Local Child Safeguarding Practice Review

“Tristan”

Commissioned by Swindon Safeguarding Partnership

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1. Introduction

1.1 Swindon Safeguarding Partnership (SSP) have commissioned this Child Safeguarding Practice Review (CSPR) in respect of "Tristan", a pseudonym chosen to protect the young person's privacy.

1.2 At the time of the referral Tristan was 17 years old, a white British boy who lives with his father. Tristan's mother left home in 2011 when he was 5 years' old and he has not seen her since. There were concerns about his school attendance from 2017, and he was referred to Education Welfare in January 2022 when his attendance dropped to 65%. Concerns were also identified in respect of his low weight that month, when Tristan was admitted to hospital following a seizure, but he was not brought to subsequent health appointments relating to this and although an assessment was completed by Children's Social Care (CSC), he was not provided with support as a child in need (CIN) or made subject of a child protection plan. In December 2022, Tristan told a member of school staff that he was severely depressed and experiencing physical and emotional abuse at home, so the school referred Tristan to Swindon's Multi Agency Safeguarding Hub (MASH), resulting in a CIN assessment being initiated and a Youth Engagement Worker (YEW) was appointed. A further MASH referral and mental health referral were made by the school in April 2023, as their concerns about Tristan's weight and emotional and social wellbeing continued to escalate.

1.3 In May 2023, Great Western Hospital received an email from Tristan's school, which included a supporting email from the Targeted Adolescent Mental Health Service (TAMHS). The referrer stated that she *was "extremely concerned about Tristan's physical health and the level of neglect."* Tristan had a child protection medical examination the following day, resulting in his admission to hospital due to concerns about his very low BMI of 12.1, (weighing less than 45kg at over 6 foot tall), cardiovascular concerns and risk of refeeding syndrome, a potentially fatal condition caused by rapid reintroduction of nutrition after a period of inadequate intake.

1.4 Tristan remained in hospital for two weeks and during this period a mental capacity assessment was completed by Children's Social Care, which concluded that he did not meet the criteria as he *'did not have an impairment to the mind or brain*'. CAMHS assessed his mental state but found no evidence of a thought disorder. He was offered alternative care arrangements under Section 20 of the Children Act 1989, but declined this. As a 17-year-old, a care or supervision order could not be made by a court. He was discharged at the end of May 2023 with a support package including carers visiting to support with healthy meals and diet. A child protection case conference was held in July 2023 and although all practitioners in attendance felt that Tristan should be made subject of a child protection plan, the independent reviewing officer took a decision that this was disproportionate, in light of Tristan's age and limited support that had been offered to the family preceding his admission. He was subsequently assessed by CAMHS eating disorder clinic and diagnosed with Avoidant Restrictive Food Intake Disorder and an anxiety disorder. He was later detained for a short period under section 2 of the Mental Health Act 1983 for an assessment of his mental health.

1.5 A rapid review was completed and submitted to the National Panel, which encouraged the SSP to initiate a LCSPR given the apparent breakdown of a multi-agency response to Tristan and his family. The Panel felt that SSP should seriously and critically reflect on how services worked with the family, and each other, to avoid a family experiencing a similar response in future.

1.6 The author wishes to thank Tristan and his father for their generous contribution to this review, it was a pleasure to meet them both and the insight they shared into their experiences of the safeguarding system has been extremely helpful. The author is also grateful to the professionals who worked with Tristan for their honest and reflective participation in the learning events. It was clear that all those involved were motivated by real concern for Tristan and a desire to ensure that he was healthy, safe and fulfilled.

2. Scope of Review

Purpose of a Child Safeguarding Practice Review

2.1. The purpose of having a LCSPR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died. It is:

- To establish whether there are lessons to be learned from the circumstances of the case and about the way in which local professionals and agencies work together to safeguard children;
- To review the effectiveness of procedures (multi-agency and individual organisations);
- To inform and improve local interagency practice;
- To improve practice by acting on learning (developing best practice); and
- To prepare or commission a summary report, which brings together and analyses the findings of the various reports from agencies, in order to make recommendations for future action.

2.2. There is a strong focus on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Tristan from harm. The learning produced through a LCSPR concerns 'systems findings', which are the underlying issues that helped or hindered in the case and are systemic rather than one-off issues**.** Systems findings identify social and organisational factors that make it harder or easier for practitioners to proactively safeguard, within and between agencies.

Themes

2.3. The timeframe for this focused review has been agreed as January 2022, when concerns escalated in respect of Tristan's weight and school attendance, through to June 2023, when he was discharged from hospital. Summary information has also been included in respect of school attendance, early intervention and health needs from 2017. Relevant background information prior to 2017 will be considered and included as necessary, particularly in respect of prevention and early intervention opportunities.

2.4. The SSP prioritised the following themes for illumination through the CSPR:

1. How did agencies recognise and respond to Tristan's needs, in particular when they were unable to engage with him looking at:
    a. His experience of education and response to poor attendance;
    b. Response to Tristan's physical health needs, including management of his weight
    c. Response to Tristan's mental health needs and concerns around self-neglect;
    d. Support for Tristan as a young carer.

2. The professional understanding of Tristan's relationship with each parent, his father's needs, belief system and parenting capacity and what support was provided to father in terms of his own health and mental health. Was a whole family approach taken?

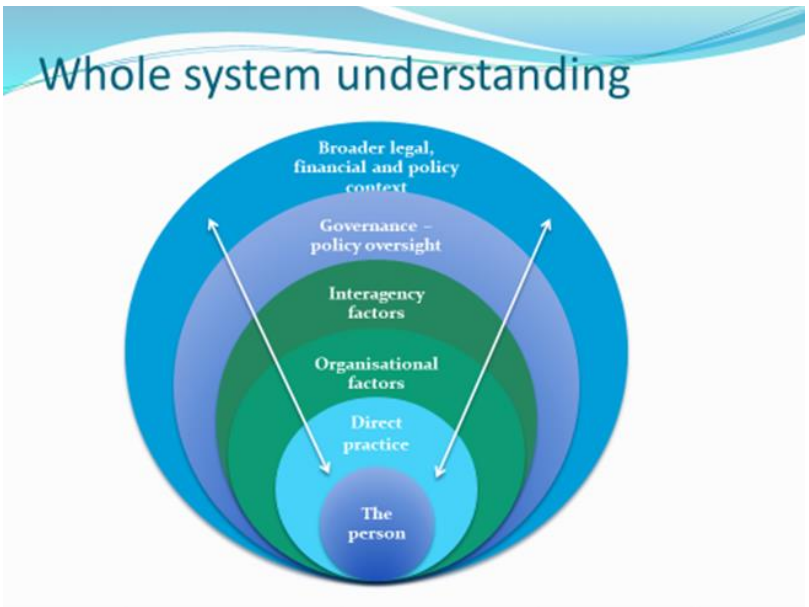
3. As concerns in respect of Tristan's presentation increased, how was the risk assessed in relation to his health (including in relation to missed appointments) and was the response appropriate, timely and proportionate? Were escalation procedures used appropriately?

4. In light of Tristan's age, how did agencies apply the principles of the Mental Capacity Act 2005 and balance these against their duties to him as a child and his parents' exercise of their parental responsibility?
    a. Was adultification a feature in the agency response?
    b. How effective was transition planning for adulthood?

Methodology

2.5. In addition to reviewing returns prepared by each agency and key documents in respect of Tristan, multi-agency learning events took place with frontline practitioners who worked directly with Tristan and his family, and senior managers responsible for overseeing the departments involved. The author also met with Tristan and his father, with the support of Tristan's youth engagement worker, who had a good relationship with them both.

2.6. The case has been analysed using a learning together approach, through the lens of evidence-based learning from research and the findings of other published LCSPRs.[1] Learning from good practice and a discussion of the legal framework will also be included. By using evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice. The review will adopt a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram below.[2] Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



[1] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement. London: LGA/ADASS

[2] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection, 17 (1), 3-18.

