WOLVERHAMPTON SAFEGUARDING TOGETHER

Table Top Review report for Child O

1. Introduction

1.1 Following discussion at One Panel, the Panel with delegated authority from WST Exec Group to make decisions on the eligibility of a referral, it has been agreed that this case does not meet the definition of a serious child safeguarding case, or the criteria for a CSPR.

1.2 However, in the case of Child O the Panel felt that the case highlighted improvements were needed to safeguard and promote the welfare of children and adolescents in psychiatric care as it is evident in this case that there are issues in local systems and local working practices across the partnership. It was agreed that a TTR should be carried out to consider learning, focussing on specific areas of practice; including the lack of appropriate robust and consistent CiN assessment and planning; the ability of professionals to recognise and address adolescent neglect; the ability to challenge non-compliance; the ability to be open and transparent and the ability for CSC and MHS to work together to a consistent and co-ordinated plan.

Scope of the TTR

1.3 The Table Top Review should identify the learning for:

- All aspects of Mental Health services involved in the care of Child O since the first admission to CAMHS in 2015
- The Early Help Intervention following the referral to MASH in July 2018
- The CiN process and decision making following the agreement to step up to CiN on 23rd October 2018
- Identifying improvements to multi-agency working

1.4 A multi-agency group will be established to carry out the TTR. This will include a representative from each of the key Safeguarding Partners along with any other agencies involved with the family and any relevant subject matter experts.

1.5 Due to the complexity of the case and the seriousness of the on-going risk to the life of Child O, an independent Lead with a mental health background, will be commissioned.

1.6 The group were required to work within agreed timescales to:

- Collate and scrutinise information provided by agencies
- Provide local context

- Provide challenge to quality of reports and the analysis of professional practice
- Identify single agency and multi-agency learning and support the development of single agency action plans
- Ensure proper lines of accountability are followed to ensure those responsible for not meeting professional standards are held to account
- Ensure the report has met the agreed Terms of Reference, is succinct and focused on improving local safeguarding arrangements
- Make recommendations to WST
- Formulate a Learning Lessons Briefing for sign off by One Panel using an agreed format

2. Methodology

- **Individual agency chronology**
- **Scoping documents completed by lead agencies**
- **Round table discussions (virtually)**
- **Discussions with family members**

2.1 A lead reviewer was appointed to lead the review. Agencies were asked to complete the scoping documents and attend the meetings to discuss the children and identify learnings. The meeting attendees had access to the key agency scoping documents and multiple meetings took place with practitioners involved with the family, where the children were discussed.

2.2 The predisposing risks and vulnerabilities that were known at the time were considered, in order to understand the case. This was followed by the consideration of the preventative and protective actions taken, in order to understand the interventions.

2.3 Drafts of this report were shared with those involved as well as with the One Panel and WST's Scrutiny Group to ensure collaboration and ownership and provide scrutiny and challenge. The recommendations were written by the Lead Reviewer and the review team.

2.4 This report has been written in the anticipation that it will be scrutinised by the One panel and used to formulate key learnings for the agencies involved.

3. Scoping Period

3.1 February 2019 to February 2021

4. Timeline Narrative as set out in referral to One Panel

4.1 Child O is a 17 year old girl who lives with her mother and father in Wolverhampton. Child O has a diagnosis of Anorexia Nervosa with anxiety related symptoms, she has had several admissions to hospital as a result of her diagnosis and has had involvement with CAMHS since the 10th March 2015.

4.2 A referral to MASH was made by Wolverhampton Girls High School on the 5th July 2018 following Child O's disclosure in school that she had been slapped by her mother and did not see the point in life. This together with the Eating disorder led to the referral being made. The outcome of the referral was for Early intervention. There was a step-up discussion between Social Care and Early intervention on the 23rd October 2018. It was agreed that Child O became subject of Child in need planning. An assessment was completed on the 16/02/19 and recommended CIN Planning. Following a further CPA meeting in December whereby Health professionals agreed to discharge Child O from hospital a professionals meeting was requested. Child O has been assessed under the Mental Health Act on the following occasions:

