Wigan Safeguarding Children Partnership

Local Child Safeguarding Practice Review

‘Elliot’

Reviewers: June 22

N Osborne and L Cunniffe

May 23 report condensed by

S Whitelaw

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INTRODUCTION

1. This Local Child Safeguarding Practice Review (LCSPR) centres around a 12-year-old child who came into Local Authority care in an unplanned way after being made the subject of an Emergency Protection Order. This child will be referred to as 'Elliot' in this report.

2. Prior to coming into the care of the Local Authority Elliot lived with his Father and sibling at home. He also has three other siblings who lived with their Mother. Elliot had regular contact with his Mother and all his siblings as they lived close by.

3. Elliot was placed in a respite care placement as a short-term measure until an appropriate placement could be found. Two days later Elliot attempted to self-ligature at his placement and was taken to Accident and Emergency (A&E) where he was admitted to hospital onto a general paediatric ward.

4. Whilst in hospital Elliot exhibited extreme emotional distress which required management in the form of physical and chemical restraint[1]. A Court order was issued authorising the Wigan National Health Service (NHS) organisations involved in providing his care and Wigan Children's Social Care staff to deprive Elliot of his liberty.

5. At a later High Court hearing the Judge declined to further authorise the deprivation of Elliot's liberty and he was satisfied that the current arrangements for Elliot constituted a breach of his human rights under Article 5 'Right to liberty and security' of the Human Rights Act (1998).

6. Wigan Council Children's Social Care subsequently identified a suitable placement within the community and Elliot was discharged from hospital after an eleven-day admission.

7. Wigan Safeguarding Children Partnership agreed that the threshold was met for a Local Child Safeguarding Practice Review (LCSPR). This report will outline Elliot's lived experiences and the identified learning from this LCSPR.

8. LCSPR Panel Members agreed that the terms of reference should start on the day Elliot became the subject of an emergency protection order, care proceedings were issued,

[1] Chemical restraint is the use of prescribed medication which is administered by health professions for the purpose of quickly controlling or subduing disturbed or aggressive behaviour (page 42, https://www.gov.uk/government/publications/reducing-the-need-for-restraint-and-restrictive-intervention)

- and he was placed in a residential care placement (Day 1); and should end when he was discharged from hospital (Day 14).

Safeguarding History

9. Elliot first became known to the Local Authority in 2011, Elliot and his siblings were made the subject of Child Protection Plans under the category of emotional abuse.

10. Between 2011 - 2015 Elliot spent periods as the subject of a Child Protection Plan and as a Child in Need.

11. In mid-2015, Elliot became a Looked After Child and was placed with foster carers. He was returned to his Father's care in 2016.

12. In 2021, Elliot was placed on a Child Protection Plan under the category of neglect.

13. An Emergency Protection Order was made in mid-2021, care proceedings were also issued on this date. Elliot was placed in a respite care placement as a short-term measure until an appropriate placement could be found.

14. Two days later Elliot attempted to self-ligature at his placement and was taken to Accident and Emergency (A&E) where he was admitted to hospital.

Elliot's Admission to Hospital and Care Management

15. Elliot had a diagnosis of attention deficit hyperactivity disorder (ADHD), epilepsy and medical staff were querying a possible autistic spectrum disorder. On admission to A&E an initial mental health assessment determined that his presenting acute emotional and behavioural difficulties were as a result of trauma and abuse.

16. From the time he was placed at the respite care placement and throughout his time in hospital Elliot communicated his extreme distress through self-harming behaviour and displaying violent behaviour to those who were caring for him.

17. Staff were unable to calm Elliot's distress and contain his subsequent behaviour which resulted in the Local Authority applying for Deprivation of Liberty to authorise management by means of chemical restraint, physical restraint and a 6:1 staffing ratio to support Elliot.

18. Staff caring for Elliot were emotionally and physically injured whilst physically and chemically restraining him. Clinical staff felt they were working outside their usual scope.

of practice, particularly in relation to the administration of sedatives and anti-psychotic drugs.

19. Following admission to hospital Elliot was detained under Section 5 (2) of the Mental Health Act (1983) to allow him to be assessed. He subsequently had a Mental Health Act assessment which determined that he did not meet the relevant criteria for further detention under Section 2 or Section 3 of the Mental Health Act. The Local Authority urgently tried to source a suitable therapeutic placement which was unavailable meaning Elliot remained on the ward despite this not being an appropriate place for him to be when not requiring medical treatment.

20. WWL general paediatric ward was closed to new admissions and beds were closed due to the risks presented to staff and towards other children on the ward due to the way Elliot communicated his extreme distress. Planned elective surgery lists for children were also cancelled.

21. Elliot's admission to hospital and presenting extreme distress was escalated to senior leaders both internally in the hospital and externally to multi-agency partners. Multiple Daily Planning Meetings were held to coordinate a multi-agency approach to meet Elliot's needs.

High Court Judgement

22. There was a High Court hearing on Day 13 in relation to Elliot. The pertinent points from this High Court Judgement in relation this LCSPR are as follows:

    a. The Judge stated that Elliot was inappropriately placed on a clinical ward.
    b. A Deprivation of Liberty application had been previously issued however at this hearing the Judge declined to authorise the continued Deprivation of Liberty of Elliot.
    c. The Judge outlined that he was satisfied that the current arrangements for Elliot constituted a breach of his human rights under Article 5.
    d. The acute lack of resources for vulnerable children in Elliot's situation has impacted severely on many other children and families.
    e. The adverse impact of the lack of appropriate provision and its impact on the health and welfare of children and families who are not involved with the court system.
    f. That professionals involved had tried to do their best.
    "Finally, I wish to make clear that nothing that I have said in this judgment constitutes a criticism of the doctors, nurses, social workers, police, and other professionals who have been required to engage with <Elliot>. They have, I am satisfied on the evidence before the court, tried to do their best in a situation.

in which they should never have been placed. All those involved have done their level best in a situation that has bordered on the unmanageable."
Wigan BC v Y (Refusal to Authorise Deprivation of Liberty) [2021] EWHC 1982 (Fam) (14 July 2021)

23. The Judge outlined his intention to direct that a copy of their judgment is provided to the Children's Commissioner for England; to Lord Wolfson of Tredegar QC, Parliamentary Under Secretary of State for Justice; to the Rt Hon Gavin Williamson CBE MP, Secretary of State for Education; to Josh MacAllister, Chair of the Review of Children's Social Care; to Vicky Ford MP, Minister for Children; to Isabelle Trowler, the Chief Social Worker; and to Ofsted.

24. As a result of the above Court judgement CSC were directed to identify a suitable placement to discharge Elliot to by Day 14. CSC identified a property which was adapted to make safe for Elliot and a wraparound support package of care was commissioned.

25. A referral was made by Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) to the Wigan Safeguarding Children Partnership (WSCP) for consideration of a Rapid Review. WWL Safeguarding Team felt that the High Court ruling demonstrated that Elliot had suffered significant harm and would therefore meet the Working Together (2018) criteria for a Rapid Review.

WSCP RAPID REVIEW PROCESS AND IDENTIFIED LEARNING

Rapid Review Process

26. A Rapid Review meeting held by WSCP considered whether the case met the criteria for a LCSPR as outlined in Working Together (2018).

27. The Rapid Review Panel concluded that it was a matter of fact that Elliot had had his human rights breached as established via the High Court ruling and that the criteria was met to proceed to a LCSPR.

28. The Rapid Review Panel noted that some of the learning identified in this case was already being addressed in other ongoing LCSPRs being conducted by WSCP. This included:

- Disproportionate professional optimism, and lack of challenge to drift and delay in permanency for children. Specifically with children subject to repeated Child Protection planning and repeat referrals to Children's Social Care.
- Attendance at core group meetings and contributions to plans was variable.

- Pre-proceedings were not effective or mobilised swiftly which probably meant the parent believed there were no consequences.
- Lack of suitable therapeutic beds and general placement sufficiency.

29. In line with National Child Safeguarding Practice Review Panel guidance, as the above themes are being addressed in other LCSPRs, this review will focus on the new learning.

Identified Learning

30. The Key Lines of Enquiry (KLOE) for this LCSPR will focus on the new learning identified by the Rapid Review Panel following Elliot's admission to hospital. A full report of the learning identified at Rapid Review was provided to the National Child Safeguarding Practice Review Panel and has been summarised below:

- **Understanding of Mental Health Act Assessment Processes**
  There appeared to be different levels of understanding regarding the Mental Health Act Assessment. This led to multi-agency disagreements regarding the outcome and quality of the assessment. This resulted in drift and delay without a clear pathway for escalation.

- **Child and Adolescent Mental Health Services (CAMHS) support to the Paediatric Ward**
  CAMHS support on the ward was described as intermittent whilst mental health assessments were ongoing which put additional pressure on clinical staff, with unclear advice regarding the use of anti-psychotic drugs. GMMH explained that in reach support is not currently commissioned. The out of hours Psychiatry support was not clear and was provided by a different NHS Trust than the in hours support.

- **Hospital as a 'Place of Safety'**
  Elliot remained in hospital inappropriately after he was assessed as not requiring an inpatient CAMHS bed due to a lack of appropriate placement alternatives. Hospital staff were injured during this time, and felt they were working outside of their usual scope of practice. More specialist training is needed for staff on the acute general paediatric ward on de-escalation, safe restraint and trauma informed practice.

- **Children's Social Care (CSC) Support and Placement Provision**
  CSC did not have an agile, responsive resource of suitably skilled staff to support children like Elliot, which meant that WWL had to care for Elliot for a prolonged period of time even though it was not an ideal environment to meet his needs.

There is a lack of national and local joined up strategy for CSC and health to manage the placement provider market, and this remains underdeveloped to address the needs of children like Elliot.

- **Planning and Escalation Procedures**
  It appears that at times planning and escalation procedures lost focus on Elliot's immediate situation. The focus was lost from Elliot to wider system issues that could never be resolved in the daily planning meetings which included senior and executive leaders.

- **Service re-design and planning around managing children and young people with complex needs.**
  Attempts had been made within the Borough to work in an integrated way to address the emerging gaps in the system for children who presented with similar needs to Elliot; however, this had not progressed quickly enough.

Good Practice

31. The Rapid Review Panel did note some good practice which has been outlined below:

- Children and Family Court Advisory and Support Service (CAFCASS) noted in their response that they saw excellent engagement and communication across all agencies.
- The risks were well understood by all agencies and escalated accordingly.
- All frontline professionals did their very best for Elliot (as noted by the Judge and outlined in paragraph 20f above).

32. The Rapid Review proposed that the learning outlined above should be explored through a short LCSPR which is limited to a timeframe of Elliot being removed from his home and his subsequent hospital admission until he was discharged. WSCP notified the National Child Safeguarding Practice Review Panel of this intention and they confirmed they agreed with this plan.

