“River”

Safeguarding Adult Review

Nicola Brownjohn

Independent Safeguarding Reviewer

1 CONTENTS

2 REASON FOR REVIEW

2.1 In October 2022, the Havering Safeguarding Adults Board Chair reviewed the evidence of the Havering SAB Case Review Working Group meeting held in September 2022 in relation to the Safeguarding Adult Review (SAR) referral for River who died in May 2022. The Group were split in their decision whether the case met the criteria for a SAR. This meeting was to consider a SAR referral relating to River, an individual who died in May 2022.

2.2 The SAB Chair concluded that the following criteria within section 44 of the Care Act 2014 had been met:

1)The adult has care or support needs

2)The adult has died

It was not clear whether the third criteria had been met:

3)The SAB know or suspect that the death resulted from abuse or neglect.

In relation to the fourth criteria, there was evidence of good multi agency working which was shown in the information supplied. Agencies have highlighted areas where learning can be gained. River clearly presented with a significant number of complex needs, and plans in place to support them, had at times limited impact.

4) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.

2.3 The HSAB Chair decided that the circumstances of the case met the criteria for undertaking a SAR.

2.4 In light of the fact that some of the case issues, such as transitioning and complex young people, linked to mental health drugs and alcohol, had already been the focus of several recent SARs commissioned by Havering SAB.

2.5 Therefore, the focus of this review is on gender issues as these have not been covered in previous SARs.

3 METHODOLOGY

3.1 The methodology used is as follows:

3.1.1 An integrated chronology covering 1st June 2021 to 12th May 2022, establishing the involvement of all agencies that provided services to River.

3.1.2 A workshop event for practitioners and managers who were directly involved in providing services to River, and decision-making in relation to this case, so that their accounts of the circumstances can form part of the developing evidence base.

3.1.3 The multi-agency practice issues and opportunities for system learning emerging from the integrated chronology, practitioner workshop and family liaison will be discussed with the Review Panel, established to work with the Independent Reviewer and meet regularly during the Review period.

3.1.4 A SAR overview report will be written which establishes and explains the multi-agency practice issues in the case, presents system findings grounded in evidence, and makes specific and focused recommendations for changes that could improve the local system.

3.1.5 A workshop event to be held to disseminate the learning from the SAR to practitioners involved in the case and from across the local multi-agency safeguarding partnership.

3.2 Key Lines of Enquiry (KLOE)

1) How gender fluidity impacted on the support offered by agencies, and what implications this has for services working in Havering and Essex;
2) How can agencies best support young people as they explore their gender identity and expression as they transition to adult services and new areas to live?

3.3 SAR Panel Members

Representation from:

Nicola Brownjohn Independent Reviewer

Chair: Joy Maguire Designated Nurse North East London Integrated Care Board (NEL ICB)

Churchill House

Havering Adults Social Care

North East London Foundation NHS Trust (NELFT)

Essex Childrens and Adults Social Care

Essex SAB

Essex Partnership University NHS Trust (EPUT) Adult Mental Health Services

The Outhouse (Essex) – expert advisor to the review group

Met Police

Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)

Havering SAB Lynn Glancy

Havering SAB Elisabeth Major

3.4 Family involvement

3.4.1 River's family were contacted and offered the opportunity to contribute to the review. A response was received from River's half-sister stating that she did not want to say anything for the review.

4 RIVER

4.1 River was a 21-year-old young person. River was assigned female at birth. However, in their later years, River often expressed the wish to be affirmed as male. At the practitioner event, it was highlighted how frequently River's gender identity moved between male and female, as well as River wanting to be known by a variety of names. At the time of their death, River identified as a female and the funeral arrangements referred to River as such. In recognition of the fluidity of River's gender, this review will use the pronouns 'they/their/them' to refer to River.

4.2 River grew up in Essex. They became known to Essex Children with Disabilities team in 1999. They had experienced childhood trauma and its impact on their life. They had been left with their maternal grandmother, who had not been able to care for them. They felt not wanted as a child. From 1999-2008, there were three foster placements for River. The third broke down due to River's sexualised behaviour at the time. Subsequently, River was placed in children's homes, where they continued to display sexualised behaviour.

