Safeguarding Adults

Review

Joe Pooley

Overview Report

December 2021

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SAR Addendum – August 2022

There were additional factors brought to light through the coronial inquest into Joe's death, which concluded Friday 29th July 2022, that are not referenced in this Safeguarding Adults Review (SAR) and were not shared with the Independent Author during the SAR process. The Suffolk Safeguarding Partnership (SSP) would like to highlight these additional factors and incorporate the learning from them across our partners alongside the existing SAR actions.

The SAR notes that a Section 42 should have been initiated before it was, and that agencies should have better shared information to identify risks to Joe. The inquest uncovered two incidents, one in June 2018 and one in July 2018, where Joe and another witness identified Luke Greenland (also known as Sebastian Smith) as having been the person coercing Joe into undertaking criminal activity out of fear. This information, given to the Police, was not shared with Social Care via referrals to the Multi Agency Safeguarding Hub (MASH), which was crucial in understanding the level of risk to Joe from those he was associating with.

Additionally, there was identification of the failure of the Public Protection Casework Section (PPCS) of the Prison and Probation Service to recall Luke Greenland (also known as Sebastian Smith) who, at the time he took part in Joe's murder, was in breach of his Home Detention Curfew (HDC) licence having removed his electronic tag on 20th June 2018. The inquest identified that significant workload pressures, staff absence, and a lack of managerial challenge and oversight in the Prison and Probation Service contributed to this failure to recall Luke. The coroner stated that "Luke Greenland was central to Joe's death, as is reflected in the trial judge's sentencing remarks and Luke Greenland's sentence. Had he been recalled to prison prior to 6th August 2018 then it is more likely than not that Joe would not have been killed."

As a result of the above information, the SSP are including an extra learning point into our action plan by which we will - as a partnership - hold discussions with the relevant agencies about how in future we integrate the offender-level and offending information these agencies hold whenever our reviews, which focus more on care and support, are undertaken.

Contents

1. Introduction

1.1 Joe Pooley was a 22-year-old care-leaver who received support from Suffolk County Council (SCC) adult services as he had a learning disability. Joe was described as lovable, impulsive, confident yet vulnerable, very trusting, and eager to make friends, but he had difficulty maintaining relationships. As an adult, Joe struggled to sustain stable accommodation, being evicted, or moving repeatedly. His cannabis use led to drug debts and Joe was subjected to threats, assaults, and financial exploitation, but Joe was not willing, or due to coercion was unable to give information to the police to prosecute those responsible. Although practitioners working with Joe worked hard to support him, there was a limited strategic approach to mitigate these emerging risks. In August 2018, Joe was attacked and drowned by associates who had become angered by private messages Joe sent over social media after an intimate relationship turned sour. In May 2021, two men and a woman were each sentenced to at least 17 years in prison for Joe's murder. A coroner's inquest is due to take place in July 2022.

1.2 The author wishes to thank those working closely to support Joe for the eloquent way in which they were able to articulate his voice. The affection the staff from all levels of each organisation involved felt towards Joe was palpable and the fond memories they shared gave insight into his vibrant and human nature.

2. Scope of Review

Purpose of a Safeguarding Adult Review

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

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

2.2. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Joe from harm.

2.3. Since Joe turned 18 and responsibility for meeting his needs transferred to adult services in 2014, substantial legislative changes have been introduced to strengthen the legal frameworks that facilitate provision of care and support for young people leaving care, with special educational needs or transitioning to adult social care, and to ensure that partner agencies work more closely to meet those needs in a holistic way. The partner agency services have also evolved over time, in particular to support more effective interagency working, with clear pathways for escalation of professional disagreement. Many key events in Joe's life pre-date these changes and it is important to recognise that this impacted on the ways in which practitioners undertook care planning for Joe. This has therefore been discussed in the body of the report. A summary timeline has also been prepared at Appendix 2, mapping Joe's life against the legislative changes.

Themes

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

Making Safeguarding Personal

- To understand and tell the story of Joe's life, particularly his lived experience, from his birth to his death, piecing the jigsaw together with those who knew him
- To consider how Joe's voice was heard and listened to, and how that may have shaped the response from agencies
- To understand what support for Joe's adverse childhood experiences and trauma was available and the impact this had on Joe's decision-making process
- To determine the pivotal points in Joe's life, especially how the responses from his family and services led to changes in decisions made by Joe and the impact on him
- To understand what caused Joe to engage and disengage with different groups of people
- To understand the professionals' judgment-making process in determining Joe's capacity to make informed choices as a care-leaver
- To identify areas of good practice that had a positive impact on Joe.

Partnership Working in the Context of Transitions

- To consider the services available to Joe in the context of a care-leaver from both adult and children's services up to the age of 25
- To understand the support Joe received when moving between adults and children's services
- To understand all the events in the handover process between children and adult services
- To understand what would be different now if someone with similar circumstances to Joe presented again
- To understand if information sharing between health and social care was appropriate and timely and the impact of any information that was not shared appropriately
- Consider the support Joe received and take a system wide, holistic view of if effective mechanisms/services/processes are in place that adequately support people in Joe's situation.

The National Picture

- To identify implications of national significance for those with similar circumstances to Joe
- To compare Joe's situation with reviews that have previously been undertaken
- To understand how practice in Suffolk compares with other jurisdictions, identifying any good practice that could be applied within the Suffolk System
- The time period reviewed included Joe's childhood and transition to adulthood, as well as his adult experiences.

Methodology

2.5. Although a SAR could not take place until after conclusion of the criminal proceedings due to the risk of this impacting on the prosecution, to avoid further delay in identifying systems learning, the Suffolk Safeguarding Partnership arranged for the conduct of a SAR using a modified version of the Social Care Institute for Excellence SAR In-Rapid-Time methodology. This was to enable learning to be turned around more quickly than usual through a SAR, but with a more detailed report that would typically be produced for a SAR in Rapid Time.

2.6. The learning produced through a SAR in Rapid Time concerns 'systems findings. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to do a good job day-to-day, within and between agencies.

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

- Suffolk Constabulary
- Suffolk County Council Children's & Young Peoples Services (CYPS) including Leaving Care Services
- Suffolk County Council Adult Community Services (ACS)
- Norfolk and Suffolk Foundation Trust (NSFT)
- Ipswich Borough Council (IBC).

2.8. Multi-agency learning events took place, both with front-line practitioners who worked with Joe and leaders who oversaw the services involved in supporting him.

2.9. Additionally, meetings took place with police officers involved in the criminal investigation into Joe's death, and teachers and head teachers (past and present) from Joe's former school who had worked with Joe. His head teacher had met earlier with Joe's former foster carer to ensure that this period of Joe's life and his voice could be captured for the review.

2.10. Joe's mother was invited to participate in the review and although she did not wish to do so, she expressed her hope that the review will make a difference for organisations learning lessons.

3. Narrative Chronology

3.1. Joe experienced multiple childhood traumas including neglect in his mother's care. Joe was then moved to the care of his father under a residence order, where again, he experienced severe neglect, abandonment, physical and emotional abuse. His deafness remained untreated for several years. As a consequence of this chronic harm, in March 2003 Joe and his brother were removed through care proceedings and within 2 weeks were placed with foster carers who were in their 60s. The couple were extremely experienced and caring but had initially taken the children on a temporary basis as they considered themselves too old to care for two children with such complex needs through to adulthood. Despite this, they were extremely committed and loving to the brothers, offering a true family environment to Joe until he was 15. His independent reviewing officer recalled Joe and his brother happily baking cakes for professionals attending their looked after child reviews. Children's Social Care considered that contact with his mother was disruptive for Joe and reduced this to 4 times annually. He had no contact with his father. Joe was fortunate to have one social worker from 2005 – 2011 and this consistency is likely to have supported his stability through this period.

3.2. Joe attended a special needs school from age 9-16, where he was noted to be amongst the more able children academically and popular with peers and teachers despite his often-challenging behaviour. He showed good understanding of daily living skills under some supervision and took pride in his appearance. Joe would often appear to listen and agree with information he was being told, but retain very little of this, leading teachers to suspect he had Asperger's syndrome, although this was never formally diagnosed because he moved placement before he could be assessed. His teachers reported that of the children in his school "…Joe was the most unrealistic about where he sat in the world", resistant to being labelled with a learning disability and very confident about his decision-making abilities. His self-confidence and 'hidden' disability could easily mask his high level of need to new professionals. Joe had little insight into the feelings or motivation of others, which could lead to fractious and indiscriminate relationships. He considered the world his friend and thrived on attention, whether positive or negative.

3.3. After Joe's older brother decided to leave their foster placement in 2010, Joe's behaviour became increasingly unsettled, both in his placement and his school. His foster placement came to an end in February 2012 when his foster carers retired, possibly influenced by the escalation in Joe's behaviour. He was moved to a foster placement that was some distance from his school, reducing his ability to travel independently. Joe was then expelled from school for extremely challenging behaviour in June 2012, though allowed to complete his GCSEs. His teachers felt that he had 'outgrown' the school and was ready for an environment which offered more independence, albeit with tailored support. Joe moved to a Further Education College in September after a careful handover from his previous school, but the new provision also broke

down after just 6 weeks and Joe received independent tuition for a period before leaving education permanently.

3.4. A further foster placement and placements in children's homes also broke down within a short period and Joe spent periods living with his mother between placements before those arrangements broke down due to their fractious relationship. Within a very short timescale, Joe had moved from a very carefully supported home and school environment to an unstructured and chaotic situation that he lacked the cognitive abilities or emotional resilience to negotiate. One participant in the leadership event, who remembered Joe with fondness, commented how frightening and lonely supported accommodation must have been for Joe, having been in such a nurturing school and foster placement for so many years. In 2013, concerns started to emerge around Joe using alcohol and chronic cannabis use. He was also reported to have difficulties with social skills, had self-harmed and allowed others to burn him with lighters.

3.5. In the 4 years following his 18th birthday, Joe had 20 different addresses; mainly sourced through ACS and were either supported accommodation placements or emergency accommodation funded by the Learning Disabilities team. A Shared Lives placement was also made. None of the placements lasted for more than 4-5 months at a time, and Joe either chose to leave himself to go and live with friends or was evicted due to his chaotic presentation, misuse of cannabis or not engaging appropriately with the support provided. He could be verbally abusive and threatening to allocated workers when they challenged his behaviour or he felt that his needs were not being met, often wanting extra money from his personal finance account. During periods when Joe was not in supported accommodation, external agencies were commissioned to provide 1-1 support, although his engagement with many workers tended to wane over time.

3.6. As a consequence of ongoing concerns that Joe was being financially exploited, an appointeeship was put in place to enable SCC to manage Joe's benefits, with his agreement as he recognised his own vulnerability. This ensured that his bills were paid, and he was given the balance of his funds in small, regular amounts so that he could afford food throughout the week. Despite this, staff across both ACS and Leaving Care reported that they would regularly provide Joe with food parcels or, on occasion buy him food from their own pockets. This was because Joe would either spend his money on cannabis or generously, but naïvely, share whatever food he had with others in need, without thinking about whether this would leave him short later in the week. Joe would also sell or exchange his possessions, such as mobile phones or play stations, for cannabis. He repeatedly expressed fears that people he owed money to intended to harm him and, on several occasions, reported that he had been assaulted, although he refused to provide details of the perpetrators to the police to enable this to be investigated.

