executive Skills – Poor*

50. There was a comprehensive package of care and education for CJ whilst at the residential school where he lived for 17 months. He began attending mainstream college in 2018, studying Animal Welfare in his aim to work in a cattery. This was likely to have been a day release arrangement from the school.

51. CJ's attendance in the residential school was 95.8% in Year 11. He worked on a variety of GCSEs and Functional Skills, made good progress and was on track for his personal targets in all subjects. In terms of GCSEs, he achieved a Grade 2 in Maths.

52. The school was inspected by Ofsted in September 2018 and given notice to improve standards in relation to their residential accommodation.[20] The Notice required a rectifying plan to be submitted to Ofsted by January 2019. This was not successful, and the accommodation had to close suddenly in January 2019. Pupils could continue to attend the school throughout the subsequent three months closure but had to live off site.

53. Each of his parents were approached to determine if CJ could live with either of them, but they felt unable to look after him. His uncle advised that he was also approached, but that he was away on holiday. He advised that he could have considered having CJ on his return, but that was not discussed. CSC were unable to find an alternative placement locally which meant he could no longer attend the school or the college thereafter.

54. CJ was moved to a crisis intervention placement (5) in North Wales, where he could stay for 12 weeks, with an option to extend for a further four weeks. The emergency placement offered care and outward-bound activities:
'Providing an immediate place of safety and a holistic assessment to inform future placement planning.'

Education was addressed thus*:*

'Due to our belief that every young person should be able to access education and should be nurtured to learn, all our response placements utilise outdoor activities which provides an alternative curriculum. The alternative curriculum utilises short-term educational projects and educational certification through the AQA unit award scheme.'

Extract from provider website

55. It is not clear if CJ achieved any success on the AQA unit award scheme, nor if these arrangements were shared with the Virtual School and the EHCP team to determine how they fitted with his needs. Local authority records show that CJ's education ceased when he left his residential school in January 2019.

[19] WISC IV Wechsler Intelligence Scale for Children | Fourth Edition David Wechsler, PhD
[20] Ofsted Notice letter (publishing.service.gov.uk)

56. During his stay in Wales, the previous residential school reopened as Ofsted had since approved the accommodation. Therefore, CJ could have returned to live at the school, which took pupils until the age of 19. Before the sudden closure, the plan was for CJ to remain living at the school where:

'The placement was to support him with his education and to develop independent living skills relevant to him.'[21]

There is no information to suggest that the option of returning was explored, nor any explanation as to why it would not be explored.

57. It is understood that CJ did not like the new placement, he was said to be unhappy there, he saw himself more as a city boy and not comfortable in the North Wales countryside. CJ did not get on with the other residents, and he and his mother both alleged that he had been bullied there. He went missing on occasions and North Wales Police were concerned that the placement was unable to keep him safe.

58. As a 16-year-old child in care in Key Stage 4 CJ was entitled to the support of the Virtual School Head[22] (VSH) in helping him to find an appropriate school placement.

Stability and continuity in education is important at all stages, but particularly so at key stage 4. If it is not possible to maintain the child's existing education placement, the child's new education placement should be arranged in consultation with the VSH at the same time as the care placement.

The VSH is responsible for supporting social workers to ensure timely provision of a suitable education placement for looked-after children.[23]

59. In March 2019, the Virtual School advised that there was nothing they could offer CJ until a 'long-term' placement was located. CJ moved back to the local area in March 2019, into what was expected to be a long-term placement. In the interim a referral was made to Prospect Services[24] and a Careers Advisor allocated to discuss options with him.

60. In June, the Virtual School were approached again, but they advised they could not add anything further, especially as by then CJ was saying he did not want to be in education, he wanted to enter the workforce. CJ found connecting with Prospects difficult, and their involvement ceased.

61. CJ age 16, with special educational needs and an existing EHCP, would have been expected to remain in education until 18 and could have continued to receive support until he was 25. Warwickshire Local Offer for SEND[25] notes:

Young people must continue their education or training until their 18th birthday. Young people with an EHC plan can apply to a study programme that continues up to the age of 25

62. The move to the residential school in September 2017 should have warranted a new EHCP Furthermore, an annual review should have been completed thereafter. No EHCP was ever issued for this school, nor was there an EHCP review. He lived and was educated there for 17 months without an EHCP detailing what his needs were and how they were to be met.

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[21] Report of Independent Reviewing Officer

[22] Warwickshire Virtual School - for children looked after and previously looked after – Warwickshire County Council

[23] Promoting the education of looked-after and previously looked-after children - GOV.UK (www.gov.uk)

[24] Prospects is a service commissioned by Warwickshire County Council for children up to 18 or young people with an EHCP up to 25, who are not in education, employment, or training (NEET) Prospects Now-help for young people with jobs, training & apprenticeships

[25] SEND_Code_of_Practice_January_2015.pdf (publishing.service.gov.uk) p125

63. The sudden ending of CJ's placement put CSC under pressure to find him an alternative placement quickly. But there does not appear to have been any focus upon his education. Discounting the annual reviews which should have taken place, new EHCPs should have been undertaken given the two significant changes in CJ's circumstances:

- Aug/Sep 2017 from day school to residential school
- Jan/March 2019 from residential school to no formal education

64. *When the child or young person is in or beyond year 9, the review meeting must consider what provision is required to assist the child or young person in preparation for adulthood and independent living.*[26]

65. The EHC Plan completed in 2017, when CJ was age 15 was the replacement for the SEN statement which did not require such provision, as that was covered by Learning Disability Assessments (LDAs) for those 16+. The new EHCPs were intended to replace SENs and LDAs into the one document and would encompass planning for transition to adulthood No further EHCPs were issued and there is no record of where these matters were addressed specifically for CJ.

66. The first EHCP review was undertaken in December 2019, when CJ had been out of education for eleven months. At the EHCP review CJ advised that he did not wish to attend education, as he wanted to work and earn money. He was concerned that he would struggle to work as he did not have any experience or qualifications, which was an opportunity to encourage him to re-engage. No reference was made to his previous EHCP to determine if the stated aims and objectives had been achieved.
This is contrary to the same 2014 legislation:

Section 21 Review of EHC plan where the child or young person does not attend a school or other institution

(5) The meeting must consider the child or young person's progress towards achieving the outcomes specified in the EHC plan.

67. However, it is understood that if a young person states they do not want to continue with education and want to find work instead there is no further need for an EHCP. The review was led by an experienced EHCP advisor with specialist 16+ expertise; CJ's position was accepted and the EHCP ceased.

68. In February 2020, CJ was encouraged through the Princes Trust[27] to undertake work experience in a retail store, which was said to be successful, but reports differ as to how long he took part. These vary from one day to two weeks, although it is understood to be considerably less than the planned four-week period. His mother explained that he had been befriended by an older homeless man who had told him he should be paid for work and that he was being exploited. At around the same time, CJ was also advised that he would be moving placements at that time which resulted in him becoming extremely unsettled.

69. As a Looked After Child CJ was required to have a Personal Education Plan (PEP), which is reviewed each term.

[26] Section 20 (6) The Special Educational Needs and Disability Regulations 2014
[27] Public sector & commissioning | The Prince's Trust (princes-trust.org.uk)

All children in the care of Warwickshire need high quality personal education plans detailing their educational support and progress. Children who are looked after generally achieve less well than their peers and so in order to close the attainment gap and enable them to achieve their full potential, education provision needs careful planning and monitoring.[28]

70. A PEP monitoring form was completed in February 2018, which suggests a review, but the form does not contain any information other than noting the next monitoring was due in Feb 2019. This suggests that the opportunities to ensure children do not get lost in the system were missed. Warwickshire's guidance to social workers on the completion of PEPs states:

All children aged 3-19 must have a PEP as part of their care plan. PEPs must be reviewed termly, at an appropriate point in the term.

71. The Virtual School oversees the standards of PEPs for children in care and are the key link to ensuring their education needs are addressed. They should have been in a position to highlight concerns about the lack of an adequate EHCP or indeed a lack of education.