- May 2015- detained under S.2.
- February 2016- not detained, provided support to remain in the community.
- March 2016- not detained, provided support to remain in the community
- June 2016- informal admission agreed to eating disorder unit
- March 2017- admitted informally
- September 2018- assessed at New Cross Hospital and accepted an informal admission
- June 2019- detained after AMHP utilised his 14 days to delay an application whilst alternative support plans were put in place in the community.
- July 2019- informal admission agreed. Child O has had the following admissions to hospital:
- May 2015-July 2015- Child O admitted to Parkview Clinic
- June 2016-August 2016- Child O admitted to Parkview Clinic- informal admission agreed by parents and Child O.
- March 2017- July 2017- Child O admitted to Newbridge Hospital.
- September 2018- Child O admitted to a Paediatric Ward at New Cross Hospital due to weight loss.
- 25/09/18- Child O admitted to Huntercombe Hospital. Mental Health Act Assessment completed; voluntary admission agreed.
- 15/07/19-05/12/19 Child O admitted to Huntercombe Hospital.

4.3 Child O's most recent admittance to hospital at the time of the referral to the Safeguarding Partnership was on the 15th of July 2019, Child O weighed 40.50kg on admittance. Child O was discharged from Huntercombe Hospital on the 5th of December 2019 weighing 47.30kg. Child O is required to maintain a weight range of between 47-49kg.

4.4 Child O has refused to engage with therapeutic input and has been reluctant to be weighed by professionals when in the community. Child O has required hospital admissions to stabilise her condition which has not been successfully managed in the community.

4.5 It is felt parents have been difficult to engage and reluctant in developing their understanding of Child O's condition or engaging in therapeutic intervention. Whilst Father appears to have abstained from taking any responsibility by frequently working away and allowing Mother and Child O to get on with it Mothers focus has been that of befriending Child O. Rather than challenging Child O and supporting her in breaking the cycle it appears Mother in her reactions and behaviours associated with the eating disorder colludes with Child O and does little to change the cycle of behaviour, in fact it could be said it is encouraged as Mother has frequently failed to follow up crucial appointments for monitoring of weight or return Child O to hospital in time for meals.

4.6 It was felt Child O is unable to manage her meal plan when not in hospital, missing meals and being overactive. It may be that mother in particular encourages this by not taking control of eating plans and by arranging for Child O to play tennis. Each time Child O has lost weight resulting in a further Mental Health Act Assessment parents have taken this to the wire by presenting as reluctant or difficult to engage until the threat of sectioning has resulted in both Parents and Child O agreeing to an informal admission. This cycle is very apparent and continues Child O has demonstrated head banging and elements of self-harm when admitted to hospital and can be verbally and physically aggressive towards mother and father.

5. Emerging themes from review discussion

5.1 Professionals talked frequently and had many meetings but the group felt that these were at times focused on differences of opinion and a reflective style meeting similar to the TTR process could have been helpful.

5.2 Communication between professionals and family arose many times within the discussion. It was felt that a clear communication plan could have assisted all partners to work more consistently with the family and reduced opportunity for the family to feel that they were receiving mixed messages.

5.3 ST often reached critical 'tipping points' quite quickly, which the review felt can sometimes lead to professionals feeling blamed. The review felt that there needs to be less of a blame discourse and more of a focus on strengths and resources and celebrating things that went well.

5.4 Some professionals clearly felt that parents did not understand the severity of Child O's eating disorder and were not open to developing their understanding. It was felt that parents were at times slow to follow medical advice or simply would not enforce. It was felt that this at times left Child O at risk of harm. There were many examples of parents not enforcing meal plans or allowing Child O to undertake physical exercise whilst she was in the red zone. This was a concern as parents would articulate views about why it was good for her to participate in physical activities.

5.5 As the meeting progressed it became clear that Child O was able to exercise a lot of control and had many techniques that enabled her to achieve her aims, whether this be through parents or professionals. More understanding of the family dynamic was gained during the review process and professionals became more aware of the threats and behaviours that parents had been subject to from Child O. There were examples of aggressive behaviour towards parents and Child O would threaten to not eat if she was not allowed to do what she wanted to do. The group also reflected on why she was able to repeatedly convince professionals to discharge her from hospital before she was at her goal weight. This provided an alternative hypothesis to the existing idea that mother and father enabled and supported her behaviour but rather acknowledged that they may have found it incredibly difficult to say no to her.