3.7. Joe's self-care skills diminished over this period, which he attributed to periods living on the street. His cannabis use escalated, which contributed to feelings of being low and paranoia. Ongoing concerns were raised in respect of Joe being vulnerable to coercion and having difficulty maintaining relationships. He was in regular contact with his mother and two of his siblings, who offered some practical and emotional support. While his mother advocated passionately for him, she could also withdraw when the relationship became fractious. Family mediation was offered by ACS but both Joe and his mother refused. Joe had chosen not to be in contact with his father as an adult.

3.8. Throughout 2015 there were multiple referrals for an autism or ADHD assessment, but when Joe met with the specialist ADHD nurse in March 2016, the assessment could not be carried out due to his high levels of substance misuse. A further clinical record in February 2017 noted insufficient indicators for ASD and that Joe's difficulties could be accounted for by a severely disrupted attachment.

3.9. Joe came into contact with police fairly regularly and there were initial safeguarding referrals made in respect of Joe by the police and other professionals, but there were never any safeguarding enquiries carried out, as they were deemed to be police only investigations or that they did not meet the criteria for a full enquiry under s42 of the Care Act 2014. Joe would either refuse to name the individuals who were involved or withdraw allegations when interviewed by the police.

3.10. He also presented as homeless to Ipswich Borough Council many times, but they assessed him as not having capacity to manage a tenancy and referred him back to ACS. This conflicted with a mental capacity assessment by the Learning Disabilities team in October 2016, which concluded that he had capacity in this regard. This left Joe in limbo, too high functioning to be placed in residential care, resistant to the structures of supported accommodation, but unable to cope with the reality of maintaining his own accommodation. Joe's difficulties in sustaining positive personal relationships meant that periods living with friends or family would rapidly break down. By 2018 he was living in a hotel which was funded by ACS, but this was not suitable for his level of vulnerability and at times he reported that he was worried that people he owed money to knew where he lived. The Learning Disabilities team referred Joe on to Leading Lives and he had a progression worker, who tried to work with him to resolve some of these housing and benefit issues. However, he disengaged from these workers and stopped meeting with them.

3.11. Joe's mother made repeated complaints from 2015 to 2018 to councillors and her MP that the council had failed to meet Joe's needs, placing him in unsuitable accommodation, resulting in him experiencing periods of street homelessness and suffering physical and financial abuse at the hands of other residents. She expressed fears that he would be seriously hurt or killed at the hands of these 'bullies. In March 2018 she met with a senior manager to discuss her complaints, which resulted in Joe's case being allocated to the new Complex Cases team.

3.12. The Complex Cases team had been established just weeks before Joe died, for the express purpose of supporting young people with additional needs who experienced multiple exclusions and unstable accommodation. Joe was their first client and low caseloads within the team enabled workers to dedicate the time needed to improve Joe's situation. They were creative in identifying a potential solution to his accommodation needs through accessing a pooled fund previously only available to mental health services.

3.13. Joe had his first meeting with support workers from a specialist accommodation provider a month before he died, to start outreach work with him with a view to moving him into his own flat with bespoke support if this was successful. Joe was excited about this opportunity as he wanted to live in a self-enclosed flat rather than shared accommodation and it is tragic that he was killed before he could move into his own home.

3.14. On the night of 5 August 2018, Joe spent the night with Becki West-Davidson, a woman with whom he had previously been in a relationship. The next day, Joe offended West-Davidson during an escalating exchange on social media. She contacted Luke Greenland (aka Sebastian Smith) who Joe had considered a friend, but had also fallen out with, provoking an angry exchange culminating in threats to harm Joe. Although Joe was initially frightened, Greenland and his girlfriend manipulated him to believe that all was forgiven, so he went to meet with them. Together with an accomplice, Sean Palmer, Greenland assaulted Joe then callously put him in the river to drown. Joe died in the early hours of Tuesday 7 August 2018 and his body was found on Monday 13 August 2018.

3.15. There is no indication that Joe told any professional about his fears for his safety on this occasion. However, it has subsequently come to light that Greenland may have been involved in a previous incident where a safeguarding referral was made, after Joe was forced to commit a minor crime to repay a drug debt. Joe had not disclosed Greenland's involvement in this incident and although this may have been a missed opportunity to implement a safeguarding plan, it is questionable whether this would have changed the tragic chain of later events. Joe's self-confidence, desire to make friends and lack of insight into the motivations of others meant that he was unlikely to comply with advice to avoid individuals who posed a risk to him, even had their involvement been known.

4. Analysis of Agencies' Actions

Therapeutic provision to prevent an emerging need from escalating

4.1. The professionals who knew Joe when he was a child reported that he presented as very happy and although impulsive, did not display significant behavioural issues prior to 2010. Consequently, therapeutic support was not considered a priority. However, in light of Joe's traumatic childhood experiences, it could be reasonably foreseen that this would impact on his long-term attachments and ability to recognise healthy relationships. Therapeutic support from CAMHS throughout his time in care may have supported him to make sense of the world and his multiple losses.

4.2. The initial concerns expressed by the foster carers in respect of their ability to care for the children throughout their minority was carefully weighed against the children's need for the stable and loving home they provided. It is unusual for a foster placement to continue until a young person turns 18 and more common for young people to move to residential homes or supported accommodation as teenagers, as they begin to challenge boundaries. The immediate disruption caused by Joe having contact with his mother as a child also needed to be carefully weighed against the benefits of developing a closer relationship with her as he moved into adolescence, particularly in light of the likely 'pull' as Joe approached adulthood. Again, support from CAMHS may have enabled a more positive, stable relationship to develop. This may also have supported the foster carers and mitigated against the eventual breakdown of the placement. Leaders recognised the importance of building family relationships during the young person's time in care to avoid a 'car crash' as they reached 16 but noted that this could be led both by the engagement of the parents and the young person themselves, particularly because contact could be particularly disruptive for young people with insecure attachments.

4.3. In 2006, a referral was made for support to be provided to the foster carers through Connect, a therapeutic resource for young people in care who are experiencing attachment, emotional and behavioural difficulties relating to trauma, primarily in respect of Joe's brother's needs although the service would have supported the entire family. Connect's records indicate that this was not taken up by the foster carers, however, there was no indication that this non-attendance was relayed to CYPS and CYPS's records indicated that the foster carers had attended. To ensure that a foster placement is a true family environment, trust must be placed in the carers to meet the day-to-day needs of the children. However, it is essential that when appointments are missed that relate to the emotional wellbeing or health of a child, clear feedback loops are embedded to maintain professional oversight by the local authority as corporate parents. It may be difficult for foster carers to relay this information during forums such as LAC reviews, given that the children will usually attend the review and the carers may want to protect them from hearing information they may find upsetting.

4.4. Irrespective of whether Joe had a diagnosable mental health condition, by the age of 15, he was clearly showing significant psychological and emotional distress, which required therapeutic intervention. He experienced multiple losses – his brother moving out of their foster placement, his own placement coming to an end and moving schools. In the context of his adverse childhood experiences, Joe is likely to have experienced these events as retraumatising rejections, even though there were good reasons for each change at the time. Intensive therapeutic intervention at this point may have prevented Joe's needs from continuing to escalate and helped to stabilise him.

4.5. Guidance recommends integrated commissioning between children's and adult mental health services that provides a quality transitions service to the cohort of young people up to the age of 25 who have risk factors with multiple poor outcomes, symptoms which do not meet a diagnostic threshold but are at risk of developing a mental disorder, and those with undiagnosed and unmet needs, particularly those whose needs become more acute as family, educational and other supports diminish[1]. This recognises that *"intervening early at the onset of mental*

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

illness improves prognosis, reduces future demand on mental health services and leads to better outcomes for patients."

What has changed

4.6. The introduction of the Children and Families Act 2014 has greatly strengthened duties in respect of partnership working between local authorities and health services in respect of young people with special needs. Education, Health, and Care Plans (EHCPs) are co-produced to ensure that needs are assessed and met in a more holistic manner. Although not relevant to Joe's case because his foster carers had retired, the Act also introduced a new duty on local authorities in England to advise, assist and support fostered young people to stay with their foster families when they reach 18, if both parties agree.

4.7. In Suffolk, Looked After Child health assessments, which include consideration of any mental health or emotional needs, have become far more detailed and are quality assured. Health assessments feed into the LAC Review and care planning process, with EHCPs clearly identifying who is responsible for progressing referrals. The Child Health Service is notified in advance of all LAC Reviews, so reports are produced in a timely way. When the service is unable to attend, minutes are provided to ensure that any actions are taken forward. A monitoring form is completed after each LAC review to provide feedback on whether actions have been completed from the past review and comprehensive and timely documentation received to inform the meeting. Where there are complex actions to take forward, a 3-month review meeting is frequently set up, rather than waiting for the next 6-monthly statutory meeting. When Ofsted inspected Suffolk's CYPS in April 2019[2], it judged the service to be outstanding overall and commented that *"Suffolk's therapeutic fostering tailored support, provided for carers of children who present with trauma and challenging behaviour, is particularly well received and it also helps to sustain placements."* (Ofsted report, paragraph 24)

4.8. However, there is currently a waiting list of over 2000 children waiting to be seen by the Emotional Wellbeing Hub, Suffolk's front-door to children's mental health services. The Safeguarding Partnership has planned to complete an audit of the children and young people on the waiting list to understand their needs and reason for referring to the hub, with a view to identifying a system wide approach to reduce the backlog and manage demand on the waiting list, incorporating resources within the voluntary and community sector. NSFT has prepared a recovery plan for operational improvement of the Emotional Wellbeing Hub, including actions to improve the quality of referrals received, safeguarding partners taking over responsibility for managing some referrals and developing a new model of care for children and young people with mental health needs. Monthly data on the waiting lists will be provided to the Safeguarding Partnership's Learning and Improvement Group to enable monitoring of the impact of the recovery plan.

Systems finding

4.9. Although systems for monitoring support for mental health and emotional wellbeing through EHCPs and LAC reviews have been greatly strengthened in recent years, there is still a gap in therapeutic services for children without a clear mental health diagnosis. During periods of crisis, therapeutic support cannot always be accessed in a timely way, resulting in escalation of emerging mental health needs.

Recommendation 1: The mental health and therapeutic offer from the CCG, NSFT and Suffolk County Council working together needs to be strengthened for children and young people who do not have a mental health diagnosis but who are nevertheless displaying significant emotional and psychological distress as a result of trauma.

Recommendation 2: Link social workers for foster carers should always provide reports for CIC reviews to ensure more effective consideration and action in response to any difficulties the foster carer/s is or are facing.

[2] Ofsted Inspection of Suffolk children's social care services 50078713 (ofsted.gov.uk)

Assessment of ADHD and Autism

4.10. From 2012 onwards, questions were repeatedly raised across the professional network as to whether some of Joe's behaviour and presentation related to either Asperger's syndrome or attention deficit hyperactivity disorder (ADHD). Referrals were made to CAMHS and then NSFT's adult mental health services, but for a variety of reasons these were not progressed. An initial referral did not come through the correct paediatric pathway, appointments were missed, Joe moved areas and by 2017, he was misusing cannabis to such an extent that he could not be assessed. Although each individual episode is justifiable – the time of expert therapists is valuable and missed appointments, for whatever reason, are a poor use of resources - the overall picture is of a professional network that failed to work together to proactively ensure that Joe's needs were properly assessed. Importantly, just days before his death, Joe told his new social worker that he believed that he had ADHD and that many of his difficulties in engaging with supports related to this. The social worker was clear that had it not been for Joe's death, he would have progressed a referral, but by this point, Joe had been waiting for 6 years for an assessment.