METHODOLOGY

33. This LCSPR which will be limited to the scope of the issues identified in the Rapid Review. A root cause analysis approach will be used in relation to some aspects (e.g., around pathways of decision making) but will be blended with the Welsh model to include family and practitioner involvement.

34. The Child Safeguarding Practice Review Panel considered this case and agreed with the proposed methodology and noted they had received correspondence from the National Network of Designated Health Professionals (NNDHPs) regarding this case along with the High Court Judgement.

35. Given the short timeframe for the Terms of Reference for this LCSPR, WSCP Executive Leaders decided that the Assistant Director for Safeguarding Children at NHS Wigan Borough Clinical Commissioning Group (WBCCG), supported by their Deputy should undertake this LCSPR.

36. It was felt that the Reviewer for this LCSPR should be independent of NHS Providers whilst having an expert knowledge of the health system, and how this interconnects with the wider system, for children who present with needs like Elliot.

37. The WSCP Rapid review took place on 5th August 2021, however due to the extreme pressures in the health system due to the Covid-19 pandemic the LCSPR did not commence until February 2022.

38. The lead reviewer left the organisation in June 2022 and had completed the draft report. The Case Review panel requested amendments were made. These amendments were undertaken but there were some issues with the assurance and sign off processes which has caused delay in finalising. WSCP worked with the National Panel to ensure that the final report was an open and accurate reflection of the presenting issues and was suitable for publication. The Case Review Panel and the Executive Panel approved the finalised report in February 2023.

Parallel Proceedings

39. Parallel proceedings have been considered to avoid potential conflict of interest. Greater Manchester Police confirmed to the LCSPR Panel that there are no criminal proceedings in relation to Elliot or his family and NHS Provider organisations were not conducting any Serious Incident Investigations under the NHS Serious Incident (SI) Framework.

Practitioner Learning Event

40. A learning event was held for practitioners from all agencies who had provided care for Elliot and had been involved in care planning discussions. Participants were asked to:

- Describe Elliot
- Tell us what his personality was like
- Reflect on what they thought Elliot would say about his experience.
    - Consider each Key Line of Enquiry and discuss:
    - Elliot's Experience
    - Operational difficulties faced by staff working with Elliot
    - Strategic Barriers
    - Good Practice
    - What is the learning?

41. The information shared within the Learning Event has been incorporated throughout this LCSPR report.

INTRODUCING ELLIOT

42. Elliot is a white British 12-year-old boy who lived with his Father and siblings prior to the time period being considered within this review. He attended a school for children with additional needs and his attendance had been 39.4% prior to him coming into the care of the Local Authority.

43. Elliot has a diagnosis of ADHD which he was not taking medication for at Father's request. He also has epilepsy and some practitioners working with him thought he may have a possible Autistic Spectrum Disorder. He had an Education and Health Care (EHC) Plan in place.

44. Elliot's Father described him as an energetic and passionate boy who loved his dog. He enjoyed playing the drums and his keyboard and loved singing and watching musicals.

45. His Mother described him as full of energy and liked watching musicals. He loves his siblings and there is the usual sibling rivalry when they come together.

46. At the WSCP Rapid Review the following description was given of Elliot *"He is known to be a fun and loving young man with a good sense of humour. His stature is very tall, and he enjoys physical interaction. He enjoys long walks and being outside and exercising."*

Elliot's Involvement and Contribution

47. The LCSPR Panel Members explored with Elliot's Social Worker how we could best involve him in the review and fully capture his voice and lived experience. It was felt by those who knew him best that to discuss this period in his life would be too emotionally painful. Elliot appears to remain traumatised following his experiences at the centre of this review. Therefore, it was agreed not to approach Elliot directly, but the Key Lines of Enquiry should robustly capture his voice and experiences.

48. In the forensic psychologist's report completed following Elliot's discharge from hospital Elliot is described as having a diagnosis of ADHD (Severe), learning disability or intellectual disability, autism and a complex trauma-based presentation.

49. In the absence of Elliot's actual voice, the Reviewers have attempted to capture this by detailed discussion with his family and frontline practitioners who were involved in his care.

Family Involvement and Contribution

50. Elliot's parents were approached to contribute to the LCSPR. Separate home visits to his Mother and Father were undertaken by the Reviewer along with a Service Manager from Children's Social Care.

51. Elliot's Father described him as a *"pleasant, beautiful child who had his frustrations."* He talked at length about his experiences and his feelings following Elliot's removal from his home. He was aware of his hospital admission but felt frustrated that he was unable to see Elliot.

52. His Mother described not being aware that Elliot had been admitted to hospital and was not contacted by any agencies at the time. She was subsequently made aware and described that Elliot's father does not always share information with her.

53. Reflections and perspectives from both parents have been included throughout the relevant sections of this LCSPR report and will be shared with the parents before final approval and publication.

TERMS OF REFERENCE AND KEY LINES OF ENQUIRY

Terms of Reference

54. LCSPR Panel Members agreed that the terms of reference should start on the day when Elliot became subject of an emergency protection order, care proceedings were issued, and he was placed in a residential care placement (Day 1) and end when he was discharged from hospital (Day 14).

Key Lines of Enquiry

55. The LCSPR Panel Members agreed seven Key Lines of Enquiry (KLOE) as outlined below:

KLOE 1	To consider if multi-agency disagreements about the outcome and quality of the mental health assessments led to drift and delay and whether there is a clear pathway for escalation in these circumstances.
KLOE 2	To explore how Elliot's presentation was managed, and his care needs met effectively; particularly focusing on effective use of mental health services expertise to support the Acute Paediatric environment including the use of antipsychotic drugs.
KLOE 3	Establish how hospital provision was used in relation to Elliot, what alternatives were available and how WWL's general paediatric provision is equipped to manage and respond to presenting need.

KLOE 4	To consider the impact on Elliot and other services of Children's Social Care (CSC) not having an agile, responsive resource of suitably skilled staff to support Elliot and explore what resources are needed.
KLOE 5	To explore the planning and escalation procedures, the involvement of senior leaders and how effective these were in responding to Elliot's immediate needs. Was there sufficient focus on Elliot as well as consideration of implications for the wider system?
KLOE 6	To establish what work has been undertaken by Children's Social Care to manage the lack of suitable therapeutic placements for children like Elliot, including joint working with Partners.
KLOE 7	To develop an understanding of Elliot's lived experience and what efforts were made to capture Elliot's voice.

SUMMARY OF KEY EVENTS

56. This section will give an overview of the key events which took place within the agreed timeframe for the terms of reference which is Day 1 when Elliot became subject of an emergency protection order, care proceedings were issued, and he was placed in a residential care placement to Day 14 when he was discharged from hospital.

57. The following table outlines the timeline of key events which has been summarised from a 60-page chronology compiled by all agencies into the LCSPR process:

Date	Key Events
Day 1 (Thursday)	• Urgent Court Hearing - Emergency Protection Order granted.
Day 2 (Friday)	• Elliot is taken to a residential placement which is a respite home for children with complex needs. • Child Protection Medical completed at WWL.
Day 3 (Saturday)	• Emergency 999 call received by NWAS as Elliot has attempted to self-ligature. • Elliot was taken to WWL A&E at 23:37hrs, he arrived in restraint to protect Elliot and staff.
Day 4 (Sunday)	• Elliot was admitted to the general paediatric ward at around 04:00hrs (around 4.5hrs after first arriving at A&E) as he required a period of observation following sedation. • Mental Health Liaison Team (MHLT) discussion with Ward Manager and a mutual decision made to delay Mental Health Assessment until Day 5 due to Elliot's level of distress.

Day 5 (Monday)	• Medical staff explored options for Rapid Tranquilisation medication with mental health colleagues. Pharmacy colleagues sourced a Rapid Tranquilisation Protocol from Alder Hey which was followed. • Three Urgent Planning Meetings held throughout the day. It was agreed that a court order should be sought. An Independent Care Provider would be contacted to provide 4:1 staff ratio to Elliot. • A request for an urgent mental health assessment was made. A mental health assessment was completed at 14:17hrs. The outcome of the mental health assessment was that Elliot's presentation was not the result of a mental health

	condition but was due to significant distress in his life and particularly over the past few days. • Section 5 (2) of the Mental Health Act Implemented following 2nd meeting.
Day 6 (Tuesday)	• Daily Planning Meetings held at 09:00hrs, 12:00hrs and 15:30hrs. • A decision was later made to reduce to ten beds and two High Dependency Unit beds, this is a reduction of seven acute medical beds. Paediatric surgery lists had to be cancelled. • Independent Care Provider sourced with four carers being provided alongside a hospital nurse who will support airway management and clinical observations – resulting in a 5:1 staff ratio to support Elliot. • Elliot remains subject of Section 5 (2) of the Mental Health Act. • Court order issued in the afternoon authorising the continued deprivation of Elliot's. liberty on the hospital ward until 16:00hrs on Day 8.
Day 7 (Wednesday)	• Daily Planning Meetings were held at 09:00hrs and 15:00hrs. • Escalation to WBCCG, CQC, NHS England and GMHSCP • At the 15:00hrs meeting concerns were raised from WWL regarding the quality of the Mental Health Act assessment. There were differences of opinion regarding the outcome and WWL and CSC were requesting a second opinion. • CSC agree to increase the number of care support workers to five alongside a hospital nurse who will support airway management and clinical observations – resulting in a 6:1 staff ratio to support Elliot. • Mental Health Act assessment was completed with three registered practitioners in line with the Mental Health Act legislation. They concluded that Elliot did not meet the criteria under the Mental Health Act, and it was not in his best interests to further detain him. • Court order remains in place authorising the continued deprivation of Elliot's liberty. on the hospital ward until 16:00hrs on Day 8
Day 8 (Thursday)	• Continued 6:1 staff ratio to support Elliot. • Daily Planning Meetings held at 09:00hrs and 12:00hrs, chaired by the CSC Practice Director. • WWL escalate concerns to Greater Manchester Gold Command regarding the impact on the Ward. • Elliot's Children's Guardian requested a second opinion in respect of the Mental Health Act assessment from the previous day, specifically regarding the medications required to manage Elliot's anxiety. • Court hearing Interim Care Order (ICO) granted alongside an authorisation for the continued deprivation of Elliot's liberty on the hospital ward until 16:00hrs on Day 13 when this will be reviewed in Court. The NHS can legally chemically and physical restrain, and the Local Authority can physically restrain.
Day 9 (Friday)	• Continued 6:1 staff ratio to support Elliot. • Between 01:24hrs and 05:00hrs Elliot continued to demonstrate verbal and physical aggression towards staff. Care staff found it difficult to settle him. Father contacted the Ward twice during this time to ask how Elliot was. • Elliot absconded from the Ward in the afternoon and required periods of regular restraint and safe holding. • Daily Planning Meetings held at 09:00hrs and 12:00hrs, chaired by the CSC Practice Director. • In the daily planning meetings (which were attended by executive leaders from various agencies) there were extended discussion regarding the quality of the Mental Health Act assessment and whether this could or should be repeated.
Day 10 (Saturday)	• Staff ratio to support Elliot remained at 6:1, however, the package of care is increased to include two Registered Mental Health Nurses and four carers. However, only one Registered Mental Health Nurse arrived for the night shift.