[28] PEP Review Process June 2016 (warwickshire.gov.uk)

Finding 1: The importance of EHCPs and the Virtual School

CJ's previous SEN statement was reviewed and updated regularly throughout primary school until being amended to name his special school which he moved to in February 2014. In August 2017, this was replaced with his first EHCP. An EHCP Review in December 2019 determined that an EHCP was no longer necessary.

CJ's experience is at odds with the expectations of Warwickshire Local SEND Offer, and with EHCP guidance. As a minimum, his EHCP should have been reviewed annually. Yet, that did not happen for over two years. Additionally, there were no plans addressing preparation for adulthood within the required EHCP process.

It has been established that there were no processes in place to ensure these things happened. Furthermore, it is understood, there is a heightened risk for non-compliance when children are educated out of borough.

These issues have been highlighted within the recent Ofsted Joint local area SEND inspection in July 2021 and an '*ambitious change programme'* implemented.[29] It is understood that Warwickshire has 4500 children with EHC Plans and needs to recruit a further eight staff to address this level of need.

Ofsted further noted: *Weaknesses in the past have led to poor outcomes for some children and young people, particularly those with ASD.*

For CJ the additional element was that he was a child in care (CIC), it is important there is assurance that the CIC systems are equally set up to ensure that these fundamental matters are identified.

CJ's last PEP seems only to have been a monitoring form, rather than a review, again this was not compliant with the relevant guidance. PEPs should have been subject to a minimum of an annual review and are recommended to take place termly.

These three workstreams in place, namely reviewing EHCPs, Virtual School oversight and conducting PEPs did not ensure that CJ's education was actively being monitored and supported or ensure there was sufficient planning for his preparation for adulthood.

Children with disabilities and children in care are amongst the most vulnerable in our society and they must be afforded proper safeguards to ensure their needs are met.

Recommendation 1

The Warwickshire Safeguarding Partnership to be provided with evidence that EHCPs are being reviewed in accordance with statutory guidelines, covering regularity and planning for adulthood.

Recommendation 2:

The Warwickshire Safeguarding Partnership to be provided with evidence that the Virtual School has a system of oversight of children in care with EHCPs and that these are being reviewed as well as receiving their PEPs in accordance with statutory guidance.

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[29] Ofsted Joint local area SEND inspection in July 2021 50011146 (ofsted.gov.uk)

Preparing for independence

72. In March 2019, 16-year-old CJ moved from North Wales close to his mother's home area into locally based supported accommodation (7) for young people 16+ moving to independence This was a completely different type of resource being sought for CJ and it is not clear as to the background to this decision. The emergency placement was said to be undertaking a holistic assessment and it remains unknown if the decision was their recommendation, or if it related to expediency.

73. A referral was made for Supported Accommodation giving CJ's history and current needs. The first mention of his diagnosed ASD and ADHD was noted in the question of Learning Disability which noted:

None apart from the impact of Autism and ADHD on his presentation, for example being unaware of risks.
He has no communication difficulties, but his understanding is influenced due to his Autism/ASD. For instance, he requires simple instructions to undertake tasks.

74. This referral did not appear to recognise the extent of CJ's difficulties. A primary factor was CJ's communication skills, this did not appear to be understood. The identified 16+ supported accommodation had no experience of providing support to children diagnosed with ASD. Initially, a keyworker was identified to lead sessions covering social skills, independent living skills and help with education, but it became apparent that the worker had left and none of these sessions had taken place, nor was there any evidence of structured activities being undertaken with CJ. There does not appear to have been a structured plan detailing how independence would be successfully achieved for CJ. What the steps would be, if specialist help would be required, what strategies would be used, and what skills and knowledge were required to work with CJ on all or any of these issues.

75. It is understood that the placement began with a full time 1:1 worker and following a placement review the Independent Review Officer (IRO) advised that 2:1 support was needed. The unit manager advised this was later reduced back to 1:1 following staff changes in the CSC social work team.

76. When CJ was moved from Wales his case was referred to the Adult Social Care Transition team. This was in recognition that he would need a service post 18 from Adult Social Care (ASC). He met the transition worker in July 2019 at his placement when the worker explained their role and again when they attended his September Looked After Child (LAC) review.

77. Six months into the placement in September 2019 CSC conducted a Deprivation of Liberty assessment[30] to ensure the care being provided was safe and appropriate, and not too

restrictive considering CJ's needs and autonomy as a young person. This legislation had changed in May 2019 and assessments were undertaken on all young people who were receiving high levels of support. The assessment concluded that despite having 2:1 care

[30] **Article 5 of the Human Rights Act** states that 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'. **The deprivation of Liberty Safeguards** is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm. A Supreme Court judgement in March 2014 referred to the 'acid test' to see whether a person is being deprived of their liberty, which consisted of two questions:
Is the person subject to continuous supervision and control? and
Is the person free to leave? – with the focus, being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.
Deprivation of Liberty Safeguards (DOLs) at a glance | SCIE

when in the supported accommodation and 1:1 when out in the community, he was not deprived of his liberty because he was neither physically restrained nor restrained through the use of medication; and he was able to leave the property.

78. The decision was contrary to the 'acid test' [31] as CJ was not free to leave without being accompanied by staff. The assessment noted:

'CJ is recognised to be vulnerable due to his age, history of absconding and risky behaviours. It is recognised that some of CJ's risky behaviours and substance misuse may be heightened due to his disability and his inability to effectively risk assess and remove himself from dangerous situations… there are plans in place should CJ leave the property, and these are instructed by birth parents who maintain PR.'

79. In November 2019, his Pathway Plan[32] meeting was held. It was noted he was undertaking independence modules with a local charity Doorway[33]. He did not take part in the meeting as he said he had already had a meeting that day. The plan covered all the required aspects, yet there was no mention of his ASD diagnosis.

80. Some of the notable comments were:

'There are concerns around CJ's fascination with picking up cigarette butts and smoking these'
'Personal hygiene is not as good as it could be, and this will likely need to improve before CJ begins employment'
'It is concerning that CJ's aspirations are focused on being homeless and dealing drugs…. can have the tendency to react badly when told something he doesn't like, and this could impact his employment status.'

81. Adult Social Care (ASC) recognised that CJ was not engaging in education neither did he seem likely to do so. Allocation to the Transition Team ceased, as being in education and subject to an EHCP was their criteria for involvement. The EHCP review in December 2019 confirmed that the plan would cease, as a result CJ's case was transferred to the Adult Learning Disability team to progress his transition.

82. In January 2020, CJ disclosed to his mother that another resident had been selling him Heroin and Cocaine, which he was using. CJ was concerned for his safety from the other young person after Police became involved, so he stayed with his mother for nine days. CSC worked with the provider to ensure that CJ felt safe to return to his placement, as the other resident was moved to another placement.

83. Both parents were unhappy to hear of CJ's drug use, especially as the information had not been shared with them by the placement and the drugs were being supplied by another resident. It was felt that trust had been broken as a result. As a result of his

disclosures about his drug use, CJ agreed to engage with a drug support service, where he was assessed and supported regularly thereafter.

84. On his return to the placement, his mother saw his room, which she felt was in a dreadful state. She passed photographs of the room onto CSC who noted:

[31] quick-guide-to-deprivation-of-liberty-orders.pdf (adass.org.uk)
[32] Pathway Plan Your Pathway Plan Report (MSWord, 432kb) (warwickshire.gov.uk)
[33] How We Help | Doorway

'*There were cigarette nub ends in tubs around the room, drawers full of such remnants and strewn across the bed, surfaces and floor, there was evidence of his medication around the room, unused sterile swabs in a container on the bed, drug paraphernalia such as a bottle made into a drug pipe, silver foil containing drug residue that had been heated, food remnants, dirty crockery, dirty clothes, duvet, mattress protector and pillow looked very grubby, no bedding on the aforementioned items and overall the room smelt very bad*'.

85. The state of CJ's room contradicted the high standards of care advertised by the organisation and was not in keeping with the standards expected by the local authority who were commissioning the placement to meet CJ's needs.

86. His mother was concerned that
'*CJ had lost weight, was sleeping all day, did not appear to be motivated to do anything and appeared very low.'*
When he did go out, he was exploited at times and gravitated towards the street homeless. He continued to collect cigarette and cannabis butts from the street which he hoarded in his bedroom. He was a regular cannabis user. Mother took him to the GP where he was prescribed antidepressants.

