



Redbridge Safeguarding Adults

# **Safeguarding Adults Review (SAR) 'Munir'**

## **Overview Report**

April 2026

Independent Reviewer:	Eileen Mills
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## 1. Introduction

1.1 In September 2025, Redbridge Safeguarding Adults Board (RSAB) received and considered a referral in respect of Munir, an 18-year-old mixed race male Care Leaver, who had been placed in semi-supported accommodation in Redbridge by LB Tower Hamlets in 2022. Munir sadly died in May 2024 from drug and alcohol toxicity.

1.2 The Redbridge 'One Panel' discussed the referral in October 2025. Following a scoping exercise and use of the decision-making tool ([Redbridge 'One Panel' Guidance](#)), it was agreed that the case met the threshold for a statutory Safeguarding Adult Review (SAR), and the case was identified as offering valuable learning through the use of **Munir's** lived experience as a lens to examine the system and processes supporting Care Leavers transitioning into adult services, particularly in relation to arrangements involving the London Borough of Redbridge.

1.3 In December 2025, the RSAB requested that the current Independent Chair undertook the review.

1.4 On behalf of the Board, the Reviewer wishes to express their sincere condolences to Munir's family for their loss and gratitude to the professionals who worked with him, for sharing their insights honestly and conscientiously. The efforts of professionals to care for and support him were apparent, as was the positive regard in which he was held. Munir was described as a bright and personable young man whose loss is still felt by professionals who worked with him.

1.5 The Review has chosen to use a pseudonym as the family of Munir have not participated in the SAR or given direction as to their preference on anonymity. The name Munir has been chosen as its meaning is "right, radiant, shining, or luminous".

## 2. About Munir

2.1 Munir was a care-experienced young person whose development and wellbeing were significantly affected by early trauma, disrupted attachments, and complex emotional and neurodevelopmental needs. His childhood involved exposure to domestic abuse, the death of his mother, separation from his siblings<sup>1</sup>, and the breakdown of a Special Guardianship placement. These cumulative experiences shaped how he interacted with professionals and coped with day-to-day life.

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<sup>1</sup> Right to maintain contact with siblings to be strengthened in law for children in care via amendment to Children's Wellbeing and Schools Bill <https://www.gov.uk/government/news/new-legislation-to-keep-brothers-and-sisters-connected-in-care>

- 2.2 At the age of sixteen, there was a significant change in Munir's presentation. In Summer 2022, he sat his GCSEs in which he did well and there were no signs of neurodevelopmental concerns at this time. During that Summer he had begun to experiment with alcohol and smoking. When he returned to school in September, he actively avoided his friends, dressed in a hat and wore face mask. His engagement with education was reduced to a bare minimum. During this time, he was unhappy at home **and didn't want to** engage with his two Guardians, nor his brother, and his placement broke down. Following the placement breakdown Munir was placed in a supported living accommodation at the age of sixteen.
- 2.3 The Manager of the supported living accommodation described how helpful Munir was in the home and made a valued contribution to the living arrangements. The placement is commissioned to support transition to independent living. From the outset, Munir needed a lot of support and workers went above and beyond in their support for him.
- 2.4 From this time onwards and into early adulthood, Munir presented himself as withdrawn and socially isolated, often spending long periods alone in his room. He experienced persistent low mood, sleep disruption including a reversed sleep pattern and fluctuating motivation. These issues contributed to disengagement from education, appointments, and daily routines. He frequently articulated feelings of emotional numbness and disconnection, occasionally expressing passive suicidal thoughts, though he tended to deny intent.
- 2.5 Munir preferred to communicate through writing or text rather than spoken conversation. Professional engagement improved when this preference was recognised and accommodated. He relied heavily on routine, predictability, and solitary interests such as anime and manga<sup>2</sup>, which provided emotional comfort and acted as coping strategies.
- 2.6 His emotional world was shaped by disrupted attachments and the ongoing impact of **separation from his siblings. He once described himself metaphorically as a "rabbit, weak and in need of care," indicating his felt vulnerability.**
- 2.7 Munir had intersecting mental health, neurodevelopmental, and trauma-related needs and was later diagnosed with autism spectrum disorder (ASD) just before his eighteenth birthday. His presentation included selective mutism, social communication challenges, sensory sensitivities, and reliance on predictable routines.
- 2.8 At various points, he engaged in behaviours such as alcohol use, suspected episodic substance misuse (which he denied), and accessing violent or harmful online content. He sometimes described these behaviours as strategies to manage distress or intrusive,

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<sup>2</sup> Anime refers to Japanese animated shows and films. Manga are Japanese comic books or graphic novels.

suicidal thoughts. His functioning fluctuated over time, with alternating periods of stability and deterioration.

