

**Investigation into a complaint against
Surrey County Council (09 007 810) &
Surrey & Borders Partnership NHS Foundation
Trust (JW-65060)**

June 2014

Investigation into complaint numbers JW-65060 and 09 007 810 against Surrey County Council & Surrey & Borders Partnership NHS Foundation Trust

Contents

Summary	5
How we consider complaints.....	6
The general standard: The Ombudsman’s Principles	6
What we found	7
Services provided for C.....	9
Provision for Mrs D	22
Complaints made by Mrs D.....	23
Provisional Conclusions	25
Summary of Provisional Findings.....	33
Recommendations	35

Key to names used

The Complainant	Mrs D
The Complainant’s son	C

Summary

1. Mrs D complains for herself and her son, C, that the services provided by the Council and the Trust between January 2007 and February 2011 were inadequate, unco-ordinated and failed to meet their needs. She says this had a devastating impact on the quality of their lives and adversely affected C's ability to achieve his full potential.
2. C was born in February 1992. His parents divorced after a long history of domestic violence and C stayed with his mother. In 2005, when he was 13 years old, the family's GP referred him to the Child and Adolescent Mental Health Services (CAMHS) because of his worrying behaviour at home and in school. The CAMHS psychiatrist initially diagnosed Obsessive Compulsive Disorder¹. In December 2007 psychiatrists at a Specialist Hospital confirmed a diagnosis of Asperger's Syndrome². C has received Disability Living Allowance (a central government benefit) since 2007.
3. C refused to return to school in January 2007 and he was out of school from then until May 2009 when he moved to a specialist boarding college. He returned to live at home during school holidays. After he stopped attending school in January 2007 Mrs D struggled to cope with his increasingly controlling and abusive behaviour. In September 2011 he moved to a supported living placement. Mrs D says that at home C was physically and mentally abusive, threatening and controlling.
4. Mrs D complains that from January 2007 to February 2011 there was a total lack of care and treatment for C and that the services provided to support them both were inadequate. C was academically very able but his education was severely disrupted. Mrs D believes the lack of support from the Trust and the Council meant he did not achieve his potential or go to university as he should have done. Their relationship was damaged and Mrs D found it extremely difficult to care for him properly. Her own physical and mental health suffered because of the lack of support and she was unable to continue working, so suffered financially and emotionally.
5. In pursuing these complaints Mrs D is seeking assurance that the failures in services for C and herself will never be repeated, as well as recognition of and compensation for the anxiety and distress both she and C have suffered as a result of those failures.

Decision

6. We found service failure by the Trust and maladministration by the Council and that as a consequence C and Mrs D suffered injustice. Therefore we uphold the complaint and make recommendations to remedy the injustice we have found.

¹ A psychiatric condition in which a person is dogged by persistent ideas that lead to repetitive, ritualised acts.

² A rare developmental disorder that is usually first recognised in childhood. Asperger's Syndrome is an autistic spectrum disorder.

How we consider complaints

7. When considering a complaint we begin by comparing what happened with what should have happened. We consider the general principles of good administration that we think all organisations should follow. We also consider the relevant law and policies that the organisation should have followed at the time.
8. If the organisation's actions, or lack of them, were not in line with what they should have been doing, we decide whether that was serious enough to be maladministration or service failure.
9. We then consider whether that maladministration or service failure has led to an injustice or hardship that has not been put right. If we find an injustice that has not been put right, we will recommend action.
10. This report has been produced following the examination of relevant files and documents and interviews with the complainant and relevant employees of the Council.
11. The complainant and the Council were given a confidential draft of this report and invited to comment. The comments received were taken into account before the report was finalised.

The general standard: The Ombudsman's Principles

12. The Ombudsman's Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy³ are broad statements of what she considers public bodies should do to deliver good administration and customer service, and how to respond when things go wrong. The same six key Principles apply to each of the three documents.
13. These six Principles are:
 - Getting it right
 - Being customer focused
 - Being open and accountable
 - Acting fairly and proportionately
 - Putting things right, and
 - Seeking continuous improvement.
14. The Principle of Good Administration relevant to this complaint is 'Getting it right'. This includes:

'All public bodies must comply with the law and have regard for the rights of those concerned. They should act according to their statutory powers and duties and any other rules governing the service they provide ...'

³The Ombudsman's Principles is available at www.ombudsman.org.uk.

It also includes:

'Public bodies must act in accordance with recognised quality standards, established good practice or both, for example about clinical care.'

What we found

National standards

15. A number of different agencies from within the Trust and the Council were involved in events which are the subject of this complaint. Legislation and guidance relevant to those agencies is referred to in the body of the report where appropriate.
16. Advice on working between agencies is given in 'Working together to Safeguard Children' published in 2006 by the Department for Education and Skills. It says:

"Safeguarding and promoting the welfare of children ... depends on effective joint working between agencies and professionals that have different roles and expertise. Individual children, especially some of the most vulnerable children and those at greatest risk of social exclusion, will need coordinated help from health, education, children's social care and quite possibly the voluntary sector and other agencies including youth justice services."
17. Neither the Council nor the Trust were able to provide copies of relevant partnership agreements, protocols or procedures covering the period being investigated.
18. The Trust and Council agencies involved in this complaint addressed the requirements for partnership working primarily through network meetings attended by all the professionals working with C. Mrs D also attended. Network meetings were held roughly monthly from September 2007 until June 2008. This investigation has identified 33 different professionals involved with C and Mrs D over the period complained about. At one time there were social workers from CAMHS, the HOPE Service (HOPE - a multi-disciplinary service run by CAMHS for young people with mental health problems) and Children's Services working with C.
19. Asperger's Syndrome is a form of autism. An Autistic Spectrum Disorder (ASD) is a lifelong development disability. Its impact can vary widely and some people who have it can live relatively independently while others have high dependency needs requiring a lifetime of specialist care. In 2006 the Department of Health (DH) issued guidance: 'Better Services for People with an Autistic Spectrum Disorder – A Note Clarifying Current Government Policy and Describing Good Practice.' It says:

"To meet the needs of young people in transition health and social care commissioners should:

 - *ensure each young person and their family/carers are supported by a single trusted adult contact who will liaise with services.*

- *meet the statutory requirement to commence transition planning from the age of 14.*

Approved Social Workers, assertive outreach teams, challenging behaviour teams and psychiatrists will be more confident and deliver better solutions if they understand the impact of major transition, crisis and change on people with an autistic spectrum disorder.”

20. At the time of the events complained of there were no relevant guidelines in place about what services had to be made available for people with autism. However, the Autism Act 2009 required publication of an Autism Strategy. The government published 'Fulfilling and Rewarding Lives' in March 2010. It aims to:
- increase awareness and understanding of autism among frontline professionals;
 - develop a clear and consistent pathway for diagnosis;
 - improve access for adults with autism to the services and support they need to live independently in the community; and
 - help adults with autism into work.
21. National service frameworks are set up by the NHS to drive up standards and reduce unacceptable variations in health and social services. The National Service Framework for Mental Health - Modern Standards & Service Models (September 1999) sets out the evidence based national standards for mental health, what they aim to achieve, how they should be developed and delivered and how to measure performance in every part of the country. It states:

'Clinical responsibility for the mental health care of older adolescents can sometimes lead to disagreements between child and adolescent mental health services and adult services if working arrangements between the two services have not been addressed. Variations exist for the 'cut-off' point for referral to adolescent services, for example, 16, 18, 21 years or school leaving. Local arrangements should be agreed to avoid confusion and possible delays.'

Services provided for C

22. This investigation covers events from January 2007 when C refused to return to school after the Christmas holidays. He was almost 15 years old. C received services from a number of Trust and Council agencies and sections below provide more detail on each of these.
23. In January 2007 C was already under the care of the CAMHS and had a diagnosis of Obsessive Compulsive Disorder. This investigation has considered the reasonableness of the care and treatment CAMHS provided for C and the support provided for him and Mrs D from then until early 2011. It includes HOPE, which C attended from March 2007.
24. The Council's Inclusion Services (including the Alternative Education Team and the Out of School Team) were involved from January 2007. Initially it did not make provision for C because he was referred to the HOPE day service which included some educational provision along with therapeutic treatment. The Out of School Team arranged home tuition for C from November 2007 until July 2008. This investigation has considered whether the Out of School Team provided home tuition at the appropriate time and to a reasonable standard.
25. The Council's Children's Services were involved from June 2007 onwards. The substantial delay of over a year in carrying out the core assessment of C's needs has already been recognised through the Council's own complaints procedures. This investigation has considered the extent to which the delay affected services provided for C. C was not eligible for children's services following his 18th birthday in February 2010 and the investigation has covered the role of the Transitions Team in managing his transfer to adult social services.
26. The sections below also describe C's involvement with the Connexions service from January 2007 to 2011 and the Youth Justice Team, between June 2007 and September 2008.
27. In August 2007 CAMHS referred C to a specialist hospital which had an Autism Unit. This is not part of the Trust and the services it provided are not included in the matters investigated. In December 2007 the specialist hospital confirmed a diagnosis of Asperger's syndrome and recommended a residential educational placement for C, which required assessment by the Council's Special Educational Needs (SEN) Team. The specialist hospital continued to provide some support for C and his mother while this recommendation was pursued.
28. The Council's SEN services decided in January 2008 not to carry out an assessment of C's special educational needs. Mrs D appealed against that decision and an assessment started in June 2008. Mrs D also appealed the statement of C's special educational needs (the SEN statement) issued by the Council in September 2008. The Council agreed funding in May 2009 and C began a two year placement at a specialist

residential school. The process of requesting an assessment and the content of the SEN statement are outside the Ombudsman's jurisdiction and are not part of this investigation.