87. Later in January 2020 CJ's LAC Review was held, placement staff advised:

Although staff provide opportunity for selfcare skills, social skills and general independent skills CJ will often refuse to engage with these.
It was acknowledged that these same issues had been raised at his previous review three months earlier, yet there had been no progress.

88. The Independent Reviewing Officer (IRO) expressed concerns regarding CJ and felt that risks were escalating in relation to his going missing, his associates, his vulnerability to criminal exploitation and his substance misuse. The IRO did not feel CJ was being offered any positive activities to try to engage him, and there was no structure or routine in his life. Despite living there for ten months, the placement manager stated that:

'He has not been willing to explore any activities. He hasn't had any structure to his days yet.'

89. This was CJ's last LAC Review due before his 18th birthday, but because of the uncertainty as to future plans for him, the IRO requested and subsequently ensured, that another meeting took place just before he reached 18. Although CJ's poor progress had been noted at the previous LAC Review it is unclear how this was being measured and evaluated and what remedial steps had been identified.

90. CJ had been living at the placement for nine months and a minimum of 1:1 care was said to be provided throughout to address his needs. The IRO was correct, there was no evidence that CJ had a structured routine, nor was he able to demonstrate the most basic of self-care skills. It is unclear what specific guidance, approach or methodology was
used in respect of CJ's particular needs, but there appeared to be a passive approach in engagement with him by this placement.

91. The concerns about his bedroom were escalated to senior management by the IRO and within days CSC commissioners gave notice to the placement.

92. CJ was made aware that an alternative placement was being sought which unsettled him. In common with previous times of living with uncertainty, he acted in ways that brought him into conflict with others. Returning to the placement following a home visit, CJ was aggrieved

and lashed out in anger. He caused damage and was racially abusive to a member of the staff. He was arrested and admitted racially aggravated intentional harassment and was referred to the Youth Offending Scheme and was issued with an Enhanced Community Resolution for which, he completed the required sessions.

93. This behaviour, along with comments he made subsequently about Tommy Robinson the far-right activist, prompted a referral to the Channel Panel [34] to ensure both his and public safety. As a result, the Prevent Service engaged with CJ and the wider network for some months until they determined that he did not pose a risk around radicalisation and extremism.

94. Just days after the assault he took an overdose of co-codamol tablets and staff called an ambulance, CJ told ambulance staff that he took the tablets with the intention of 'getting high,' rather than any suicidal intent. As he had taken a less than toxic dose and did not want treatment, the ambulance crew decided that hospital treatment was not necessary.

95. This pattern of behaviour had been seen many times, when his living circumstances were uncertain or when he felt anxious about what was happening in his life. Often, he would act in ways that brought him into conflict with others, or that placed himself at risk or by taking sufficient drugs and alcohol which warranted contact with emergency services. CJ's inability to manage his anxiety and problem solve were invariably followed by such risk-laden behaviour.

96. In late February 2020, CJ successfully completed a taster session for his planned four-week retail work experience and then started it properly. It is not entirely clear how many times he attended but it is known that on two occasions over the next week, he went missing overnight but offered no explanation. Thereafter he refused to continue with the work experience. His mother explained that a homeless friend had told CJ he should not be working without pay, which she felt had influenced his decision to stop going. This was an unsettling time for CJ as he was visiting alternative placements because of his intended move, which he found distressing.

97. In March 2020 CJ was moved to alternative supported accommodation (8) where he lived for eight months. It is understood he was the sole resident. He was unhappy with the planned move and had been reluctant and resistant to moving. The previous placement advised this review that he was often seen back in the area hanging around the property. They reported seeing him on CCTV sleeping on their driveway. Within a couple of weeks of his move, the pandemic lockdown was implemented, and CJ was locked down with staff in his new placement (8).

98. During this time CJ had a number of missing episodes. These were due to CJ not keeping to the lockdown rules as he struggled with timekeeping and relationships, as well as being 'locked' in his placement with workers, which he would have found stressful.

99. CSC funded the placement, and within two months he would be the responsibility of ASC. This move needed to be to a placement suitable to both Children's and Adults to ensure smooth transition and continuity of care for CJ.

[34] The aim of Prevent is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. Delivery of Prevent is grounded in early intervention and safeguarding
Channel Duty Guidance: Protecting people vulnerable to being drawn into terrorism (publishing.service.gov.uk)

100. The new placement was not a resource regulated by the Care Quality Commission, therefore was not thought to be able to be funded by Adults Social Care, this would mean that CJ would not be able to remain when he transferred to ASC. This was an unnecessary move for a young person who found change so difficult.

101. Whilst an ASC representative had attended his LAC Review in January 2020, little action had been progressed to prepare for the transition. As a minimum, a Care Act assessment should have been completed to determine what level of support CJ required, the assessment began a week before his 18th birthday.

102. CJ's final review as a child in care was held two weeks before his 18th birthday. Both his parents attended, but he did not. Records note a recommendation for a mental health assessment, as well as a Financial Assessment to be undertaken. CSC agreed to fund the placement for a further six months until the assessments had been completed and eligibility determined.

103. In late May, the decision was changed to fund three months rather than six months. This was in recognition that CJ was continuing to have further assessments regarding his mental health, whereby it was to be established if CJ was to access ongoing support from Adult Mental Health.

Finding 2: Placement and transition arrangements

CJ was moved in an emergency from his residential school to an outward-bound centre and then to the 16+ supported accommodation. This was not a specialist resource for providing services to children and young people with autism. CJ's needs were over and above their usual client group. An extra pair of hands, i.e., an additional 1:1 worker was not adequate to address his needs and equip CJ for independence.

The provider acknowledged the extra efforts they made to help acquaint CJ with new staff, but there was no explanation about preparing him for independence which was their primary purpose. As a result, his patterns of behaviour became more entrenched, and no solutions or expertise were enlisted to seek to help CJ change or adapt that behaviour which was detrimental to his day-to-day living.

Children in transition from children to adults, must be afforded a long-term lead in time, with planned preparation and understanding of what will be provided and what they are required to do. This is important for all children but is essential for children with a diagnosis of ASD. Whilst that had been the original intention, it was not achieved.

CJ had not been assessed and his history and circumstances were not well known by ASC. His placement had been made without ASC's agreement to take over the funding beyond his 18th birthday. Whilst CSC initially agreed to fund the placement for six months to ensure continuity and certainty for CJ, within weeks this changed to three months. Where you live, is a fundamental issue for anyone, but was of particular concern to CJ given his high anxiety about change.

Tasks identified at his last Looked After child review needed to part of the ongoing workplan in ASC, this did not appear to happen.

From April 2022, Warwickshire County Council is bringing together the Children with Disabilities and Transitions Team under a single line management with the aim of improving transitions.

Recommendation 3

Evidence should be supplied to the Warwickshire Safeguarding Partnership as to the suitability and availability of placements provided to children and adults with complex needs such as ASD, drug use and mental health needs.

Recommendation 4

The Warwickshire Safeguarding Partnership should regularly review progress to ensure effective preparation for adulthood and transition to adult services is in place, this should include transition arrangements for children who are not in education.

Child and Adult Safeguarding

104. In common with all his previous experiences and characteristic of many who have ASD, CJ did not cope well with the change. He avoided engaging in the new placement and went missing on four occasions over the first ten days. This pattern of going

missing continued beyond the first few weeks and became a regular concern. Some episodes were just a couple of hours but on several occasions, CJ would be out overnight, frequently using drugs and alcohol and often requiring either Police help or emergency medical support to assist him in the situations he found himself.

105. It was reported that on his return from missing episodes, CJ was without his shoes, bank card and phone after having apparently 'blacked-out;' others offered him drugs; shared alcohol and he used other's needles. There were persistent concerns that he was being exploited, financially and sexually. He described being used by people he met on the streets to try out substances for them and would allow himself to be injected. He said he did not know them very well and did not trust them. Drug and alcohol staff were of the view that CJ was almost allowing himself to be used as a 'guinea pig.'