	• One episode of Elliot absconding from the Ward at 21:20hrs-21:50hrs. Elliot was sedated whilst receiving physical restraint. • There was no daily planning meeting on Day 10 as it was the weekend.
Day 11 (Sunday)	• Staff ratio to support Elliot remained at 6:1, including two Registered Mental Health Nurses and four carers. • There was no daily planning meeting on Day 11 as it was the weekend and no system escalations.
Day 12 (Monday)	• Staff ratio to support Elliot remained at 6:1, including two Registered Mental Health Nurses and four carers. • Consultant Psychiatrist has made changes to the medication prescribed which means the Alder Hey Rapid Tranquilisation Policy will no longer be needed. • Daily Planning Meetings held at 09:00hrs and 15:30hrs. • WBCCG Designated Nurse escalated further concerns to GMHSCP regarding the level of restrictive practices. • A decision is made that Mental Health Act assessment should not be repeated unless there are changes to Elliot's presentation
Day 13 (Tuesday)	• Staff ratio to support Elliot remained at 6:1, including two Registered Mental Health Nurses and four carers. • Order made in the High Court, Family Division. In this hearing the Judge declined to authorise the continued deprivation of liberty of Elliot. The Judge outlined that he was satisfied that the current arrangements for Elliot constitute a breach of his Article. 5 rights.
Day 14 (Wednesday)	• Staff ratio on the Ward to support Elliot remained at 6:1, including two Registered Mental Health Nurses and four carers. • CSC sourced a temporary placement for Elliot with a 3:1 staff ratio with mental health trained staff. Discharge Planning Meeting held with key agencies and workers to ensure a robust plan of support was in place to reduce risks in the community. • Court order updated regarding authorised restrictive practices. • Elliot discharge to placement at 18:45hrs

KEY LINES OF ENQUIRY

(KLOE) KLOE 1:

To consider if multi-agency disagreements about the outcome and quality of the mental health assessments led to drift and delay and whether there is a clear pathway for escalation in these circumstances.

What happened?

58. Elliot was admitted to A&E at 23:37hrs on Day 3 accompanied by two carers. He was brought to A&E following an emergency 999 call received by NWAS as Elliot had attempted to self-ligature. A high level of restraint was needed to protect Elliot and the staff.

59. There were prolonged discussions between medical staff who were unclear about appropriate use of chemical sedation in this circumstance. The A&E Doctor (Registrar) discussed sedation with an Anaesthetic Consultant who advised not to sedate due to the potential of airway complications. Nurses also highlighted concerns regarding Elliot requiring sedation.

60. MHLT first reviewed Elliot at 00:20hrs (Day 4), 43 minutes after Elliot was admitted. The MHLT challenged the clinical staff's reluctance to prescribe sedation to Elliot. This was discussed with the on-call Psychiatrist who agreed to prescribe sedation. The MHLT then advised WWL staff that they were unable to complete a mental health assessment due to Elliot's level of sedation. They did however advise that the staff ratio should be increased from 2:1 to 4:1 to support Elliot.

61. Later that day (Day 4) the MHLT had a discussion with the ward Manager and a mutual decision was made to delay mental health assessment until Day 5 due to Elliot's level of distress.

62. On Day 5 the MHLT advised WWL staff how they could de-escalate and calm Elliot. They completed a mental health assessment at 14:17hrs which suggested that presenting behaviours were likely to be due to Elliot being unable to self-soothe.

63. Following the 2nd Daily Planning Meeting a request for an urgent Mental Health Act (MHA) assessment was made as professionals from WWL and Wigan Council CSC disagreed with the outcome of the mental health assessment. Following this meeting

Section 5 (2) of the MHA was implemented which allowed professionals 72-hours to undertake a full MHA assessment.

64. On Day 6 concerns continued to be raised at the Daily Planning Meetings regarding Elliot not yet having had an MHA assessment. Mental health colleagues held an urgent meeting to discuss next steps and consulted with inpatient CAMHS colleagues for advice. An MHA assessment was arranged but this had not taken place.

65. On Day 7 an MHA assessment was completed at 13:00hrs with three registered practitioners in line with the MHA legislation. Elliot became extremely agitated, and the Police were called to assist the ward in management of his behaviours. The assessment concluded that Elliot did not meet the criteria under the MHA, and it was not in his best interests to further detain him. He was assessed as not requiring a CAMHS inpatient Tier 4 admission as it was felt that a mental health setting would be highly likely to exacerbate Elliot's presentation. Therefore, the Section 5 (2) was rescinded. They made some changes to his prescribed medication to assist with agitation.

66. At the Daily Planning Meeting held at 15:00hrs concerns were raised from WWL regarding the quality of the MHA assessment. WWL staff felt that the MHA assessors had not spent time with Elliot and had based their opinions on a review of health records. WWL and CSC requested a second opinion and wanted the MHA assessment to be repeated.

67. On Day 8 the Children's Guardian for Elliot requested a second opinion in respect of the MHA assessment from the previous day, specifically regarding the medications required to manage Elliot's anxiety.

68. On Day 9 in the Daily Planning Meetings (which were attended by executive leaders from various agencies) there were extended discussion regarding the quality of the MHA assessment and whether this could or should be repeated. It was highlighted by some participants in the meetings that MHA assessments cannot be repeated unless there are significant changes in a person's presentation. It was agreed at this point that the MHA assessment would be repeated, and discussions would take place to explore how and when this could take place.

69. On Day 12 at the Daily Planning Meeting participants were informed the MHA assessment documentation was reviewed from a quality perspective and deemed appropriate. A discussion had taken place between senior leaders within CSC and health, and despite a previous agreement that the MHA assessment would be repeated, GMMH believed that a repeat assessment was not clinically indicated and did not happen. This therefore this meant that professionals needed to focus on sourcing an appropriate placement to enable a safe

discharge for Elliot into the community.

70. On Day 13 a written report was shared with the ward regarding the MHA assessment that had taken place on Day 7. There was a High Court hearing in which the Judge declined to authorise the continued deprivation of liberty of Elliot. This meant that Elliot needed to be discharged the following day to a suitable placement.

KLOE 1 Findings

71. The findings of KLOE 1 are that there was drift and delay in the care planning for Elliot due to other agencies challenging the outcome and quality of mental health assessments.

72. As a result of the WWL staff and CSC staff being unwilling to accept the outcome of the Mental Health Act assessment, mental health staff felt there was a lack of respect for their professional opinion. They also felt that other agencies view an inpatient CAMHS admission as a place of safety and the solution for all children who present like Elliot. Mental health professionals were also highlighting the potential impact of a hospital admission on a child with autism and or a learning disability. They felt a long hospital admission for a childlike Elliot would be traumatic.

73. This dynamic was further complicated by the Daily Planning Meetings including a range of professionals from frontline practitioners to executive senior leaders. This led to protected discussions about the right way to proceed.

74. It is clear from the information provided to the LCSPR that there is confusion regarding the steps in the process for a child to be referred and assessed under the Mental Health Act. The Reviewers concluded that whilst challenge should be encouraged it is imperative that this is done with professional respect.

75. Ultimately it was apparent that there is a lack of understanding regarding the MHA assessment criteria, when an inpatient CAMHS admission is in the best interests of the child, and how and when to appropriately challenge decision making by those services outside mental health.

KLOE 1 RECOMMENDATIONS:

Recommendation 1: Greater Manchester Mental Health NHS Foundation Trust and Pennine Care NHS Foundation Trust need to clearly outline the process for a child to be referred for a Mental Health Act assessment, criteria for inpatient CAMHS admission and the routes for professional challenge when there is a disagreement. This document should be accessible to all agencies.

Recommendation 2: A joint Health and Social Care Escalation Policy should be developed to ensure that when there is a risk of a child remaining on a general paediatric ward inappropriately and we are unable to achieve a safe discharge there are clear processes to alert senior leaders to take action.

KLOE 2

To explore how Elliot's presentation was managed and his care needs met effectively; particularly focusing on effective use of mental health services expertise to support the Acute Paediatric environment including the use of antipsychotic drugs.

What happened prior to admission to hospital (Days 1-3)

76. On Day 2 Elliot was taken to a residential placement which is a short-term respite home for children with complex needs. Elliot stated that he did not want to live with his Father.

77. On Day 3 the residential placement made an emergency 999 call to Northwest Ambulance Service (NWAS) as Elliot had attempted to self-ligature. Police, NWAS and the Fire Service attended the care home, and six members of the Fire Service were required to physically restrain Elliot. Elliot was taken to WWL A&E at 23:37hrs along with two carers. On arrival at A&E care home staff expressed concerns to WWL staff that the placement was not right for Elliot as they usually provide care for children who have complex disabilities, and their families require respite.

What happened in A&E (Day 3-4)

78. Once at A&E Elliot was distressed and needed a high level of restraint.

79. There were prolonged discussions between medical staff who were unclear about appropriate use of chemical sedation in this circumstance as Elliot was only 12 years old. The hospital records reflect that clinical staff were concerned about sedating Elliot due to potential airway complications. A&E medical staff consulted with colleagues in the Intensive Care Unit (ICU) and Anaesthetics.

80. The Police were requesting to leave the A&E Department as they were out of their policy timeframes for restraint and concerned about breaching Elliot's human rights. The Police were also concerned about needing four officers to restrain Elliot for long periods. Police officers were also querying why sedation had not been given. The nursing staff felt that it was unsafe for the Police to leave and outlined why sedation had not been given. Police and nursing staff continued to work together and follow their restraint policies to keep Elliot as safe and comfortable as possible.

81. Initially Elliot was deemed as not requiring admission to the General Paediatric ward as *"he had no medical needs".* However, the Mental Health Liaison Team (MHLT) attended at 00:20hrs and challenged clinicians' reluctance to prescribe sedation. Sedation was discussed by the MHLT with the on-call psychiatrist due to Elliot's *"high levels of distress and aggression"* who agreed to prescribe sedation.

82. Elliot was given intramuscular sedation at 01:23hrs and the Police left A&E shortly after as Elliot was calm. MHLT advised WWL staff that they were unable to complete a mental health assessment due to Elliot's level of sedation.

83. At around 03:30hrs records reflect that Elliot was no longer in restraint or attempting to leave the room. Elliot had 2:1 staff ratio of Care Home Staff and MHLT recommended to CSC that this should be increased to a 4:1 ratio to support Elliot.

What happened during Elliot's stay on the General

Paediatric ward Day 4

84. Elliot was admitted to the General Paediatric ward at around 04:00hrs (around 4.5hrs after first arriving at A&E) on Day 4 as he required a period of observation following sedation. CSC informed Elliot's Father in the early hours that he had been admitted to hospital.