Contributing agencies

2.7. The following agencies provided documentation to support the LCSPR and participated in the learning reviews:

- Swindon Borough Council – Children, Family & Community Health
- Swindon Borough Council – Education
- Swindon Borough Council – Adult Services
- Youth Engagement
- BANES, Swindon & Wiltshire Integrated Care Board
- Great Western Hospital NHS Trust
- Oxford Health NHS Foundation Trust - CAMHS
- Swindon Carers Centre
- Tristan's high school
- NSPCC
- Swindon Safeguarding Partnership – Strategic Support Unit

3. Pen picture of Tristan

3.1. Tristan is highly articulate and intelligent, with a wry sense of humour, but when speaking with him, he expressed a profound listlessness and lack of joy in life, presenting with anhedonia. When asked about his interests and hobbies, he said "*nothing really"* although he had previously told practitioners that he enjoyed gaming and loved his cats. When he was younger, Tristan liked attending the Young Carers' group, which included outings like going to the cinema, but he outgrew this service. Tristan found the move from primary school to high school difficult, and did not like many of his classmates, subjects or teachers. He quickly realised that due to his intelligence, he could pass exams with minimal effort and that there were no consequences if he did not attend classes, particularly once these moved online during the pandemic.

3.2. Tristan had a clear understanding of his legal rights and felt that periods when he had been forced to stay in hospital had been an injustice. He explained that he felt that efforts to make him gain weight were a "*sticking plaster"* as his underlying mental health needs had not been addressed. He said that when he had reported the "*domestic issues*" at home in December 2022, he really wanted help with his mental health as he felt "*miserable*", but the focus became the child protection issues and he never received any therapy. Even in hospital, he described feeling ignored by professionals on the ward, and that their sole focus was to force him to eat. While Tristan was adamant that he had capacity to take decisions in respect of his nutrition and medical treatment, he believed that when clinicians told him that he could die as a consequence of his malnutrition, this was an attempt to bully him into eating, and there appeared to be a degree of denial about the seriousness of this risk by both Tristan and his father.

3.3. Tristan hates to be patronised, and explained that the professionals he has built a positive relationship with, in particular the pastoral support assistant at school, youth engagement worker (both of whom were extremely impressive during the practitioner events) and one of the carers provided by Children's Services after he was discharged, were those who had taken the time to get to know him. He had clear views on practitioners who he did not like, valuing an empathetic, compassionate response and consistent care. The youth engagement worker advocated to remain allocated after Tristan was opened to CSC (as usually this would result in the service ending), and continued to work with him post-18 so that he could support him to reengage in college and attend the genetic testing that excluded Marfan's syndrome as a health diagnosis. This was commendable transitional practice.

3.4. Practitioners who worked with Tristan described him as polite, eloquent and witty, but very isolated, rarely going more than a 10 minute walk from home, in part because he has become so underweight that he now struggles to walk, and his joints are extremely painful. They explained that his relationship with his father was very close but complex, as his father had his own health needs and was also quite isolated in the home. Practitioners commented that there was absolutely no doubt that Tristan's father loved him and wanted the best for him, but that at times they could struggle to communicate with him effectively, identifying some key practitioners who had worked positively with him to support him to understand some of the complex issues facing Tristan. Although Tristan's father was his "*cheerleader"*, advocating for Tristan's rights and wishes during hospital admissions, he could also overwhelm Tristan, speaking on his behalf. Tristan's father is generally very friendly and engaging, but practitioners reported that when he felt challenged, he could become emotionally dysregulated and shout, although he would always apologise for this immediately. Tristan's mother left home when he was 5 years' old and she has not been involved in his life since. Other than his father, Tristan socialised very little and sadly, his grandmother, who had been an important part of his life and provided him with a lot of care until she had to self-isolate during the pandemic, recently passed. Their world seemed quite closed and enmeshed and practitioners described that father and son had formed a 'trauma bond' between them.

3.5. Despite practitioners' positive view of his personality and abilities, they commented that Tristan had a low sense of self and would deflect any positive feedback. They felt that he had not experienced much positive reinforcement as a child and were very worried that he felt that he did not have a future. Although they felt that he showed a lot of autistic traits, they were unclear how much this resulted from trauma as opposed to neurodiversity. Practitioners expressed a huge amount of warmth and clearly genuinely cared about Tristan, and it is very sad to reflect that he would struggle to accept this.

4. Analysis of agencies' actions

Early response to emerging health issues

4.1. Tristan was born in late 2005 at a gestational age of 34+3 weeks. His birth weight was on the 75-91st centile and his height was on the 75th centile (both just above average, and indicating a normal height and weight). No other significant maternal health issues were noted and health visitor records indicate normal growth at his first health check. Tristan was enrolled with the Young Carers' Centre that year and invited to attend term time groups. In September 2011, father commented on collection that Tristan had lots of issues at the moment and his head was fuzzy. Tristan said to his father, he could not wait to be older so he could strangle him. In October 2011, a Team Around the Child [TAC] meeting was convened and it was noted that Tristan was not eating at school, however, there is no indication of ongoing concerns about his eating, weight or emotional wellbeing during primary school.

4.2. In April 2018, Tristan was assessed and his weight and height were checked (although these are not recorded in the chronology). The nurse discussed his diet, his lifestyle (games, consoles, struggles with sleep) young carers, low school attendance and that he could go to his Nan and auntie for support. He reported concerns about his father and finances. Tristan was pale dark circle under eyes and appeared very thin, but reported that he was tested for anaemia with no concerns. Tristan's aunt highlighted her concerns about his health and that Tristan was born with a congenital syndrome, although this was not reflected in his medical records at birth. Actions were agreed for these concerns to be discussed with Tristan's father and explore possible need for further investigation, however, it is not recorded that these concerns were

followed up at this time. Tristan's father said that although the GP arranged some blood tests for anaemia, nothing further came of this.

4.3. Attendees at the learning events noted that school nursing does not undertake universal work in high school, and statutory requirements to periodically monitor children's height and weight only apply to primary aged children. Children will only be weighted if they are referred through to school nursing and in Tristan's case, he was only referred in 2018. However, the member of staff who saw him left shortly after reviewing him, and it appears his case was not handed over to the new school nurse. Swindon also provided early support for mental health within schools through Trailblazer's Project, which was introduced in 2018, and it is unclear why Tristan was not picked up through this service at this time.

4.4. There are very close parallels between Tristan's case and another local child safeguarding practice review completed by SSP in March 2023, 'Alan'[3], a 16 year old who attended the same school as Tristan, which included concerns that he was found to be very thin and potentially malnourished, very isolated and self-deprecatory. The review identified that barrier between Early Help and statutory intervention, mechanistic application of thresholds and understanding of transitional safeguarding and mental capacity contributed to the delays in identifying and mitigating the harm Alan was experiencing. Further, understanding of different forms of neglect and an underused escalation procedure were identified as key themes of the review.

4.5. Unquestionably, the pandemic had a very significant impact on the school's ability to identify the fact Tristan's health needs were escalating. Physical education classes in particular are used to monitor the health and weight of children, but these stopped during this period. School leaders noted that a senior teacher had been responsible for monitoring the welfare of young carers, and as a registered young carer, Tristan was telephoned by the young carer lead at least once each week during lockdown, possibly more often due to the concerns that his attendance had dropped (discussed further below). S17ZA of the Children act 1989 places a duty on local authorities to assess whether a young carer in their area has needs for support, which must have regard to the extent to which they are participating in education. This also requires explicit consideration of whether the young carer is a child in need. There is no indication that Tristan's young carer's needs assessment had been reviewed since primary school, had this taken place, this would have provided an early framework to consider the impact of his poor school attendance as well as his more holistic support needs, before these started to escalate during the pandemic. CSC leaders acknowledged that Tristan was not well recognised as a young carer after moving to secondary school. They noted that a Young Carers Charter[4] was introduced in 2023, confirming the council's commitment to identifying supporting and championing the rights of young carers. However, they acknowledged that this needed to be strengthened in practice, with clear understanding across the partnership of the additional support needs and vulnerabilities of young people coping with the pressures of caring for family members with health and mental health needs.

4.6. Although Tristan came into school for exams during his GCSEs, temporary invigilators are engaged to oversee the exams on an ad hoc basis, meaning that teaching staff and pastoral support assistants would not regularly see children, removing an important opportunity to monitor their welfare. When Tristan returned to school in Year 12, school staff observed that he had noticeably lost weight, however, this does not appear to have resulted in referrals to health or CSC at that time. Had this been explored with Tristan or his father at the time, it may have been possible to identify that Tristan's grandmother had been prevented from providing him with support due to her need to socially isolate, which appears to have been one of the factors contributing to his weight loss.

