North Yorkshire County Council

Supplementary Agenda Items

Notice of a public meeting of **Scrutiny of Health Committee**

To: **Councillors Lindsay Burr MBE, Liz Colling (Vice-Chair), Caroline Dickinson, Richard Foster, Sam Gibbs, Paul Haslam, Nathan Hull, Peter Lacey, Andrew Lee (Chairman), John Mann, Rich Maw, Heather Moorhouse, Andrew Murday, David Noland, Clive Pearson, Andy Solloway.**

District and Borough Councillors Susan Graham, Kevin Hardisty, Nigel Middlemass, Pat Middlemiss, Jennifer Shaw-Wright, Robert Ogden and Jane Mortimer.

Date: **Friday, 16th December, 2022**

Time: **10.00 am**

Venue: **Council Chamber, County Hall, Northallerton, DL7 8AD**

This meeting is being held as an in-person meeting and in public. The government position is that of learning to live with COVID-19, removing domestic restrictions while encouraging safer behaviours through public health advice. In view of this, hand cleanser and masks will be available for attendees upon request. The committee room will be well ventilated and attendees encouraged to avoid bottlenecks and maintain an element of social distancing.

Please do not attend if on the day you have COVID-19 symptoms or have had a recent positive Lateral Flow Test.

Please contact the named supporting officer for the committee, if you have any queries or concerns about the management of the meeting and the approach to COVID-19 safety.

Further details of the government strategy (Living with COVID-19 Plan) is available here – https://www.gov.uk/government/news/new-guidance-sets-out-how-to-live-safely-with-covid-19.

Business

8. **TEWV CQC Reports - Follow Up from Brian Cranna, Care Group Director, Tees,Esk and Wear Valley NHS Foundation Trust** **(Pages 3 - 136)**

Barry Khan
Assistant Chief Executive

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(Legal and Democratic Services)

County Hall
Northallerton

Wednesday, 14 December 2022.
Original agenda published 8 December 2022.

An independent investigation into the care and treatment of Christie at Tees, Esk and Wear Valleys NHS Foundation Trust

November 2022

Final Abridged Report

Note 1: This report has been abridged from the full investigation report 'the full and unabridged report'. Elements of the full and unabridged report were not deemed appropriate for full publication for the following reasons:

1 It contains unavoidable third-party information which was deemed important to the investigation and report;

2 It contains private information about Christie and her family; and

3 The report contains detailed information on self-harm and limitations exist on the extent of publication of such information which should be obligated (Safety Alert (NatPSA/2020/001/NHSPS) published 03/03/20).

Author: Nick Moor, Partner, Mental Health investigations, Niche Health & Social Care Consulting

First published: **November 2022**

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our Abridged Report has been developed from the 'Full and Final Report' written in line with the Terms of Reference for the internal investigation into the care and treatment of Christie. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose. We have aimed to remove all sensitive, personal third-party information from this report.

Events which may occur outside of the timescale of this investigation will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

This report was commissioned by NHS England and cannot be used or published without their permission. No other party may place any reliance whatsoever on this report as this has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report, the Final Abridged Report should be regarded as definitive.

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Contents

Summary

About this Investigation

1.1 The family have asked for us to use the first name in full of their daughter, Christie, throughout this report.

1.2 This investigation was commissioned by NHS England and NHS Improvement as an independent investigation into the care and treatment that Christie received before she died in June 2019. The report is in addition to a wider review into the governance and management of West Lane Hospital.

1.3 This independent investigation follows the Serious Incident Framework (SIF) and is conducted as a Level 3 independent investigation. The terms of reference (ToR) for our investigation were compiled following consultation and in agreement with Christie's mother and stepfather.

1.4 We have conducted our investigation applying a root cause analysis approach, by establishing a chronology, and identifying care and service delivery problems as well as contributory factors.

1.5 This report is abridged from the full report provided to the family and to the organisation and other key stakeholders for learning. The family were keen to ensure that the learning from their daughter's death be shared. However, elements of the unabridged report were not appropriate for publication for the following reasons:

- The rights to privacy of the deceased person extends beyond death;
- The rights of the family to have their private information maintained is paramount;
- All third-party information must be removed; and
- Some information relating to the mechanisms of self-harm are not deemed appropriate for publication and limitations exist on the extent of publication of such information (Safety Alert (NatPSA/2020/001/NHSPS) was published 03/03/20).

1.6 Christie's report does, however, contain some key chronological detail which outlines and describes the number of moves undertaken during her care and treatment. The extent of this is important to the abridged report.

1.7 The main purpose of an independent investigation is to ensure that serious incidents in health care are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process should identify areas where improvements to services might be required which could help prevent similar incidents occurring. The overall aim of any investigation

process is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

1.8 The ToR ask us to review and assess compliance with local policies, national guidance, and relevant statutory obligations. Where we have reviewed local guidance, we have referred to this in the text. Where we have considered other guidance, we have referenced this in the text and added a footnote identifying the publication referred to.

1.9 The investigation was carried out by a lead author supported by a panel of subject matter experts:

Nick Moor (lead author)	MBA, PGDip (Law).
Dr Nicole Karen Fung	Consultant Child and Adolescent Psychiatrist, MBChB, MRCPsych, CCT Child and Adolescent Psychiatry.
Jane Sedgewick	RN (MH), MSc, BMedSc (Hons), ENBCC603, ENBCC998.
James Ridley	Diploma in Professional Studies (Learning Disability), Diploma in Higher Education (Learning Disability Nursing), Registered Nurse (Learning Disability), BSc (Hons) Behaviour Analysis and Intervention, Post Graduate Certificate in Teaching and Learning in Higher Education, Fellow of Higher Education Academy, Registered Nurse Teacher (NMC Approved), MA Clinical Education.
Dr Carol Rooney	BA, Registered Nurse (Mental Health), MSc, DProf Prac.
Nic Hull	BA (Hons), CQSW.
Sharon Conlon	RMN, RNLD, MA Adult Safeguarding, MA Child Care Law and Practice, BSc (Hons) Community Health Specialist Practitioner.

1.10 The report was peer reviewed by Kate Jury, Partner at Niche.

1.11 To review the care and treatment provided to Christie we reviewed care records and information from:

- Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)
- NHS England Specialised Commissioning
- Durham County Council (DCC)
- South Tees Hospitals NHS Foundation Trust
- Young Foundations (the Daltons)
- The Care Quality Commission (CQC)
- River Tees Multi-Academy Trust
- Cleveland Police
- Middlesbrough Safeguarding Children Board (MSCB)
- North East Ambulance Service (NEAS)

1.12 We also carried out over a hundred interviews and undertook a site visit to West Lane Hospital. We triangulated this information and sought assurance against the standards outlined in the policies in place at the time of the incident to examine the care and treatment Christie received, and identify any care and service delivery problems, the contributory factors and possible root cause.

1.13 The draft report was sent to relevant stakeholders for factual accuracy checks. This provided an opportunity for those organisations who had contributed significant pieces of information and those whom we interviewed, to review and comment upon the content. We considered the comments and corrected factual inaccuracies where relevant.

Investigation limitations

1.14 Overall, our investigation start was delayed by six months, and took over 24 months to complete, which is significantly longer than the initially anticipated six months. We recognise the additional pressure this has placed on the family who are keen to understand the events surrounding their daughter's death.

1.15 We were unable to commence our independent investigation until Cleveland Police had concluded their investigation following Christie's death.

1.16 Also, this investigation and report were completed during the Covid-19 pandemic. This meant that there were significant additional delays due to the NHS having to focus attention and divert resources to respond to the pandemic. Completion and final checks were therefore delayed.

Parallel processes

1.17 Because Christie was under 18 when she died, her death is subject to a Child Death Overview Panel (CDOP) review by the County Durham CDOP, administered by Durham Council. We have been informed by the CDOP administration that Christie's death will be reviewed by the Panel when this NHS England commissioned investigation is complete.

1.18 There may also be enquiries by HM Coroner.

Contact with Christie's family

1.19 We met with Christie's mother and stepfather to introduce the investigation team in January 2020. They were accompanied by Christie's maternal grandmother and the family solicitor. We have subsequently had several meetings with them to keep them informed of investigation progress.

1.20 Christie's mother and stepfather contributed to the investigation alongside Christie's maternal grandmother. They all wished to be interviewed and gave

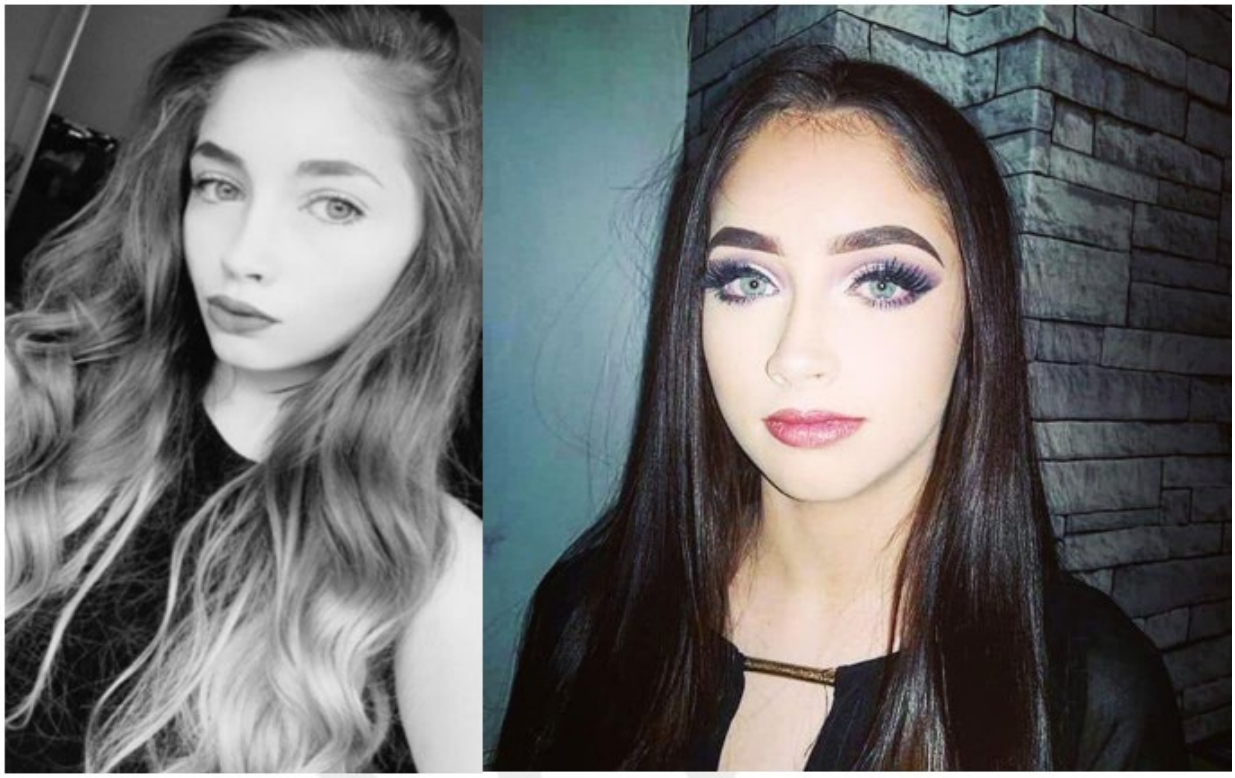
us much valuable information. They also provided a list of questions which we answered, wherever possible within our full investigation report.

1.21 We would like to express our sincere condolences to Christie's family. We recognise that this report will be difficult to read in places and we would like to apologise in advance if the manner of our report and the way we have written it in any way adds to their distress.

1.22 Niche and NHS England met with Christie's mother and maternal grandmother to share the findings of our report in June 2022. They were accompanied by the family solicitor.

About Christie

1.23 Christie's family have provided the following description of Christie.



Christie, 13th February 2002 – 27th June 2019

"Christie was born at Wexham Park Hospital in Slough at 35 weeks gestation. Her birth was a very calm, relaxed birth and she was born En Caul (in her amniotic sac) which is supposed to be lucky. She was a very happy baby, meeting all her developmental guidelines and was our little ray of sunshine. When she started talking, she became a chatterbox, able to hold conversations with people from the age of 2 years old.

Christie couldn't wait to go to school with her big sister and they would walk down the road together holding hands and skipping. As she grew, Christie loved to sing and dance. As soon as she was able, she joined the school choir and she sang all day every day, captivating everyone who was entertained by her. Christie was

academically bright and for the most part, enjoyed school, she was always involved in school productions of plays, concerts etc. and she excelled in this. She loved to watch musicals and have everyone sing and dance along with her. The Greatest Showman was a particular favourite. She didn't have a massive group of friends but was a popular, loyal, caring friend to those that were close to her.

Christie was a very talented artist, could craft too and would often make baby blankets or ornaments and frames for family and friends so she could earn money to go shopping. My goodness she could shop!! Next to singing, shopping was her favourite pastime and especially so if she could have family and friends tagging along. Shopping for Prom was great, she wanted sparkle. A lot of sparkle! We were happy to oblige.

After school, Christie really came into her own, style wise, she regularly changed her hair colour, had several facial piercings and wasn't a rigid follower of fashion, she had her own style and wore what she liked, when she liked. Vintage clothes were a favourite, and she was bohemian in her outlook. Christie was a beautiful, courageous, caring, independent young woman, with a fiery temper and spirit. Somebody who would fight for the underdog, her friends and family with no regard to what it would cost her to do so. She wouldn't ever let somebody fight or struggle alone; she would always have their back.

There was never a dull moment with her around especially with her cracking sense of humour. Christie was the 2nd oldest of 6 Children, with an older sister and four younger brothers. Christie was like a mother hen to her siblings and loved nothing more than to boss them around, she loved them all so much and wanted to be around them all the time, much to their annoyance. She had a soft spot for her youngest brother with him being 10 years younger, they were super close having sleepovers and Christie would take him out with her friends.

Christie also adored her stepdad who had brought her up from her being 5 years old. Christie was amazing, everyone who met her loved her, she was such a warm loving girl who could make you happier just by being around and was always trying to make people happy, she loved being able to brighten up people's day just by being herself she really did have the most amazing smile that just lit up a room. Christie was just starting to grow into her adult self. We could all see this vibrant, passionate, exuberant, beautiful young woman who was going to step into her future life, with her heart-warming smile on her face, and make a positive difference to the lives of everyone who would get to know her or cross paths with her. Somebody who would be helpful, caring, forthright, determined and above all loving.

Family was everything to Christie and we all miss her so much, nothing will ever be the same again now our sunshine has gone. Our lives darker, our hearts forever broken."

Chronology

The full chronology of care and treatment events contains extensive personal information about Christie's care and treatment. Much of which contains detailed information about episodes of self-harm, family information, third-party information, and the significant difficulties that Christie and staff had in managing her worsening presentation. This information is deemed private and unsuitable for publication.

The key timeline for Christie's care from 2017 is as follows:

Hospital or placement	Trust/ organisation	Comment	Date
Darlington Memorial Hospital	County Durham and Darlington NHS Foundation Trust	The nearest acute hospital to Newton Aycliffe	17 May to 1 June 2017
The Evergreen Centre, West Lane Hospital	TEWV	A 16-bed ward eating disorder specialist inpatient unit for children and young people at West Lane Hospital	1 June 2017 to 23 January 2018
The Newberry Centre, West Lane Hospital	TEWV	A 14-bed general adolescent ward for assessment and treatment of 12-18 year olds experiencing serious mental health problems, at West Lane Hospital.	22 February to 28 February 2018
Tunstall Ward, West Lane Hospital	TEWV	The adult mental health acute ward designated to receive female patients under 18 if there is no CAMHS bed available.	4 March to 19 March 2018
The Westwood Centre, West Lane Hospital	TEWV	A 12-bed ward providing assessment and treatment for young people in a low secure environment, at West Lane Hospital	19 March to 11 October 2018
The Newberry Centre, West Lane Hospital	TEWV		11 October to 26 October 2018
The Daltons, Seaham, County Durham	Young Foundations Ltd	Residential step-down services for up to 6 young adult residents with learning disability or mental health needs	26 October to 29 November 2018

Hospital or placement	Trust/ organisation	Comment	Date
Tunstall Ward, Lanchester Road Hospital, Durham	TEWV		23 to 30 November 2018
Hotels	Various	Around Newton Aycliffe	30 November to 12 December 2018
Slough		Visit to her grandparents	12 December to 20 December 2018
Hotels and supported accommodation	Various	Around Newton Aycliffe	20 December to 30 December 2018
Tunstall ward, Lanchester Road Hospital, Durham	TEWV		30 to 31 December 2018
Hotels and holiday cottage	Various		31 December 2018 to 12 January 2019
Ferndene PICU, Prudhoe	CNTW	Psychiatric Intensive Care Unit (PICU)	12 January to 1 March 2019
The Newberry Centre, West Lane Hospital	TEWV		1 March 2019 to 6 March 2019
Intensive Therapy Unit, James Cook University Hospital	South Tees NHS Foundation Trust	The nearest acute hospital to West Lane Hospital.	6 March to 9 March 2019
The Newberry Centre, West Lane Hospital	TEWV		9 March 2019 to 8 May 2019
Neighbours home with visits to family	Newton Aycliffe		8 May to 20 May 2019
Cypress Grove, Newton Aycliffe	Rented accommodation	Where Christie lived independently	20 May onwards
Ward 21 Darlington Memorial Hospital	County Durham and Darlington NHS Foundation Trust	The nearest acute hospital to her family home.	27 May to 28 May 2019
The Newberry Centre, West Lane Hospital	TEWV		28 May to 23 June 2019
James Cook University Hospital	South Tees NHS Foundation Trust		23 June to 27 June 2019

Table 1: Dates of hospital admission or placement for Christie

Early years

1.24 Christie was born in Slough in 2002. At that time, she was the youngest of two children.

1.25 In 2008 Christie and her family moved to Durham. By that time, she had three younger siblings. The family left behind paternal grandparents and a maternal grandmother in the south of England. Christie had close relationships with her maternal grandmother and her paternal grandparents.

1.26 Christie first came into contact with South Durham Child & Adolescent Mental Health Services (CAMHS) provided by Tees Esk & Wear Valleys NHS Foundation Trust (TEWV) on 4 October 2012 (aged 10), whilst in Year 6 at primary school.

January – May 2017

1.27 In 2017 Christie was re-referred to CAMHS for further support for anxiety and depression.

1.28 By April 2017 Christie was not eating properly and was engaging in self-induced vomiting, leading to significant weight loss. She was referred to the Eating Disorder team in May 2017.

1.29 Christie was assessed by Child & Adolescent Mental Health Services (CAMHS) and admitted to Ward 21 in Darlington Memorial Hospital (DMH) with concerns about her weight on 17 May 2017. She had lost a significant amount of weight and had not eaten for 3 days whilst at home.

May 2017 to January 2018

The Evergreen Centre (1 June 2017- 23 January 2018)

1.30 Christie was assessed whilst she was in DMH by the Eating Disorders Team from the Evergreen Centre, West Lane Hospital, on 30 May 2017.[1] She was detained under a Section 2 of the Mental Health Act 1983 (MHA)[2] on 1 June 2017 and transferred to the Evergreen Centre, the eating disorders inpatient service, West Lane Hospital. Christie's episodes of self-harm and aggressive behaviour continued through the summer.

1.31 Eventually, Christie's behaviour settled. She was self-harming less frequently and had put on weight. She was allowed short periods of leave under Section 17 MHA, extended to weekends and Christmas at home.

[1] The Evergreen Centre is a 16-bed ward, providing specialist eating disorder treatment for children and young people.
[2] Section 2 MHA permits detention for 28 days to allow for the assessment of a person's mental health and some limited treatment.

1.32 Christie was discharged on 15 January 2018, with support at home from community CAMHS and the CAMHS Crisis team.

January and February 2018

1.33 Christie struggled to eat when she was back at home. By the 19 January 2018 she had been admitted overnight to a paediatric ward in DMH with severe weight loss. Christie had to be restrained to prevent her self-harming and was on constant observations by staff from the Evergreen centre. The plan was to keep Christie on the ward until she ate and drank properly.

1.34 Christie was discharged from DMH on 23 January 2018 and was supported at home by the Intensive Home Treatment (IHT) team on a regular and frequent basis.

1.35 On 22 February Christie had to be readmitted to the Newberry centre, West Lane Hospital (the general adolescent unit) under Section 2 of the MHA. She had attempted to jump out of a car whilst on a visit into town with IHT staff.

1.36 Her parents also reported that Christie was experiencing an increase in command/auditory hallucinations telling her to hurt people.

1.37 After a short admission, a formulation meeting involving Christie and her parents agreed that a prolonged admission would not be helpful. Christie was discharged on 28 February 2018 with further support from the IHT team.

March to October 2018

1.38 On 4 March 2018 Christie became distressed at home and started self-harming. Christie was taken to the local Emergency Department (ED). She was assessed and detained under Section 4 MHA,[3] and initially admitted to Tunstall Ward[4] at Lanchester Road Hospital, Durham on 4 March 2018, because there were no adolescent beds available.

1.39 Christie had to have a brief admission to ward 21 DMH on 13 March as she had refused food and was taking only sips of water.

1.40 Christie's need for a social worker was discussed on 14 March 2018. It was agreed that she now needed to have her own social worker from the Young Peoples Service. At a care team conference call held on 15 March 2018 it was also agreed to refer Christie for a Forensic CAMHS (FCAMHS) assessment, as the severity of her risks to others was increasing.

[3] Section 4 MHA is an emergency detention for 72 hours on the basis of one medical recommendation and one application by an Approved Mental Health Professional (AMHP), in the event that providing two medical recommendations would delay the detention.
[4] The female adult mental health acute admissions and assessment ward to be used for female adolescent admissions when there were no adolescent beds.