106. In May, during lockdown, he was reported missing from placement and West Midlands Police attended what was reported as a burglary in progress at a supermarket in the early hours. CJ was found with a known homeless adult male, 20 years his senior. Police reported: *'The two males were sitting by the loading bay area of a supermarket; they were both scruffy and dirty with a number of bags around them and a few bottles of strong cider. They had started a fire which looked as if it was an attempt to keep them warm and were sitting on the steps for shelter*'

107. CJ was searched and found to be carrying a knife which he said was for his own protection, and a razor blade which he said for cutting cocaine. He was charged with possession of a bladed article and released from custody the next day but did not return to the placement until two days later. His whereabouts over those two days were unknown, he was under 18 at the time.

108. Support for CJ would normally have come from the Youth Justice Service. However, as they were not undertaking 'face to face' visits at this time due to Covid lockdown, it was agreed that appropriate support could be provided by CJ's placement. As a missing child CJ was provided with Return Home Interviews (RHIs) whereby he would be visited to discuss the missing episode. Invariably CJ would share the details of what had happened, and the workers became increasingly concerned about his safety and welfare. The emerging picture was of CJ's considerable vulnerabilities and the strong likelihood that he was being exploited. Missing staff were of the view that:
'CJ's behaviours were not considered to be lifestyle choices but rather as a consequence of his unique needs, substance misuse and isolation.'

109. There was an expectation that a child exploitation assessment would be able to provide an overview of the concerns, and which should have been presented to the Multiagency Child Exploitation (MACE) panel where a safety plan could have been drawn up.

110. Although, it is not clear why a contextual safeguarding approach was not undertaken.[35] the Missing Team repeatedly asked Children with Disabilities to complete a Child Exploitation assessment, but this was never achieved.

[35] Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Therefore, children's social care practitioners, child protection systems and wider safeguarding partnerships need to engage with individuals and sectors who do have influence over/within extra-familial contexts, and recognise that assessment of, and intervention with, these spaces are a critical part of safeguarding practices. Link to Contextual Safeguarding Network

111. A variety of professionals had concerns about CJ's vulnerability and exploitation and came together at a strategy meeting shortly after his 18th birthday. Agreement was given that this would be progressed by ASC under adult safeguarding.

112. Warwickshire's Exploitation Strategy 2020 – 2023[36] emphasises the importance of not losing sight of young people in transition:
Since the implementation of the Care Act 2014, the range of statutory duties placed upon Local Authorities in protecting Adults at Risk from abuse has widened to include people leaving care, increasing the importance of effective working across the transition period from childhood into adulthood.

- *Exploitation does not stop just because the child turns 18*
- *Young adults as well as children are also vulnerable to all forms of exploitation. Perpetrators target vulnerability not age*

113. The Missing team suggested they continue supporting CJ, beyond his 18th birthday, as they did with some other young people, but his permission to continue was required, which he refused to give.

114. Usual practice suggests that as an adult, CJ would not have been regarded as missing when he was away from his accommodation because he could and did return successfully to it, although not every day. Although the definition for missing people in Warwickshire includes both children and adults, information regarding adult missing episodes do not appear to be shared with wider social care services, unless there is a concern for the person's safety.

115. As agreed at the strategy meeting, a Safeguarding Adult Referral was made and sent to the area that CJ was living. However, they advised it would not be progressed as Warwickshire were required to investigate as they were paying for his placement. This is incorrect as section 42 of the Care Act 2014[37] places the safeguarding duty on the local authority to "an adult in its area (whether or not ordinarily resident there)". Although the other authority should have undertaken the safeguarding work, this does not explain why Warwickshire did not escalate this or take their own action in the absence of the other authority doing so.

116. Despite the strategy meeting recommendation, the outcome was that no adult safeguarding assessment was undertaken by either area, or indeed a safeguarding plan for CJ ever drawn up.

117. *'All working in adult safeguarding have the difficult task of understanding risk, assessing the level of this for the individual and constructing a plan to manage this which works for the person concerned and is understood by those around them'*[38]

118. The professionals involved were clearly concerned about the risks to CJ and talked to him about these concerns. However, this should have been done in more detail and there should have been greater consideration given to the underlying reasons and potential interventions. In addition, risk assessments should have been completed. It is appreciated that as an adult he had the right to choose what he did and there was no legal

[36] WS_Exploitation_Strategy_2020-23.pdf (safeguardingwarwickshire.co.uk)
[37] Section 42 Enquiry by local authority Care Act 2014 (legislation.gov.uk)
[38] WM_Adult_Safeguarding_PP_v20_Nov_2019.pdf (safeguardingwarwickshire.co.uk)

framework to intervene without his consent because he was thought to have capacity (which should have been formally assessed) and he did not meet the criteria for the Mental Health Act. However, this does not explain why this was not progressed as a safeguarding matter. Doing so would have formalised interventions and risk assessment, sought his views more clearly, made planning more explicit and better safeguarded CJ.

Finding 3: Child & Adult Safeguarding

There were a host of factors that showed how at-risk CJ was and how he was being exploited. A strategy meeting thought the responsibility had been passed onto another authority, yet when that was refused, nothing was done.

His vulnerabilities placed him at a disadvantage that was not being addressed or ameliorated by specific targeted safeguarding plans. These incidents were well known, but there was no formal assessment and analysis of risk. Plans were not drawn up by either service to weigh up the safeguarding issues and identify what could be done to help protect him.

CJ was not afforded a safeguarding approach from either Children's or Adult Social Care. These are basic requirements and expectations of each service. So, it is important to establish what got in the way?

There is some suggestion this was within his lifestyle choice as a teenager, but that overlooks the patterns of behaviour he had developed historically, when he could not cope with situations. CJ's need for friendship and acceptance placed him at high risk from those who were content to exploit him.

Taking his money to buy drink and drugs, using his body for sex and substance experimentation, encouraging him to engage in criminal activities, acting as a look-out on burglaries, in addition to robbing and assaulting him to take what they wanted, when they wanted.

CJ was in dire need of protection.

Recommendation 5

The Warwickshire Safeguarding Partnership to seek assurances that where risks to a child or an adult are identified, that expected actions and processes are followed to safeguard the child or adult from abuse and exploitation.

Adulthood – Care Act Assessment

119. Autism is a lifelong condition and the challenges of dealing with change can bring acute difficulties. CJ struggled with change, both in his living arrangements and in managing changes of personnel. Because CJ was articulate and knew some subjects very well (e.g., specific knowledge about the origin and composition of certain drugs), assumptions could easily be made about his capabilities. When he was first considered by Adults Learning Disability Service, after Transitions stepped away, it was thought he did not meet the criteria for a service.

120. The high turnover of staff working with him, could have diluted the specific knowledge needed to build a relationship and engage with him. Between April and June, he had a total

of four different social workers allocated from Adults Social Care, the fourth worked with him for the last six months of his life.

121. ASC undertook a Care Act Assessment.[39] The assessment, which was completed and signed off by management in August, confirmed that CJ was eligible for support, and that he needed help in the following areas: -

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Being appropriately clothed
- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationships
- Accessing and engaging in work, training, education, or volunteering

122. The assessment was further informed by contributions from his parents and other staff.
'CJ was not able to read body language and non-verbal signs which made interacting with others difficult'. Advice from mother.
'CJ was not able to generalise information which made it difficult to apply that learning to different places or scenarios.' Advice from father.
'CJ was not always able to remember conversations or apply that conversation to another situation despite having discussions about it previously.' Children's staff member.

123. The assessment captured CJ's views and wishes. He recognised he needed support with some things but was clear that he did not want this to be long term because being independent was very important to him. Whilst this was his stated intention, he was a significant way from achieving that. The approach therefore needed to be two-fold, in encouraging him to learn independent living skills and be able to carry those out for himself and to come to terms with what he was not yet capable of doing. The evidence suggested he was not capable of living independently, either then or anytime soon.

124. The Care Act assessment recommended a psychological assessment be undertaken to help understand CJ's communication needs, decision making and behaviour which Children's Services agreed to fund. However, CJ declined to engage, and the assessment was not achieved. Whilst the assessment was explained to CJ, he may have been more amenable if encouraged to take part for the purpose of finding a suitable home to work towards his stated intention of living without support, and enlisting the support of those he did trust, not least his mother, and his uncle.

