Overview report

PARTNERSHIP LEARNING REVIEW

Child MM

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1. Introduction and background to the review

MM is a child in Surrey's care. At the time of the incidents that are the subject of this review she was thirteen years old. As a result of escalating emotional and behavioural difficulties in the latter half of 2015 she reached a position where no community provision could be identified which could keep her safe and nor was there any secure care available to her. As a result, and despite the efforts of those caring for her, MM experienced emotional and physical harm.

This partnership review has been commissioned as a result of a serious case review referral by Surrey Children's Services to Surrey Safeguarding Children Board. Following advice from the National Panel it was agreed that a local partnership review would be undertaken. This review covers the period between June and November 2015 and focuses in most detail upon the week between 19-25 November when MM came to the most harm and when the system for keeping her safe was most tested.

The terms of reference deliberately point the work of the review towards the systems in place and particularly the pathways into secure care for complex and vulnerable children whose needs cannot be met by non-secure community provision. The focus of this review is therefore to identify why care pathways failed to work to protect MM and to make recommendations as a result of this learning to ensure other children are better protected in the future.

2. The questions the review will consider are:

What does an examination of the circumstances of this case from mid 2015 tell us about:

- Planning for the most complex young people where there is a need to restrict their liberty?
- How well the commissioning of secure placements, be that on criminal, welfare or health grounds, recognises and responds to the complexities and overlapping needs of children and young people whose liberty might need to be restricted?
- Whether legislation, statutory guidance and local and national policy support the best outcomes for children and young people who present with over-lapping mental health, criminal justice and welfare needs?
- The need to do things differently both locally and nationally?

3. The review process and methodology

This review was commissioned by the Independent Chair of the Surrey Safeguarding Children Board and oversight was provided by a senior stakeholder panel drawn from relevant agencies. The review process reflects the principles set out in *Working Together 2015 (DfE 2015)* and aims to contribute to learning and improvement through consolidating good practice and identifying where practice could be improved.

The methodology for the review reflected Social Care Institute of Excellence (SCIE) guidance and included service specific chronologies, a learning event for practitioners and agency decision-makers including the senior stakeholder panel, and individual interviews with key participants and policy makers.

It is good practice to involve the child and family in learning reviews. After discussion with the social work team with responsibility for MM I met with her in March 2017 at the secure forensic mental health facility where she is placed. While the meeting was extremely helpful for me as the report author in bringing together all the things I had been told and read about MM I am not sure she benefitted greatly. MM was anxious and distracted by other events during our meeting (which included her social worker who has an extremely good relationship with her) and with hindsight I don't think this represented the best approach to capturing the child's voice in this review. This is something that I will reflect upon for the future and may provide a lesson to others undertaking similar reviews. MM's social worker has agreed to continue to seek opportunities to support her in learning from and addressing the experiences reflected in this review. MM is on a full care order and I took the view that approaching her family (who were not involved at any point in the period under consideration) to contribute to the review would not have added significantly to the learning.

4. Communication and learning from this review

The Board has a well-developed learning and improvement framework and where appropriate the learning from this review will be incorporated into existing training. As much of the focus of the review is upon local and national systems and care pathways much of the work to learn to improve will be at a strategic level. In support of this aim the report will be presented to local, regional and national stakeholders and feed into work to address the care pathways for complex and vulnerable children and young people. The action plan stemming from this review will be monitored by the Board.

5. MM background information and overview

MM was born in Surrey in 2002, the fourth oldest child in a family who have had an extensive history of involvement with Surrey Children's Services. She is now one of ten children. MM was accommodated in 2009 following previous periods on child in need and child protection plans. A full care order was made in 2011. MM had suffered severe neglect and has been identified as having acute attachment issues. When she came into care at seven years of age her extreme behaviour already identified her as a child who would need highly specialist support to aid her recovery. She did have a therapeutic educational placement and a relatively stable and successful period in residential care followed by a placement with committed foster carers. When this broke down in 2013 she was placed in a series of out of county residential settings which were typically short-lived because of behavioural management issues and an ability to safely manage the risks she posed to herself and others. What is evident in MM's care trajectory is that there was careful planning

to attempt to meet her needs but as these needs escalated over the two years prior to November 2015 the placement options became ever more limited.