1.41 By this time, she was medically fit to return to Tunstall Ward. However, that late afternoon/early evening she became distressed and threw a cup of boiling water at escorting staff. Security staff and police managed to restrain Christie and she was then transferred to Tunstall Ward.

1.42 Although the intention was to arrange for Christie to be admitted to a PICU, no bed could be found. Christie was eventually transferred to the Westwood Centre (adolescent low secure unit) West Lane Hospital on 19 March 2018.[5]

The Westwood Centre (19 March - 11 October 2018)

1.43 On Westwood, blood test results showed that Christie's phosphate levels were low. This was 'refeeding syndrome' a known risk of restricted diet and recommencing eating.[6]

1.44 She was placed on 12 observations an hour and dressed in 'strong clothing' (anti-tear clothing to reduce the risk of self-harm). Christie also started to attend dialectical behavioural therapy (DBT) sessions.

1.45 The initial plan was for a short eight-week admission, but Christie was still self-harming and needing restraint. She had also disclosed to her Responsible Clinician[7] (RC1) that she was hearing voices. Christie was assessed and detained under Section 3 MHA[8] on 29 March 2018.

1.46 Later in April Christie was assessed for risk of developing psychosis using the Comprehensive Assessment of At Risk Mental States (CAARMS) tool.[9] This identified that Christie met the threshold of psychosis in two areas and was at risk of developing a psychotic experience in several other areas, such as feeling suspicious and paranoid around people, and voice hearing experiences.

1.47 In the case review meeting on 23 April 2018, it was planned that Christie was to:

- remain on Westwood for the time being;
- attend DBT group;

[5] The Westwood Centre was a 12-bed ward, providing assessment and treatment for young people within a low secure environment.
[6] "Refeeding syndrome can be defined as the potentially fatal shifts in fluids and electrolytes that may occur in malnourished patients receiving artificial refeeding (whether enterally or parenterally [through a feeding tube or an intravenous line]). These shifts result from hormonal and metabolic changes and may cause serious clinical complications". Hisham M. et al. *Refeeding syndrome: what it is, and how to prevent and treat it*. British Medical Journal, 28 June 2008, Vol 336.
[7] The Responsible Clinician has overall responsibility for care and treatment for service users being assessed and treated under the Mental Health Act (1983).
[8] Section 3 MHA (1983) Section 3 allows for a person to be detained for treatment if their mental disorder is of a nature and/or degree that requires treatment in hospital, initially for six months then in renewable periods of one year.
[9] The Comprehensive Assessment of At Risk Mental States (CAARMS) is a semi-structured assessment tool used by mental health professionals and researchers to identify help-seeking young people who are at ultra-high risk (UHR) of developing psychosis. The CAARMS can also be used to track a range of psychopathology over time and to identify the onset of first episode psychosis.

- complete further clinical psychology assessments;
- have further family therapy sessions;
- be assessed by the Early Intervention in Psychosis (EIP) team; and,
- build up a relationship with a community CAMHS care coordinator and the Crisis team to start planning for discharge.

1.48 Over the summer Christie's episodes of self-harm and restraint became less frequent. Although there were some episodes of self-harming, her observation levels were reduced, and she was allowed more leave.

1.49 On 29 July 2018 she started to self-harm and hid the object in her hair. Although the object was then handed in, Christie was asked to hand over anything else that she could self-harm with. When asked if staff could check her hair, Christie agreed, but then she responded by punching the staff member when they approached her. Christie was restrained, her clothing cut from her, and she was placed in strong clothing.

1.50 When Christie informed her maternal grandmother of this, Christie's grandmother phoned the ward wanting to understand why Christie had been stripped and placed in strong clothing. She informed the ward that she had complained to the Care Quality Commission (CQC). The CQC had passed this to the Local Authority Designated Officer (LADO), the office responsible when allegations are made about staff from any service. In August 2018 Christie's mother and grandmother made a formal complaint to the Chief Executive of TEWV and this was investigated formally.

1.51 Christie and her social worker (SW1) had been trying to find suitable places for Christie to live when she was discharged, as at that time her home wasn't seen as a safe option.

1.52 It was noted that Christie had generally been managing herself very well on the ward. There had been occasions when Christie's mood had become low following leave or positive events. It was agreed that the aim was for Christie to be discharged at the beginning of November. Efforts were to be made to progress confirmation of funding of Christie's placement with social services. Christie felt that staying in Westwood would be more detrimental to her mental health.

1.53 On 1 October 2018 Christie attended the Hospital Managers hearing to review her detention under Section 3 MHA.

1.54 On 2 October, The Daltons at Seaham, provided by Young Foundations, was identified as a possible placement for Christie on discharge.[10]

[10] The Daltons is a residential step-down service for up to 6 young adult residents with learning disability or mental health needs.

1.55 On 4 October Christie was to visit The Daltons on Section 17 leave, so she could decide whether she thought it would be suitable for her. The visit was successful, and Christie liked the placement.

The Newberry Centre (11 October - 26 October 2018)

1.56 On 11 October 2018 Christie was discharged from her Section 3 MHA by the Hospital Managers hearing and transferred to the Newberry Centre as an informal patient. Funding for placement at The Daltons was also agreed by Durham Social Services and NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group (CCG).[11] She was to start attending there on leave from the ward.

1.57 Christie became a looked after child (LAC) after being placed under Section 20 Children Act (1989).[12] She went on extended leave and was discharged to The Daltons from the Newberry Centre on 26 October 2018.

October to November 2018

The Daltons (26 October - 29 November 2018)

1.58 Initially Christie settled in relatively well to The Daltons, but shortly after, her episodes of self-harming increased. Daltons staff reported this happening multiple times a day, often resulting in Christie being taken to Sunderland Royal Infirmary ED.

1.59 A looked after child review on 9 November noted almost daily incidents of self-harm. The review decided that Christie's placement at The Daltons should continue, she was to remain a looked after child under Section 20 Children Act 1989, and that she was to be supported to explore options for education, training, and employment in January 2019.

1.60 On 21 November 2018 Christie had to be returned to The Daltons by care staff and police after threatening self-harm. Although the CAMHS crisis team were involved overnight, things did not improve. The next day Christie was assessed under the MHA and recommendations for detention under Section 2 were agreed, identifying that Christie needed a CAMHS PICU bed.

1.61 It was agreed Christie needed more security than an open ward. A return to Westwood was not possible due to a shortage of staff following the large number of staff suspensions after inappropriate restraints of young people had been identified. Newberry was ruled out because staff were supporting

[11] Because Christie had been detained under Section 3 MHA, there is a duty under Section 117 MHA placed on the local authority and the NHS, via the CCG, to pay for aftercare post discharge.
[12] Section 20 Children Act 1989 places a duty on a local authority to provide accommodation for a child in need in their area, because either no one has parental responsibility, they have been lost or abandoned, or the carer for the child is prevented from providing them with suitable care and accommodation.

Westwood, and because Christie had had a relationship with another young person who was still a patient there.

1.62 The NHS England Specialised Commissioning Case Manager stated that there were no PICU beds available anywhere in the country.

1.63 The plan agreed late afternoon was to admit Christie to Tunstall Ward under Section 2 MHA over the weekend for review in the next week. She was taken there on the evening of 23 November, and was to be nursed on 1:1 observations due to her being a 16 year old on an adult ward, with support from the CAMHS crisis team

Tunstall Ward (23 – 30 November 2018)

1.64 Christie had an episode of self-harm over the weekend. On the Sunday evening she spoke at length to a member of staff from the CAMHS crisis team, exploring the triggers for self-harm and the voices Christie was hearing.

1.65 In a multidisciplinary team (MDT) meeting on Monday 26 November 2018, it was agreed that Christie should return to The Daltons, starting with short periods of Section 17 leave. If these went well Christie was to be discharged from Tunstall Ward, her Section 2 MHA rescinded, and her care was to be handed back to the community CAMHS team.

1.66 In a care planning meeting on Friday 30 November, the community CAMHS Consultant psychiatrist stated that although Christie was undoubtedly suffering with complex emotional needs, she was settled on the ward and did not warrant further detention. The appropriate plan would be a well-structured package of care in the community. However, The Daltons felt they could not keep her safe and terminated the contract.

December 2018

Hotels and supported accommodation (30 November – 12 December 2018)

1.67 Christie's Section 2 MHA was rescinded on the evening of 30 November 2018. She refused to stay in the hospital and was discharged to local hotels near Newton Aycliffe, with family, community CAMHS and CAMHS Crisis team support.

1.68 Christie's Social worker, SW1, recorded her concerns about the inappropriateness of Christie being in a hotel with social care and Crisis team support, and that it was not sustainable due to the impact this was having on the rest of Christie's family and likely adverse impact on Christie. The Social Services Placement Team were having difficulties finding an alternative placement.

1.69 When SW1 visited Christie on 11 December Christie said she was going to stay with her paternal grandparents in Slough. SW1 advised Christie that this would end her “LAC status” (looked after child). Christie left for Slough on 12 December 2018, travelling alone by train.

Slough (12 December – 20 December 2018)

1.70 On Friday 14 December, Christie’s stepfather contacted the Crisis team to tell them Christie had called and said she had taken an overdose of all her medication whilst at her paternal grandparents. They had called 999 and Christie was taken to Wexham Park Hospital ED. Christie was seen by the CAMHS Rapid Response team and it was agreed that she could return to her grandparents.

1.71 Christie was also seen by a CAMHS AMHP from Berkshire Healthcare NHS Foundation Trust on 15 December 2018. Christie told the AMHP that she had taken the overdose because of hearing voices. The CAMHS AMHP was in contact with the Durham and Dales CAMHS Crisis team and informed them of the plan.

Hotels and supported accommodation (20 December – 30 December 2018)

1.72 Christie returned on 20 December 2018. She had to be placed urgently in a hotel as her stepfather had to work nights leaving her mother to look after the rest of the family.

1.73 Over the next few days Christie started to self-harm again, and her attempts became more serious and frequent. She lashed out at support staff provided by Social Services and the CAMHS crisis team became involved. On 30 December an ambulance had to be called as Christie had seriously self-harmed.

Tunstall Ward (30 – 31 December 2018)

1.74 Christie was assessed by the on-call Consultant psychiatrist in ED at DMH that evening. She said she was noted to have severe emotional dysregulation. Because of the assault on the support worker the previous day, it was agreed Christie needed a PICU admission.

1.75 However, after calling Ferndene in Prudhoe (the local CAMHS PICU)[13] it was found there were no CAMHS PICU beds available. Christie was detained under Section 2 MHA and admitted to Tunstall Ward on enhanced observations that night.

[13] Ferndene, a CNTW service, provides regional and national Tier 4 Child and Adolescent Mental Health Services (CAMHS) for children and young people between the ages of 13 and 18. Ferndene has four wards (Redburn, Psychiatric Intensive Care Unit (PICU), Fraser and Stephenson) providing a total of 29 beds.

1.76 A multi-agency and MDT meeting held on Tunstall Ward reviewed Christie on the afternoon of 31 December. Opinions differed about what was best for her. SW1 advised that social services had not been able to identify a suitable placement for Christie.

1.77 Christie was discharged that day and the Social Services Emergency Duty Team (EDT) booked Christie into a local hotel for New Year's Eve and New Year's Day. Christie was accommodated under Section 20 Children Act (1989), becoming a looked after child again.[14]

January 2019 to June 2019

Hotels and the holiday cottage (1 January – 12 January 2019)

1.78 Christie was reviewed on 2 January by the CAMHS community consultant psychiatrist who advised that because deficiencies had been noted in Christie's social communication there was a need to assess her for a possible diagnosis of autism spectrum disorder (ASD). Her parents agreed and provided contact details for a support worker from Christie's school to help with the assessment. It was planned to review Christie in two weeks. Christie's self-harming escalated, and the CAMHS crisis team were again involved.

1.79 Christie was then placed in a holiday cottage near Chester-Le-Street on 9 January 2019 with two support workers.

1.80 Christie was assessed by the CAMHS community consultant psychiatrist at 1.30pm on 12 January 2019.

Ferndene PICU (13 January – 1 March 2019)

1.81 Christie was assessed for detention under the MHA by the CAMHS community consultant psychiatrist on 12 January 2019 and was admitted to the PICU in Ferndene under Section 2 MHA.

1.82 During her first few days she frequently attempted to self-harm, requiring restraint on several occasions. Christie refused to eat or drink.

1.83 A looked after child review at the end of January noted that Christie was engaging well with her educational activities. As the plan was for a six-week admission the local authority and ward staff were to develop a service specification for Christie when she left hospital.

1.84 Christie's Functional Assessment in Care Environments (FACE) risk assessment revised on 5 February identified that Christie was at significant

[14] If the young person cannot find anywhere to live, he/she may be accommodated by the local authority. This is known as 'Section 20 accommodation' (Children Act 1989 (legislation.gov.uk) and the young person acquires 'looked after' status. Children's services have a duty to take such steps which are reasonably practicable to accommodate the young person.

risk of self-harm, suicide, violence/harm to others and was a risk to a family member.

1.85 Later that day she attended her Care Programme Approach (CPA) review. Her frequent self-harm episodes were noted. RC2 reported that a referral had been made to the Westwood Centre low secure unit for assessment, as it was recognised that PICU was intended to be for a maximum of a six-week pathway and that Christie would require further care until a suitable placement had been identified. It was stressed by RC2 that although Ferndene staff would contribute to the service specification for Christie's future placement, the local authority had the responsibility of providing this.

1.86 In the daily care review on 1 March 2019, it was noted that Christie had been speaking like a child. It was recorded that Christie no longer needed care in a PICU.

1.87 Christie was very distressed by this decision. Christie's mother phoned her care coordinator and told her that she did not want Christie to go the Newberry Centre. She disclosed that Christie had been the victim of bullying on social media whilst there previously, and that she had an unresolved complaint with TEWV about previous care. Christie's mother also said that on previous admissions Christie had deteriorated very quickly.

The Newberry Centre (1 March 2019 – 6 March 2019)

1.88 Christie was admitted to the Newberry Centre at 7pm on 1 March 2019, remaining on a Section 3 MHA.

1.89 Over the next few days, Christie is reported to have been quiet and settled on the ward, often spending time in her room or on her phone.

1.90 On 5 March a Team Around the Patient (TAP) meeting attended by Newberry MDT noted Christie's risk to herself and others and also that the lack of a social care placement and being a looked after child were risks.

1.91 Shortly after this, Christie's care coordinator and SW1 met with SW2 and Christie's Named Nurse[15] from Ferndene and the Ferndene Ward Manager to discuss the service specification. There was still a need for the completion of the ASD assessment. SW1 was to look at the legal procedures regarding Deprivation of Liberty Safeguards (DoLS)[16] and the issues surrounding Christie being restrained and given PRN medication in the community.

[15] The Named Nurse has the responsibility to ensure the actual delivery of safe and effective care during a patient's inpatient stay. This is achieved by having a clear understanding of the role of Named Nurse, and the competencies to be able to deliver the interventions.

[16] The Deprivation of Liberty Safeguards (DoLS) ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. They are an amendment to the Mental Capacity Act (2005). ***NB. DoLS cannot be used for people under the age of 18, for**

James Cook University Hospital (6 March – 9 March 2019)

1.92 At 8pm on 6 March 2019 Christie was found to have self-ligatured using the fixtures in her bathroom. Christie was not breathing, and paramedics were called. Christie was unconscious and transferred to James Cook University Hospital (JCUH) at 9.30pm. Christie was sedated and moved to the intensive therapy unit (ITU) where she was intubated[17] and ventilated.

1.93 Over the next few days Christie recovered, returning to the Newberry Centre on 9 March 2019.

The Newberry Centre (9 March 2019 – 8 May 2019)

1.94 Christie was discharged back to the Newberry Centre on 9 March at 11.20am. Over the next few days, she had some episodes of self-harm, but often settled after PRN medication.

1.95 A case review on 12 March noted the serious ligature incident of 6 March and other self-harm episodes. Christie remained on a Section 3 MHA. Christie's new Responsible Clinician, RC3, was to liaise with NHS England, the Clinical Commissioning Group (CCG) and other relevant professionals to discuss Christie's future ongoing care.

1.96 It was felt that Christie was presenting with increased risks that were difficult to manage at the Newberry Centre. It was also noted that the level of acuity on the Newberry Centre remained high with multiple incidents taking place simultaneously, which was thought to be unsettling Christie. It was agreed to nurse Christie at the Westwood Centre over the weekend to manage her risks, until a Stop the Line[18] meeting was held the next week.

1.97 Christie transferred to the Westwood Centre on 16 March 2019.

1.98 The Stop the Line meeting held on 18 March 2019 at 3pm, had full MDT attendance from TEWV, Ferndene and social services. It was discussed that being in hospital presented risks to Christie, but all agreed that there were no risk-free options, and that up to this point the highest risk behaviours Christie had engaged in tended to be in hospital or in a community setting that replicated the hospital setting.

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whom any deprivation of their liberty must be authorised by the Court of Protection or the High Court. As such, use of "DoLS" for someone under 18 is a misnomer, albeit a very common one.

[17] Intubation is when an endotracheal tube is inserted into the patient's trachea (windpipe) to help them breathe. Ventilation is when a machine is used to help the breath.

[18] A Stop the Line meeting is one of the principal elements of the quality control method as part of the Toyota Production System, known as the 'Andon system'. It empowers workers to stop production when a defect is found, and immediately call for assistance, so that the production team can remedy the root cause of the defect. It has been adopted in healthcare to encourage staff to question and, if required, stop any activity that has the potential to cause further harm.

1.99 After this meeting the clinical team actively changed the approach to one in line with the TEWV Protocol for the Reduction of Harm in Young People with Borderline Personality Disorder (BPD),[19] which recognised that there were risks associated with admission and heightened observations for Christie. A 'less is more' approach to her care was agreed, where she could seek help when she struggled but would be supported to take more personal responsibility. This became the overarching approach to Christie's care.

1.100 RC3 met with Christie's mother as her nearest relative on 20 March. It was acknowledged that Christie's highest risk behaviours had been whilst in hospital, and that over-intrusive observations from well-meaning staff were counterproductive. It was also discussed how important it was to increase Christie's independence and personal responsibility. Christie's Section 3 was rescinded after lengthy discussion about the risks of continued admission versus the risks in the community. Christie agreed to stay as an informal inpatient at the Newberry Centre whilst plans were being made for future accommodation.

1.101 Although there were further incidents of self-harm, throughout March, April and May Christie was allowed more leave, extending to overnight leaves. Social Services were still struggling to identify a suitable place for Christie to live. In a conversation with SW1 in early May Christie disclosed she had been staying with a friend when on leave.

1.102 Christie was discharged from inpatient care on 8 May, collecting her belongings and leaving the ward at 12.50pm. She was to stay with her family in the interim until more permanent accommodation had been found.

The family home (8 May – 20 May 2019)

1.103 Christie's family have told us that Christie would stay with them during the day but would sleep at a family friend's house at night. Christie had ongoing appointments with the CAMHS crisis team three times a week, which she started to cancel as they could be increased or decreased as Christie wished.

1.104 At some point between 8 May and 20 May 2019 SW1 was successful in finding a rented property for Christie. It is not clear from either health or social care records provided when this was.

Cypress Grove, Newton Aycliffe (20 May onwards)

1.105 Christie had received the keys to her new house and moved in on 23 May 2019. As the crisis team were still visiting her, Christie was reminded to contact them if she felt she was struggling.

[19] *Protocol for the Reduction of Harm Associated With Suicidal Behaviour, Deliberate Self-harm and its Treatment(for young people with a diagnosis of borderline personality disorder and related conditions)*. Ref CLIN-0017-002-v1, now withdrawn.

1.106 When the Crisis team support worker visited on 27 May at 1.30pm, Christie asked if they could talk in the car. When asked if she was okay Christie began crying and said she was overwhelmed with everything and did not know how to keep herself safe. She was praised for reaching out and seeking help. Christie said she did not believe her medication was working and wanted it reviewing.

1.107 At 3pm Christie rang the Durham and Darlington CAMHS Crisis team office. Christie reported that she had seriously self-harmed as her voices were too distressing for her.

Ward 21 Darlington Memorial Hospital (27 May – 28 May 2019)

1.108 Christie was admitted to Ward 21 DMH. It was agreed that Christie did not have capacity to refuse treatment.

1.109 When the CAMHS Community Consultant Psychiatrist assessed Christie that afternoon, they recorded that Christie had told her mother that she would kill herself when she returned home

1.110 Christie was assessed under the MHA on the ward. It was agreed to detain her under Section 2 MHA and to admit her to the Newberry Centre. Christie and her mother were advised that this was likely to be a very short admission and that she may be discharged the next day.

1.111 The CAMHS community consultant psychiatrist arranged admission to Newberry. The plan from the Stop the Line meeting and the risks of admission were discussed but the consultant psychiatrist felt that Christie could not be kept safe in the community.

The Newberry Centre (28 May to 23 June 2019)

1.112 Christie was admitted to the Newberry Centre at 9:30pm on 28 May 2019. She was placed on two observations an hour with Christie's agreement, as it was felt more intrusive observations were counterproductive. Later that evening Christie was found to have self-harmed.

1.113 On 29 May Christie's observation levels were reduced to once an hour and one meaningful engagement per shift, based on the TEWV policy for reducing harm and suicidal behaviour.[20]

1.114 Christie spent time on leave at her home but on Friday 31 May she attended DMH ED as she had self-harmed. Over the next few days Christie was seen regularly by crisis team staff and was reported to be positive and making plans for the day.

[20] *Protocol for the Reduction of Harm Associated with Suicidal Behaviour, Deliberate Self-harm and its Treatment (for Young People With a Diagnosis of Borderline Personality Disorder and Related Conditions).* Ref CLIN-0017-002-v1. Now withdrawn.