85. At 08:43hrs the ward Manager contacted the Residential Placement Manager to discuss safety planning and the residential placement agreed to continue to provide a 2:1 staff ratio until next day (Day 5) when a Discharge Planning Meeting had been arranged.

86. The MHLT arrived on the ward and had a discussion with the Ward Manager. A mutual decision was made to delay the Mental Health Assessment until Day 5 due to Elliot's level of distress.

87. In the afternoon Elliot absconded from the ward followed by his two carers. The Police were called, and Elliot was located across the road from the hospital and brought back to the ward by Police. Upon arrival back to the ward Elliot climbed under his hospital bed and attempted to injure his arm in the bed mechanism. This resulted in him being restrained by the Police and the bed frame was removed from the room. This led to Elliot having only a mattress placed on the floor of his room for his own safety.

Elliot's Presentation Day 5-14

88. Between Day 5 and Day 14 when Elliot was discharged, he presented as a child in extreme emotional distress. He communicated this distress in a number of ways including self-harm, screaming, attempting to leave the ward, verbally and physically assaulting staff, and damaging fixtures and fittings of the ward.

89. There were several escalations in Elliot's distress each day with no evident triggers which often resulted in medical staff, nursing staff, support staff and security officers needing to restrain him. The Alder Hey Rapid Tranquilisation Policy was utilised in order to help calm Elliot.

Police Assistance to the Ward

90. The Police were called to assist in the management and restraint of Elliot via emergency 999 call from WWL on nine occasions. On some of these occasions (Days 3-7) between two and six Police officers were required to remain on site for prolonged periods of time including overnight. On Day 5 the highest number of Police officers were dispatched to the ward and needed to use a high level of restraint to keep Elliot safe.

Staff Ratio to Support Elliot during his Admission.

91. On admission to the ward (Day 4) Elliot had a 2:1 staff ratio (Care Home Staff). The MHLT recommended to CSC that this should be increased to 4:1 staff ratio.

92. On Day 5 it was agreed at the Daily Planning Meeting that an Independent Care Provider would be commissioned by CSC to provide 4:1 staff ratio to support Elliot. Professionals agreed that at least one of the four carers should be a Registered Mental Health Nurse (RMN). This was implemented on Day 6 with four carers being provided alongside a WWL hospital nurse who would support airway management and clinical observations – resulting in an overall 5:1 staff ratio to support Elliot. This change supported WWL staff to be able to more safely care for Elliot.

93. On Day 7 CSC agree to increase the number of care staff to five alongside a WWL hospital nurse who would support airway management and clinical observations – resulting in an overall 6:1 staff ratio to support Elliot. This staffing ratio continued until Elliot's discharge, however on Day 10 the package of care was increased to include two Registered Mental Health Nurses as part of the five carers.

Physical and Chemical Restraint

94. Paragraphs 81-86 clearly outline that Elliot arrived in A&E already in physical restraint put in place by the Police and there were discussions between clinical staff regarding the need for chemical sedation soon after his arrival in A&E.

95. During Elliot's admission he required physical and chemical restraint every day

on multiple occasions with Rapid Tranquilisation being utilised several times. Elliot required daily administration of both intramuscular sedatives and/or intramuscular antipsychotic drugs.

96. Medical staff explored the possibility of introducing oral medication to replace the intramuscular injections, but it was felt that these would take too long to take effect and Elliot often refused to take or covertly discarded oral medication.

97. On Day 9 WWL medical staff liaised with CAMHS and was advised by a Registrar to consider giving oral medication covertly. The WWL Legal Team advised there was no provision to do this within the agreed Court order. On Day 11 he asked if he could have this in tablet form. Medical staff agreed and Elliot was given the medication orally. This resulted in his level of distress reducing.

98. On Day 12 there were discussions between the Paediatric and Psychiatric Medical Teams due to disagreements about prescribed medication. The Psychiatric Team was uncomfortable with prescribing routine medications for a 12-year-old child who did not have a formal mental health diagnosis. Following this conversation, the Consultant Psychiatrist made changes to the medication prescribed which meant that the Alder Hey Rapid Tranquilisation Policy would no longer be needed.

99. In a statement to the High Court Elliot's Paediatric Consultant explained that on one occasion they had administered the maximum amount of daily sedative to Elliot that would be safe and in his best interests. They went on to outline that despite the high 6:1 staff ratio chemical restraint was still required several times a day. This statement is supported by the documentation submitted to the LCSPR and the reflections from clinical staff in the LCSPR Learning Event. Staff expressed that when Elliot's levels of agitation and distress increased staff struggled to calm, de-escalate, and physically restrain him.

100. The continued inability to contain Elliot during physical and chemical restraint led to an increase in the care staff ratio. The WWL Security Team also arranged additional security officers for the weekend shifts in order to support the ward.

101. Some of the difficulties experienced in the physical restraining of Elliot were due to care staff sometimes being provided by different organisations who worked to different policies. This meant they used different methods of physical restraint and for differing maximum lengths of time.

102. Hospital records outlined that Elliot appeared to be having vacant episodes during physical restraint which medical staff felt were being triggered by the circumstances and environment rather than a medical reason. During these episodes staff experienced difficulties obtaining physical observations due to Elliot's distress. This made it difficult for staff to ensure his safety.

103. There were frequent discussions evident in the information provided to the LCSPR that Paediatric Consultants felt uncomfortable and inexperienced in the prescribing and administration of sedatives and antipsychotic medication. WWL did not have a policy or protocol to support this and arrangements for psychiatric support in relation to this was unclear, particularly out of hours.

104. Generally, the out of hours Psychiatrist on call was not a Paediatric Psychiatrist. The out of hours provision was delivered by a different NHS Mental Health Trust to the in hours provision. This led to delays in medical staff being able to access specialist advice needed to administer Rapid Tranquilisation. However, there were examples of occasions when support was more easily accessed. For example, on Day 10 the Paediatric Consultant rang the on-call Psychiatrist as per the Alder Hey Rapid Tranquilisation Policy and was able to obtain advice regarding suitable dosage for Elliot.

Legal Framework

105. On Day 5 Section 5 (2) of the Mental Health Act was implemented in relation to Elliot with a view to undertaking a full Mental Health Act assessment within 72 hours.

106. On Day 6 a Court order was issued in the afternoon authorising the continued Deprivation of Elliot's Liberty on the hospital ward until 16:00hrs on Day 8.

107. A Mental Health Act assessment was completed with three registered practitioners in line with the Mental Health Act legislation on Day 7. They concluded that Elliot did not meet the criteria under the Mental Health Act, and it was not in his best interests to continue to detain him. It was felt that a mental health setting would be highly likely to further exacerbate his presentation, therefore the Section 5 (2) was rescinded.

108. On Day 8 an Interim Care Order (ICO) was granted alongside an authorisation for the continued Deprivation of Elliot's Liberty on the hospital ward until 16:00hrs until Day 13 when this would be reviewed in Court. This authorised the NHS to legally chemically and physical restrain Elliot, and the Local Authority to physically restrain.

109. On Day 13 an order was made in the High Court, Family Division. In this hearing the Judge declined to authorise the continued Deprivation of Liberty of Elliot. The Judge outlined that he was satisfied that the current arrangements for Elliot constituted a breach of his human rights under Article 5.

KLOE 2 Findings

Management of Elliot's Presentation and Care Needs

110. Despite the best efforts of all staff Elliot's presentation was extremely difficult to manage and this resulted in his care needs not being met effectively. This led to an increase in Elliot's distress.

111. In paragraph 59 of the High Court ruling the Judge commented that *"All the evidence in this case points to the current placement being manifestly harmful to <Elliot>".* However, later in the published judgement the Judge states *"Finally, I wish to make clear that nothing that I have said in this judgment constitutes a criticism of the doctors, nurses, social workers, police, and other professionals who have been required to engage with <Elliot>. They have, I am satisfied on the evidence before the court, tried to do their best in a situation in which they should never have been placed. All those involved have done their level best in a situation that has bordered on the unmanageable."*

Support from Mental Health Services to the Acute Paediatric Team

112. It was clear from the information provided to the LCSPR that WWL medical staff felt they were working outside of their usual scope of practice, and at times felt unsafe and unsupported by mental health services.

113. Out of hours Psychiatry support was provided by a different NHS Provider to the main in hours support for the ward. This was confusing for clinical staff and did cause delays in WWL accessing out of hours Psychiatry advice and support.

114. This gap appears to have been created during the April 2021 transfer of services from one mental health NHS provider to another. It seems that the comprehensive NHS due diligence process for this transfer may not have adequately considered the out of hours CAMHS arrangements.

115. It was clear from discussions with staff at the Learning Event that the relationships between WWL and CAMHS staff was at times strained. However, there is evidence that ward staff and the MHLT did work together to explore how they could de-escalate and calm Elliot.

Physical and Chemical Restraint

116. Staff attending the LCSPR Learning Event told the Reviewers that Elliot had expressed to staff that he was scared of injections and did not like the feeling the medication gave him. Nursing staff explained that the intramuscular medication, particularly Haloperidol, is likely to feel uncomfortable.

117. Staff also described that prescribing advice for antipsychotic drugs was being provided virtually and there was little face to face support from Psychiatrists. WWL medical staff were using the Alder Hey Rapid Tranquilisation Protocol as they had no internal policy, procedures, or guidance in respect of this.

118. There was a Court order in place which authorised NHS staff to chemically restrain Elliot and use Rapid Tranquilisation in his best interests. In the High Court Ruling on Day 13, the Judge stated in paragraph 56 that whilst this had been authorised by the Court, he felt that the "current regime of chemical restraint cleaves closer to that of constant sedation". His honour went on to comment that *"This is not the result of malice or negligence but simply of an increasingly desperate attempt to contain <Elliot> in a situation that is not designed, in any way, for that purpose."*

119. Overall, it was clear to the Reviewers that all staff quickly recognised that they were unable to effectively meet all of Elliot's presenting care needs. As a result, this was escalated internally in a timely manner and there were efforts to obtain the appropriate advice and expertise to inform Elliot's care plan.

KLOE 2 RECOMMENDATIONS:

Recommendation 3: Commissioners need to work with Greater Manchester Mental Health NHS Foundation Trust to review the current out of hours Psychiatry provision for children and ensure that arrangements are fit for purpose and clear to other NHS providers who use this service.

Recommendation 4: Work needs to be completed to facilitate the coming together of clinical staff at Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation (WWL) Trust and Greater Manchester Mental Health NHS Foundation Trust (GMMH). This will need to fully explore perspectives, roles, and responsibilities with a view to improving working relationships and developing clear joint protocols for working together. WWL must also develop an agreed, easily accessible Rapid Tranquilisation Policy for use within Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.

KLOE 3:

Establish how hospital provision was used in relation to Elliot, what alternatives were available and how WWL's general paediatric provision is equipped to manage and respond to presenting need.

Use of Hospital Provision

120. When Elliot was admitted to A&E medical staff determined he had no medical needs and therefore did not require admission to the general paediatric ward.