[3] Alan_practice_learning_brief.pdf

[4] Swindon_young_carers_charter.pdf

4.7. The robust approach taken by the school in challenging decisions taken by CSC following the referrals they made in December 2022 and April 2023 are evidence that the learning from the 'Alan' case, in particular around escalation, had a positive impact on the school's response to Tristan's needs. The school has introduced non-teaching pastoral support assistants, who are allocated to each year group and 'travel' with the students as they progress through the school. This ensures that a dedicated member of staff is able to get to know each child in that year as well as their parents, build trust and be in position to recognise if there is a change in their presentation. This was further strengthened by appointment of a designated safeguarding lead who was a qualified social worker and therefore was familiar with the CSC system and well equipped to challenge their decision making. School staff commented on the confidence this role had provided in their efforts to ensure their concerns for Tristan were addressed.

4.8. Additionally, the school now records all child welfare issues, however minor, on its new CPoMs system. This, together with a digital register that immediately flags absences and patterns of absence, would have provided the designated safeguarding lead and school leaders with greater oversight of Tristan's developing needs.

4.9. At the point of Tristan's hospital admission in January 2022, his low BMI and poor school attendance both required careful investigation. Whilst it was unclear at that point whether his weight loss was due to underlying health issues, the fact that he had not been taken to the GP in respect of this prior to having a seizure indicated possible neglect. He was open with clinicians that his father did not help with his diet, which was poor. An effective plan to monitor Tristan's weight going forward was required, and although Tristan's father said that he would attend the GP and the hospital clinician had requested a referral to the community dietician service, clear feedback loops were needed to ensure these were actioned. The hospital explained that because the waiting lists for many community services can be very lengthy, they do not wait for feedback that an appointment has been offered before discharging the patient back to the GP. Tristan clearly met the threshold for support as a child in need, and a child in need assessment should have been carried out, involving the wider professional network both to build an understanding of his holistic needs, but importantly, to share information in respect of his health needs and resulting risks and develop a plan to ensure these were being adequately monitored.

4.10. A team around the family approach was not used to monitor whether Tristan was gaining weight. Ideally this would include that would not preclude a multi-agency discussion to gather information and ensure that the key risks and cohesive plan were overseen by the professional network. Because this did not happen, Tristan's school, education welfare and the school nursing service were all unaware of his hospital admission. Although Tristan was discharged to his GP for his weight to be monitored, this did not reference that this should be monitored to determine whether it related to child protection issues. Crucially, this meant that when Tristan's father stopped taking him to the GP after two appointments, having told the GP he was doing well and gaining weight, and the hospital's referral to the Eating Disorder Clinic was not received, no agencies were aware of this. This was a significant missed opportunity for early intervention.

4.11. In October, the school liaised with Tristan's youth engagement worker (YEW) to see if he could get free school meals, and he was noted by a teacher to look '*tired and careworn, bless him… I wonder if he's anorexic… but I presume that's already been considered'.* The school discussed their concerns with the YEW and designated safeguarding lead and complied an absence intervention plan in November 2022. Had the school been aware of his previous hospital attendance in January, it is likely that the safeguarding risk would have been identified and referred earlier. However, the school's concern was not referred to Children's Social Care, Tristan's GP or the school nursing service, again indicating a lack of a joined up approach between education and health partners, which meant that the risk analysis was based on incomplete intelligence and that those agencies could not support safety planning and risk management going forward.

Systems finding

4.12. Early opportunities to identify Tristan's developing health needs were missed by the school and health partners. Even when his low BMI was visible to school staff and resulted in a hospital admission, insufficient consideration was given to whether neglect was a factor in his condition at the time, so this did not result in appropriate multi-agency information sharing or child in need support to ensure that his condition was robustly assessed and monitored. His support needs as a young carer were not kept under review. Although learning from the recent 'Alan' LSCPR has strengthened agency understanding of neglect and escalation processes, the multi-agency team around the family approach is under-developed locally.

Recommendation 1: *SSP should take steps to embed a collaborative team around the family framework across all agencies to support more effective multi-agency working.*

Recommendation 2: *Swindon's Children's Services should consider how to promote understanding of the needs and rights of young carers across the partnership, and conduct an audit of young carers locally to ensure that young carer's needs assessments are carried out, kept under review and appropriate support plans are in place.*

Recommendation 3: *Partner agencies should continue to ensure that during periods of wide-scale service disruption, systems are in place to proactively reach out to isolated families, increasing services where necessary to address any increased stressors.*

Educational needs

4.13. In September 2017, Tristan started high school and attended a school that continued through to sixth form. He reported that he found this transition difficult and that although some of his primary school friends had transferred to the same school, over time these friendships fell away. The transition to high school presents developmental challenges for young people that rely on the previous acquisition of essential social skills, as young people adapt to relationships with multiple teachers and a new, much larger peer group.[5] This places more complex academic demands, and greater need for self-monitoring and self-reliance, with the need to move around several classrooms. These challenges will be even greater for young people who have unidentified additional needs.

4.14. In January 2018, the school contacted the Young Carers Centre raising concern that Tristan did not get out after school and spent most evenings reading or watching TV. By March 2018, Community Health were becoming more concerned about Tristan's mental health and asked for Tristan to be seen at the next school nursing drop off.

4.15. Practitioners commented that prior to Year 11, Tristan's attendance had hovered around the trigger point for persistent absence action which is 90% attendance and that his intelligence masked the impact of the school he missed. Attendees at the learning events commented that despite meeting the statutory definition of persistently absent, it is likely that he would have been a lower priority for a response from Education Welfare than a child whose attendance was extremely poor. Tristan reported that as a result of his hypermobility, he constantly suffers knee and shoulder injuries and would avoid going to school on icy days due to the risk he could fall and injure himself. He said that he reported this to the school nurse, but that no reasonable adjustments were offered until Teams became widely used during the pandemic.

4.16. Tristan was in the last term of Year 10 when the Covid-19 pandemic struck in 2020. As part of these restrictions, schools were closed to all pupils in March 2020 (except for vulnerable and

[5] Kellam, S., X. Ling, R. Merisca, C. Brown and N. Ialongo (1998) "The effect of the level of aggression in the first grade classroom on the course and malleability of aggressive behavior into middle school" *Development and Psychopathology*, 10:165-185.

key worker children), before re-opening to certain year groups in June. His attendance dropped, averaging just 83% across the whole year, but many of these absences were in the first months of lockdown. Tristan has acknowledged that the Covid-19 pandemic played a significant role in his increased school absence, although this was initially masked by lessons being delivered online, as national lockdowns disrupted education for all children and reduced professional oversight.

4.17. All school children returned to the classroom in September, but a further lockdown was announced in December 2020, closing schools until March 2021. Tristan's attendance deteriorated very significantly, to 51%. Tristan reported that although the school was aware of this, there was no consequences for him as a result of his poor attendance, leaving him with little motivation to return to school once in-person lessons resumed. Attendees at the learning events noted that education welfare officers did make contact with Tristan and his father, but that this was done via a Teams meeting rather than a face-to-face meeting, which may have helped to contextualise Tristan's home situation. An action plan was created, but this was not revisited, even when Tristan's attendance remained poor. Leaders noted that during this period, the Education Welfare service was under resourced and that their primary focus was behavioural, rather than attendance issues.

4.18. Although this was understandable given the challenges of this period, Ofsted's Annual Report 2022/23 noted "*a troubling shift in attitudes since the pandemic. The social contract that has long bound parents and schools together has been damaged. This unwritten agreement sees parents get their children to school every day and respect the school's policies and approach…Unfortunately, there is ample evidence that this contract has been fractured, both in absenteeism and in behaviour.*"[6]

4.19. Tristan's attendance never recovered after the social restrictions imposed as a result of the pandemic ended, and after his disclosure of abuse in December 2022, his attendance dropped further. When he was admitted to hospital in May 2023, Tristan's school attendance effectively ended, and although arrangement were made to support him sitting an exam while in hospital, his clinicians felt that this was not in his best interest in light of his poor health. Tristan was frustrated by this and felt that he was being given mixed messages about the importance of education. The school showed good practice by going against its admissions policy by keeping him on the roll even when he effectively stopped attending, in recognition of their safeguarding concerns for him and desire to continue to support him. Although the school continued to try to engage Tristan over the 2023 school holidays, providing him with coursework, support, home visits and offers of a bus pass or taxis to and from school, and raised concerns about the home conditions following home visits, he was formally removed from the school roll in September 2023.