4.3 During River's childhood, there were incidents of alleged sexual assaults by male peers. This led to agencies recognising that River was at risk of child sexual exploitation.

4.4 River had a diagnosis of Emotional Unstable Personality Disorder, mixed anxiety and depressive disorder and a mild learning disability. They had spent most of their life in the care system and under mental health services, including being detained under 136 MHA 83. They were on a CPA (Care Programme Approach). As a looked after child, River was under the care of Essex Local Authority and had placements in various locations, including within the London Borough of Havering.

River transitioned from Essex Children Services to Essex Adult Services in 2020, as funders of their placements.

4.5 River was assessed to be high risk and presented many complex challenges including self-harm and threatening suicide. Engagement with services was described as erratic. River was vulnerable to exploitation, was known to associate with individuals who placed them at risk and misused drug and alcohol.

4.6 In June 2021, River was transferred from Redbridge Community Recovery Service where they had been living in supported living, to Havering Community Recovery Service and a new residential Care Home (Churchill House).

4.7 In June 2021, River disclosed an alleged sexual assault. Shortly after this they had a mental health crisis and were arrested for criminal damage against a person who they alleged had raped them. Two weeks later they became suicidal and were admitted to a female mental health unit. From here they were discharged, in July 2021, to the care of the Home Treatment team (HTT). They continued to have suicidal intentions during the first half of July. This was followed by drug taking, risky behaviour and engaging with individuals who, according to professionals, were not supportive of River's wellbeing.

4.8 In August 2021, River suffered a further mental health crisis and became suicidal leading to being detained under s136 of the Mental Health Act. They were discharged back to the care of the HTT but by the end of the month had again attempted suicide. They wanted to be admitted to the mental health unit and remained there until being discharged back to Churchill House late September 2021.

4.9 Between the end of September and October 2021, River found it difficult to remain in the care home. They went out, possibly engaging in risk taking behaviour and caused damage in the home due to being offended by the way a staff member looked at them. This resulted in a further mental health crisis. Then they seemed to settle down and was assessed by the Crisis Team (CRT) as being low risk.

4.10 Then, during the Christmas 2021 period, River was accused of public order offences when they were found intoxicated. Following this incident they were uncontactable by the Care Coordinator as not present at Churchill House.

4.11 2022 commenced with River reporting to Churchill House staff that they were the victim of robbery by a 'friend' on a train. Following this they self-harmed, using a knife, and reported being upset with care home staff when they misgendered and referred to River as a female when they identified as male at that time.

4.12 In February 2022 River reported to police that they were assaulted by a friend because they were trying to get their phone back. Following this police were called as the 'friends' vandalised the care home as River would not come out. River wanted to move as they were fearful of leaving the home.

4.13 River started to go out again and was out all night in April 2022. On return they requested a pregnancy test and reported that they had ingested bleach, although the tests undertaken did not confirm this.

4.14 In early May 2022, River disclosed to their Care Coordinator that they had been anally raped by a known male. A few days later they reported feeling suicidal due to breaking up with their girlfriend. They were found on the top floor of a car park and taken to the Emergency Department. River was requesting an admission to the mental health unit as they had a clear suicidal plan. Subsequently, they agreed to HTT support, as the least restrictive measure, and returned to the care home. They were visited by their Care Coordinator but later left the home, returning to the car park where they were found deceased, having fallen from a height.

5 PRACTITIONER EVENT

5.1 A practitioner event was held on 18 April 2023. It was attended by a range of practitioners who either had worked with River directly or represented a service which had contact with them.

5.2 The purpose of the event was to provide a reflective, safe space for the practitioners to talk about their experience of working with River. The reviewer is grateful for the informative and constructive way the practitioners shared their experiences and discussed areas for improvement.

5.3 The questions asked of the practitioners, prior to the event, were to reflect on:

1. In your role, what worked well with River?

2. What could have been done differently?

3. How confident are you in supporting young people who are exploring their gender identity and/or expression?

4. What changes are needed in how young people who are questioning their gender identity and/or expression are supported?