2.9 The transition to adulthood took place during a period of emotional fragility. Turning eighteen brought increased expectations of independence and reduced statutory oversight, even as his underlying needs remained significant. Multiple events, including diagnosis of autism confirmation, service transitions, disengagement from education, and non-attendance had a cumulative rather than isolated impact. Just after his eighteenth birthday he was admitted to Goodmayes Hospital on an adult in-patient mental health ward.

2.10 Despite these challenges, Munir consistently expressed a desire for stability. He reported liking his placement where relationships felt supportive. At times, he engaged well in Pathway Planning and articulated aspirations to return to education and work toward future goals, particularly when he felt emotionally settled and adequately supported.

### 3. Barriers and intersectionality

3.1 To fully consider Munir's unique characteristics and how they impacted on his lived experience the Research in Practice (RiP) Social GRRAAAACCEEESSSS Tool<sup>3</sup> was used as a framework of analysis for the barriers he faced in accessing services.

3.2 Several personal factors relating to Munir were identified as part of the Review, including:

- Munir faced barriers related to autism, trauma history, bereavement, emotional numbness, and difficulties expressing distress. These factors affected his ability to engage consistently, articulate risk, and seek help proactively.
- His neurodevelopmental assessment for possible autism was incomplete at the time of his death, and an ADHD assessment was pending.
- Munir's sleep dysregulation and profound insomnia impacted on his daily functioning.
- He had low self-esteem and used avoidance as a coping mechanism, refusing appointments, withdrawing, staying in bed, shutting down.
- Munir had difficulty trusting professionals, experienced anxiety in social environments.
- Munir was reliant on care staff for motivation and supervision.

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<sup>3</sup> [https://adultsdp.researchinpractice.org.uk/media/2cojlyqp/adultsdp\\_tools\\_1-6.pdf](https://adultsdp.researchinpractice.org.uk/media/2cojlyqp/adultsdp_tools_1-6.pdf)

3.3 The following cultural and identity factors relating to Munir were identified as part of the Review:

- As a young mixed-race British male, Munir's cultural identity and experiences of racism were noted but not consistently explored in assessment or care planning including his care experience and experiences of instability. Cultural expectations around masculinity, emotional expression, mental health stigma, and substance use may have influenced how he understood and communicated distress, and how willing he felt to engage with support.
- Information shared as part of the **Review indicated Munir's father was not** allowed to contact his children, the details of why are not clear, but it is known he perpetrated domestic abuse on his mother and had been radicalized whilst serving a prison sentence. There is no sense of what the impact of his father being absent in his life or if his father made any contact as Munir got older. Munir had to navigate his identity as a young British man with minimal family support.

3.4 Structural and systemic factors **pertinent to Munir's case were identified as follows:**

- Munir's care leaver status, out-of-borough placement, reliance on supported living, and transition between children's and adult services created structural vulnerabilities. These included:
  - reduced continuity of relationships;
  - gaps in follow-up during non-attendance;
  - variable information sharing; and
  - limitations of supported living in being able to meet his emotional and relational needs.

3.5 Several environmental barriers impacted Munir including a shared living environment which affected sleep and anxiety; isolation and reliance on using the online space, which created online risk (catfishing) and accessing unhealthy content.

3.6 In line with the RiP Social Graces and Intersectionality framework, Munir's experiences are best understood as the interaction of multiple personal, relational, and structural factors rather than a single presenting issue. His mental health difficulties intersected with early trauma, bereavement, separation from siblings, care experience, and the structural challenges associated with transition to adulthood and changing service thresholds. These intersecting factors influenced how Munir experienced support, exercised autonomy, and engaged with services over time, and shaped both his vulnerabilities and strengths.