CAMHS

29. CAMHS is a multi-disciplinary service run by the Trust, providing help and treatment for children and young people experiencing emotional or behavioural difficulties or mental health problems, disorders or illnesses.
30. The family GP referred C, who was then 13 years old, to CAMHS because of his anti-social behaviour at school and obsessive-compulsive patterns of behaviour at home and school. He was offered appointments to see a psychiatrist, fortnightly from January 2006. C did not always attend his appointments. His psychiatrist diagnosed an obsessive-compulsive disorder. The psychiatrist noted features of an Autistic Spectrum Disorder (ASD) but there was not enough evidence to make a diagnosis at that time. In October 2006 the psychiatrist prescribed medication for depression and in May 2007 prescribed psychotropic (anti-psychotic) medication to control aggression. C was reluctant to take the medication prescribed. CAMHS allocated a community psychiatric nurse (CPN) and a social worker to support C.
31. In March 2007 (after C stopped attending school) CAMHS referred him to the HOPE community outreach service and to the Alternative Education Service (see paragraph 55 below).
32. In May 2007 the psychiatrist reported that C's prognosis was poor, his functioning was severely impaired and he needed care and supervision because of his age (he was then 15 years old) and severe mental illness. He noted that C could not look after himself and would be likely to live in squalor if his carer did not clear up after him. The psychiatrist noted that he discussed with Mrs D the possibility of C being admitted to hospital but she would not agree to this.
33. Mrs D says that, after C set fire to a wheelie bin on 26 June 2007 and caused considerable damage, he said he wanted to be admitted to hospital. Mrs D told CAMHS about this but they said he could not be admitted. There is a record of a telephone call to the psychiatrist on that day but it does not mention an admission request. There is no reference to a hospital admission in the notes of C's session with the psychiatrist two days later.
34. In June CAMHS referred C to the Council's social care Children's Services because the level of domestic violence (from C towards his mother) had increased significantly. In August 2007, because his behaviour had worsened and he was not responding to the programme of treatment, the CAMHS psychiatrist decided to refer C to a hospital which has a specialist centre for Autism. Authorisation had to be obtained for funding before the referral could be made, because the specialist hospital was part of a different health trust. C's first appointment at the specialist hospital was in

November 2007.

35. CAMHS arranged a series of multi-agency network meetings of the professionals involved in C's care, including CAMHS psychiatrists, C's CPN and HOPE keyworker, social workers from HOPE and the Council, and representatives of the Education Department, Connexions and Youth Justice Team. The first meeting took place in September 2007 and agreed the main focus should be C's mental health problems but that he needed some educational input in the meantime.
36. The psychiatrist C had been seeing left CAMHS about this time and was replaced by locum psychiatrists. Mrs D asked a locum psychiatrist for an urgent appointment in October 2007. The locum psychiatrist said it would not be helpful as he did not know C and he was still waiting for the assessment by the specialist hospital. His note of the conversation says he advised that as a locum he could not provide much continuity, that things "were in a mess" at the Trust, and he advised Mrs D to contact HOPE as they were providing a lot of support. Mrs D recalls the locum psychiatrist telling her she would have to seek help elsewhere.
37. The professionals at the network meetings in January and February 2008 discussed whether or not C had mental health problems and whether health or education should take the lead on his case. Although it is not recorded in the meeting notes, it appears from individual attendees' notes that by that time CAMHS had received the report from the specialist hospital and they were quite certain that C did not have mental health problems and so met the criteria to be signed off by CAMHS. There is no record that C was discharged by CAMHS.
38. C did not have regular appointments with CAMHS psychiatrists after September 2007. In March 2008 he saw a new psychiatrist. The psychiatrist noted the animosity C had shown his mother, a lack of respect and a "reversal of power". (Mrs D attended appointments with the psychiatrist by herself in January, May and November 2008.)
39. In December 2008 the Specialist Hospital advised CAMHS that it should arrange home based behavioural intervention with a psychologist involving C and Mrs D. CAMHS did not agree with this recommendation. The CAMHS psychologist said its psychology service did not have the resources for this type of intensive work. She expressed doubt about whether C's behaviour could be modified because it was very fixed in pattern and C did not see the need to change. She believed a boarding school placement would be more effective. In response to a subsequent complaint from Mrs D, the CAMHS psychologist said that there were concerns about working with C at home because of his violence. However there is no record that this concern was raised at the time or discussed with Mrs D.
40. In February and March 2009 Mrs D wrote to CAMHS asking for an appointment with the psychiatrist. After the GP chased the CAMHS team another psychiatrist (the fourth to have been involved in C's case) telephoned Mrs D on 9 April, apologising for lack of contact over the past few months. He said they were exploring the options for home based therapy as recommended by the Specialist Hospital if C did not get a residential

placement. The residential placement was approved in May 2009 and CAMHS did not provide the home based therapy.

41. In February 2010 when C turned 18, he was no longer eligible for CAMHS. We have seen no evidence that the Trust had any relevant protocols in place for the transition from children's to adult mental health services. No action was taken to facilitate his transition from children's services.
42. C's GP referred him to Adult Mental Health Services in October 2010. C's mental health needs were assessed but he did not meet the criteria for the provision of adult services. Following representations from C's GP the Trust's Out of Area Treatments Panel considered C's case in January 2011. It agreed that C could benefit from a statutory community care assessment and should be referred to the Council's Adult Care Services and the Adult Community Mental Health Team.

HOPE

43. HOPE is run by CAMHS. It provides services for young people (11- 18 years) who have complex mental health, social, emotional and behavioural difficulties. It has a multi-agency team of professionals aiming to prevent or shorten admissions to inpatient units and to prevent family breakdown. HOPE is a registered short stay school. The service is mainly therapeutic but also includes a day programme providing individually tailored education in small groups. The outreach service includes psychiatrists, therapists, social workers, psychologists and others providing support in the community.
44. Young people referred to the HOPE service are allocated a care co-ordinator. C attended the day programme at the HOPE centre from April 2007. He was then 15 years old and had been studying for his GCSEs while at school. Initially C attended the day programme at the HOPE centre four days a week but he experienced some difficulty working with the other children attending the HOPE centre. As a result within three weeks the service reduced his attendance to two days a week.
45. C was not following GCSE courses during his attendance at the HOPE centre but followed 'general' education. In addition to the educational programme C had weekly Art Therapy sessions and sessions covering drama, Personal Health and Social Education (PHSE), aromatherapy and gym. The objectives identified in his individually tailored programme were to:
 - control anger and raise awareness of anger triggers
 - alleviate symptoms and look at underlying issues
 - return to education.

At review meetings staff noted C's continual threats and referred C to a young person's domestic violence project.

46. C was still on roll at his school while he attended the HOPE centre. The centre wrote to his school in June 2007, noting it was unlikely C would be able to return to mainstream school. It asked the school to arrange a review meeting to discuss his educational plans for Year 11 (2007/08). In July 2007 the HOPE centre wrote to the Council's Out of School Team asking whether it would provide some home tuition for C. There is no evidence of a reply from the Out of School Team at that time.
47. The HOPE centre day programme for C ended in October 2007 because of his continuing difficulties with other service users. C continued to attend Art Therapy sessions and to receive support from the HOPE community outreach team, including home visits to him and his mother. This provision continued until May 2009 (when C was discharged from the HOPE Service pending his move to the specialist residential school). C benefited from the sustained relationship with the art therapist during this period.

The Specialist Hospital

48. The Specialist Hospital is not part of the Surrey and Borders Partnership NHS Foundation Trust and is not covered by this complaint. It is referred to only for clarification.
49. After the Trust approved funding for the Specialist Hospital referral, C had his first appointment in November 2007. The Specialist Hospital completed its assessment in December 2007. The specialist psychiatrist said it was clear C had Asperger's Syndrome and it was difficult to understand why this disorder was not picked up earlier.
50. In a letter to Mrs D in December 2007 the Specialist Hospital wrote:
- "It is our view that appropriate educational provision for [C] would be provided by a residential school specialising in Asperger's syndrome/high functioning Autism. It is important that [C] should receive 24 hour consistency of approach in order to give him the structure and predictability he needs. Without such provision it is unlikely that [C] will be able to progress academically and socially and to find a productive and fulfilling niche in the world as an adult."*
51. The responsibility for arranging and funding residential educational placements lies with the Council's SEN Team (see paragraph 89 below).
52. A specialist psychologist and her team provided six therapeutic sessions for C at the specialist hospital, the last on 23 April 2008. During 2008 the specialist hospital supported Mrs D with her application for a SEN statement for C.