121. Elliot subsequently required sedation to manage his level of emotional distress and self- harming behaviour. As a result of this sedation, he was admitted facilitate a period of observation. observation following sedation.

122. Elliot was presented to A&E on Day 3 and admitted to the general paediatric ward on Day 4. He had a mental health assessment by the MHLT Team on Day 5 and subsequently a Mental Health Act assessment on Day 7. The Mental Health Act assessment determined that Elliot did not meet the criteria for further detention under Section 2 or Section 3 and the Section 5 (2) was therefore rescinded.

123. Following the outcome of the Mental Health Act assessment on Day 7 Elliot did not require continued admission to a general paediatric ward. Therefore, Elliot remained on the ward for further 6 days because a safe discharge could not be achieved due to lack of an appropriate placement being sourced by CSC.

Hospital Environment and Staffing

124. The general paediatric ward is situated on the fourth floor of the district general hospital. The ward has capacity for 34 paediatric beds for children and young people aged 0-16 years. The ward has twelve individual cubicles and four bays each with up to five beds, and two High Dependency beds. The ward offers a wide range of services and cares for children with a range of conditions and illnesses.

125. For the safety of the patients, access to and from the ward is via an intercom system located on the wall on each side of the entrance doors. Only ward staff can provide access. Pressing the buzzer will identify that access is needed and visitors are asked for identification and who they are visiting.

126. The ward is staffed by registered paediatric nurses and support staff. At the learning event WWL staff described feeling that they were not trained to care for children who

presented like Elliot. Staff said that they are not experienced in managing challenging behaviour, de-escalation of children in extreme emotional distress and the level of physical restraint that Elliot needed.

127. As outlined in KLOE 2 above medical staff also felt that they were working outside of their scope of practice.

Elliot's Room

128. Elliot's room on the ward needed to be made increasingly sparse in an attempt to keep Elliot safe. The High Court Judgement gave an overview of the condition Elliot was experiencing in Paragraph 26 *"The door to the shower in which he washes himself has been removed, and therefore <Elliot> has no privacy at all when showering or dealing with other aspects of his hygiene. He is at present sleeping on a mat on the floor and he is unable to have a pillow, or a sheet due to the risk of self-harm and suicide."*

Additional Resources and Impact

129. In order for Elliot to remain on the general paediatric ward the following list of measures were required:

- Elliot was subject to chemical restraint, physical restraint and 6:1 staffing to attempt to control his behaviour.
- Police were called to the ward to assist in the management and restraint of Elliot via emergency 999 call from WWL on nine occasions.
- WWL Security Team increased the number of staff on duty to support the ward.
- Capacity and activity needed to be reduced in the department to safely care for Elliot and the other patients.

Alternative Provisions Available

130. At the Daily Planning Meetings CSC explained that they were exploring placements available nationally that could meet Elliot's needs. They continued to highlight that there was a chronic shortage of therapeutic placements across the country, and they were at the mercy of private providers who were more inclined to accept children with less complex needs. They advised they were exploring secure placements and non- regulated placements.

131. CSC also explored the possibility of obtaining a secure placement for Elliot but again highlighted that there were a handful of vacant beds with a long waiting list. The CSC Placement Team advised the Daily Planning Meeting that there was only one secure bed in England, with 47 applications being considered. The

level of staff ratio Elliot required, and his young age further challenged the CSC Placement Team in finding a willing placement provider.

132. At the Daily Planning Meetings other agencies voiced that CSC should establish an 'in house' placement for Elliot. CSC were reluctant to pursue this option as this would be 'unregulated' and therefore an illegal placement.

133. Despite CSC's reluctance to establish an unregulated placement and because there was a lack of regulated therapeutic placements available to commission CSC were making arrangements to commission an unregulated placement.

134. CSC identified a property and arranged for the necessary work to be undertaken to make it a suitable and safe environment within which Elliot could be cared for. They arranged for commissioned providers to continue to provide a wraparound package of support on a 2:1 staff ratio. The commissioning of a safe package of care took many days to arrange due to its complexity.

Elliot's Discharge from the Ward

135. Elliot was discharged from the ward on Day 14 into a property sourced and staff by Wigan Council CSC. This was arranged following the High Court Ruling on Day 13 when the Judge declined to further authorise the Deprivation of Elliot's Liberty.

136. CSC arranged for commissioned providers to continue to provide a wraparound package of support on a 2:1 staff ratio. Elliot was therefore discharged into the care of the Local Authority on Day 14.

KLOE 3 Findings

Use of Hospital Provision

137. WWL is commissioned to admit children to hospital who require an assessment of their mental health. Once a mental health assessment has been completed the child should be safely discharged to the most appropriate place such as their home, an appropriate placement or when the Mental Health Act criteria is met, transferred to an NHS inpatient CAMHS provision.

138. The challenges begin when a child has had a Mental Health Act assessment and is not assessed as meeting the Mental Health Act criteria and therefore is not eligible for an inpatient CAMHS admission. In Elliot's case he was assessed as not requiring a CAMHS admission on Day 7 however it was clear that he continued to present as a risk to himself.

139. Therefore, Elliot's safe discharge was delayed by seven days due to the lack of an appropriate placement which could meet his needs, and the time that it takes to commission a safe complex package of care. This resulted in Elliot being

Deprived of his Liberty and enduring extremely restrictive practices to be kept safe on the ward. This included him being sedated most of the time as articulated by the Judge.

140. Nationally, Children's Social Care are dealing with a chronic shortage of appropriately registered therapeutic placements for children like Elliot. This leads to long periods of time when children are 'medically fit' for discharge but an appropriate safe place for the child to be discharged to cannot be sourced.

141. This is particularly highlighted within the briefing paper published by the Children's Commissioner in November 2020 entitled 'The children who no-one knows what to do with'. On page one of this briefing paper the Children's Commissioner outlines that *"Again and again the courts have castigated the Government for a failure to plan and provide for these most desperately vulnerable children"* and goes on to assert that thousands of children with complex needs fall through these gaps in the system each year.

142. This assertion by the Children's Commissioner is supported by paragraph 2 of the High Court Judgement regarding Elliot. The Judge commented *"In what will be a scenario now depressingly familiar to those in the habit of reading on BAILII judgments given by High Court judges and Deputy High Court judges in cases of this nature, and within the context of acute emotional and behavioural difficulties consequent on past abuse, <Elliot> has been assessed as not meeting the relevant criteria for detention under ss.2 or 3 of the Mental Health Act 1983 as he is not considered to be suffering from a mental disorder. At the same time, the therapeutic treatment within a restrictive clinical environment for acute behavioural and emotional issues arising from past trauma that he does urgently require is simply unavailable".*

143. As a result, nationally general paediatric wards are increasingly being used as a 'Place of Safety'. Paragraph 55 of the High Court Ruling outlined that the challenges faced by WWL in caring for Elliot *"…have their roots in the fact that a paediatric hospital ward is simply not equipped to undertake the task that circumstance, and an acute lack of appropriate resources, has assigned to it".*

How equipped is general paediatric provision to manage and respond to presenting need?

144. As outlined above some staff from the general paediatric ward at the learning event described feeling ill equipped and uncomfortable in caring for children who present with needs such as Elliot. There appeared to be a culture of 'these children' should not be on our ward and when there is an emotionally distressed child on the ward it is more difficult to care for physically ill children. Some staff feel they are not trained to nurse children with mental health needs and seemed to clearly separate physical and mental health needs as being very different.

145. The main issues of concern included a lack of training in mental health, managing challenging behaviour, de-escalation skills, and more enhanced levels of physical restraint.

146. The Reviewers concluded that in response to the changing presentation and complexities of children requiring admission to general paediatric wards, NHS Providers need to evolve existing provision. This could include reviewing skill mix of the ward team to include employing Registered Mental Health nurses as part of the ward's establishment. Reconfiguring the skills of the team would facilitate the needs of children and young people being fully met and reduce risks created by lack of training and experience.

147. The view of the Reviewers is supported by a joint statement issued by the Royal College of Psychiatrists with the Royal College of Emergency Medicine and the Royal College of Paediatrics and Child Health on 21st December 2021.

148. The position statement entitled *"Meeting the mental health needs of children and young people in acute hospitals: these patients are all our patients"* highlights that the number of children presenting with to A&E with *"complex psychosocial crises"* is significantly increasing. It acknowledges that CAMHS is struggling to manage *"unprecedented demand"* especially following the Covid-19 pandemic with more children being admitted to general paediatric wards *"…simply because it is the safest place for them at that moment in time".*

149. The statement clearly outlines that *"Regardless of where children and young people present to care or what their specific health needs are, we must work together to ensure they receive the highest quality care, from qualified clinicians, as quickly as possible."* They go on to say, *"These patients are all our patients, and we must work together to ensure they receive the right treatment, in the right place, at the right time."*

What Alternative Provision was Available?

150. As outlined above Wigan Council CSC were attempting to source a therapeutic placement for Elliot in the private provider market. They also considered the possibility of a secure placement; a child can only be placed in a secure placement if supported by a Court Order under Section 25 of the Children Act (1989).

In the view of the Reviewers the only realistic alternative available to CSC was to establish an 'in house' unregulated placement which ultimately, they were directed to do by the High Court. CSC maintain that this was their least preferred option and were trying to secure a regulated therapeutic placement whilst commissioning an unregulated placement as a last resort.

151. In 'The children who no-one knows what to do with' the Children's Commissioner

points out that Local Authorities have a statutory responsibility to take steps, as reasonably practicable, that ensure children in care are provided with accommodation that *"(a) is within the authority's area; and (b) meets the needs of those children"* (Children Act 1989).

152. She states that Local Authorities need to work together to better to improve provision, making best use of their buying power to better shape the market. She suggests this can be achieved through the *"greater use of regional commissioning and frameworks"* (page 11).

KLOE 3 RECOMMENDATIONS:

Recommendation 5:

Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust should:

- Consider the skill mix of staff on the general paediatric ward, this could include employing Registered Mental Health Nurses as part of the ward establishment.
- Consider developing a 'Safe Place' within WWL where children who have been admitted can be assessed and cared for in an appropriate safer environment (e.g., ligature risk free).
- Complete a Training Needs Analysis of the training requirements of existing staff in relation to safer clinical holding and restraint techniques, de-escalation skills, mental health needs of children and young people etc.
- Work with staff to encourage parity of esteem between physical and mental health and develop confidence when providing care to children who present with mental health needs.

Recommendation 6:

Children's Social Care should work in partnership with other Local Authorities and health colleagues to explore the provision and/or the joint commissioning of suitable registered residential therapeutic placements. Children like Elliot need to be cared for in a suitable and safe setting that meets their needs and prevents them remaining in hospital unnecessarily.

KLOE 4:

To consider the impact on Elliot and other services of Children's Social Care (CSC) not having an agile, responsive resource of suitably skilled staff to support Elliot and explore what resources are needed.