## 4 Approach to the Review

### 4.1 Purpose of a Safeguarding Adult Review

4.2 The purpose of a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died. The purpose of a SAR 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. This often involves reviewing the effectiveness of procedures (both multi agency and those of individual organisations) and informing the improvement of local interagency practice. There is a strong focus on understanding the underlying issues that informed professional actions and what, if anything, prevented them from being able to help and protect Munir from harm.

### 4.3 Key Lines of Enquiry

The Review will explore the period May 2022 - May 2024, which is the period from when Munir moved to supported accommodation Redbridge, until his death. The Terms of Reference (ToR) agreed to the following Key Lines of Enquiry (KLOEs) for the Review:

- Was it clear from the case that safeguarding was person-centered and the principles of Making Safeguarding Personal applied?
- Was the context of **Munir's** lived experience and identity fundamental to the support provided?
- How did transition pathways support Munir from child to adult, were they effective?
- Which internal procedures were implemented and followed?
- Which multi-agency procedures were implemented and followed? Examples could include vulnerable adult risk management, multi-agency risk management, safeguarding, Mental Health Assessments, Mental Capacity Assessments, self-neglect etc.
- **Were "Did not attend"/"Did Not Engage" procedures in place and implemented appropriately?**
- Were escalation procedures in place and implemented appropriately?
- Were management/supervision procedures followed to ensure appropriate decision-making including triaging referrals/concerns and staff support?

### 4.4 Methodology

Information Sharing Templates were distributed to agencies known to have provided services/worked with the subject. The returned single-agency Information Sharing Templates and chronologies were collated to form comprehensive multiagency chronology and analysis report of findings.

A Roundtable Event was held on 26 March 2026 at which the information was reviewed and discussed with professionals involved with Munir and safeguarding leads. The Roundtable Event findings, learning and recommendations were developed into a report for presentation to the RSAB in April 2026. The following agencies were represented at the Roundtable Event having supplied information for the SAR or contributed professional expertise:

- Department of Work & Pensions (DWP)
- Education providers from LB Newham and LB Redbridge
- East Area Borough Command Unit Metropolitan Police Service
- London Ambulance Service (LAS)
- Designated Nurse – Looked After Children NHS NEL ICB
- Safeguarding Adults Advisor NELFT
- LB Redbridge – Legal Services
- Children Looked After & Throughcare LB Tower Hamlets
- Designated Professional Safeguarding Adults NHS NEL VIA
- LB Redbridge – Adult Services
- Adult Mental Health & Learning Disabilities NELFT
- Prevent Regional Delivery Officer LB Redbridge

**At the time of drafting this report Munir’s family**, contacted by LB Tower Hamlets, had not agreed to speak with the author. The Supported Living Provider where Munir lived also declined to engage in the SAR process but later did speak with the author to discuss the final report. The SAR recognizes that their contributions would have led to a richer **and greater understanding of Munir’s experiences**.

#### 4.4 Parallel Processes

A Serious Incident Investigation was conducted by NELFT following Munir’s death. This review triggered the submission of the SAR referral. **A Coroner’s inquest was held** to determine the cause and nature of Munir’s death. The inquest concluded with the determination that the cause of death as ethanol and ketamine toxicity. The circumstances of Munir’s death met the criteria for review under the [preventing drug and alcohol deaths \(DARD\) partnership review process](#) and the approach has also included this lens.

## 5 Learning from Research

5.1 National analyses of Safeguarding Adult Reviews (SARs), thematic reviews, and transitional-safeguarding research identify recurring patterns that closely align with the issues emerging in this SAR. The learning below draws on the Second National Analysis of SARs (2019–2023)<sup>4</sup>, thematic multi-agency reviews, and national findings on care-experienced young people.

### *Multi-Agency Information Sharing and Coordination*

5.2 National SAR learning continues to highlight significant shortcomings in how agencies share information, particularly during key transitions and periods of heightened risk. The Second National Analysis of SARs (2019–2023) found that weak documentation, unclear professional responsibility and poor handovers were common, often leading to fragmented care and missed opportunities for intervention.

5.3 National commentary emphasises that despite repeated learning over many years, **“agencies working in silos”** remains one of the most persistent systemic problems, undermining safe and coordinated practice across sectors.

5.4 These findings echo the challenges seen in this case, where communication gaps across **children’s services, adult mental-health services, schools, and supported accommodation** contributed to the absence of a cohesive safeguarding response.