1.115 In the morning of 3 June Christie's mother called SW1. They discussed the CPA meeting arranged for that afternoon. Christie's mother said that Christie had had a tough weekend and had been seeing robots and was not well.

1.116 SW1 visited Christie at her home on 3 June. This was recorded as a statutory visit as Christie was still a looked after child. Christie appeared anxious and said she was still worried about robots.

1.117 At the CPA meeting that afternoon, Christie disclosed she was hearing a new voice and suspected that everyone around her and in the hospital were robots. She said she wanted to go home and "come off her section". The plan agreed was that Christie would go on leave from the Newberry Centre that day with IHT and crisis team support.

1.118 Over the next few weeks Christie continued going on leave in the day, although there were frequent episodes and incidents of self-harming. Christie's mother would say that she had not seen Christie so unwell. Christie was also voicing some paranoid thoughts, saying staff were poisoning her and seeing robots. On one occasion Christie smashed all the crockery in the ward kitchen. Christie needed to be restrained and talked about seeing robots.

1.119 On 17 June 2019 RC3 had a telephone conversation with Christie's mother where Christie's mother reported how Christie was "OK but still not herself", that she was describing paranoid thoughts and voicing delusional beliefs about robots. RC3 explained the plan to reformulate Christie's diagnosis, and that they were about to start the depot aripiprazole.

1.120 At a CPA review meeting on 19 June the agreed plan was for Christie to remain as a patient on Newberry but to have home leave with support. There was no further update from social services but additional support for when Christie was to be discharged was being discussed with the social services management team. Christie was to begin work with Newberry's Occupational Therapist. Short term work with a clinical psychologist was discussed, and Christie was to start depot medication.

1.121 Christie received the first dose of her depot medication, aripiprazole 400mg IM after lunch on 20 June 2019. Later that day she started to self-harm and was violent to staff when restrained. She then self-harmed again and went to JCUH ED for treatment.

1.122 Christie went on leave for the weekend on 22 June. On the morning of 23 June Christie phoned the ward and told a staff nurse she didn't know how she was going to get back. Christie was told it had been agreed that she could have a further night of leave. Calls were made to the crisis team to confirm arrangements for collecting Christie the next day. Later that afternoon Christie called the ward to say she was struggling and wanted to return to the ward. It was arranged after some difficulty for two staff from the ward and one from

the crisis team to collect Christie and bring her back. She returned to the ward at 6.40 pm. She was observed to be subdued and pacing the ward.

Events on the evening of 23 June 2019

1.123 Between 6.59pm and 7.20pm Christie was offered further support on four separate occasions. One member of staff spoke to her for about five minutes while she was in the quiet room.

1.124 Christie went to the bedroom area and requested bath towels from one of the HCAs at 7.21pm. She returned to her bedroom area. At 7:29pm Christie left her bedroom to go to the bathroom. Christie is then reported to have entered the night lounge where she got herself a drink of water from the water chiller at 7.31pm.

1.125 At 7.47pm, following the night shift handover, the wards alarms were raised for the ward bathroom. A fellow patient had observed water coming from underneath the bathroom door. An HCA checked and found Christie had self-ligatured. The bath had been filled and was overflowing.

1.126 An ambulance was called using 999 (time not recorded) and Christie was taken to James Cook University Hospital emergency department (JCUH ED). Two members of staff accompanied Christie to the hospital. The Nurse in Charge on the night shift telephoned Christie's parents to inform them of the incident.

James Cook University Hospital (23 June - 27 June 2019)

1.127 Christie was admitted to the ICU. She was on full life support at this time. However, shortly after this Christie was placed on the end-of-life care pathway and at 11.05am on 27 June Christie sadly died from hypoxic brain injury.

2 Analysis of Christie's Care and Treatment

2.1 Christie had a complex mental health disorder, with emotional dysregulation[21] leading to serious self-harm and violent assaults on other people, albeit most often perpetrated when being restrained to prevent her self-harming.

2.2 Christie once commented that before she had gone into hospital, she had only really known two addresses, but once admitted she had experienced many more. Between October 2018 and January 2019, she had stayed at The Daltons in Seaham, supported accommodation in Newton Aycliffe, the Holiday Inn and the Premier Inn near to Newton Aycliffe and a holiday cottage near Chester-Le-Street. Because no notice was given following the breakdown of her placement in The Daltons, and after being discharged from hospital on New Year's Eve 2018, social services had to find somewhere for Christie to stay urgently. After her admission to Ferndene and then the Newberry Centre, she was eventually placed in her own rented accommodation in Newton Aycliffe by social services. She was 17 years old.

2.3 Between 17 May 2017 and 23 June 2019, Christie spent 603 nights out of 752 in hospital. Excluding admissions to Darlington Memorial Hospital (DMH) and JCUH, Christie was admitted as a mental health services inpatient on 10 occasions. She was detained under the Mental Health Act (MHA) on 11 occasions, seven under Section 2 MHA, three under Section 3 MHA and once under Section 4 MHA. Of the 259 days that Christie was a 'looked after child'[22] by County Durham Children's and Young People's Services, Christie spent just 97 days in the community, supported by social services commissioned support, CAMHS crisis and intensive home treatment teams and her family. In total she spent 556 days as a detained patient in just under three years.

2.4 Although these appear to have been multiple admissions, they were in fact just three significant episodes of inpatient care, preceded by sometimes several short admissions as precursors to the longer period in hospital. The first, when Christie had stopped eating and lost significant amounts of weight, led to admission to the Evergreen Centre in West Lane Hospital (provided by

[21] "Emotional dysregulation is a complex collection of processes that are thought to include the following four main aspects:
- A lack of awareness, understanding, and acceptance of emotions
- A lack of adaptive strategies for regulating emotions (the intensity and/or duration)
- An unwillingness to experience emotional distress whilst pursuing desired goals
- An inability to engage in goal-directed behaviours when experiencing distress"

From: Gratz, K. L., & Roemer, L. (2004). *"Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale."* Journal of Psychopathology and Behavioural Assessment, 26(1), 41-54

[22] Section 20 Children Act 1989 places a duty on a local authority to provide accommodation for a child in need in their area, because either no one has parental responsibility, they have been lost or abandoned, or the carer for the child is prevented from providing them with suitable care and accommodation.

Tees Esk and Wear Valley NHS Foundation Trust or TEWV) in 2017 for 236 days. The second episode commenced in March 2018, and she spent 206 days in the Westwood low secure centre and 15 days in the Newberry Centre, both in West Lane Hospital. The third and final episode followed two serious self-ligature attempts after multiple self-harming events in early January 2019. She was admitted to the psychiatric intensive care unit (PICU) in Ferndene (provided by Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust or CNTW) and then transferred to the Newberry Centre.

2.5 Whilst in Ferndene, Christie had four sessions with a clinical psychologist where it was noted she would need ongoing work to help her deal with trauma. Despite the regular 1:1 sessions with her Responsible Clinician and on occasions with the Ward Manager and other staff involved in her care, Christie did not receive any specialised inputs to help her deal with trauma.

2.6 A service specification written in Ferndene for Christie's future placement suggested that Christie would need "2:1 support" in the community, and therapeutic input to help address her trauma.

2.7 There was a Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Protocol for the Reduction of Harm Associated with Suicidal Behaviour, Deliberate Self-harm and its Treatment (for Young People with a Diagnosis of Borderline Personality Disorder and Related Conditions), which was approved in May 2016 and reviewed in April 2020. This protocol has now been withdrawn by TEWV. In our view the language used in this protocol is open to misinterpretation, and skilled interpretation by consistent and experienced CAMHS staff would be required for the protocol to be effectively implemented. These staff were not consistently available during Christie's admission in 2019.

2.8 It was in the Newberry Centre in March 2019 that Christie had a serious self-ligature incident which resulted in admission to JCUH ICU. Shortly after this the clinical team in the Newberry centre actively changed the approach to one in line with the TEWV Protocol for the Reduction of Harm in Young People with Borderline Personality Disorder (BPD), [23] which recognised that there were risks associated with admission and heightened observations for Christie. A 'less is more' approach to her care was agreed, where she could seek help when she struggled but would be supported to take more personal responsibility. This became the overarching approach to Christie's care but one that made commissioning appropriate support for Christie in the community very difficult.

2.9 Following this incident, we have not seen any evidence that this was adequately investigated by TEWV. A Head of Service review was eventually

[23] *Protocol for the Reduction of Harm Associated With Suicidal Behaviour, Deliberate Self-harm and its Treatment (for young people with a diagnosis of borderline personality disorder and related conditions)*. Ref CLIN-0017-002-v1, now withdrawn.

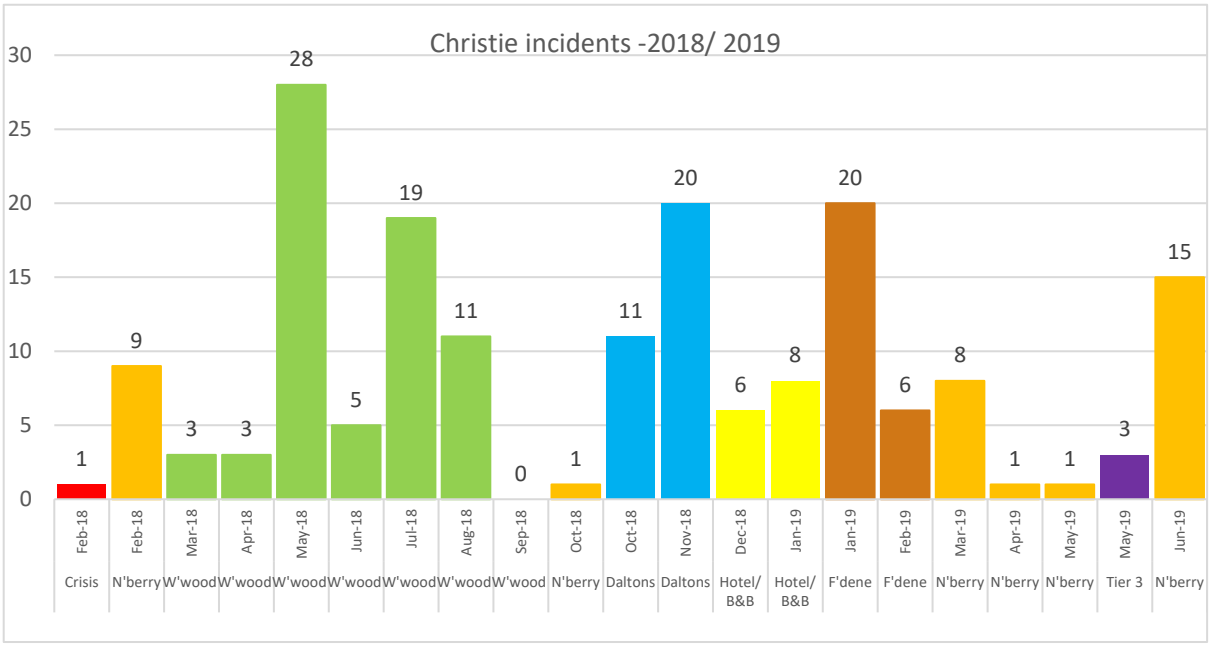
undertaken on 3 May 2019, but this did not inform the Trust's approach to managing low level ligature risks, which were being addressed in response to the NHS Estates and Facilities Alert (EFA/2018/005) Assessment of Ligature Points. This meant that there was little consideration of the risks posed by bathroom fixtures and self-ligature for Christie and we found no evidence of any care planning for self-ligature risk.

2.10 Although we note that she attended occupational therapy (OT) sessions when in the Westwood Centre and later in the Newberry Centre, we have not been able to identify any specific plans to help her develop the life skills for living alone.

2.11 County Durham Children and Young People's Services (CDCYPS) had commissioned support and placements for Christie in December 2018 and early January 2019, and we were told also when she was discharged from the Newberry Centre in May 2019, although we have not seen any evidence this was the case. Support for Christie at this time was also provided by the child and adolescent mental health services (CAMHS) Crisis team.

Christie's self-harm incidents

2.12 Through the period of Christie's contact with mental health services her episodes of self-harm fluctuated dramatically. The following diagram provides a broad overview of episodes of harm:



2.13 We identified that Christie would have frequent incidents of self-harm following admission to a new environment, but this would eventually settle down. This did not seem to have been recognised in her care planning. We also found that the increasing episodes of self-harm in June 2019 were not recognised as indicative of a change in Christie's presentation.

Family complaints (August 2018)

2.14 Following the incident when Christie's clothes were cut from her, and she was placed in strong clothing, Christie's mother and grandmother complained to the Chief Executive of the TEWV.

2.15 Because Christie's grandmother was not next of kin the Trust said they needed Christie's consent to review the complaint. They wrote to Christie but as they did not receive a reply this was not progressed further. However, at that time Christie was on the ward and had already provided consent to a manager that she was willing for the complaint to be investigated.

2.16 The TEWV Director of Nursing and Governance and the Lead Nurse for Quality and Risk (the patient safety lead nurse) met Christie's family in December 2019, sixteen months after the original complaint had been raised.

2.17 At this meeting Christie's mother raised the lack of a response to her complaint. It was agreed with the family that the Lead Nurse for Quality and Risk would investigate the complaint and this delay. The Lead Nurse for Quality and Risk met again with the family (after one meeting was cancelled by them) on 21 January 2020. In that meeting it was agreed that the TEWV formal response to Christie's mother's concerns about the removal of clothing would be sent after this meeting. This formal response was sent on 28 February 2020.

2.18 The length of time it took the Trust (18 months) to formally respond to the original complaint has not been explained and this response was seven months after Christie's death.

Care and service delivery problems

2.19 We have identified 29 care delivery problems which occurred during or just after Christie's care in West Lane Hospital, and 20 service delivery problems. We believe these combined as contributory factors which led up to her fatal self-ligature on 23 June 2019. Whilst many of these factors are the responsibility of TEWV to address, several belong to other key stakeholders involved in Christie's care, and include Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW), County Durham Children and Young People's Services (CDCYPS), Middlesbrough Safeguarding Children Board (MSCB), NHS England Specialised Commissioning (NHSE Spec Com) and the Care Quality Commission (CQC).

2.20 The care and service delivery problems are grouped and shown in the tables overleaf:

	Care delivery problems identified for Christie	
	Assessment, care planning and care delivery	
1.	TEWV and CNTW	Post-traumatic stress disorder (PTSD) rating scales to evaluate symptom change were not used.
2.	TEWV	Assessment for autism spectrum disorder (ASD) not undertaken despite being identified as a need.
3.	TEWV	Systematic monitoring of medication efficacy was not undertaken.
4.	TEWV	Trauma-focused therapy was not provided for Christie in Newberry or when she was in the community.
5.	TEWV	No assessment and documentation of Christie's motivation and use of previously learned dialectical behavioural therapy (DBT) skills.
6.	TEWV	No documentation of attempts to broach the subject of her past trauma and related PTSD or attempts at motivation interviewing.
7.	TEWV	The Positive Behaviour Support (PBS) plan lacked functional assessment. Inconsistent psychological input, absence of PBS informed service specification and absence of techniques and skills in PBS plan led to an inadequate response to help Christie manage her behaviours.
8.	TEWV	Absence of consideration of completed outcome scales to inform care planning.
9.	TEWV	Care planning at the Newberry Centre did not describe any plans to manage risk of self-ligature or cutting.
10.	TEWV	Plans of Care did not provide any consideration of how male staff involved in restraint would provoke a more aggressive response and how to mitigate the risk of this.
	Preparation for change	
11.	TEWV and CDCYPS	Christie was not given adequate support in preparation for living alone at age 17, whilst still a vulnerable young person and a looked after child.
12.	CNTW	Absence of adequate preparation for the transfer from Ferndene to the Newberry Centre, and failure to involve family in the arrangements.
	Local authority social care	
13.	CDCYPS	Failure to consider an application for a Secure Accommodation Order or secure order under inherent jurisdiction to provide a legal framework to support Christie when hospital not appropriate.
14.	CDCYPS	No adequate community provision for Christie once The Daltons had refused to have her.
	Record-keeping	
15.	TEWV	Care Programme Approach (CPA) care planning documentation lacked detail of overarching actions to meet Christie's needs.
16.	TEWV	Care planning was written in a mixture of first and third person, with evidence of a 'copy and paste' approach and it was not easy to find most recent plan of care.
17.	TEWV	Observations were not adequately or robustly recorded.

	Risk assessment	
18.	TEWV	Lack of consideration of longitudinal risks and behaviours as part of the assessment for low secure care in March 2019.
19.	TEWV	No direction given about minimum standards of when to reassess risk in West Lane Hospital ward operational policies.
20.	TEWV	Risks not reassessed weekly, in line with Trust policy.
21.	CNTW	Absence of a risk management plan to mitigate risks identified in the Functional Assessment in Clinical Environments (FACE) risk assessment.
22.	CDCYPS	Inadequate risk assessment of placements in the community left supporting staff unprepared and unable to manage Christie's risks of self-harm.
23.	TEWV and CDCYPS	Once Christie was provided with a home in May 2019, the impact of the sudden change in her environment leading to the change in her presentation was not adequately considered.
	Safeguarding	
24.	CNTW, CDCYPS, and TEWV	Despite Christie being admitted under Section 2 for attempts to kill a family member, safeguarding risks to them and the wider family were not discussed or considered after 2018, and not at all in 2019 when Christie was going on regular leave to the family home.
25.	CDCYPS	Absence of safeguarding perspective and challenge to care provided in West Lane Hospital after concerns raised by Christie's stepfather about increased opportunities for self-harm whilst Christie was in West Lane Hospital.
26.	TEWV	Local authority was not notified when Christie was placed in seclusion.
27.	TEWV and CDCYPS	Lack of effective safeguarding challenge to the safety of discharge to hotel accommodation in December 2018.
	Resuscitation	
28.	TEWV	Scenario-based training in resuscitation was not provided to West Lane Hospital due to high patient acuity and staff shortages.
29.	TEWV	Post-resuscitation debriefs not provided to Newberry Centre staff due to high patient acuity and staff shortages.

Table 2: Care Delivery Problems (CDPs) identified for Christie

	Service delivery problems identified for Christie	
	Capacity and skills	
1.	TEWV	Absence of sufficiently skilled child and adolescent mental health services (CAMHS) staff to provide robust care in line with Trust policy on borderline personality disorder (BPD).
2.	TEWV	Absence of staff skilled in trauma-informed psychological therapy, and absence of trauma-informed care provision.
3.	NHSE Spec Com and all northeast local authorities.	Absence of adequate capacity to care for the increased acuity and number of young people with complex and challenging behaviours, including a shortage of psychiatric intensive care unit (PICU) and low secure beds and local authority secure accommodation.

	Service delivery problems identified for Christie	
	Safeguarding challenge	
4.	TEWV, MSCB (now South Tees Safeguarding Children's Partnership) and NHSE Spec Com	Absence of external scrutiny and challenge regarding the ward's ability to keep Christie safe after 6 March 2019 incident.
5.	CDCYPS	Social workers deferred to Health, rather than becoming directly involved in Christie's inpatient care.
	Clinical governance	
6.	NHSE Spec Com and CQC	Absence of the consideration of total instances and incidences of harm in West Lane Hospital when concerns were raised, focussing instead on self-declared serious incidents only.
7.	TEWV	Absence of adequate analysis of patterns, instances and incidences of harm and causes of harm in West Lane Hospital within clinical governance processes.
8.	TEWV	Failure to investigate Christie's serious self-ligature attempt on 6 March 2019.
	Risk management	
9.	TEWV	Inadequate internal Environmental Risk Assessment tool, with lack of challenge when risk mitigation was bespoke care planning and relational security in West Lane Hospital, which was known to have staffing problems.
10.	TEWV	Failure to implement urgent low-level ligature risk mitigation work in a timely manner, and actions not informed by Christie's serious self-ligature attempt on 6 March 2019.
11.	TEWV, NHSE Spec Com	Failure to consider impact of mass staff suspension in November 2018.
12.	TEWV	Too many rapid and unclear changes brought into West Lane Hospital practice with too few consistent staff to implement them, coupled with the Reducing Restrictive Practice initiative.
13.	CQC and NHSE Spec Com	The impact on local Tier 4 CAMHS care and provision when local authority safeguarding was found to be weak by another regulatory body (Ofsted) was not considered.
14.	TEWV	Failure to respond adequately to staff, patient and family concerns in December 2018 and January 2019.
	Record-keeping	
15.	TEWV	Clinical records were not completed consistently in time or date order or entered by each individual staff member.
16.	TEWV	There is not always a record in the clinical notes of the staff involved in a restraint and their roles.
17.	TEWV	Documentation of observation and engagement levels was not clear.
	Response to complaints	
18.	TEWV	Inadequate, inappropriate, and delayed response to complaints made by Christie's family in August 2018.

	Service delivery problems identified for Christie	
	Duty of candour	
19.	TEWV	There was a lack of tracking and follow-up of the Duty of Candour Policy expectations.
	Social media	
20.	TEWV and NHSE Spec Com	The absence of guidance meant that young people could be exposed to inappropriate content on social media.

Table 3: Service Delivery Problems (SDPs) identified for Christie

3 Conclusions and recommendations

3.1 Christie's increasing risk as a looked after child does not appear to have been recognised or to have warranted more intensive intervention from social services such as applying for a Secure Accommodation Order under the Children Act (1989). Although Christie had regular and very positive contact with her social worker (SW1) once allocated in summer 2018, we believe that there was a view from earlier in 2018 that Christie's problems were all health related. This led to a delay in involvement from County Durham Children & Young Peoples Services (CDCYPS).

