

Case of Concern

Cyrus

A key question for the system: Could this happen to another child like Cyrus?

Introduction

Cyrus is a young person with autism, a severe learning disability, ADHD, epilepsy and PICA. He is non-verbal and depends on the adults around him to understand his communication, advocate for him and keep him safe.

Following a period of significant behavioural escalation and a hospital admission, Cyrus became looked after and moved to an out-of-borough residential placement. His care required health, social care, education and placement services across different organisations and geographical areas to work together.

Concerns subsequently emerged about gaps in clinical oversight, access to health and therapeutic services, restrictive practice and legal safeguards, placement suitability, education, transition planning and multi-agency coordination.

The circumstances were considered a near-miss safeguarding event and were reviewed through the Croydon Safeguarding Children Partnership Case of Concern process.

The purpose was not to investigate individual professionals or agencies. It was to understand why decisions and actions made sense at the time, identify what helped or hindered effective practice, and ask whether the same system conditions could affect another child with similarly complex needs.

Keep in mind as you read - For children with complex needs, a small gap in communication, ownership or follow-through can have a significant impact on their safety, wellbeing and quality of life.

Seeing and hearing Cyrus

Communication is not dependent on speech. Understanding behaviour, relationships, routines and preferences is essential to hearing a child's voice.

Who is Cyrus?

A teenager with complex disabilities and health needs.

He has very limited verbal communication.

Relies on adults to recognise and interpret his individual ways of communicating.

Depends on others to advocate for his needs, rights, safety and wellbeing.

People who know Cyrus describe an infectious smile and say that **“this boy loves life.”**

- He enjoys water and swimming, sensory play, music, crunchy foods and being outdoors.
- Food is important to him and is also part of his cultural identity and connection with family.
- Familiar people, routines and relationships help him feel secure.

Cyrus's lived experience

Cyrus experienced several significant changes within a relatively short period, including separation from home and family, coming into care, a lengthy hospital stay, moving out of borough, losing his established school and moving to tuition, changes in carers and professionals, and planning for further placement and adult-service transitions.

Multiple transitions can compound risk.

Changes in placement, education, carers, professionals and services should be considered together, not as separate events. Their cumulative impact may be especially significant for children who rely heavily on familiarity, relationships, routine and predictability.

This raises an important question for practice: When a child's behaviour changes, are we asking only how to manage the behaviour — or what the child may be communicating about distress, loss, unmet need or changes in their environment?

His mother's perspective

Cyrus's mother, described him as “a very happy boy who has his moments.” She spoke about his love of water, going out, traditional food and family life.

She described a close relationship between Cyrus, herself, his sibling and wider family, and valued the placement's efforts to reflect his Caribbean heritage through food.

Cyrus's mother was concerned about changes she had seen in Cyrus since he left home, including changes in his appearance and behaviour. She felt that his inability to communicate verbally was central to understanding him, explaining that he can lash out because he cannot tell people what is happening for him.

His mother emphasised that she has important insight into Cyrus's communication and needs. She described visits and separations as difficult for them both and reported receiving no support to manage the grief and loss associated with him living away from home. **The review identified this as a gap in support for Cyrus's family.**

✅ When services change, the child's communication, relationships and lived knowledge **must move with them.**

Improving Practice

When working with a child who communicates differently:

- Who knows this child best, and how are we using that knowledge?
- How does the child communicate choice, distress, comfort and/or consent?
- Does their communication profile travel with them when placements or services change?
- Are culture, relationships, sensory needs, routines and what brings them joy visible in their plans?
- What support does the family need to remain involved and advocate effectively?

Key Lines of Enquiry

The following questions and findings can help agencies consider whether similar gaps may affect other children with complex needs.

KLOE 1

Health, assessments and access to services

- How were Cyrus's health needs assessed, overseen and responded to across agencies over time?