### *Weaknesses in Risk Assessment and Professional Curiosity*

5.5 National reviews show that cumulative risk is frequently not recognised, with agencies responding to isolated incidents rather than synthesising patterns of deterioration. The London-region findings from the national analysis reported significant increases in cases involving self-neglect (60%) and neglect or abuse by omission (46%), highlighting the need for a whole-person, whole-system approach to risk <sup>5</sup>.

5.6 National evidence demonstrates that where professionals do not fully explore emerging risks, safeguarding responses remain superficial and ineffective mirroring the pattern observed in Munirs experience.

5.7 Previous SAR undertaken in Redbridge identify the absence of a Multiagency Risk Management Framework (MARM) to support practitioners to bring partners together to fully consider risk in a more holistic way. The development has been a priority for the RSAB during 2025 2026.

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<sup>4</sup> <https://www.saeb.org.uk/safeguarding-adults-reviews/national-analysis-of-sars/>

<sup>5</sup>

<https://www.healthwatchkingston.org.uk/sites/healthwatchkingston.org.uk/files/Presentation%201%20SARS%20Review%20-%20Michael%20Preston-Shoot.pdf>

### *Transitional Safeguarding: Structural Gaps at Age 18*

5.8 National learning repeatedly highlights the vulnerability of care-experienced young people at the point of transition to adulthood. Research by Professor Christine Cocker on transitional safeguarding stresses the long-recognised “cliff edge at 18,” where young people lose consistent relationships, service thresholds shift, and critical needs are not met <sup>6</sup>.

5.9 The review identifies that local authorities often struggle to fulfil statutory duties around pathway planning, continuity of mental-health support, and coordinated multi-agency oversight.

### *Neurodiversity, Mental Health and Trauma: Lack of Integrated Response*

5.10 The Second National Analysis of SARs shows that adults featured in SARs often have overlapping needs including mental-health conditions, neurodevelopmental conditions (e.g., autism), trauma histories, and substance misuse. However, national findings indicate that services frequently fail to adapt communication methods, risk planning, or support pathways to a person’s neurodiversity.

5.11 Similarly, thematic learning reviews highlight gaps in trauma-informed practice, insufficient attention to attachment disruption, and the need for more skilled emotional and relational-based support for individuals with complex developmental histories.

5.12 These national findings correlate strongly with Munir’s experience, where the autism diagnosis, trauma impacts, and communication needs were not fully integrated into risk formulation or care planning.

### *Substance Misuse Risks Under Recognised and Responded to*

5.13 Across national SARs, substance misuse, particularly when occurring alongside mental-health needs, is consistently identified as an area where risk is underestimated. The national dataset shows increasing overlap between mental-health concerns, alcohol misuse, and drug use, and highlights the need for assertive dual-diagnosis approaches and multi-agency escalation.

5.14 These findings mirror the missed opportunities identified in this case, where substance-use risks were repeatedly noted but not synthesized into a coordinated risk-management plan.

### *Insufficient “Think Family” Practice*

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<sup>6</sup> <https://www.tandfonline.com/doi/pdf/10.1080/09503153.2021.1979505>

5.15 National reviews emphasize the importance of understanding family dynamics and assessing risk across households, particularly when under-18s may be exposed to harmful environments. Thematic SARs highlight recurring gaps to consider the impact of substance misuse, unsafe adults, or mental-health crises on siblings and younger family members.

5.16 This national learning corresponds with gaps identified in this case, where incidents involving younger siblings did not prompt safeguarding assessments or multi-agency review.

#### *Recognising Cumulative Risk Over Time*

5.17 The Second National Analysis of SARs (2019–2023) stresses that one of the most persistent national themes is not seeing the **“bigger picture,” with agencies often** responding to single events instead of recognising deterioration across months or years.

5.18 This pattern is strongly reflected in Munir's chronology, where numerous warning signs; including isolation, sleep reversal, withdrawal, missed appointments, escalating mental-health symptoms, and substance use, were documented but not brought together into a single risk-focused plan

## 6 Analysis and findings in response to the KLOE

6.1 Analysis of the information identified several findings, which are grouped under the following headings:

#### *Multi-Agency Information Sharing*

6.2 Critical information about Munir's Child Looked After and Care leaver status, trauma, his trauma history, risks, SEND needs, autism considerations, mental-health history was not shared in a timely way during transition of schools, the care home were not always fully aware of relevant history for Munir.

