Milton Keynes

Multi-Agency Child Safeguarding Practice Review

Child K

Final Report

Author Dr C Connor

Publication Date: 28 February 2022

Contents	Page
Introduction	3
Process	3
The Family and Background information	4
Agency Involvement	5
Analysis	8
Good Practice	21
Conclusion	21
Learning Points	22
Question for the MK Together Partnership	23

1. Introduction

1.1 In April 2021 the MK Together Partnership commissioned a multi-agency Child Safeguarding Practice Review[1] in respect of K, a 16-year-old looked after child with a diagnosis of autism spectrum disorder (ASD). K alleged that he had been raped by another resident whilst placed in semi-independent accommodation. The alleged perpetrator was a looked after child at the same placement and police investigations into the allegation are ongoing.

1.2 It was recognised that there was potential learning from this case in the way that agencies work together to safeguard children in Milton Keynes. The national CSPR Panel was informed of the review.

1.3 ASD[2] is the medical name for autism however autistic spectrum condition (ASC) is also used instead of ASD to highlight the broad spectrum of autism and avoids the label of having a 'disorder.' Autism affects how people communicate and interact with the world; with the right level of help and support people with autism can lead fulfilling lives. This review will use the term autistic spectrum condition.

2. Process

2.1 This report has been written with the intention that it will be published, and only contains information about K and the family that is required to identify the learning from this case.

2.2 The review considered agency chronologies, relevant records, and assessments. The independent author met individually[3] with key professionals. A learning event was attended by practitioners and opportunities for multi-agency practice improvement were identified. All who participated in the review had an opportunity to comment on the draft report and information shared informed the learning and recommendations.

2.3 The review timeline included multi-agency practice from December 2019 (one month before K's discharge from an inpatient mental health unit) until May 2020 when the allegation was made. Relevant information beyond this timescale also contributed to practice learning.

2.4 K, his Mother and Stepfather were invited to participate in this review, K's views were obtained by the social worker and there was no response from other family members. Comments attributed to Mother and Stepfather within this report have been obtained from agency records.

---

[1] Child Safeguarding Practice Reviews (CSPRs) replaced SCRs; CSPRs should be considered for serious child safeguarding cases where: *abuse or neglect of a child is known or suspected, and a child has died or been seriously harmed*. https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[2] https://www.nhs.uk/conditions/autism/what-is-autism/
Autism is not a mental health problem although it can affect a person's mental health Autism and Mental Health | Signs & Symptoms of Autism | YoungMinds

[3] Via Microsoft Teams

3. The Family and background information

3.1 K was diagnosed as autistic at 9 years of age and was home schooled between ten - fifteen years. Agencies had limited involvement with the family at this time. Records indicate that college made a referral to children's social care (CSC) when K was sixteen years old, due to challenges with social interactions, maintaining appropriate boundaries with peers, and it was reported that he was vulnerable to bullying. K's mother did not engage with children and families practice (CFP) and considered that the behaviour was due to K's autism and could be managed within the home[4].

3.2 Following several incidents[5] college assessed that the risk to K and his peers was too great, and the placement broke down. It was recorded that K did not understand why the college placement had ended and not attending college was a trigger for an escalation of self-harming behaviour which included attempts to take his own life and threats to harm others.

3.3 K presented at Milton Keynes University Hospital Foundation Trust accident and emergency (A&E) department on three occasions within a two-month period. K's mother and stepfather became unwilling for him to return home due to the potential risk to younger siblings following increased violence at home and K's obsession with knives. K's mother also expressed concerns that she was unable to keep him safe.

3.4 A Local Emergency Area Protocol (LEAP) meeting was chaired by the CCG Commissioner and Transforming Care lead at Milton Keynes[6]. Northamptonshire CCG was the responsible commissioner at the time as K's GP was in that area. The Northamptonshire HSE Case Manager and Transforming Care Lead were informed that that the LEAP meeting had taken place. Professionals agreed that the risk was too high for K to remain in the community and there was a need to manage behaviours which may be a result of his autism. It was recommended that K should be admitted to a mental health in-patient unit for a short period of assessment. The focus of the assessment was to clarify if K had an underlying mental health need and to identify a clear plan for support in the community on discharge[7].

3.5 As an in-patient K continued to struggle with social interactions and it was recorded that he was vulnerable and bullied by peers. K told medical staff that his educational life was ruined after suspension from college and there was no

---

[4] Information from the minutes of a Local Area Emergency Protocol (LEAP) meeting

[5] Involving knives and challenging communication/physical interactions with peers

[6] When admission is being sought in an urgent and unplanned way, a LEAP meeting must be undertaken to avoid unnecessary admissions: '*The aim of the Local Area Emergency Protocol is to provide the commissioner with a set of prompts and questions both to prevent people with learning disabilities being admitted unnecessarily into inpatient learning disability and mental health hospital beds and, where there is a clearly supported clinical indication for admission to ensure that there is clarity about the intended outcomes and timescales*'. Care and Treatment Reviews (CTRs): Policy and Guidance, NHS England, 2017 p 102 https://www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf

[7] Minutes of the LEAP meeting noted that: '*All [professionals] were clear that a period of admission for assessment is what was needed with a clear plan to support in the community.*

point to life. Following a verbal and physical assault by another patient K was transferred to a different mental health unit for his own safety.