4.11. Since 2012, NSFT has had a specialist mental health service for young people aged 16-25, which is consistent with good practice. This recognises that this cohort have specific needs that can make it difficult for them to engage with adult services. Practice in this service is to ensure that staff are proactive in offering appointments, rather than closing a case because young people, who may be experiencing chaos in their lives, have missed appointments. It is unfortunate that Joe did not progress through the 'gatekeeping' processes within this service. However, NSFT reported that when a young person was diagnosed as being on the autistic spectrum, unless there is a co-morbid mental health diagnosis, the case would be closed to mental health services as autism, in itself, is not a neurological condition requiring secondary mental health services.

4.12. It may be that a comprehensive assessment would have concluded – as is indicated in some of the preliminary assessments undertaken – that Joe's difficulties were largely a consequence of his early childhood traumas and deprivation rather than a diagnosable condition. However, this is unclear without proper assessment, which may in any event have provided professionals with valuable insight into Joe's functioning which could have enabled them to better support him. Both ADHD and autism are conditions which encompass individuals with a very wide range of abilities and traits and a nuanced understanding of Joe's particular needs was important.

4.13. Additionally, the lack of clarity within the professional network as to whether Joe did in fact have a diagnosis is highly problematic. NSFT are clear that he was never diagnosed with ADHD and that autism had been ruled out in an assessment in 2017. Joe's social worker in the Learning Disabilities team recorded in early 2018 that he had a diagnosis of ADD/ADHD for which he was prescribed (though not taking) medication, but not autism. However, the police criminal records state that Joe had both ADHD and autism. This lack of clarity may go some way to explaining why assessments were not chased.

What has changed?

4.14. In early 2020, CYPS introduced a tracker to ensure that when young people up to the age of 25 were referred for an autism assessment, these referrals were followed up until an outcome was received from CAMHS or NSFT. Leaders explained that this ensured that there were no longer cases which drifted or failed to be completed, because the cases never came off the tracker unless a clear outcome was received.

Systems finding

4.15. A complex referral process, delays in progressing referrals and under-resourced local mental health services result in many children and young people's mental health needs remaining unassessed and unsupported in Suffolk and nationally. This is of particular concern for young people who are looked after, whose underlying conditions are likely to be exacerbated by childhood trauma and who are likely, through no fault of their own, to move placements resulting in assessments not being progressed.

Recommendation 3: The CCG's and NSFT should review their referrals pathways for mental health, learning disability and autism, to ensure young people who are hard to engage are not prematurely excluded from assessment and service provision without serious attempts to engage.

Recommendation 4: Suffolk Safeguarding Partnership to obtain an assurance report about waits, waiting times and waiting list management for young people needing autism and ADHD assessments.

Recommendation 5: NSFT and the CCG should develop accessible information for individuals, their families, and carers to explain the referral process for autism and ADHD, to demystify these processes and support engagement with assessments.

Transitions and Leaving Care

4.16. At the point Joe turned 18, the Care Act 2014 was not yet in force, so the current transitions regime, requiring local authorities to start transition planning for young people from the age of 14 had not yet been introduced. Likewise, the special education needs provisions introduced under the Children and Families Act 2014, which require local authorities and health to cooperate to ensure that young people with special needs have an Education Health and Care Plan until the age of 25 was not in force.

4.17. The duty to meet Joe's needs therefore fell under the National Assistance Act 1948 and Chronically Sick and Disabled Persons Act 1970, together with the supporting Fair Access to Care Services (FACS) Guidance. As a matter of good practice at the time, this planning would start no later than 6 months before the young person's 18th birthday. Although Joe was referred to ACS for a FACS assessment when he was 17 ½ years old, there was a delay and when a worker was allocated, they initially assessed that he did not require supported accommodation to meet his needs. It may be that Joe's self-confidence and articulate presentation resulted in the worker underestimating his need for care and support. However, when Joe met with Ipswich Borough Council to apply for housing, they assessed that he would not be able to manage a tenancy and challenged ACS's position. Consequently, CYPS had planned for Joe to remain in the supported accommodation he was living in post-18, but this broke down shortly before his 18th birthday.

4.18. Referrals were also starting to be received that Joe was experiencing bullying and exploitation. Cohesive, multi-disciplinary planning should have taken place to ensure that a safeguarding plan was in place during the multiple exclusions from education– an escalation of risk was predictable as he approached adulthood. Adult safeguarding staff should have been involved in planning the responses as it was likely that Joe's vulnerability would continue into adulthood. This should then have translated into a post-18 safeguarding plan.

4.19. At the time Joe was approaching his 18th birthday, Leaving Care services for SCC were outsourced to a commissioned service, Catch-22, a social enterprise that specialises in leaving care services. The intention behind this was to secure provision from an organisation with

expertise and a national frame of reference to improve service for young people. However, concerns were raised about the quality of the service some young people were receiving. There may have been some confusion around the status of the service as an external provider of a statutory service which may have impacted on communication at times, in particular the ability of staff from Catch-22 to access wider council resources to support young people.

4.20. However, generally Joe received a good quality, thoughtful Leaving Care service, with workers who cared about him achieving his potential. Handover from CYPS was detailed and introductions to new staff members were made in person by the previous worker. Two personal advisors were allocated to Joe's case, both to ensure that he always had someone available to support him during periods of leave and because Joe could be quite demanding of staff time, this reduced the risk of worker fatigue. The personal advisors spent a lot of time working with Joe around boundaries, in particular the issue of his cannabis use as this repeatedly put his placements at risk. Joe was offered referrals to substance misuse services and although he continually refused these, social workers and personal advisors were appropriately persistent in trying to support him to engage with services. This complied with the 2007 NICE guidance[3] recommending that health and social care take a preventative, pro-active approach to the identification of young people who may be at risk of substance misuse.

4.21. The Leaving Care team worked in collaboration with ACS staff to support Joe until he was 21, when the service terminated in accordance with the legal framework at that time as Joe was not in education. Despite closing his case, staff reported that they remained in regular contact with Joe and always supported him if he asked for help. However, when Joe's case was initially allocated to the Learning and Disabilities Service within ACS, cases were only allocated to a social worker for specific pieces of work to be completed, before returning to being held on duty. He was only allocated to a social worker in ACS on a long-term basis in May 2017, when Leaving Care was closing Joe's case as he had turned 21. This was not appropriate for someone with Joe's complex needs and unstable situation. Overreliance on services designed to provide 'life skills' support (namely the leaving care services) impeded preventative work to stop risks from escalating. Whilst the continuity of support provided by the allocated Leaving Care personal advisors may have gone some way to bridging this gap, practitioners were unable to effectively manage his high levels of need and risk without the necessary legal or managerial infrastructure in place.

What has changed

4.22. The legislative changes made by the Government since 2014 recognise that a 'cliff-edge' at 18 is detrimental to young people leaving care or with care and support needs. In addition to the transition's provisions in the Care Act 2014, both the special needs provision in the Children and Families Act 2014 and the leaving care provisions in the Children Act 1989 provide for continuous service from social care for young people with complex needs, up the age of 25. Since enactment of this suite of legislation, Suffolk has made significant changes at a strategic level to strengthen its offer to this vulnerable cohort.

4.23. The Leaving Care service was brought back in-house by SCC in 2017, to provide the council with more control over the service. The Local Offer from the Leaving Care service is published on the council's website, and an accessible copy is given to all young people from the age of 16. Specialist homelessness personal advisors have been introduced to link into districts and boroughs to prevent young people experiencing instability or homelessness. This is supported by a Joint Protocol between Suffolk's County, district, and borough councils to meet the needs of homeless 16/17-year-olds[4], to eliminate unsuitable accommodation for young people and ensure that thresholds are consistently applied across the county. A Transitions Panel[5] was

[3] First published in 2007, but more recently updated in 2017 and available at: https://www.nice.org.uk/guidance/ng64/resources/drug-misuse-prevention-targeted-interventions-pdf-1837573761733

[4] 2019-06-12-Joint-Protocol-2019-2021-re-Homeless-16-17-Year-olds-v3.pdf (suffolksp.org.uk)

[5] In Suffolk, 'transitions' in this sense denotes a young person transitioning from care to independence, rather than in the context of Transitions duties under the Care Act 2014 in respect of children who are likely to have care and support needs as they reach adulthood

introduced in mid-2018, including representatives from Leaving Care, locality housing leads from each of the district and borough councils and the police to plan for housing options for young people in care as they approach their 18th birthday. This aims to secure stable accommodation that meets the individual needs of all care-leavers, including any additional support required to sustain the placement. The 2019 Ofsted inspection found that:

> *"The help and support that care-leavers receive is much better than at the time of the last inspection. The local authority is now in touch with the vast majority of care-leavers. It has increased the accommodation options available, and almost all care-leavers now living [sic] in suitable accommodation, many of them with their former foster carers as part of a staying put arrangement. The ongoing professional support offered as part of the 'staying close' initiative eases some of the stress for young people moving from residential care into semi-independent accommodation. Feedback from young people also points to good improvement to the support they receive." (Ofsted Report, paragraph 28)*

4.24. Following the restructure of the Learning and Disability service in 2018, all cases within the service are now allocated to specific social workers and are not held on duty. This enables staff to build relationships with their clients over time and improves their understanding of their needs, wishes and feelings. Additionally, a Leaving Care/Adult Community Services panel was introduced in 2019 for young people in care who are likely to have care and support needs when they reach adulthood, to ensure that the services they are likely to require are in place and kept under review. Planning starts no later than the young person's 17th birthday. This includes senior representatives from Leaving Care, ACS Mental Health, Learning & Disabilities and Autism services and NSFT. In situations where a young person is suspected to have undiagnosed mental health or learning needs, the panel will ensure that these are completed in advance of their 18th birthday.

4.25. Additional services have also been made available to help support care-leavers in Suffolk. For example, since 2019, a mental health nurse provides a drop-in service for young people who are leaving care. They are able to work with colleagues in Staying Close, supported accommodation or residential care to provide additional support to improve and sustain the stability of placements. A new 'grand-mentor' service of older volunteers works with care-leavers up to the age of 25 to provide them with practical and emotional support as they navigate adulthood.

4.26. Leaders are of the view that the strategic oversight provided by the new Transitions and Leaving Care/ACS panels has resulted in improved outcomes for young people through better partnership collaboration and planning. They are confident that many of the barriers that faced practitioners who were trying to support Joe have been removed and that clear pathways are in place to provide a strategic response to complex cases.

Systems finding

4.27. Although individual practitioners worked hard to meet Joe's needs, structures were not in place to enable professionals to draw on the multi-agency partnership to develop a strategic response to mitigate identified risks and stabilise Joe's situation. However, systems changes since 2018 have greatly improved the ability of the partnership to track cases, resolve disagreements or delays and provide a holistic, multi-disciplinary response to escalating risk.

Recommendation 6: In line with the SAR National Analysis improvement priority 23, the Safeguarding Partnership should review how it seeks assurance on individual agencies' practice standards and contributes to improvement across their partnerships, in particular how partner agencies encourage practitioners to routinely make reasonable adjustments so that service delivery is designed to better support young people transitioning to adulthood successfully access mainstream adult services.