Education's Out of School Team

53. The Education Act 1996 (S.19) says that if a child of compulsory school age (between 5 and 16 years old) cannot attend school for reasons of illness, exclusion from school or otherwise, the local authority must make arrangements to provide 'suitable education'. In September 2011, after the period covered by this investigation, this law

was amended so that the duty was then to provide full-time education.

54. 'Access to Education for Children and Young People with Medical Needs' was issued by the Department for Education and Skills in 2001. It sets out guidance on the minimum national standards for education of children who are unable to attend school because of medical needs. It advised that:
- pupils of compulsory school age are not at home without access to education for more than 15 working days
 - pupils who have an illness/diagnosis which indicates prolonged or recurring periods of absence from school, whether at home or in hospital, have access to education so far as possible, from day one
 - pupils receive an education of similar quality to that available in school, including a broad and balanced curriculum
 - pupils educated at home receive a minimum entitlement of five hours teaching per week; this is a minimum and should be increased where necessary to enable a pupil to keep up with their studies, particularly important when a pupil is approaching public examinations.
55. The Council's Education Department was involved through the Alternative Education Team in January 2007 when C was refusing to return to school. C began attending the HOPE centre in April where he was receiving an education programme so the Alternative Education Team did not make any provision for him at that time. The HOPE Centre wrote to the Council's Out of School Team in July 2007 and asked if it could provide some home tuition for C. There is no record of a reply to this letter and the Out of School Team did not make any provision at that time.
56. A representative from the Out of School Team attended the first network meeting held in September 2007. The Children's Services team representative advised the Out of School Team 'to put C's case on hold' pending a risk assessment. This risk assessment by Children's Services was completed six weeks later (November 2007) and concluded that C was unlikely to pose any risk to his tutor.
57. C's programme at the HOPE centre had ended in October 2007. From November 2007 the Out of School Team provided C with five hours per week of one-to-one tuition at his home. The Tutor prepared him for English Language and English Literature exams to be taken in June 2008. C could not sit the Maths GCSE exam because he could not complete enough course work in the time available. He did not take any other GCSE examinations at that time.
58. C achieved good grades in the exams he took. He did not miss any of the one-to-one sessions and was never late. His tutor said that he had a hunger for knowledge and would benefit from and appreciate further education.
59. The Council did not normally provide one-to-one tutoring after GCSE exams had been taken but the Council agreed to continue funding the sessions for C to the end of term

in July 2008. Children's Services agreed to fund an additional hour per week of one-to-one tutoring for C from May 2008 until the end of term.

60. C had his 16th birthday in February 2008 and so reached statutory school leaving age at the end of the spring term. At that time the Council had the power to provide education after compulsory school leaving age. The duty to do so was not introduced until the Education Act 2010. The Council did not consider making out-of-school provision after July 2008 as C had reached school leaving age and he received no education between July 2008 and May 2009 when his specialist boarding placement began.
61. The education officer told our investigators that five hours per week was the amount of one-to-one tuition usually provided. And that the Council did not normally provide one-to-one tuition past compulsory school leaving age. The initial referral of C in January 2007 from C's school gave the reason for referral as "will not attend school". A referral from CAMHS had noted "cannot attend school". C was on the roll with the Out of School Team from 7 November 2007 to 23 July 2008. Mrs D's correspondence with the school shows he had experienced bullying and this was the reason he would not attend.

Social Care

62. The Children's Act 1989 sets out councils' duties to safeguard children and provide for children in need. A child is 'in need' if he is unlikely to achieve or maintain a reasonable standard of health or development without the provision of services by the local authority or if he is disabled. A child is considered disabled if he or she suffers from a substantial and permanent physical or mental disorder.
63. Children's Services received the first referral for C in June 2007. The case was allocated to a social worker from the Child in Need team. The Council has explained that it did not refer C to the Children with Disabilities Team because that team dealt with children who had severe learning or physical disabilities.
64. The social worker visited C and Mrs D in July 2007 and should have begun a core assessment of C's needs but did not do so.
65. The multi-agency meeting in September 2007 agreed that a core assessment should be carried out jointly by Children's Services and the care co-ordinator from HOPE services. The case was re-allocated to a locum social worker who visited C and Mrs D but did not do the core assessment.
66. The locum social worker left the Council in early 2008 and C's case was not reallocated. At about the same time the HOPE social worker and the CAMHS psychiatrist also left. The Out of School Team leader noted "Mrs D is struggling to cope and C is clearly distressed". The Children's Team decided not to reallocate the case to a social worker after the Education Department was asked to begin the

statementing process in December 2007.

67. The Specialist Hospital made representations to the Children's Team about the lack of a social worker and C's case was allocated to another social worker in June 2008. He completed the core assessment in July 2008.
68. The core assessment report was sent to Mrs D in September 2008. In a lengthy report it described C's background and behavioural problems. In summing up it said:

"Consistent with his Asperger's Syndrome and suspected Obsessive Compulsive Disorder, [C's] behaviour towards his peers in school and his mother at home has been described as provocative, confrontational and aggressive. His challenging behaviours have made it difficult for social interaction. Without many age-appropriate friends, [C] seems socially isolated and he usually spends much time at home being idle, causing his mother to be at his mercy for longer periods. The resultant lack of structure and activities in his life has in turn increased his tendency to remain in the house ritualising and often persecuting his mother.

From mother's account it sounds as if [C's] father displayed mentally and physically abusive behaviours toward C and his mother. However [C] himself has been engaging in behaviours that, if they escalate, could represent significant risk to both people and property, including kicking his mother, pushing his grandmother and setting a fire. It is clear that his mother is very frightened of [C] and fears that he may resort to violence in the same way as his father. He is verbally abusive towards her and very vindictive ... His mother admitted that he "rules the household" and she is fearful to leave him alone for any length of time because of his risky behaviours. It is difficult to know how much of [C's] increasingly destructive and violent behaviour towards his mother relates to his intrinsic lack of empathy and social understanding and how much is based on the only male role model he has known. The situation at home is clearly fragile and places both [C] and his mother at serious risk if they remain unsupported.

Academically too [C] is in danger of falling so far behind his peers that, despite his high intellectual ability it will eventually be very difficult for him to catch up. Although [C] has recently been statemented to receive specialised education, his mother is concerned that he may refuse to attend a unit that caters for a wide range of disabilities because of his long standing negative attitudes towards disabilities. [C] is very verbally able and has, to some extent, learnt a degree of social interaction which much of the time disguises his intrinsic difficulties. This could be the reason why his Special Educational Needs were picked up late. As per the CAMHS assessment of [C], it is also evident that when he was younger and mixing with younger children his eccentricities were much better tolerated. However since transfer to secondary school the gap between him and his peers has clearly become much more evident and more distressing, this ultimately resulting in [C] falling out with his peers and refusing to attend school. His confrontational and obsessive behaviour was putting him at risk of being bullied and harmed by other peers at school and he ended being out of education."

69. Mrs D says the core assessment report totally understated the seriousness of C's problems. It did not reflect the extreme nature of his behaviour or its impact on her and on their home. For example:
- he would threaten her if she spoke to him about playing loud music in the early hours of the morning, used foul language, calling her offensive names, telling her she was pathetic, not worthy of living and worthless;
 - he would shout at her during the night or bounce on her bed if he wanted her to talk or to change his bed because he hadn't seen her wash her hands before she changed it earlier in the day;
 - he twisted her arm, stamped on her toe just to hurt her;
 - he shut her in rooms or out of the house altogether;
 - he spat, urinated and defecated around the house and soiled his clothes and carpets;
 - he had obsessions about washing and would not touch door handles without a paper towel which he would then discard on the floor;
 - he used excessive amounts of soap, shampoo and shower gel, sometimes flooding the bathroom, being in the shower for an hour at a time, sometimes three or four times a day; and
 - he left sodden towels and clothes lying around.
70. Mrs D said that the report misrepresented her situation as it did not make clear she had been unable, since 2007, to continue her job as a lunch time supervisor because of her extreme stress related illness.
71. Mrs D wrote to the social worker in October 2008 that the core assessment report was inaccurate and misrepresented the problems. He replied on 17 October 2008 explaining it was only a draft and had been sent to her so that she could comment on it. He asked her to make clear where she believed the report was inaccurate. The Council says Mrs D did not respond to this letter and the report was not amended. Mrs D returned her copy of the core assessment to the Council unsigned.
72. The core assessment recommended:
- an appropriate SEN placement for high-functioning pupils with Asperger's syndrome (it referred to a specific school recommended by CAMHS);
 - the level of risk from C's behaviour to be monitored by local social services and police until he began the SEN placement;
 - HOPE services to continue working with C pending his SEN placement;
 - Agencies to identify social activities for C to attend, to reduce his social isolation and idleness;
 - to consider a referral for C to a domestic violence group for young people;
 - when appropriate, Children's Services to monitor contact arrangements between C and his father;
 - the Connexions worker to continue working with C; and