4.20. During the early stages of the pandemic, the Government disapplied the legal requirements in respect of addressing persistent absence as schools struggled with the challenges of delivering education while complying with constantly changing risks and guidance. Ofsted published research in February 2022 "*Securing good attendance and tackling persistent absence*",[7] which explored the rise in absenteeism during the pandemic, which had not recovered since the national lockdowns ended. This was thought to be a combination of child and parental anxiety, health vulnerabilities and illness, and pupil disengagement from education. The figures for the 2022/3 academic year showed that 22.3% of pupils were persistently absent across England[8], and although Tristan's school reported that overall its attendance levels were higher than the

[6] The Annual Report of His Majesty's Chief Inspector of Education, Children's Services and Skills 2022/23 - GOV.UK (www.gov.uk)

[7] Securing good attendance and tackling persistent absence - GOV.UK (www.gov.uk)

[8] Pupil attendance and absence in schools in England (shinyapps.io)

national average, lockdowns had a disproportionate impact on children who were already struggling in education.

4.21. To address this, the Government has introduced guidance to help schools, trusts, governing bodies, and local authorities maintain high levels of school attendance, which became statutory from February 2024.[9] Leaders commented that the professional network was now far more focussed on attendance, with earlier identification of emerging patterns of absenteeism and taking a multi-agency approach to devise strategies to reengage students. Swindon's Education Welfare team has been expanded from two to six education welfare officers, with recruitment underway for another four, and this is co-located with the Exploitation team in recognition of the risks to young people who are persistently absent or missing from education. An education tracking officer is also embedded in the MASH, with regular attendance clinics and a formal attendance plan for children with poor attendance, which is reviewed during each core group meeting. Children on child protection plans cannot be taken off their plan without director authorisation, unless their attendance is above 80%. Leaders emphasised the importance of schools recognising the vital role engagement in education plays in protecting children from safeguarding risks, both contextual and in the home, and a facilitator has been engaged to work with school leaders to support their understanding of this.

Systems findings

4.22. A 'light-touch' approach to addressing attendance for pupils who are at the borderline of the threshold for persistent absence sends a message to children and their parents that this is not a priority and risks entrenching poor attendance. Absenteeism is then likely to escalate significantly during periods of crisis, whether a national issue such as the Covid-19 pandemic, or a crisis in the child's life. Since the review period, substantive changes have been made to Swindon's approach to school attendance in accordance with recent government guidance, but the impact of this needs to be kept under review.

Recommendation 4: *In consultation with schools and colleges, including academies, Swindon's Education Welfare Service should review whether its new approach is effectively reducing absences, and providing a more ambitious framework to support children to remain in education that is fulfilling for them.*

Safeguarding response

4.23. CSC's safeguarding response to the strong indicators that Tristan was experiencing harm was poor. As noted above, when Tristan was admitted to hospital in January 2022, a child in need assessment should have engaged all agencies, ensured appropriate information sharing and risk analysis and provided a cohesive plan. But certainly, when the school made a referral to Swindon's MASH in early December 2022 after Tristan disclosed serious physical and emotional abuse and suicidal ideation, the threshold for him to be made subject of a child protection plan was met.

4.24. The referral from the school was very high quality, detailed, and very explicit about the serious harm Tristan had experienced. Tristan told school staff that his father had threatened to kill him and smashed his belongings (including phone) with a hammer 2 weeks' prior. Tristan spoke of wanting to kill his father, kill himself or running away. He reported physical abuse, including his father knocking out his baby teeth when he was younger, verbal and emotional abuse, withdrawal of food as a punishment and his father physically harming the dog when angry. The school made a referral to CSC outlining concerns in respect of Tristan's mental health and relationship with his father; "*Tristan has disclosed that this has been his life as long as he remembers. He says dad puts " good performance" on when talking to us here at school, but as*

[9] Working together to improve school attendance (publishing.service.gov.uk)

soon as he puts the phone down, he starts abusing Tristan saying things like: "you fucking cunt, you will never accomplish anything, you are useless and lazy." Abuse like this is a regular in Tristan's house. He genuinely feels like his father despises and hates him… Father has not provided food on occasions as a punishment. Tristan said that now he is not even scared when dad threatened to kill him, he feels emotionless. Tristan said that lower down the school, when staff tried to talk to him, and asked if he is ok, Tristan lied saying he is ok, but truly wanted to scream, "please help me". He didn't see the point to say anything as he felt noting [sic] will be done... Tristan doesn't see reason to live but he knows that ending his own life is not the option. The only reason why he hasn't done it yet is because he is afraid it would hurt. He said if he had a gun, and could kill himself pain free, he would have done it long time ago. He feels unloved, abused emotionally constantly, and feels like dad is "coming up" with reasons to punish him."[10]

4.25. On receipt of this referral, MASH took a decision for an Early Help Assessment and Plan to be completed, although the rationale for this decision was not shared with the school. The school liaised with the YEW and MASH and school staff undertook a home visit a week after the disclosure to check Tristan's welfare, which went badly. The following day, the school formally challenged MASH's decision to refer to Early Help by email, noting the risk that Tristan would self-harm or harm his father, that his physical health was being neglected with missed appointments including a heart scan scheduled for November 2022 and that "*Tristan's mental health has rapidly declined, he has thoughts of hurting himself. His presentation has also declined, he looks extremely underweight, pale and withdrawn. We have offered mental health support however the waiting lists would mean it wouldn't be imminent*." The case was therefore referred for MASH enquiries. Attempts by CSC to contact Tristan were unsuccessful it was not until two weeks after the initial disclosure, when MASH spoke to Tristan and his father to obtain consent for a statutory assessment, but father felt school were 'overreacting'. The school reported that the social worker undertaking the assessment had commented that they intended to close the case because '*father was not engaging'*. After meeting with Tristan on three occasions, CSC assessment was completed, expressing optimism that Tristan and his father would engage with the available support. No health checks were carried out.

4.26. The 'rule of optimism' is an unconscious bias towards a favourable view of the situation, makes it less likely that practitioners will imagine (and prepare for) the poor outcomes, even if these are, as they were in this case, foreseeable. Practitioners commented that often, the onus is placed on the young person to gain resilience to their abuse, and the young person is pathologised. They felt that Tristan's courage in disclosing what was happening at home had been invalidated and that he felt very let down by the inadequate response to his cry for help.

4.27. As the school's concern for Tristan's welfare continued to grow, in late March 2023 the school arranged a TAF meeting, and contacted Tristan's paediatric consultant in an effort to bring forward his appointment. In mid-April 2023, the GP referred Tristan to the community health team, who allocated the case to a TAMHS practitioner, and referred Tristan to school nursing, who also allocated the case. The school nurse tried unsuccessfully to call Tristan's father to discuss the referral. After securing father's consent to a referral to CSC, the school made a further referral to MASH, highlighting their original concerns, and raising concerns that Tristan's health and dental needs were not being met and there had been a deterioration in his school attendance which was at 37%. The referral noted, "*I am extremely concerned that if we do not help Tristan, he will die – either of the undiagnosed and untreated illness that he is suffering from, or that Tristan will take his own life*." A decision was taken by MASH to take no further action on the basis that father has been allocated a Father's Worker for support. This decision was deeply flawed. For a partner agency to raise concerns that a child will die and not even be contacted by CSC to explore their concerns shows a fundamental gap in understanding of safeguarding processes, partnership working and thresholds.

[10] Referral from Tristan's school in December 2022

4.28. It is to the credit of the school that they took a multi-agency approach to tackle this inaction. The hospital paediatrician agreed on 26 April to arrange an outpatient appointment, and spoke to the GP who shared concerns. The school advised that they were physically picking Tristan up to take him to appointments and that he had not attended school for several weeks, although his YEW checked in on him weekly for safeguarding purposes.