Recommendation 7: In order to validate the views of practitioners and leaders that the improvements to the transitions and leaving care systems have resulted in improved outcomes for young people, the Safeguarding Partnership should undertake an audit using the

Preparations for and Transitions to Adulthood audit tool. Forums should be used to capture the views of young people working with these services, to comply with the principles of Making Safeguarding Personal.

Mental Capacity

4.28. The Mental Capacity Act 2005 sets down the right of a competent adult to take decisions, even unwise ones. To take a competent decision, an adult must be able to understand information about the decision to be made, retain that information, and apply it to the decision-making process, and communicate a decision. Professionals must ensure they break down the information to be weighed in a manner that will best facilitate this process. However, the associated guidance does not address "executive capacity", which is the ability to implement decisions taken and to deal with the consequences and the impact of someone else's undue influence on the decision-making process.

4.29. In 2018, the concept of executive capacity was not well understood across the professional network. There was a disagreement between Ipswich Borough Council's housing department and SCC's Adult Social Care as to whether Joe had capacity to enter a tenancy. Joe's social worker felt that he did have capacity as he understood how much items cost and what type of accommodation he wanted, but the Housing department assessed that he did not, because he could not understand the consequences of breaching the conditions of his tenancy. No clear escalation process was in place and relationships between the two services were not well established. This resulted in a 'stalemate' where Joe's housing was not progressed, which meant that he remained in unsuitable and unstable hotel accommodation for an unacceptably long time.

4.30. A professionals' meeting to resolve this issue was only arranged between IBC and SCC in June 2018, after Joe's case transferred to the Complex Cases team. At this time, Joe's new social worker agreed that Joe did not have the capacity to manage a general tenancy and confirmed that ACS was arranging specialist supported accommodation for him.

4.31. Additionally, when Joe's mother made a formal complaint about this, the response from SCC's Corporate Director for ACS was clear that Joe was viewed as having capacity to take decisions around his accommodation and that therefore his inability to sustain his accommodation was as a consequence of his 'unwise decisions'. This response was lacking in empathy for Joe's situation and did not consider his executive capacity.

4.32. Mental capacity assessments should explore rather than simply accept notions of lifestyle choice. This means applying understanding of executive capacity and how adverse childhood experiences, trauma and 'enmeshed' situations can affect decision making. Repeating patterns may be one clue here, particularly when someone does not follow through on expressed intentions, as in Joe's case.

4.33. It is important to note that due to ongoing concerns that Joe was being financially exploited, an appointeeship was in place to enable SCC to manage Joe's benefits. This ensure that his bills were paid, and he was given the balance of his funds in small, regular amounts so that he could afford food throughout the week. Despite this, staff across both ACS and Leaving Care reported that they would regularly provide Joe with food parcels or, on occasion buy him food from their own pockets. This was because Joe would generously, but naïvely share whatever food he had with others in need, without thinking about whether this would leave him short later in the week.

4.34. It is a fundamental principle of the Mental Capacity Act 2005 that, when assessing whether someone has capacity to decide any matter, they are given time and information in a manner they can understand. For some, including Joe, this would have required practitioners to first address the 'normalisation' of abuse and the impact of trauma. This requires a system that enables specialist behavioural input to be delivered through a smaller core, trusted group. Those working closely with Joe believed for any offer of support to have a long-term impact, he needed safe accommodation as a starting point. From there, he could have been encouraged to take greater involvement in shaping the priorities for change with more realistic timescales.

4.35. All practitioners were clear that they considered it would not have been appropriate to apply to the Court of Protection for authorisation to deprive Joe of his liberty, to compel him to live in specific accommodation to protect him from these individuals. On the information made available to this review, it was reasonable for professionals to conclude that this would have been a serious and disproportionate breach not only of his article 5 rights (the right to liberty), but also his article 8 rights (the right to respect for family, private life, home, and correspondence). Whilst Article 8 is a qualified right, public bodies can only interfere with this right if they can demonstrate the way in which they do so is lawful, necessary, and proportionate to the risk of harm. Likewise, an application under the Inherent Jurisdiction of the High Court for an injunction to prevent Joe's associates from making contact with him could only have been sought if there was evidence of specific individuals repeatedly harming and coercing him. Joe rarely made disclosures about who was involved in these incidents and the available evidence indicates that different individuals were involved in the various incidents over time.

4.36. In any event, practitioners considered that any such placement would be likely to break down very quickly, as Joe valued his independence and would have been likely to respond with escalating aggression to attempts to restrict his liberty. Nor did they consider that there was any realistic possibility that the court would have granted such an application. Again, on the evidence, this was a reasonable conclusion.

What has changed

4.37. Over the past 2 years, SCC has undertaken a comprehensive training programme in respect of mental capacity with a focus on executive capacity, reinforced by 6-weekly workshops where practitioners can present complex cases to an expert solicitor. This has resulted in understanding of executive capacity becoming better understood and well-embedded across ACS, resulting in improved outcomes for adults. Additionally, a requirement has been introduced that all mental capacity assessments must be quality assured and signed off by a manager. Regular audits of the quality of assessments take place indicating improved understanding of mental capacity across ACS, although similar audits by NSFT indicated that practitioners, who predominantly work under the Mental Health Act 1983, continue to struggle with the nuances of mental capacity and executive capacity in particular.

4.38. The Safeguarding Partnership has reviewed its escalation policy to clarify for staff across all agencies how to address conflicts between different services and use of this policy, together with the managing professional disputes policy, need to be more widely used to avoid delays in resolving disagreements.

4.39. The ability of the frontline practitioners during the learning event to articulate the concept of executive capacity and apply this to Joe's case was very impressive. The frontline practitioners involved in the learning event discussed that they considered the original assessment by SCC that Joe had capacity to manage a tenancy was wrong, given current understanding of executive capacity. Consequently, they now thought it likely earlier consideration would have been given to alternative accommodation for Joe, rather than allowing a 'stalemate' to hinder progression of an effective care plan.

Systems finding

4.40. Limited understanding of executive capacity resulted in practitioners taking a dogged approach to providing Joe with accommodation and support which prevented resolution of these issues. A highly effective training programme has since embedded understanding of mental capacity across ACS and CYPS, however, it is important that this knowledge is equally embedded across all other agencies across the Safeguarding Partnership to improve outcomes for adults.

Recommendation 8: Suffolk Safeguarding Partnership to seek assurance about the robustness of the competency and accountability framework for mental capacity in use across Suffolk, including whether training needs are being met. Use of the ACS framework for this is recommended.

Recommendation 9: Annually, Suffolk Safeguarding Partnership should review how the inter-agency escalation policy is being used, including by front-line staff.

Trauma-Informed Care

4.41. It is highly likely that Joe's early childhood traumas had a very significant impact on his behaviour and response to professional intervention throughout his childhood and into his adult life. There is now a well-established evidential basis for the impact that trauma and adverse childhood experiences has on the development of the brain and, consequently, adult mental health. There is both a greater awareness of the prevalence of trauma in society and deeper knowledge of its long-term effects on survivors[6]. It is recognised that experiencing trauma in the past can affect the ways a person perceives and responds to their environment in the present. Aspects of a situation that may seem benign to someone with no history of trauma can trigger overwhelming feelings of distress in a trauma survivor, leading the individual to behave in ways that might be labelled as, for example, 'non-compliant', 'aggressive' or 'disengaged'. If an organisation reacts to these behaviours with seclusion or exclusion, further trauma may result.

4.42. During Joe's childhood and transition to adulthood, academic research into trauma-informed care was rapidly expanding, but professional understanding of this issue was not widespread. Conversations and training were starting to take place in the context of exploitation, but not in more general practice. In Joe's case, his early childhood traumas and resulting disordered attachments are likely to have resulted in him experiencing the breakdown of both his long-term foster placement and long-term school placement within a few months of each other as rejections, potentially retraumatising him. Following this, there were increasingly frequent incidents where Joe was evicted from accommodation or had support services terminated because he had not complied with the rules of the placement or became aggressive to staff when confronted about his behaviour. This was a particular issue in non-regulated commissioned services such as supported accommodation. Had staff within those services received training in trauma-informed care, this may have resulted in a more nuanced approach to stabilise Joe's situation.

4.43. Additionally, although Joe reported repeated incidents where he was assaulted or threatened, he would then refuse to name the individuals or withdraw the allegations when interviewed by police. A trauma-informed approach by the police, building a relationship with Joe over time and giving him opportunities to revisit his decision not to provide evidence, may have facilitated an investigation of these crimes.

4.44. Equally it can be difficult for practitioners to conceptualise how the causes and effects of abuse or trauma may prevent a person from keeping themselves safe or managing activities of daily living. One of Joe's care reviews in 2015 described his difficulty in maintaining a hygienic environment as being due to him being "lazy", rather than recognising the impact of trauma on the development of brain functions such as organisation and prioritisation. Another letter from a senior manager in 2018 recorded that Joe needed to "…take responsibility for his actions and modify his behaviour to keep the terms of his tenancy", again lacking insight into the impact of trauma on impulse control and decision-making.

[6] Jones & Wessely, 2007; Scottish Government, 2012; Becker-Blease, 2017

4.45. One of the complexities in Joe's case was that he disliked support workers intruding on his personal space, for example by tidying his room. Although Joe would listen and verbally respond positively to advice, for example around his cannabis use, he would then take his own decisions and could become aggressive if continually challenged. This presented two key difficulties. Within supported accommodation, this response could result in the accommodation being terminated and the support and accommodation were intrinsically linked. When commissioned support was being provided in other types of accommodation, it became too easy for Joe to stop engaging with services, which meant that his needs were not being met.

4.46. Joe's last care review in July 2017 was detailed and thoughtful, showing real insight into Joe's complex needs. It captured his voice and desire for independence and the need for professionals to tailor support in a manner that took account of Joe's preferences, to ensure that he did not disengage from the services that were necessary to maintain his daily care needs. The Making Safeguarding Personal principles of empowerment and proportionality were clearly reflected in this document. However, the professional network had been unable to resolve the challenge of identifying accommodation or support for activities of daily living which were both suitable for Joe's needs and sustainable.

4.47. Despite this, many examples of trauma-informed practice could be identified throughout Joe's life, as many workers who had expertise in working with young people who had suffered early childhood adversity used their experience and insight to respond empathetically to Joe's behaviour.

4.48. As an example, when Joe was allocated to the Learning Disability and Autism service initially, all calls were received through the central customer services centre. Joe could become frustrated by this process, becoming abusive to staff and on one occasion threatening to set fire to the offices. Rather than banning Joe or blocking his number, to ensure that this did not become a barrier to Joe receiving the support he needed, the practitioners allocated to Joe's case in the Complex Cases team gave him their mobile numbers, setting some boundaries for him to ensure that he did not abuse this. Additionally, the workers recognised Joe's difficulty in remembering to attend appointments, so called and text him daily to remind him of appointments, attending initial appointments with him to introduce him to new staff.

4.49. This trauma-informed response was excellent practice. However, formal training in trauma-informed care across the professional network may have enabled staff to better articulate to other services, in particular his commissioned accommodation providers, how to interpret and respond to Joe's behaviours.

What has changed

4.50. Meetings with frontline staff evidenced that since 2018 some services, in particular those working with young people at risk of exploitation, had received training in trauma-informed care and understood how to apply this to the young people they worked with. Others, as outlined, had an instinctive understanding of how to apply this in practice. One of the statutory partners in the Suffolk's Safeguarding Partnership – Suffolk and Northeast Essex CCG, is reviewing their current trauma-informed practice and training. This mapping exercise will ensure that gaps in knowledge and provision about trauma-informed care can be embedded across services, including the voluntary and charity sector and commissioned services. However, this needs to be developed in a cohesive way across the Partnership to ensure a consistent, joined-up approach.