- the out-of-school tutor to continue working with C two days a week until the end of the school term.
73. In October 2008 Children's Services allocated the case to a family support worker. Mrs D was unhappy the allocation was not to a social worker. The family support worker told our investigators she believed the case was given to her because it did not have sufficient priority for allocation to a social worker.
 74. The family support worker visited Mrs D on 19 January 2009. Because of her workload and only working two days a week she had not been able to visit earlier. During the visit she explained to Mrs D about the carer's assessment. Children's Services expected a maximum six month involvement by the family support worker.
 75. The family support worker told our investigators that she made referrals to a project for young people with Asperger's and to Crossroads (a carer support agency). She said that in February 2009 she made a telephone call to home care services to ask about support for Mrs D. There is no record on file of these referrals. Mrs D says they heard nothing about them and no services were provided as a result of referrals. The family support worker said she was not sure what happened but thinks C and Mrs D did not take up services offered. The Children's Services files hold no record of any reviews of the core assessment or the provision recommended.
 76. The family support worker left the Council in September 2009 and the case was not reallocated to any other worker.
 77. C began attending the specialist residential school in May 2009. Mrs D says that his behaviour improved as a result, but that when he returned home for the holidays the same problems recurred and she found it extremely difficult to cope. She says she asked Children's Services to provide activities for him while he was at home but nothing was done about this.

Connexions Service

78. The Council is responsible for the Connexions service which supports young people in career and personal development. It provides information, advice, counselling, personal development opportunities and referral to specialist services. Young people with learning difficulties and/or disabilities are a particular priority for Connexions who should work closely with the other agencies involved. Connexions appoint a personal adviser to work with each young person taking up its services.
79. C had his first appointment with a personal adviser in February 2006 when he was 14. The personal adviser drew up an action plan with him, which noted his interest in studying medicine or psychiatry or setting up his own business. C's personal adviser regularly communicated with education and social care and with Mrs D and made suggestions for finding work or activities during the holidays. She offered appointments to C to visit at her office. Connexions considered a referral for C to an

outdoor education and pursuits course but it was not suitable for him.

80. At an annual review in July 2008 the Connexions personal adviser agreed to ask Social Services about funding for a school placement that had been suggested to C. This placement would require a SEN statement.
81. After C began attending the specialist residential school the personal advisor contacted the Connexions service at the residential placement. They confirmed that C was doing well and exploring options for after school.
82. Connexions drew up C's 'moving on' plan in December 2010. It said C:
 - was a very motivated and determined person, enthusiastic about his studies with an excellent attendance record;
 - avoids social situations in which he feels uncomfortable and needed on-going help to develop confidence and self reliance to address this; and
 - had been developing good domestic task skills at the residential school and would need ongoing therapy to help develop strategies for adapting to a new environment.
83. In early 2011 C applied for a university place. At the request of the residential school the personal advisor contacted Mrs D to offer support with C's student finance application. She gave some initial advice as applications could only be made from April. She told Mrs D to call when she needed further help, which she did and support was provided.

Youth Justice Team

84. Youth Justice Teams are established to prevent offending by children and young people (aged 10-17 years). They are multi-agency teams including a probation officer, a police officer and representatives of health, education and social care services.
85. In June 2007 C set fire to a wheelie bin which badly damaged his home and a neighbouring property. The Out of School Team referred C to the Youth Justice Team in October 2007, because they believed C needed a strong male role model. The Youth Justice Team identified a low to medium risk of C offending. A youth justice officer met C for intervention sessions on 19 occasions over the following eight months.
86. At the end of 2007 the youth justice officer reported to the CAMHS psychiatrist that he was concerned about Mrs D's mental health. He said he planned to take C on 'social engagements'. The Youth Justice Team closed the case in September 2008 having completed the planned programme of work with C without significant improvement. The closing statement said:
 - C appeared to be bitter about not taking all his GCSEs and seemed to take it out on Mrs D;
 - the risk of vulnerability and serious harm to C and others was still there;

- because of C's Asperger's it was difficult to adhere to an intervention plan in a conventional way; and
- the main change C needed in his life was specialist education and care for his Asperger's.

Special Educational Needs

87. Part IV of the Education Act 1996 (the Act) makes provision for the education of children with special educational needs. A child has special educational needs if they have a learning difficulty which calls for special educational provision to be made for them. It requires councils to have regard to the Code of Practice on Special Educational Needs in carrying out assessments. The Act also defines the rights of parents to appeal against decisions not to undertake an assessment of special educational needs and on the content of a SEN statement. Appeals are to the Special Educational Needs and Disability Tribunal (SENDIST).
88. The Code in operation in 2008 said the Council must decide within six weeks of a referral whether or not to carry out an assessment. The time limit for carrying out the assessment from referral to issue of a SEN statement should normally be no more than 26 weeks. The Code specified that in carrying out the assessment the local education authority must seek parental, educational, medical, psychological and social services advice. They must also seek any other advice they consider appropriate.
89. Mrs D applied to the SEN Team requesting an Assessment of C's special educational needs following a network meeting in December 2007. The Council says that this was the first referral to the SEN Team for C. In accordance with standard procedure the request was referred to the SEN Panel (the Panel) which met on January 2008. The Panel decided it was not appropriate to assess C's special educational needs at that time. Mrs D appealed against that decision. The Tribunal heard the appeal in June 2008 and ordered the Council to undertake an assessment.
90. The Council carried out the Assessment in accordance with the Code and issued a SEN statement in September 2008. The SEN statement said C needed increased access to tutoring at home and a placement in an educational setting with planned integration into mainstream further education. It did not specify the school which C was to attend. Mrs D had wanted C to attend a specialist college and the Council agreed funding but the college was due to close in July 2009 so this placement was not pursued.
91. In October 2008 Mrs D appealed to SENDIST against the content of the SEN statement. The appeal was not heard by the Tribunal because in April 2009 the Council agreed funding for a placement at a specialist boarding school.
92. C attended the specialist boarding school until July 2011 and achieved two A-levels. He was offered a place at Oxford Brookes University. He did not take up the place because he did not feel able to cope and wanted to pursue therapy for the psychological disturbances he had been experiencing.

The Council's Transitions Team

93. Young people can cease to be eligible for services once they turn 18. Children's Services and Adult Services should plan for the transition to minimise the impact on the young person. The Council's Transitions Team supports the young person in working with other professionals to achieve this. Guidance makes clear that the Council should plan for transition from children's to adult's services from age 14.
94. Until recently it was the Council's normal procedure to refer children to the Transitions Team when they reached 18. In February 2010, when C turned 18, the Transitions Team wrote to Mrs D offering an assessment of C's needs. Mrs D was upset that the letter in places referred to C by the wrong name. She felt this echoed the lack of engagement with C's case from Children's Services. Children's Services wrote to Mrs D shortly after that they were closing C's case (because he had turned 18) and had referred the case to the Transitions Team.
95. Adult Social Care Services carried out a telephone assessment of C's needs which established that C was not eligible for services. His needs were assessed as moderate. At that time the Council was only funding clients with substantial or critical needs level.
96. In June 2010 Mrs D asked the Specialist Hospital to contact the Transitions Team. The Specialist Hospital sent a note addressed 'To whom it may concern'. The note described some of C's extreme behaviours and said that since attending the residential school C had become increasingly easier to accommodate during his visits home but that his behaviour could easily revert during a home visit. It recommended essential support for C during the summer holidays, to include support workers with experience and expertise in working with Asperger's. The Specialist Hospital also recommended support at home so that Mrs D could go out for 'desperately needed' respite as she felt unable to leave C at home alone even though he was 18 years old, because of his extreme behaviour.
97. Mrs D wrote to the Transitions Team in September. She had heard nothing further about an assessment by the Transitions Team begun in June 2010 and she had understood that support was to be provided for C for the holidays.
98. In October 2010 the Transitions Team wrote to C's GP that he was not eligible for services for people with learning disabilities. It noted the psychologist had said C has a tendency to sabotage his relationships and would need ongoing therapeutic support.

Developments after February 2011

99. Mrs D believes that if she and C had received better support from the agencies involved and if the recommended therapeutic support had been provided some of the problems experienced after C left the specialist school might have been avoided and C

would have adapted better to living independently in the community.

100. Mrs D appealed against the Council's decision that C was not eligible for adult services and in April 2011 he was re-assessed. He was found to be eligible for services and the Transitions Team was tasked with completing a comprehensive assessment. C was very anxious about leaving the residential school in July 2011 and sent his mother texts of suicidal thoughts. The School strongly recommended that he be referred to his GP for an assessment of his mental health.
101. Mrs D could not cope with C's behaviour or with caring for him so when C left college in July 2011, he did not return to live at home. He moved to a Council funded supported living placement. The accommodation was about 60 miles from the family home. Mrs D says it was an emergency and temporary solution as, despite her many requests, the social worker did not make any arrangements in advance.
102. In September 2011 C decided to defer going to university because he felt drained with the effort of taking two A-levels in one year and wanted to pursue therapy before moving to a new and uncertain environment. Mrs D says C's social worker said she would arrange a supported living placement at university if C could not cope with living in halls of residence. But when C asked for this to be arranged the social worker said it would not be possible.