4. Agency involvement December 2019 - May 2020

4.1 The following key services were involved with K:

Milton Keynes Children's Social Care (CSC)
Thames Valley Police (TVP)
Milton Keynes Virtual School
Central and North West London (CNWL) Foundation Trust, Child and Adolescent Mental Health Services (MK CAMHS)
Milton Keynes University Hospital Foundation Trust (MK UHFT)
Essex Partnership University Foundation Trust EUPT
Northamptonshire Child and Adolescent Mental Health Services (N CAMHS)
Milton Keynes Clinical Commissioning Group (MK CCG)
Northamptonshire Clinical Commissioning Group (N CCG)
St Christopher's (provider of semi-independent accommodation)
Milton Keynes Christian Foundation (education/training provider)

Chronology of key activity

4.2 December 2019

Following admission to the in-patient unit K received support with anxiety and a high level of observation for his own safety, there were ongoing concerns about K's interaction with peers. K's mother and stepfather were unwilling for him to return home due to their concerns about increased aggression, unpredictability of his behaviour, and risk to younger siblings. CSC explored the options for K to remain within the family and a family group conference took place[8]. Discharge from the in-patient unit was delayed and it was recorded that this was due to the challenge of identifying an appropriate placement[9].

4.3 January 2020

K's social worker sought advice from the MK CCG commissioner regarding community support and specialist autism provision. The Northamptonshire transforming care lead was informed of the need for support. K became a looked after child (s.20 Children Act 1989) and CSC submitted a placement request to local authority commissioners for a 16+ provider and independent fostering agency (IFA).

St Christopher's was one of two 16+ providers identified and confirmed that they were able to provide appropriate support to K. Medical professionals and K's mother expressed concerns about whether the placement would meet his needs.

---

[8] The purpose of the family group conference was to bring together family members to explore, how K might be supported to return to the care of his mother, or an extended family member, and how the family might support one another to meet K's needs.
[9] It is important to note that 24 hours following receipt of a referral from CSC, local authority commissioners identified placement options.

K moved into St Christopher's and the Christian Foundation was identified as the education/training provision.

There was a change in GP and transfer of care to a GP practice based in Milton Keynes.

N CAMHS agreed to provide 7 days post-discharge follow up[10], as the transfer of care to MK CAMHS had not progressed. A referral from N CAMHS requesting post in-patient discharge follow up was refused by MK CAMHS citing no evidence of moderate to severe mental health disorder.

4.4 February 2020

The mental health in-patient unit sent a discharge letter to the GP with details of the care and treatment provided to K and an outline of his ongoing needs and vulnerabilities[11].

The police responded to incidents when K alleged that he was threatened and physically abused by peers in the community.

An initial looked after child review was held. CSC records indicated that K was happy in placement and engaging with the Christian Foundation.

4.5 March 2020

K advised professionals at Christian Foundation that he did not feel safe in Milton Keynes and CSC were informed about concerns regarding K's presentation.

N CAMHS care coordinator liaised with support workers at St Christopher's and K's social worker regarding concerns about a deterioration in K's mental health.

The police responded to further incidents; K was described as vulnerable to ongoing abuse and threats by peers and there were concerns that he may take his own life. A female resident at St Christopher's contacted the police stating that K had a knife, was threatening to self-harm and she was injured[12].

K was moved to a different house within St Christopher's following this incident and ongoing concerns for his wellbeing and challenges in making female relationships were noted. GP records indicate that the Police contacted MK CAMHS for information and were advised there was no identified role for mental health services.

[10] The case worker was advised to focus on practical support rather than therapeutic intervention due to the proposed transfer.

[11] The discharge letter included behavioural and social difficulties, past behaviour, and risks, including knives and ligature use, impulsivity self-harm, threat to others and description of inappropriately coercing and touching another patient at the inpatient unit and vulnerability of him from others.

[12] The female resident did not pursue a complaint when subsequently contacted by the police.

K presented at MK UHFT A&E department[13] on two successive days and was seen by the MK Liaison and Intensive Support Team (LIST-CAMHS Crisis Team). The MK Children & Young People Commissioner was notified of K's presentation by CAMHS LIST through the Transforming Care referral process. K remained in hospital and health professionals liaised with the social worker regarding his social care needs. A LEAP meeting was held, and a safety plan agreed between professionals.

St Christopher's requested additional funding from CSC to provide 1-1 support for K. A keyworker from Compass (community substance misuse service) was allocated. K was presented by CSC at an adult transitions meeting.

The transfer of care was agreed from N CAMHS to a Locum Consultant Psychiatrist at MK CAMHS.

4.6 April 2020

Following an initial review, the Locum Consultant Psychiatrist planned to see K every 6-8 weeks. It was recorded that K experienced periods of stability and deterioration was due to social factors rather than mental health relapses.

Staff at St Christopher's contacted the police as K refused to follow Covid-19 lockdown rules.

Police responded to a further call from support staff at St Christopher's who expressed concern for K's welfare, a safety plan was agreed, and a child protection report was shared with CSC.

K told his social worker that he wanted independence and said that he did not want to move placement and was not happy with the education provision. St Christopher's requested additional funding from CSC to enable the provision of 2-1 support for K. A meeting to discuss the Interim Personal Education Plan was held at the Christian Foundation.

A looked after child review took place and the support plan noted that a medication review was required, and psychological support was to be considered. Minutes of the review include the views of K's mother, that St Christopher's was not a suitable provision for K's high level of need.

4.7 May 2020

K presented at MK UHFT A&E following an alleged overdose, K declined CAMHS, and no suicidal ideation was noted, K was discharged following observations.

Support staff at St Christopher's made a report to CSC emergency duty team that K had self-harmed.

[13] K had self-harmed presented with heightened anxiety around a recent incident within the placement

K's mother contacted the police regarding malicious postings on social media and expressed concern for K's wellbeing[14].

Staff at St Christopher's reported K missing from home to the police on successive days and said that he was vulnerable due to his mental health condition. K returned to the placement on both occasions.

