Background: Stephen is 16 years old and is currently living in a mental health inpatient unit for over 12 months, he is the only patient in this unit. He is currently living in an annex to the main hospital. The furnishings in his accommodation are bare as there is a need to deep clean his room regularly. Stephen is restrained daily by staff wearing hazmat suits, to be fed liquid food and medication via a naso gastric tube and receive personal care. Stephen has not spoken for 12 months and his interaction with the external world is minimal, Stephen sits on the floor in a crouched position every day and has not engaged with any activities or with staff until very recently. Stephen's mother (Ms. Wilson) has been involved throughout this CSPR.

Reason for this review: Stephen was admitted to hospital when he was 15 years of age from an inpatient adolescent mental health unit. On admission to hospital staff expressed concerns about his physical and emotional health. Stephen appeared emaciated and dehydrated, his clothes were dirty and was distressed and afraid. There were significant concerns Stephen had suffered neglect and emotional harm whilst at the impatient unit. A Local Authority Designated Officer (LADO) and criminal investigation commenced. The conclusion of these investigations was that Stephen's welfare had been put at risk of significant harm due to institutional processes. Stephen's mother (Ms. Wilson) has been involved throughout this CSPR.

One Minute Guide

Learning from a Child Safeguarding Practice Review:

Stephen Wilson

June 2022

Coventry Safeguarding Children PARTNERSHIP

Executive Summary: Mental health inpatient care is by no means a panacea, research is clear that it should not be regarded as a cure and for many children, particularly for children with an ASD diagnosis, everything possible should be done to avoid admission. The CSPR has identified that whilst the lack of availability and suitability of inpatient beds is a clear issue affecting the care and treatment of children, there are wider systemic issues that also require attention particularly in relation to how services work together to prevent difficulties escalating.

Many of the issues identified in this CSPR are not new, many are national issues effecting a wide group of children. Since this time, multi-agency services have evolved and strengthened in some key areas that may have made a difference to Stephen and his family. The CSPR has identified that there is still more to be done if we are to safeguard children such as Stephen and provide children and their families with the help they need at an early point.

Throughout the CSPR it has been clear that the workforce proving care to children such as Stephen is a compassionate work force often doing the best they can. However, in a fallible system compassion fatigue may set in and this requires attention by organisations tasked with providing human services.

I could not believe that this could happen in this country in the 21st century …. People normalise and collude because they are working in a fallible system that is not fit for purpose.

(Stephen's mum)

History & Involvement of agencies: History & Involvement of agencies:

- During infancy and early childhood there were no behavioural difficulties or concerns about Stephen.
- At the age of 8 it was noticed that Stephen was experiencing high levels of anxiety. Ms. Wilson and teachers were concerned about his anxiety and questioned whether Stephen may have Autistic Spectrum Disorder (ASD).
- A referral was made to CAMHS. Steven was 10 when he was seen at CAMHS for an initial appointment.
- Stephen was diagnosed with ASD in **2018**. During this time, Stephen's parents separated and Stephen was experiencing increasing levels of anxiety. Stephen had also severely struggled with the transition of secondary school and his brother leaving home to attend University
- In **September 2019** Stephen attended regular CAMHS appointments, though the beginning of the school year was difficult for Stephen (14 years), and he began struggling with his eating.
- In **October 2019** a referral was made for CAMHS Eating Disorder Team (EDT). It was agreed that Stephen was presenting with Avoidant/Restrictive Food Intake Disorder (ARFID) and that this does not constitute an eating disorder (ED) and the EDT would not meet their needs.
- Escalating concerns about Stephen's anxiety, loss of weight and fainting at school led to him attending part time education. This represented a loss of structure and routine at this time which Stephen found difficult.
- Over the following weeks, there was a rapid deterioration in his mental health and wellbeing and by mid **February 2020** he was out of school altogether.
- In **March 2020** Ms. Wilson took Stephen to hospital where he was admitted due to physical concerns & ritualistic behaviour. She felt he was deteriorating in hospital and suggested he should return home.
- A bed was found in an inpatient unit. In the meantime Stephen returned home to await admission. Whilst at home, Ms Wilson reported that things had improved; Stephen was managing to eat, attending to self care and communicating with her.
- She decided not to take Stephen to the inpatient unit in part because of the restrictions on her contact with Stephen due to the pandemic, and in part because her fears of Stephen catching coronavirus.
- **June 2020 Stephen was admitted to an inpatient unit** under Section 2 MHA which was subsequently changed to Section 3 MHA.

Key Learning & Recommendations:

- CSCP to ensure the primary schools are routinely identifying children who may struggle with transition with a particular focus on children with ASD.
- CSCP to ascertain how to strengthen multi-agency working with children with mental ill health
- CSCP to continue to oversee wait times for ASD assessments and support the ICB in reduction of wait times.
- Coventry local education services to review the EHCP strategy with a view point from ASD and mental health needs.
- CSCP to ensure that partner agencies review approaches to children with complex needs and demonstrate how the workforce are equipped to respond.
- Coventry & Warwickshire ICB to give regular updates to CSCP about updates in relevant areas in the Mental Health Implementation Plan
- CSCP to depict to National Panel about the need for a National review on matters highlighted
- CSCP to assure that support provided to staff on paediatric wards enables the best care to be provided to children in a mental health crisis
- CSCP to review the role of the local authority in leading investigations into concerns of significant harm in an institutional setting
- CSCP to review referral pathways for notifying CSCP of serious incidents
- CSCP to issue framework of expected multi-agency working based on recommendations from recent JTAI.
- CSCP to include importance of trusted adults in the multi-agency framework for children with mental ill health/complex needs
- Children in inpatient mental health units must be offered an independent advocate

Covid-19: It is important to recognise that during the key period under review the Coronavirus Pandemic was an important systems dynamic that had multiple consequences across the entire multi-agency system.

Additional Reading & Resources:

Link to the full report:

CSCP website: https://www.coventry.gov.uk/lscb