153. The impact on Elliot and other services due to CSC not having an agile, responsive resource of suitably skilled staff to support Elliot has already been identified as part of the discussion in KLOE 2 and KLOE 3.

154. This included reference to:
- Elliot's room being made increasingly sparse in an attempt to keep Elliot safe.
- The need for additional resources to be put in place for Elliot to remain on a general paediatric ward.

155. In KLOE 2 the Reviewers identified that there were difficulties experienced in the physical restraining of Elliot due to care staff being provided by different organisations who worked to different policies. This meant they used different methods of physical restraint and for differing maximum lengths of time.

156. These issues were discussed in the High Court Judgement. WWL informed the Court that their staff on the ward did not have the training or expertise to manage the challenging behaviour that was exhibited by Elliot. Specifically, regarding the deployment of physical restraint techniques to the level Elliot required. For this reason, Wigan Council CSC and Wigan CCG agreed to provide trained staff to undertake these tasks and provide the majority of the staffing ratio to support Elliot. In the High Court Ruling (Paragraph 14) WWL described that there had been difficulties with both the attendance of and the qualifications of the staff provided by the Wigan Council and Wigan CCG. This has resulted in the Trust having to make frequent calls to the duty social worker in relation to the care provision for Elliot.

157. As established in the previous KLOEs above in an attempt to coordinate a multi-agency care plan for Elliot and manage the escalating risk Daily Planning Meetings were held. As these were held up to three times a day this presented a significant demand on time for all professionals.

KLOE 4 Findings

Impact on Elliot

158. It has been established by the Reviewers in the above KLOEs that Elliot's safe discharge was delayed by seven days due to the lack of an appropriate placement which could meet his needs. This resulted in Elliot being subject to extremely restrictive practices, including daily physical and chemical restraint. is behaviour most likely escalated due to the level of restrictive practices being deployed in an attempt to keep Elliot safe. His human rights were breached and whilst his admission was intended to provide sedation and observation following sedation and due to the breakdown of his social placement, ultimately it contributed to his trauma.

159. Participants at the Learning Event described Elliot as feeling scared and frightened when the Police came to the ward. He told staff he felt he was in prison.

160. WWL nursing and medical staff were clear that Elliot hated injections and often begged not to be injected.

161. When participants were asked what they thought Elliot would say about his stay in hospital one nurse commented *"I think he would say he had been violated. He spoke in adult terms about his restraint, accusing staff of abusing him. One trigger was anyone going near his suitcase".*

162. Another Learning Event participant from WWL reflected that much of the workforce looking after him was female and *"He did not have a very favourable opinion of them. As a service we (WWL) felt powerless".* Other participants observed that he did bond with some female Nurses.

163. Some staff were concerned about the restrictions needed in his room to keep him safe. In relation to Elliot's Room one participant said *"The room was stripped bare – but the only way to keep him safe. A blanket was only put on him once he was asleep. The bathroom was also stripped. He had no privacy/dignity – no lock on the door of the bathroom. He only slept in his room. Outside these times he had the play area, sensory room, and the rest of the ward. A child's bedroom should be their own place where they feel safe".*

164. Elliot only had one visit from his two schoolteachers during his stay in hospital. His Father and sibling attended the ward to drop off clean clothes and snacks for Elliot but did not see him. Learning Event participants described that the one thing Elliot was clear in articulating was that he did not want to see his Father. When one of the Reviewers spoke with his Father as part of the LCSPR process he was clear that he desperately wanted to see Elliot. His perception was that he was not allowed to attend the ward due to Covid-19 pandemic restrictions on

hospital visiting.

Impact on Health Services

WWL had to reduce activity to be able to safely care for Elliot and the other children which had a detrimental impact on other children and families who needed care.

165. Although Wigan CSC and Wigan CCG did commission additional care staff to support Elliot's specialist care whilst in the ward, this took some time to arrange, and it was problematic and needed to be refined as original agency staff were not meeting his needs. This placed WWL staff in the difficult situation of having to provide care that they did not feel suitably equipped to deliver.

166. As a result of CSC being unable to source a suitable placement for Elliot, relationships became strained between health and social care staff with each agency becoming increasingly frustrated.

167. The Court ordered that Elliot had to be discharged by 5pm on Day 14 as the Judge refused to further authorise his Deprivation of Liberty. CSC identified a property and wrap around staff to enable this Court directed discharge to take place. This led to health staff feeling that CSC had not done everything within their power in the preceding days. CSC had been commissioning an unregulated placement as a last resort and were trying to source a regulated therapeutic placement as a preferred option, but it is clear that other agencies were unaware of this and assume that the unregulated placement was arranged within a day, which is not the case. This impacted on trust and partnership working between agencies.

Impact on Police

168. There was a significant impact on their resources with nine calls to 999 and significant numbers of Police officers attending the ward. They were clearly highlighting the potential of breaching Elliot's human rights right at the beginning when they were called to accompany Elliot to A&E.

What is Needed?

169. At the Learning Event representatives from all agencies explored what they felt the learning was and what is needed to prevent a similar situation should a child presenting like Elliot be admitted to a general paediatric ward today.

170. Reflections included the need for:

- Wigan Council to commission an emergency placement provision in the Borough, staffed by people appropriately trained in trauma informed practice and building nurturing relationships, de-escalation skills, least restrictive practices, and physical restraint techniques. This emergency placement provision should be 'on call' and with the ability to mobilise in a

short timeframe.

- An ‘in reach’ wrap around service which can support children at home, in A&E, on a ward, in transition and to their placement in the community. This service needs to be 24 hour, 7 days a week, with more staff and direction over the weekend.

171. The Reviewers were made aware that CSC and Wigan Borough Clinical Commissioning Group have already initiated work in partnership with the Greater Manchester Health and Social Care Partnership to identify funding and develop provision. CSC and WBCCG are currently developing a business case to commission a ‘Parachute Team’ who would provide ‘in reach and wrap around support as well as exploring an emergency placement provision in the Borough.

172. Multi agency planning meetings need to focus on providing detail about how long it takes to commission a complex placement and an expected date of admission so that agencies have a clear understanding of the length of time that someone will need to remain in the hospital.

KLOE 4 RECOMMENDATION:

Recommendation 7: Wigan Children’s Social Care and NHS Wigan Borough Clinical Commissioning Group to continue the work initiated to develop a ‘Parachute team’ and residential provision in the Borough. This should include the development of standardised requirements for supporting staff including appropriate training (de-escalation skills, safe restraint, and clinical holding), trauma informed practice, clear standardised policies which outline a consistent approach to restraint.

KLOE 5:

To explore the planning and escalation procedures, the involvement of senior leaders and how effective these were in responding to Elliot's immediate needs. Was there sufficient focus on Elliot as well as consideration of implications for the wider system?

What Happened

173. Elliot was admitted to A&E on Day 3 (Saturday) at 23:37hrs. He was admitted to the general paediatric ward in the early hours of Day 4, 4.5 hours after first arriving at hospital.

Day 5 - Monday

174. The first formal escalation of the situation was made internally in WWL by the Ward Manager on Day 5 (Monday) at 09:00hrs to the Child Health Senior Leadership Team at WWL.

175. Three Urgent Planning Meetings were held throughout Day 5 which included ward management, health providers and commissioners, CAMHS staff and CSC. Prior to the 2nd meeting ward staff escalated the situation to WWL Head of Safeguarding and WWL Legal Department who attended the 2nd Urgent Planning Meeting.

Day 6 - Tuesday

176. On Day 6 there were three Daily Planning Meetings held at 09:00hrs, 12:00hrs and 15:30hrs. At one of the meetings, it was decided that an email would be sent from WWL Deputy Director of Operations to senior leaders at WWL, GMMH, WBCCG and CSC outlining concerns about the dangers to staff and other patients on the ward in the light of the issues with support staff provided by CSC and the possible need to close the ward.

177. An emergency CAMHS meeting held to discuss next steps. Galaxy House (Tier 4 inpatient Mental Health Unit) approached to explore if they can assist. Galaxy House explained that they do not accept emergency admissions and they have no beds available.

Day 7 - Wednesday

178. Daily Planning Meetings were held at 09:00hrs and 15:00hrs.

179. The WWL Named Nurse for Safeguarding Children escalated the situation to the WBCCG Designated Nurse for Safeguarding Children. The Designated Nurse at WBCCG subsequently escalated concerns to Executive Leaders and relevant commissioners at

WBCCG and the Head of Nursing at Greater Manchester Health and Social Care Partnership.

180. WWL Chief Operating Officer advised in one of the meetings that she had escalated the case to the Care Quality Commission (CQC) as they were on site at the hospital.

181. At the 15:00hrs meeting concerns were raised from WWL regarding the quality of the Mental Health Act assessment. There were differences of opinion regarding the outcome and WWL and CSC were requesting a second opinion.

Day 8 - Thursday

182. Daily Planning Meetings held at 09:00hrs and 12:00hrs, chaired by the CSC Practice Director.

183. WWL escalated concerns to Greater Manchester Gold Command regarding the impact on the ward.

Day 9 - Friday

184. Daily Planning Meetings held at 09:00hrs and 12:00hrs, chaired by the CSC Practice Director.

185. In the daily planning meetings (which were attended by executive leaders from various agencies) there were extended discussions regarding the quality of the Mental Health Act assessment and whether this could or should be repeated.

Day 10 – Saturday

186. There was no daily planning meeting on Day 10 as it was the weekend.

187. WWL escalated concerns to CSC Manager and WWL Head of Safeguarding that one of the Mental Health Nurses caring for Elliot stated they were unable to maintain Elliot's safety and required additional support.

Day 11 – Sunday

188. There was no daily planning meeting on Day 11 as it was the weekend and no system escalations.

Day 12 - Monday

189. Daily Planning Meetings held at 09:00hrs and 15:30hrs.

190. WBCCG Designated Nurse escalated further concerns to GMHSCP regarding the level of restrictive practices.

Day 13 and Day 14 (Monday and Tuesday)

191. On day 13 and Day 14 discussions took place between relevant frontline professionals to develop a robust discharge plan.

KLOE 5 Findings

Planning and Escalation Procedures

192. The first escalation of this case was made internally by WWL ward staff to the Senior Child Health Leadership Team. Elliot was admitted to A&E in the last hour of Day 3 (which was a Saturday) and admitted to the ward in the early hours of Day 4 (which was a Sunday). This explains why the situation was not escalated to senior leaders within WWL prior to Day 5.

193. The situation was not escalated to the WWL Safeguarding Team or the WWL Legal Team until Day 5 (Monday) following which the WWL Named Nurse for Safeguarding Children escalated to the WBCCG Designated Nurse for Safeguarding Children. This then led to subsequent escalations of concerns to Executive Leaders and relevant commissioners at WBCCG and the Head of Nursing at GMHSCP and NHSE. This appears to have been a timely escalation.

194. The Reviewers have identified that despite there being no formal joint multi-agency escalation process in place, once the case was escalated all agencies were responsive and understood the risks.