125. Although if CJ would not engage directly, there was sufficient information for a psychologist to give a view on the situation and offer advice to the professional group of the best ways to work with him. This was of particular importance as ASC were working without access to the previous psychological assessment undertaken at his residential school, although it is not clear why.

126. It is routine practice that a Care & Support Plan is drawn up to accompany a Care Act assessment. Warwickshire County Council website [40] advises:

If we determine you are eligible for support, we will discuss with you, your family, and carers (with your permission), the options available to you. We will then agree with you a support plan that sets out how you will be supported to achieve your outcomes.
Although, ASC advised this review that

[39] Care Act 2014 section 9 Assessment of an adult's needs for care and support
[40] Assessing and reviewing your needs – Warwickshire County Council

It is normal practice within Warwickshire, that the care & support plan is not completed until named providers are identified.

127. ASC assessed that CJ had care and support needs however, as no provider was identified the care and support plan was unable to be completed. The assessment concluded:
'*Warwickshire County Council's typical spend on the level of support to meet the needs we have discussed is £451.00 per week'*

128. Searches began in May and were supported by referral for Supported Living submitted to the commissioning team; and on 24 July 2020 a person-centred plan was drawn up and shared with providers of supported living in Warwickshire. Additionally, individual providers were approached and options outside of Warwickshire explored.

129. This process is understood to have continued into November 2020, with concerted effort from the team but no suitable accommodation was identified. Providers explained their decision not to offer CJ a place due to his combination of needs, his drug and alcohol use and his offending in addition to autism and ADHD. Most schemes were primarily supporting people with learning disabilities so some felt that there may be compatibility issues with their existing residents as well as for CJ.

130. The requested package stated that CJ required:

'Between 15-20 hours per week – to support with menu planning, shopping, food preparation, cooking. Cleaning, helping with correspondence and reminding / prompting for appointments, prompting to maintain personal hygiene and laundry. Help to budget / learn budgeting skills. Promoting self- worth, problem-solving skill and positive choices.'

131. The Care Act assessment described the support he required which was:
'Mainly prompting and encouraging because he was able to carry out most daily living tasks himself when reminded and encouraged to.'
The irony was that CJ had been living for more than eighteen months, in one-to-one supported environments where such prompting was a daily staff role and where it could not be judged there had been any measure of success.

132. It is not clear if there is a standard procedure within ASC when supported living accommodation is not found. It is understood that there were regular meetings and active liaison between the various agencies working with CJ, and the matter was escalated for advice in seeking an alternative solution. Despite this, no solution was identified.

133. On reviewing the case for this process following CJ's death, a senior manager was able to advise that the placement that he was being required to leave could have been

approved as a spot purchase as no personal care or medication was being supplied to him. That information should have been made available to staff at the time.

Finding 4: Care Act Assessment and Care & Support Plans

The Care Act assessment concluded that CJ needed support, yet despite months of considerable effort no accommodation provider would offer him a place. It was recognised that specialist help was needed as to CJ's communication needs. He was articulate but had specific issues about transferring knowledge and understood things at a very literal level. He needed information to be given in small instalments, reinforced over time, which would be further helped by being written down. It was important to seek support with this, previous assessments about his communication skills were in CSC records, but these were not accessed by ASC.

The assessment identified the need for an independent psychological assessment, a mental capacity and best interest assessment, and a risk assessment. The assessment was signed off by a manager, yet none of these required assessments were achieved. This undermines the assessor's position as they felt these were necessary to help planning for CJ's future care needs.

Recommendation 6

The Warwickshire Safeguarding Partnership should seek assurance how the recommendations made in Care Act assessments are being achieved.

Adulthood - Mental Capacity Act Assessments

134. The Care Act assessment reasons for seeking Mental Capacity and Best Interest Assessment and a Risk Assessment were: -

Mental Capacity Assessments (MCA)would be required; -

- *to determine if he is able to make a decision regarding where he lives and the level of support, he requires to develop his life skills.*
- *relating to managing money and finances and holding a tenancy.*

A risk assessment is required to determine; -

- *How to keep him safe due to his vulnerability and potential for criminal activity, financial abuse, sexual exploitation, and drug abuse.*

135. The first principle of the Mental Capacity Act 2005[41] is:

A person must be assumed to have capacity unless it is established that he lacks capacity.

Although capacity should be assumed, in CJ's case, it was recognised that he did have some problems in making decisions. Those who worked with him understood that he needed information given to him in a manageable way and to be given time to make decisions. At times he told different people different things and some of his decisions were inconsistent and appeared to others to be very risky.

[41] Mental Capacity Act 2005 (legislation.gov.uk)

136. Whilst a further principle in the Act is that unwise decisions should not be considered on their own to indicate lack of capacity, there was clearly sufficient reason for those working with CJ to have decided an assessment was needed.

137. The assessment is a two-stage test and CJ's diagnosis of autism met the first stage that the person must have an impairment of the brain or mind. The second stage being the assessment. MCAs are undertaken to establish the person's capacity to make a decision and must be linked to the decision in question.

138. In May, ASC asked the drug and alcohol service to undertake an MCA in respect of CJ's drug use. CJ was well known to the service, having attended for five months, and had met with the worker on 12 occasions Over those sessions, CJ was never judged to be under the influence of substances.

139. The MCA was completed in June and determined that CJ did not have capacity to make decisions surrounding his substance use. Of the four MCA elements it was judged that CJ: -

- Could not understand the information,
- Could not retain the information,
- Could not use or weigh up the information
- But it was thought that he could communicate his views.

140. ASC were provided with the completed MCA, but the conclusion that CJ did not have capacity was questioned by ASC. Where professionals disagree with an assessment they should work to try and resolve differences and should undertake their own assessments, but this was not achieved. Despite this finding and the other MCAs which had been recommended, no other MCAs were ever undertaken.

141. CJ was intelligent and presented as very able in many respects, the difficulties he had in making decisions were not fully assessed and appreciated. The 2018 psychology report highlighted deficits in executive decision making which could explain why CJ was quite able when supported and given time but may have struggled in more demanding situations. His EHCP included interventions to help him improve this and other areas impacted by his autism. The understanding in the psychology report and EHCP, do not seem to have been carried forward and worked with as he moved between services and placements.

142. CJ resisted efforts to engage again with psychology and psychiatry input. As with many areas of the country, specialist expertise in autism is available in NHS learning disability teams but at the time was not available to people without a learning disability. This has been recognised nationally and funding has been given and plans are underway to create a service**.** It is understood that the Coventry & Warwickshire Partnership Trust are developing this locally. Although CJ never agreed to a referral to psychology, having access to specialist advice may have helped the workers understand and develop more

successful strategies to support him and could have informed capacity and risk assessments.

Finding 5: Mental Capacity Act Assessments

The Care Act assessment concluded that MCAs were required on specific decision areas. The assessment was signed by the responsible manager however, the MCAs were not completed. No specific reason for this has been provided but it is important to gain a sense of the situation for staff at the time.

It has been suggested that from May to October staff were prioritising finding CJ somewhere to live; that CJ was often missing or in crisis and those times were not conducive to carrying out such an assessment.

The MCAs needed to be done, they needed to be informed by specialist information and advice about his condition. The MCA completed by the drug and alcohol service spelt out the risks associated with CJ's drug use, but the no capacity decision was challenged by ASC and despite repeated chasing from the drug and alcohol service, no resolution was achieved.

The outcome was that the Care Assessment was undermined as these fundamental issues had not been tackled. Completing these would have provided greater understanding of CJ's needs and informed accommodation providers as to how he could be engaged and supported.

Adult Social Care have advised there has been an MCA practice improvement programme in place for a year. It includes training, revised guidance and proactive support to workers doing assessments. ASC, advise they have seen an increase in the quality and number of assessments.

Recommendation 7

The Warwickshire Safeguarding Partnership should seek assurance that Mental Capacity Assessment dispute resolution arrangements are in place, and they take account of all parties and specify what action must be taken when there are disagreements with decisions or findings.