In the months before November 2015 Children's Services' attempts to place MM became increasingly desperate and rather than a process of careful matching of placement to need (as she had experienced when younger) it was much more a case of who was willing to take her. Ultimately in November 2015 no one was willing to have MM and Surrey Children's Services were left to manage a child in a crisis with no access to any recognised placement. For a week MM's placement consisted of a police cell, a bed and breakfast hotel, a paediatric ward and a put-me-up bed in a family centre; for much of this time she remained in crisis and required frequent restraints and up to six social care and police staff managing her at any one time. Ultimately after two days in the family centre a Mental Health Act assessment was undertaken and determined that she met the grounds for s.2 secure assessment. An arrangement was reached with a Surrey Mental Health Trust to open an un-used s136 suite, which was an adjunct to an adult ward and MM was transferred to this accommodation, which while far from ideal was at least safe and offered appropriate medical care. After a day in the s.136 suite an NHS tier 4 adolescent provider assessed MM and offered her a placement. She has been in tier 4 secure adolescent mental health provision since then.

The overwhelming view of those involved in MM's care, as expressed in the original serious case review referral, the learning event and in subsequent interviews, is that MM's treatment was inhumane, degrading, and distressing and placed her and others at an intolerable level of risk. Staff from a range of agencies held MM (literally in many cases) through this period of acute crisis and demonstrated a huge commitment to her care, often at their own physical and emotional cost. The abiding feelings expressed are those of frustration, anger and impotence at an inability to enable MM to access the care and treatment she required.

6. Summary of events from June 2015

The following is a brief summary of events which provides the background to the analysis to enable connections to be made between these events and the learning arising from the review.

By February 2015 MM was resident with a residential care unit in Kent. Remaining here until September 2015 represents an unusual degree of continuity for MM in the period following the break-down of her foster care placement in 2013. Nonetheless it is evident from the chronology provided by the residential care unit that this placement was always fragile and MM's behaviour was extremely difficult to manage. By June 2015 MM's behaviour had deteriorated to the point where she was being physically restrained on most days. In the final days of her placement in Kent there were a number of serious incidents which culminated in MM being taken into police protection having twice been found on the side of the M20 motorway. MM was moved to a placement in Nottinghamshire which provided 2:1 staff to child care in a solo placement but this lasted less than two weeks before MM was moved to Peterborough in a unit offering similarly intensive support. This lasted less than a week when MM was again taken into police protection having climbed on to a roof having threatened to

kill herself. A further non-secure placement was identified but this lasted only one day when MM again climbed on to a roof. At this point MM was detained under the Mental Health Act for assessment.

MM was admitted to an adolescent psychiatric intensive care unit (PICU), within a mental health hospital in the North West of England under section 2 of the Mental Health Act on the 2nd October 2015. During her time there she was secluded on several occasions due to her aggressive behaviour and staff assessing her to be a risk to herself and others. Prior to her admission to hospital Children's Services had experienced significant difficulties in identifying a placement for her which would be able to manage her behaviour safely. Children's Services placement team reported on the 22nd September that they had unsuccessfully approached over 150 residential providers across the whole of the UK.

MM appealed her section and a tribunal was held on 14 October 2015. Her responsible doctor at the PICU reported that MM did not have a mental health disorder and the appeal was successful. It was agreed during the tribunal that a planned move needed to be supported, however, the social worker described being put under considerable pressure to take MM with her immediately despite there being no placement for her. It was later agreed that the PICU would keep MM for a maximum of the 28 days (from admission) to enable Children's Services to identify an alternative placement.

Children's Services attended court on 16 October and an Interim Secure Order was granted. This Order was further extended on 13 November. Children's Services had already unsuccessfully looked for a secure bed on previous occasions with authorisation from the Assistant Director on 29 September and 14 October.

No secure units were willing to accept MM as they either considered her to be too high risk or that she would not be suitable given their current mix of children in placement. After an increasingly desperate search for a placement it was agreed to move her to a residential placement (not secure) on 28 October again with the same residential care unit in Kent, with the agreement that she would be the only child in placement. The placement gave notice on 13 November following repeated violent incidents. Initially they wanted MM to be moved within a few days but after some discussions agreed to keep her for a week. On the 19th November there was an incident at the placement where MM became aggressive to staff, she also swallowed stones and pieces of pottery and was taken to hospital. The placement stated that MM could not return to placement from hospital and she was then taken from the hospital to a police cell.