195. All agencies participated in the escalation and concerns were raised beyond local organisations, for example to NHS England and Greater Manchester Health and Social Care Partnership. Daily Planning Meetings were held up to three times a day, participants included front line practitioners up to the most senior leaders within the system.

Daily Planning Meetings

196. The Reviewers concluded that following escalation from Day 7 there was good attendance at the Daily Planning Meetings. Although the range of seniority of those attending sometimes led to insufficient focus on Elliot due to of implications for the wider system being considered and debated.

197. Elliot, his presentation, and his voice were a significant focus of the Daily Planning Meetings. It was clear from the records that participants were very much focused on the lived experience of Elliot in these challenging circumstances. Despite professionals capturing the voice of Elliot this did not lead to any tangible improvement in Elliot's experience because ultimately, he was being cared for in an inappropriate setting and staff had to keep him safe in an environment that was not suitable to support his emotional distress.

198. Those involved knew that the situation was not appropriate and that the level of restrictive practices was at risk of breaching Elliot's human rights. Participants in the Learning Event described knowing it was not right but feeling completely powerless to do anything different to keep Elliot safe.

199. Participants at the Learning Event were also asked to reflect on the Daily Planning Meetings and the following themes were identified in relation to:

Power imbalance and operational v strategic

200. Due to frontline practitioners and executive leaders attending the meetings, some frontline staff sometimes felt intimidated and unable to challenge. Discussion in the meetings often included operational care delivery issues such as the staff rota, as well as strategic considerations about the risk being held in the wider system such as closing beds and cancellation of elective surgery lists. Other staff reported that they felt supported by their managers and able to participate.

Professional challenge and professional respect

201. At times discussions became emotive and strained as participants sometimes felt frustrated. There were some key issues which were highly debated such as whether the Mental Health Act assessment had been completed to an appropriate quality standard and the lack of placements available for CSC to commission. Mental health professionals felt their expertise and clinical decisions were challenged and they were not professionally respected by ward staff and CSC.

Consistency

202. There was a lack of consistent structure and approach to the Daily Planning Meetings. This was likely due to the inconsistency of people attending leading to a repetition of information being shared. Meeting invitations were often forwarded on to numerous other colleagues. As the meetings were held virtually via Microsoft Teams this often meant there was no limit to the number of participants.

203. Overall, the level of escalation and response was appropriate once senior leaders were aware of the situation.

204. There needs to be a clear route for full discussion of operational and care planning considerations alongside the formal escalation pathway and consideration of implications for the wider system.

KLOE 5 RECOMMENDATIONS

Recommendation 8: A joint health and social care escalation policy needs to be developed which:

- Is responsive and proactive to present drift and delay.
- Outlines roles and responsibilities for all agencies including who will take the lead.
- Provides a clear structure for points of discussion at the escalation meetings.
- Ensures the focus remains on the child.
- Considers legal frameworks and ensures that all restrictive practices are the least restrictive and proportionate.
- Directs that operational care planning discussion should take place separately to senior leaders/strategic meetings.
- Directs organisations to nominate a consistent contributor to attend the meetings with the right level of seniority/ability to decision make.
- Encourages integrated working and articulates how collective risk is shared.

KLOE 6:

To establish what work has been undertaken by Children's Social Care to manage the lack of suitable therapeutic placements for children like Elliot, including joint working with Partners.

Work Already Undertaken

205. Wigan Children's Social Care informed the LCSPR Reviewers that they have developed a strategic plan which includes the commitment to progress an overall sufficiency plan with providers to ensure there are a variety of homes and therapeutic support available. They are also working closely with other Local Authorities within Greater Manchester and across the Northwest to collaborate on a larger geographical footprint and ensure that their plans anticipate future needs.

206. In 2020 Wigan health and CSC leaders recognised that the Borough had an increasing number of children and young people being admitted to hospital with complex health and social care needs. These children often did not meet the criteria for detention under the Mental Health Act and due to the lack of suitable placements agencies were unable to achieve a safe discharge.

Healthier Wigan Partnership Complex Children and Young People Workshop

207. In response to this emerging need in December 2020 a Healthier Wigan Partnership workshop was arranged to focus on complex children and young people. Over 30 professionals from various organisations came together including NHS Wigan Borough CCG, WWL, NHS mental health providers, Wigan Council, GM Rapid Response Team, GP leads, Advancing Quality Alliance (AQuA), school leaders and looked after children leads.

208. The objective of workshop was to look at how they could work effectively together as a system to support the most vulnerable children and young people whose individual health and social care needs could be difficult to meet through the existing services, as a result of their unique and complex circumstances.

209. The workshop gave an overview of the Wigan Deal 2030, the NHS Long Term Plan – Children and Young People's Urgent and Emergency Mental Health, and the GM Crisis Care Pathway. A story was presented to participants told through the eyes of a child in a trauma informed way.

210. Learning from recent case examples was presented around the following themes:
    - Inpatient CAMHS criteria and children who do not fit this
    - Care Placements and Looked After Children
    - Commissioning Arrangements
    - Parity of Esteem
    - Workforce Development and Training
    - Communication and Information Sharing
    - Planning and Risk Assessment
    - Escalation Pathways
    - Messages from *"The children who no one knows what to do with"* (Children's Commissioner, November 2020)

211. A comprehensive multi-agency action plan was developed including creating a Wigan System Toolkit to standardise the system approach to escalation of children with complex health and social care needs, data analysis to identify trends, the creation of a risk register, and workforce development to encourage parity of esteem. The action plan was overseen by the Wigan Mental Health Programme Board. Regular updates were provided to WSCP Partners Improving Practice Subgroup and the WSCP Executive Meetings.

KLOE 6 FINDINGS

212. Health and CSC had clearly recognised that children presenting in extreme emotional distress due to trauma, and therefore not meeting the criteria for inpatient CAMHS admission, was increasing. Appropriate steps had been taken to bring together key partners across the system to explore the reasons for this and develop a coordinated plan to begin to address this.

213. The Reviewers concluded that whilst the right actions were being taken, pace in implementing them was not fast enough. It is likely that the Covid-19 pandemic slowed the pace of progress as health and CSC staff did not have the capacity to progress the work although they did continue to meet.

214. To some degree this work did have a positive impact on the way in which Elliot's admission was managed. Elements of the toolkit that being developed were utilised such as escalation to senior leaders, the use of Daily Planning Meetings, and the consideration of legal frameworks and restrictive practices. CSC mobilised quickly to identify and provide care support staff to the ward and all relevant agencies participated in the Daily Planning Meetings.

215. In KLOE 7 we will explore how staff developed an understanding of Elliot's lived experience and what efforts were made to capture Elliot's voice. The toolkit in development included the need to focus on the child's lived experience.

Actions Taken Since the High Court Ruling

GMHSCP Children and Young People Mental Health Severe Incident System Panel

216. The day after the High Court Ruling in relation to Elliot, Greater Manchester Health and Social Care Partnership (GMHSCP) held an emergency Children and Young People Mental Health Severe Incident (SI) System Panel, which was chaired by Professor Sandeep Ranote, GM Medical Executive Lead for Mental Health.

217. The Panel was convened due to GMHSCP seeing a significant rise in mental health and social care demand across the ten localities and the issues escalated to GMHSCP specifically related to Elliot.

218. There was system-wide senior level representation from the GMHSCP, GM commissioning, NHS mental health Providers, CSC including the Directors of Children's Services, safeguarding, nursing and quality, NHS England, and GM Paediatrics.

219. Ten example cases of children and young people with high complexity, acuity and risk who had been escalated to GMHSCP over a four-week period were presented for discussion. A system discussion of themes was facilitated by the Chair to support further recommendations with a focus of this panel to be on immediate solutions to mitigate identified risks.

220. The Panel made several recommendations, and an action plan was developed to be monitored and reviewed at the GM CYP Crisis Care Board.

Health Wigan Partnership Activation Board

221. At the end of July 2021, the Healthier Wigan Partnership held an Activation Board in relation to this High Court Ruling regarding Elliot and to further explore children and young people with complex health and social care needs.

222. The following actions were agreed:

- Consider developing a joint mental health and social care alternative crisis care placement in Wigan, expanding on the GM offer which is being developed.
- Rapid development and implementation of an GM Integrated Care System Joint Social Care and Mental Health Escalation Policy for children and young people in Wigan.

- Delivery of trauma informed training for staff at WWL.
- Open five paediatric beds on the general paediatric ward to manage demand.
- Option to be explored to have community CAMHS staff on the ward.
- Training for ward staff on understanding of mental health, emotional and behavioural issues in children and young people.

223. A small task and finish group of key people from each organisation was convened to quickly progress these actions, which were monitored via the Wigan Mental Health Programme Board and the Wigan Urgent Emergency Care Board.

224. Subsequently health and CSC leaders in Wigan are currently developing a business case to fund a 'Parachute Team' and residential therapeutic placement in the Borough. Parachute Practitioners aim to provide short term, young person centred, trauma informed, de-escalation support for young people aged 11-18 integrating with key existing professionals and existing and emerging health and social care pathways, supporting young people and professionals as they navigate and agree a response to their wider requirements.

Concluding Comments

225. The Reviewers concluded that prior to Elliot's admission health and CSC leaders had recognised the issues highlighted by Elliot's Case and had attempted to work together to address them. As stated above this work in Wigan was good but did not progress at the required pace. The Reviewers are also of the opinion that this issue required a whole system approach beyond the Wigan Borough.

226. At a GM and Wigan Borough level the system mobilised quickly to respond to the highlighted risks and gaps in the system following the High Court ruling in relation to Elliot. The action plans developed as a result are more likely to be successful as this complex issue requires a wider system response. It is evident that the action plans continue to progress at the time of writing this report. It is vital that this work is completed at the earliest opportunity and that WSCP are assured that the actions implemented lead to improved outcomes and a better experience for children like Elliot.

KLOE 6 RECOMMENDATIONS

Recommendation 9: The joint work that has been initiated between health and social care to explore a 'Parachute Team' and associated residential placement needs to be completed. Once implemented evidence should be provided to Wigan Safeguarding Children Partnership which gives assurance that this work has positive outcomes for children like Elliot.

KLOE 7

To develop an understanding of Elliot's lived experience and what efforts were made to capture Elliot's voice.

227. Throughout the recordings from all agencies reviewed for the LCSPR it was evident that professionals have attempted to develop an understanding of Elliot's lived experience. All agencies could evidence that they had captured Elliot's voice within their records and this included recording his words verbatim around various aspects of his care.

228. The Daily Planning Meetings were minuted and included lengthy discussion regarding the impact the situation was having on Elliot. Participants clearly attempted to view the situation through Elliot's eyes. Staff working directly with Elliot who attended the Daily planning Meetings shared with participants examples of Elliot's views and feelings on what was happening to him.

229. Whilst Elliot's behaviour was aggressive and difficult to manage, viewed his behaviour through the lens of trauma informed practice. Staff clearly understood that Elliot was communicating his level of distress and anxiety through his behaviour.