4.29. From early May 2023, extensive discussions took place between TAMHS, school nursing and the school in respect of Tristan's physical and mental health needs, in particular his 'skeletal' appearance. Following a Team Around the Child meeting with this practitioner group where a clear plan was made to escalate concerns, the next day the GP was asked to convene a professionals' meeting until Tristan was due to be seen by GWH at the end of the month, and for the named nurse to take Tristan's height and weight when he was seen. Three days later Tristan was opened to CAMHS's Getting More Help pathway following a referral, but he did not return a subsequent phone call to book an assessment. He attended his GP for a blood test, but his height and weight were not taken as requested. TAMHS took Tristan's height and weight the following day and found that he was seriously underweight at just 45.2kg, with a BMI of 12.1[11]. TAMHS contacted MASH, expressing concerns about neglect of Tristan's physical and mental health. The school contacted GWH's consultant paediatrician to report the concerns raised by TAMHS, and the paediatrician contacted MASH to request an urgent strategy meeting. The paediatrician also contacted the GP, who reported that Tristan's BMI had been monitored monthly and remained around 12. MASH agreed that threshold was met for a strategy discussion, and when this took place the following day, a decision was taken to progress a s47 on the basis that Tristan's low weight was potentially life threatening, and an immediate safety plan was identified for Tristan to be taken to hospital for a child protection medical and he was admitted to hospital for dietetic support, CAMHS assessment and cardiac evaluation of heart murmur and echocardiogram due to concerns about his heart function. The social worker who contacted the school to conduct enquiries was only aware of the TAMHS referral, not the school's two earlier referrals, which made the school feel that there was a lack of parity of esteem. On admission to hospital, CAMHS completed a mental health assessment with Tristan on the ward, the clinical impression was that his presentation was congruent and reactionary to sustained emotional and verbal neglect. Children's Social Care were contacted to arrange a Discharge Planning Meeting and consider safety planning prior to discharge due to the risks around Tristan returning home and his father's ability to provide consistent parenting.

4.30. Swindon Children's Social Care was inspected by Ofsted in July 2023, and found to be inadequate overall. Of relevance to this review, the inspector identified *"Thresholds for the assessment and provision of services to children who may be at risk of harm or in need are not consistently understood by multi-agency partners, staff and managers in the multi-agency safeguarding hub (MASH). This means that, too often, children are left in situations where their needs or risks have not been understood. Therefore, some of these children continue to live in need or experience harm and are the subject of repeated referrals before the harm or need is recognised and needs are met."* However, the report also noted, "*When these concerns were raised with the local authority, the senior leadership team took prompt action to review the service and begin to address the issues raised."*

4.31. Attendees at the learning events highlighted their concern that decision making in respect of safeguarding for older teenagers was not robust, one commenting, "*they're just waiting for them to become adults*.*"*

4.32. Practitioners also noted that although there was significant evidence of neglect in this case, the framework for safeguarding children places heavy focus on the parents' care of the young person and that in cases where the primary concerns related to the young person's health or mental health, this could alienate the parents or result in losing focus on the current risks to the

[11] A BMI below 18.5 is low weight for a 17-year-old male; a BMI of 12.1 is far below the 0.4th centile.

children. The requirement within the local child protection procedures for the conference chair to determine which 'category' of significant harm a child was at risk of suffering (the categories being physical, emotional or sexual abuse or neglect) did not sit comfortably in the context of health or mental health of a young person who was over 16 and, subject to mental capacity, legally entitled to take their own decisions in respect of treatment and sometimes felt punitive to the parents. It is important to note that although the statutory definition of 'harm' in section 31(9) of the Children Act 1989 includes the types of harm used as categories in the local procedures, this is not exhaustive and the definition refers to 'ill-treatment' more generally. While the parental capacity to support a young person will be relevant to any assessment, there was a clear need for more tailored assessments and a bespoke child protection approach for cases involving older children. *Working Together* explicitly endorses local authorities and their partners developing local protocols for assessment.[12]

4.33. In the context of a young person who has the capacity to take their own decisions around treatment and eating, children's services can helpfully borrow from the established body of research and safeguarding reviews in respect of adults who self-neglect, particularly as there is strong evidence that children who experience neglect often grow into adults who self-neglect. A lack of multi-agency coordination, information sharing and legal literacy (predominantly in respect application of the Mental Capacity Act 2005), are identified frequently within Safeguarding Adults Reviews as areas requiring practice improvement, especially where the risk arises from perceived self-neglect. This is made more acute in the context of refusal or non-adherence to medical treatment where the adult is suffering from physical and mental health conditions. National analysis identifies that often a focus on specific need or behaviour obscures recognition of foreseeable risk, reporting that:

> *"…even when self-neglect was recognised, it was little understood and poorly explored, lacking detailed personal history and exploration of the person's home conditions or health management routines. Refusal of services was not explored or understood. Professional curiosity was not exercised. Assessment, particularly in the hospital context, relied heavily on self-reporting, with home circumstances not observed. In some cases, assurances about actions the individual would take were accepted at face value, despite evidence to the contrary*."[13]

4.34. In January 2024, the SSP published multi-agency policy and guidance on responding to self-neglect.[14] This calls for practitioners to work with any adult at risk of self-neglect in a person-centred way, understanding their wishes and the insight they have into their situation. It highlights the characteristics of self-neglect, including a lack of self-care in relation to daily needs to an extent that it adversely affects well-being, personal health and safety, and an inability or unwillingness to accept essential care and support, and services, or necessary medical treatment to avoid harm to self.

4.35. The policy encourages setting achievable goals, supporting autonomy, ongoing involvement and contact with the adult to develop trusting relationships that might motivate change rather than confrontation so that challenge is sensitive and trauma informed. The importance of finding consensual ways forward without downplaying or ignoring the risks of the situation is also emphasised. The policy provides gives advice to support effective assessment of a person's mental capacity. Local guidance, in common with national best practice, calls for a multi-agency approach, although this would be strengthened by greater emphasis on exploring the dynamics between family members, ensuring that carers are not left out of assessment and care planning. It provides templates for multi-agency needs and risk assessments and details of the procedure,

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[12] Working Together to Safeguard Children 2018 (publishing.service.gov.uk) at paragraph 46

[13] National Sar Analysis. ADASS/LGA, Michael Preston Shoot, 2020 {p101] available at: https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

[14] Multi_agency_policy_and_guidance_on_responding_to_self_neglect_____January_2024.pdf

including options for legal interventions. The policy could helpfully be adapted in accordance with the legal framework for children, to support the assessment and response for young people who are self-neglecting.

Systems findings

4.36. Thresholds for the assessment and support for children in need, or at risk of or experiencing harm are not consistently understood across the partnership, in particular in respect of older children. There is a clear need for more tailored assessments and a bespoke child protection approach for cases involving older children where their autonomy and mental capacity must be balanced against their right to be protected from harm.

Recommendation 5: *Swindon Safeguarding Partnership should develop an Adolescent Safeguarding Framework, to support practitioners to recognise and assess the harm experienced by older children and young people, understand the relevant legal framework and provide the tools to respond in an age-appropriate manner.*

Eating disorders and treatment.

4.37. While in hospital, CAMHS noted that Tristan did not appear to be suffering with an eating disorder, but his eating issues appeared congruent with lack of resources and poor education around nutrition and diet linked to neglect, and that his low mood appeared to be in context of many years of trauma and neglect. However, CAMHS planned to further assess once Tristan was discharged from hospital, possibly through its Crisis and Home Treatment Service, as it was not clear what support he needed. Initially Tristan lost weight while in hospital, so was told that he would need to remain in hospital, although he refused any option other than returning home. Tristan and his father explained that while in hospital, Tristan was restricted to a very limited diet with small servings of food and when his father tried to bring him takeaways that he enjoyed, hospital staff stopped them from doing this.

4.38. Clinicians were concerned that because Tristan had a BMI of just 12, he was at high risk of refeeding syndrome. Increased nutrition following a prolonged period of starvation can result in refeeding syndrome, which is defined as medical complications that result from fluid and electrolyte shifts as a result of aggressive nutritional rehabilitation, and can be fatal. Tristan and his father seemed unaware of this, and it is not clear whether this was explained to them in a way they understood.

4.39. After 11 days in hospital, CAMHS assessed Tristan's mental state on the ward, finding no evidence of thought disorder. Tristan appeared able to follow the conversation appropriately and appeared orientated to time and place, with normal, congruent speech. Tristan rated his mood as 2/10 (when he was feeling suicidal a few months earlier, he rated his mood as -5/10). Tristan felt his mood had been low like this for as long as he could remember and had low motivation, without ideas about the future. A series of discharge planning meetings took place through this period, with a multi-agency plan in place to assess and support Tristan in the community.