MM remained in a police station in Lincolnshire until 21 November. There were still no placements willing to accept her (general or secure) and it was agreed that she would return to Surrey and be placed at a bed and breakfast hotel cared for by 4 residential workers. MM assaulted the staff (breaking a worker's nose) and absconded, later being found by police on a tramline. MM was taken to Surrey hospital 1 where a further mental health assessment was completed which concluded that there was no identifiable mental health disorder that warranted secure section under MHA. MM remained in a room on the paediatric ward of the hospital overnight with support of additional staff and police. MM had to be repeatedly restrained by police and Children's Service staff during her time in hospital 1. She did

receive sedative medication in the early hours of the morning of 22 November but she had been in hospital for a significant period before this was made available.

On 22 November it was clear that she could not stay in the hospital as her behaviour posed a risk to other children on the ward and so it was agreed for MM to move to a family centre (this is an office base and has no residential provision) to be cared for by social work staff.

On the 24 November a Mental Health Act assessment was completed and MM was placed on a S.2, initially being moved to the un-used s.136 suite at Surrey hospital 2 and then being assessed and moved to a Norfolk hospital on the 26 November. After a period of assessment at this secure learning disability unit MM was transferred to an adolescent forensic unit where (as of February 2016) she remains.

7. Messages from the learning event

Fifteen professionals who had either had direct personal involvement with MM during the period under review or had been involved in decision-making about her were invited to come together in December 2015 to share their experiences to identify learning for this review. Here key reflections are included to inform the subsequent analysis and to bring to life the thoughts and feelings of those who were involved with MM's care during this period.

What was MM like when not in crisis?

"A very likeable child, big for her age, but very young emotionally."

"A bubbly, lovely, young woman, quick to want to build relationships… I enjoyed her company."

What are your reflections on the way we responded to MM?

"Effectively the local authority had a secure accommodation order but could not implement it. So even though professionals worked very hard the systems are preventing them keeping children safe."

"As employers we have a duty of care to staff and attacks were severe. We weren't able to keep staff safe or MM."

"There was enormous pressure on the social worker to take MM with her when the secure mental health placement was terminated, which was totally unfair and would have been unsafe for her to do so."

"Enhanced provision is the answer. When MM was in the PICU Hospital in she was contained and safe. However, enhanced provision is only available under s.2 [Mental Health Act] so after that we weren't able to meet her needs."

"Welfare secure units would not be able to manage her so it wasn't surprising that they refused to take her."

What are your reflections on inter-agency working for MM in this period?

“Professionals did not step out of their rigid legal framework to think what could have been done differently.”

“There were issues about professionals not identifying the child’s needs. A lot of discussion about not meeting thresholds /criteria but not much about what her actual needs were.”

“Everyone was wanting police to use s.136 but MM was in a hospital and then a family centre and we did not have the powers to use s.136 in those places. If she was sectionable she was in hospital and medical staff were the ones to make that judgement not police.”

“We make assumptions that other professionals already understand our point of view. You learn a lot when you get to hear what was guiding other professionals’ decision-making.”

What did you learn from MM’s experience?

“In the residential care unit in Kent we now have a mental health nurse on site when we work with these children.”

“Children’s Services now have the Extended Hope Service so we can be more effective with crisis/out of hours work. We also have mental health nurse input for residential placements.”

“For me what made the difference was escalation and the fact that the crisis was in Surrey and MM was a Surrey child so ultimately it made a difference that we had the local connections we could use.”

“MM is now in a medium secure unit under s.3 but she will never fit one single category.”

What recommendations would you make following MM’s experience?

“A recommendation for this case would be around understanding the role of other professionals besides our own.”

“For me it is about escalation – leverage for the local authority to get a bed when we need it.”

“Placements locally and not out of county for children with such complex needs.”

“DfE and NHS England need to be able to exert more pressure on secure units to take children.”

“Escalation (local and national) at earlier stage.”

“Better systems and escalation when out of hours.”

8. Analysis

This analysis draws on the original SCR referral, the integrated chronology, the learning event, the serious and untoward incident report (from the Surrey Mental Health Trust) and

individual interviews with key participants. Additional research and interviews have been undertaken in relation to the care and placement of complex and vulnerable children such as MM. The analysis follows the structure and key questions from the terms of reference for this review.

What does an examination of the circumstances of this case from mid-2015 tell us about:

How well we plan for the most complex young people where there is a need to restrict their liberty?