5. How do you feel now about River' experience? Is there anything you want to reflect on?

5.4 Thirteen practitioners attended the event. The key reflections have been divided into categories which provide insight into River' life.

6 FINDINGS FROM PRACTITIONER EVENT

6.1 River's identity as a child (identified as female)

6.1.1 At school River identified and affirmed as female. Numerous placements broke down due to their sexualised behaviour. They were not allowed to be alone with the other children as they expressed the wish to abuse other children and was oversexualised. River was very open about their aim to become pregnant and to give birth to an infant so that they could abuse them. The SAR has not had information regarding any investigations resulting from these concerns. It was reported that this was shared with the adult services. Sexual health support was included in the care plan when River was a looked after child. This did not identify any suggestion that River was gender fluid.

6.1.2 The issue of the oversexualised behaviour and risk to other children did not appear to be known by the practitioners working in adult services. Nevertheless, there was knowledge of how previous placements for River broke down.

6.1.3 An assessment of River's sexualised behaviour as a child could have helped to understand their gender fluidity as an adult. This might have helped in considering the impact of the trauma they had experienced as a child. There could have been more clearly defined support provided to help River on their journey in a way where they could feel confident and safe to move forward into a fulfilling life, as their authentic self.

6.1.4 At the event each practitioner explained how they perceived River. This demonstrated that River was known to identify as female or male, whilst some practitioners were aware of the gender fluidity and would ask River how they identified on each occasion they had contact with them. There were also numerous names by which practitioners knew River.

6.1.5 The practitioner group concluded that training and resources to help them to understand gender identity and /or expression, and how to support young people would be highly beneficial.

6.2 Transition from child to adult services

6.2.1 The practitioners discussed the differences in how River presented as a child, in contrast to when they became an adult.

6.2.2 As a looked after child River had been seen for regular reviews and attended school. It was reported that throughout their school life and at all reviews, including health reviews, River was female. As they reached adulthood, and a care leaver, River started to question their identity. River's GP saw them annually for a learning disability review and would ask them on that day how they identified.

6.2.3 In addition, it was recognised how adult services work differently to children's services, e.g., mental health services. Within children's services, there is work undertaken with the child and carers. In adult services, the onus is more on the

individual to seek the help they need and to engage with the support plan offered.

6.2.4 River was struggling with their mental health, questioning their gender identity and/or expression, and was lonely, desperate for love. To have to navigate adult services was also difficult for them. They relied on those practitioners with whom they had been able to develop a trusting relationship.

6.2.5 River was a care leaver. There was support for them through social care and they had legally ceased to be a care leaver in 2021. However, given the move around localities, and their lack of grounded community support, they would not have had the resilience and tools to be able to navigate the adult world, outside of the care home. A young person who has had a stable home life as a child, would be more able to access their social network for support as an adult.

6.2.6 Practitioners commented that, even though they had a good relationship with River, it was clear to them that they were professionals, not their family.

'(He) needed a buddy, (he) was lonely'

6.2.7 As River had been moved around localities, it was difficult for them to maintain long-lasting friendships. They seemed to develop relationships with others who were patients in the mental health unit or other care leavers in the local area. This is not unusual for those in similar circumstances. However, it means that young people who are vulnerable due to the trauma they have experienced as children have limited opportunities to develop trusting relationships across the community.

6.3 River's Care Plan

6.3.1 When River was admitted to Churchill House, the long-term plan was for them to develop independent living skills for supported living.

6.3.2 Communication between the care coordinator and the home was very good. They worked together and with River. This was positive in supporting River when they needed help, such as when they were threatened by peers outside of the care home.

6.3.3 Although it was River's aspiration to reach supported living, they would not fully engage with the work they needed to do to achieve this independence. There was a sense of workers being stuck and not able to find a way through to achieve better outcomes for River, due to River not being able to fulfil the smallest of actions to reach their goal.

6.3.4 The care plan did not feature River being genderfluid. Had it, there could have been more understanding of what services could be put in place to support them. This could have enabled professionals to consider what support networks there were for gender fluid young people.