Provision for Mrs D

103. Mrs D has received counselling through her GP surgery since 2006.
104. In 1997 Mrs D had begun to work part time as a school lunch time supervisor. She enjoyed this job and valued the sense of emotional well-being as well as the financial reward it gave her. She described it as her 'sanctuary'. After C refused to return to school in 2007 she found it increasingly difficult to look after him. She felt anxious about leaving him home alone because of his extreme behaviour. From June 2007 she could not work because she was suffering severe stress-related illnesses. She subsequently had to give up her job.
105. The HOPE outreach service made several home visits to Mrs D during the autumn of 2007.
106. In June 2007 the Council's social worker referred Mrs D to a service for women affected by Domestic Violence. She attended 10 sessions and found this helpful.
107. The CAMHS social worker suggested to Mrs D that she take up the next stage of counselling which had been offered by the counsellor who Mrs D had seen at the GP surgery. The CAMHS social worker reported at a network meeting in October 2007 that Mrs D said there was a long waiting list for this and she would think about it. In January 2008 the locum psychiatrist also suggested to Mrs D that she take up the

further counselling from the GP surgery. There is no evidence that Mrs D attended any such further counselling. During 2008 the third CAMHS Psychiatrist held five sessions with Mrs D which included counselling and advice on behavioural management, encouraging her to adopt a firmer approach to C.

108. The Carer's (Recognition and Services) Act 1995 says that if a carer requests an assessment the council must assess the carer's ability to continue caring before it makes a decision on whether the cared for person needs services. Social Services are legally obliged to let a carer know of their right to ask for an assessment.
109. Mrs D says that in April 2008 the specialist hospital asked social services to carry out a carer's assessment. The Council has no record of this request.
110. Mrs D was not advised of her right to ask for a carer's assessment until January 2009. At that time the family support worker explained the process and how carer vouchers were assessed. The Council's records show that a carer's assessment was completed in February 2009 but it has not been able to provide a copy of the assessment so we do not know what provision [if any] was recommended. The Council did not make any provision to support Mrs D in caring for C or to address the dangers identified in the core assessment completed in July 2008.

Complaints made by Mrs D

The Trust

111. During early 2009 Mrs D complained to CAMHS about the decision not to provide the home based therapy recommended by the specialist hospital. In April 2009 she complained that there had been no direct contact between CAMHS and C since June 2008 and that there had been no network meetings since his SEN statement had been issued in September 2008. She felt the network meetings had achieved very little except some education and that neither C nor herself were central to the case because the latest network meeting had been arranged without any consideration of whether they would be available.
112. The Trust responded in June 2009 acknowledging an unacceptable failure in communications with her, attributing this mainly to the number of key staff remaining who left their positions between 2007 and 2009. It offered unreserved apologies for this failure.
113. Mrs D was not satisfied and pursued the complaint through the Trust's formal complaints procedure. The Trust arranged an independent review of the care provided for C. Mrs D wrote to the Trust on 4 June 2009 detailing her concerns about lack of service provision since 2007 but this letter was not taken into account in the review. This review did not identify any failures in the care provided for C.

114. Mrs D submitted her complaint to the Health Service Ombudsman. The Trust offered compensation of £200 because of a serious failure during the investigation of her complaint, which had not taken account of her letter of 4 June 2009. The Health Service Ombudsman initially decided not to investigate her complaint. However, Mrs D did not consider the compensation offered adequate or that failures in service had been recognised. She made representations and the Health Service Ombudsman subsequently agreed to investigate the period January 2007 to February 2011, in conjunction with the investigation of the complaint against the Council.

The Council

115. In June 2008 Mrs D complained about the Council's Social Care Services. In accordance with the statutory complaints procedure the complaint was investigated by an independent investigator at Stage 2 of the procedure. The investigator's report stated that Mrs D wished to complain about the inadequacy of services provided for her son and herself from the time they were first requested in 2007. The report identified 13 specific heads of complaint. At Stage 3 of the complaint procedure in July 2009 the Council's response to the complaint was reviewed by an independent Panel. The Panel accepted much of the Council's response which upheld or partly upheld complaints that:

- C had had four different social workers since autumn of 2007;
- Mrs D found letters from the Social Care Team leader patronizing and offensive;
- the Social Care team had not acknowledged the impact of its failures on C and herself;
- the Social Care Team Leader had used the wrong name in a letter about her son;
- the Social Care Team Leader had misrepresented the request for a SEN statement for C, which Mrs D had requested herself;
- there was unacceptable delay in starting the core assessment of C's needs;
- the Social Care Team failed to inform Mrs D that it would be sharing the core assessment with the SEN Team preparing C's SEN statement;
- the social worker in June 2008 promised to arrange summer activities for C but failed to do so;
- CAMHS and the Specialist Hospital requested a carer's assessment in April 2008 but she did not receive the draft assessment until March 2009; and
- C's current social worker delayed sending details of a group for young people with Asperger's as she had promised.

116. The Panel was unable to reach a conclusion on the complaints that:

- social workers had frequently missed appointments or been very late in arriving; and
- the core assessment Mrs D received in September 2008 was inaccurate and misleading.

117. The Panel noted the Children's Team had offered to meet Mrs D with a view to discussing her concerns about the core assessment and encouraged Mrs D to accept the offer as soon as possible.

118. The Panel did not uphold a complaint that the Children's Team had not allocated a social worker despite written requests from CAMHS and the Specialist Hospital. The Panel said the central themes around the complaint were poor communication and poor record keeping which, together with rapid turnover of staff, compounded the negative impact on C and Mrs D. The Panel did not make a general finding about the adequacy or otherwise of the services provided for C and Mrs D.

119. In July 2009 the Panel recommended:

- a meeting be arranged for Mrs D with the family support worker and a representative from the SEN Team to discuss arrangements to support C's immediate and short term needs;
- the Children's Team and the Transitions Team undertake early discussions; and
- the Council carefully consider the award of compensation in respect of time, trouble and distress suffered by C and Mrs D in the light of the acknowledged failings of the service.

120. Mrs D considered the Council's offer of £750 unacceptable and that the impact of failures in service had still not been recognised. She pursued the complaint with the Local Government Ombudsman. The Council then agreed to offer compensation of £1,500 for the delay in completing the core assessment. Mrs D contacted the Local Government Ombudsman again, saying she believed the devastating consequences of the failings in the Council's service had been minimised by the Ombudsmen's decisions to investigate separately. The joint investigation was then agreed.

Clinical Advice

121. A full copy of the clinical advice we have relied on in making our findings about the Trust is attached as Annex A.

Changes to procedures

122. During the investigation changes have been made to the Council procedures:

- the Transitions Team now works with children from age fourteen and into adulthood;
- following a referral CAMHS and social services hold a consultation meeting;
- there are now formal links with joint commissioning, and health and social services are able to develop joint packages; and
- staff are trained in autism and an Autism Champion has been appointed.

Conclusions

123. In reaching our findings on Mrs D's complaints we have taken account of the Ombudsman's Principle of Good Administration – 'Getting it right' – which includes that public organisations must act in accordance with recognised quality standards, established good practice, or both, for example about clinical care. We have also taken account of the clinical advice received on established good practice (Annex A). In order to get it right the Trust and Council should have acted in line with the DH guidance on transition and the need for people with autism to have contact and support from a single 'trusted adult' (paragraph 19); and the transition guidance in the National Service Framework for Mental Health (paragraph 21).
124. Both the Trust and the Council have recognised and apologised for failings during their own consideration of Mrs D's complaints. Some compensation has been offered. However C and Mrs D continue to feel aggrieved and believe that the inadequacy of the services and support for them has not been recognised or addressed in any way. This investigation has considered particularly whether additional services and support should have been provided for them and whether any lack of services or support was the result of fault by the Council or service failure by the Trust.

Provision for C

CAMHS

125. The first matter we have considered is whether the services provided by the Trust were sufficient to meet C's behavioural and special health needs in the period January 2007 to February 2011.
126. Our Adviser said the first CAMHS Psychiatrist followed the applicable guidance in that he took a joined up approach to the management of C's needs that included medication, psychological and educational measures and referral to a tertiary service. He said that C's presentation was complex and it was reasonable for there to be a period of observation following the initial diagnosis. The Adviser said there was a reasonable period of time (18 months) for this observation and continued intensive support. He said the referral to the specialist hospital for further diagnosis and management in August 2007 was appropriate when it became clear that the management plan was not progressing sufficiently. As such, we conclude that the timing and decision to refer C to the specialist hospital was reasonable and in line with established good practice.
127. We now turn to the continuity and provision of care by CAMHS once the referral to the specialist hospital had been made. From the clinical advice received, it is clear that CAMHS should have had a continuing role in C's case. This should have included monitoring his psychotropic medication for its effectiveness and possible side effects; and co-ordinating the behavioural and educational interventions that were recommended for C.
128. The Adviser said that CAMHS appropriately supported the educational measures suggested for C, for example by attending (or providing reports for) the multi-agency

network meetings. However, he noted some significant gaps in the CAMHS psychiatry input - between October 2007 and February 2008 and again in early 2009 – during which time there was no monitoring of C’s medication as there should have been.