K was discussed at a multi-agency complex needs forum, MK CAMHS raised concern that K's presentation was impacted by his autism. MK CCG Commissioner sent an email to the CAMHS Locum Consultant Psychiatrist regarding the need for an urgent multi-agency behavioural/supportive approach to care to avoid an inappropriate hospital admission.

St Christopher's made a third request for additional funding from CSC, to enable the provision of 2-1 support for K.

A strategy meeting was held to discuss the increased number of reports that K was missing from home and escalation of self-harming behaviour. The record indicates that professionals acknowledged that St Christopher's was not an appropriate placement for K. It was noted that police had responded eight times in a two-month period to incidents and concerns regarding K.

K attended MK UHFT A&E following an assault by a peer and information was shared with the LAC nurse, social worker, and school nurses. The CMET (Youth Risk Group) was contacted due to the identified risk of exploitation due to K's vulnerability.

The MK CAMHS locum consultant psychiatrist requested the MK CAMHS manager to urgently allocate a care coordinator to provide supportive therapy to K. A crisis plan was circulated to key agencies to cover situations of distress, overdose, and self-harm.

K attended MK UHFT A&E following attempted asphyxiation in response to a girl saying she wants to be a friend and not K's girlfriend, this was assessed as self-harm not suicidal ideation.

K alleged that he had been raped by another resident at St Christopher's.

5. Analysis

5.1 Guided by the Terms of Reference for this Review and following analysis of the available information, key themes and potential opportunities for multi-agency practice improvement when working with young people who have complex needs were identified as:

1. Decision-making process and assessment of strengths, needs and vulnerabilities when placing young people in semi-independent[15] living.

---

[14] K's mother later advised the matter had been resolved and the posts removed so police involvement was no longer needed.

[15] Accommodation with support for young people to assist in the development of skills to enable them to transition to independent living.

2. Provision of support and intervention following discharge from hospital into the community.
3. Professional understanding of autism, appreciation of K's lived experience and response to presenting behaviour.
4. Escalation of concerns by professionals.

5.2 Multi-agency practice is discussed below, and key learning points identified. Some information is relevant to more than one theme and care has been taken to avoid repetition.

1. Decision-making process and assessment of strengths, needs and vulnerabilities when placing young people in semi-independent living

5.3 Professionals had different views about the needs and vulnerabilities of K and his capacity to function effectively with limited support. This was reflected in the decision to place K in semi-independent accommodation. There was a lack of communication between practitioners and agencies and the different views were not effectively communicated or resolved.

5.4 K became a looked after child when his Mother and Stepfather were unwilling for him to return home following discharge from the mental health unit as they considered that the risk to the younger siblings was too great. This view was supported in the discharge summary letter to the GP which noted: '*K's behaviour is at times aggressive, and although may be brief and followed by regret, posed a risk of serious injury to family members and K themselves'.* In contrast, the initial view of CSC professionals was that it was appropriate for K to remain within the family, however efforts to explore[16] family relationships that may enable this were unsuccessful. It became apparent that K would not be able to return home and CSC subsequently made a referral to the Local Authority commissioning team for 16+ semi-independent living providers and an Independent Fostering Agency (IFA), the referral did not request a specialist autism placement.

5.5 Efforts of professionals to explore options for keeping K within the family, and lack of effective communication regarding K's needs delayed the discharge process which had a negative impact on K. There were concerns that he would self-discharge and become homeless. Health records detail K's needs and vulnerabilities at this time and a clear purpose of the hospital admission was to identify K's needs for support following discharge into the community. Information provided to this review indicates that multi-agency discussions and meetings at the end of the hospital admission were focussed on identifying a resource to accommodate K rather than understanding the support required to reduce his known vulnerabilities and meet his complex needs.

5.6 The local authority commissioning team submitted two 16+ providers and an IFA[17] to CSC for consideration. St. Christopher Homes provided assurance to CSC that they could meet the needs of K and it was decided that he would be

[16] A family group conference to explore a placement with extended family members was unsuccessful.
[17] Following discussions between CSC and the IFA the offer was withdrawn as the placement was short term.

placed at St Christopher's, a semi-independent living service for young people 16+. This decision contradicts the record of a Care Plan Review (CPR) meeting, four weeks before K was discharged which noted that K would not be considered for supported housing due to the high levels of social risk.

5.7 At the learning event support staff from St Christopher's stated that the initial referral did not contain a lot of detail and: *"K's challenging behaviours became apparent during the first couple of weeks."* Support staff informed the review that following a risk assessment shortly after K moved into St Christopher's CSC were advised via email that the placement was unable to meet K's needs. This information was not followed up by St Christopher's or CSC staff and it was not effectively addressed in LAC reviews. Consequently, the needs of K remained unmet and contributed to a deterioration in his presenting behaviour and increased anxiety. At the learning event there was consensus among professionals that semi-independent living was not appropriate for K as this did not provide the level of care required to meet his needs or support him with specific vulnerabilities relating to his autism.

5.8 The local authority commissioning team advised that they followed the legal requirements to source the placement for K and were not involved in decision making regarding the suitability of the placement, as this was the responsibility of CSC and the provider. At the Learning Event, managers from the CCG and CSC stated that it would be helpful to have a more joined up approach with the local authority commissioning teams, specifically, when working to place a young person with complex needs, to ensure that knowledge about a young person's vulnerabilities and needs are shared effectively.

5.9 The local authority commissioner confirmed that: *"In exceptional circumstances, when commissioned services do not have sufficient capacity or are considered unsuitable to meet the needs of the young person, the Local Authority Community Resource team may also Spot Purchase provision."* It is unclear why CSC did not request that a specialist placement was sourced, this was a missed opportunity that had a significant negative impact on K and his experience following discharge from hospital.