Reflections and Learning from Agencies

230. Elliot's allocated Social Worker visited Elliot on the ward on several occasions. The Social Worker felt that they were developing a very positive relationship which has continued to develop since his discharge from hospital. Elliot's voice was captured but it was recognised that given his heightened state that this was not fully explored and at times it was difficult to engage with him.

231. His Social Worker arranged for his two school teachers to visit him on the ward to facilitate contact with some familiar people who knew him. Ward staff reflected that Elliot had "*taken great joy"* in this visit. CSC felt that on reflection that they could have explored the benefits of engaging Elliot's family. This might have included visits or telephone calls to give him a sense familiarity. His family may have been able to help capture his voice and inform more care planning and interventions.

232. It is evident from the records that Elliot's Father and sibling consistently contacted the ward to request to see Elliot or to enquire about how he was. They attended the ward to drop clean clothes and snacks for Elliot. Elliot had been vocal to staff about not wanting to see his Father.

233. When one of the Reviewers met with Elliot's Father, he stated that Elliot was "*Scared to death of Covid and didn't want to be in the hospital as he was worried about people dying".* His Father felt that these worries contributed to his agitated state. He described Elliot as having a lot of energy and being *"cooped up"* in hospital without the freedom to run around would explain his behaviour. Elliot's Father said he was updated regularly by the hospital and CSC via phone calls but would have preferred home visits. He described being very rude to staff on the phone but felt that in person he was better able to control his emotions and relate to professionals.

234. When meeting with Elliot's Mother she was unsure of the reason for his hospital admission, although her eldest child had a good recollection of what happened. His Mother described not being updated at the time of Elliot's admission, but she was made aware at a later stage. CSC have acknowledged that on reflection they should have ensured that Elliot's Mother was as well informed as his Father.

235. It is clear from the WWL health records that several attempts were made to work jointly with CSC, care home staff and through liaison with Elliot's Father to identify ways to effectively support Elliot when staff were unable or not best placed to.

236. Ward staff used the 'likes and dislikes' framework to understand his routine and how best to support his needs. A copy of this was shared with participants on the Learning Event. Elliot was often included within discussions with doctors and nursing staff regarding his care such as being asked his wishes to share at Daily Planning Meetings. The ward also obtained copies of existing documentation such as his EHCP and Child Protection Plan to best understand him and listen to his voice.

237. CAMHS visited Elliot on the ward and attempted to engage and interact with him. CAMHs and Liaison staff described attempting to maintain a consistent practitioner in order to help build a relationship and encourage engagement.

KLOE 7 Findings

238. Attempts were made to capture and incorporate Elliot's voice into care planning. However, whilst his voice and feelings were recorded, and reasonable adjustments were made, when possible, staff felt unable to meet his all of expressed needs whilst keeping him safe because the environment was not conducive to attending to his emotional distress. Capturing his lived experience and wishes did not lead to significant change or improved outcomes for him. From Elliot's perspective, even when he told staff what he wanted it must have felt to him as if he was ignored.

239. His behaviour is representative of a child feeling scared and in despair. Elliot's Diagnosis of ADHD and his possible autism adds additional complexities to how he processed and understood what was happening to him and why. On Day 5 a Mental Health assessment outlined that this admission into hospital would be new, unknown, and very frightening to Elliot and would exacerbate the difficult traits that may be associated with ADHD and autism. Many of Elliot's soothing mechanisms involved being outside, however, due to his high risk of absconding this could not be safety facilitated. Ward staff felt that the subsequent MHA assessment did not adequately involve Elliot, however his escalating presentation made it extremely difficult for staff to develop trusting relationships.

240. Staff tried hard to engage Elliot and make him feel safe, examples of this would include buying him a Nintendo Switch and bringing him treats.

241. The National Child Safeguarding Practice Review Panel Annual Report 2020 (page 27) highlighted that 'Understanding what the child's daily life is like' is vital in good safeguarding practice. Understanding what a child sees, hears, thinks, and experiences on a daily basis, and the way this impacts on their development and welfare, is central to protective safeguarding work.

242. Key learning from case reviews has highlighted the importance of practitioners building trusting and respectful relationships with the children, which go beyond listening to and recording the child's views, to critically reflecting on what the child is trying to communicate through their behaviour, interaction with others and physical presentation.

243. In this case staff went beyond just recording and documenting Elliot's wishes and feelings. They did recognise that Elliot's challenging behaviour was a reflection of his extreme emotional distress.

KLOE 7 RECOMMENDATIONS

Recommendation 10:

Partners should undertake workforce development activities to support staff to develop skills to critically reflect on how children communicate through their behaviour, interaction with others and their physical presentation; and how this can be used to plan their care. This should be supported by practice tools which assist staff to advocate for the child and focus on their voice translating to their care planning.

OVERVIEW OF RECOMMENDATIONS

The recommendations are different in both reports. Feedback from panel members is that the second set of recommendations are not accurate and not based on the analysis of the first review. Organisations have based their working action plans on the first recommendations not the second, so I propose we leave the first recommendations below in the report.

KLOE and Number	Recommendation	Theme
KLOE 1		
Recommendation 1	Greater Manchester Mental Health NHS Foundation Trust and Pennine Care NHS Foundation Trust need to clearly outline the process for a child to be referred for a Mental Health Act assessment, criteria for inpatient CAMHS admission and the routes for professional challenge when there is a disagreement. This document should be accessible to all agencies.	**Mental Health Processes**
Recommendation 2	A joint Health and Social Care Escalation Policy should be developed to ensure that when there is a risk of a child remaining on a general paediatric ward inappropriately and we are unable to achieve a safe discharge there are clear processes to alert senior leaders to take action.	**Escalation**
KLOE 2		
Recommendation 3	Commissioners need to work with Greater Manchester Mental Health NHS Foundation Trust to review the current out of hours Psychiatry provision for children and ensure that arrangements are fit for purpose and clear to other NHS providers who use this service.	**Commissioning**

Recommendation 4	Work needs to be completed to facilitate the coming together of clinical staff at Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation (WWL) Trust and Greater Manchester Mental Health NHS Foundation Trust (GMMH). This will need to fully explore perspectives, roles, and responsibilities with a view to improving working relationships and developing clear joint protocols for working together. WWL must also develop an agreed, easily accessible Rapid Tranquilisation Policy for use within Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.	**Professional Relationships Policy and Procedures**

KLOE 3		
Recommendation 5	Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust should: • Consider the skill mix of staff on the general paediatric ward, this could include employing Registered Mental Health Nurses as part of the ward establishment. • Consider developing a 'Safe Place' within WWL where children who have been admitted can be assessed and cared for in an appropriate safer environment (e.g., ligature risk free). • Complete a Training Needs Analysis of the training requirements of existing staff in relation to safer clinical holding and restraint techniques, de-escalation skills, mental health needs of children and young people etc. • Work with staff to encourage parity of esteem between physical and mental health and develop confidence when providing care to children who present with mental health needs.	**Workforce Development Parity of Esteem Safe Environment**
Recommendation 6	Wigan Children's Social Care should work in partnership with other Local Authorities and health colleagues to explore the provision and/or the joint commissioning of suitable registered residential therapeutic placements. Children like Elliot need to be cared for in a suitable and safe setting that meets their needs and prevents them remaining in hospital unnecessarily.	**CSC Placement Commissioning**
KLOE 4		
Recommendation 7	Wigan Children's Social Care and NHS Wigan Borough Clinical Commissioning Group to continue the work initiated to develop a 'Parachute team' and residential provision in the Borough. This should include the development of standardised requirements for supporting staff including appropriate training (de-escalation skills, safe restraint, and clinical holding), trauma informed practice, clear standardised policies which outline a consistent approach to restraint.	**Commissioning Workforce Development**

KLOE 5		
Recommendation 8	A joint health and social care escalation policy needs to be developed which: • Is responsive and proactive to present drift and delay. • Outlines roles and responsibilities for all agencies including who will take the lead. • Provides a clear structure for points of discussion at the escalation meetings. • Ensures the focus remains on the child. • Considers legal frameworks and ensures that all restrictive practices are the least restrictive and proportionate. • Directs that operational care planning discussion should take place separately to senior leaders/strategic meetings. • Directs organisations to nominate a consistent contributor to attend the meetings with the right level of seniority/ability to decision make. • Encourages integrated working and articulates how collective risk is shared.	**Escalation**
KLOE 6		
Recommendation 9	The joint work that has been initiated between health and social care to explore a 'Parachute Team' and associated residential placement needs to be completed. Once implemented evidence should be provided to Wigan Safeguarding Children Partnership which gives assurance that this work has positive outcomes for children like Elliot.	**Commissioning** **Placement Sufficiency**
KLOE 7		
Recommendation 10	Partners should undertake workforce development activities to support staff to develop skills to critically reflect on how children communicate through their behaviour, interaction with others and their physical presentation; and how this can be used to plan their care. This should be supported by practice tools which assist staff to advocate for the child and focus on their voice translating to their care planning.	**Workforce Development**

REFERENCES

Human Rights Act (1998) https://www.legislation.gov.uk/ukpga/1998/42/contents [Accessed 30.03.2022]

Wigan BC v Y (Refusal to Authorise Deprivation of Liberty) [2021] EWHC 1982 (Fam) (14 July 2021) https://www.judiciary.uk/wp-content/uploads/2021/07/Wigan-BC-v-Y-Refusal-to-Authorise-Deprivation-of-Liberty-judgment.pdf [Accessed 30.03.2022]

APPENDIX 1: LOCAL CHILD SAFEGUARDING PRACTICE REVIEW PANEL MEMBERS

The Local Child Safeguarding Practice Review (LCSPR) Panel was comprised of:

Reviewer Assistant Director Safeguarding Children/ Designated Nurse for Safeguarding Children & Looked After Children	NHS Wigan Borough Clinical Commissioning Group (WBCCG)
Supporting Reviewer Deputy Designated Nurse for Safeguarding Children & Looked After Children	WBCCG
Assistant Director of Commissioning and Transformation	WBCCG
Commissioning and Transformation Manager – CYP, Mental Health and Learning Disability	WBCCG
Business Manager	Wigan Safeguarding Children Partnership (WSCP)
Learning and Improvement Officer	WSCP
Specialist Nurse for Safeguarding Children	Wrightington, Wigan, and Leigh Teaching Hospitals NHS Foundation Trust (WWL)
Head of Safeguarding	WWL
Named Nurse for Safeguarding Children	WWL
Head of Nursing & AHP for Surgery and Child Health, WWLFT	WWL
Named Nurse for Safeguarding Children	Greater Manchester Mental Health NHS Foundation Trust (GMMH)
Service Lead, Children's Social Care	Wigan Council
Legal	Wigan Council
Detective Constable, Public Protection & Serious Crime Division, Investigation & Safeguarding Review Unit	Greater Manchester Police
Registered Manager	Leaf Complex Care