Restricting a child's liberty can result from decisions of a criminal court, a family court or as a result of a Mental Health Act assessment by a psychiatrist and approved mental health social worker (decisions which are subject to review and ratification by a mental health tribunal).

MM first had her liberty restricted following a Mental Health Act assessment on 2 October 2015 with the decision that she met the grounds to be sectioned under s.2 MHA for assessment in a PICU environment. MM successfully appealed this decision on 14 October although she remained 'voluntarily' within the same environment for a further two weeks while an alternative placement was sought.

In the course of this search for a placement the local authority successfully applied to a family court for a secure welfare order under s.25 (Children Act 1989). In order to make such an order the court needs to be convinced that a child is likely to experience significant harm or cause such harm to someone else without the provision of secure accommodation. From the point the s.25 order was obtained the focus shifted away from the mental health pathway to seeking a placement within one of the country's secure children's homes. No secure unit would offer a placement to MM, despite there being beds available, citing variously the risk she posed and her unsuitability based upon the existing children in placement. Department for Education and NHS England senior officials were engaged in the attempt to access a bed for MM but as every secure children's home is locally commissioned and locally managed each is at liberty to decline any referral.

A further complication was that having obtained a secure order this effectively dis-barred MM from any non-secure placements. Providers understandably shied away from the risk MM represented following the court's determination that she should be in a secure environment and many said their insurance would not cover such a placement. In this respect the local authority was in a double-bind: no secure unit would have MM and having obtained a s.25 order no non-secure placement would take her. Ultimately on the basis of having previously known MM the residential care unit in Kent offered her a non-secure placement, "against our better judgement", which was short-lived.

In this case it is clear that the s.25 order, while formally recognising the level of risk MM posed to herself and others, was of no use in providing a means of managing this risk. In enacting s.25 Children Act 1989 it was clearly the will of parliament to provide the courts (and local authorities) with a mechanism for protecting children and the public. MM's experience and that of those caring for her demonstrates that when it is most needed the provision to discharge the duties under s.25 cannot be reliably accessed. This appears to be in contravention of parliament's intention in enacting s.25.

The recent review of secure children's homes for the Department of Education (Hart, La Valle 2016) recognised the need to review s.25 Children Act as its use appears to differ significantly between authorities and where a child is placed in secure under s.25 its provisions are unhelpfully inflexible. The authors argue this runs counter to the therapeutic interests of children and aspirations for successful community reintegration. In addition the Minster for State has committed to reviewing the functioning of secure children's homes in England, including their interface with other secure provision (DfE 2016)

Recommendation (1): The Department for Education should review commissioning and placement arrangements for secure children's homes to ensure that provision is available where an s.25 order has been made

How well does the commissioning of secure placements, be that on criminal, welfare or health grounds, recognise and respond to the complexities and overlapping needs of children and young people whose liberty might need to be restricted?

The commissioning of health, welfare and justice secure placements are relatively discrete activities. NHS England Specialist Commissioning is responsible for commissioning mental health secure beds, local authorities commission secure welfare beds and the Youth Justice Board commissions children's criminal justice secure placements. The only place where secure placements have any integration is in the secure children's homes which include placements commissioned by both the Youth Justice Board and local authorities and admit children from both criminal and family courts. Ordinarily mental health secure placements admit only children who have been assessed as meeting the MHA criteria for detention and the rest of the youth justice secure estate is reserved for those meeting the criminal grounds for detention.

The relationship with NHS England was described by practitioners with responsibility for finding a secure placement for MM as distant and lacking in responsiveness to deal with escalating crisis of the type MM experienced. Local practitioners felt support was lacking out of hours and particularly over the critical weekend of 21-22 November. For their part NHS England recognise that there have been bed capacity issues which have impacted upon their ability to support local areas to access placements but believe that these pressures have eased somewhat since 2015. As with secure children's homes it is individual mental health units who determine who they take and there is no national authority to direct placement decisions. In this respect local practitioners may have unrealistic expectations as to what NHS England can do on their behalf. NHS England commissioners recognise that more localised commissioning arrangements which involve clinical commissioning groups and local authorities would be likely to be more responsive to local need and work is underway to achieve this.