Adulthood – Finding a place called home.

143. In July 2020, over a period of four days CJ was found unconscious on the street, heavily intoxicated and laying in his own urine and he required hospitalisation. He was found stumbling and incoherent and had to be given opioid overdose medication and required hospitalisation. He had a fractured hand, had a graze and bruising to his face, was missing his belongings, and had blood on his clothing. He went missing overnight, was returned to the placement by West Midlands Police, was under the influence of drugs, but refused to attend hospital and had run out screaming into the street.

144. At the same time, CJ was struggling with the advice that he had to register himself as homeless. His first attempt was just before this four-day spree. This process took him three

attempts, on the first he became stressed and could not continue. On the second occasion again, it could not be completed, he became stressed and stated:

"He didn't want to do this, he was getting confused, didn't know what the housing officer was saying and what he had to say."

At the third attempt in early August, CJ was accompanied by a support worker and the registration was able to be completed.

145. Whilst it is understood that registering as Homeless is the process by which accommodation can be provided, it seems an uncomfortable position for a young person who already had two legitimate routes of receiving support, i.e., being an adult who was approved for supported living and as a former relevant child in care[42] and therefore entitled to ongoing support from the Leaving Care Service. Furthermore, his last Statutory Review undertaken in May had confirmed that the placement would be funded for six months from then. It is not clear that he was informed of the subsequent change in that decision to three months. This must have been a very confusing situation for CJ.

146. Further to one of his hospital presentations, CJ was notified he had a raised liver function so needed to go to the GP for follow up. Further GP tests found CJ to have liver and kidney damage and Hepatitis C, all of which required further treatment.

147. The placement advised of their concerns that CJ was not eating or sleeping, nor was he buying food, he was spending his money on drugs and alcohol. His uncle advised that he was contacted by the placement several times to advise that CJ had no food, and he would come to ensure that he was fed. His uncle said this was an odd situation given the placement was meant to be supporting and teaching CJ independence skills; therefore, how could he be left with nothing to eat?

148. At this time CJ was highly anxious about the court case he was facing for possession of a knife for which the date had been postponed several times. In addition, despite being a child when the incident happened, he was required to appear in adult court. The case was heard in September 2020, CJ attended with his uncle where he was convicted of possession of a bladed article and sentenced to 18-month Probation Supervision Order, and 150 hours unpaid work rehabilitation order.

149. ASC advised that their assessment showed that CJ did not need the intensive level of support he had been receiving previously, and they were trying to find providers that would support him, but no alternative option had been identified. Despite a significant effort no provider that had vacancies was willing to accept him.

150. The CCG AALDER service (Autism and Learning Disability Admission Avoidance Intervention Register). stepped in to provide funding until the end of September. It is understood that this may have been a preventative measure to avoid CJ needing inpatient mental health treatment related to his autism and unmet needs. No information was forthcoming to explore this in more detail.

151. The CCG provided support at the level determined by ASC. This included seventeen hours daytime support per week, plus sleep-in support on four nights.

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[42] ***Former relevant children*** are those who before reaching the age of 18 were either eligible or relevant children. Section 5c Children Leaving Care) Act 2000 Children (Leaving Care) Act 2000 - Explanatory Notes (legislation.gov.uk)

152. By the end of September, no other options were yet identified by ASC and the CCG extended their agreement to cover a further four weeks into October.

153. Throughout these months, staff spoke to almost 30 different organisations providing supported living, but the combination of drug and alcohol use in addition to ASD was a major obstacle. Potential placements, suitable for his autism determined that his behaviour might have a negative influence on other residents. Equally, CJ's vulnerability could make him an easy target for others to exploit.

154. CJ continued to experience worrying incidents such as, drinking on the street, he was assaulted and robbed by two homeless men on the street; brought back drunk by Police.

155. He maintained his contact with the drug and alcohol service who were very keen to get him to understand the importance of having a Naxolone overdose kit. CJ did accept the kit, but the team had real anxieties about his likelihood of using it - he said his homeless friends would think he was *'with the Police'* if he used it, also that it would bring down his 'high.' It was reinforced that he was at higher risk to overdose because he was using heroin occasionally, therefore the kit was vitally important to help. This approach reinforced the need for the drug and alcohol service and ASC to find a resolution to questions about his capacity regarding his drug use.

156. It was made clear to CJ that despite considerable efforts, at that time there remained only two options available. That of seeking support with housing from the homeless service or moving to a drug rehabilitation unit, which he ultimately agreed to do. His placement was of the understanding that a 12-week rehabilitation placement was being sought and hoped CJ could remain with them until it was arranged.

157. A rehabilitation unit that would accept CJ was identified and CJ asked if he could remain at the current placement until it became available. Ultimately, the rehabilitation option was ruled out. CJ had become abstinent from heroin and cocaine during September and October; therefore, he no longer met the funding criteria for a rehabilitation resource.

158. In the last week of October 2020, the CCG funding for the placement ended. Although advised that the placement had ended, CJ remained, reluctant to move out. He overstayed for a week, he was clear he did not want to move, and he had nowhere else to go to. The placement did not receive any funding for that week. They sought advice from the Emergency Duty Service of the local authority and were advised to change their locks and return his belongings to his mother's address. Mother advised that she visited with CJ to collect some belongings and found the locks changed, which upset them both.

159. CJ became homeless (9).

Finding 6: Finding a place called home

"*Children, young people, and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe, and fulfilling life.*[43]

Throughout the period that ASC were working with CJ, their focus was in finding a suitable placement. This was never achieved. This questions the availability of specialist support, and the importance of engaging commissioners early in the process to ensure appropriate providers can be identified.
There was an option that CJ could have remained living where he was, by way of a spot purchase, which was not identified until after his death.
If it had been known at the time, continuity could have been provided until more suitable support and accommodation was found. This was an unusual situation and required arrangements outside of the usual procurement procedures. This required more unpicking and knowledge than teams might have on a day-to-day basis.
Despite escalation to management, the solution of a spot-purchase was not identified. CJ was left without any housing or support provision, he had nowhere to go.
Whilst, Recommendation 3 addresses the suitability of provision, this section is about how flexible and creative attempts can be made to ensure that a young person has a home.

Recommendation 8
The Warwickshire Safeguarding Partnership should seek assurance that creative and flexible attempts are made to provide accommodation to children and adults and that all possible options are known and explored.

43

Adulthood - Responding to Emotional/Mental Health needs

160. CJ had a history of receiving support from CAMHS with his mental health needs. They had worked with him for some considerable time, and in 2017, just prior to becoming looked after by CSC, CJ was attending regular weekly psychotherapy sessions and CAMHS had oversight of his ADHD medication.

161. On moving to the out of area residential school, the local CAMHS service was alerted. His therapeutic needs were actively addressed by the residential placement. (See point 45 for detail).

162. At his last review in May 2020, there was a recommendation for a referral to Adult Mental Health. This was completed and the service wrote to CJ on 13th May to advise they had tried to reach him to offer a triage appointment to assess his suitability for Community Mental Health Services. CJ did not respond, and the referral was closed.

[43] Link to transforming care model-service-spec-2017.pdf (england.nhs.uk)

163. On the 19th of October, CJ took part in his Pathway Plan over the phone with the Leaving Care Team. CJ was able to show some insight into his circumstances and appeared willing to engage to achieve some stated aims:

- He wanted to work and train towards achieving an SIA licence[44] (Security Industry Authority)
- He was not managing his Universal Credit, so wanted to change that
- He spent his money on drugs and alcohol and had no money for food, tended to live off snacks, and had to visit his mum to get fed
- Had stopped using crack and heroin (was using opioid substitutes instead)
- Felt he could do with psychotherapy as:

'He has been through a lot of trauma in his life and seen a lot and feels he is not coping with it all. He spoke about seeing a lot of bad things recently and would like to speak to someone about his thoughts and feelings. He said he feels mentally unstable. He used to see a CAMHS Psychiatrist and at the time he did not use the therapy to his advantage and was not interested but feels he would really benefit from this now.'

The action from the meeting was for CJ to explore this with his GP and to liaise with professionals regarding therapy namely the social worker and the personal advisor. There is no evidence to suggest this was achieved.