5.6 It is commonplace in eating disorder presentations for the eating disorder to affect family life to a significant degree physically, socially, and psychologically. The team were persistent with their work with Child O. The review reflected on how difficult it would have been for parents to confide in the professional group about Child O's behaviours towards them and how hard they would have found it to admit that they felt they had no choice but to support her for fear of the consequences. It was raised again

about Child O's control over her parent's and her being the dictator, and it appearing as if parents 'walk on eggshells'.

5.7 It was noted that the fact the Child O was admitted to various hospitals may not have help as each time the treatment team were new. It was felt that they were therefore open to the pitfalls of not having case experience and therefore essentially starting again with the family. It was noted that she is incredibly articulate and intelligent. This may have enabled her, possibly with the support of her mother to control her care in a way that was not ultimately in her best interests.

5.8 Many agencies commented that father's involvement was very scarce. The majority of the time professionals spoke with Child O's mother. It was noted that father works out of the country a lot of the time. The group reflected on a period of time when father did take more of an active role largely due to social cares involvement. Child O appeared to respond positively to this. The group reflected on whether social care closed too early after a little progress had been made by the family. Social care could have further explored Dad's role within the family, how she felt about this, what she wanted from him and whether his influence could have been better utilised to help Child O.

5.9 Professionals felt that it was important to understand and make note of how legislation has supported and potentially not supported professionals during their involvement with Child O. The Mental Health Act had at times let professionals down, as they had reached the point where they felt there is no other option but to request a Mental Health Act assessment to keep Child O safe. This has not always resulted in an admission which has left professionals with very little power to safeguard Child O.

5.10 Child O has on occasion, voluntary accepted admission to hospital, where she has shown compliance, eaten her meals but then manipulated discharge at a lower goal weight, but at this point, the mental health act can't be used as she has proven she has engaged.

6. Analysis

6.1 The review reflected that working with Child O had been fraught with many difficulties. It was clear that Education and Health colleagues had been deeply concerned for Child O's wellbeing and had worked hard and put many hours of work into attempting to help her. Social care was no less pro-active when they were involved but there were periods when it was felt she did not meet the threshold for statutory social care intervention.

6.2 Professionals did however feel that communication between the professionals and with parents could have been strengthened at times. It was acknowledged that everyone was doing their role well and was focused on helping Child O. There were regular meetings but these were focused on process and what needed to happen rather than slowing down and giving thought to what they could do differently as a team around the child.

6.3 As stated above It is commonplace in eating disorder presentations for the eating disorder to affect family life to a significant degree physically, socially, and psychologically. As the meeting progressed the impact of Child O's disorder on mother in particular became more apparent. There were examples of Child O exhibiting aggressive behaviour towards her mother and examples of her potentially using self-harming behaviour to demand parents did what she wanted them to do. The impact of

this could have been better understood by the professional group and this led to the idea that a reflective meeting could have been helpful during the work.

6.4 The review members felt that at times legislation had not helped them to safeguard Child O as a child. At critical points the Mental Health Act Assessments had not recommended that she be detained under the Mental Health Act. This meant that the team around the child were left with very little ability to ensure she ate enough food to continue to survive.

7 Lessons Learned

- The relational work with parents undertaken by social care seemed to make a difference but was not consistent and may not have been valued enough by social care. Social Care may not have understood how important the work they were doing was in helping Child O. Social Cares role in helping the family explore their relationships and roles could have helped understanding around the root cause of Child O's condition and facilitating the conversation between parents and health professionals helped parents engage a little better.
- It was felt that there needed to be clear and open conversation with parents that did not make them feel blamed and criticised. This may have engendered better engagement from them.
- The review felt that it would have been useful for the group to have noticed the change in Child O's behaviour when her father was more engaged in her life and when he was spending quality time with the family. It was also noted that when he was involved in her care he seemed to have a little more leverage than mother. With the help of social care it is possible that more could have been made of the potential he had to make a difference for Child O.
- The review felt that a communication plan should be developed whenever there are various teams and professional groups involved with a child with complex needs. This would reduce opportunities for misinformation to be shared and reduce the opportunity for families to divert attention away from the crucial matter of safeguarding the child.
- The review felt that a reflective conversation between professionals similar to the table top review process would have been helpful
- A Chronology of hospital admissions and Child O's weight fluctuations may have given new hospitals important information to assist them in their treatment plans.