During the period this review is considering there were no national arrangements for managing referrals to secure children's homes in England. This meant that Surrey Children's Services placements team had to repeatedly approach each unit during the weeks when they were searching for a secure welfare bed. A striking feature of the Children's Service chronology is the time and energy spent referring to both secure and non-secure placements. The development of a national referral hub (hosted by Hampshire County Council) is therefore seen as a welcome development. While this does not alleviate the

capacity issues in relation to secure welfare placements it does at least streamline the system. This development may also assist in speeding up decisions in regard to secure placements as another feature of MM's experience was that hopeful placement leads, which ultimately proved un-fruitful, meant she remained in inappropriate environments longer than she might otherwise and delayed decisive action on the part of those caring for her.

It is of note that in the search for a secure bed for MM the Youth Justice Board made available beds in secure units which are normally reserved for children meeting the criminal threshold for detention. Despite this unusual move it did not mean MM was able to access one of these beds as discretion still remained with the individual units to decide whether to accept her.

There is no doubt that from September 2015 (at the latest) MM's needs and risks were such that she warranted a secure placement. It is also evident that because of a lack of mental health diagnosis and uncertainty in relation to her formulation – her specific needs and the best way to respond to these – the available pathways did not work for her. MM clearly has significant emotional and mental health concerns despite the fact at the time under review these had not led to a specific mental health diagnosis. In fact after over a year in a secure psychiatric environment MM still does not have any specifically diagnosed mental disorder. Without a diagnosis MM's behaviour, as severe and dangerous as it was, did not afford her admittance to a secure mental health bed. The same behaviour has, nonetheless, meant she has been detained in a secure mental health setting since November 2015.

It is worth considering why MM did not meet the threshold for detention through a criminal justice route. This is largely as a result of a framing of her behaviour as a reflection of her health and welfare needs rather than as criminal. MM has been arrested on many occasions (since the age of ten) as a result of violent behaviour both in the community and within her various placements. On almost all occasions charges were not pursued or prosecutions discontinued and as a result she has a limited history of convictions. In 2015 alone multiple charges were dropped as 'not in the public interest' as a result of submissions to the Crown Prosecution Service by the local authority. In this respect the local authority can be seen as being at the front edge of good practice in relation to the de-criminalisation of children in care (and was acknowledged as such by Lord Laming's review into the subject) but ironically for MM this closed off one of the routes into secure care for her. At another time or in another place (particularly if she were an older boy with the same history and presentation) MM's behaviour would very likely have led to her detention through a youth justice route.

While it is not suggested that being secured on criminal grounds would have been the right response for MM the changing policy context is an important backdrop to this review. The move away from custodial responses has been a feature of recent youth justice history; the number of children in custody has fallen by more than two-thirds over the last decade from a peak of around 3000 to less than 1000 at any one time in 2016. Within a local and national context this means more complex and vulnerable children either being managed in the community (often in the type of fragile arrangements we have seen with MM) or vying for entry to a secure welfare or mental health bed. It does not appear that the commissioning of either secure or non-secure alternatives for these children has kept pace with the changing policy and practice context.

Recommendation (2) NHS England should work with CCGs and local authorities to develop joint commissioning arrangements which are more responsive to local need and better integrate tier 3 and 4 CAMHS provision.

Recommendation (3) NHS England should consider how access to mental health secure provision can be improved and what arrangements can be made to assure local services that such provision will be made available in a timely way when children are in crisis.

Does legislation, statutory guidance and local and national policy support the best outcomes for children and young people who present with over-lapping mental health, criminal justice and welfare needs?

> "Children whose needs have not been adequately met see the world as comfortless and unpredictable and they respond by either shrinking from it or doing battle with it." *Bowlby (1973) Attachment and Loss Vol. 2*

It has been recognised in recent national reviews of children's mental health services (Future in Mind 2015), justice (Taylor 2016) and care (Laming 2016, Narey 2016, Hart and La Valle 2016) that legislation, guidance and policy have un-helpfully separated children's needs into what have become overly siloed pathways. Those who reach the apex of the mental health, justice and welfare systems have typically suffered adverse childhood experiences, which are compounded by further social and environmental stressors, leaving these children uniquely vulnerable. The following extract in relation to children requiring secure forensic care could equally apply to the majority of those who are secured on welfare or justice grounds:

> "their social backgrounds are often characterised by socio-economic deprivation, multiple losses and traumas, adverse life events, family discord, poor scholastic achievements, learning difficulties, substance misuse and criminality. In addition some young people are involved with multiple agencies in complex legislative frameworks." (2013/14 NHS Standard contract for secure mental health service for young people)

This description would encompass MM's childhood experiences and "complex legislative frameworks" are certainly a feature of this case review and something those with responsibility for her care struggled to negotiate.