6.3.5 At Churchill House, River was seen to move between names and gender identity. Staff found it a challenge not to make a mistake in how they referred to them, due to the level of gender fluidity River experienced.

6.3.6 River would get annoyed with Churchill House staff, at times, and they had difficulty in articulating when they were angry. They would then complain that a member of staff had not looked at them the right way or had misread how they wanted to be identified.

6.3.7 Practitioners found that River engaged well when allowed to be themselves, and when treated in a non-judgemental way. Some practitioners spoke about how River responded well when their choices, even the bad ones, were respected.

6.3.8 River picked out professionals they felt safe with. It would take a long time to develop the relationship. Practitioners made good use of texting, telephone calls and just sitting with River. They understood River, when they were mentally well, their life went well.

6.3.9 River lacked individuals who loved them. Their good relationships tended to be with those who could only offer professional based relationships which were time limited. When River felt unloved, they would take a dislike to people and could then become violent.

6.3.10 It had been difficult to find River the right placement as they set fire to their last placement and was evicted. Churchill House was home to much older adults, the next youngest to River was 54 years old. River chose the placement and got on well with the residents who were protective of them. They developed good mutual relationships with other residents. River called them their family. River wanted to hear "*love you*" back.

6.3.11 However, River also craved relationships with peers of their own age, and this was a gap at the home. Therefore, River would go out to the community but then mixed with those who were as vulnerable as they, or those who would exploit them.

6.3.12 At times of crisis, River wanted to return to hospital as they had made friends there. They managed to engage with therapeutic support when on the ward. Whilst there, on one occasion they were able to send a text to someone to 'unfriend' them. It was described as a grounded ending to the relationship with River feeling good about it.

6.3.13 Whilst in hospital River had access to a psychologist but once back in the community they would not respond to calls by some professionals as they would not be known to them. It was commented on at the practitioner event, that the hospital psychologists do not follow the individual into the community as that work is totally separate from the ward work. This means that there can be an limited continuity of care for an individual such as River, who needs to be able to trust any professional working with them.

6.3.14 At the practitioner event, it was discussed how a drop-in centre might have been helpful for River, somewhere for peer mentoring, where they could feel comfortable and not excluded. There was a drop-in centre – Cocoon, but this was where there were other care leavers and there were difficult relationships for River.

6.4 River at Risk of Exploitation

6.4.1 Practitioners found it difficult to deal with the unwise decisions that River sometimes made. They would make risky decisions to enable them to spend time with 'friends', despite being at risk of financial exploitation.

6.4.2 Money was a big problem for River. They received benefits and when they did, individuals would visit them. At Churchill House, staff developed a plan to help River to keep some of their money safe, so that they had sufficient funds to pay for cigarettes.

6.4.3 There were mental capacity assessments undertaken in relation to financial decisions due to the risks to River of being financially exploited by others.

6.4.4 There was a discussion at the practitioner event about the one stop shop (Cocoon) and local housing opportunities. There was a consistent view that the efforts to provide support for care leavers and young people with mental health problems had inadvertently created 'ghettos' of these cohorts of young people. These cohorts are at risk from organised crime groups.

6.4.5 When River was threatened by peers, who proceeded to cause criminal damage to the care home, there was support for them from the staff and police. River did not want to go out without staff for a period of time. This provided some community support for River.

6.4.6 It was reported that the violent attack on the home had been carried out due to River contacting the police because their phone had been taken. River got a new phone and had all social media removed but then they contacted the individuals again and reinstated the social media contact. This demonstrated how difficult it could be for carers to help River to maintain their safety.

6.4.7 River disclosed two sexual assaults in their final year of life. They were also known to make allegations of sexual abuse by staff in some of their placements, prior to Churchill House.

6.4.9 At the practitioner event, the police representative commented on how police officers do not have a good understanding of gender identity issues. When River reported the alleged sexual assault, the investigation was more about the criminal damage perpetrated by River. They had a restraining order made against them. The problem was that River refused to take the sexual assault allegation forward. However, there should have been recognition of this counter allegation in the police response.