6.3 Lack of clearly documented actions frequently led to confusion, duplication, gaps, and lost continuity at crucial moments (e.g., transition to a new school, transitions between CAMHS and Adult Mental Health services).

6.4 In 2023 Munir shared information about his online activity during a contact with his mental health professional concerns were recorded that the content could be potential extremism and would reach the criteria of a PREVENT<sup>7</sup> referral. The supported living

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<sup>7</sup> PREVENT is part of the UK's counter-terrorism safeguarding strategy. It is about protecting people from being drawn into terrorism or violent extremism, in the same way that other safeguarding work protects people from abuse or exploitation.

accommodation manager recalls having a discussion but agreement that criteria were not met. Which meant the concerns were never reflected upon on a multi-agency basis through the Channel Panel.

#### *Inconsistent Risk Assessment & Lack of Professional Curiosity*

- 6.5 Repeated deterioration (withdrawal, selective mutism, poor diet, suicidal ideation, hallucinations, alcohol/drug use) did not trigger consistent escalation or coordinated multiagency risk reviews.
- 6.6 Professionals often documented concerns but did not explore root causes, triggers, or the impact of trauma, bereavement, social isolation or online harms. This is particularly apparent when the sudden change in Munir was noted in the summer of 2022. His needs were met but there was no curiosity as to what led to such dramatic changes in behaviour. His history of trauma, without being curious about which traumas he experienced were impacting on behaviour, and evolving evidence of neurodiversity became the dominant hypothesis without exploration of substance misuse and possible exploitation.
- 6.7 Munir experienced use of alcohol and drugs, mental wellbeing; ASD; self-neglect (food refusal, self-care etc.) and lack of motivation. Whilst some multi-agency meetings and discussions took place, there is no record of any holistic multi-agency plan which encompassed all his needs. Issues such as mental health and school attendance dominated but other issues had less consideration.
- 6.8 All Munir's needs and professional concerns were not brought together in one place. His lived experience was never considered in a context of risk; that Munir was eligible for adult social care services due to his care and support needs and self-neglect. **Professionals'** responses were framed in responding to Munir as an adult with autonomy to choose how he lived.

#### *Fragmented Mental Health Pathways & Transition*

- 6.9 Transition from CAMHS to Adult Services was not well coordinated, with unclear ownership, delays, and inconsistent involvement from adult mental health teams. Munir's Autism diagnosis was confirmed but not embedded into risk formulation, support plans, or communication strategies.
- 6.10 Very shortly after turning 18, Munir **was admitted into 'in patient's'** mental health services, which is a completely different directorate within NELFT than the community services he was transitioning through.

6.11 CAMHS services demonstrated good practice by remaining involved beyond their usual remit to continue to support

*Education Safeguarding:*

6.12 Both secondary schools showed excellent safeguarding curiosity, rapid response, and proactive engagement. Schools repeatedly raised concerns and requested multi-agency action, but other agencies did not respond with equal urgency.

6.13 There was no SEND input sought at the onset of Munir's significant mental-health needs, despite prolonged non-attendance. **Following diagnosis Munir's could have been considered as eligible for the Dynamic support register** is sometimes called a DSR<sup>8</sup>, which may have led to oversight via Care (Education) and Treatment Reviews, which provides a holistic view of needs.

*Care Home Central to Supporting Munir, but not always connect to wider service plans*

6.14 The placement repeatedly escalated risk, removed hazards, shared information transparently, and implemented safety plans. However, they were often left without timely mental-health support or guidance, particularly during crisis events.

6.15 No evidence of coordinated multi-agency safeguarding planning for a looked After Child /Care Leaver experiencing severe mental-health crisis.

6.16 Following his final **Looked After Children's Health assessment no health passport<sup>9</sup> (a local name for a "summary of all health records" that is required to be provided)** was generated or outstanding health needs shared with partners to offer ongoing support.