Despite the commonality of experience between these children our responses to them can vary markedly. Depending on the pathway a child is on, and sometimes depending on the presentation and behaviour on a given day, a child with acute emotional and behavioural difficulties may find themselves subject to greatly differing regimes and types of care between the differing settings. The three pathways can be characterised as having a dominant ethos of either treatment (health), care (welfare) or control (justice). For many children and young people (Khan 2016, Little 2015) and many professionals (Children's Commissioner 2015) this response is arbitrary and reflects organisational and system needs rather than those of children.

Underpinning the escalating crisis in caring for MM was a dispute as to whether she had a mental health disorder requiring treatment or behavioural disorder requiring the right type of care. This disputed territory is recognised in the recent DfE review of secure proviosion;

> There appears to be a particular gap in services for children with attachment, conduct, emerging personality or post-traumatic stress disorders, with these children falling between social care and health provision (Hart and La Valle 2016)

Clearly MM did have significant emotional and mental health problems (if not a diagnosable disorder) as part of a range of social and behavioural needs and challenges. Responses to MM appear to have been overly binary, concerned with specific pathways to which professionals aligned themselves, working overly rigidly within governing legislative and practice frameworks. A number of practitioners commented in the course of this review that MM's needs got lost in the dispute between who should have primary responsibility for her care. As a result by the week of 19 November she had fallen between a care system which had run out of options to meet her needs and a mental health system which was unable (in both legal and practical terms) to accept responsibility for her.

MM's experiences are far from unique. NHS England report similarly distressing cases occurring with relative frequency where children cannot be placed. Often it is police cells or adult mental health units which have to hold on to children while those with responsibility for their care desperately seek a better alternative. For MM professionals still fear that when she is discharged from her current section a new crisis will again see them fire-fighting in the face of minimal placement options. These concerns have been shared with senior health and children's services managers and there is a commitment to retain close senior oversight of MM's discharge and subsequent placements to ensure there is no repeat of the crisis which engulfed her and the people working with her in November 2015.

Recommendation (4) NHS England, DoH, DfE, MoJ should commit to integrated responses to complex and vulnerable children which recognise their common experiences and seek to draw together services and care pathways.

What do we need to do differently both locally and nationally?

"The provision of mental health support should not be based solely on clinical diagnosis but on the presenting needs of the child or young person and the level of professional or family concern" Future in Mind (Department of Health 2015)

Many of the systemic issues which are reflected in the crisis which unfolded for MM are articulated in Future in Mind, the report of the government's Children and Young People's Mental Health and Well-Being Task Force. Critically in considering care for the most vulnerable Future in Mind recognises that children who have had the most adverse childhood experiences will have varying degrees of emotional disturbance, which may or may not be identifiable through a specific mental health diagnosis. These children will often be in our care system, will frequently have special educational needs and may also appear in the youth justice system. Rather than being solely the responsibility of a commissioner /

provider of education, care, youth justice, or health services the requirement for our pathways for these children is to integrate services in order to join up around them.

Nationally Future in Mind has contributed to the NHS's Five Year Forward View for Mental Health within which sits the Children and Young People's Mental Health Transformation Programme. This programme has three key workstreams all of which are relevant to this review. The first workstream is reform of the environments in which children are detained in order to equip staff with the skills and knowledge to provide psychologically informed and trauma aware care as a whole staff group within secure settings. Secondly regional forensic CAMHS teams are being rolled out to provide specialist support to professionals managing the most complex and vulnerable children who are on the cusp of secure care. Thirdly commissioning for secure care is being reviewed with partners to deliver more local joint commissioning arrangements.

Future in Mind has also led to a requirement for each local authority area to produce a CAMHS whole system transformation plan and the DoH has identified dedicated resources to improve local services. Surrey's local transformation plan identifies crisis care and inpatient commissioning as two of its priorities. Since the period looked at by this review crisis care in Surrey has been enhanced by the development of the Extended Hope Service. Established in 2016 Extended Hope provides intensive outreach and respite residential care for children at the top of CAMHS tier 3 services who are at risk of requiring tier 4 in-patient provision. This out of hours provision builds upon and integrates with the existing Hope day service. Extended Hope would usefully have added to the resources available to support MM once she had returned to Surrey in November 2015. It should, however, be noted that Extended Hope's respite residential provision is specifically for those who should be diverted from a tier 4 setting it is not intended to take the place of that provision for those for whom it is appropriate. Clearly MM fell into the second category. The potential for local commissioning and greater integration of CAMHS tier 3 and 4 services offers the opportunity to build upon the Extended Hope developments, providing more holistic options for those with over-lapping mental health, education, and behavioural (including offending) needs. This would offer new opportunities to consider both how children in crisis could be better supported in local settings (not in a bed and breakfast or police station) and to develop local tier 4 provision, ideally in conjunction with neighbouring local authority areas.