3.2 Christie's experiences of the adult world and her care through 'the system' must have been one of people making plans that were never fully carried out, not delivering what they had said they would or the system being too inflexible to cope with her. Examples include:

- the lack of CAMHS beds, so having to be admitted to an adult ward;
- the lack of PICU beds, so having to be admitted to a general adolescent unit;
- the Daltons refusing to have her back;
- the transfer from Ferndene to the Newberry Centre when it had been suggested the previous day that she needed further care in the PICU;
- despite being suggested on several occasions, the assessment for autistic spectrum disorder was never carried out;
- wrap around social care not being provided; and
- trauma-informed therapy not being provided.

3.3 We also believe the impact that instability and frequent change had on Christie was never fully understood. Shortly after any admission or significant change, Christie's self-harm behaviour escalated. This may have been due to the increasing acuity[24] of her underlying mental health problems, but it may also have been related to the change in her circumstances. Eventually Christie's behaviour would settle, but when she moved to somewhere new (e.g., the Daltons, hotels and B&Bs in November/December 2018, Ferndene

[24] In this context acuity means the severity of a patient's illness and the level of attention they require from professional staff.

and the Newberry Centre in early 2019 and then to live alone in her own rented home in May 2019) Christie's self-harm incidents would escalate with increasing severity and frequency. Christie herself commented that not knowing where she was staying and who would be supporting her in the hotels during December 2018 was a major stressor.

3.4 Although Christie had asked for the move, she also recognised herself that moving to her own home in May 2019 was causing her significant amounts of stress. With the benefit of hindsight, we can see that the move in May 2019 led to an escalation in Christie's self-harming and believe that this change and its impact failed to trigger sufficient concern with the multidisciplinary team.

3.5 Christie's mother was increasingly concerned that Christie "was not right," as she was reporting seeing "robots" and was becoming increasingly paranoid and suspicious that staff were robots. The pattern and frequency of self-harm increased significantly in June. Still working within the less is more approach, Christie had initially been allowed six hours of leave a day and on the weekend was cautiously allowed overnight leave. RC3 had started to reassess Christie and reformulate her diagnosis, and the Early Intervention in Psychosis (EIP) team were about to re-engage with Christie when the fatal self-ligature happened on 23 June.

3.6 Christie, in our view, was always at risk of death by misadventure from when she had first started self-harming and most especially from 2017 onwards.

3.7 It was her use of self-ligature that placed her life most at risk. Christie had many self-ligature attempts but following the serious self-ligature attempt in March 2019 which resulted in admission to the intensive care unit (ICU) in James Cook University Hospital, Middlesbrough (JCUH), we would have expected to see a care plan which specifically informed staff how to care for Christie and mitigate the risks of self-ligature. Although we found a care plan for a zero-tolerance approach to head banging (following an episode which led to burst blood vessels in 2019) we could find no evidence of anything similar for her risk of self-ligature.

3.8 We note also that the March 2019 incident was never adequately investigated, being treated as a near miss until after her death when NHS England recommended that the incident be graded as a serious incident. We heard at interview that Christie was subsequently moved to another room, but this had not been documented and did not lead to any other changes to approaches to managing her risk of self-ligature.

3.9 TEWV were also responding to an NHS Estates and Facilities Alert (EFA)[25] from 2018 regarding low-level ligature risks at that time, but we found no

25 NHS Estates and Facilities Alert EFA/2018/005 Assessment of Ligature Points

evidence that this serious self-ligature attempt helped inform the Trust's response and led to urgent remedial action.

3.10 We recognise the risks entailed in managing the care of young people at risk of self-harm with BPD, and that hospital admission was not guaranteed to mitigate Christie's risks. We also acknowledge that overly intrusive interventions often resulted in Christie's behaviour escalating. Christie herself had said that when placed on closer observations she would escalate her behaviour, as if to justify it. She also said that she would only self-harm when she thought she would be rescued.

3.11 However, we believe it was the organisational failure to mitigate the environmental risks of self-ligature, accompanied by Christie's increasing risk and changed presentation because of the recent move to her own home not being fully recognised, and the unstable and overstretched services in West Lane Hospital that were the root causes of Christie's death.

3.12 Our observation is that the failings at West Lane Hospital were multifaceted and systemic, based upon a combination of factors, including reduced staffing, low morale, ineffective management of change, lack of leadership, aggressive handling of disciplinary problems, issues with succession and crisis management, failures to respond to concerns from patients and staff alike, and increased patient acuity.

3.13 This was all set within weak internal and external systems of safeguarding governance, as well as systemic pressures due to the lack of appropriate places (both NHS and social care) for young people nationally.

3.14 Part of the scope of the terms of reference is to "identify any actions that could have led to a different outcome for Christie." In our view there are care and systems issues that had a direct impact on Christie's death.

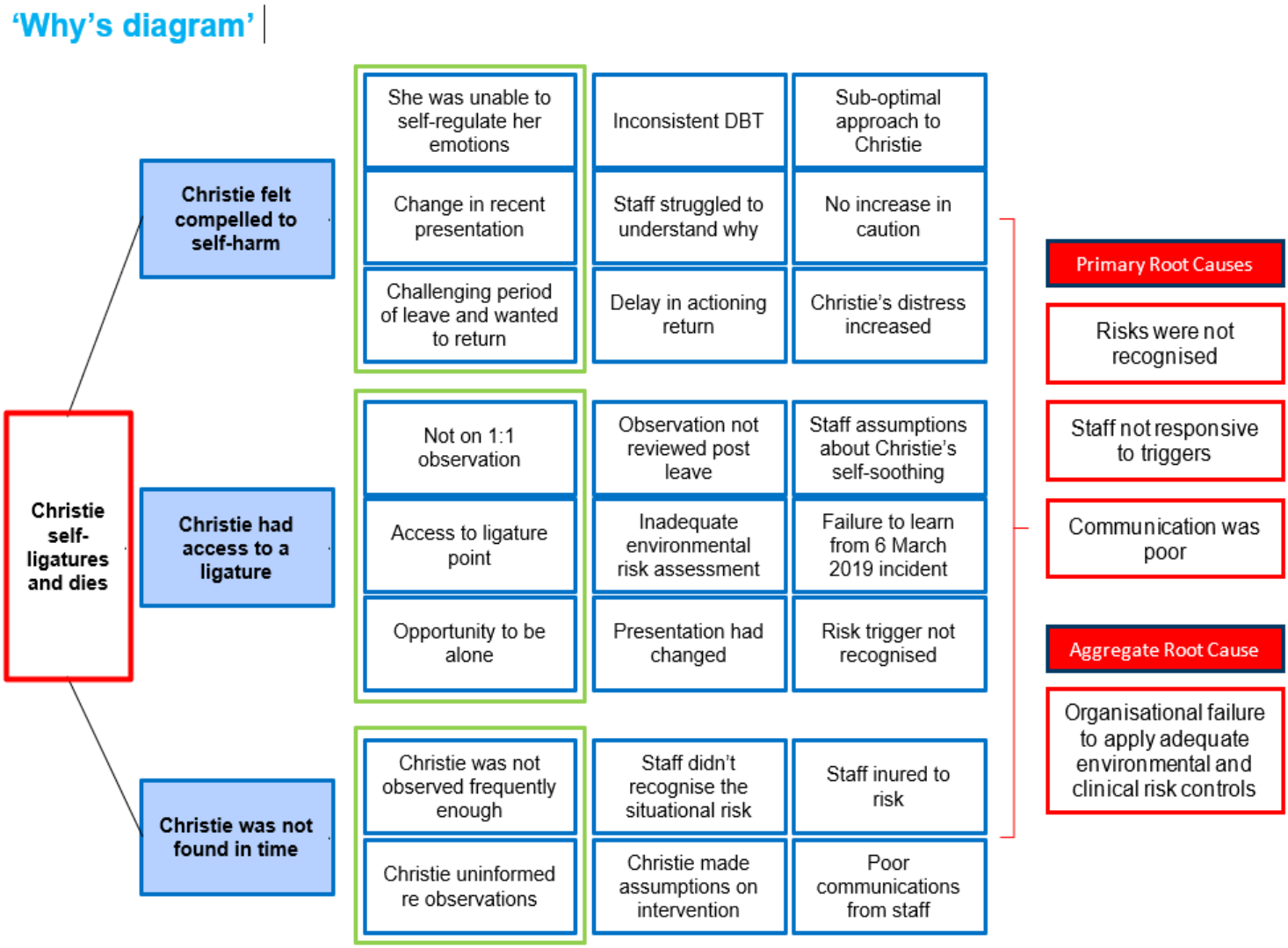
1. Factors leading to an increase in her risk (uncertainty, instability, and the recent move to her new home etc.) were not fully recognised.
2. Trauma-informed care and psychological therapy was not provided.
3. There was a lack of local authority commissioned services to support Christie in the community.
4. The lack of secure (NHS and social care) places for young people with complex needs and challenging behaviours.
5. A failure by Durham County Council (DCC) to consider the legal means available to them to help manage Christie's care, including apply for a Secure Accommodation Order.
6. An absence of consideration of safeguarding issues.
7. An overly complex and confusing care planning process that did not identify how to manage self-ligature risk.

8. A failure to recognise and act upon the increased risk of serious harm or death following Christie's self-ligature attempt in March 2019.

9. A poorly planned and executed transfer from Ferndene to the Newberry Centre in March based on a systemic pathway and not Christie's presenting needs.

10. A shortage of skilled CAMHS staff following the 'restraint' incident in November 2018.

3.15 The following diagram provides an overview of the event, as well as the key reasons why the event occurred. The index incident is described in the left-hand box and the diagram flows to the right, expanding reasons at each interval. The root causes are described within the right-hand boxes:



Recommendations

3.16 We recognise that care in West Lane Hospital is no longer provided by TEWV. However, there is still learning for agencies involved in the care and treatment of young people in Tier 4 mental health services, and also for TEWV in other service areas. We have made 22 recommendations to address the issues identified in this investigation. This report also makes recommendations about the governance issues identified where we believe they directly impacted upon Christie's care.

Recommendation 1: Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) must provide significant assurance to the Trust Board and its commissioners that it has a robust environmental and ligature risk assessment process and the ability to respond effectively and urgently to mitigate risks identified through this process.

Recommendation 2: TEWV must ensure that risk assessments for young people in child and adolescent mental health services (CAMHS) are based on a psychological formulation and a full understanding of the longitudinal patterns and instances of harm, and where possible are developed by a multidisciplinary team (MDT) in conjunction with the young person and their family.

Recommendation 3: TEWV and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) must ensure that any young person with a recent history of self-ligature has a written care plan that identifies how staff (or families in the case of a community setting) are to care for the young person, and mitigate the risks of fatal self-ligature.

Recommendation 4: TEWV and CNTW must ensure that plans of care for young people in CAMHS incorporate evidence-based practice.

Recommendation 5: CNTW must ensure that where there is a risk of re-traumatising young people in restraint, the triggers for trauma are recognised and there are written plans of care to manage this risk.

Recommendation 6: TEWV must ensure that decisions about observation levels are clearly recorded and that all interventions are clearly documented.

Recommendation 7: TEWV must ensure that plans of care are written so that they are clear, patient-centred, easy to understand and follow, and guide staff to care for the young person based on the assessment of all needs and risks.

Recommendation 8: TEWV must ensure that trauma-informed therapy is a routine aspect of a young person's care provision where there are any considerations of previous trauma, not just diagnosed post-traumatic stress disorder (PTSD), and that there are sufficient staff with the requisite skills to provide this.

Recommendation 9: Health and social care agencies must provide appropriate challenge where there are concerns about unsafe discharge arrangements from Tier 4 inpatient care, including appropriate escalation up to chief officers where concerns for children's safety are high.

Recommendation 10: Local Authorities and Health providers must ensure that there is clarity about the roles and responsibilities of each agency in the planning and delivery of care to young people in Tier 4 CAMHS provision where they are in the care of the Local Authority to ensure that support is holistic and meets the educational; social; physical health and emotional needs of children and young people as well as their mental health needs.

Recommendation 11: CNTW must ensure there is a written protocol that details the pathway for discharge from Ferndene Psychiatric Intensive Care Unit (PICU), including timescales for informing and involving families and the young person in arrangements so that, wherever possible, a young person is not suddenly transferred without adequate preparation.

Recommendation 12: TEWV and CNTW must ensure the organisational approach to safeguarding young people proactively involves and informs the relevant local Safeguarding Children's Partnership of all instances where a young person is placed at risk, including the use of unregulated and unsupported accommodation in the community.

Recommendation 13: TEWV must ensure that services consider and document robust risk management processes to safeguard children where threats have been to made to harm them by older family members who are also service users.

Recommendation 14: NHS North East and North Cumbria (NENC) Integrated Care Board, as system leaders, should work with the Directors of Children's Services North East region to commission services that will meet the needs of the small but growing number of young people with complex needs and challenging behaviours that have both health and social care needs. This should include a review of demand to ensure services have the appropriate capacity locally to minimise placing children out of area.

Recommendation 15: NHS North East and North Cumbria Integrated Care Board, the NENC provider collaborative and relevant local authorities

must ensure there is appropriate commissioner safeguarding oversight of all Tier 4 CAMHS inpatient services in the region.

Recommendation 16: NHS England Specialised Commissioning and the Care Quality Commission (CQC) must ensure that when there is enhanced surveillance of services following quality concerns, the themes and patterns of all incidents are rigorously scrutinised and analysed.

Recommendation 17: TEWV should ensure there is much greater detail and understanding of the patterns and instances of harm within services through the regular reporting and interrogation of data, when required, to inform both individual patient clinical care planning, and Trust and service understanding of safety and quality issues.

Recommendation 18: TEWV must redesign its response to incidents and patient safety to provide robust clinical governance, so that it conforms with the NHS England Serious Incident framework (SIF),[26] its successor policies and other relevant guidance and best practice, so that it is assured that all relevant incidents are investigated thoroughly, and organisational learning can be quickly put in place.

Recommendation 19: NHS England Regional Team, NHS North East and North Cumbria Integrated Care Board and the CQC must consider the impact and risks on Tier 4 CAMHS if a local Safeguarding Board is found to be weak or inadequate, or a local provider is found to have a major staffing issue.

Recommendation 20: TEWV should ensure that it improves its response to complaints, so that complaints are managed in line with NHS England best practice guidance – tracking and reporting this through the relevant Board subcommittee processes.

Recommendation 21: TEWV should review the Duty of Candour Policy and ensure that it is monitored through the relevant Board subcommittee processes. As part of this it must ensure that where there has been a death in a service, whether through self-harm/suicide or homicide, that families are given appropriate meaningful and regular family liaison and support through personal contact with a nominated officer of the Trust.

Recommendation 22: Commissioners should assure themselves that providers are following the NHS Child and Adolescent Mental Health Services Tier 4 (CAMHS T4): General Adolescent Services including specialist eating

[26] NHS England (2015). *Serious Incident Framework: Supporting Learning to Prevent Recurrence*. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

disorder service specification and the QNIC standards for use of mobile phones and social media.

3.17 There was one issue that arose from our findings which is not applicable to TEWV, because the Trust no longer provides Tier 4 CAMHS services. This is summarised below as lessons learned, for the attention of NHS England.

The management of restrictive interventions must be part of an agreed philosophy and approach, with clear protocols embedded to guide practice.

Good practice

3.18 We have identified examples of good practice which relate to Christie's care:

- SW1 (Christie's Social worker), the CNS1(Clinical Nurse Specialist and also Christie's Care Coordinator) and the Durham and Darlington CAMHS Crisis team maintained significant continuity with Christie and her family, working strenuously to keep in touch.
- Christie's Responsible Clinician in the Newberry Centre recognised that Christie's presentation had changed in May and June 2019 and started to reassess her.
- Christie's risks were robustly and appropriately managed in Ferndene, resulting in Christie and her family feeling that she was more secure and understood.

Appendix A – Terms of Reference

1. The following Terms of Reference for a system wide Independent Investigation into concerns and issues raised relating to the safety and quality of CAMHS provision at West Lane Hospital operated by Tees Esk and Wear Valley NHS Foundation Trust, have been produced by NHS England and Improvement with input and agreement of South Tees Safeguarding Children Partnership.

2. The Terms of Reference have been developed in collaboration with the investigative supplier, key stakeholders, affected families and with an established staff group and family forum.

Purpose of the investigation/commission

3. To commission an overarching independent investigation with recognised subject matter expertise to scrutinise and assess areas of concern identified and raised by; NHS England Specialised Commissioning as the commissioner of CAMHS services and the Care Quality Commission as part of their inspection regime.

4. This system wide investigation will also include two parallel serious incident investigations into the inpatient deaths of two young service users and will incorporate elements of a Serious Case Review for one identified incident.

5. Additional lines of enquiry in response to family questions are included with points from South Tees Safeguarding Children Partnership included.

Involvement of the affected family members/patients and staff groups

6. It is expected that affected family members, appropriate patients and staff are; fully informed of the investigation, the investigative process and understand how they can contribute to the process.

Investigation

7. Determine a comprehensive chronology, within an agreed timeframe, of the sequence of events which led to the escalation of concerns by NHS England and Improvement, the Trust and the regulatory actions taken by the CQC.

8. In parallel, undertake a critical review and analysis of the care and treatment of identified individuals, identifying but not limited to; any gaps, deficiencies or omissions in the service and individual care and treatment.

9. Include input from affected families for further scrutiny of care and determine whether the statutory Duty of Candour was appropriately applied.

Taking into account the key lines of enquiry detailed, review the appropriateness of the treatment of Christie in the light of identified health needs, identifying both areas of good practice and areas of concern with reference to supporting expert evidence.

Consider the organisational response to the serious incidents which resulted in the death of Christie, recognising that no substantive internal investigation was conducted on the basis of an ongoing criminal investigation, and the agreement with stakeholders that an independent investigation would be commissioned.

Determine any further lines of enquiry from an investigative perspective.

Establish whether the risk assessment and risk management of Christie was sufficient in relation to their needs including assessing the risk of self-harm or taking their own life.

Examine the effectiveness of the patient's care plan (Christie) to determine:

- the level of involvement of the patient and their family;
- how the Trust listened and acted on any concerns raised by the family;
- how Trust clinicians communicated with the family; and,
- what multi-agency structures are in place to support the ongoing needs of young people upon discharge into the community.

Identify any areas of best practice, opportunities for learning and areas where improvements to services are required including quality assurance processes and pathways in and out of the unit.

Review and assess compliance with local, multi-agency policies and national guidance, specifically, Trust wide clinical observation, ligature and risk assessment policies, identifying areas of good practice and any areas of concern.

Establish what lessons are to be learned from the Trust's response to the incidents taking into account the early learning themes, regarding the way in which professionals work individually and together.

Identify clearly what those lessons are, how and within what timescales they should be acted on, and what is expected to change as a result.

Apply these lessons to required service responses including changes to policies and procedures as appropriate.

Based on overall investigative findings, constructively review any gaps in professional working and identify opportunities for improvement.

Identify any issues in relation to, culture, leadership, capacity or resources that impacted on the Trust's ability to provide safe services, identify any actions that could have led to a different outcome for Christie.

Deliverables

Provide a final written report to; NHS England and NHS Improvement, Tees Safeguarding Partnership and families that identifies learning which supports the development of measurable, sustainable and outcome focussed recommendations.

Provide an executive summary and a learning case study referring to the two inpatient deaths.

Provide an opportunity for the families to receive supported feedback related to findings.

Based on investigative findings make organisational specific recommendations which may include NHS England, which are outcome focused with a priority rating and expected timescale for completion.

Deliver an action planning event for the Trust and other key Stakeholders to share the report's findings and to provide an opportunity to explore and fully understand the intention behind all recommendations.

Contribute towards a multi-agency media/publication strategy.

Support the commissioners (where required) in developing a structured plan for review of implementation of recommendations. This should be a proposal for measurable change and be comprehensible to those with a legitimate interest.

Conduct an assurance follow up visit with key stakeholders, in conjunction with the relevant CCG, 12 months after publication of the report to assess implementation and monitoring of associated action plans. Provide a short-written report, for NHS England and Improvement that will be shared with appropriate stakeholders and which will be made public.

The following additional lines of enquiry should be considered alongside corresponding family questions and review of the overall effectiveness of care delivered to Christie.

Consider and comment on the rationale for discharge decisions and the appropriateness of discharge arrangements.

Consider whether parental perspectives regarding mental health state informed clinical decision-making including whether a PICU placement would have been appropriate.

Consider the lines of communication with families and clinicians and the application of Duty of Candour principles (including how staff dealing compassionately and sensitively with families) and informing families of the occurrence of further incidents involving their child.

Consider the quality of clinical record keeping, care planning and associated risk assessment documentation.

Determine whether environmental risk assessments were undertaken in respect of ligature point reduction.

Appendix B – Glossary of acronyms

ASD	autism spectrum disorder
BPD	borderline personality disorder
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CDCYPS	County Durham Children & Young Peoples service
CDOP	Child Death Overview Panel
CNS	Clinical Nurse Specialist
CNTW	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
CPA	Care Programme Approach
CQC	Care Quality Commission
DBT	dialectical behaviour therapy
DoLS	Deprivation of Liberty Safeguards
ED	Emergency Department
ICU	Intensive Care Unit
IHT	Intensive Home treatment team
IM	intramuscular
JCUH	James Cook University Hospital
MDT	multidisciplinary team
MHA	Mental Health Act
NEAS	North East Ambulance Service
NICE	the National Institute for Health and Care Excellence
Ofsted	Office for Standards in Education, Children's Services and Skills
PBS	Positive Behaviour Support
PICU	Psychiatric Intensive Care Unit
PRN	pro re nata (as required)
RC	Responsible Clinician
NHSE Spec Com	Specialised Commissioning
SIF	Serious Incident Framework
SW	Social Worker
StEIS	Strategic Executive Information System
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
ToR	terms of reference

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An independent investigation into the care and treatment of Emily at Tees, Esk and Wear Valleys NHS Foundation Trust and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

November 2022

Final Abridged Report

Note 1: This report has been abridged from the full investigation report 'the full and unabridged report'. Elements of the full and unabridged report were not deemed appropriate for full publication for the following reasons:

1 It contains unavoidable third-party information which was deemed important to the investigation and report;

2 It contains private information about Emily and her family;

3 Emily was legally an adult at the time of her death and her right to privacy extends beyond death;

4 The report contains detailed information on self-harm and limitations exist on the extent of publication of such information which should be obligated (Safety Alert (NatPSA/2020/001/NHSPS) published 03/03/20).