129. The Trust acknowledged a lack of communication with Mrs D and C, but there was also a failure to provide any continuity of contact with their service while C was being assessed at the specialist hospital. The Adviser said that personal continuity of care was an important aim when managing C’s care, particularly as he had an ASD. The Adviser said such contact could have been provided by a psychiatrist or by a key worker / care co-ordinator, who would assist Mrs D by guiding her through all the services and interventions on offer, and would be a single ‘trusted adult’ contact for C, as recommended by the DH guidance (paragraph 19).
130. The HOPE art therapist was a constant and helpful presence for C. By default she perhaps fulfilled the function of the single trusted adult, but it was not her role to co-ordinate the rest of C’s care. It seems that there was no one single contact for C and Mrs D. There was a large number of professionals involved in C’s care, and several of these individuals within CAMHS and HOPE, including social workers, were called care co-ordinators or key workers. So, while care co-ordination was a recognised aim, it is not clear how it was to be achieved in the circumstances. The main point of having one individual acting in that role is the continuity of contact and for that person to have an overall understanding of the different strands of care and input that need co-ordinating. This was especially important when there were frequent staff changes from September 2007 onwards.
131. CAMHS was the first agency involved with C in a substantial way. It should have maintained the lead in co-ordinating services unless and until a clear decision was made that another agency should take the lead. Although there was discussion at network meetings, in particular in January and February 2008, about whether C’s needs were primarily mental health, social or educational, no clear decision was made about which should be the lead agency. Network meetings were the primary method of co-ordinating the different agencies involved and should have recorded this important decision. CAMHS should have taken a lead on care co-ordination but failed to do so.
132. In December 2008 the specialist hospital recommended home based behavioural psychological therapy for C. The Trust said they did not have the resources to provide this. What national guidance there was on services for people with ASDs at that time (see paragraph 19) did not specify that certain types of intervention must be made available, and so there is nothing to say that it was mandatory for the Trust to provide this therapy. In the Trust’s review of Mrs D’s complaint in October 2010, it said there were concerns about the risks of such psychological therapy in C’s case. But our Adviser found no contemporaneous records to demonstrate that this concern was discussed among professionals or conveyed to Mrs D at the time. As our Adviser said, more timely communication of this decision may have been helpful. As it was, the CAMHS Psychologist appears to have had reservations about how effective such therapy would be for C (paragraph 39) and she suggested alternatives, such as the

HOPE Outreach service. CAMHS continued to support a placement at a residential school, and funding for this was approved by the Council in May 2009.

133. In line with the DH guidance (paragraph 19), from about the time when C was 14 there should have been plans being put in place for his transition from children's to adults' services, should they be required. The Trust should have had protocols for this, in accordance with the NSF standards (paragraph 21) and in line with the Royal College of Psychiatrists' recommendation as cited by our Adviser (Annex A). We have seen no evidence that the Trust had any such protocols, or that they acted to ensure that the transition process was effective for C. There was confusion about who was co-ordinating C's care, and the transition period was fragmented due to the frequent staff changes. In early 2008 there was also some debate between Council and Trust staff about who was leading in C's case: health or social services (paragraph 37). He was referred to the adult community mental health team in October 2010, when he was already too old to remain under CAMHS's care but did not meet the criteria for the adult mental health team. Our Adviser said this quite often happens despite patients having impaired everyday functioning.
134. In summary, the Trust got a lot of things right in providing care for C during the period in question. There was a reasonable period of time to evaluate the initial diagnosis and treatment plan before a referral to a tertiary provider for specialist assessment and further management was made. This referral was made within a reasonable timeframe. There was adequate and reasonable input into supporting C's ongoing educational requirements and valuable regular input by the HOPE service, particularly through the art therapy sessions. However, once the referral to the specialist hospital had been made, there was a failure by CAMHS to continue to provide support and co-ordination of C's care as they should have done in line with established good practice. This included failure to monitor C's psychotropic medication more regularly, failure to provide continuity of input through a keyworker, and failure to take the lead on care co-ordination. CAMHS also failed to communicate regularly with Mrs D about the course of C's ongoing management and failed to plan effectively for C's transition from children's services.
135. These failings, when taken together, fell so far below the applicable standards that they amounted to service failure.

Out of School provision

136. After C refused to return to school in January 2007 CAMHS took the lead in his care. The placement at the HOPE centre aimed primarily to address his behavioural problems and to aid his return to mainstream education. Therefore it was not unreasonable for the Education Department initially to leave it to the HOPE centre to make educational provision for C.
137. However, in July 2008 the HOPE centre advised the Out of School Team that some home tuition was required. In September 2007, when the first network meeting was held, it had been accepted that C would not be returning to mainstream education in

the near future. The provision of home tuition was initially delayed by the need to undertake a risk assessment. This was not unreasonable but, given the period of time for which C had been out of school, the six weeks taken by Children's Services to complete assessment was too long. C had been out of school since January 2007 and had not covered necessary GCSE coursework. The risk assessment should have been given higher priority so that home tuition could begin as soon as possible.

138. It had also been recognised that C had a high level of academic ability. Guidance issued in 2001 (see paragraph 54) makes clear that five hours home tuition per week was the minimum and should be increased to enable a pupil to keep up with studies, particularly where public examinations are approaching. C was due to sit GCSE examinations in July 2008. In those circumstances the Education Department should have considered providing more than the 'usual' five hours per week home tuition. C could not have made up all the ground lost since January 2007 in all his GCSE subjects. But he was capable of achieving more than was possible in the hours allocated and he wanted to do so. C was receiving other relevant support – from Connexions, from the Youth Justice Team and from his Art Therapy sessions. But the Council had a duty to provide 'suitable' education and, given C's recognised academic ability, the failure to consider additional provision for a wider range of academic work was maladministration.
139. At the relevant time the Council had the power, but not a duty, to provide post-16 education for children unable to attend school. However it did not consider whether to use its powers to provide post-16 home tuition for C after July 2008 when he reached the usual school leaving date. By then C was the subject of an SEN assessment and detailed consideration was being given to how to meet his continuing educational needs. It was clear that he was very capable academically and wanted to continue his education but he received no educational provision for almost nine months (September 2008-May 2009) when he could reasonably have expected to be in education. We cannot say that C was wrongly deprived of post-16 home tuition, because even if the Council had considered this option it might have decided quite legitimately that provision could not be funded. However, the failure to consider provision of post-16 home tuition pending the SEN placement was maladministration.
140. The time taken to arrange the specialist residential school placement for C was largely a function of the SEN procedures. As noted above, the decisions made by the Council during this process have not been part of this investigation because they were the subject of appeals to SENDIST. So we do not comment on them. We can say however that there was no undue delay by the Council in implementing the SEN procedures, as the timescales from the referral to the SEN Team and for the completion of the assessment to the issue of C's SEN statement complied with those set out in the Code of Practice.

Children's Services

141. When the locum social worker left in late 2007 Children's Services decided not to allocate C's case to another social worker. Children's Services believed C would be

supported through the SEN process, since in December 2007 Mrs D had requested an assessment of C's SEN. However, at that time the core assessment had not been completed, even though the first request was made in June 2007 and was repeated at the network meetings between September and December 2007. The HOPE social worker who had been supporting C left the service in early 2008 and Mrs D was experiencing substantial difficulties in coping with C's behaviour. It would have been evident that the SEN procedures would not produce any outcome for many months (even without the initial decision not to undertake an assessment). So Children's Services were at fault in deciding not to allocate the case to another social worker at that time. The decision was changed in June 2008, but C and Mrs D had experienced a lack of social work support, which they could reasonably have expected, for six months.

142. The Council has already recognised the unacceptable delay of over a year (June 2007-July 2008) by Children's Services in completing the core assessment of C's needs. There was also some delay (from July to September 2008) in sending the assessment report to Mrs D. The first recommendation in the core assessment was the provision of a specialist residential placement. The delay did not affect this provision since it was dictated by the SEN Team and was in the process of being considered from December 2007. However, the core assessment did recognise that "The situation at home is clearly fragile and places both [C] and his mother at serious risk if they remain unsupported." The situation at home was not significantly different in July 2007 when the core assessment should have been completed. At that time a specialist residential placement was not considered. It is probable therefore that a need for specific provision to assist Mrs D care for C at home would have been accepted. We cannot say now what that provision would have been but C and Mrs D reasonably believe that their lives would have been very much easier if they had received some specific support from mid-2007 until May 2009 when C moved to his residential placement.
143. Mrs D contends that not only was the core assessment delayed, but that it was inadequate and failed to recognise the severity of C's condition or the impact on them and their home. It did not describe all the extreme examples of C's obsessive and abusive behaviour which Mrs D felt very strongly were necessary for a proper understanding of their situation. The core assessment report did not mention that C had been in receipt of Disability Living Allowance, so had been recognised as suffering from a disability, since 2007.
144. The Council confirmed in October 2008 that the report could be amended if Mrs D explained where she felt it was inaccurate. Mrs D did not respond to the invitation to provide comments on the report. At that time she was dealing with the appeal against the SEN statement and had begun to pursue her complaint through the social services complaints procedures.
145. That said however, the core assessment report did recognise that both C and Mrs D were vulnerable. It clearly recognised that C and Mrs D faced severe problems because of his obsessive and abusive behaviour. The report did identify the principal issues and was not incorrect, and Mrs D was offered the opportunity to amend it. So

we do not find maladministration in the content of the core assessment report.