5.10 It was a significant omission that the referral to local authority commissioners did not specify the need for a specialist autism placement[18]. When requesting placements for children and young people with complex needs it would seem appropriate that there is an opportunity for professionals to discuss specific requirements in addition to submitting an electronic referral form. Increased communication and collaboration between the CCG, CSC, and the Local Authority commissioning teams, is likely to improve the process of providing young people in care, who have similar requirements to K, with appropriate placement opportunities to meet their complex needs.

---

[18] The Local Authority commissioning team advised that *'despite the market shortage of specialist residential ASD, MKC does manage to locate placements when requested by CSC (although the search would take more time and the provider may not necessarily be in the Milton Keynes area).'*

5.11 There was consensus among professionals involved in this review that there is a gap in Milton Keynes of suitable placements for children and young people with autism, particularly 16+. It was acknowledged that lack of funding and resources are significant factors which have a negative impact on the placement options for young people with complex needs. This is a national issue, as highlighted by the Report of the UK Children's Commissioner, *Unregulated* (2020)[19] which documents concerns about children in care living in unregulated placements.

5.12 The report notes:

> '*It is true that some 16- and 17-year-olds may be ready to begin to make steps towards independence. However, as our research suggests, our assumption should be that most are not, and are being forced into semi-independent living, unregulated provision when it is not in their best interests, simply because there is no other option available – including children with complex needs and multiple vulnerabilities'.*

There was no indication that the possibility of sourcing a specialist placement was considered, prior to K moving into St Christopher's, and whilst information provided to this review suggests that staff did their best to support K, this was not adequate given his vulnerabilities and needs.

5.13 This review has found that there was no communication between St Christopher's and CSC when K moved houses within the unit. It is a concern that the social worker and IRO for both K and the alleged perpetrator were not aware of the needs and vulnerabilities of other young people within the placement prior to the allegation of rape which triggered this review. This was a missed opportunity to identify appropriate intervention and support, to safeguard both young people.

5.14 A key purpose of the hospital admission was to identify K's support needs within the community. The assessment of health professionals at the mental health unit did not inform decision-making regarding K's placement following discharge. There was a lot of knowledge about K's needs however this was not shared effectively. Decisions were resource-led not needs-led and resulted in K being placed in an inappropriate semi-independent provision.

Learning points

1 It is important that young people with complex needs, their family and key professionals, have a meaningful opportunity to contribute to a holistic multi agency assessment, to identify strengths, vulnerabilities, and clarify support required, prior to the identification of a potential residential placement.

2 Decision-making when identifying placements for young people with autism and additional vulnerabilities should be needs led, this will be

[19] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/09/cco-unregulated-children-in-care-living-in-semi-independent-accommodation.pdf

supported by improved communications between CSC and the Local Authority commissioning teams when making a placement request, to increase understanding about specific requirements and available resources.

3 **It is essential that key partners have confidence that placements for young people with complex needs have the capacity and expertise to meet assessed needs, and specialist services are spot purchased if necessary.**

2. Provision of support and intervention following discharge from hospital into the community

5.15 K was entitled to receive robust wrap around intensive support via the Transforming Care Programme which aims to improve the lives of children, young people, and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition (NHS England 2017)[20]. There were a series of factors which impacted on the capacity of agencies and key professionals to respond in a timely way and work proactively to provide the appropriate level of support to K. These included: poor information sharing and professionals not being aware that K was in their area, omission to involve all key practitioners at the in-patient Care and Education Treatment Review (CETR), and challenges in the transfer of care between N CAMHS and MK CAMHS.

5.16 The multi-agency support and intervention provided to K following discharge from hospital lacked coordination and was inadequate to address his needs and vulnerabilities. The chronology provided by N CAMHS noted that: '…*everything was fixated on finding a placement rather than overall support and care for crisis, his ASD, education etc. There was no holistic plan for discharge'.* Limited information sharing between agencies and inconsistent understanding among professionals of K's needs and vulnerabilities impacted on the development of effective multi-agency care planning.

5.17 The response to recommendations within the LEAP meeting (see paragraph 3.4) held prior to admission was not robust and key professionals were not involved in planning for K's discharge[21]. The discharge plan lacked clarity, was inadequate to address K's complex needs and vulnerabilities, and K was not effectively supported to manage his anxieties and impulsive behaviours. Consequently, practitioners and agencies spent a significant amount of time and resources responding to crisis as K's needs remained unmet and his self-harming and challenging behaviour within the community increased.

[20] model-service-spec-2017.pdf (england.nhs.uk)

[21] K's social worker was not in work when K was discharged and had limited involvement with the discharge plan. MK CAMHS were not involved in any care planning meetings.

5.18 There were missed opportunities to hold a timely Care Education and Treatment Review[22] (CETR). The foreword to the CETR policy and guidance (2017) notes that: *'People with learning disabilities, autism or both have a right to CTRs if they are in hospital for a mental health problem or behaviour that challenges services. And if they are at risk of going into one'.* The aim of the CTR is to bring a person-centred and individualised approach to ensuring that the care and treatment and differing support needs of the person and their families are met, and that barriers to progress are challenged and overcome.

5.19 The provision of appropriate early intervention and support to meet the needs of children and young people is essential, particularly for those with complex needs. In the absence of appropriate early help K experienced a crisis which resulted in an admission to an assessment and treatment unit. Professionals involved in the Review stated that given the history of K's presentation at home and college it would have been appropriate for a multi-agency coordinated approach and a Transforming Care referral for a community CETR to have been considered earlier. There was a view among professionals at the Learning Event that had these meetings taken place it is possible that admission to hospital may have been prevented.