Author: Dr Carol Rooney, Associate Director, Niche Health & Social Care Consulting

First published: **November 2022**

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our Abridged Report has been developed from the 'Full and Final Report' written in line with the Terms of Reference for the internal investigation into the care and treatment of Emily. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose. We have aimed to remove all sensitive, personal third-party information from this report.

Events which may occur outside of the timescale of this investigation will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

This report was commissioned by NHS England and cannot be used or published without their permission. No other party may place any reliance whatsoever on this report as this has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report, the Final Abridged Report should be regarded as definitive.

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Contents

1 About this Investigation

1.1 The family have asked us to use the first name in full of their daughter throughout this report.

1.2 This investigation was commissioned by NHS England and NHS Improvement as an independent investigation into Emily's care and treatment by Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW). A serious incident such as Emily's death would normally be subject to an internal (Level 2) investigation.

1.3 After the closure of West Lane Hospital in October 2019, NHS England commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake a review of the governance and management of West Lane Hospital by TEWV. Emily's father had raised serious concerns about West Lane Hospital when she was an inpatient and continued to raise concerns about her care by TEWV, along with other parents.

1.4 After Emily's death in a hospital managed by TEWV, NHS England agreed that the investigation of her care and treatment should be conducted independently. The terms of reference were added to Niche's existing work and an independent (level 3) investigation was commissioned, with the agreement of Emily's family.

1.5 The terms of reference (ToR) for our investigation are set out in full in Appendix A and were developed following consultation with Emily's parents. These ToR include Emily's care in West Lane Hospital at their request.

1.6 We have conducted our investigation by applying a root cause analysis approach, establishing a chronology, and identifying care and service delivery problems as well as contributory factors.

1.7 This report is abridged from the full report provided to the family, and to the organisation and other key stakeholders for learning. The family were keen to ensure that the learning from their daughter's death be shared, however, elements of the unabridged report were not appropriate for publication for the following reasons:

- The rights to privacy of the deceased person extends beyond death;
- The rights of the family to have the confidentiality of their private information maintained is paramount;
- All third-party information must be removed; and

- Some information relating to the mechanisms of self-harm are not deemed appropriate for publication and limitations exist on the extent of publication of such information (Safety Alert (NatPSA/2020/001/NHSPS) was published 03/03/20).

1.8 The main purpose of an independent investigation is to ensure that serious incidents in health care are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process should identify areas where improvements to services might be required which could help prevent similar incidents occurring. The overall aim of any investigation process is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

1.9 The ToR ask us to review and assess compliance with local policies, national guidance and relevant statutory obligations. Where we have reviewed local guidance, we have referred to this in the text. Where we have considered other guidance, we have referenced this in the text and added a footnote identifying the publication referred to.

1.1 The investigation was carried out by a lead author supported by a panel of subject matter experts:

- Dr Carol Rooney (lead author) BA, Registered Nurse (Mental Health), MSc, DProf Prac.
- Dr Nicole Karen Fung, Consultant Child and Adolescent Psychiatrist, MBChB, MRCPsych, CCT Child and Adolescent Psychiatry.
- Jane Sedgewick RN (MH), MSc, BmedSc (Hons), ENBCC603, ENBCC998.
- James Ridley, Diploma in Professional Studies (Learning Disability), Diploma in Higher Education (Learning Disability Nursing), Registered Nurse (Learning Disability), BSc (Hons) Behaviour Analysis and Intervention, Postgraduate Certificate in Teaching and Learning in Higher Education, Fellow of Higher Education Academy, Registered Nurse Teacher (NMC Approved), MA Clinical Education.
- Nic Hull, BA (Hons), CQSW.
- Sharon Conlon, RMN, RNLD, MA Adult Safeguarding, MA Child Care Law and Practice, BSc (Hons) Community Health Specialist Practitioner.
- Dr Mark Potter, BmedSci, BM, BS, MRCPsych.
- Nick Moor, MBA, PGDip (Law).

1.10 The report was peer reviewed by Kate Jury, Partner at Niche.

1.11 To review the care and treatment provided to Emily we reviewed care records and information from:

- Tees Esk and Wear Valleys NHS Foundation Trust (TEWV);
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW);
- NHS England Specialised Commissioning;
- Durham County Council (DCC);
- South Tees Hospitals NHS Foundation Trust;
- University Hospital of North Durham
- The Care Quality Commission (CQC);
- River Tees Multi-Academy Trust; and
- North East Ambulance Service (NEAS).

1.12 We reviewed many pages of documents, clinical records, policies and procedures, and meeting notes, including policies and procedures from TEWV and CNTW. We also reviewed written accounts of what happened from some of the staff involved. We also carried out over a hundred interviews, and a site visit to West Lane Hospital and Tunstall Ward.

1.13 We triangulated this information and sought assurance against the standards outlined in the policies in place at the time of the incident to examine the care and treatment Emily received, and to identify any care and service delivery problems, contributory factors and possible root causes.

1.14 A full list of all documents reviewed is available upon request.

1.15 The draft report was sent to relevant stakeholders for factual accuracy checks. This provided the opportunity for those organisations that had contributed significantly and those whom we interviewed, to review and comment on the content. We considered the comments and corrected factual inaccuracies where relevant.

Investigation limitations

1.16 Overall, our investigation took 18 months to complete, which is significantly longer than the anticipated six months. We understand the additional distress that this has caused to Emily's family and to staff involved, and we are very sorry for this.

1.17 In addition, this report was completed during the Covid-19 pandemic. This meant that there were significant additional delays due to the NHS having to focus attention and divert resources to respond to the pandemic. Completion and final checks were therefore delayed.

Parallel processes

1.18 An inquest has been opened and adjourned by the Durham Coroner's Office, and we understand it will be reconvened following completion of this independent investigation report.

Contact with Emily's family

1.19 We initially met Emily's parents at their home in July 2020. We have had several meetings with them, and we interviewed them formally as part of the investigation. Her parents were very clear that their main concerns centred on the care Emily received from TEWV, both before and after the period of care at Ferndene. For these reasons, her care from her first contact with Child and Adolescent Mental Health Services (CAMHS) has been included.

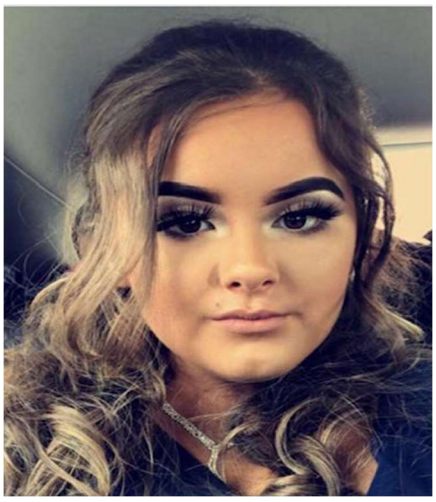
1.20 The family contributed to the questions we asked at interviews, and we have updated them regularly about the progress of the investigation. The family also shared a further series of questions following their review of the full first draft of the report, these have been answered in detail within the full report.

1.21 We have facilitated a meeting between the investigation team, the other bereaved families and their legal representative.

1.22 We would like to express our sincere condolences to the family of Emily. We recognise that this report will be difficult to read in places and we would like to apologise in advance if the manner of our report and the way we have written it in any way adds to their distress.

About Emily

1.23 Emily's family have provided the following description of their daughter:



Emily, 4th February 2002 – 15th February 2020

"Born in Bishop Auckland, County Durham, a beautiful daughter to David and Susan and sister to Ben. Emily grew up and lived in the current family home in Shildon. At a young age she attended brownie's, gymnastics, swimming and also ballet lessons all of which she enjoyed and was keen to attend and spent a lot of weekends going out with her Mam and Grandma Barbara who she was very close to. The schools Emily attended were Timothy Hackworth primary school and Sunnydale/Greenfield Comprehensive, she was a well-liked pupil with a fairly large group of friends and very bright, again attending many after school activities and did very well in her exams considering her mental health at the time.

Emily loved shopping from as far back as we can remember and was an animal lover with many pets throughout her short life and loved elephants, but we stopped at only allowing Guinea pigs and cats! Holidays and TV were a big part of her life also growing up and ironically our daughter passed away on the same day as the TV presenter Caroline Flack who she loved watching on Love Island one of her favourite programmes.

Emily had her whole life ahead of her, she really did, sadly taken by mental health issues and lack of proper professional care.

We miss you every single day 'Our Emily'

Always in our hearts and never forgotten.
Love

Mam, Dad and Ben x"

Summary Chronology

Contact with mental health services 2017 – 2020

1.24 An extensive chronology is provided in the full, unabridged version of Emily's report. The contents of that chronology are deemed private and not suitable for publication. Additionally, Emily was an adult when she died and her rights to privacy extend beyond death.

1.25 Emily's contacts with mental health services in the three years before her death are detailed in the table below. Local community mental health services were provided by Tees, Esk and Wear Valleys Foundation NHS Trust (TEWV) and Emily was under the care of the South Durham CAMHS service. West Lane Hospital and Tunstall Ward were both TEWV services.

1.26 The Ferndene unit where Emily moved to in July 2019 is provided by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW).

1.27 Emily had been under the care of the TEWV community CAMHS after taking an overdose in February 2017. She had two periods of inpatient care in West Lane Hospital from January to February 2018 and March to July 2019.

1.28 She was transferred to Ferndene from West Lane Hospital in July 2019, and then to TEWV adult services at Lanchester Road Hospital when she turned 18.

1.29 She was an inpatient under the care of TEWV Adult Services (Tunstall Ward) when she took her own life.

Service	Date admitted	Date discharged
South Durham CAMHS	February 2017	January 2018
Newberry Ward	January 2018	February 2018
South Durham CAMHS	February 2018	March 2019
Newberry Ward	March 2019	July 2019
Ferndene PICU	July 2019	September 2019
Ferndene Stephenson	September 2019	February 2020
Tunstall Ward	February 2020	

Emily's death

1.30 Emily harmed herself using a ligature on 13 February 2020 and sadly died on 15 February 2020.

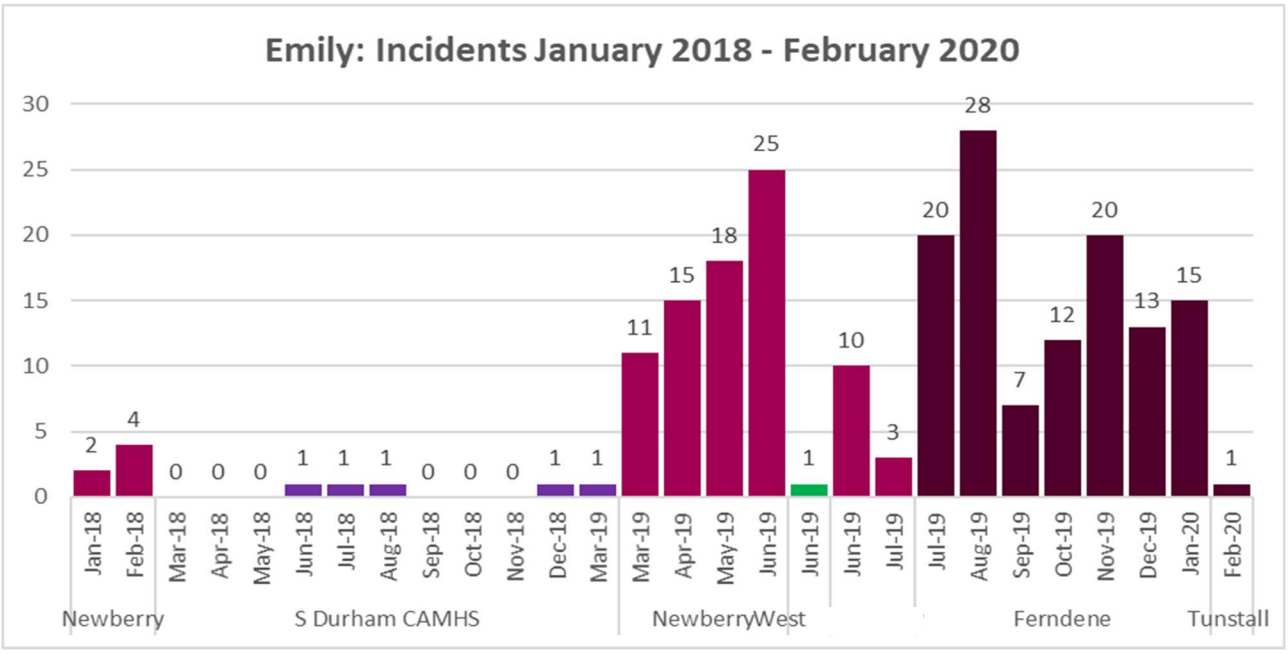
2 Analysis of Emily's care and treatment

2.1 Emily first presented to secondary mental health services in 2017 with low mood and feelings of hopelessness and low self-worth.

2.2 The community Child and Adolescent Mental Health Services (CAMHS) team initially treated Emily as experiencing a severe depressive episode. As she began to refer to hearing voices in 2017, she was assessed by the Early Intervention in Psychosis (EIP), who thought she could be at risk of developing a psychosis.

2.3 After Emily's admission to Newberry Ward in March 2019 the working diagnosis was emotionally unstable personality disorder (EUPD). This diagnosis was also confirmed after her transfer to Ferndene later in 2019. Emily did not agree with this diagnosis. Efforts were made to explain it to her and her parents, but she remained very unhappy with it.

2.4 Because harm to herself was a feature of her presentation from January 2018, the chart below shows the number of incidents of self-harm by year, month and service between 2018 and February 2020.



Care and Service delivery problems

2.5 Care Delivery Problems (CDPs) are problems that arise in the process of care, usually actions or omissions by staff. Service Delivery Problems (SDPs) are acts or omissions identified during analysis but are not associated with direct care provision. They are associated with procedures and systems that are part of the process of service delivery.

2.6 Following our analysis of Emily's care and treatment, a range of CDPs and SDPs were found.

2.7 There is no evidence that a functional analysis was carried out to develop the initial Positive Behaviour Support (PBS) plan, although there is a more person-specific narrative provided by Emily. We have not found evidence of a consistent approach to embedding this within her PBS care plans on Newberry Ward.

2.8 Emily's care plans in Newberry Ward were fragmented, incomplete and inconsistent with the recommendations for access to evidence-based interventions in inpatient settings.

2.9 In May 2019, a care planning meeting went ahead without the Social Worker present in case this exacerbated the situation, and the Social Worker agreed noting that they had not met either the family or Emily.

2.10 There were gaps in psychology provision for the ward which limited any opportunity to consult on or to review care and the PBS plan. Lack of consistent and regular individual psychology sessions meant assessment of Emily's motivation to engage with her formulation and take responsibility for her safety and recovery, and to review her psychological progress was fragmented.

2.11 The clinical team did not have effective risk management plans in place for Emily from May 2019. This was a missed opportunity to develop a formulation and understanding of her self-harm and to engage her family in understanding the treatment approach.

2.12 From April to July 2019, Emily's father raised concerns regarding the multiple self-harm incidents despite Emily being on increased observations. However, there is little evidence of these concerns being considered in accordance with multi-agency procedures. There is no evidence that a strategy meeting was conducted to determine if the threshold for a Section 47 investigation[1] had been met. There was an over-reliance on the internal complaint investigation by the Trust with no evidence of scrutiny and challenge from external partners.

2.13 Although regular meetings were arranged and efforts were made to listen to Emily's parents' concerns, a complete breakdown of trust occurred.

2.14 There is a TEWV Protocol for the Reduction of Harm Associated with Suicidal Behaviour, Deliberate Self-harm and its Treatment (for Young People With a

[1] A Section 47 enquiry means that Children's Social Care must carry out an investigation when they have "reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm." https://www.scie.org.uk/publications/introductionto/childrenssocialcare/childprotection.asp#:~:text=Section%2047%20investigations,suffer%2C%20significant%20harm'1.

Diagnosis of Borderline Personality Disorder and Related Conditions). This was approved in May 2016 and reviewed in April 2020. In our view the language used is open to misinterpretation, and skilled interpretation by consistent, experienced CAMHS staff would be required for the protocol to be effectively implemented. Such staff were not consistently available during Emily's admission in 2019.

2.15 The TEWV policy for standards for clinical record keeping states that documents should be fully completed to identify the staff involved and must be signed and dated. The expectation is that each staff member should make an entry on their own login to the system, which acts as the digital signature. Most Newberry Ward entries did not comply with this standard.

2.16 Whilst on Ferndene, Emily had alleged that staff at Newberry Ward would shout and swear at her when she harmed herself. Ferndene staff also raised concerns that risk items had been found in her 'self-soothe' box on transfer from Newberry Ward. There is no evidence that any further action was taken in relation to these concerns. A safeguarding referral should have been made, this would have enabled the local authority to triangulate information and maintain oversight of the care and treatment of young people on Newberry Ward at West Lane Hospital.

2.17 In August 2019, Emily was assessed as being able to move to the LSU, but no bed was available. Her risks indicated that she could not transfer to an open unit. It was inappropriate to keep her on the PICU, so a decision was made for Emily to step down to Stephenson Ward in September 2019.

2.18 In January 2020, a Consultant Social Worker employed by Durham County Council audited this case and noted that during the period of their involvement, which started in March 2019, until the change of Social Worker in July 2019, the social work provision was "wholly inadequate". The report noted that Emily and her parents were not seen until June 2019. An assessment had been completed in May 2019 without any involvement from Emily or her family. There was no involvement with other professionals, no family involvement, meetings, plans or management oversight during this period.

2.19 On Tunstall Ward, risk items were found in Emily's property after transfer from Ferndene. Although we do not wish to diminish the concerns of her parents, it would not be routine practice on admission to a ward to search Emily on return from leave or to carry out regular property searches. The initial search of her property was noted at admission. There was a record that some contraband items had been removed at admission, but the detail was not recorded.

2.20 There is a TEWV protocol in place to guide the transition from CAMHS to Adult Services[2]. The expectation is that where a young person is in a CAMHS inpatient service and is approaching the age of 18, contact and planning should start at least three months before their birthday. Although plans for her transition from a CAMHS service were developed six months before she was due to turn eighteen, no suitable provider was identified. There was no provision for an alternative, clinically appropriate, placement after the specialist provider turned down the referral.

2.21 It is clear from the records that Emily was unable to keep herself safe in a secure unit with fewer beds and high numbers of specialised CAMHS staff. These facts were lost in the system expectation that she must leave the care of CAMHS.

2.22 We asked if there had been a particular focus on the progress of care for former West Lane patients who were approaching 18 in 2019/2020 and 2020/2021. We were informed that there was no such oversight, but that TEWV have since developed a structure which provides oversight and communications as the young people concerned approach the age of 18.

2.23 The lack of suitable placements in the community for young people with this level of risk-taking behaviour was again highlighted. Given the lack of a community option it is difficult to see what other course of action could have been taken by Children's Services during this period.

2.24 A national safety alert was issued by NHS bodies in September 2018 regarding assessment of ligature points[3]. This alert was not new guidance; the aim was to clarify existing guidance and emphasise the importance of considering multiple factors in assessing the risk posed by ligature points. Part of the shared learning was that current risk assessments be reviewed.

2.25 A programme of ligature review and subsequent action planning was undertaken across the Trust in 2019. It was noted at the time that the previous Tunstall Ward Suicide Prevention Environmental Survey was out of date. En-suite furniture was identified as a low level ligature risk in 2019.

2.26 There were no actions to change the design of the en-suite bedroom furniture, and no revision to the survey which emphasised these as risk areas. Following Emily's death, the design of the toilets was changed to reduce the risk of ligatures.

2.27 TEWV care plans for observation levels should specify whether the staff member should enter the room or not, based on the person's presentation.

[2] Transitions Protocol Child and Adolescent to Adult Services / Primary Care CLIN-0023-v10. August 2019

[3] Assessment of ligature points, Estates and Facilities Alert, EFA/2018/005.19 Sept 2018.

2.28 The Trust have installed a system called Oxehealth[4]. Each bedroom on Tunstall ward has a camera installed which can show if it is occupied, whether the person is in bed or not, and note their vital signs. There is a dashboard in the nursing office which shows green, amber or red depending on the person's state of health, and there is an electronic tablet version so nurses can have this with them as they work around the ward.

2.29 If this had been in place when Emily was an inpatient, staff would have been able to tell whether she was in the room or not, but good practice would still to be to open the door to check. In our view, care plans for observation levels should specify whether the staff member should enter the room or not, based on the person's presentation.