4.51. In 2020, SCC carried out an inquiry into Stella Maris[7], a supported living scheme for tenants with complex needs and chaotic lifestyles. The Inquiry concluded that the scheme had been set up without sufficient due diligence and scenario planning and that the needs of some tenants far exceeded the capacity and capability of the care service that was commissioned to look after them. In respect of trauma-informed practice, the report recommended that SCC and NSFT make their training modules and materials, including techniques to manage challenging

[7] Stella Maris Inquiry 2020, Anthony Douglas CBE, StellaMarisInquirypublishedreportpdfversion.pdf (suffolk.gov.uk)

behaviour and training in trauma-informed practice, available to care agencies to whom individuals with the most complex needs are nominated or placed.

Systems Finding

4.52. There is some good practice within Suffolk in respect of a trauma-informed approach that embodies the MSP principles within some key operational partners, but there is not yet the infrastructure or clear leadership to embed this across all key agencies. The implementation of strategic cultural and operational practice change is currently restricted by lack of national or regional input. This should be reflected in any revised multi-agency commissioning strategy, with multi-agency specialist oversight at senior level that understand the additional risks and benefits bought by trauma-informed care.

Recommendation 10: Suffolk SSP should promote the continuous improvement of trauma-informed practice across agencies.

Recommendation 11: Suffolk Constabulary should ensure that victims of multiple safeguarding crimes have a single point of contact to give them confidence about giving evidence

Housing

4.53. Section 23 of the Care Act 2014 and supporting statutory guidance seek to clarify the boundary between care and support and housing legislation. Suitable accommodation is one way of meeting a person's care and support needs, as the lack of suitable accommodation puts health and wellbeing at risk, although where a local authority is required to meet a person's accommodation needs under the Housing Act 1996, it must do so. Where housing is part of the solution to meet a person's care and support needs, or prevent them, then the care and support plan may include this, even though the housing element is provided under housing legislation. Any care and support required to supplement housing is covered by the Care Act 2014.

4.54. The Housing Act 1996 requires the local authority to secure accommodation for the applicant's occupation. This is owed to those who are homeless and eligible for assistance, have a priority need, and did not become homeless intentionally. Priority need includes vulnerability arising from disability. Bespoke and flexible rather than standardised responses are often needed for addressing the needs of people experiencing multiple exclusion homelessness. These needs extend beyond housing to include physical health, mental health and care and support. However, nationally there is a shortage of specialist housing to meet the need of individuals who have complex needs. Therefore, to achieve that bespoke response requires a collaborative and collegiate culture across the partnership that endorses challenge, values information-sharing, and discussion, appreciates the value of integrated approaches towards prevention and of sharing expertise, and supports practitioners[8].

4.55. Additionally, the Care and Support Guidance, which accompanied the Care Act 2014, underlines the importance of adopting a human right, person centred approach, requiring practitioners from all 'relevant agencies' to exercise their powers and fulfil their legal duties in a manner that complies with the positive obligations under the Human Rights Act 1998 and respond appropriately where there is a real and imminent risk. This may require proactive consideration of the duties to prevent social care needs escalating (under s2 Care Act 2014) and to prevent homelessness (s195 Housing Act 1996) by providing advice and support before eligibility thresholds for services are crossed. Practitioners must take into account everything they can reasonably be expected to know and record why they believed any action or inaction was within legal powers, necessary in the circumstances and proportionate to the risk.

4.56. In Suffolk, responsibility for meeting housing needs sits with the borough and district councils, whereas responsibility for meeting adult social care needs, including supported accommodation, is held by Suffolk County Council. This division of responsibility requires careful coordination to ensure that there is no gap in services, particularly in cases where there

[8] Adult Safeguarding and Homelessness: a briefing on positive practice; ADASS and the Local Government Association.

are questions about whether the individual can manage a tenancy or requires supported accommodation.

4.57. All practitioners involved in Joe's case made extensive efforts to secure him suitable accommodation. From the age of 18, Joe was placed in 3 different supported housing placements, which provided specialist support to young people with complex needs such as learning disabilities. Within those provisions, Joe received 1-1 support to help with the elements of daily living he could not manage on his own. However, each of these placements broke down due to issues such as Joe not staying at the accommodation for lengthy periods, continually smoking cannabis in the accommodation despite being told repeatedly that this was in breach of the rules, or assaults on members of staff when Joe's behaviour was challenged.

4.58. More imaginative solutions were also tried, such as a Shared Lives arrangement, where Joe effectively lived with an adult foster carer to create a more family-like environment. However, Joe found the strictures of this arrangement stifling and asked to be moved.

4.59. Each successive placement breakdown not only reduced the relatively limited pool of options available, but because the reasons for the breakdowns had to be incorporated in referrals for new placements, many alternative providers refused to offer him a place, considering Joe to be too high risk. The discrepancy between the cold facts of the incidents relating to placements breaking down due to drug use and aggression and the very vulnerable, sweet young man Joe was in real life, was difficult to capture in these referrals.

4.60. Joe wanted to move into his own flat, but as set out above, IBC staff were consistent in their assessment, evidenced by their meetings with him and the reasons for his placements breaking down, that Joe would not be able to sustain a tenancy independently. During periods when Joe was homeless, they would at times provide 'ordinary' homelessness accommodation in hostels on an emergency basis, while referring Joe back to ACS because they did not believe this accommodation was suitable for his needs. This stalemate resulted in the wholly unsatisfactory outcome that Joe repeatedly lived in hotel accommodation for months at a time, interspersed with periods living with friends or family and most regrettably, on the street for short periods. It must be noted to their credit that ACS have advised that at any time Joe presented to them as homeless, they always provided him with temporary accommodation while trying to arrange a permanent solution. However, at times there were periods when Joe slept in parks as he had left accommodation because he felt unsafe, but because this was still available to him there were delays in identifying alternative accommodation.

4.61. A lack of effective communication or dispute resolution processes between IBC and SCC, together with structures that limited creative problem solving, resulted in the risks to Joe continuing to escalate throughout this period. IBC staff considered that this was not an unusual situation as escalation routes were not clear and at that time, strategy meetings were not commonly used to explore difficult cases. On two occasions, the Leader of IBC contacted ACS directly to ensure that suitable accommodation was found for Joe, demonstrating responsive leadership. However, even intervention at the most senior level did not result in a strategic approach to resolving Joe's accommodation needs.

4.62. Although efforts were also made to provide Joe with 1-1 support within his hotel, by early 2018 he had stopped allowing support workers to visit him as he found their support intrusive. Despite this Joe recognised that he did need more support, explaining this to a police medical assessor during an incident when he had been exploited into committing a minor crime. As set out above, a broader understanding of trauma-informed care across commissioned services may have resulted in a more tailored response from workers that Joe would have been able to utilise.

4.63. Joe's mother advocated powerfully on his behalf with the councils, raising repeated complaints about the inadequacy of his accommodation through councillors and her Member of Parliament (discussed further below). As a consequence, when SCC went through a restructure which moved its Learning Disability and Autism service under its Mental Health Service rather than more general ACS, Joe was the first person allocated to the newly formed 'Complex Cases' team (subsequently renamed the 'Special Support' team).

4.64. This was specifically established to meet the needs of young people with learning disabilities, mental health conditions or personality disorders, who experienced multiple placement

breakdowns or homelessness. The team was set up with practitioners with expertise in relevant fields such as mental health, exploitation, or rough sleepers, who held low caseloads of highly complex cases. The multi-disciplinary structure and bespoke approach of the team is consistent with national good practice guidance[9]. Because the Complex Cases team was in its nascency, Joe was allocated to the team's manager, who was extremely experienced, with a background in mental health.

4.65. At the same time, IBC staff arranged a meeting with ACS to seek resolution of Joe's case, due to their concerns that his hotel accommodation was unsuitable. Although this meeting should have been arranged much earlier given the long period of instability Joe had experienced, it is positive that IBC staff initiated this to resolve the impasse. The newly allocated Complex Cases team manager immediately accepted that Joe needed supported accommodation through ACS and that mainstream housing was not suitable to meet his needs. She identified a creative solution, accessing specialist services commissioned through the mental health pooled fund, as the team was now sitting within ACS's mental health structure. Although outside the terms of reference for this funding pool in strict terms, generous leadership approved this approach.

4.66. A referral was quickly made to a specialist provider, who could provide an individual flat for Joe with tailored 1-1 support included. This was consistent with Joe's express wishes, reducing the risk of the placement breaking down. However, because of the number of Joe's placements that had previously been disrupted, the provider wanted to undertake outreach work with Joe in the community initially, to assess whether their provision was suitable for him before offering him a placement. This was appropriate and in accordance with best practice for providers of supported accommodation or residential homes. Very sadly, this assessment was ongoing at the point of Joe's death, so he never had the opportunity to move in.

What has changed

4.67. The success of the Special Support team has resulted in positive outcomes for many of the young people it works with, achieving pathways to stable housing which have enabled the cases to transfer back to more mainstream services. The team comprises a team manager from a mental health background, with two senior social workers, who co-work cases with the Leaving Care team from the age of 17. The specialist staff have close relationships across a variety of housing providers, including bulk commissioned, specialist provision for people with mental health difficulties or disordered behaviours. They also work closely with police and mental health services and have mental health specialists to provide a holistic service. As a consequence, the team is now expanding to provide a separate service for young people with a mental health diagnosis, as their needs can be very different to those with learning disabilities or autism. The Young Persons Housing Action Group has also been strengthened in terms of representation from CYPS and ACS to provide strategic oversight of the housing needs of young people and care-leavers with a focus on commissioning and homelessness prevention.

4.68. Leaders report that not only has this resulted in improved outcomes, but that despite the intensive and relatively expensive nature of the service offered, the timely resolution of complex situations and reduction in levels of harm experienced by those using the service means that this is an efficient use of their budgets, resulting in savings overall. Additionally, wider ACS services are able to approach the experts within the team to seek advice on options for progressing cases where they are struggling to secure stable housing.

4.69. Clearer lines of communication and escalation between ACS and district and borough councils, including increased use of strategy meetings in complex cases, facilitate faster resolution of barriers to accommodation, although there is still room for improvement, in particular to build stronger relationships between frontline housing and ACS officers. Housing staff reported some frustration that in longstanding cases, practitioners or managers who were new to the matter could attempt to 'reinvent the wheel' in terms of solutions. It is therefore important that information flows effectively between panels and strategy meetings to avoid duplication and delay.

[9] Adult Safeguarding and Homelessness: a briefing on positive practice; ADASS and the Local Government Association.

4.70. The range of specialist commissioned providers has expanded since the inception of the team, however, demand continues to outstrip supply. In particular, there is limited availability of flexible providers who can design a bespoke placement in consultation with the Special Support team to meet the needs of the most complex individuals. Creative commissioning is also needed to ensure that tailored care is provided to those individuals who could potentially sustain a mainstream tenancy with a higher level of support, closing the gap between housing provision and supported accommodation. Housing initiatives such as Housing First England[10] provide an alternative, trauma-informed housing model that prioritises the need for stable housing for people with high needs and entrenched homelessness to provide a secure base for personalised support but does not make the tenancy conditional upon the individual engaging with that support.