4.40. Tristan is very clear that he considers that the professional response to his mental health needs has been inadequate. He said that when he made the disclosure to his pastoral care assistant in December 2022, he was desperately hoping for a therapeutic mental health service to address his feeling of despair. He felt that the focus on the safeguarding issues he disclosed had distracted professionals from what he was asking for. Whilst undoubtedly, the allegations of abuse needed to be urgently addressed and safeguarding measures put in place, a holistic child protection response also needed to address his wider needs, and given that Tristan was expressing hopelessness and suicidal ideation, an urgent CAMHS referral was needed, but he was not opened to CAMHS until his hospital admission in May 2023.

4.41. Practitioners discussed their concern that Tristan's Avoidant Restrictive Eating Disorder (ARFID) and mental health needs were not identified earlier. They queried whether a gender bias existed that had delayed recognition of his very low weight, noting that it was common for people with anorexia to be hospitalised when their BMI was higher than Tristan's. ARFID is a mental health condition, where people do not eat enough food, or enough different kinds of food to meet their energy or nutritional needs, but is not linked to weight or body image, nor attributable to a concurrent medical condition or better explained by another mental health condition. Diagnostic criteria for ARFID state: "*This disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.*"[15] AFRID may be linked to sensory aversion, fear of consequences such as choking or stomach upsets, lack of interest in food or trauma.

4.42. ARFID behaviours are common in people with autism of all ages as they will typically have a narrow range of foods they feel able to eat. There is no standard treatment for ARFID, though different types of therapies may be helpful, including cognitive behavioural therapy (CBT), family-based therapy and occupational therapy. Practitioners noted that there was limited support available from CAMHS for young people with an ARFID diagnosis, which they felt was in part due to the labour intensive treatment protocol required to reduce the behaviours, creating a systemic bias against providing a service. Clinicians who attended the practitioner event agreed that CAMHS' eating disorder clinic was probably the right service for Tristan, and were shocked that he had not been seen by them until his hospital admission.

4.43. Leaders noted that CAMHS is currently liaising closely with the ICB around the known gap in service provision for the assessment, diagnosis and therapeutic provision for children and young people who present with symptoms consistent with an ARFID diagnosis. It is recognised that this disorder requires multi-agency input to support treatment and that significant funding would need to be identified to set up a pathway to support this. CAMHS/TEDS does already offer support, where indicated, to a number of young people who have ARFID. This support will often be initiated when a young person is at significantly low weight or experiencing significant physical or psychological health concerns. The remit at that stage would be to support medical colleagues in implementing care plans to restore weight. Further intervention will depend on the ARFID 'driver', the presentation of the young person. It may be appropriate for this intervention to be offered by CAMHS services, or indeed community dietetics and or occupational therapy where sensory issues are identified.

4.44. The absence of any mental health or eating disorder support from the point of Tristan's first hospital admission in January 2022, or at least his disclosure in December 2022 meant that at the time he was admitted in May 2023, he was extremely anxious about being in hospital and distrustful of professionals. It is likely that this contributed to his hospitality towards some clinicians and practitioners involved in his care, although Tristan noted that even while in hospital, he did not actually receive any therapeutic provision. He felt like he was being held in for feeding, rather than receiving any therapy for his underlying needs, and that this was therefore unlikely to improve his nutrition in the community. It is acknowledged that hospital wards are not therapeutic environments and for Tristan, the noise and sharing his space with a number of younger children was quite overwhelming. Efforts could be seen to resolve this, as clinicians tried to have him moved to a quieter side-room, but the constant stress and lack of sleep are likely to have contributed to his resistance to staying longer for treatment.

4.45. At the time of this review, although Tristan had turned 18, CAMHS was continuing an assessment to determine whether he had autistic spectrum disorder (ASD), as clinicians suspect that his disordered eating may relate to autistic traits. The decision to continue this

[15] American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington D.C.: 2013 (DSM-5)

assessment post-18 is excellent transitional safeguarding practice, and will avoid a very lengthy waiting list before he would be assessed by adult mental health services. The impairments associated with autism are on a dimensional spectrum, characterised by difficulties in social communication, restricted interests, repetitive behaviours, and sensory behaviours. In addition to these central features, up to 70% of children and young people with autism can have at least one co-occurring mental health diagnosis.[16] The National Autism Strategy[17] sets out that *"Autism is a lifelong developmental disability that affects how people perceive, communicate and interact with others, although it is important to recognise that there are differing opinions on this and not all autistic people see themselves as disabled."* Without pre-empting the outcome of the assessment, children with higher IQs are often diagnosed later in childhood than those with lower IQs, and it is common for diagnosis to occur as emotional, behavioural and social difficulties escalate during adolescence.[18]

4.46. Tristan does not think that he has ASD, and believes that clinicians are seeking a diagnosis to explain the fact that he does not agree with the treatment they propose for his low weight. Clinicians acknowledged that it was unclear whether Tristan's presentation was linked to ASD or high levels of childhood trauma. There is now a well-established evidential basis for the impact that trauma and adverse childhood experiences has on the development of the brain and, consequently, adult mental health. There is both a greater awareness of the prevalence of trauma in society and deeper knowledge of its long-term effects on survivors.[19] Children who have normalised high levels of harm are often resistant to help as they do not see the risk posed to them. Tristan experienced high levels of Adverse Childhood Experiences (ACEs), which are "*highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity*."[20] People who experience four or more ACEs are three to four times more likely to experience health and mental health inequalities, and twelve times as likely to complete suicide.

4.47. The impact of these multiple traumas is likely to have contributed directly to the difficulties practitioners across some agencies reported in trying to build trusting relationships with Tristan. Good practice could be identified from some practitioners in respect of their efforts to connect with Tristan and his father using relational techniques and a strength-based approach, and Tristan spoke positively of those who took the time to get to know him in an empathetic way. However, earlier intervention was needed to develop trusted professional relationships characterised by consistency and integrity, which could then have been used as a foundation for positive engagement as Tristan grew older. In its 2020 annual report,[21] the Child Safeguarding Practice Review Panel identified that organisations must be agile and flexible enough to respond immediately to 'critical moments', when the child is more likely to be open to change.

4.48. Leaders noted that during the pandemic, the usual processes for identifying emerging neurodiversity or mental health needs were disrupted, as schools and other agencies had reduced face-to-face contact with children. Although there were two pathways for diagnosis, either through CAMHS or community paediatricians, there were currently lengthy delays in assessments taking place. Consequently, cases were being prioritised when diagnosis would

[16] Simonoff E, Pickles A, Charman T, Chandler S, Loucas T, Baird G. Psychiatric disorders in children with autism spectrum disorders: prevalence, comorbidity, and associated factors in a population-derived sample. J Am Acad Child Adolesc Psychiatry 2008; 47:921. https://pubmed.ncbi.nlm.nih.gov/18645422/.

[17] National strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK (www.gov.uk)

[18] Mental health and social difficulties of late-diagnosed autistic children, across childhood and adolescence - Mandy - 2022 - Journal of Child Psychology and Psychiatry - Wiley Online Library

[19] Jones & Wessely, 2007; Scottish Government, 2012; Becker-Blease, 2017

[20] Young Minds, 2018

[21] The Child Safeguarding Annual Report 2020 (publishing.service.gov.uk)

have a significant impact on ongoing care, as in Tristan's case where eating disorders were suspected to relate to neurodiversity.

4.49. The Mental Health Act 1983 (MHA) and the Code of Practice (para 2.5) both identify eating disorders as a mental disorder under the means of the Act. In most cases compulsory admission and the use of the MHA is not necessary or appropriate to be used with patients with eating disorders. However, in extreme cases, where the physical health or survival of a patient may be seriously threatened by the refusal of food or fluid then this may result in professionals considering the use of the MHA. This is further illustrated by the Care Quality Commission (2008) who state, '…*that it is only in its most severe manifestations that anorexia nervosa may be considered to require compulsory admission under MHA 1983. Detention is justified in rare cases of serious threat to health, where compulsory feeding may be necessary to combat both the physical complications and the underlying mental disorder*.' NICE guidance on eating disorders[22] indicates that as many as 25% of people with an eating disorder are male, and that they most commonly start in adolescence, however, this excludes ARFID from the definition of an eating disorder, which is unhelpful.

4.50. Although outside the scope of this review, Tristan was detained under the MHA for assessment under s2 in autumn 2023. He reported that he was only provided with a leaflet explaining his legal right to appeal his detention to the Mental Health Tribunal and his right to an independent mental health advocate three weeks after he was detained, which he knew to be a breach of his Article 5 and Article 6 rights. It is suggested that partners investigate this and if correct, that urgent steps are taken to ensure that detained patients are being informed of their rights and given access to an advocate immediately upon being detained.