2.30 The 15 care delivery problems, and 9 service delivery problems which occurred during Emily's care are shown in the tables below:

	Care Delivery Problems identified for Emily	
	Assessment, care planning and care delivery	
1.	TEWV and CNTW	PBS care plans incomplete, and not based on a functional analysis.
2.	TEWV	Gaps in psychology provision.
3.	TEWV	Fragmented incomplete care plans inconsistent with the recommendations for access to evidence-based interventions.
4.	CNTW	A low secure bed was not available, and Emily stayed on the PICU longer than was clinically necessary.
5.	TEWV/NHSE /CNTW	The system expectation was that Emily had to leave the inpatient CAMHS service at aged 18, regardless of her treatment needs.
	Local authority social care	
6.	DCC	After the referral in March 2019, her parents were not seen until after the assessment was completed
7.	TEWV/DCC	Planning for discharge was arranged without the input of a social worker.
8.	DCC	A Section 47 investigation into her parents' concerns was not conducted.
	Record keeping	
9.	TEWV	Clinical record keeping was not completed to expected standards.
	Risk assessment	
10.	TEWV	Lack of effective risk management plans.
11.	TEWV	Contraband items were found in Emily's property on transfer.
12.	CNTW	Details of the contraband found on admission were not recorded.
	Safeguarding	
13.	CNTW	A referral to the LADO should have been made by Ferndene, after Emily's allegations about Newberry staff.

[4] https://www.oxehealth.com/applications/patient-safety

14.	DCC	Social workers did not explore Emily's perspectives on the concerns raised with the CQC.
	Family involvement	
15.	TEWV	A complete breakdown of trust occurred between the Trust and Emily's parents.

	Service Delivery Problems identified for Emily	
	Capacity and skills	
1.	TEWV	The language of the BPD+ protocol is open to misinterpretation and requires consistent experienced CAMHS staff, which was not the case during Emily's second admission to Newberry.
	Clinical governance	
2.	TEWV	Clinical record keeping was not completed to expected standards.
	Risk management	
3.	TEWV	Lack of oversight of the risks of former West Lane patients who were approaching 18.
4.	TEWV	Remedial actions were not carried out to address all ligature risks identified on Tunstall ward in 2019.
5.	TEWV	TEWV care plans for observation levels should specify whether the staff member should enter the room or not, based on the person's presentation.
	Service provision	
6.	CNTW	A low secure bed was not available and Emily stayed on the PICU longer than was clinically necessary.
7.	TEWV	No provision for an alternative, clinically appropriate, placement on transition after age 18.
8.	TEWV/NHSE /CNTW	The system expectation was that Emily had to leave the inpatient CAMHS service at age 18, regardless of her treatment needs.
9.	DCC	There is a lack of suitable placements in the community for young people with this level of risk-taking behaviour.

3 Conclusions and recommendations

3.1 Emily's parents were particularly concerned about the quality of her care at West Lane Hospital and felt very strongly that her care and treatment in West Lane should be part of this review. The strength of their feelings about this was influenced by the deaths of two young girls which occurred at West Lane before it closed.

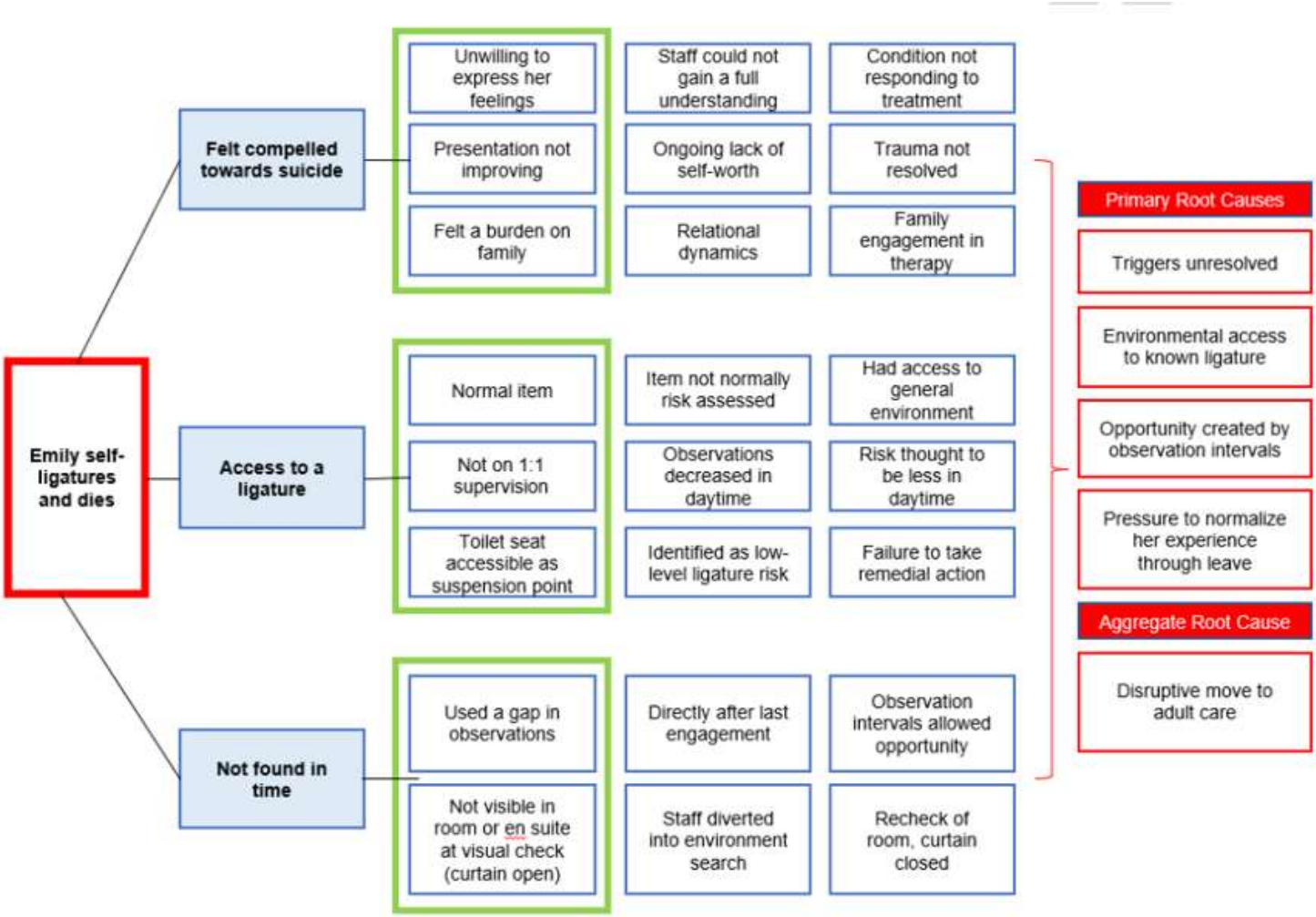
3.2 However, Emily had not been an inpatient at West Lane since July 2019, and the issues at West Lane cannot be seen to have been immediate contributory factors in her death.

3.3 Part of the terms of reference is to “identify any actions that could have led to a different outcome for Emily.” In our view there are two systems issues that had a direct impact on Emily’s death:

- The transition from CAMHS to Adult Services which was based entirely on age and did not take Emily’s clinical needs into consideration; and
- The failure to address the low-level ligature risks identified in en-suite bathrooms on Tunstall Ward in 2019.

Why’s Diagram

3.4 The following diagram should be read from left to right. It contains an ascending flow of causes with the ultimate aims of establishing root causes (in the right-hand boxes). This diagram is known as a ‘Why’s Diagram’.



Recommendations

3.5 We recognise that care in West Lane Hospital is no longer provided by TEWV. However, there is still learning for agencies involved in the care and treatment of young people in Tier 4 mental health services, and also for TEWV in other service areas. We have made 13 recommendations to address the issues identified in this investigation. This report also makes recommendations about the governance issues

3.6

Recommendation 1: Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) must ensure that young people in Child and Adolescent Mental Health Services (CAMHS) have a clear plan of care incorporating evidence-based practice.

Recommendation 2: TEWV must ensure that risk assessments for young people in CAMHS are based on a psychological formulation and are developed by a multidisciplinary team (MDT) in conjunction with the young person and their family.

Recommendation 3: TEWV must ensure that the management of restrictive interventions (including contraband items) is part of an agreed philosophy and approach, with clear protocols embedded to guide practice.

Recommendation 4: Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) must ensure that where risk items are found in a patient's possession, there is clear recording and appropriate care planning to address the risk identified.

Recommendation 5: Durham County Council must ensure that social workers are directly involved in planning for a young person's discharge from an inpatient environment.

Recommendation 6: Durham County Council must ensure that responses to referrals are completed within expected time frames, and subsequent assessments always incorporate the views of the family and young person.

Recommendation 7: Durham County Council must respond formally to serious concerns raised about the care and treatment of a young person under their care and explore those concerns with the family and young person.

Recommendation 8: CNTW must provide assurance that there are protocols in place for Local Authority Designated Officer (LADO) referrals and ensure that these are understood and followed by all staff on Ferndene.

Recommendation 9: NHS England Specialised Commissioning and the North East region Integrated Care Systems (ICSs), as system leaders, should work with the Directors of Children's Services in the North East region to commission services that will meet the needs of the small but growing number of young people with complex needs and challenging behaviours that have both health and social care needs. Durham County Council and CNTW/TEWV must work together to secure effective joint Section 117 aftercare packages. Where children are looked after by the Local Authority, Durham County Council and the North East & North Cumbria Integrated Care System must provide suitable placement options to support discharge arrangements.

Recommendation 10: TEWV must provide assurance that clinical records are kept to expected standards.

Recommendation 11: TEWV, CNTW, NHS England and Durham County Council must provide assurance that all transitions between services for children and young people are completed in line with NICE guidance on the Transition of Children and Young people.

Recommendation 12: TEWV must provide assurance that all ligature risks identified in Tunstall Ward in 2019 have been addressed.

Recommendation 13: TEWV must ensure that the Supportive Observation and Engagement Procedure requires that care plans specify whether to enter the individual's room if they cannot be observed from the doorway.

Good practice

3.7 We have identified several examples of good practice, all which relate to Emily's care on Ferndene:

- Emily's move to Stephenson Ward was the least restrictive option and kept continuity within the same service with the Consultant Psychologist.
- The Consultant Psychologist devised a matrix for Emily to complete to explore her self-harm in more detail. Using these tailored methods gave Emily the opportunity to explore and express her experiences in a safe and supportive way.
- A detailed psychological formulation of the maintaining factors and the purpose of Emily's self-harm was handed over to the new care team and assessments of continued risk and the absence of understanding of triggers were shared.
- The multidisciplinary team (MDT) increased Emily's leave to meet the family's hope that Emily could go on holiday in July 2019, and to facilitate

time with family at Christmas overnight in Ferndene, with some time spent in the family home.

- The team were aware at admission that there had been a difficult relationship between Emily's parents and the West Lane team and made every effort to develop open and positive communication.

Appendix A – Terms of reference

Terms of reference for Independent Investigations in accordance with Appendix 3 of NHS England's Serious Incident framework 2015.

The following terms of reference for an Independent Investigation into the care and treatment of Emily provided by Tees, Esk and Wear Valley NHS Foundation Trust (TEWV), have been drafted by NHS England and NHS Improvement.

The terms of reference will be developed further in collaboration with the investigative supplier, Emily's family and key stakeholders.

Purpose of the investigation/commission

To commission an independent investigation with recognised subject matter expertise to scrutinise and assess the effectiveness of Emily's care and treatment specifically following transfer from Child and Adolescent Mental Health Services (CAMHS) services at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) to Adult Mental Health Services (AMHS) within Tees, Esk and Wear Valley services, with particular scrutiny of the assessment and management of risk.

Additional lines of enquiry in response to family questions are included.

Involvement of the affected family members

It is expected that Emily's family are fully informed of the investigation and the investigative process and that they understand how they can contribute to the process.

Investigation

Determine a comprehensive chronology, which includes care delivered within Cumbria Northumberland Tyne and Wear and Emily's transition from CAMHS to Adult Services.

Undertake a critical review and analysis of the care and treatment of Emily, identifying, but not limited to, any gaps, deficiencies or omissions in the service and individual care and treatment.

Consider and comment on the assessment and management of care in the time leading up to the incident (including whether due consideration was given to relevant risk history and the needs of the patient).

Include input from Emily's family for further scrutiny of care and determine whether the statutory Duty of Candour was appropriately applied.

Review the appropriateness of Emily's treatment in the light of identified health needs, identifying both areas of good practice and areas of concern with reference to supporting expert evidence.

Determine any further lines of enquiry from an investigative perspective.

Establish whether the risk assessment and risk management of Emily was sufficient in relation to her needs including assessing the risk of self-harm or of taking her own life.

Examine the effectiveness of Emily's care plan to determine:

- the level of involvement of the patient and their family;
- how the Trust listened and acted on any concerns raised by the family;
- how Trust clinicians communicated with the family; and
- the effectiveness of multidisciplinary team (MDT) working.

Identify any areas of best practice, opportunities for learning and areas where improvements to services are required.

Review and assess compliance with local, multi-agency policies and national guidance, specifically clinical observation, ligature and risk assessment policies, identifying areas of good practice and any areas of concern.

Establish what lessons are to be learned regarding the way in which professionals work individually and together.

Identify clearly what those lessons are, how and within what timescales they should be acted on, and what is expected to change as a result.

Apply these lessons to required service responses including changes to policies and procedures as appropriate.

Based on overall investigative findings, constructively review any gaps in professional working and identify opportunities for improvement.

Cross reference and correlate any emerging themes, findings and learning with the systemwide investigation commissioned by NHS England and NHS Improvement.

Identify any issues in relation to culture, leadership, capacity or resources that impacted on the Trust's ability to provide a safe service to Emily and identify any actions that could have led to a different outcome for Emily.

Deliverables

Provide a final written report to NHS England and NHS Improvement, that identifies learning which supports the development of measurable, sustainable and outcome focussed recommendations.

Provide an executive summary and a learning case study.

Provide an opportunity for Emily's family to receive supported feedback related to the findings.

Based on investigative findings make organisational specific, outcome focussed recommendations which may include NHS England. Recommendations are to include a priority rating and expected timescale for completion.

Deliver an action planning event for the Trust and other key stakeholders to share the report's findings and to provide an opportunity to explore and fully understand the intention behind all recommendations.

Contribute towards a multi-agency media/publication strategy.

Support the commissioners (where required) in developing a structured plan for review of implementation of recommendations. This should be a proposal for measurable change and be comprehensible to those with a legitimate interest.

Conduct an assurance follow-up visit with key stakeholders, in conjunction with the relevant Clinical Commissioning Group (CCG), 12 months after publication of the report to assess implementation and monitoring of associated action plans. Provide a short written report for NHS England and NHS Improvement that will be shared with stakeholders and will be made public.

Appendix B – Glossary of acronyms

BPD	borderline personality disorder
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CNTW	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
CQC	Care Quality Commission
EIP	Early Intervention in Psychosis
EUPD	emotionally unstable personality disorder
LADO	Local Authority Designated Officer
LSU	low secure unit
MDT	multidisciplinary team
NEAS	North East Ambulance Service
PBS	Positive Behaviour Support
PICU	Psychiatric Intensive Care Unit
SI	serious incident
SIF	Serious Incident framework
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust

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An independent investigation into the care and treatment of Nadia in West Lane Hospital by Tees, Esk and Wear Valleys NHS Foundation Trust

November 2022

Final Abridged Report

Note 1: This report has been abridged from the full investigation report 'the full and unabridged report'. Elements of the full and unabridged report were not deemed appropriate for full publication for the following reasons:

1 It contains unavoidable third-party information which was deemed important to the investigation and report;

2 It contains private information about Nadia and her family;

3 The report contains detailed information on self-harm and limitations exist on the extent of publication of such information which should be obligated (Safety Alert (NatPSA/2020/001/NHSPS) published 03/03/20).

Author: Dr Carol Rooney, Associate Director, Niche Health & Social Care Consulting

First published: **November 2022**

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance, and quality, including undertaking independent investigations following very serious incidents.

Our Abridged Report has been developed from the 'Full and Final Report' written in line with the Terms of Reference for the internal investigation into the care and treatment of Nadia. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose. We have aimed to remove all sensitive, triggering, personal third-party information from this report.

Events which may occur outside of the timescale of this investigation will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

This report was commissioned by NHS England and cannot be used or published without their permission. No other party may place any reliance whatsoever on this report as this has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report, the Final Abridged Report should be regarded as definitive.

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Contents

1 Summary

About this investigation

1.1 The family have asked for us to use the first name in full of their daughter Nadia throughout this report.

1.2 This investigation was commissioned by NHS England and NHS Improvement as an independent investigation into the care and treatment that Nadia received before she died in August 2019. The report is in addition to a wider review into the governance and management of West Lane Hospital.

1.3 This independent investigation follows the Serious Incident Framework (SIF) and is conducted as a Level 3 independent investigation. The terms of reference (ToR) for our investigation were compiled following consultation and in agreement with Nadia's mother and father.

1.4 We have conducted our investigation applying a root cause analysis approach, by establishing a chronology, and identifying care and service delivery problems as well as contributory factors.

1.5 This report is abridged from the full report provided to the family and to the organisation and other key stakeholders for learning. The family were keen to ensure that the learning from their daughter's death be shared. However, elements of the unabridged report were not appropriate for publication for the following reasons:

- The rights to privacy of the deceased person extends beyond death;
- The rights of the family to have their private information maintained is paramount;
- All third-party information must be removed; and
- Some information relating to the mechanisms of self-harm are not deemed appropriate for publication and limitations exist on the extent of publication of such information (Safety Alert (NatPSA/2020/001/NHSPS) was published 03/03/20).

1.6 The main purpose of an independent investigation is to ensure that serious incidents in health care are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process should identify areas where improvements to services might be required which could help prevent similar incidents occurring. The overall aim of any investigation process is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

1.7 The ToR ask us to review and assess compliance with local policies, national guidance, and relevant statutory obligations. Where we have reviewed local

guidance, we have referred to this in the text. Where we have considered other guidance, we have referenced this in the text and added a footnote identifying the publication referred to.

1.8 The investigation was carried out by a lead author supported by a panel of subject matter experts:

Nick Moor	MBA, PGDip (Law).
Dr Nicole Karen Fung	Consultant Child and Adolescent Psychiatrist, MBChB, MRCPsych, CCT Child and Adolescent Psychiatry.
Jane Sedgewick	RN (MH), MSc, BMedSc (Hons), ENBCC603, ENBCC998.
James Ridley	Diploma in Professional Studies (Learning Disability), Diploma in Higher Education (Learning Disability Nursing), Registered Nurse (Learning Disability), BSc (Hons) Behaviour Analysis and Intervention, Post Graduate Certificate in Teaching and Learning in Higher Education, Fellow of Higher Education Academy, Registered Nurse Teacher (NMC Approved), MA Clinical Education.
Dr Carol Rooney (lead author)	BA, Registered Nurse (Mental Health), MSc, DProf Prac.
Nic Hull	BA (Hons), CQSW.
Sharon Conlon	RMN, RNLD, MA Adult Safeguarding, MA Child Care Law and Practice, BSc (Hons) Community Health Specialist Practitioner.

1.9 To review the care and treatment provided to Nadia we reviewed care records and information from:

- Hirsell Medical Centre, Middlesbrough
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- NHS England Specialised Commissioning
- Middlesbrough Council
- South Tees Hospital NHS Foundation Trust
- South Tees Clinical Commissioning Group (CCG), now Tees Valley CCG.
- North East Ambulance Service (NEAS)
- Thornbury Community services (TCS)

1.10 We also carried out over a hundred interviews and undertook a site visit to West Lane Hospital. We triangulated this information and sought assurance against the standards outlined in the policies in place at the time of the incident to examine the care and treatment Nadia received, and identify any

care and service delivery problems, the contributory factors and possible root cause.

1.11 The draft report was sent to relevant stakeholders for factual accuracy checks. This provided an opportunity for those organisations who had contributed significant pieces of information and those whom we interviewed, to review and comment upon the content. We considered the comments and corrected factual inaccuracies where relevant.

Investigation limitations

1.12 Overall, our investigation start was delayed by six months, and took over 24 months to complete, which is significantly longer than the initially anticipated six months. We recognise the additional pressure this has placed on the family who are keen to understand the events surrounding their daughter's death.

1.13 We were unable to commence our independent investigation until Cleveland Police had concluded their investigation following Nadia's death.

1.14 Also, this investigation and report were completed during the Covid-19 pandemic. This meant that there were significant additional delays due to the NHS having to focus attention and divert resources to respond to the pandemic. Completion and final checks were therefore delayed.

Parallel processes

1.15 Because Nadia was under 18 when she died, her death is subject to a Child Death Overview Panel (CDOP) review by the Middlesbrough CDOP, administered by Middlesbrough Council. We have been informed by the CDOP administration that Nadia's death will be reviewed by the Panel when this NHS England and NHS Improvement commissioned investigation is complete.

1.16 There may also be enquiries by HM Coroner.

Contact with Nadia's family

1.17 We initially met Nadia's parents with their solicitor in January 2020. We have had several meetings with them, and we have interviewed them formally as part of the investigation.

1.18 They have contributed to the questions we have asked at interviews, and we have updated them regularly about the progress of the investigation.

1.19 We would like to express our sincere condolences to the family of Nadia. We recognise that this report will be difficult to read in places and we would like to apologise in advance if the manner of our report and the way we have written it in any way adds to their distress.

1.20 Nadia's parents have read the report, which was also provided as a translated version and asked for some amendments to be made, which were done.

1.21 Niche and NHS England met with Nadia's mother and father to share the findings of our report. They were accompanied by the family solicitor.

About Nadia

1.22 Nadia's family have provided the following description of Nadia.

Nadia, 1st February 2002 – 9th August 2019

Nadia was born on 1 February 2002 to loving parents. Nadia was close to her siblings and had a little nephew, who she doted on. Nadia grew up in Middlesbrough in the North East of England. She was caring, very bright, always smiling and funny to be around. She had an ordinary childhood, loved going shopping, getting dressed up and spending time with her family and helping around the house.