4.71. In 2020, the Stella Maris Inquiry recommended that a housing needs analysis of people with complex needs, including chaotic lifestyles, should be developed by the Suffolk Housing Board, leading to a 25-year housing strategy for this group. Additionally, a recommendation was made for a new care, support, and housing plan for the next 5-10 years to be produced, commissioned, and overseen by the Suffolk Chief Officers Leadership Team. The recommendations in respect of the commissioning of specialist housing set out in the report are detailed and if followed, will remove many of the barriers that prevented practitioners from identifying accommodation which could have met Joe's needs. SCC, together with the district and borough council are in the process of developing a housing protocol for care-leavers that is informed by the recommendations of the Inquiry. Both CYPS and ACS now attend the Suffolk Housing Board, to ensure that strategic commissioning decisions are informed by local social care needs.

Systems analysis

4.72. A lack of clear escalation procedures and siloised approach by services resulted in practitioners becoming 'stuck' in terms of meeting Joe's accommodation needs for several years. The newly introduced service Joe was allocated to 10 weeks before his death appeared to have made real progress in securing the support and accommodation he needed and practice within this service is consistent with national guidance around best practice. However, there is still a gap in the availability of commissioned services able to offer bespoke placements for individuals with complex needs, both locally and nationally. There is a clear need for specialist placements or, in the interim, greater flexibility from commissioners locally to use powers under National Health Service Act 2006[11], Mental Health Act 1983 and Care Act 2014 to provide accommodation based, trauma-informed holistic support so as to not over rely on accommodation provided via Housing Act 1996 duties that is designed to provide life skills support.

Recommendation 12: Housing pathway and protocol for vulnerable adolescents and young adults should be agreed between Suffolk's County, district, and borough councils, to ensure that young people and young adults already at risk are not placed at an even greater risk as a result of being placed in unsuitable housing. The protocol and pathway must be based upon joint commissioning with health involvement.

Recommendation 13: Where the risks to a young person or a young adult as a result of their housing provision persist, a multi-agency strategy meeting should be convened either by CYPS or ACS to ensure that risk is continuously re-assessed and managed.

Identification of Safeguarding Concerns and Information Governance

4.73. On several occasions, Joe's mother raised complaints through councillors and her Member of Parliament in respect of the support Joe was receiving, the inadequacy of his accommodation or risks arising from homelessness. These complaints identified a number of safeguarding issues in respect of Joe experiencing financial exploitation, physical assaults and on one occasion, risk of sexual abuse. Whilst ACS responded to the complaints either directly or through the politicians (albeit those responses were delayed at times), there is no indication that

[10] The Principles for Housing First.pdf (homeless.org.uk)

[11] Consistent with the obligations set out in National Framework for Continuing Healthcare

the safeguarding issues raised were investigated as a consequence, or that a strategic safeguarding plan was devised. Instead, the complaints were approached from the perspective of Joe's accommodation needs.

4.74. A letter from Joe's mother's solicitor to the coroner[12] records that the mother explicitly set out her fears in further emails to councillors that Joe may be killed by those who were bullying or exploiting him, however, these emails have not been located in Joe's files by Housing, CYPS, ACS, or SCC's Democratic Services. Despite extensive searches for the missing emails during the course of this review, including requesting these through the mother's solicitor and councillors directly, it is not clear who these were sent to, whether they represent a county, borough, or district council, whether these forwarded onto either ACS or Housing or resulted in any action. They have not been recorded as safeguarding referrals or referred to the MASH. It is not clear where this breakdown in record keeping and information sharing has occurred, but this presents as a significant safeguarding risk and does not comply with statutory guidance on good record keeping for safeguarding purposes[13].

4.75. SCC's Democratic Services have confirmed that safeguarding training forms part of the induction process for all new councillors. Although there is cross-party agreement by SCC councillors that this training should be mandatory, the statutory framework around elected members means that this is not legally enforceable. Records confirm that the IBC councillor who received the complaints that could be located had attended safeguarding training and informed senior managers in both ACS and IBC's Housing department of the mother's concerns.

4.76. SCC explained that when safeguarding concerns are incorporated within complaints through their formal complaints process, their procedure is for the complaints service to refer these to the MASH team for investigation. However, it is not clear that this procedure is applied in circumstances where the 'complaints' come through by way of a councillors' or MP's enquiry, even though such enquiries are dealt with at a corporate level with politicians generally contacting corporate directors of relevant services directly. It is likely, and not unreasonable, that councillors may have assumed that this would result in the safeguarding concerns being identified and carried forward by the departments. However, a key principle of safeguarding is never to assume that someone else will make a safeguarding referral and training for councillors should explicitly set out the importance of making referrals directly to avoid any risk that these could be overlooked.

4.77. Additionally, safeguarding concerns identified through the complaints route fall outside the usual auditing mechanisms for safeguarding referrals within ACS, so the Safeguarding Partnership has no oversight of the efficacy of this procedure.

4.78. It is not clear from his files that Joe was consistently told about the complaints received on his behalf. Whilst there were some recordings confirming that he had been asked for consent to respond to complaints, it is not clear that he was told what information had been passed on to third parties.

What has changed

4.79. SCC has recently launched a new Safeguarding Policy which sets out its commitment that all elected members, senior officers, and all staff will be made aware of corporate safeguarding responsibilities and participate in mandatory safeguarding training. Both the Council and the Safeguarding Partnership's websites provide clear information for members of the public and professionals to make safeguarding referrals.

Systems finding

4.80. Record keeping by statutory agencies of complaints received through councillors was poor and serious safeguarding concerns were not identified or progressed as safeguarding enquiries.

[12] Dated 19 May 2021

[13] Care and Support Statutory Guidance paragraphs 14.180-14.186

Recommendation 14: All Councillors, MPs, and those who advise them, should always make a formal safeguarding referral to the Suffolk MASH when a safeguarding concern is apparent. Advice as to whether to make a referral can be gained from the MASH Professional Consultation Line.

Recommendation 15: When information is shared about a customer (the subject) to a third party, the full correspondence needs to be logged against the subject's case record including information on if consent had been obtained from the customer.

Recommendation 16: Safeguarding training delivered to county, district and borough councillors should be refreshed every year, including clear advice on when and how to make a formal safeguarding referral through the MASH, incorporating a presentation on the relevant aspects of Joe's case.

Safeguarding Response

Analysis of practice

4.81. Section 42 of the Care Act 2014 requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. An early response to emerging harm is essential to stop risks from escalating. In circumstances where multiple agencies or individuals are making safeguarding referrals to ACS, a s42 enquiry should be undertaken, even if individually each concern would not meet the threshold for further investigation.

4.82. Following a missing episode in November 2015, Joe reported that he had been held against his will, physically abused including being shot with a BB gun and forced to give money to those involved. A s42 enquiry was undertaken but when interviewed by police, Joe refused to provide any details so no further safeguarding action was taken. Although it is important to respect the wishes of a competent adult who refuses intervention[14], it is unclear whether safeguarding options outside the criminal justice routes were discussed with Joe, or consideration given to whether he had been coerced to remain silent.

4.83. There were a number of other safeguarding referrals made by the police in respect of Joe experiencing physical abuse and financial exploitation, which were referred to the Multi-Agency Safeguarding Hub (MASH). On each occasion, these were assessed by police, health and social care as falling below the threshold for a s42 safeguarding enquiry and were all dealt with as single-agency referrals. There is no indication that, in accordance with procedure at the time, any consideration was given to the preceding referrals and how taken together, these evidenced a higher level of overall risk to Joe, warranting a s42 enquiry.

4.84. Joe himself expressed fears about being at risk of abuse or violence from other individuals during a number of his placements, both to SCC and IBC. Although concerns were consistently raised that Joe was mismanaging his money, using this to buy drugs or gifts for others, this was only addressed through use of the appointeeship and a strategy meeting in respect of financial exploitation was not convened. On one occasion, Joe asked for a support worker to go shopping with him to protect him from abuse in the community and although this was agreed on a one-off basis, this did not result in a formal safeguarding plan.

4.85. Joe also told police during a mental health 'triage' assessment on 24 June 2018 that he had been paid by a cousin to break a window and that he was assaulted with a belt to force him to follow through on this when he was initially unsuccessful. This was referred to the MASH who assessed that this did not meet the threshold for a s42 enquiry and passed the information to the ACS team manager allocated to Joe's case to deal with as a single agency process. The team manager spoke to Joe about the incident and although he did not make any disclosures about who was involved, he did talk about being frightened of people he owed money to in the local area. The manager's view was that the immediate step required to safeguard Joe was to

[14] Care and Support Statutory Guidance paragraphs 14.76-14.99

identify specialist accommodation to meet his needs and was proactive in pursuing this. It has subsequently come to light that one of Joe's killers, Luke Greenland, may have been involved in this incident, although there is no indication that Joe spoke of Greenland's involvement to professionals. Had this serious incident been progressed as a multi-agency s42 enquiry, expertise across the disciplines may have facilitated a more comprehensive investigation utilising tools such as mapping of Joe's social network and analysis of contextual safeguarding risks, in accordance with the principles of Signs of Safety[15], the safeguarding model adopted by Suffolk ACS.

4.86. Leaders acknowledged that at this time, there had been difficulties with social workers, who were struggling with high caseloads, inappropriately challenging MASH decisions around s42 decisions to avoid being allocated new cases that had been assessed as only requiring a single agency response. The safeguarding enquiry decision procedure had therefore been revised to discourage challenge to the MASH decision. This was not a safe way to manage an issue that stemmed from high caseloads and does not comply with the legal principle of due process, which requires public bodies to provide mechanisms for proper challenge of decision-making.

4.87. This incident should also have triggered a referral through the National Referral Mechanism under the Modern Slavery Act 2015. Police and the local authority are under a duty to make a referral when they suspect that human trafficking has taken place, which includes situations such as this where a person has been transported domestically and coerced or threatened for the purpose of criminal exploitation. Although Joe's informed consent would have been required to make this referral, even if he did not consent, recognition that this incident met the definition of human trafficking may have resulted in a more urgent safeguarding response from all agencies. There was a disparity between the comments by frontline practitioners that understanding of exploitation was more widely embedded in children's services than adult services and that of leaders that exploitation, in particular 'mate crime' and financial exploitation, was well understood across adult services.

4.88. There were a number of occasions recorded when Joe was reported missing from his accommodation, though some of these reports were received up to 10 days after he had last been seen. When Joe went missing in August 2018, the social worker was very proactive in attempting to make contact with him, including contacting family and friends, demonstrating excellent practice. It is likely that the fact that staff at Joe's hotel told the social worker, in error, that he had been seen the day after his death delayed a missing report being made to the police, although this would not have changed the outcome for Joe. Currently, there is no missing policy in place within the Safeguarding Partnership for adults with vulnerabilities. This may have supported better reporting of Joe's missing episodes throughout his adulthood and may have allowed for analysis of safeguarding risks through 'safe and well' interviews with Joe upon his return.