6.4.10 There was no evidence that other workers involved with River supported them to seek support from the Sexual Assault Referral Centre (SARC), although the care coordinator supported River to go to the police in May 2022 when they disclosed the alleged anal rape. This was a missed opportunity for River to have their voice heard and for professionals to consider the impact of these sexual assault allegations, along with those made when River was a child.

7 LEARNING THEMES

7.1 Affirming Gender Identity

7.1.1 How was the issue relevant to the case?

7.1.1.1 Gender identity is the personal sense of one's own gender. Gender identity can correlate with a person's assigned sex at birth or can differ from it. A genderfluid person is someone who does not identify with a single fixed gender or has a fluid or unfixed identity. An individual's affirmed gender is the gender that matches their gender identity.

7.1.1.2 River's gender identity moved between male or female and was likely to be genderfluid. We acknowledge that this was not a term that River was known to have used. River responded well to those workers who asked them how they wanted to be addressed at a specific time.

7.1.1.3 River expressed self-harm, serious risk taking and suicidal intent. It was not clear to what extent River's mental health was affected by their genderfluid experience.

7.1.1.4 Agencies address gender identity inconsistently. For example, at the practitioner event, it was discussed how Primary Care have a gender identity

marker within their records which can alert staff if someone identifies differently to their sex assigned at birth. The individual can then be asked which name and pronouns they would like used that day. Meanwhile, the police perceptions of gender would be based on how the individual appears, e.g., for River, the police would not have checked how River identified on that specific day, rather they would have addressed them on their appearance that day, so if dressed as a male, they would have perceived them as such. Additionally, emergency health services would check at the first contact, whether someone is male or female.

7.1.2 National Research

7.1.2.1 Transgender and nonbinary youth who report having their pronouns respected by all or most of the people in their lives attempted suicide at half the rate of those who did not have their pronouns respected.[1]

7.1.2.3 Gender affirmation is important to a young person to make them feel comfortable in their environment and able to trust professionals to give them the support they request.

Recommendation 1

It is essential that police, adult social care and health services commit to having a substantial number of staff at the training programme which will cover issues surrounding gender identity and/or expression.

Recommendation 2

Following on from the training, there should be a HSAB task and finish group to develop key principles for effective responses to the needs of non-binary, and other gender diverse, individuals. There should be a commitment by all SAB members to adopt these principles into their practice.

[1] The Trevor Project (2020) National Survey on LGBTQ Mental Health

7.2 Mental Illness and Gender Fluidity

7.2.1 How was the issue relevant to the case?

7.2.1.1 River was diagnosed with Emotionally Unstable Personality Disorder (EUPD). When in hospital they had access to therapeutic interventions but in the community, they chose not to respond to offers of psychological support. It is not clear what impact River's mental illness had on how they managed their gender fluidity. River repeatedly sought inpatient care as they felt safe there and had made friends.

7.2.2 National Research

7.2.2.1 Within schools, it has been found that trans, gender diverse and non-binary children and young people experience disproportionately high levels of mental ill health.[2] In 2020, it was found that 40% of LGBTQ respondents to the Trevor Project survey reported that they had seriously considered attempting suicide in the past twelve months. Whilst more than half of transgender and nonbinary youth have seriously considered suicide.[3]

7.2.2.2 In the same survey, nearly 50% of transgender and nonbinary youth were wary of having mental health support due to concerns related to the LGBTQ competence of providers.[4]

Recommendation 3

NELFT should review how individuals are able to have continuity of therapeutic provision between hospital and community services.

7.3 Professional responses to sexual assault

7.3.1 How was the issue relevant to the case?

7.3.1.1 River alleged two sexual assaults during the last year of their life. However, they were unwilling to proceed with the first allegation, and this meant that

[2] Written Evidence submitted by Mermaids (CYP0097) to the Government 2021.
[3] The Trevor Project (2020) National Survey on LGBTQ Mental Health
[4] The Trevor Project (2020) National Survey on LGBTQ Mental Health

police closed the case. River does not appear to have been referred to the Sexual Assault Referral Centre (SARC) on either occasion. On the first occasion, River went on to cause criminal damage against the person they accused. This led to River being treated as the perpetrator of a crime, with a restraining order taken out against them.