5.20 Records indicate that a CETR was held whilst K was an in-patient however the impact of this on the care and support provided to K was unclear. Practitioners stated that one of the challenges to holding a CETR was that agencies with responsibility for health and social care were in different areas. However, it should be expected practice to facilitate a CETR for all young people who would benefit, and the location of key agencies should not be an issue.

5.21 When K's behaviour escalated in the community following discharge from the in-patient unit the Transforming Care Lead for Milton Keynes was proactive in challenging services to provide intensive support to meet K's needs and facilitated a CETR with the purpose of preventing a further hospital admission for K.

5.22 Effective multi-agency cooperation and collaboration is essential when working to support children with complex needs. This is highlighted in the Code and Toolkit guide for commissioners which notes: '*Multi-agency CETRs are driven by the NHS but the involvement of local authorities and education services in the CETR process and its* outcomes *is integral to improving care, education and treatment for children and young people with learning disabilities, autism or both and their families'.*[23]

[22] CETRs were developed as part of NHS England's commitment to improving the care of people with learning disabilities, autism, or both in England with the aim of reducing admissions and unnecessarily lengthy stays in hospitals and reducing health inequalities.
NHS England » Care, Education and Treatment Reviews (CETRs)

[23] (p6) https://www.england.nhs.uk/wp-content/uploads/2017/03/children-young-people-cetr-code-toolkit.pdf

5.23 Information within the chronologies provided by N CAMHS and MK CAMHS identified challenges to the referral process between services, and lack of clarity and different expectations amongst professionals about the role and responsibility of each service when K moved from hospital to the community. In addition, practitioners at the learning event noted a discrepancy in thresholds, and lack of understanding about the role of CAMHS when working with autistic young people.

5.24 K had three sessions with N CAMHS post discharge and following transfer to MK CAMHS was reviewed by a consultant psychiatrist every six weeks. A crisis plan was developed and arrangements to provide therapeutic support from MK CAMHS were made immediately before K alleged that he had been raped in placement. There was an expectation by some practitioners that CAMHS would provide therapeutic intervention for K.

5.25 St Christopher's staff advised that significant efforts were made to support K and understand his needs. However, it appears that there was a lack of resource, knowledge, and experience to meet K's needs and prevent the escalation of K's behaviour. K was heavily influenced by peers within the placement and community to drink and smoke cannabis. St Christopher's requested additional funding from CSC on three occasions to enable the provision of increased support. There was a lack of clarity about how the additional support would impact on the care provided to K and funding was not provided. It appears that agencies were working in isolation to support K, the adequacy of this support was not effectively monitored, and the responsibility and accountability of agencies was unclear. Intervention was unplanned and reactive, often in response to a crisis. This was supported by staff from St Christopher's who stated: *'K needed more support, and he wasn't engaging. All the staff at the placement are trained, but K's needs were so complex, and he needed such a large support package, the placement needed the professionals to be on board and they didn't have them'.*

5.26 Chronologies provided by MK CSC and the Virtual School noted that K's needs were not fully known or assessed. It was an omission that there was a lack of focussed support to assist K to engage in education following discharge. This is significant as there was evidence to suggest that loss of a college place was linked to the initial deterioration in K's wellbeing prior to the hospital admission. Agency records indicate that education was closely linked to K's sense of self-esteem and hope for the future. K's attendance at education whilst in placement was sporadic and it was the view of professionals that he was distracted due to influences in the community and placement. There were further challenges as K was not suited to online learning which was in place during lockdown. There was a lack of exploration by professionals to understand why K was not engaging in education and what may help him to do so.

5.27 It is important to note the challenges experienced by services during this time due to Covid-19. K should have been visited in person by a social worker weekly during lockdown due to his vulnerabilities. However, statutory visits took place

virtually for six months[24] and the social worker advised that it was difficult to understand what was happening for K who would pace and avoid eye contact. K talked during virtual visits about feeling scared and wanting education, there was no indication that his views were robustly explored and responded to within the statutory LAC review process.

5.28 At the learning event professionals stated: *'K struggled with lockdown restrictions, not going out, not seeing family. The reduced interaction with adults really negatively affected him and he didn't really understand lockdown'.* There was no multi-agency assessment to clarify K's understanding of lockdown and identify what support may be provided to mitigate the constraints and challenges presented. It is possible that increased rules and restrictions contributed to K experiencing fear and increased anxiety. The significant and negative impact of coronavirus on autistic people and their families is highlighted in a report by the National Autistic Society *'Left Stranded'* (2020)[25].

5.29 Whilst Covid-19 presented significant challenges for agencies, it was an omission that K was not reallocated to a social worker able to visit K in person. Face to face meetings with a social worker may have supported K to understand the Covid-19 lockdown restrictions and provided an opportunity to fully explore the deterioration in his behaviour. K was a looked after child and the local authority did not fulfil its responsibility as corporate parent. There were gaps in the provision of support, and intervention fell short of what K should have received as outlined in the MK pledge to looked after children[26].

5.30 The concerns which resulted in K being admitted to an in-patient mental health unit[27] were not effectively addressed and increased during the period considered by this review. K's needs were unmet and his presentation to emergency services at times of crisis increased. Whilst professionals were aware of K's needs and vulnerabilities multi-agency support lacked coordination and did not prevent K from experiencing ongoing distress and crisis.

5.31 The absence of a coherent discharge plan and robust care plan had a significant impact on the provision of effective multi-agency support and intervention to meet the needs of K. Lack of clarity about professional roles and responsibilities, different understanding of K's needs, inappropriate placement and limited collaboration between agencies were contributory factors which impacted on the provision of support and contributed to K experiencing ongoing vulnerabilities and unmet needs.

