## Background

Q and Y were white British males, who had been known to children's and adult social care, mental health and drug support services. Both had a history of presenting with very complex needs including substance misuse and suicidal ideation. They also had a history of adverse childhood experiences.

Q was found unresponsive in his bedroom in May 2020. He was aged 18 years old when he died. At a Coroner's inquest, the cause of death was recorded as a mixed drug overdose and a verdict of accidental death was reached.

Y was 20 years old when he died in June 2020. He was found in a room in his semi-independent living accommodation. A Coroner's inquest concluded a mixed drug overdose and suicide as the cause of death.

## Recommendation

A summit on transitional safeguarding practice should be held to help enhance policy frameworks and practice, as well as to review the operation and experiences of the transitions panel. Partners should outline how panels should work together and to ensure practitioners understand when pathways to particular panels are appropriate.

There should be collaboration with young people who have lived experience of transitional safeguarding to help co-produce a vision statement of shared expectations about how services should work together.

Furthermore the development of a dual diagnosis should be kept under review, and a Section 42 Care Act audit considered.

## Key Findings

Relationships are key to a young person's engagement and recovery. Children transitioning to adult services struggle with leaving behind established relationships and being responsible for seeking help.

Assurance that transitional safeguarding practice is person-centred, relational and outreach is a central component. A whole system approach with the commissioning of knowledge and skills based training on mental capacity, executive capacity and on young people is required.

Legal advice needs to be routinely sought, be made available and be obtained by the transitions panel. A clear escalation pathway is required when plans are not addressing need or mitigating risk.

Havering Safeguarding Adults Board

# Thematic Analysis of Cases Q & Y

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## Review

The Havering Adults Safeguarding Board commissioned a discretionary SAR to review the effectiveness of how services work together with children approaching transition from children's services to adult services.

A thematic analysis of cases Q and Y aimed to explore:

**1.** The good transitional safeguarding practice as well as the shortfalls.
**2.** What is working well and the barriers to effective transitional safeguarding in Havering.
**3.** How effective is the transitions panel for young people to whom leaving care duties are owed and the support for those who do not meet the criteria.
**4.** How services are working together to support young people with both mental health and substance misuse.
**5.** Partnership working for children & young people with complex needs, & their families.
**6.** Flexibility of service thresholds and eligibility criteria to provide a whole system response to the needs of young people.
**7**. Understanding of the Mental Capacity Act 2005 and its application to young people aged 16-17
**8.** To what degree is practice trauma informed.

The analysis also aimed to consider the changes made as a result of the Ms A SAR and its recommendations, and to see what further learning could be had with cases Q and Y.

## Key Findings

There has been focus on developing transitional safeguarding policy and practice, with services and agencies working together strategically and operationally.

The thematic analysis identified good practice in both Q and Y cases of the use of multi-agency meetings to share information and plans, liaison between drug and alcohol service providers for young adults, and efforts to maintain contact.

Shortfalls were evident e.g. focus was being placed on eligibility and thresholds, seeing services withdrawn despite ongoing risk. There is a need for transition work to begin earlier when complex needs and risks are apparent, for robust contingency planning to be put in place and followed through. A greater use of outreach could overcome obstacles to engagement.

Professionals meetings were held, information shared and risks were escalated, but a review of plans or the approach being taken was needed. Legal advice for child care options and mental health law could have been sought. The Mental Capacity Act 2005 must be applied in assessing the mental capacity of 16 and 17 year olds, and should consider executive capacity and the impact of addiction or impulse control disorder on decision-making.

## Key Findings

Services are having to respond to young adults with complex needs and risks, but the focus of the work tends to lie solely with mental health rather than with exploring family history, culture, health and education. Adult Safeguarding, specifically Section 42 Care Act 2014 was underutilised to safeguard these young people.

There is a commitment to mental health and substance misuse services working together, but challenges remain in bridging diverse legal rules to align a response that gets close to the evidence-base of transitional safeguarding practice.

Services should reflect on whether trauma-informed individual and family work begins sufficiently early, in order to take into account any familial and extra-familial risks in young people's lives. Staff need to have the skills to undertake trauma-based work, to be able to manage the emotional impact of the work and the complexity of need.

# 7-minute briefing