Recommendation (5) Commissioners of Surrey's CAMHS and looked after children's placements should work with NHS England to further develop crisis and specialist care provision in Surrey, which better meets the needs of children who require specialist placements and provides for both health and welfare needs.

There are opportunities to improve Surrey's responses to children such as MM exhibiting behavioural dis-regulation through the developing behavioural, emotional and neuro-developmental (BEN) pathway, which is a key innovation in the new CAMHS contract. This approach seeks to respond in a more holistic way to children's needs without requiring mental health labels to access appropriate support. One example of this attempt to promote greater integration, earlier identification and intervention, and crisis support is through the development of mental health 'safe havens'. Surrey's first Haven for under-18's is opening in Spring 2017 offering mental health support within a youth centre environment, with services provided by mental health practitioners and youth workers. The Haven integrates with Surrey's existing CAMHS, Extended Hope and young people's / youth justice services

with a view to providing the holistic, non-stigmatising support which children and young people have said they want. This provision has the potential to provide a platform for better crisis care and joined up support for the most complex and vulnerable young people in the future. As Future in Mind identified, and has been explored by the Social Research Unit's participatory research with young people facing multiple disadvantage, such integrated approaches are sorely needed for this cohort of children and young people,

> Those with multiple needs struggle to navigate systems designed for education, mental health, social care or youth justice. A proportion rapidly drop out of view without receiving any assessment. Many fall between the cracks of the multiple referral pathways. Others bounce between systems for many years before support rapidly evaporates at the boundary of adulthood. (Little 2015)

Drawing together support which can hold on to children and young people who will in Bowlby's words either "shrink from the world…or do battle with it" is the central challenge to services which seek to effectively support children like MM.

The local / national debate played out around the commissioning of secure placements and the integration of tier 3 and 4 CAMHS services has parallels and indeed interdependencies with the debates around care placements for the most complex children in local authority care. Typically for children such as MM who escalate through fostering and in-house residential options the answer has to be found in specialist out of county placements. As described previously the more challenging the needs of the child the more difficult it is to place them and ultimately this can mean poorly matched placements or no placement at all and the child being escorted back to Surrey. While it is recognised that not every child's needs can be met in-county and there will always be times when out of county is appropriate, there are reasons to focus upon developing local provision. In ordinary times when a child is out of county it can be difficult to access the range services they require (health, justice, education etc) from a range of unfamiliar providers; in a crisis these negotiations become more fraught. As difficult as the situation was when MM returned to Surrey after 19 November it was ultimately local leverage and access to local services that led to the resolution of the crisis.

Recommendation (6) Surrey County Council and Surrey CCGs with local health providers should develop provision for emergency care for children unable to access a secure mental health or welfare setting.

Recommendation (7) Surrey County Council and Surrey CCGs should work with national commissioners and neighbouring authorities to develop local provision for complex and vulnerable children who would ordinarily meet the threshold for secure provision (health, welfare or justice). This provision should be integrated with tier 3 community provision and provide both secure requirements and non-secure.

Importantly consideration of the development of local placements and supporting services for complex and vulnerable children should not be left to any one agency but should be jointly developed with national commissioners (NHS England, DfE, DoH, MoJ) and local partners led by CCGs and the Surrey County Council. Thus far decisions regarding commissioning and development of provision appear to take place within single government and local agencies, as MM's experience illustrates this is greatly to the detriment of children.

As described above it was when MM returned to Surrey that the crisis in her care was finally resolved. Professionals involved with her care believe this local resolution could have happened sooner and that the decision to open the Surrey Hosptial 2 s.136 suite could have been taken on 19 November rather than MM having to endure five days effectively without a placement. Two conclusions were drawn by many of those involved in the course of these days; firstly that the child's needs were obscured by overly rigid adherence to professional codes and guidance and secondly there should have been a better escalation process to the most senior officers in the health, local authority and police services in Surrey.

