Lessons Learned

Warwickshire Safeguarding

CJ's Story….

CJ was a vulnerable young White British adult with a diagnosis of ASD and ADHD since the age of 5. CJ was intelligent, articulate and very able in many respects, however he had significant difficulties with his communication skills for which he had attended specialist schools from the age of 12.

CJ was aware that he was treated differently to people his own age because of his vulnerabilities, which frustrated him. He was keen to make friends and more latterly, CJ gravitated to spending much of his time amongst the street homeless where he felt more accepted, and concerns grew that he was being exploited. CJ frequently sought opportunities to change 'how he felt inside his head' and had a history of trying to 'get high'. There were numerous occasions CJ had stockpiled his ADHD medication then taken it all at once. This increased to using alcohol and drugs to excess to seek to feel differently. Inevitably, all these methods resulted in him needing emergency medical treatment.

CJ had a history of self-harm and was the subject of a safeguarding referrals as both a child and an adult. At the age of 15, CJ was taken into care by Warwickshire at his parents' request after they felt unable to care for him. Between the ages of 15 and 18 years old, CJ had experienced 12 different placements both in and outside of Warwickshire. Placements ranged from foster carers, supported accommodation, hostels, hotels, emergency temporary accommodation and a residential specialist school. Between placements CJ also stayed with family members and would occasionally sleep rough. CJ struggled with change, both in his living arrangements and in managing changes of personnel, of whom there were several. As he reached 18, responsibility for his day to day care and living arrangements moved from Children's Social Care to Adults Social Care, although as a previous child in care, he remained in receipt of support from the Leaving Care Service.

In late 2020, West Midlands Police visited CJ at his new temporary accommodation in Coventry at the request of his mother, who had been unable to reach him for some days. Police sadly found CJ dead in his room. The inquest concluded that CJ's death was drug related.

What we have learned….

CJ's previous SEN statement was reviewed and updated regularly throughout primary school until being amended to name his special school which he moved to in 2014. In 2017, this was replaced with his first EHCP. An EHCP Review in 2019 determined that an EHCP was no longer necessary. CJ's experience is at odds with the expectations of Warwickshire Local SEND Offer, and with EHCP guidance. As a minimum, his EHCP should have been reviewed annually. Yet, that did not happen for over two years. Additionally, there were no plans addressing preparation for adulthood within the required EHCP process.

Learning for Practice: *EHCPs should be reviewed in accordance with statutory guidelines, covering regularity and planning for adulthood.*

At CJ's LAC Review in January 2020, little action had been progressed to prepare for the transition. As a minimum, a Care Act assessment should have been completed to determine what level of support CJ required, the assessment began a week before his 18th birthday.

Learning for Practice: *Children in transition from children to adults, must be afforded a long term lead in time, with planned preparation and understanding of what will be provided and what they are required to do. This is important for all children but is essential for children with a diagnosis of ASD.*

Lessons Learned (cont.)

Warwickshire Safeguarding

What we have learned (contd.)…..

There were a host of factors that showed how at risk CJ was and how he was being exploited by members of the homeless community. A strategy meeting thought the responsibility had been passed onto another authority where CJ was living at the time, yet when that was refused, nothing was done. CJ's vulnerabilities placed him at a disadvantage that was not being addressed or ameliorated by specific targeted safeguarding plans. These incidents were well known, but there was no formal assessment and analysis of risk. Plans were not drawn up by either service to weigh up the safeguarding issues and identify what could be done to help protect him.

Learning for Practice: *When situations are complex, in crisis, urgent or especially where the normal processes are not working, professional and agencies can lose sight of key issues. Taking time to pause and reflect is important and managers, colleagues and supervisors should support this and help professionals to take stock.*

The Care Act assessment concluded that MCAs were required on specific decision areas. It has been suggested that staff were prioritising finding CJ somewhere to live; that CJ was often missing or in crisis and those times were not conducive to carrying out such an assessment.

Learning for Practice: *Completing the assessment could have helped to bring a clearer view and level of understanding of CJ's needs. Even where there is a lack of clarity and/or differing views, it can be helpful to describe these in the assessment. When a Care Act assessment advises that further work needs to be completed this should be completed in a timely way. Whenever professionals are unable to complete essential tasks this should be communicated with their line managers so that guidance and support can be given.*

The Care Act assessment concluded that CJ needed support, yet despite months of effort no accommodation provider would offer him a place. It was recognised that specialist help was needed as to CJ's communication needs.

Learning for Practice: *Where teams face barriers and they are unable to find solutions they need to seek help beyond those they normally talk to, which in this case it would have been the commissioning team. The usual procedure of escalating to line manager or senior manager would always continue to apply.*

What do I need to do….

Advice for professionals

1. Familiarise yourself with the Mental Capacity Act and how to use it.
2. Read the 7 Minute Briefings – The Importance of History in Assessments and Escalation Protocol.
3. Review the WM Child Protection Procedure - 2.1 Children affected by Exploitation and Trafficking (including Gangs).
4. For more information about Autism and useful tools to aid with communication, visit The National Autistic Society website.

Advice for communities

1. For information on about the local services and support available across education, health and social care for families with children and young people aged 0 to 25, who have special educational needs and/or disabilities, view Warwickshire's local SEND offer.