*Substance Misuse Risks Were Repeatedly Minimized*

6.17 Known ketamine use, binge drinking, intoxication episodes, online risks, and mixing substances with prescribed medication were not jointly risk-managed. There were missed opportunities under the age of eighteen for intervention regarding substance misuse. Over the age of eighteen referrals were made but refusal of Munir to attend were

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<sup>8</sup> The Dynamic Support Register (DSR) is a tool to identify and support people with learning disabilities or autism at risk of unnecessary hospital admission, integrating with Care (Education) and Treatment Reviews (C (E)TRs) to ensure timely, person-centred care

<sup>9</sup> s The Statutory Guidance for the health of Looked after children does not use the term Health Passport and prefers the phrase "summary of all health records."

not explored further but seen as autonomous decisions outside of a wider assessment of risk. There was no sustained multi-agency plan addressing alcohol and drug risks.

*Gaps in Think Family Practice*

6.18 A significant incident, when Munir, whilst intoxicated ended up in water and required hospitalisation and subsequent admission to Goodmayes acute Mental Health admission (under the Mental Health Act) involved younger siblings which included alcohol use, drug exposure, dangerous environment).

6.19 The Review provided no evidence of referrals, joint assessments, or safeguarding actions to protect Munir's siblings. **Adult services did not apply "Think Family" standards** despite clear safeguarding obligations.

6.20 Munir's relationship with his family was not consistently considered and supported as part of his support plan.

*Care Planning was not holistic of all Munir's needs or constantly reviewed for impact.*

6.21 Prompts to monitor diet, sleep, mood, medication risks and online safety were often not documented or not followed up in review of impact.

6.22 Plans for psychotherapy, tutoring, risk assessments, or online safety repeatedly stalled or disappeared due to inconsistent oversight. No single professional or agency held consistent responsibility for oversight.

*Repeated Missed Opportunities for Prevention and not Recognizing Cumulative Risk*

6.23 Munir's long-term decline withdrawal, mutism, social isolation, lack of routine, reversed sleep pattern, nihilistic beliefs were visible over many months. Each deterioration point represented a chance for meaningful intervention that could have changed the way in which services worked with Munir, but agencies worked in parallel rather than in a coordinated way.

6.24 There was no consideration of a Safeguarding Adult referral relating to self-neglect or section 42 enquiry. The Round Table event explored the impact of cross borough working and it was felt that relationships across children and adult services are strong at a borough-based level and therefore conducive to seeking guidance etc. However, those relations with out-of-borough services are more formal and not always aligned.

6.25 Individual episodes were documented, but no agency or professional considered risk across time. The pattern of increasing vulnerability was not recognised as a critical, escalating risk profile demanding intensive action.

6.26 The absence of a coordinated response left Munir without a clear plan of support.

## 7 Framing the findings in the context of the KLOEs

7.1 Was it clear from the case that safeguarding was person-centered and the principles of Making Safeguarding Personal (MSP) applied?

7.2 The SAR identified that there was no safeguarding referral following the deterioration of Munir's presentation in 2023 when he turned eighteen (i.e. self-neglect) and the escalation of risks. A transitional safeguarding meeting was not requested as Munir's presentation was viewed in the context of mental health and ASD only, excluding risks of substance and alcohol misuse, and possible exploitation.

7.3 Transitional safeguarding is not enshrined in legislation, and local areas develop their own pathways and frameworks to support where need is considered to require an adult services response. There is a transitional safeguarding response developing in the placing authority based around specific concerns about a child rather than a general rule for all care leavers. It has already been recognized that this is a gap. The challenges of cross-borough work identified is one of professional relations and different ways of working across other authorities, which makes transition more challenging for professionals.

7.4 The placing authorities recognise that a high number of CLA and Care Leavers live outside of the Borough, which is the situation across London. LB Redbridge does have high number of children Looked After and Care Leavers due to the number of care provisions in the Borough. The SAR identifies that there is a potential for the Boroughs coming together, to consider a consistent transitional safeguarding approach across the region.

7.5 As the findings identify agencies often worked in parallel to each other rather than together under joint planning and risk assessment. The RSAB have identified from other SARs that there is a need for a MARM to support practitioners to share plans and formulate risk and when escalation is required. Again, it is a finding that this approach being developed across partners would have supported the bringing together of concerns, consideration of legal threshold for adult safeguarding interventions, mental capacity etc.

7.6 **Was the context of 'Munir's' lived experience and identity fundamental to the support provided?**

7.7 Munir shared with professionals that his siblings were important to him, **but this doesn't** appear to have been explored any further or included in plans about how contact and

relationships could be maintained. The SAR has not identified sufficiently curious behaviour about his lived experience.