What we found

Health oversight was fragmented across boroughs. Assessments, referrals and follow-up were delayed, and there was no consistently clear clinical ownership of Cyrus's health needs.

Services did not adapt consistently around complex need. This meant important health concerns were not always addressed in a timely, coordinated way.

KLOE 2

Legal frameworks, medication and restrictive practice

- How were restrictive practice, medication and legal safeguards recognised, authorised and reviewed?

What we found

Restrictive practice, medication and legal safeguards were not identified, authorised or reviewed consistently. Oversight of PRN medication and liberty restrictions was unclear.

This created uncertainty about who was responsible for monitoring risk, reviewing practice and ensuring the right legal and clinical safeguards were in place.

KLOE 3

Multi-agency coordination and information sharing

- Who held the whole picture, and how were information, challenge and escalation used to keep Cyrus safe?

What we found

No single professional held the whole picture. Information was not consistently triangulated across agencies, and escalation gained pace only after significant concerns were raised.

As a result, risks were understood in parts rather than as a whole. Opportunities for earlier challenge, coordination and action were missed.

KLOE 4

Placement, education and transition

- How were placement suitability, education and transition planning coordinated to meet Cyrus's needs?

What we found

Placement, education and transition planning were not sufficiently joined up. Support did not consistently match need, and planning for adulthood started too late.

Important changes across care, education and services were not always coordinated. This increased the risk of drift, delay and unmet need.

What this suggests for the wider system

Taken together, these findings suggest wider system vulnerabilities rather than a single isolated issue. Without stronger coordination, oversight, transfer arrangements and escalation, children with similarly complex needs could experience similar gaps in support.



The 6 System Commitments

The learning from Cyrus's experience has been distilled into **six** system commitments. They set out the changes needed across agencies to strengthen coordination, oversight and accountability for children with complex needs. Agencies are encouraged to use this section in training, supervision and practice discussion. It is intended to support reflection, test the robustness of current practice, and strengthen child-centred decision-making.

1



Hold the whole picture

Identify a lead professional who can coordinate the network, track actions and recognise drift.

Bring together information from all sources, including family knowledge, so the child's needs, risks and strengths are understood in context.

Reflective Question:

Who is coordinating the child's overall plan, and how do we know agreed actions are being followed through?

2



Make Transfers safe

When a child moves between areas, services or placements, confirm who is taking over, what has been handed over, what remains outstanding and when it will be reviewed.

A referral made is not the same as a service being received.

Reflective Question:

When a child moves between services, placements or areas, what have we actively handed over and what are we assuming someone else will pick up?

3



Adapt around the child

If a child cannot access standard appointments or pathways because of disability, distress or communication needs, make reasonable adjustments and agree flexible approaches rather than allowing needs to remain unmet.

Reflective Question:

If the usual pathway is not working for this child, what have we changed to make support accessible and responsive to their needs?

4



Recognise rights and risk

Consider whether supervision, restraint, medication or restrictions on movement engage the Mental Capacity Act, best-interest decision-making or deprivation-of-liberty safeguards. Ensure medication has clear clinical oversight and apply [STOMP and STAMP principles](#).

Reflective Question:

Are any restrictions, medication or care arrangements limiting this child's rights, and are the necessary legal and clinical safeguards in place?

5



Prevent drift

Plan early for changes in placement, education, health provision and adulthood. Monitor progress, escalate when actions are not happening and consider the cumulative impact of multiple transitions on a child's wellbeing.

Reflective Question:

Are we planning early enough, and have we tested whether the proposed placement, service or transition can actually meet the child's assessed needs?

6



Strengthen Assurance

Use multi-agency quality assurance to identify children in similar circumstances, triangulate information across agencies and test whether agreed improvements are making a difference.

Reflective Question:

What evidence do we have that similar children are not experiencing the same gaps elsewhere in our system?

Explore further learning from local reviews and safeguarding practice at croydonsafeguarding.org

Stronger questions. Brighter practice. Better outcomes for children.