4.89. Taken together with the complaints raised by Joe's mother, this series of safeguarding concerns gave a picture of a young man with significant vulnerabilities who was experiencing 'mate crime' on a regular basis. While on a practical level, practitioners were aware of the risks Joe faced and provided him with regular support and advice, this did not translate into a strategic approach to safeguarding. A s42 enquiry would have drawn together a multi-agency meeting to investigate the issues and may have provided an opportunity to map Joe's social network to identify the perpetrators and unsafe associates. This was a missed opportunity to draw on expertise across a number of disciplines to brainstorm creative solutions to these issues and establish a robust, clear safeguarding plan in consultation with Joe and the positive members of his network. Consideration should be given to application of guidance and, in particular, the practice checklists given within Alcohol Change UK's project report 'Safeguarding Vulnerable Dependent Drinkers' regarding the use of the legal framework and Alcohol Change UK's Blue

[15] What Is Signs of Safety? - Signs of Safety

Light project manual[16] in respect of possible practical interventions to support those at risk of abuse due to or linked with substance misuse.

4.90. It remains questionable whether this would have safeguarded Joe against the individuals who killed him, whose relationship with Joe was not known to safeguarding partners. However, a multi-disciplinary safeguarding plan may have helped mitigate against Joe's vulnerability to exploitation and reduce his risk of harm arising from his housing situation and drug debts.

What has changed

4.91. As set out above, since 2018, ACS has developed a multi-disciplinary progression pathway for vulnerable young adults with learning disabilities, mental health issues or autism through the Special Support team and supporting panels to provide sound governance. These aim to identify emerging risks and develop strategies to prevent these escalating. Use of multi-disciplinary strategy meetings to investigate risk on individual cases and develop safeguarding plans has also improved. The rapid introduction of virtual meetings during the pandemic has made these easier to arrange and attend, which has also built stronger partnership working.

4.92. The factors which led to revision of the safeguarding enquiry decision procedure to discourage challenge to the MASH decision are no longer relevant. The decision to allocate all cases open in the Mental Health service (including the Learning Disability and Autism service) to specific social workers means that MASH decisions do not impact caseloads. Additionally, having a consistent social worker supports better analysis of thematic safeguarding risks as social workers have a more detailed knowledge of the individual's history, network, strengths, and vulnerabilities.

4.93. When cases are escalating in terms of risk including mental health or homelessness, social workers and other professionals are able to refer cases to the Dynamic Support Register meeting that takes place every week with the CCG and NSFT. This forum provides operational management oversight, facilitates escalation to other services and can agree emergency funding. These changes are in line with good practice expectations, including those advocated by the Chief Social Worker's Briefing[17] as it should provide both an effective team around the person and organisational support for team members.

Systems finding

4.94. Consideration was not given to thematic risks from multiple safeguarding referrals received through different routes and whether these should give rise to a formal s42 enquiry. This prevented the implementation of a robust multi-agency safety plan developed in consultation with Joe, leaving him exposed to harm. Whilst the changes detailed above should lead to practice improvements, the Safeguarding Partnership should consider how best to monitor the efficacy of these arrangements to ensure a system-wide oversight of transitional safeguarding.

Recommendation 17: The multi-agency referral form should be amended to require staff to explicitly consider whether the specific issue under investigation is similar to previous enquiries. Where there is an identifiable pattern of risk, a multi-disciplinary strategy meeting should be convened to facilitate development of a safeguarding plan. The safeguarding referral procedure should include a clear mechanism for practitioners to challenge decisions in respect of whether a referral should be progressed as a s42/s47 enquiry or a single agency response.

Recommendation 18: The next round of the Safeguarding Partnerships' safeguarding audits should include analysis of whether thematic risk is being properly captured from multiple referrals, whether strategy meetings are being convened when required and whether the

[16] Michael Preston-Shoot and Mike Ward Draft report published report will be available via Alcohol Change UK website. The Blue Light Project Manual is available at: https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/The-Blue-Light-Manual.pdf?mtime=20181118115002&focal=none

[17] 'Bridging the Gap: Transitional Safeguarding and the role of social work with adults', DHSC, June 2021 available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990426/dhsc_transitional_safeguarding_report_bridging_the_gap_web.pdf

safeguarding plans resulting from such strategy meetings are resulting in a reduction of harm to the individual, applying the principles of Making Safeguarding Personal.

Recommendation 19: Review oversight mechanisms and training modules for young people and young adults in respect of transitional safeguarding and exploitation, including knowledge of the National Referral Mechanism and the 'Missing' policy and protocol.

5. Recommendations Emerging from this Review

Therapeutic Provision to Prevent an Emerging Need Escalating

5.1. Recommendation 1:

The mental health and therapeutic offer from the CCG, NSFT and Suffolk County Council working together needs to be strengthened for children and young people who do not have a mental health diagnosis but who are nevertheless displaying significant emotional and psychological distress as a result of trauma.

Recommendation 2:

Link social workers for foster carers should always provide reports for CIC reviews to ensure more effective consideration and action in response to any difficulties the foster carer/s is or are facing.

Assessment of ADHD and Autism

5.2. Recommendation 3:

The CCG's and NSFT should review their referrals pathways for mental health, learning disability and autism, to ensure young people who are hard to engage are not prematurely excluded from assessment and service provision without serious attempts to engage.

Recommendation 4:

Suffolk Safeguarding Partnership to obtain an assurance report about waits, waiting times and waiting list management for young people needing autism and ADHD assessments.

Recommendation 5:

NSFT and the CCG should develop accessible information for individuals, their families, and carers to explain the referral process for autism and ADHD, to demystify these processes and support engagement with assessments.

Transitions and Leaving Care

5.3. Recommendation 6:

In line with the SAR National Analysis improvement priority 23, the Safeguarding Partnership should review how it seeks assurance on individual agencies' practice standards and contributes to improvement across their partnerships, in particular how partner agencies encourage practitioners to routinely make reasonable adjustments so that service delivery is designed to better support young people transitioning to adulthood successfully access mainstream adult services.

5.4. Recommendation 7:

In order to validate the views of practitioners and leaders that the improvements to the transitions and leaving care systems have resulted in improved outcomes for young people, the Safeguarding Partnership should undertake an audit using the Preparations for and Transitions to Adulthood audit tool. Forums should be used to capture the views of young people working with these services, to comply with the principles of Making Safeguarding Personal.

Mental Capacity

5.5. Recommendation 8:

Suffolk Safeguarding Partnership to seek assurance about the robustness of the competency and accountability framework for mental capacity in use across Suffolk, including whether training needs are being met. Use of the ACS framework for this is recommended.

5.6. Recommendation 9:

Annually, Suffolk Safeguarding Partnership should review how the inter-agency escalation policy is being used, including by front-line staff.

Trauma-Informed Care

5.7. Recommendation 10:

Suffolk SSP should promote the continuous improvement of trauma-informed practice across agencies.

Recommendation 11:

Suffolk Constabulary should ensure that victims of multiple safeguarding crimes have a single point of contact to give them confidence about giving evidence

Housing

5.8. Recommendation 12:

Housing pathway and protocol for vulnerable adolescents and young adults should be agreed between Suffolk's County, district, and borough councils, to ensure that young people and young adults already at risk are not placed at an even greater risk as a result of being placed in unsuitable housing. The protocol and pathway must be based upon joint commissioning with health involvement.

5.9. Recommendation 13:

Where the risks to a young person or a young adult as a result of their housing provision persist, a multi-agency strategy meeting should be convened either by CYPS or ACS to ensure that risk is continuously re-assessed and managed.

Identification of Safeguarding Concerns and Information Governance

5.10. Recommendation 14:

All Councillors, MPs, and those who advise them, should always make a formal safeguarding referral to the Suffolk MASH when a safeguarding concern is apparent. Advice as to whether to make a referral can be gained from the MASH Professional Consultation Line.

Recommendation 15:

When information is shared about a customer (the subject) to a third party, the full correspondence needs to be logged against the subject's case record including information on if consent had been obtained from the customer.

Recommendation 16:

Safeguarding training delivered to county, district and borough councillors should be refreshed every year, including clear advice on when and how to make a formal safeguarding referral through the MASH, incorporating a presentation on the relevant aspects of Joe's case.

Safeguarding Response

5.11. Recommendation 17:

The multi-agency referral form should be amended to require staff to explicitly consider whether the specific issue under investigation is similar to previous enquiries. Where there is an identifiable pattern of risk, a multi-disciplinary strategy meeting should be convened to facilitate development of a safeguarding plan. The safeguarding referral procedure should include a clear mechanism for practitioners to challenge decisions in respect of whether a referral should be progressed as a s42/s47 enquiry or a single agency response.

5.12. Recommendation 18:

The next round of the Safeguarding Partnerships' safeguarding audits should include analysis of whether thematic risk is being properly captured from multiple referrals, whether strategy

meetings are being convened when required and whether the safeguarding plans resulting from such strategy meetings are resulting in a reduction of harm to the individual, applying the principles of Making Safeguarding Personal.

5.13. Recommendation 19:

Review oversight mechanisms and training modules for young people and young adults in respect of transitional safeguarding and exploitation, including knowledge of the National Referral Mechanism and the ‘Missing’ policy and protocol.

6. Glossary

ACS	Adult Community Services within Suffolk County Council
CAMHS	Child and Adolescent Mental Health Services
CCG	NHS Clinical Commissioning Group
CYPS	Children's Young People Services within Suffolk County Council
GP	General Practitioner
LAC	Looked After Child
IBC	Ipswich Borough Council
MASH	Multi-Agency Safeguarding Hub – central point through which all safeguarding referrals are made
NSFT	Norfolk and Suffolk Foundation Trust
SCC	Suffolk County Council
SCOLT	Suffolk Chief Officer Leadership Team
SEN	Special Educational Needs
SSP	Suffolk Safeguarding Partnership

7. Appendices

Appendix 1: Terms of Reference

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Appendix 2: Summary Timeline

Please note that this is a summary of key events drawn from multiple agency chronologies to provide an overview of Joe's life and is not intended to be comprehensive.

Date	Action
19.03.03	Joe and his older brother were taken into care due to severe neglect and physical abuse and subsequently made subject of a care order. After a brief emergency placement, the brothers are placed with experienced long-term foster carers, where they each remain until they turn 16
Sept 2005	Joe moves from education in the SEN unit of a mainstream school to a specialist school for children with moderate learning disabilities and autism, with residential provision. Joe does very well in this school, is popular and one of the more academically able students.
1.09.10	Joe's brother (then 16yo) choses to leave the foster placement hoping to live with his mother, but she refuses to be assessed. Joe's behaviour in his foster placement and in school starts to deteriorate
18.02.12	Joe's long-term foster placement ends when the foster carers retired, and he is placed with another experienced foster carer
20.06.12	Joe turns 16
June 2012	Joe leaves the Priory after being excluded due to poor behaviour and moves to West Suffolk College but is taken off roll after 6 weeks due to disruptive behaviour which is becoming dangerous. A bespoke 1-1 education package is provided
November 2012	Referral to CAMHS for assessment for possible Asperger's; re-referred in March 2013 – the outcome is not recorded on CYPS files. This assessment did not go ahead initially as he had not been assessed by a community paediatrician, then a further appointment was not attended due to Joe's placement breaking down. NSFT records that the social worker was advised to re-refer when his locality was known. A further appointment is offered on 21 July 2014, but Joe does not attend – this is not recorded on CYPS's files.
26.04.13	Joe's foster placement breaks down and he moves in with his mother temporarily. Placed with emergency carers, then in a children's home, Fevaca, where he experiences bullying. This breaks down in September 2013 and he again moves in with his mother temporarily