146. There were a number of recommendations made in the core assessment (see paragraph 72), most of which were implemented to some degree. However, the important recommendation for agencies to arrange social activities for C was not. Such services might have made a very real difference for C and Mrs D. While he was living at home and when he returned for holidays C did not have specific activities arranged outside the home and Mrs D had to cope with his behaviours without this respite. Her requests for activities to be arranged while he was home from school were not met which meant there was nothing in place to reinforce progress made at school. This was maladministration.

The Transitions Team

147. Guidance issued in 2006 (paragraph 19) was clear that councils should have arrangements in place for transition between children's and adult services from the age of 14. C was already 15 years old when Children's Services first agreed to carry out a core assessment in 2007. Involvement of the Transitions Team at that stage should have been considered. However the Council's procedures at that time did not follow the guidance so C was already 18 before the Team was involved. This was maladministration.
148. The Transitions Team began an assessment in June 2010 but had not completed this before September 2010 when Mrs D wrote to ask what was happening. This delay was also maladministration.
149. Adult Services decided that C's needs were not substantial or critical so that it could not make provision for him from resources available at that time. This was a decision the Council was entitled to make and we do not criticise it. The decision was confirmed to C's GP in October 2010. Following a review, in April 2011 Adult Services did find C eligible for Adult Service provision, but this does not mean the earlier decision was wrong on the evidence available at that time.
150. C was 18 in February 2010 but was not accepted as being eligible for Adult Services until April 2011. If he had been referred to the Transitions Team in accordance with the guidance the uncertainty about his eligibility could have been resolved before he ceased to be eligible for children's services and the gap in services could have been avoided. This might have ensured that C received specific provision during holidays when he was home from school and more advanced planning of what would happen to him after he finished school. C and Mrs D might not have endured the extended period of uncertainty until he was placed in supported living accommodation in September 2011. This might have enabled him to plan more effectively to take up the offer of a university place.

Provision for Mrs D

151. We have considered whether the services provided by the Trust were sufficient to meet Mrs D's needs and support her caring role in the period from January 2007 to February 2011.

CAMHS

152. The National Service Framework for Children, Young People and Maternity Services recognises the need to support parents and carers of young people with mental health needs or long-term conditions and direct them to appropriate local services.
153. The Adviser noted that when the domestic situation worsened in May 2007 Mrs D received input from various sources within the Trust. This included practical support and advice from CAMHS psychiatrists; meetings with them specifically to discuss her own mental health needs; some counselling sessions with the third CAMHS Psychiatrist; and outreach support from the CAMHS social worker. CAMHS also supported Mrs D's requests relating to C's educational needs. There is no evidence that Mrs D attended any further counselling from the GP surgery counsellor. On seeing the draft report Mrs D told us she would not have turned down any further counselling had it been offered. However, this was not something that was offered by CAMHS. Given the level of input outlined above, the Adviser said the support provided to Mrs D by CAMHS was reasonable.
154. Taking account of the advice received, we conclude that the Trust provided adequate services to meet Mrs D's needs and support her care role in the period January 2007 to February 2011. We have already commented on the adverse impact on Mrs D from the service failure identified in the Trust's provision of care for C. While it is clear that Mrs D was adversely affected by her son's behavioural problems, we are satisfied that the Trust provided reasonable input for her in as far as it was appropriate for a parent of a patient of their service. Therefore, we do not find service failure in this aspect of Mrs D's complaint.

Children's Services

155. The Council failed to inform Mrs D of her right to a carer's assessment when the core assessment was first proposed. The evidence is not clear on Mrs D's understanding that the Specialist Hospital requested a carer's assessment in April 2008. But the Council should have recognised from July 2007 when the core assessment for C was first requested, that a carer's assessment should have been offered. The failure to offer the carer's assessment until January 2009 was maladministration.
156. We have identified above the failure to allocate a social worker for C between January and June 2008 and the resulting lack of support for Mrs D. However, we have not seen specific evidence that the delay in completing the carer's assessment deprived Mrs D of services which she would have received but for the delay. Mrs D has not raised any specific concerns about the document. However, given the content of the

core assessment we consider it likely that some provision would have been agreed had a carer's assessment been completed in mid-2007 as it should have been.

157. The lack of a carer's assessment for an extended period contributed to the anxiety and distress Mrs D was suffering. She might have felt more reassured that her needs had been considered even if it was not possible to offer the level of support she hoped for.
158. Mrs D was unable to work from June 2007 onwards because of stress-related illness and because she was concerned about leaving C at home alone. The loss of her job was a cause of great distress to her but it was not the result of failures identified in this investigation. In June 2007 CAMHS was still working with C and offering therapeutic support through the HOPE service. The failures identified in this report largely occurred after that time. Given the seriousness of C's Asperger's and its impact on Mrs D, we could not conclude that, but for the failures identified, she would have been sufficiently stress-free to enable a return to work.

Summary of Findings

159. CAMHS got a lot right in the services they provided for C and Mrs D. However they failed:

- to monitor C's psychotropic medication regularly;
- to provide continuity of input through a keyworker;
- to take the lead on care co-ordination;
- to communicate regularly with Mrs D about the course of C's case management; and
- to plan effectively for C's transition from Children's Services.

160. Education failed:

- to provide an appropriate amount of home tuition to help C prepare for GCSE examinations; and
- to consider continued provision of home tuition after July 2008.

161. Children's Services failed:

- to undertake a risk assessment with appropriate urgency;
- to allocate a social worker for a significant period;
- to complete the core assessment in a reasonable time;
- to arrange the social activities for C recommended in the core assessment;
- to refer C to the Transitions Team in accordance in accordance with statutory guidance;
- to advise Mrs D of the availability of a carer's assessment; and
- to complete the carer's assessment within a reasonable time.

162. These failures resulted in injustice to C and Mrs D because:

- they both suffered avoidable anxiety and distress;
- C was unable to take as many GCSE examinations as he could have and was out of education altogether for an extended period;
- C did not benefit from social activities which had been identified as necessary in the core assessment or from other provision which might well have been recommended had the core assessment not been delayed;
- Mrs D did not benefit from respite afforded by social activities for C or from specific provision which might have been recommended had the carer's assessment not been delayed; and
- they will always feel that their circumstances would have been better if there had been no failures in services provided.

The injustice suffered

163. We have identified a number of failures in the services provided by the Trust and the Council for C and Mrs D. The evidence does not support a conclusion that C's mental health, development or general well being would now be better but for these failures. So we cannot say that there would have been a better outcome for C but for the failings by the Trust and the Council. Also we cannot say that C suffered any specific harm from the failure to monitor his psychotropic medication more regularly. Nor can we say that his relationship with his mother would be better or that he would have been equipped to live at home rather than in a supported placement. But their understandable feeling that things might have been better is in itself an injustice.
164. Better communication with Mrs D and better co-ordination of services with a single point of contact would have lessened the difficulty for Mrs D in pursuing services for her son and reduced anxiety and distress. This was particularly evident in early 2008 when key members of staff from CAMHS and the HOPE service were leaving and the Council had not allocated a social worker.
165. We cannot say that a single point of contact would have meant that more and better services were provided for C and Mrs D. But it might have reduced uncertainty and given Mrs D more confidence that their needs were being considered.
166. C fell a long way behind in his education while he was out of school. It was clearly very upsetting for him and for his mother that he did not obtain the number of GCSEs he was capable of achieving. For a lengthy period he did not benefit from the mental stimulation of education. This is a clear injustice. Fortunately the specialist residential placement enabled him to make up ground so that he achieved sufficiently good A-levels for a place at university.
167. With earlier planning the uncertainty about how to support C after leaving school and his eligibility for adult services would probably have been avoided. He might have achieved a smoother transition to living independently as an adult and felt more confident about the move to university.