Systems findings

4.51. National challenges in respect of the availability of child and adolescent mental health services have resulted in a local system that is not sufficiently agile in its response to critical moments when a young person is seeking care and open to change, nor to consistently respond in a way that is targeted to individual needs. Treatment of physical health needs in relation to disordered eating needs to be provided in conjunction with an immediate and robust plan of support for the young person's emotional, social and mental health. Learning from this case and the recent LCSPR in respect of 'Alan' indicates that there is a particular gap in early recognition and response for boys with disordered eating.

Recommendation 6: *The BSWICB should review the commissioning arrangements for young people with Avoidant Restrictive Eating Disorder, to ensure this is adequate to meet local need.*

Recommendation 7: *When practitioners have struggled to find a way to engage with young people with suspected neurodiversity or emotional, social or mental health needs, partners need to share support plans that are developed in collaboration with the young person, their family/carers and trusted professionals.*

Recommendation 8: *SSP should ensure that learning from this case and the 'Alan' LCSPR are used to educate the professional network in respect of recognising and responding to the needs of boys with disordered eating.*

[22] Context | Eating disorders: recognition and treatment | Guidance | NICE

Mental capacity and the Children Act 1989

4.52. The term 'Transitional Safeguarding' describes the need for an approach to safeguarding adolescents and young adults fluidly across developmental stages[23], despite the differences between the legal frameworks for children and adults. The Chief Social Worker and Research in Practice's Transitional Safeguarding briefing[24] highlights the important contribution made by adult social work within transitional safeguarding, pointing specifically to the expectation within the Care and Support guidance, which accompanied the Care Act 2014, of adopting a human rights-based, person centred approach. All public bodies must exercise their legal powers in an ethical way that complies with duties under the Human Rights Act 1998, Mental Capacity Act 2005 (MCA) and Equality Act 2010. Personal freedoms must be weighed against duties placed on public bodies to protect lives and mitigate risks to vulnerable young people. While Article 2 of the European Convention on Human Rights (ECHR) places a duty on public bodies to prevent avoidable deaths, this must be balanced against the right to freedom from inhumane treatment (Article 3), the right to liberty (Article 5) and respect for your private and family life (Article 8).

4.53. Although the Children Act 1989 (the 1989 Act) defines anyone under the age of 18 as a 'child', the MCA and associated Code of Practice distinguishes a 'child' as being under the age of 16, and a 16 or 17 year old is defined as a 'young person'. The MCA sets out the right of a competent person over the age of 16 to take decisions. There can be a significant tension between the principle under section 1 of the MCA, that the fact a decision may be unwise does not mean that the young person lacks the capacity to take that decision, and the safeguarding duty on a local authority and partners under section 47 of the 1989 Act. This places a duty on the local authority to make enquiries if they believe that a child under the age of 18 may be at risk of significant harm, including physical harm, and to take decision about whether any action should be taken to safeguard and promote the child's welfare.

4.54. This is further complicated by parental responsibility, which is defined under s3 of the 1989 Act as "…*all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child*…" and applies to any child under the age of 18. [25] This includes a duty to ensure that the child's basic care needs are met, including adequate nutrition and health care, and failure to do so may constitute neglect. However, people with parental responsibility for a young person may only make decisions on behalf of that young person that are seen to sit within the scope of parental control, which is a legal concept describing which decisions a parent should be able to take concerning their child's welfare. Although this is not clearly explained under the 1989 Act or related guidance, the Mental Health Act 1983 Code of Practice[26] explicitly sets out that "*Parental consent should not be relied upon when the child is competent or the young person has capacity to make the particular decision*." [para. 19.39]. It further sets out that when determining whether an intervention can be undertaken on the basis of parental consent, the two key questions that must be addressed are "*First, is this a decision that a parent should reasonably be expected to make?*", having regard to the type and invasiveness of the proposed intervention, the age, maturity and understanding of the child or young person and the young person's views. "*Secondly are there any factors that might undermine the validity of parental consent?*" such as the parent's own mental capacity, whether they are able to focus on the child's best interests, conflict between the parents and the child, or two parents disagree about the proposed treatment. [para. 19.41] If either of these applies, it will not be appropriate to rely on parental consent and the proposed intervention must be lawfully authorised by other means. [para.19.42]. Although this specifically relates to application of the Mental Health Act 1983,

[23] Holmes and Smale (2018) Mind the Gap:
[24] Bridging the gap: Transitional Safeguarding and the role of social work with adults (publishing.service.gov.uk).
[25] Parental responsibility will be held by the mother, the father if he is married to the mother or named on the birth certificate, people granted PR through an order of the court, such as adopters, special guardians, child arrangements order, a parental responsibility agreement or order, or testamentary guardians.

[26] Mental Health Act 1983 (publishing.service.gov.uk)

these principles are helpful more generally when considering what actions a parent can reasonably expect or be expected to take in respect of safeguarding their child.

4.55. Outside of treatment under the Mental Health Act 1983 (MHA), the provision of care and treatment is only lawful if the person receiving the care/treatment has either given capacitated consent or, if the person lacks capacity, acts are done in accordance with the legal obligations under the MCA and ECHR. Every person over the age of 16 capable of making decisions has an absolute right to accept or decline medical treatment,[27] regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. Without consent, any invasion of the body, however well meaning or therapeutic, will be a criminal assault.

4.56. The MCA sets out that a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for them self in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. A person is unable to make a decision for them self if they are unable to understand, retain, and weigh the information relevant to that decision, or to communicate this. The fact that a person is only able to retain the information for a short period does not prevent them from being able to make the decision and capacity may fluctuate over time. There is a presumption of capacity unless otherwise evidenced and a person cannot be treated as lacking capacity, merely because someone else considers their decision to be unwise.

4.57. The executive function of the brain is a set of cognitive or understanding/processing skills that are needed to plan, order, construct and monitor information to set goals or tasks. Executive capacity is the ability to implement decisions taken, to deal with the consequences and to make adjustments to changing risks in the real world. The MCA Code of Practice (para 4.21) notes: "*For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. A person must accept the information and take it into account. A person may appear to be able to weigh facts while sitting in an interview setting but if they do not transfer those facts to real life situations in everyday life (executing the plan) they may lack mental capacity*."

4.58. The Court of Protection has explored 'articulate and demonstrate' models of assessment in the 2014 case of *GW*:

> "*It is not surprising that GW was able to recall some safety issues in oral evidence, or to describe the route she took into town. The question was whether in practice she had the ability to apply insight and understanding about road safety when she was out and about. Every time someone walks into town, it is a different experience, no matter how well they know the route. The question is whether GW has an appreciation of the risks that may arise every time she steps out of the front door*." (*GW v A Local Authority* [2014] EWCOP20)

4.59. Mental capacity assessments should explore rather than simply accept notions of 'lifestyle choice'. This means applying understanding of executive capacity and how adverse childhood experiences, trauma and 'enmeshed' situations and conditions such as neurodiversity or health conditions like diabetes can affect decision making. NICE guidance[28] advises assessments should take into account observations of the person's ability to execute decisions in real life situations, highlighting the situational aspect of decision making. This should have been applied throughout the assessment, care planning and provision of support and healthcare to Tristan. Where there is evidence that outside of an assessment environment the person is not able to understand or weigh up information to enact a decision, this should be thoroughly explored. The presumption of capacity under section 1 of the MCA does not override professional and statutory

[27] Section 8 Family Law Reform Act 1969

[28] NICE (2018) Decision Making and Mental Capacity. London: Overview | Decision-making and mental capacity | Guidance | NICE.

duties to ensure that young people or adults with care and support needs are safe from abuse, neglect or exploitation. "*There is a difference between someone who has an appreciation of risk and yet goes on to take the risk – albeit unwisely – and someone who… lacked awareness of the risk and sufficient problem-solving ability*." [29]

4.60. Consideration also needed to be given to whether the degree of malnutrition Tristan was experiencing could have led to his mental capacity fluctuating. In the leading case of *RB Greenwich v CDM* [2018] EWCOP15, which involved a 63-year old woman with a diagnosis of personality disorder and poorly controlled diabetes who had fluctuating capacity to take decisions, the Court of Protection held that an assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made and not their ability to make decisions in general.