164. After being locked out of the former placement CJ returned to stay, albeit temporarily with his mother, she advised that she was harassed by the landlord whenever he stayed there. Within a few days he left, after Warwickshire Police were called because of an altercation between his mother and his sibling. CJ was upset by this, and it is possible that he thought he was in trouble with the police which may have influenced his decision to leave. CJ advised that he slept in a ditch that night. It also emerged that his sibling moved that day from the mother to live with the father, where they remain.

165. There was a very close and positive working relationship between the workers, especially ASC, drug, and alcohol team and the AALDER team at this time. Information was shared in real time and the wider network was kept updated. Each time CJ was without accommodation all his workers collaborated and made great efforts to find where he was and to help him get to a safe place. CJ did not always follow their advice and he was often hard to reach; his mobile phone being out of battery.

166. When he was found, the Probation Service stepped in to offer help. They had access to 'vulnerable persons drug free accommodation' (10) in another area which could be funded by his Housing Benefit. Seventeen hours support was included. CJ moved in, but soon advised that he did not feel safe, he got into conflict with, and was threatened by, other residents and was banned from using the kitchen after trying to cook a tin of beans in the microwave, which blew up as a result.

167. The support worker for the accommodation advised that the risks were too high for him to live there, advising that the level of support was insufficient for his needs. CJ remained only a few days at the property, before he left and returned to sleeping rough (11).

168. After several nights on the streets, where he was understood to have suffered two separate assaults, his mother picked him up again to bring him home. CJ returned to

the Homeless department and advised that he had slept on the 6th floor of a car park and had contemplated jumping off.

[44] SIA | Get Licensed October 2021 (publishing.service.gov.uk)

169. Housing asked ASC if CJ had capacity and if living independently was the right thing for him? Housing advised if a tenancy could not be found he would be placed in an HMO (house of multiple occupancy), their concerns being that both CJ and other residents could be at risk from each other.

170. In a period of approximately three weeks CJ spoke on several occasions of feeling suicidal and staff from three different agencies notified ASC of their concerns about his mental state as a result of their contact with him, (Housing, Prevent and Probation). This was in addition to Leaving Care advising that CJ was 'feeling mentally unstable.'

171. When CJ spoke to his probation officer about thoughts of killing himself, this was explored with him, and he said he would not do it, but life was tough for him. They discussed strategies and it was clear CJ was thinking about the future. On another occasion CJ told his drug support worker that he had been feeling suicidal the day before but was not feeling the same that day. His worker made sure he had the number and encouraged him to contact the Samaritans when he felt like this.

172. Each of these workers responded in a kind and thoughtful way and alerted their concerns to ASC. His social worker had talked to him on several occasions and explained what psychology would involve, addressing his previous negative experiences of it and he did start to be more open to the idea. Although he did not get to the point of agreeing to a referral being made.

Finding 7: Responding to Emotional/Mental Health needs

CJ's situation was becoming increasingly desperate, he had left the probation hostel and slept rough, an argument at home had prompted him to leave his mother's; again, he slept rough and had nowhere to live. It is highly likely this situation felt overwhelming for CJ. Staff were liaising closely in their attempts to find him; his mobile phone was invariably without battery. It is recognised this was a pivotal time for CJ. There was very frequent and regular contact between the multiagency team in keeping each other appraised of CJ's whereabouts and welfare. There was a collective anxiety for him and concerted effort by staff trying to find him and assure themselves and each other regularly of his safety and well-being.

It would appear this was a reachable moment[45] for CJ, his life was at a turning point, he had recognised that he needed help with making sense of his troubling experiences and he was almost inevitably overwhelmed with his homeless situation. His sense of acceptance amongst the homeless did not equate to being content to live on the streets. This was an opportunity to engage with him to use that vulnerability awareness to help him take positive steps that he would not normally consider.

It was acknowledged that CJ needed emotional/mental health support, and this was a reachable time. But the instability of his life, including a lack of suitable accommodation, was a clear factor in how CJ could be provided with the support he needed.
The provision of accommodation to a young person which is so critical to their wellbeing, has been covered in previous recommendations.

45

Adulthood - Independent accommodation

173. In mid-November, the Housing Department Homeless section provided CJ with temporary housing. (12) This was an urgent response to him being found being homeless, with the aim of securing him somewhere safe to stay. CJ was provided with single ensuite student accommodation which had on-site security. Because of the pandemic students were not using the accommodation. It was accepted that whilst this was not ideal it was more preferable than being left homeless on the streets. A referral was made for direct support for CJ to be provided.

174. This was CJ's first experience of living alone. Unfortunately, the organisation it was hoped would provide CJ with support were not able to do so at that time. It is not clear who, if anyone, was aware that he was without the required support package being provided.

175. Furthermore, security staff were said to be on site 24/7 and would be able to monitor comings and goings so he knew that no one else was allowed to enter the accommodation. But the on-site security was working remotely because of the pandemic, there were no staff on the site. It appears that for the five weeks CJ lived at the student accommodation, he did so without the support package that was deemed necessary to enable him to live in the community.

176. In early December, CJ spent a few days with his mother, who washed his clothes and gave him food to take to his new property. He wanted to spend time at his mother's home over Christmas and his social worker confirmed with housing that this was agreed and would not affect his accommodation.

177. On the 9th of December the Learning and Disability Team of Adults Social Care (ASC) sought Legal advice in relation to which of the two local authorities were responsible for CJ. One authority was where he had lived with his mother and the other where he had most recently lived and where he preferred to stay. There were three areas of responsibility for which clarity was being sought, housing, social care, and support needs. It transpired that each authority was responsible for different elements.

178. On the 10th of December CJ met with his drug and alcohol worker and advised he was continuing to abstain from heroin and was not drinking every day. CJ had received his universal credit, so they went together and completed a food shop.

179. On the 16th of December CJ was seen for his Probation appointment, where it was reported there was:

[45] Chapter 8 Critical moments The Child Safeguarding Practice Review Panel - It was hard to escape - report (publishing.service.gov.uk)

'*a lengthy and positive discussion about his life to date, current circumstances, state of mind and future choices.'*

This was the last face to face contact CJ had with any staff members. Several agencies tried to phone CJ but were unable to reach him.

180. Several days later, CCTV noted CJ entering the student accommodation, but he was not seen to leave.

181. On 23rd December 2021, his mother requested support from the Police as she had been unable to gain contact with CJ. Police visited his address, sadly, CJ was found deceased surrounded by drug paraphernalia.

182. The Coroner has considered the circumstances of CJ's death. His death was regarded as drug related. No recommendations were made to any agency by the Coroner.

CJ's voice in 2020

183. CJ was open and honest when answering questions, often giving answers that were to his own detriment, but that fitted with his honesty. Here are some of the varied remarks CJ made to staff in 2020.

I can…I know the number for the Samaritans… I need some support now, but I do not want support to go on for ever…I have phoned 111 when I wanted advice, but they ask too many questions…People have called me vulnerable all my life and I do not want to be seen this way…I want to be independent.

I told others…Didn't feel safe and felt threatened and bullied by the other residents…Felt alone and abandoned…Considered throwing himself from the 6th floor as he felt desperate about his situation…Struggled with his identity in that he felt alone in life

What I like and would like…. I want to live in Coventry…To go to college…I enjoy watching Top Boy…I like weed, alcohol, opiates, and things. I have done lots of research about drugs…I walk around 10 miles a day to meet up with my friends…I would like to do work periodically. I don't think I could stay at any one job.

Family views

Mother:

CJ's mother reported a huge number of professionals being involved with CJ and his care and felt this was overwhelming for her, let alone CJ. She felt that professionals often worked in silos and there was a lack of communication between them.

She felt that things fell apart for CJ as soon as he reached 18 and that he slipped through the net. That Covid was given as a reason for disruption in the face-to-face support

CJ was receiving; however, she was aware that many services were functioning and did not feel this was a good enough excuse when CJ was so vulnerable.

Mother praised a social worker in Children's Services, the IRO, the ASD coordinator, and the Care Coordinator at CWPT.