She was an extrovert in that she loved going out and being out with friends and family.

She was a dancer and a gymnast, bubbly with her friends and sociable until she went into hospital.

Her one dislike has always been loud noises: this never changed!

Prepared by her family

Summary Chronology

1.23 The full chronology of care and treatment events contains extensive personal information about Nadia's care and treatment. Much of which contains detailed information about episodes of self-harm, family information, third-party information, and the significant difficulties that Nadia and staff had in managing her worsening presentation. This information is deemed private and unsuitable for publication. The key timeline is as follows:

Year	Care environment
November – December 2016	Newberry (TEWV)
December 2016 – June 2017	PICU, Cygnet Bury
June – September 2017	Westwood (TEWV)
September – October 2017	Newberry
October 2017 – April 2018	Westwood
April – May 2018	Belford Terrace (North East Autism Society)
May – December 2018	Westwood
December 2018 – March 2019	Pulse Community Healthcare/Thornbury Community Services (TCS) placement
March – June 2019	Adult ICU(JCUH)/Westwood
June 2019 – August 2019	TCS placement/Newberry/Westwood

Early years

1.24 Nadia was born and raised in Middlesbrough; she was the second eldest of five children. She was 17 years old when she died in August 2019 and would have been 18 in February 2020.

1.25 She was very gifted at Maths and enjoyed doing artwork, she enjoyed going on fast rides at theme parks, shopping and watching TV. Her appearance was really important to her and she loved shopping for clothes and make-up.

1.26 Her family are of Pakistani Muslim background, her father was raised in the north-east and her mother moved to England when they were married.

2012 - 2019

1.27 Nadia had been under the care of the TEWV community Child and Adolescent Mental Health Services (CAMHS) since 2012. She was initially referred due to problems in school, and psychology reports showed a learning difficulty.

1.28 In April 2016 she was diagnosed with autism spectrum disorder (ASD)[1] by a multi-agency autism assessment team. There were concerns about her aggression to family members and controlling behaviours at home, which had become worse over the previous year.

1.29 Nadia had a series of periods of care in West Lane Hospital, including on Newberry and Westwood wards. Her first admission to West Lane was to Newberry ward in November 2016, and she was transferred to a Psychiatric Intensive Care Unit (PICU) in Bury for seven months.

1.30 Nadia had started to self-harm in the PICU in Bury, and her restricted eating became more frequent. She was then admitted to Westwood low secure unit in June 2017.

1.31 Apart from a short period in a residential placement, Nadia remained in Newberry or Westwood until the discharge to her own flat in December 2018,

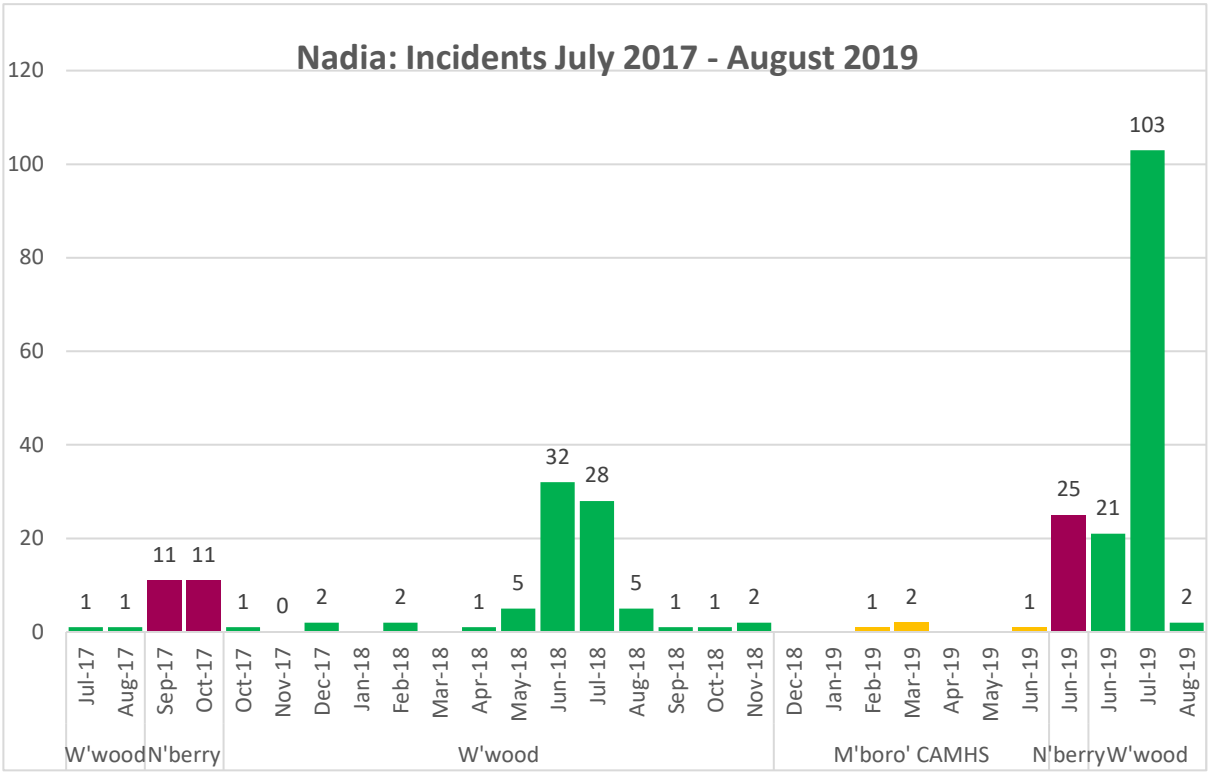
1.32 From December 2018 Nadia was living in her own flat and was provided with an individual package of care by Thornbury Community Services (TCS)[2]. The clinical records show that as risks increased, she was admitted back to a hospital environment for short periods. The funding and resources for the TCS package of care remained in place, and the intention was for her to move back to her flat.

1.33 After a series of risk events this placement also broke down and Nadia was readmitted to Westwood in June 2019.

[1] Autism is a lifelong developmental disability which affects how people communicate and interact with the world. Autism is a spectrum condition and affects people in different ways. https://www.autism.org.uk/advice-and-guidance/what-is-autism

[2] Thornbury Community Services (TCS) is an independent provider of health care services. https://www.thornburycommunityservices.co.uk/

1.34 From July 2017 onwards, the frequency of Nadia's episodes of self-harm fluctuated dramatically. The following diagram provides a broad overview of episodes of harm:



Events leading up to Nadia's death

1.35 At the time of her death, Nadia was an in-patient on the Westwood centre, West Lane Hospital.

1.36 On the morning of 5 August Nadia was in bed with her music on, under the quilt. At 8am staff noted that they entered her bedroom, and she sat up. The care plan was not to engage with her directly, and it had been agreed that the nurse giving morning medication would do the first observations.

1.37 At 8.30am a Staff Nurse entered her room to give her morning medication; there was no response to calling Nadia and she was not visible. The Staff Nurse found her sitting under the desk, unresponsive.

1.38 The ambulance call was made at 8.42am and they arrived at the scene at 8.49am. The ambulance staff recorded that they were told that her observations had recently been reduced to 15-minute observations.

1.39 Nadia was admitted to the Cardiac Intensive Care Unit at James Cook University Hospital at 2.20pm after a period in A&E, accompanied by Westwood staff. She was sedated and breathing with assistance, using an

airway. Her family refused permission for any information to be shared with TEWV.

1.40 On 9 August the tests for brain stem death had been completed, and Nadia died at 2.04pm.

2 Analysis of Nadia's care and treatment

2.1 When Nadia was aged 14 in April 2016, a structured assessment for autism was carried out, with input from CAMHS, a speech and language therapist and psychologists. It was concluded that Nadia met the criteria for a diagnosis of Asperger's syndrome (ICD10:F84.5). She fell within the average range to borderline disability. There were no concerns about her overall intellectual ability, although there were concerns that she easily disengaged.

2.2 She demonstrated rigid behaviours and black-and-white thinking, had difficulty in engaging with the assessment, and difficulties with initiating or sustaining social interactions. Her strengths were noted as cooperating with numeracy lessons, liking to look after her appearance, and enjoying using an iPad. Nadia had few friends and was isolated socially; she had begun to show very controlling behaviours at home, such as chasing family out of a room and stopping others from going upstairs by sitting on the steps.

2.3 Nadia's first CAMHS outpatient appointment was in July 2016. There were concerns about her controlling and aggressive behaviours at home, which had become worse over the past year. She tended to decide who could be in each room, who could watch TV, and she would hit her younger siblings regularly. Recently she had grabbed knives and the police had been called. It was suggested that she start on the Positive Behaviour Support (PBS) pathway and be referred to Social Services for additional support.

2.4 During 2016 the situation at home deteriorated, with a number of serious incidents taking place and police being asked to attend the family home to try and defuse incidents that had arisen. Other agencies including CAMHS and Education were also concerned and made referrals to local authority Children's Services.[3]

2.5 Nadia was brought to Newberry ward in November 2016 by police accompanied by the Mental Health Act (MHA) assessment team of an Approved Mental Health Professional and two doctors. She was detained under Section 2 MHA and was very distressed and agitated on admission and required physical restraint. She was transferred to Cygnet Bury Psychiatric Intensive Care Unit (PICU) after an increase in aggression to staff and had been detained on Section 3 MHA.

[3] After the age of 14 (2016) Nadia was under the care of the Transitions Team which is part of Adult Social Care.

2.6 The risk assessment at admission to Bury identified risks of aggression towards staff and of absconding, risk of self-neglect referencing poor dietary intake and not sleeping. There was no documented history of self-harm, but she started to self-harm whilst admitted there. Her restricted eating increased, and she was discharged from Cygnet Bury to West Lane Hospital on 27 June 2017, after an assessment by the Westwood team.

2.7 Nadia appeared to benefit from the structured environment at Westwood, and apart from brief transfers to Newberry and an external placement, was largely settled on Westwood during 2018.

2.8 In July 2018, it was agreed that a bespoke supported tenancy would be sought for Nadia, with care provided by Pulse/Thornbury Community Services (TCS), who provided specialist autism care.

2.9 We have had access to a TEWV serious incident investigation report[4] dated August 2019, which described an investigation into an allegation that another Westwood patient was subject to inappropriate restraint. The investigation centred on a series of restraints in October 2018. During the investigation into these allegations, a review of CCTV footage and ward staff rosters was undertaken to identify the date of the allegation. This review revealed that Nadia was also restrained inappropriately on two occasions in early October 2018 (she is referred to in this report as Patient B). Although the report does not describe the restraints in detail, we have watched the CCTV and have observed Nadia being 'dragged' down a corridor backwards with staff holding her under her arms.

2.10 The restraints that raised the concern are on two dates in early October. There is no reference at all to these events in Nadia's clinical records. There is no reference to any additional scrutiny or investigation of these restraints, or any communication with Nadia or her parents about the inappropriate techniques used. There is no record of an explanation, apology or referral to the LADO.[5] We have been informed by TEWV that the Head of Service personally spoke to Nadia's father on the telephone to inform him of the restraints and explained there would be investigations regarding individual staff members. It was reported that the same member of staff also gave his apologies during the call. It was acknowledged that there is no written evidence of this communication.

2.11 Nadia's section 3 was rescinded, and she was discharged from Westwood in December 2018. On discharge from hospital into the community Nadia engaged well and enjoyed living in her own home. She took pride in her belongings and appearance and would love to clothes shop. Nadia spent time

[4] Serious Incident review report 2018.27928
[5] Local Authority Designated Officer - the office responsible when allegations are made about staff from any service abusing vulnerable young people

accessing chosen activities which included her education and was completing her GCSEs in Maths, English and Science. She stated that she would like to work in accountancy. She had a swim and gym membership and was engaging in this well.

2.12 In February 2019 Nadia started to display increased self-harm behaviours. TCS devised emotions cards, visual cards and more robust activity plans to ensure that she had increased predictability during times of heightened anxiety. Identified triggers were that she was told she could not have a driving licence by DVLA, she was awaiting certain decisions from the social care team around meeting patients in hospital, and inconsistencies of a staff member (who was taken out of the care package). Nadia also wanted to lend her friends money, but without understanding the possible consequences of doing this, and she was using social media a lot more than usual.

2.13 Her self-harm still increased however, and she had several emergency admissions to hospital. She was readmitted to Westwood in June 2019, and her self -harm, restricted eating and aggression escalated. in July 2019 she had many episodes of seclusion, and a staged care plan was developed to help support her to calm and return to sleep in her bedroom.

2.14 There was a Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Protocol for the Reduction of Harm Associated with Suicidal Behaviour, Deliberate Self-harm and its Treatment (for Young People With a Diagnosis of Borderline Personality Disorder and Related Conditions), which was approved in May 2016 and reviewed in April 2020. This protocol has now been withdrawn by TEWV. In our view the language used in this protocol is open to misinterpretation, and skilled interpretation by consistent and experienced CAMHS staff would be required for the protocol to be effectively implemented. These staff were not consistently available during Nadia's admission in 2019. The protocol does not make it clear how or if this approach would be adapted to young people with "related conditions" and young people who are "challenged by similar long-term issues of self-harm, suicidal thinking and behaviour, emotional difficulties and difficulties with relationships" but do not have a diagnosis of BPD+.

Care and service delivery problems

2.15 We have identified 26 care delivery problems during her care, and 21 service delivery problems that occurred in her care, across the various agencies. We believe these combined as contributory factors which led up to her fatal self-ligature on 5 August 2019. Whilst many of these factors are the responsibility of TEWV to address, several belong to other key stakeholders involved in Nadia's care and include Middlesbrough Children and Young People's Services (Middlesbrough Safeguarding Children Board (MSCB), NHS England Specialised Commissioning (NHSE Spec Com) and the Care Quality Commission (CQC).

2.16 The care and service delivery problems are grouped and shown in the tables below:

	Care Delivery Problems identified for Nadia	
	Assessment, care planning and care delivery	
1.	TEWV	Nadia did not have an identified Consultant Psychiatrist in the community at discharge in December 2018.
2.	TEWV	There was a lack of autism-informed care, which impacted directly on care in August 2019.
3.	TEWV	There was a lack of Psychology input in July and August 2019 to inform care planning and risk assessment, notwithstanding sustained efforts to recruit a specialist psychologist from February 2019.
4.	TEWV	Seclusion was included in a therapeutic care plan.
5.	TEWV	The care plans in July and August 2019 expected Nadia to 'earn' access to her own clothes.
6.	TEWV	Positive Behaviour Support and staged care plans in July and August 2019 focus on tertiary interventions.
7.	TEWV	Care plans are written in the first person and include language highly unlikely to be used by a teenager, with no evidence that the patient has written them.
	Local authority social care	
8.	MCC/NEAS	The educational and residential placement was terminated without explanation.
9.	MCC	The local authority did not ensure that Nadia's parents understood the Section 20 agreement.
10.	MCC/TEWV	Social workers were not aware of the extent of Nadia's challenging behaviour and seclusions in July and August 2019.
	Record keeping	
11.	TEWV	There is a record of only one post-restraint debrief in the records.
12.	TEWV	There are gaps in the recording of observations carried out.
	Risk assessment	
13.	TEWV	Traffic light risk assessments were not updated.
14.	TEWV	There was a lack of clarity in July and August 2019 about how staff should approach Nadia's self-harm.
15.	TEWV	The recording of the observation levels in August 2019 is confusing, and there is a lack of clarity about the correct level.
16.	TEWV	Nadia was observed every 15 minutes on the morning of 5 August 2019. There is no record of the decision to reduce to this level.
	Safeguarding	
17.	MCC	There was no escalation to senior management regarding the absence of a legal framework to guide care at her flat in 2018/2019.
18.	MCC/TEWV	There was a missed opportunity to triangulate multiple concerns and take action to safeguard Nadia.
19.	MCC	On 14 June 2019 the Social Worker was concerned that Nadia had extremely severe bruising on her face. A safeguarding referral should have been made.

20.	MCC/TEWV	Safeguarding referrals were not made when Nadia was in seclusion for a protracted period.
	Family involvement	
21.	TEWV	There was no provision for alternative language, in either written information or the provision of interpreters.
22.	TEWV	Parents were not informed of the inappropriate restraint in November 2018, or of any investigation.
23.	TEWV	Her family were not involved in developing care plans.
24.	TEWV	TEWV staff continued to make contact with Nadia's parents after 5 August 2019, despite being asked not to.
25.	TEWV	A lack of senior guidance led to misunderstandings and upset for the family when Nadia was in JCUH in August 2019.
26.	TEWV	The Duty of Candour was not met regarding the November 2018 incidents.

	Service delivery problems identified for Nadia	
	Patient safety	
1.	TEWV	The Safewards model was not implemented effectively.
2.	TEWV	There is no policy which guide staff practice in managing and removing ligatures.
3.	TEWV	There was no practice guidance about the completion and use of the traffic light risk assessment.
4.	TEWV	The seclusion room on Westwood had observation blind spots and ligature suspension points.
	Clinical care	
5.	TEWV	The language of the borderline personality disorder + (BPD+) protocol is open to misinterpretation and requires consistent experienced CAMHS staff, which was not the case during Nadia's admissions in late 2018 and 2019.
	Social care	
6.	Middlesboro Council	There was no legal framework instigated to guide the care at her flat in 2018/2019.
7.	Middlesboro Council	The family were not provided with a package of coordinated multi-agency support after the initial assessment.
8.	TEWV/ Middlesboro Council	Tension existed between Children's Services and Health around planning for Nadia.
9.	Middlesboro Council	There were difficulties in finding community placements with the skills and robustness to meet the needs of young people with complex difficulties.

10.	Middlesboro Council	Social workers deferred to Health, rather than becoming directly involved in her inpatient care.
	Autism informed care	
11.	TEWV	There was insufficient attention to management of sensory sensitivity in the environment, which was not conducive to autism-informed care.
12.	TEWV	Westwood staff did not have training in autism approaches.
13.	TEWV/ NHS England	There was no autism pathway at West Lane.
	Record keeping	
14.	TEWV	Clinical records were not completed consistently in time or date order, or entered by each individual staff member.
15.	TEWV	There is not always a record in the clinical notes of the staff involved in any restraint and their roles.
16.	TEWV	Documentation of observation and engagement levels were sometimes conflicting.
17.	TEWV	Care plans are noted as being “Carried Out” and “Signed Off”, with a lack of clarity over which is the final version.
18.	TEWV	Documentation of observation and engagement levels were sometimes conflicting.
19.	TEWV	The absence of guidance meant that young people could be exposed to inappropriate content on social media.
	Safeguarding	
20.	TEWV	Safeguarding procedures were not instigated to protect Nadia.
	Duty of Candour	
21.	TEWV	There was a lack of tracking and follow-up of Duty of Candour policy expectations.

3 Conclusions and recommendations

3.1 Nadia’s presentation was chronic and complex; she presented with aggression from a young age, initially towards family members. This broadened to aggression to her peers, wider family, police, and healthcare staff.

3.2 A diagnosis in April 2015 included borderline scores on intelligence testing and overall average cognitive ability. In April 2016 she was diagnosed with Asperger’s/autism spectrum disorder (ASD) by a multi-agency autism assessment team.

3.3 Services did not always adapt approaches to Nadia’s needs. There was an acknowledgement in 2019 in Westwood of the lack of autism awareness and

training within the team. Lack of autism knowledge meant that rather than giving positive instruction and alternative behaviours for Nadia to engage in, she was given a list of risk behaviours not to engage in. Lack of autism knowledge meant staff did not use precise language but gave vague or abstract answers, rather than concrete responses to her questions about seclusion and observation reductions.

3.4 Lack of approaches to manage sensory sensitivity, as outlined in the occupational therapy (OT) sensory profile (2017 OT discharge summary), for example, the noise from alarm systems on the wards, were not taken into account and the risk of sensory sensitivity/overload was not managed as it could have been, for example by dampening effects with ear defenders.

3.5 Psychology had not explored her inner world and the risk of 'all-or-nothing thinking' in ASD. Her ongoing hopelessness from seclusion was not identified.

3.6 In June/July 2019 Thornbury Community Services (TCS) staff were visiting regularly to provide inreach support to Nadia on Westwood. They had offered to train Westwood staff in autism approaches, and to spend time with Nadia on the ward, both of which were refused. This was a missed opportunity to provide continuity of care for Nadia, and for Westwood staff to access bespoke training.

3.7 Although Nadia had a history of aggression when living at home, visits were usually positive. The impact of lack of contact with parents when in seclusion was not explored or addressed and might well have contributed to iatrogenic causes and a worsening of presentation.

3.8 We have noted that Nadia's mother was not included in discussions about her care. Her first language is not English, and there was an assumption made that Nadia's father would translate. No efforts were made to facilitate Nadia's mother's involvement in her care, leaving her excluded.

3.9 The lack of direct psychology input meant that there was limited exploration and/or management of psychological triggers which may have increased Nadia's risks, such as:

- the effects of other peers and the hospital environment itself;
- the uncertainty and unpredictability of the use and skills of agency staff;
- the significance of the suicide of a peer in June 2019;
- the impact of making a disclosure in July 2019 about care in Manchester; and
- ongoing hopelessness.

3.10 However, we believe it was the organisational failure to mitigate the risks of self-ligature, accompanied by Nadia's increasing risks, individual needs and

changed presentation not being recognised, and the unstable and overstretched services in West Lane Hospital that were the root causes of Nadia's death.

3.11 Our observation is that the failings at West Lane Hospital were multifaceted and systemic, based upon a combination of factors, including reduced staffing, low morale, ineffective management of change, lack of leadership, aggressive handling of disciplinary problems, issues with succession and crisis management, failures to respond to concerns from patients and staff alike, and increased patient acuity.