Firstly, to the view that in the eye of the storm practitioners fell back upon rigid professional practice and policy frameworks which lost sight of the child's needs. MM needed to be in a safe place but practice in relation to s.136 was such that police did not feel authorised to use this power. Similarly facilities existed in Surrey and were ultimately used to provide a place of safety (in adult provision) but this was contrary to NICE guidance and does not appear to have been considered until 24 November. A further example is the reliance upon mental health diagnostic criteria which distanced mental health services from responsibility for MM's 'behavioural' problems. All these reflect understandable but ultimately unhelpful approaches and decision-making in the face of a child in crisis. Subsequent review by Surrey Police has confirmed the decision not to use s.136 powers but has also highlighted the police's willingness to assist in moving MM to an alternative place of safety had they been asked or one been made available.

In relation to the escalation procedures MM's circumstances were well known to the Children's Services Assistant Director and she was actively involved in seeking a resolution. It is not known how much involvement there was by the most senior officers in the County Council. It is also unclear how much senior decision-makers were involved in the other key agencies, although the mental health trust (who admitted MM to the s.136 suite attached to the adult ward) said that their senior management were not consulted until 24 November. When consulted they quickly made the resource available in spite of the knowledge that in doing so they would have to account for this as a 'serious and untoward incident'. For circumstances as serious as MM's it would appear appropriate to ensure that an inter-agency escalation protocol exists to provide the level of senior input that can bring resources and authority to bear to more quickly resolve crises.

Recommendation (8) Surrey Police, health and county council chief officers should agree an inter-agency children's escalation protocol where they or officers directly authorised on their behalf should be informed and make decisions in relation to the most serious cases.

Recommendation (9) Surrey Safeguarding Children's Board should identify multi-agency training and development opportunities to support professionals in learning together about maintaining a focus upon the needs of the child at times of crisis when inter-agency relationships are most tested.

Recommendations (10) The findings of this review should feed into Surrey's CAMHS transformation plan and the Children and Young People's joint commissioning strategy. This review should also be shared with NHS England, Department for Education, Department of Health, the Youth Justice Board and Ministry of Justice.

9. Concluding remarks

This review has not levelled criticism at any professional or agency. Individuals made heroic attempts to care for MM and promote her safety. That said collectively the adults tasked with keeping MM safe found they could not do so as they were hamstrung by systems which fail to adequately account for the needs of our most complex and vulnerable children. The problems identified are systemic and can only be addressed through system reform guided by a genuine desire to see the child, without needing to label or require a definitive diagnosis, and put their needs at the heart of a transformed response.

10. Recommendations

(1) The Department for Education should review commissioning and placement arrangements for secure children's homes to ensure that provision is available where a s.25 order has been made.

(2) NHS England should work with CCGs and local authorities to develop joint commissioning arrangements which are more responsive to local need and better integrate tier 3 and 4 CAMHS provision.

(3) NHS England should consider how access to mental health secure provision can be improved and what arrangements can be made to assure local services that such provision will be made available in a timely way when children are in crisis.

(4) NHS England, DoH, DfE, MoJ should commit to integrated responses to complex and vulnerable children which recognise their common experiences and seek to draw together services and care pathways.

(5) Commissioners of CAMHS and looked after children's placements should work with NHS England to further develop crisis and specialist care provision in- local authorities, which better meets the needs of children who require specialist placements and provides for both health and welfare needs.

(6) The local authority and CCGs with local health providers should develop provision for emergency care for children unable to access a secure mental health or welfare setting.

(7) The local authority and CCGs should work with national commissioners and neighbouring authorities to develop local provision for complex and vulnerable children who would ordinarily meet the threshold for secure provision (health, welfare or justice). This provision should be integrated with tier 3 community provision and provide both secure requirements and non-secure.

(8) Police, health and local authority chief officers should agree an inter-agency children's escalation protocol where they or officers directly authorised on their behalf should be informed and make decisions in relation to the most serious cases.

(9) Safeguarding Children's Board should identify multi-agency training and development opportunities to support professionals in learning together about how to maintain a focus

upon the needs of the child at times of crisis when inter-agency relationships are most tested.

(10) The findings of this review should feed into CAMHS transformation plan and the Children and Young People's joint commissioning strategy. This review should also be shared with NHS England, Department for Education, Department of Health, the Youth Justice Board and Ministry of Justice.

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