---

[24] Between March and August 2020

[25] https://s4.chorus-mk.thirdlight.com/file/1573224908/63117952292/width=-1/height=-1/format=-1/fit=scale/t=444295/e=never/k=da5c189a/LeftStranded%20Report.pdf

[26] https://www.milton-keynes.gov.uk/children-young-people-families/kic-mk-home

[27] Aggressive, impulsive, and risk-taking behaviour, handling of knives, threatening others lack of routine/education, poor relationships with peers, being easily led/manipulated/exploited by others, inability to manage emotions/behaviour.

5.32 From information provided to this review there is little evidence that K received adequate practical and therapeutic support from agencies to assist with the difficulties he experienced. It was a challenge for professionals within CSC, who had limited prior knowledge of K, to gain a full appreciation of his needs and vulnerabilities in the timeframe required. Omission to hold a CETR and ineffective discharge planning limited the effectiveness of multi-agency partnerships and opportunities to develop constructive relationships with key family members were missed.

Learning points

4. **Effective collaboration of all key partner agencies, as directed by the Transforming Care Programme, will support the prevention of inappropriate hospital admissions, and enable young people with complex needs to live to their full potential.**

5. **It is essential that there is a holistic multi-agency discharge plan for young people admitted to a mental health in-patient unit, to clarify the support required to prevent a further hospital admission.**

6. **When statutory visits to young people in care who have complex needs and vulnerabilities are face-to-face, the opportunity for professionals to fully understand and appreciate ongoing risks and vulnerabilities will increase.**

3. Professional understanding of autism, appreciation of K's lived experience and response to presenting behaviour

5.33 There was inconsistency in the understanding of professionals from different agencies about the impact of autism on the behaviour of K and his mental health, which was not resolved during the time considered by this review.

5.34 For many years, the family managed K's behaviours within the home and there was limited involvement of external agencies. K's Mother declined the involvement of CSC following a referral by college and advised that K's behaviour was due to his autism and was being managed within the home. When K turned sixteen the family was no longer able to manage his presenting behaviours or safeguard the younger siblings. At this time K had extensive vulnerabilities and needs which were not holistically assessed.

5.35 There was a fundamental discrepancy in the way in which professionals perceived and understood the impact of autism on K's presentation and emotional wellbeing. There was a lack of information sharing between agencies and professionals had different views about the level and nature of support required to meet K's needs, as illustrated by the following examples:

a) Medical records from the in-patient unit noted that: '*The team is of the view that if K was to return home the impact of his behaviour (intentional or unintentional) on younger siblings would place them at risk of developing mental health issues themselves and should therefore be considered a*

safeguarding risk'. Around the same time CSC was exploring options, which included a Family Group Conference (FGC) to identify the support needed to enable K to return home or live with other family members. It is unclear whether the view of the in-patient team was communicated to CSC professionals.

b) Health professionals focussed on K's behaviours in the context of his autism. The discharge summary provided to the GP concluded that a: *'Combination of ASD and anxiety [were] responsible for many of the issues'.* Professionals from other agencies, including CSC and staff in placement, were more concerned about what was described as K's *'mental health needs'* and there seemed to be a reliance on CAMHS to provide a therapeutic intervention.

c) At the learning event professionals shared the view that K's behaviour escalated as he sought attention and affection from his family and peers. The influence of family and peer relationships on the wellbeing and presentation of K was not fully explored. Professionals spoke about attachment issues and possible unresolved trauma[28] however these were not effectively assessed or addressed. It was acknowledged that the escalating behaviour of K may have been a response to unmet needs and there was a lack of understanding or exploration about whether the behaviour was designed to elicit care and protection.

5.36 The 2020 summary report of the Child Safeguarding Practice Review Panel[29] identified '*understanding the child's daily life'* as a key practice theme for learning and noted: *'It is important for practitioners to build a trustful and respectful relationship with the child and critically reflect on what the child is trying to communicate through their behaviour, interaction with others and physical presentation. Practitioners should be aware that challenging or help-seeking behaviour may reflect harm and distress'.*

5.37 Absence of a shared understanding of K's needs and vulnerabilities contributed to a disjointed approach by agencies regarding the provision of support. At the learning event professionals stated K's behaviour was not seen in the context of his autism and the perception that his escalating presentation indicated a deterioration of his mental health may have contributed to the initial hospital admission. A report by the National Autistic Society and the All-Party Parliamentary Group on Autism[30] highlighted inequalities for autistic people in the provision of support for physical and mental health, and the need for early intervention and support to prevent inappropriate hospital admissions.

---

[28] During a family argument K found out that he had a stepfamily and professionals expressed concern that this was not verbalised or processed

[29] file:///C:/Users/cathc/Documents/MK%20CSPR/child-safeguarding-practice-review-panel-annual-report-2020-summary.pdf

[30] nas_appga_report.pdf (thirdlight.com)

5.38 Efforts by CSC to have a FGC with a view to maintaining K within the family, impacted negatively on the working relationship with the social worker. When K was placed in semi-independent living it was recorded that Mother and Stepfather were very angry and felt that K had been failed by professionals and agencies.

5.39 Professionals had a very different understanding of K's wellbeing, behaviour and associated risks, which was informed by his presentation which fluctuated rapidly. This was demonstrated in an email response from the MK CAMHS Psychiatrist in response to an urgent request to increase multi-agency support to prevent a further hospital admission. The Psychiatrist met with K following an incident and reported that K was in good spirits and stated, *"I was just a bit upset at the time...it could have been avoided if I just talked to someone but wasn't sure who I could talk to".* In addition, records from CSC provided a positive reflection about K's progress and the stability of the placement, however shortly afterwards health records indicated that K had presented to A&E following self-harm and concerns of support staff about taking his own life.