Recommendations

168. When deciding on recommendations to the Trust and the Council we have taken account of the Principles for Remedy. Three of the principles are particularly relevant to this complaint:
- *Being customer focused* which includes apologising for and explaining the poor service;
 - *Putting things right* which includes compensating the complainant appropriately; and
 - *Seeking continuous improvement* which includes using the lessons learnt from complaints to ensure that poor service is not repeated.
169. To remedy the injustice suffered as a result of the maladministration and service failure identified we recommend that, within a month of the issue of the final report of this investigation, the Trust and the Council should write jointly to Mrs D to acknowledge the failings identified in this report and apologise for the impact of those failings on C and Mrs D.
170. The Trust has already offered compensation of £200 for the failure in its complaints procedure. In addition the Trust should pay C and Mrs D £500 each in recognition of the distress resulting from the failures we have identified.
171. The Council has already offered compensation of £1,500 for the delay in completing the core assessment. In addition the Council should pay C and Mrs D £2,500 each in recognition of the injustice listed in paragraphs 163-167.
172. The Council should offer to work with C, using resources from Connexions and the Autism Champion, to help him achieve his ambition of higher education.
173. The Trust and Council should also, within three months of the date of the final report develop action plans to address the failings we have identified. They should send a copy of the action plan to us and Mrs D, update us on progress periodically and tell us when the action plan has been implemented.

Final remarks

174. In this report we have set out our investigation, findings, conclusions and decision with regard to Mrs D's complaint.



Dr Jane Martin

Local Government Ombudsman



Dame Julie Mellor DBE

Parliamentary and Health Service Ombudsman

12 June 2014

Annex A

Clinical Advice

Decision to refer C to the specialist hospital

The first CAMHS Psychiatrist followed established good practice by taking a joined up approach involving medication, psychological and educational measures and referral to a tertiary service (the specialist hospital).

This was a complex case where features of several different mental disorders appear to have been present. The diagnostic process may involve a period of observation. After 18 months, when hospital admission was being considered and the management protocol based on the first diagnosis of OCD had not yielded sufficient progress, it was reasonable to reconsider the diagnosis and make a referral to the specialist hospital (for assessment and advice on further treatment).

It took a few months to arrange funding for the involvement of tertiary services. In November 2007 the specialist hospital diagnosed Asperger's syndrome and provided further management suggestions, particularly in relation to C's education.

The overall process from referral to secondary services (November 2005) up to the initial management recommendations by a tertiary service thus took about two years. This was not unduly long considering that intensive support was offered by the secondary services in the meantime and given that the last medication prescribed (Risperidone) is also used in patients with Asperger's syndrome.

Continuity and provision of care after referral to the specialist hospital

The severity of C's Asperger's syndrome and obsessive compulsive disorder was such that it required treatment with an antipsychotic drug, Risperidone, and assessment and intervention from the specialist hospital. In such circumstances, continued involvement of the local CAMHS would normally be required. Key tasks would be for a psychiatrist to monitor the psychotropic⁴ drug treatment for effectiveness and possible side effects; and for co-ordination of behavioural and educational interventions and specialist assessments.

In accordance with national guidelines, personal continuity in the care co-ordinator role should certainly be an aim for the care of patients with an ASD. The importance of this is highlighted by the DH document (paragraph 19) which specifically mentions a single 'trusted adult' contact.

There were two major gaps in direct contact with C.

⁴ Psychotropic drugs are used to treat or manage a psychiatric symptom or challenging behaviour. Some psychotropic medications fall into specific medication classes like antipsychotics (like Risperidone) or antidepressants. In other cases, the medications may be primarily used for other diseases but have been found effective in controlling behaviours thus making that specific use a psychotropic medication.

The first was from October 2007 to February 2008, during the locum appointment of the second CAMHS Psychiatrist, who said he would not see C in person because of the involvement of other professionals from the specialist hospital and the temporary nature of his appointment. However, these professionals were mainly psychologists, and it was important that a psychiatrist should have monitored C's psychotropic medication more regularly during this period.

In conversations with Mrs D, the second CAMHS Psychiatrist explicitly referred to the confused state of the service, which points to an organisational failure at the Trust at that time. The Trust acknowledged this.

In February 2008 the second CAMHS Psychiatrist (according to his documentation) raised concern about the limited benefit that might be derived from further involvement of his service. Given that C was receiving interventions at the specialist hospital, it was reasonable to withhold more intensive (eg psychological or behavioural) intervention until the conclusion of this process, which seems to have been in April 2008. However, as already mentioned, it was not reasonable not to monitor the psychotropic medication and not to provide personal contact with CAMHS.

It would also have been reasonable, during this time, for CAMHS to provide some continuity of personal contact, for example through a key worker.

The second gap was in early 2009 after the third CAMHS Psychiatrist's departure. At this time, the specialist Psychologist and her team had recommended intensive home-based behavioural intervention for C, and the Trust found that their psychology service could not provide this. A more timely communication of this might have been helpful. The Trust acknowledged this.

The frequency of the multi-agency network meetings was reasonable. A higher frequency was initially necessary to incorporate the feedback from the specialist hospital and instigate the educational assessment process. Further into 2008, the meetings monitored the progress of the educational provision and thus could reasonably be scheduled at a slightly lower frequency. Three of these meetings were attended by the HOPE social worker; the second CAMHS Psychiatrist attended one; and the third CAMHS Psychiatrist either attended or provided a report for another.

In sum, the involvement of CAMHS continued after the first CAMHS psychiatrist left in September 2007 but with difficulties caused by staff changes. During that time, C had a least one appointment with CAMHS on 13 March 2008 with the third CAMHS Psychiatrist; he was offered another for 7 May 2008 (though it is unclear from the paperwork whether he attended); and he missed an appointment in November 2008. There was also some level of personal continuity provided during the period in question through the HOPE service art therapy sessions. The locum consultant psychiatrists seem to have fulfilled their duty of care in

co-ordinating specialist assessments (from the specialist hospital), offering sessions with the psychiatrist and planning and assisting C's educational needs in conjunction with education authority representatives. However, given the clinical history and severity of C's ASD, he and

his mother could also reasonably have expected more direct contact with a CAMHS psychiatrist and there should have been more frequent monitoring of C's psychotropic medication (which then fell to the GP). It would also have been desirable to identify a clear contact point for the patient and his mother to act as a key worker, and for this person to co-ordinate the involvement of the different services and guide Mrs D through them, especially at a time when the psychiatrists were changing frequently. This role seems to have switched between CAMHS and social services. Mrs D was rightly concerned at times about not knowing who was co-ordinating her son's care.

Transition to adult services

It is usual practice to discharge patients from CAMHS when they turn 18 and, where mental health needs persist, refer them to the appropriate adult services. It is then not uncommon for patients to be found not to meet the criteria for any of the adult services, as in C's case, although they are clearly impaired in their everyday functioning. Thus the transition from adolescent to adult services is a recognised difficulty. Transition teams classically have the remit to fill this gap. The National Service Framework for Mental Health identifies the need for services that bridge this gap (paragraph 21). A paper by the Royal College of Psychiatrists in May 2008⁵ recommended that:

'... specific agreement is reached and protocols written regarding the transfer of care for young people who are in treatment with children's mental health services and are within the diagnostic groups listed ... [which includes Autistic Spectrum Disorder/ Asperger's Syndrome].'

In keeping with this recommendation the Trust should have protocols regarding transfer of care from CAMHS. Where these are not available, case conferences between CAMHS and the potential adult service providers are needed to discuss the continuation of input beyond a person's 18th birthday.

When C's transition from CAMHS to adult services had to be orchestrated, it was particularly important that there was personal continuity in the key worker / care co-ordinator arrangements.

The Trust's decision not to provide the psychological treatment recommended by the specialist hospital

There are no firm requirements for the types of interventions to be offered by secondary services. It is therefore impossible to construe a duty on the Trust to have provided such a service. In her letter of 14 January 2009 the CAMHS Psychologist made alternative suggestions, for example involvement of the HOPE service. In relation to the resource limitations of the clinical psychology service, I understand that the Trust was planning to raise

⁵ *Working at the CAMHS/Adult Interface: Good practice guidance for the provision of psychiatric services to adolescents/young adults* by the Interfaculty working group of the Child and Adolescent Faculty and the General and Community, Faculty of the Royal College of Psychiatrists.

unmet needs with the commissioners, but there is no documentation as to the outcome of those discussions.

The Trust's independent review in October 2010 stated that CAMHS apparently had concerns about a potential increase in risk of violence towards Mrs D arising from such an intervention. However, there was nothing further about this in the paperwork I have seen.

Support for Mrs D

When the domestic situation worsened, in May 2007, the first CAMHS Psychiatrist suggested hospitalisation for C, but Mrs D did not agree to this. At this time, the first CAMHS Psychiatrist had regular conversations with Mrs D both about practical matters (eg police involvement) and about her feelings and difficulty coping with her son's illness and behaviour. The second CAMHS Psychiatrist also had discussions with Mrs D about her own mental health, and offered several dedicated meetings with her alone to discuss support for her own needs. In addition to these direct support sessions both the first and second CAMHS Psychiatrists followed up on the progress of counselling sessions that Mrs D was having at the GP surgery. The third CAMHS Psychiatrist (according to her notes) saw Mrs D five times to provide counselling sessions and advice on behavioural management. The CAMHS social worker visited Mrs D a number of times in the autumn of 2007 to provide support for her as part of the outreach service.

Team members also attended multidisciplinary meetings and wrote letters supporting Mrs D's requests for educational assessments/ placements for C.

Therefore, the level of care and support provided to Mrs D appears reasonable.

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