4.61. The principles embedded in s4 MCA require that any decision taken on behalf of a person who lacks capacity to make it, follows the least interventionist approach, and is taken in the person's best interest. This is not just the person's medical best interest, but rather their welfare in the widest possible sense, considering the individual's broader wishes and feelings, values and beliefs. All decisions should follow careful consideration of the individual circumstances of the person and focus on reaching the decision that is right for that person – not what is best for those around them, or what the "reasonable person" would want. The person who lacks capacity to make a decision should still be involved in the decision-making process as far as is possible, and those who know them best should be consulted. The courts have held that in cases where treatment for a condition such as anorexia nervosa becomes oppressive and disproportionate, prolonging the patient's suffering without hope of improvement in their condition, such patients should be discharged from s3 MHA and only treated on a voluntary basis, even if they lack capacity to take a decision in respect of their treatment and this may result in their death.[30]

4.62. CSC visited Tristan in hospital in May 2023 to determine if a mental capacity assessment was required (albeit it is unclear what decision he was being asked to take), but concluded that he did not meet the criteria as he *'did not have an impairment to the mind or brain'*. While Tristan is an erudite and intelligent young man who may have capacity to take all relevant decisions, a more nuanced understanding of the impact of his eating disorder or trauma on his ability to take decisions about his nutrition and treatment was required. Input from clinicians and CAMHS was needed to understand his cognitive functioning and understanding of the impact of poor nutrition on his health and mental health. The fact he did not have a diagnosis was not determinative of his mental capacity, and leaders noted that there was a lot of generalised discussion that Tristan 'had capacity' indicating a misunderstanding of the MCA and its use.

Systems findings

Significant progress has been made in respect of professional understanding of the general principles of the Mental Capacity Act in Swindon. However, a more nuanced understanding of the impact of trauma and co-occurring needs such as neurodiversity and eating disorders on executive functioning will better support practitioners when assessing a young person's capacity to take decisions in respect of risks and medical treatment.

Recommendation 9: *Swindon Safeguarding Partnership to seek assurance about the robustness of the competency and accountability framework for mental capacity in use across children's services.*

Recommendation 10: *In complex cases, practitioners from key partner agencies working with the individual should collaborate to formulate a shared analysis of how the individual's cognition*

[29] Baker J, *GW v A Local Authority* [2014] EWCOP20, para. 45
[30] Cheshire & Wirral Partnership NHS Foundation Trust v Z [2016] EWCOP 56 (30 December 2016) (bailii.org)

function is impacted in different circumstances, to support frontline practitioners in undertaking mental capacity assessments that are decision and time specific.

Managing professional disagreement between agencies

4.63. During the learning events, practitioners and managers discussed the considerable efforts that were made to resolve the differing views in respect of Tristan's needs, capacity, treatment and care in what was, unquestionably a very complex and emotionally challenging case. Fundamentally, all agreed that something needed to change and that he needed more care, but each agency felt limited by the bounds of their respective legal and practice frameworks and the practicalities of resources. The levels of professional anxiety meant that agencies were working against each other, not together.

4.64. This was exemplified by the child protection case conference in July 2023, when all professionals were of the view that threshold was met for a child protection plan, but the decision was overruled by the conference chair, who was concerned that professionals had known of Tristan's disordered eating and the impact on his health since at least January 2022, but possibly for years, with missed opportunities by the whole multi agency group that had allowed Tristan to become so malnourished, without appropriate support for Tristan and his father to make the necessary changes. Tristan was then at a point where he was starting to make those changes, and the chair felt it would be unhelpful to put him on a child protection plan for the first time 4 months prior to his 18th birthday. The chair was concerned about blame being unhelpfully attributed to Tristan and his father, and between different professionals, instead a constructive approach. The hospital and school formally dissented from this decision. A clear action plan was agreed to support Tristan to meet his health, mental health and educational needs, and to transition to adult services. Practitioners felt undermined by this decision, and felt that it sent a message to Tristan and his father that they would not have to work with professionals, when they were conscious that the family needed really intensive support for the limited period professionals had to intervene.

4.65. While the level of concern was understandable, and some panel members expressed their concern that this relates to a wider reluctance to offer protection to children nearing 18, careful reflection on the case shows that the chair's approach was fair and appropriate. At that point, Tristan had only been open to CAMHS and eating disorder support since his hospital admission in May 2023. He and his father were allowing the youth engagement worker, CSC visits, and carers provided by CSC to support Tristan's eating to attend the home daily. Further, in light of his age and capacity, agencies' options to compel Tristan or his father to engage with support or consent to treatment were limited to the legal pathways under the MCA or MHA. Section 31(3) of the Children Act 1989 prevents a care or supervision order being made by a court for a child over the age of 17, which meant CSC had very limited options to intervene. A collaborative approach, offering support and building trusted relationships was the best way to secure ongoing engagement from Tristan as he transitioned to adult services.

4.66. There were also good examples of effective escalation, in particular by the school in December 2022, when they challenged the decision to triage the safeguarding referral to early help, and in April/May 2023 when they drew together partners from health to support their referral to CSC. This persistent, robust approach was good practice. However, there may be circumstances where professional concern has not been mitigated and issues through existing escalation processes, there may still have been areas where agreement cannot be reached. In those circumstances, an application to the Court of Protection or High Court, seeking exercise of its Inherent Jurisdiction, may be the appropriate forum for resolution.

4.67. Where, as in Tristan's case, rights protected by way of article 3 (the prohibition against torture, inhuman and degrading treatment) and article 5 (the right to liberty) conflict with proactive legal duties on public bodies under article 2 (to protect life) it is essential to provide clarity on how

those treatment and care decisions are reached and on the legal framework relied on by clinicians and practitioners. Of relevance in this case is the judgment of Mostyn J in *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 1317 where he said:

> "*In my judgment where the approved clinician makes a decision not to impose treatment… and where the consequences of that decision may prove to be life-threatening, then the NHS trust in question would be well advised, as it has here, to apply to the High Court for declaratory relief. The hearing will necessarily involve a 'full merits review' of the initial decision. It would be truly bizarre if such a full merits review were held where a positive decision was made under section 63, but not where there was a negative one, especially where one considers that the negative decision may have far more momentous consequences (i.e. death) than the positive one."*

4.68. Practitioners also discussed the personal impact caused by their ongoing worry that the harm Tristan was experiencing had not been resolved. They described feeling distressed and ignored, and individual practitioners felt that other agencies were not treating their concerns about Tristan seriously. This was exacerbated by the perception by some practitioners that the father's emotional dysregulation meant it could be unsafe to enter the home, reducing the oversight of Tristan's welfare. Meetings and email exchanges became adversarial, entrenching rather than resolving areas of professional disagreement. Practitioners were not necessarily aware of the limitations faced by other agencies in terms of working with a young person who has reached an age where they are legally entitled to make their own medical treatment decisions. All agreed that opportunities for multi-agency reflective supervision may have helped to improve understanding of the rationale behind individual agency decisions and deescalate the tensions outside the heat of the moment.

4.69. The rapid review of Tristan's case recommended 'roles and responsibilities' training to help practitioners from different agencies to understand what is within the portmanteau of options for partner agencies when dealing with complex cases. This would clearly be beneficial for all agencies involved.

4.70. During the review, leaders noted that the reintroduction of Swindon's multi-agency risk panel has not only provided an opportunity for agencies to present children they are concerns about, but a forum for discussion and resolution when there is disagreement in respect of risk levels or agency response to emerging harm.

Systems finding

4.71. Understandable professional anxiety and conflicting views on appropriate interventions meant that communication between agencies became adversarial, entrenching rather than resolving areas of professional disagreement.

Recommendation 11: *Swindon Safeguarding Partnership should review how the inter-agency escalation policy is being used, including by front-line staff, and whether this is resulting in timely resolution on areas of dispute between agencies. Multi-agency reflective supervision sessions should be introduced to support practitioners in complex cases.*

Recommendation 12: *In situations where apparently conflicting legal frameworks governing the actions of partner agencies mean that the multi-agency risk panel or escalation procedure does not or cannot resolve a situation where the individual's article 3 and article 5 rights conflict with proactive legal duties on public bodies under article 2, agencies should take timely legal advice in respect of resolution through the Court of Protection or the High Court's inherent jurisdiction.*

Recommendation 13: *Leaders should consider how to recognise and respond to vicarious trauma of the staff working with the children and families.*