5.40 Information was not always shared with professionals who responded to incidents. At the learning event a Police Officer described responding to a call from staff at St Christopher's regarding a 17-year-old with a knife who was agitated and threatening to hurt himself. Information about K's autism, and complex needs was not shared. Whilst K was calm when the officer arrived, this information would have assisted the officer to be better prepared to respond to the presenting behaviours and ensure that any intervention was proportionate and appropriate.

5.41 Lack of a shared multi-agency understanding of K's vulnerabilities and the impact of autism on his behaviour contributed to practitioners and agencies providing a reactive response to incidents. Support and intervention focussed on containing behaviour rather than assisting K to improve his capacity to control his own behaviour and emotions. In addition, there was a lack of clarity amongst practitioners regarding the roles and responsibilities of other agencies. At the learning event a professional from CSC stated: *"There's a lack of understanding of autism and related needs. There's a lot of discussion about risk and management but a lack of joined up working".*

5.42 Throughout the period considered by this review the Police were involved in a significant number of incidents involving K. At times officers were contacted by staff at St Christopher's in response to challenging behaviour which was considered threatening to staff, K, or others. Records indicate that the Police were, on occasion, used to control and de-escalate the behaviours of K which were due to his autism. This was not an appropriate use of Police resources, however it was evident that staff at St Christopher's did not have the capacity or experience to de-escalate K's behaviour and presentation.

5.43 The report of the UK Children's Commissioner into unregulated placements[31] noted that: *'contacting police can be the default response to unwelcome behaviour in unregulated accommodation, instead of situations being dealt with by the settings alone. This can land young people with criminal records for low-level incidents and contribute to negative relationships between themselves, police and the staff around them'.*

5.44 K attended the A&E unit at MK UHFT three times on the same day. On one occasion it was recorded that he was cared for on social grounds and not discharged until contact had been made with a social worker due to concerns about unmet social care needs and suitability of placement. Colleagues in health provided challenge to partner agencies regarding the discharge of K to a more suitable place.

5.45 At the learning event autism training was noted to be a significant priority for agencies[32], it was acknowledged that some practitioners lacked knowledge and understanding regarding autism which impacted on their confidence and skills to provide appropriate support. Practitioners acknowledged that: "*It would be helpful for everyone to come together to discuss needs and requirements and find a suitable resolution when working with young people who have complex needs".*

5.46 Whilst the voice of K was recorded within agency reports, there was no evidence that his views were explored or influenced decisions about his care. There was a pattern of K being moved when his behaviour could have been an indication of heightened distress. He was transferred from one in-patient unit to another and moved house while at St Christopher's. It is a concern that K told professionals that he had been moved because of his behaviour which may indicate that K felt blamed and punished for behaviours which he was struggling to manage and contain.

5.47 There was a gap in professional knowledge and understanding of K's needs due in part to the limited involvement of agencies before he was 16 years old. Whilst outside the timeline considered by this review, there is potential learning to ensure the education and health care needs of autistic children and young people who are home schooled are met.

5.48 There was limited understanding among professionals about the impact of autism on K's behaviour. Lack of collaborative and effective multi-agency cooperation impacted on the ability of professionals to work in partnership with the family, and the needs of K were not fully understood and remained unmet during the period considered by this review.

---

[31] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/09/cco-unregulated-children-in-care-living-in-semi-independent-accommodation.pdf p23

[32] Autism is to form part of the 2022 vulnerability-training programme for TVP

Learning Point

7. **Professionals require appropriate knowledge, skills, and competence, to provide effective support to young people with autism and to develop a clear understanding of needs and vulnerabilities.**

8. **It is important that professionals have a shared understanding of the impact of autism on the behaviour, wellbeing and mental health of a young person and work collaboratively to understand what the young person may be attempting to communicate by their behaviour to develop a consistent multi-agency response.**

9. **It is important that multi-agency assessments of young people with autism support the development of a shared understanding amongst professionals of the key strengths, vulnerabilities, needs and risks which should inform a consistent approach to the provision of care and support.**

10. **When young people with autism are home-schooled, effective oversight is required to ensure that education and health care needs are met, and effective support is provided to enable the child to reach their full potential.**

4. Escalation of concerns by professionals

5.49 It was evident from information shared by professionals at the learning event and within agency chronologies, that concerns regarding the provision of intervention and support to K were escalated within and between agencies during the period considered by this review. Examples of professionals sharing concerns include:

- N CAMHS care coordinator escalated concerns to managers in N CAMHS regarding the declined referral by MK CAMHS.
- MK LAC nurse liaised with MK GP and raised concerns about the declined referral by MK CAMHS.
- MK Transforming Care Lead raised concerns with N Transforming Care Lead about the absence of multi-agency support and intervention in the care of K and risk of a further inappropriate hospital admission.
- K's social worker reported concerns about K's unmet needs and ongoing risks to their manager.
- St Christopher's informed CSC that they did not have the capacity to meet K's needs and were unable to contain his behaviours shortly after he moved in.
- The IRO for K consistently informed senior managers that St Christopher's was not an appropriate placement for K.
- K's Mother and Stepfather were angry that the placement identified for K was not adequate to meet his complex needs or keep him safe.

5.50 Whilst professionals and K's Mother and Stepfather expressed their concerns, there was little impact on the provision of support to K during the timeframe

considered by this review. Formal procedures were not implemented, and informal escalation of concerns were ineffective.

Learning Point

11. When professionals have concerns about the provision of care and support to a young person with complex needs it is important that the formal escalation policy is implemented to highlight unmet needs and practice shortcomings, effect change and prevent drift.