Date	Action
25.6.13	Bullying incident results in strategy meeting; outcome work to be done with Joe around healthy relationships
25.10.13	Jo moves into Belstead Mews, a children's home, but his behaviour deteriorates.
February 2014	Joe allocated to the Accommodation Review Team, working jointly with CYPS to move on from Belstead Mews in preparation for 18th Birthday.
04.03.14	FACS assessment concludes that Joe has substantial needs, is able to make hot meals and maintain personal care with support and prompting, recommends supported accommodation to support his wish for more independence. However, funding for supported living is subsequently declined as support hours are deemed not in line with assessed need. Accommodation review team end their allocation – no reason given.
20.06.14	Joe turns 18, responsibility for meeting his care needs transfers to Adult Social Care, though leaving care support continues through Catch-22
June 2014	Belstead Mews placement breaks down following an assault on staff, he again moves in with his mother
6.07.14	Joe moves into supported accommodation, Sanctuary Housing. From this point, Joe has multiple placements moves, which each break down after a few months, with periods of living with friends or sofa surfing
01.09.14	Children and Families Act 2014 came into force, replacing SEN statements for young people up to the age of 16 with EHC plans, supporting young people up to the age of 25.
14.11.14	Adult Safeguarding Enquiry carried out after another young person took Joe's phone off him and refused to return it unless Joe took his top off.
27.11.14	Joe first presents as homeless to Ipswich Borough Council's (IBC) Housing department. Temporary hotel accommodation provided whilst an assessment is completed.
12.12.14	IBC take decision that Joe is not suitable for general housing and notifies Catch-22 of this. Joe returns to live with his mother, who complains to an IBC councillor.
February 2015	Joe referred to NSFT for autism assessment. He attends an appointment in February but does not attend appointments in July and October so this could not be completed. Joe's social worker was notified of this.
05.03.15	Joe assessed as likely to have an attachment disorder and developmental trauma due to chronic exposure to neglect, abuse, and changes of carer
01.04.15	Most provisions of the Care Act 2014 came into force, including the legal framework around the duty to plan for young people transitioning from children to adult services and safeguarding.

Date	Action
21.10.15	Joe reported missing from his supported accommodation, returning 2 days later stating that he had been staying with a friend
Nov 2015	S42 enquiry into allegation of false imprisonment. Joe was missing from his placement from 02.11.15 - 14.11.15. On his return he alleged to his support worker that he was kept against his will, physically abused including being shot with a BB gun and coerced to give money to those involved. When subsequently interviewed, Joe refused to speak to police.
23.11.15	Joe's mother emails a councillor, noting "*I fear Joe is going to end up being killed by some of these nasty youngsters that take their bullying too far*." In a further email dated 29 November 2015 she states, "*as a mother I am terrified that Joe is going to become a statistic of one of these bullying deaths*."
4.12.15	Care assessment concludes that "*Joe needs support with day-today tasks like food shopping, cooking, washing clothes etc, and if he does not receive support, it will impact his health, personal hygiene, and accommodation. He would continue to turn towards drugs and the negative social activities that surround it and may lose his accommodation if the care and support is not provided.*"
14.01.16	Joe goes missing for 2 days and on his return, refuses to say where he was staying.
17.02.16	In an email sent to a councillor Joe's mother states "*it really is only a matter of time before something awful happens to Joe and I have tried in vain to get help and to get people to listen to me to no avail. I have no doubt that one day Joe will be a headline in the newspaper for the failings he has suffered*."
16.03.16	Joe is reported missing and later discloses that he has been selling his property to pay for drugs and is now frightened to return to his placement because he owes people money and is being bullied.
17.03.16	In an email sent to a councillor Joe's mother states "*I really feel that if he remains living like this it is only a matter of time before he ends up in prison or dead. I do not want that for my son, and he deserves to be safe."*
12.04.16	ADHD assessment could not be completed due to Joe's chronic cannabis use
12.04.16	In an email sent to a councillor Joe's mother states "*I am terribly worried that it is only a matter of time before he ends up in serious trouble or is seriously hurt by someone*."
11.04.16	Street homeless and in a poor physical condition, Joe expresses suicidal ideation and paranoia linked to being harassed in public
14.04.16	Safeguarding referral received, setting out that Joe was assaulted on 10.4.16, likely due to drug debts. Catch-22 report that he presented with very poor hygiene and had been exploited/assaulted by a friend
19.04.16	Joe's mother complains to her MP, raising concern that Joe has been street homeless for 2 weeks because he is waiting for a capacity assessment. The

Date	Action
	LA responds that Joe has not consented to disclosure of his personal information
29.09.16	Joe's mother again complains to her MP that Joe's support hours had been reduced, resulting in his eviction from supported accommodation and becoming street homeless. She alleges that he was vulnerable to sexual predators
October 2016	A Mental Capacity Assessment concludes that Joe has capacity to understand and make decisions on future accommodation and support options
13.10.16	Response to MP advising that Joe has agreed to a private tenancy, with Leaving Care support and that mother was happy with the provision
18.10.16	Joe reports being assaulted and unable to return to his accommodation as the people who assaulted him know where he lives
07.11.16	Joe is reported missing from his placement for 7 days although had called them asking for money for food. Joe later says that he was staying with a friend because of concerns for his safety
28.02.17	Clinical record from NSFT concluded that there were insufficient indicators for ASD and that Joe's difficulties could be accounted for by severely disrupted attachment, due to past abuse.
09.05.17	Care review. Detailed and thoughtful assessment, that considered the impact of Joe's autism and childhood trauma on his behaviours and decision-making processes. "*It is clear that Joe has specific needs that he will require support within order that he can better look after himself in the future. However how this support is offered is key to its [sic] success or failure. Joe has a long history of placement breakdown almost all due to his refusal or willingness to engage with the support staff in question… He feels that he only requires a minimum amount of support on a daily basis, and it will be necessary for an agreement to be reached with Joe and the support staff prior to the support commencing that can meet his needs based around his rigid thinking, but also ensures that he is supported in those key areas around his daily activity needs*."
30.5.17	Joe tells customer services he had been robbed but could not report this to the police due to fears of reprisals
20.06.17	Joe turns 21, Leaving Care Service ends its formal support
Late 2017	From 10.10.17 – 8.01.18 Joe made 8 requests for additional funds to be released from his account so that he could 'buy Christmas gifts'
02.03.18	Joe's mother again complains through her MP that Joe has been placed repeatedly in accommodation that does not meet his needs and where he experienced physical abuse, theft, and emotional manipulation, resulting in repeated periods of homelessness

Date	Action
Mid 2018	From 17.04.18 – 6.7.18 Joe made 6 requests for additional funds because he had lost money, lost mobiles, or owed people money
01.04.18	Children & Social Work Act 2017 came into force on 1 April 2018 extending local authorities' duty to all care-leavers from 21yo unless they are in education, to 25yo, irrespective of whether they are currently in education.
01.04.18	Homelessness Reduction Act 2017 came into force, introducing duty to create a personalised housing plan for vulnerable adults experiencing or at risk of homelessness
20.04.18	Joe requests a support worker to support him while shopping because he was worried that people might harm him while he is out
14.05.18	A support worker goes to a bank appointment with Joe as he is afraid to go out alone because people are after him. Joe later calls ACS and reports feeling bullied and unsupported despite his vulnerability
17.05.18	A senior manager meets with Joe's mother to discuss her complaints about Joe's accommodation and vulnerability. Consequently, a decision is taken to transfer Joe's case to the newly established specialist Complex Behaviours Team.
22.05.18	Joe's case transfers from the Transitions and LD team to the Complex Behaviour team
20.06.18	Professionals' meeting between IBC and the Complex Cases team to resolve the dispute in respect of Joe's ability to manage a general tenancy. The Complex Cases team accepts that be lacks capacity for this and confirms they are seeking specialist supported accommodation. IBC closes Joe's case.
24.06.18	Following Joe's arrest for breaking a window, a 'triage' medical assessment concludes that he does not have mental health problems, but is low due to his situation, vulnerable to coercion from others and misusing cannabis heavily. A referral is sent to MASH setting out that Joe alleges that his cousin paid him to break the window. One of the occupants then chased Joe and hit him with a belt, cutting his head. Joe said that life is horrible and that he does not receive enough support. He asked for help to get away from people who take advantage of him. The referral is assessed as 'Amber' risk (RAG rating), but MASH concludes that this does not reach threshold for safeguarding enquiry and the referral is passed to Joe's allocated social worker to address mate crime issues as a single agency referral. Joe's mother has subsequently alleged that one of Joe's killers was involved in this incident.
10.07.18	Allocated worker from CCT facilitated initial appointment with Joe with the specialist supported accommodation provider for Community Support and Mental Health Supported Housing, to assess his suitability for this provision. They agree to provide 2 hours' support per week to facilitate their assessment. During the assessment process Joe had felt that he required support with budgeting, opening a bank account and obtaining a citizenship card. He required prompting with his activities of daily living such as changing and

Date	Action
	washing his clothes regularly and learning to use a washing machine. Joe said he was living on snack type foods, as he felt he needed support to make meals. He felt he would also require help maintaining the tenancy, paying bills and find social activities to do. Joe showed a keen interest in Carpentry.
11.07.18	Mental Capacity Assessment commences to establish whether Joe had capacity to manage his own finances as he is asking to relinquish the appointeeship, but this is not completed before his death
18.07.18	Joe's mobile is stolen. Joe requests all of his PIP be paid to him rather than in weekly amounts. Request made to ACS Personal Finance, Joe understood he would not have any money until 17.08.18 if he spent this.
27.07.18	Allocated worker on annual leave for 2 weeks, and cover is provided within the CCT by an experienced social worker, who Joe already knows well. Joe is made aware of these arrangements.
01.08.18	Joe attends a support meeting with specialist supported accommodation provider.
02.08.18	Joe misses a scheduled meeting with specialist supported accommodation provider.
03.08.18	Allocated worker rings Joe to discuss the outcome of the previous day's meeting. Joe advises that he overslept and did not attend, but he did get a text from them which he chose to ignore. Joe is short of food, so the allocated worker took Joe shopping for some essentials to last over the weekend as it is too late for a food parcel.
05.08.18	Joe spent the night with Becki West-Davidson, a woman with whom he had previously been in a relationship.
06.08.18	Joe attends a meeting with the specialist supported accommodation provider. He does not raise any concerns for his safety. This is the last time he was seen by professionals.
06.08.18	Joe offends West-Davidson during an escalating exchange on social media. She contacts Luke Greenland (aka Sebastian Smith) who Joe considered a friend but had also fallen out with. The messages rapidly escalate into threats. Later the same night Joe is persuaded to feel safe to meet with Greenland and an associate, who assault Joe and put him in the river, where he drowned in the early hours of 07.08.18.
07.08.18	Allocated worker leaves a message on Joe's mobile confirming the time for a meeting at his hotel the next day.
08.08.18	Allocated worker leaves message on Joe's mobile reminding him of visit, then goes to the hotel around midday. Staff attempt to raise Joe from his room but there is no reply. Staff erroneously advise the social worker that Joe had been seen the previous day.

Date	Action
09.08.18	Another message left on Joe's mobile to get in contact as the social worker wanted to arrange getting a backdated medical certificate from his GP for benefit purposes.
10.08.18	The social worker becomes concerned about Joe's disappearance, makes enquiries via staff at the hotel, Joe's mother, and a friend, none of whom had seen him. Joe was therefore reported missing to the Police.
13.08.18	Joe is found dead in the River Gipping.

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