7.8 It was known and understood that Munir had a difficult childhood with several causes of trauma, however, this wasn't necessarily translated into how this impacts risks and shaping decision-making, alongside cultural and relational identity. The placing authority reflected that a difficult time was when he and his younger sister came back into care, and the other siblings maintained their relationships with their Guardians. It was good practice that there was an Anna Freud assessment as part of the discharge of the Special Guardianship Order (SGO), but it was questionable that the findings were consistently applied and understood.

7.9 Munir missed out on being supported through SEND/EHCP processes and wrap around support as his ASD diagnosis came as he became an adult. With a relatively late diagnosis, there wasn't anything around coping mechanisms or strategies to support him, particularly in relation to trauma. The review discussed if the diagnosis/ seeking a diagnosis for Munir's presentation drew attention away from the underlying issues. Essentially, Munir was experiencing depression and trauma.

7.10 Munir's needs were multifaceted and analysis of behaviour and risks were never fully considered in the context of his lived experience and identity.

7.11 The SAR also noted good practice by his accommodation provider supporting Munir to engage in activities that interested him, to reduce his social isolation.

7.12 How did transition pathways support Munir from child to adult and were they effective?

7.13 Findings highlight that Mental Health Pathways were fragmented and gaps in expected transition pathways. These were underpinned by unclear ownership, delays, and inconsistent involvement from adult mental health teams. At times critical information to support transitions was not always shared across professionals to give Munir the best holistic support possible.

7.14 Munir presented at his last school without any of his needs and Care Leaver status being known. He had made the application himself without any professional support, which links to the absence of a holistic approach and understanding of his wishes and feelings. The previous section explored the transitional safeguarding pathway and not be repeated in this section.

7.15 Following Munir's final Looked After Children's Health assessment, no summary of all health records was generated or outstanding health needs shared with partners to offer ongoing support, which again feeds in the absence of a holistic approach transition.

- 7.16 Which internal procedures were implemented and followed?
- 7.17 Agencies demonstrated procedural compliance except for not providing a summary of all health needs, after Munir's last health assessment; not referring PREVENT concerns; or child safeguarding referral, when risk to his younger sibling were identified.
- 7.18 Whilst overall there was procedural compliance there was an absence of curiosity and holistic risk assessment viewed over time, which led to lack of escalation of risk and reflection of why nothing was getting better for Munir. For example, the placing local authority consistently increased the package of support in response to Munir's escalating need, but there was no evaluation of impact or escalation of risk that it was not making a positive change for Munir.
- 7.19 Which multi-agency procedures were implemented and followed? Examples could include vulnerable adult risk management, multi-agency risk management, safeguarding, Mental Health Assessments, Mental Capacity Assessments, self-neglect etc.
- 7.20 There is no evidence of safeguarding adult risk management being considered or consideration of self-neglect and therefore no subsequent consideration mental capacity etc. A Mental Health Act assessment was initiated appropriately when admission was required. The MARM again is highlighted as a gap as there is an absence of guidance to bring professionals together to consider risk and pathways to support. Following diagnosis of ASD consideration of the Dynamic Support Register and associated Care (Education) and Treatment Reviews does not appear to have been considered as way in which to support Munir.
- 7.21 Were escalation procedures in place and implemented appropriately?
- 7.22 The findings identify that there were missed opportunities to fully consider the risk to Munir and so was not recognised in the context of escalating risk, by the multiagency team. Whilst individual agencies shared concerns on individual incidents or episodes of concerns, no agencies took the lead in overseeing all aspects of concerns and considered escalation.
- 7.23 Were management/supervision procedures followed to ensure appropriate decision-making including triaging referrals/concerns and staff support?
- 7.24 Information shared with the review did not extensively explore management oversight. However, as findings identify, on a single agency basis the risk and lived experience of Munir did not trigger high risk concerns, therefore did not trigger managerial oversight/discussion.



form about mental health which could be used by the VIA Duty Manager when reviewing all the referrals coming in.

#### 8.7 What needs to happen next?

##### *Strengthen Multi-Agency Risk Management and Coordination*

8.8 The Review identifies that agencies repeatedly worked in parallel rather than through coordinated planning, and that no mechanism existed to bring together and analyse cumulative risk or oversee escalation across services. It is recommended that:

A Multi-Agency Risk Management (MARM) Framework is formally implemented across the Redbridge Adult partnership, with clear expectations for:

- joint risk formulation,
- coordinated planning,
- escalation pathways,
- and identification of a lead professional where multiple agencies are involved.