7.3.1.2 River had been known to be a risk, as a child, to other children due to their oversexualised behaviour. As a teenager, River (then identifying as female) expressed a desire to have a baby so that they could abuse them. This information was shared when River moved to the adult services. However, not all services were aware of this, including the disability team and Churchill House. Had this been shared, there might have been more risk assessments undertaken when River disclosed the alleged sexual assaults. This could have helped professionals to identify the appropriate support for River.

7.3.2 National Research

7.3.2.1 The Casey Review highlighted police issues with an increasingly depleted workforce from 2015, and from 2018 a change to how the Public Protection teams were structured.[5] The Casey Review found significant variation in how caseloads were viewed and a lack of oversight as to the structure and functioning of public protection units.[6] The review commented on the need for specialist knowledge and training for police officers working on cases of rape or sexual assault.[7] As part of the Casey Review, the London Victims' Commissioner facilitated two listening events with victims of crime. The feedback highlighted how victims did not have trust in the police to effectively support them through an investigation.[8] When the focus is on LGBT+ victims,

[5] Baroness Casey of Blackstock DBE CB (2023) *BARONESS CASEY REVIEW Final Report An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service*.
[6] Baroness Casey of Blackstock DBE CB (2023) *BARONESS CASEY REVIEW Final Report An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service*.
[7] Baroness Casey of Blackstock DBE CB (2023) *BARONESS CASEY REVIEW Final Report An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service*.
[8] Baroness Casey of Blackstock DBE CB (2023) *BARONESS CASEY REVIEW Final Report An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service*.

the trust in the police is significantly lower than from the Non-LGBT+ community.

7.3.2.2 LGBT+ survivors guidance suggests that non-binary people may feel that they are not welcome or understood in binary services.[9] There can be a fear of being judged or blamed.[10]

Recommendation 4

The Metropolitan Police should report to the HSAB on the progress with the recommendations from the Casey review in terms of how to create greater trust in the police by the LGBTQ+ community in relation to rape and sexual assaults.*

Recommendation 5

The HSAB should raise awareness with its members as to the appropriate health support (SARCs) for victims of alleged rape or sexual assaults.

* Police response to the recommendation

Since this recommendation, the Metropolitan Police Commissioners have developed a New Met for London Plan.[11] This particularly highlights the following, which will be of use for the HSAB in gaining assurance regarding recommendation 4 :

- Recruitment focused on attracting 'recruits and leaders better represent London's diverse communities' (including LGBTQ+)
- Increased scrutiny across the Met but also locally through quarterly scrutiny panels with councillors
- Under 'More Trust' in the New Met for London Plan there is a mission to track levels of improvement within Black, ethnic minority and LGBT+ communities, and among women, where it is known that confidence has historically been low and damaged over the last decade
- Under 'less crime' there is a commitment to 'improve our ability to identify and reduce levels of disparity in outcomes achieved for Black, ethnic minority and LGBT+ communities, and for women in London'.

[9] London Survivors Gateway (2019). *LGBT+ people and sexual violence* https://survivorsgateway.london/wp-content/uploads/2019/06/Galop-Gateway-Resource-web.pdf
[10] London Survivors Gateway(2019) *LGBT+ people and sexual violence* https://survivorsgateway.london/wp-content/uploads/2019/06/Galop-Gateway-Resource-web.pdf
[11] A New Met for London | Metropolitan Police :accessed 03 August 2023.

- LGBT+ Community Liaison Officers have been introduced to ensure every LGBT+ person living or working in the capital is confident to report crime, seek our help or tell us their concerns.
- Victims of sexual violence, gender-based violence or domestic abuse will have the right to request that the officer conducting the interview is of a sex/gender of their choice. There is a commitment to meeting that request unless doing so would prejudice the fairness of the criminal proceedings
- There is a commitment to ensure that communities can co-design approaches to combatting discrimination in their areas. There will be research commissioned into overall crime disparity to improve Met Police understanding of the issues facing women and girls, Black, LGBT+ and disabled Londoners, and other ethnic minority communities. This will be used to design interventions that are properly data-driven.