She felt that the communication from Adult Social Care was poor and that she received little or no response to concerns she raised and was often told that her queries were not within their remit and there was no signposting to who may be able to help.

She reported that CJ felt overwhelmed and anxious by the prospect of turning 18 and what this meant for him, and he would tell her that he was not an adult yet and was still a child and could not look after himself.

She stated: 'His chaotic and sub-standard experiences within the care system caused him significant emotional and psychological harm, which is totally unacceptable to those who loved him. We were let down by so many agencies who were meant to be keeping him safe and well. My beautiful boy, CJ, deserved so much more.'

Father:

'One significant feature of WCC Social Services involvement with my family was that there was a continuous change of case workers, approximately every six months (sometimes more frequently) there were a number of case workers that I never actually met, or only met once.'

'At the many LAC meetings various professionals were tasked with numerous actions including capacity tests and a Pathway Plan for CJ as he was over 16 years of age. Up to and including the last LAC meeting a matter of a week or so before CJ's 18th birthday, these hadn't been performed.

'As a consequence of the many failings by professionals in various teams involved, I was assured that Children's Services had agreed to fund CJ's existing under 18 years arrangements, for 6 months beyond his 18th birthday to allow extra time for the tasks to be performed and suitable arrangements post 18yrs to be put in place.

CJ's father said that 'CJ was comprehensively failed by WCC Social Services.
It was my greatest hope that he would survive long enough to mature and realise his undoubted potential to live a good and purposeful life.

My view is that my only son died pointlessly and alone, in entirely avoidable circumstances, due to a litany of systemic failures by WCC Social Services and associated agencies.'

Uncle:

CJ's uncle felt that the work and workers were very disjointed, no one person had the overall picture and responsibility to lead on CJ's case.

He felt too many services were outsourced, with tasks being farmed out and that there was no connection between them. Was it known whether the tasks were completed to the required standard? Issues could be commissioned but it was a tick box exercise, one worker had admitted he did not know his role, it was to do 'whatever CJ wanted,' which he thought was ridiculous. He could not keep up with the large number of staff involved and who was to do what, and CJ had even less of an idea.

His uncle felt it was important for services to remain child focused and to hear CJ's voice.

Conclusion

As an intelligent teenager with ASD and ADHD, CJ knew he was regarded as vulnerable and treated differently from other young people his age. He railed against that and was conscious that he did not like the way he felt inside his head. He often sought to change that feeling using drugs and alcohol.

He was unable to live with his family, his mother could not manage him, and he was estranged from his father. He continued to have active support from his mother and paternal uncle, but he would not engage with his father. He craved friendship but struggled for acceptance amongst his peers. He found a level of acceptance from street homeless, but recognised he was being exploited and used by them.

His journey through the local authority childcare system was affected by significant difficulties in addressing his needs and securing positive outcomes for CJ. There was a vast array of practitioners, teams and multiagency services involved in his life, and, on various occasions, required standards of practice were not met. The sudden closure of his residential school and move to 16+ supported accommodation when he was far from ready, resulted in the loss of his education and a loss rather than gain of self-care skills. This was a critical point in his life.

Despite a wealth of information, preparation for adulthood, and transition to Adult Social Care the multiagency response fell far short of expectations. Multiple staff changes, late assessment, inability to source the right support, lack of mental capacity and risk assessments, and inadequate safeguarding, all made what was a complex situation more difficult and had a direct impact on CJ's daily life.

Increasing uncertainty and change saw CJ increase his use of alcohol and drugs. Despite availability of funding for supported living, many providers rejected requests to offer him care. He was given the stark choice of rehabilitation or accessing homeless services. Although he chose rehabilitation, it transpired this was not a real option.

The result was that he was homeless, his life continued to be chaotic, and he continued to be at significant risk of ongoing trauma and harm.

CJ finally moved to emergency homeless accommodation. He was entitled to daily support of up to 20 hours per week, but none was provided. He died alone five weeks later, from a drug related death.

CJ's situation was highly complex, and staff sought to get alongside him to find solutions that would improve that difficult situation. SARs are required to draw conclusions and make a judgment on predictability and preventability of the persons death. From the myriad of evidence presented to this SAR, the conclusion is that it is likely that CJ's death could have been reasonably predicted and it is clear that opportunities were lost to prevent his death.

Maureen Floyd

01 July 2022

Recommendations

Recommendation 1
The Warwickshire Safeguarding Partnership to be provided with evidence that EHCPs are being reviewed in accordance with statutory guidelines, covering regularity and planning for adulthood**.**

Recommendation 2:
The Warwickshire Safeguarding Partnership to be provided with evidence that the Virtual School has a system of oversight of children in care with EHCPs and that these are being reviewed as well as receiving their PEPs in accordance with statutory guidance.

Recommendation 3
Evidence should be supplied to the Warwickshire Safeguarding Partnership as to the suitability and availability of placements provided to children and adults with complex needs such as ASD, drug use and mental health needs.

Recommendation 4
The Warwickshire Safeguarding Partnership should regularly review progress to ensure effective preparation for adulthood and transition to adult services is in place, this should include transition arrangements for children who are not in education.

Recommendation 5

The Warwickshire Safeguarding Partnership to seek assurances that where risks to a child or an adult are identified that expected actions and processes are followed to safeguard the child or adult from abuse and exploitation.

Recommendation 6

The Warwickshire Safeguarding Partnership should seek assurance how the recommendations made in Care Act assessments are being achieved.

Recommendation 7

The Warwickshire Safeguarding Partnership should seek assurance that Mental Capacity Assessment dispute resolution arrangements are in place, and they take account of all parties and specify what action must be taken when there are disagreements with decisions or findings.

Recommendation 8

The Warwickshire Safeguarding Partnership should seek assurance that creative and flexible attempts are made to provide accommodation to children and adults and that all possible options are known and explored.

184. A SAR Panel was established with representation from the following organisations:

- Coventry & Warwickshire CCG
- Coventry & Warwickshire Partnership NHS Trust
- National Probation Service
- Positive Choices Change, Grow Live
- South Warwickshire NHS Foundation Trust
- Warwickshire County Council Adult Legal Services
- Warwickshire County Council Adult Social Care
- Warwickshire County Council Children's Social Care
- Warwickshire County Council Education Services
- Warwickshire Police
- Warwickshire Safeguarding Partnership (Adults & Children)
- West Midlands Police

185. Independent Reviewers were appointed to the Review. Bridget Griffin to Chair the SAR and the Review Panel and Maureen Floyd author of the review.
Bridget and Maureen were co-authors of the Croydon Safeguarding Children Board Vulnerable Adolescent Review, a thematic review looking at the lives of 60 Vulnerable Adolescents.[46]

186. The Review Panel agreed Terms of Reference noting that the review would focus upon all agency interventions during the last 12 months of CJ's life. In addition, for the review to consider the intervention of all agencies associated with placements provided by Children's Social Care (CSC) whilst CJ was a child in their care. In addition to the agencies above, a range of other private organisations, and voluntary and statutory agencies who had provided services to CJ, contributed to this review.

187. The agreed methodology was:

For each agency to

- Provide a comprehensive 12-month Chronology.
- Submit a report addressing the key lines of enquiry.
- Provide information relating to placements whilst CJ was in care.

For the Review Panel to critically evaluate information and contribute to the findings.

For the Independent Reviewers to

- Present a Reflective Learning Event to all relevant staff. This to include CJ's history and experiences, give initial findings and gain feedback from the staff involved.
- Gain the views of CJ's parents and any other family members who wished to contribute to the report.
- Draft a report to be shared with the Review Panel, family, and staff.
- Provide a final report to be provided to the Safeguarding Executive for formal approval and agreement for publication.

[46] https://library.nspcc.org.uk/link to Croydon Vulnerable Adolescent Review

188. Key Lines of Enquiry (KLOEs)were agreed within the Terms of Reference. Each agency was asked to comment upon these areas within their written submissions

a) How your agency worked with CJ and partner agencies to prepare and manage each transition
b) Adolescent Development
c) Responding to complexity
d) The role of the ‘corporate parent’
e) Prevention of suicide and self-harming behaviour
f) Equality and Diversity