6 Good Practice/ improvement

- The MK CCG commissioner worked proactively to inform N CCG commissioner about K and facilitated a timely LEAP in response to K's escalating behaviour when this was not her responsibility.
- Medical staff at MK UHFT liaised with K's social worker regarding his social care needs prior to discharging him from hospital.
- MK LIST CAMHS referred K to MK CCG transforming care lead for multi-agency triage. This is good practice as when K was in crisis the responsible CCG commissioner was notified in a timely way and able to act and prevent an inappropriate admission.
- The police provided a consistent response to K and worked with partners to address K's immediate need for support at times of crisis.
- The police provided a comprehensive analysis of single agency practice and identified opportunities for learning and improvement that have been addressed.

7. Conclusion

7.1 It was evident that professionals worked to establish a relationship with K and meet his needs with the resources and knowledge they had. In addition, it must be noted that the restrictions of lockdown due to Covid-19 had a significant impact on K and all professionals who worked to support him during the period considered by this review.

7.2 K did not receive appropriate multi-agency help and support to address his needs and vulnerabilities, and it is possible that his escalating behaviour was a response to distress due to unmet needs. This review has benefited from the frank reflection of professionals, many of whom worked hard to support K in very challenging circumstances. The review has highlighted specific shortcomings in multi-agency practice and an urgent need for autism training for key practitioners. High quality robust training will increase the competency of the workforce and have a positive impact on the support provided to vulnerable young people.

7.3 This review has highlighted the experience of K, a looked after young person with autism whilst living at a semi-independent placement that was inappropriate and unable to meet his needs. It is recognised that there are serious funding and resource issues which require complex solutions and the shortage of residential provision for young people with autism aged 16+ is a national issue.

7.4 Since this Review, multi-agency practice improvements have been progressed by MK Child and Young People's Integration Project (Health, Social Care and Education). This improved joint approach has already had a tangible positive impact on the lives of young people with complex needs. Also, following the learning event for this review a senior manager refused to place a child with significant vulnerabilities and complex needs with a provider due to lack of clarity about how the child's needs would be met. Increased focus on the needs of the child, and robust scrutiny of the capacity of providers to provide appropriate support and meet assessed needs, is an example of practice improvement following the learning from this review.

7.5 These developments are positive, and it is necessary that practitioners and managers have the confidence to always place the needs of vulnerable young people at the centre of their decision-making when considering a residential placement if positive progress is to continue.

7.6 MK Child and Young People's Integration Project is facilitating a shift in culture and change to systems to improve multi-agency collaboration when working with young people with complex needs. It is important that all key partners are committed to promote cultural change and practice improvement if vulnerable children with complex needs are to have the opportunity to live meaningful lives and reach their potential.

8. Learning Points

1 It is important that young people with complex needs, their family and key professionals, have a meaningful opportunity to contribute to a holistic multi agency assessment, to identify strengths, vulnerabilities, and clarify support required, prior to the identification of a potential residential placement.

2 Decision-making when identifying placements for young people with autism and additional vulnerabilities should be needs-led, this will be supported by improved communications between CSC and the Local Authority commissioning teams when making a placement request, to increase understanding about specific requirements and available resources.

3 It is essential that key partners have confidence that placements for young people with complex needs have the capacity and expertise to meet assessed needs, and specialist services are spot purchased if necessary.

4 Effective collaboration of all key partner agencies, as directed by the Transforming Care Programme, will support the prevention of inappropriate hospital admissions, and enable young people with complex needs to live to their full potential.

5 It is essential that there is a holistic multi-agency discharge plan for young people admitted to a mental health in-patient unit, to clarify the support required to prevent a further hospital admission.

6 When statutory visits to young people in care with complex needs and vulnerabilities are face-to-face, the opportunity for professionals to fully understand and appreciate ongoing risks and vulnerabilities will increase.

7 Professionals require appropriate knowledge, skills, and competence, to provide effective support to young people with autism and to develop a clear understanding of needs and vulnerabilities.

8 It is important that professionals have a shared understanding of the impact of autism on the behaviour, wellbeing and mental health of a young person and work collaboratively to understand what the young person may be attempting to communicate by their behaviour to develop a consistent multi-agency response.

9 It is important that multi-agency assessments of young people with autism support the development of a shared understanding amongst professionals of the key strengths, vulnerabilities, needs and risks which should inform a consistent approach to the provision of care and support.

10 When young people with autism are home-schooled, effective oversight is required to ensure that education and health care needs are met, and effective support is provided to enable the child to reach their full potential.

11 When professionals have concerns about the provision of care and support to a young person with complex needs it is important that the formal escalation policy is implemented to highlight unmet needs and practice shortcomings, effect change and prevent drift.

9. Question for the MK Together Partnership

How can the safeguarding partnership obtain assurance from partner agencies that key learning from this review is effectively addressed within multi-agency improvement plans and that actions have a positive impact on the lives of children and young people? With a specific focus on:

- The provision of holistic discharge plans when young people are in-patients at a mental health unit.
- Improving the knowledge and confidence of practitioners to support effective work with autistic children and young people.
- Ensuring that placements have the capacity and expertise to meet the identified needs of young people and supporting the spot purchase of a specialist provision when required.
- Ensuring that multi-agency assessments of young people with autism promote a shared understanding among key professionals about needs and vulnerabilities.
- Implementation of the formal escalation procedure when professionals have concerns about unmet needs of autistic children and young people.
- Ensuring there is effective collaboration between CSC, health professionals, local authority and CCG commissioning teams when identifying placements for young people with complex needs.

- Development of a clear plan with young people and professionals for use in crisis to reduce the inappropriate use of emergency services, specifically A&E and the police.
- Monitoring the educational and health care needs of autistic young people who are home schooled and ensuring that these are met.