8.9 The RSAB to then provide multi-agency training and guidance to embed the MARM approach across adults' services, including when external an external Local Authority places a young person in Redbridge.

##### *Improve Information-Sharing at Key Transitions*

8.10 Critical information about Munir's trauma, Care Leaver status, SEND profile, autism diagnosis, and risk indicators were not consistently shared across agencies during school transitions, CAMHS to AMHS transfer, or between care staff and mental-health services. It is recommended that:

LB Tower Hamlets consider developing a multi-agency transition protocol for all Care Leavers, requiring:

- A transition meeting with agreed multiagency information requirements (Recent research, such as The Inbetweeners Summary Report<sup>10</sup> should inform guidance)
- mandatory confirmation that receiving services understand the risks and needs.
- Cross-borough arrangements are strengthened to ensure consistent information-sharing and oversight when young people are placed outside their home authority.

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<sup>10</sup> [https://www.ncepod.org.uk/2023transition/The%20Inbetweeners\\_summary%20report.pdf](https://www.ncepod.org.uk/2023transition/The%20Inbetweeners_summary%20report.pdf)

- LB Tower Hamlets to consider introducing a care leaver practitioner<sup>11</sup> - practitioners are already in place in other Northeast London Boroughs and one due to start in Redbridge.

#### *Embed Cumulative and Holistic Risk Assessment*

8.11 The Review found repeated indicators of deterioration including self-neglect, substance use, isolation, sleep disruption, missed appointments, which were documented but never considered cumulatively. It is recommended that:

All agencies adopt a requirement to review patterns of risk over time, supported by a single shared chronology.

Managers ensure supervision explicitly explores cumulative patterns, and underlying causes of behaviour.

#### *Strengthen Trauma-Informed and Curiosity-Led Practice*

8.12 Professionals did not sufficiently explore the drivers of Munir's sudden behavioral deterioration in 2022 and later subsequent decline, the impact of trauma, bereavement, or cultural identity, nor the significance of his family relationships, and possible exploitation. It is recommended that:

Practitioners are required to interrogate and record hypotheses regarding underlying causes of behavioral change, especially when presentation alters suddenly.

#### *Substance misuse risks*

8.13 Ketamine use, binge drinking, and intoxication were minimised by professionals and not managed jointly across agencies. It is recommended that:

All substance-misuse concerns for Children in care and Care Leavers must trigger a multi-agency review of their needs and are reflected in care planning.

#### *Strengthening Oversight of Care Leaver Support Packages*

8.14 The Review found that increasing levels of support may have masked deterioration and that the impact of the package was not routinely evaluated. It is recommended that:

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<sup>11</sup> [https://www.transformationpartners.nhs.uk/wp-content/uploads/2023/11/Meeting-the-mental-health-needs-of-care-leavers\\_guidance.pdf](https://www.transformationpartners.nhs.uk/wp-content/uploads/2023/11/Meeting-the-mental-health-needs-of-care-leavers_guidance.pdf)

- Support packages for Care Leavers are reviewed regularly against clear outcomes, not only service inputs.
- Placement providers must escalate concerns when support is no longer sufficient or functioning as intended.

*Embed Self-Neglect Pathways Within Adult Safeguarding Responses*

8.15 Despite significant evidence of self-neglect—including withdrawal, refusal of appointments, poor self-care, no safeguarding referral or Section 42 consideration occurred after Munir turned 18. It is recommended that:

- After care services embed a self-neglect decision-making tool for all Care Leavers presenting with deteriorating functioning.
- A safeguarding referral must be considered whenever self-neglect or inability to maintain safety is identified even where autonomy is expressed.

*Improve Educational Safeguarding Responses for Post-16 Students*

8.16 The Review noted that home learning offered during non-attendance may reinforce isolation and disengagement. It is recommended that:

- Local education partners develop guidance on appropriate use of home learning for vulnerable post-16 students.
- Prolonged non-attendance, refusal to leave accommodation, and social withdrawal must trigger multi-agency escalation rather than educational adjustments in isolation.