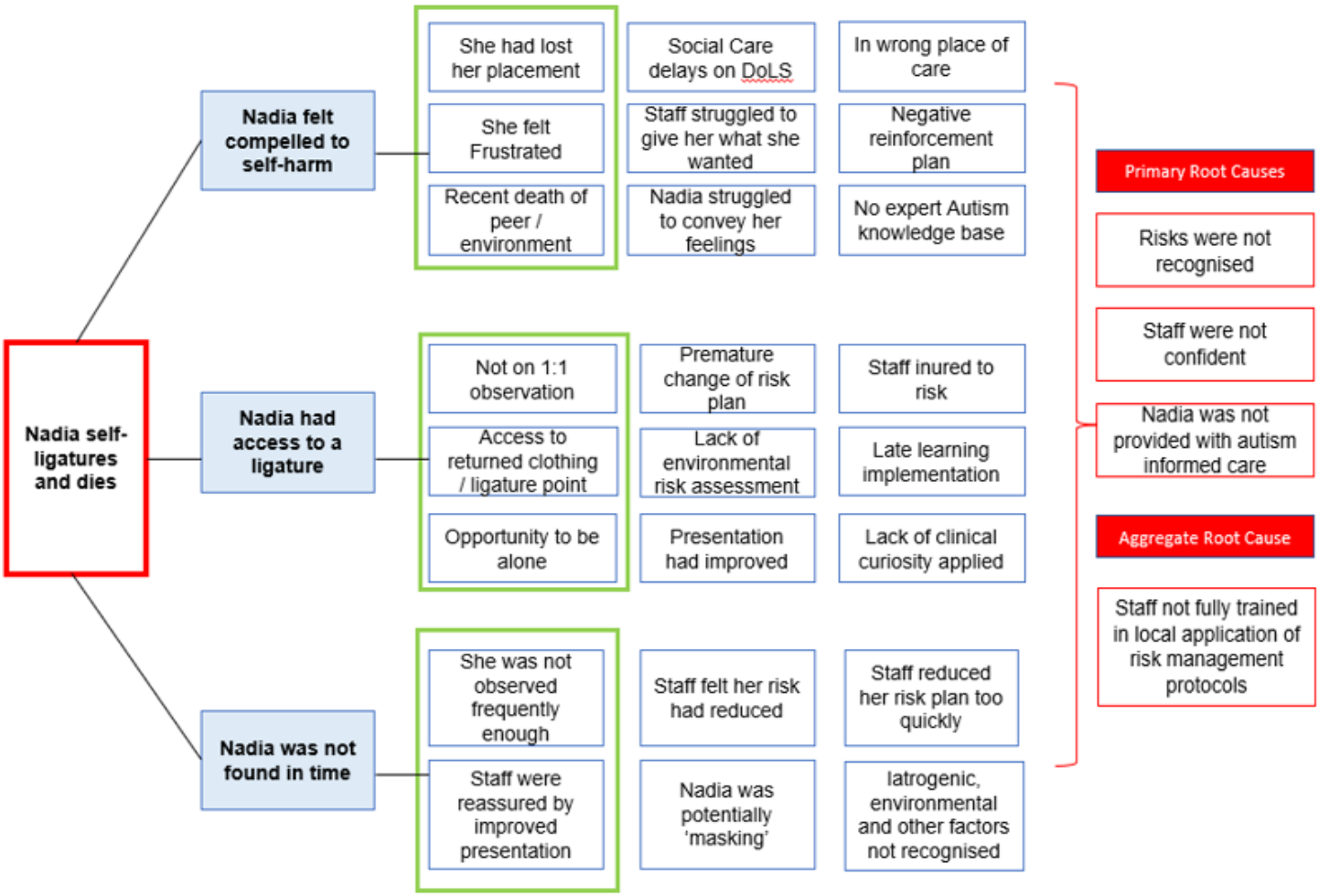
3.12 This was all set within weak internal and external systems of safeguarding governance, as well as systemic pressures due to the lack of appropriate places (both NHS and social care) for young people nationally.

3.13 Part of the terms of reference are to "identify any actions that could have led to a different outcome for Nadia". In our view, there are care and systems issues that had a direct impact on Nadia's death:

- An increase in risk was not recognised, even though there had been a marked increase in the number of her attempts to harm herself.
- Observation levels were unclear, there were decisions made which were not communicated clearly, and there was a 30-minute gap in observation at the time of her death.
- Autism-informed care was not provided.
- Many of the staff were not experienced in CAMHS.
- Staff were not fully trained in the local application of risk management protocols.

3.14 The following diagram provides an overview of the event, as well as the key reasons why the event occurred. The index incident is described in the left-hand box and the diagram flows to the right, expanding reasons at each interval. The root causes are described within the right-hand boxes

Why's diagram



Recommendations

3.15 We recognise that care in West Lane Hospital is no longer provided by TEWV. However, there is still learning for agencies involved in the care and treatment of young people in Tier 4 mental health services, and also for TEWV in other service areas. We have made 12 recommendations to address the issues identified in this investigation. This report also makes recommendations about the governance issues identified where we believe they directly impacted upon Nadia's care.

Recommendation 1: TEWV must ensure that plans of care for young people in Child and Adolescent Mental Health Services (CAMHS) incorporate evidence-based practice.

Recommendation 2: TEWV must ensure that risk assessments for young people in CAMHS are based on a psychological formulation and are

developed by a multidisciplinary team in conjunction with the young person and their family.

Recommendation 3: TEWV must provide assurance that race and ethnicity, gender and religious issues are routinely addressed in Care Programme Approach (CPA) needs assessment and care planning as per the Trust's policy.

Recommendation 4: Middlesbrough Council and Health providers/key partners must ensure that there is clarity about the roles and responsibilities of each agency in the planning and delivery of care to young people in Tier 4 CAMHS provision to ensure that support is holistic and meets the educational; social; physical health and emotional needs of children and young people as well as their mental health needs.

Recommendation 5: Middlesbrough Council must respond formally to serious concerns raised about the care and treatment of a young person under their care and explore concerns with the family and the young person.

Recommendation 6: TEWV must provide assurance that there are protocols in place for safeguarding and Local Authority Designated Officer (LADO) referrals, and that these are understood and followed by all staff caring for young people.

Recommendation 7: Where a young person is in receipt of T4 care and transferring back to T3, there must be a joint response between health and Middlesbrough Council children's services so that the young person is prepared for life in the community and can be properly supported and their risks appropriately managed.

Recommendation 8: TEWV must provide assurance that clinical records are kept to expected standards.

Recommendation 9: TEWV/NHS England and Middlesbrough Council must provide assurance that all looked after children with a diagnosis of autism have care provided that is in line with the NICE guidance on Autism spectrum disorder in under 19s: support and management, recognising the challenges in the system.

Recommendation 10: NHS England and provider collaboratives must provide effective quality oversight of inpatient environments for young people with autism, with auditable standards.

Recommendation 11: TEWV Serious Incident processes must meet the expectations of the Serious Incident Framework and Duty of Candour.

Recommendation 12: South Tees Safeguarding Children's Partnership must seek assurance that the needs of young people in inpatient mental health care in the locality are appropriately safeguarded.

3.16 There were five issues that arose from our findings which are not applicable to TEWV, because the Trust no longer provides Tier 4 CAMHS services. These are summarised below as lessons learned, for the attention of NHS England.

The management of restrictive interventions must be part of an agreed philosophy and approach, with clear protocols embedded to guide practice.

Decisions about observation levels are clearly recorded and that all interventions are clearly documented.

Practice guidance should be developed for the management of ligatures in inpatient environments.

Trusts must provide quality oversight of seclusion policy and process, showing how national standards are met and maintained.

Trusts must provide guidance for the management of social media access in inpatient environments.

Good practice

3.17 Planning for future care had started six months before Nadia's 18th birthday.

3.18 To reduce the risk of secreting medication, Nadia's medication was changed to orodispersible and liquid format. Intensive follow-up and support to staff from Child and Adolescent Mental Health Services (CAMHS) and the Eating Disorder team were arranged for discharge in April 2019.

3.19 Discharge occurred after a period of three months' stability and allowed time for transition and for Nadia to get to know the Thornbury Community Services team before she moved to the placement in December 2018.

Appendix A – Terms of reference

1. The following terms of reference for a system-wide independent investigation into concerns and issues raised relating to the safety and quality of Child and Adolescent Mental Health Services (CAMHS) provision at West Lane Hospital operated by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) have been produced by NHS England and NHS Improvement with input and agreement of South Tees Safeguarding Children Partnership.

2. The terms of reference have been developed in collaboration with the investigative supplier, key stakeholders, affected families and with an established staff group and family forum.

Purpose of the investigation/commission

3. To commission an overarching independent investigation with recognised subject matter expertise to scrutinise and assess areas of concern identified and raised by NHS England Specialised Commissioning as the commissioner of CAMHS services and the Care Quality Commission (CQC) as part of their inspection regime.

4. This system-wide investigation will also include two parallel serious incident investigations into the inpatient deaths of two young service users and will incorporate elements of a Serious Case Review for one identified incident. Additional lines of enquiry in response to family questions are included with points from South Tees Safeguarding Children Partnership included.

Involvement of the affected family members/patients and staff groups

5. It is expected that affected family members, appropriate patients and staff are fully informed of the investigation and the investigative process and understand how they can contribute to the process.

Investigation

6. Determine a comprehensive chronology, within an agreed timeframe, of the sequence of events which led to the escalation of concerns by NHS England and NHS Improvement, the Trust and the regulatory actions taken by the CQC.

7. In parallel, undertake a critical review and analysis of the care and treatment of identified individuals, identifying but not limited to; any gaps, deficiencies or omissions in the service and individual care and treatment.

8. Include input from affected families for further scrutiny of care and determine whether the statutory Duty of Candour was appropriately applied.

9. Taking into account the key lines of enquiry detailed, review the appropriateness of the treatment of Nadia in the light of identified health needs,

identifying both areas of good practice and areas of concern with reference to supporting expert evidence.

10. Consider the organisational response to the serious incidents which resulted in the death of Nadia, recognising that no substantive internal investigation was conducted on the basis of an ongoing criminal investigation, and the agreement with stakeholders that an independent investigation would be commissioned.

11. Determine any further lines of enquiry from an investigative perspective.

12. Establish whether the risk assessment and risk management of Nadia was sufficient in relation to their needs including assessing the risk of self-harm or taking their own life.

13. Examine the effectiveness of the patient's care plan to determine:
    - the level of involvement of the patient and their family;
    - how the Trust listened and acted on any concerns raised by the family;
    - how Trust clinicians communicated with the family; and
    - what multi-agency structures are in place to support the ongoing needs of young people upon discharge into the community.

14. Identify any areas of best practice, opportunities for learning and areas where improvements to services are required, including quality assurance processes and pathways in and out of the unit.

15. Review and assess compliance with local, multi-agency policies and national guidance, specifically, Trust-wide clinical observation, ligature and risk assessment policies, identifying areas of good practice and any areas of concern.

16. Establish what lessons are to be learned from the Trust's response to the incidents, taking into account the early learning themes, regarding the way in which professionals work individually and together.

17. Identify clearly what those lessons are, how and within what timescales they should be acted on, and what is expected to change as a result.

18. Apply these lessons to required service responses including changes to policies and procedures as appropriate.

19. Based on overall investigative findings, constructively review any gaps in professional working and identify opportunities for improvement.

20. Identify any issues in relation to, culture, leadership, capacity or resources that impacted on the Trust's ability to provide safe services, identify any actions that could have led to a different outcome for Nadia.

21. Determine how effectively the transitions between services, care settings, care providers and localities were managed. This should include but not be limited to:
    - How were these transitions coordinated and communicated across providers and localities?
    - How were these arrangements recorded, reviewed, and evaluated?
22. How effective were Looked After Child Reviews processes, including Health Assessments, in identifying and understanding holistic assessment of needs?
23. How well did Trust staff understand the specific needs of a Looked After Child in their care and how well did non-Trust staff understand the specific needs of Nadia while she was detained under the Mental Health Act?
24. Were Deprivation of Liberty Safeguards considered during the periods that Nadia was not detained under the Mental Health Act, and should they have been?
25. Did the clinical assessments and behavioural monitoring processes adequately assess risk, and was escalating risk effectively identified and acted upon?
26. How were the challenges of inter-organisational communication and sharing of confidential information managed after Nadia's admission to acute services?
27. What areas of good practice have been identified?

    <u>The following additional lines of enquiry should be considered alongside corresponding family questions and review of the overall effectiveness of care delivered to [Nadia].</u>

28. Consider and comment on the rationale for discharge decisions and the appropriateness of discharge arrangements.
29. Consider whether parental perspectives regarding mental health state informed clinical decision making including whether a Psychiatric Intensive Care Unit (PICU) placement would have been appropriate.
30. Consider the lines of communication with families and clinicians and the application of Duty of Candour principles (including how staff deal compassionately and sensitively with families) and informing families of the occurrence of further incidents involving their child.
31. Consider the quality of clinical record keeping, care planning and associated risk assessment documentation.
32. Determine whether environmental risk assessments were undertaken in respect of ligature point reduction.

Appendix B – Glossary of Acronyms

ASD	autism spectrum disorder
BPD	borderline personality disorder
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CCQI	College Centre for Quality Improvement
CDOP	Child Death Overview Panel
CPA	Care Programme Approach
CQC	Care Quality Commission
DVLA	Driver and Vehicle Licensing Agency
ICU	Intensive Care Unit
JCUH	James Cook University Hospital
LADO	Local Authority Designated Officer
MHA	Mental Health Act
NEAS	North East Ambulance Service
NICE	the National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
OT	occupational therapy
PBS	Positive Behaviour Support
PICU	Psychiatric Intensive Care Unit
SIF	Serious Incident Framework
TCS	Thornbury Community Services
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
ToR	terms of reference

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TEWV response to NHS England independent investigation – Christie Harnett

Tees, Esk and Wear Valleys NHS Foundation Trust response to the recommendations that arose from the Niche Health and Social Care Consulting independent investigation (CH)

The following assurance statements have been produced as a response to the Niche independent investigation into the care and treatment of (CH) in Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and Cumbria, Northumberland, Tyne, and Wear NHS Foundation Trust (CNTW)

The independent investigation made a total of 22 recommendations.

This section addresses recommendations 1, 2, 6, 7, 8, 13, 17, 18, 20, and 21, in order as made by the report.

Recommendation number 5, 11, 14, 15, 16, 19, 22, and relate to other organisations and are therefore not included in these assurance statements.

Recommendation 3, 4, and 12 was made jointly with TEWV, and CNTW. This statement provides only the TEWV response.

Recommendation 9 and 10 is a joint recommendation for the Local Authority and Health Providers. This statement provides only the TEWV response.

Introduction

We would like to apologise unreservedly for the unacceptable failings in the care of Christie which the report clearly identifies.

We accept in full the recommendations made in the report – all the improvements required are being made where applicable to our services.

TEWV has not delivered CAMHS inpatient services since September 2019. CNTW provides these inpatient services to children and young people from the West Lane Hospital site - this arrangement was formally put in place NHS England in September 2020 and opened to admissions in April 2021.

Following a governance review in March 2021, and a comprehensive public engagement exercise that followed, a new TEWV organisational and governance structure was put in place from 1 April 2022 with simplified governance processes and strengthened reporting from teams through two new care groups directly to the Trust's Board, embedding increased line of sight and oversight from ward to Board.

As part of this, we have recruited two lived experience directors into our leadership team to make sure the patient voice is heard at the very highest level in the organisation.

Importantly, all the necessary changes are being made to the services we deliver, with the knowledge and oversight of the CQC and NHS England and reviewed by them monthly at an external Quality Assurance Board, chaired by NHS England.

In the three years since these tragedies, we've made significant improvements – how we assess the risks to our patients, how we organise and staff our services, and how we more closely involve the families and loved ones themselves.

These improvements are being delivered through our five-year change programme "Our Journey to Change", which sets out why we do what we do, driven by three big goals to create a great experience for our patients, carers and their families, for our staff, and for our partners.

This includes an unrelenting focus on patient safety, with clear priorities set out in our patient safety strategy – this is our absolute priority.

This is supported by a quality assurance programme, and our quantitative and qualitative data shows that we have made considerable progress, and these are continually measured, evaluated, and reported upon.

We have completely overhauled the community services we provide to young people in Child and Adolescent Mental Health Services (CAMHS) to provide safe and kind care, today and every day.

Improvements we have made in CAMHS have been acknowledged by the CQC in a recent inspection, where services had improved – they said our senior management team had responded promptly to address issues identified at the previous inspection - we recognise there is still work to do, however we are moving in the right direction.

We are working hard to put patients and carers at the centre of everything we do – treating everyone with respect and compassion and taking responsibility for our actions.

These assurance statements outline the improvements we have made in response to the report recommendations.

Overarching context

To provide additional and important context, the following information provides details about service developments that have been underway within TEWV CAMHS over the last few years. This demonstrates that specific recommendations have been considered and acted upon and provides additional assurance regarding the fundamental changes to our services that are underway.

Service development work has been undertaken in CAMHS to improve care for young people and their families and carers. This began with a detailed analysis of the data based on different levels of need. This included the development of principles of care for people with the most complex presentations which include specific guidance for multi-agency and multi-disciplinary working.

During 2021-22 a significant programme of work got underway to develop evidence-based pathways of care using what's known as the iTHRIVE system framework, which is

recognised nationally as a way of promoting good practice. These pathways follow evidence-based National Institute for Clinical Excellence (NICE) guidance and have been developed by staff using the available evidence base and clinical expertise. Pathways include guidance on assessment, formulation, re-formulation, treatment approaches and care planning, with shared decision making considered with children, young people and their families and carers. All pathways include guidance for any adjustments which may need to be made for autistic people.

These new clinical pathways are due to be launched in November 2022 with a clear plan for evaluation, review and continual improvement.

Recommendation 1

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) must provide significant assurance to the Trust Board and its commissioners that it has a robust environmental and ligature risk assessment process and the ability to respond effectively and urgently to mitigate risks identified through this process.

TEWV response:

The Trust has undertaken a comprehensive ligature reduction programme across its inpatient services since 2019, and this programme continues to date in both a planned way and in response to emerging risks or themes from incidents and national alerts. We have invested over £5m in this programme since 2019, with a further £2.8m due for completion by March 2023.

In January 2020, a Trust-wide environmental risk group, was established with executive level oversight to agree service standards, oversee the estates works delivery programme and report on progress.

The role of the group is to assist the Trust in its management of patient safety through the oversight and management of environmental risks. The group has specifically strengthened systems and processes for identifying and reporting environmental risks and deficiencies, including emerging risks identified from themes, and trends from incidents. A report from the group outlining work completed as well as planned work went to the Trust's Quality and Assurance Committee (a Board sub-committee) in May 2022, providing assurance on the work undertaken to date. We have also invested in assistive technology called Oxevision, which has been installed in a number of wards. This system supports clinical teams and enhances patient safety by using contact free, vision-based monitoring technology to monitor a patient's vital signs and high-risk activity. This offers safe and unobtrusive care, which is respectful of people's privacy, and we are developing and evaluating our services to ensure we embrace the benefits of this assistive technology.

The group meet monthly to review the work programme, and a monthly ligature incident data from the Datix system is reported, including anchored ligatures identified of greatest risk. The group membership includes representatives from the Trust's estates and facilities department, infection, prevention and control team (IPC), compliance team, as well as clinicians and managers representing our care groups. Advice and agreement are sought

from the service development groups on replacements and standards across specialties as required.

Following the publication of a national alert to review all policies in relation to low level ligature risks, the Trust's Suicide Prevention Environmental Survey and Risk Assess Procedure (our ligature risk assessment process), was reviewed and updated in October 2020. This procedure strengthens our ability to respond effectively and urgently mitigate identified risks. The survey is conducted annually to identify any Trust fixtures and fittings, materials and equipment which may pose a risk of self-harm. The procedure covers the Trust's formal approach to ligature reduction and has minimum standards in place to reduce harm within inpatient settings. Timeliness of completion of surveys and actions taken are monitored through the environmental risk group alongside incident data to ensure risks are effectively mitigated in a timely way.

In line with The Samaritan's media guidelines for reporting on suicide, the Trust will not publish any further information on the specific nature of this work.

Recommendations 2, 4 and 7 -have been combined - responses are outlined below and should be considered together.

Recommendation 2

TEWV must ensure that risk assessments for young people in child and adolescent mental health services (CAMHS) are based on a psychological formulation and a full understanding of the longitudinal patterns and instances of harm, and where possible are developed by a multidisciplinary team (MDT) in conjunction with the young person and their family.

TEWV response:

The Trust has developed new safety summary and safety plan documents. These support a psychological formulation approach to risk assessment with children, young people, their families and carers. The documents require a consideration of a young person's history regarding what has happened to them, and any patterns to help understand when they have been better or become more unwell. The risk assessment and management plans need to be developed alongside a thorough understanding of the young person within their context. Risks of harm to self and others are considered including where there are younger siblings present in the family. This forms an integral aspect of care planning building on the assessment, formulation and shared decision-making process described above and includes consideration of risk to others. Safeguarding policies are followed where required.

These were introduced into CAMHS in April 2021. Our Quality Assurance Programme currently shows that 96.8% of children in treatment have a safety summary and safety plan in place across the Trust. We continue to work with clinicians to enhance the quality and have established processes to support this via caseload supervision, clinical supervision and daily discussions (huddles). We have assurance processes including fundamental standards and peer reviews to ensure clinicians have a variety of sources of support.

Recommendation 4

TEWV and CNTW must ensure that plans of care for young people in CAMHS incorporate evidence-based practice.

Recommendation 7

TEWV must ensure that care plans are written so that they are clear, patient-centred, easy to understand and follow, and guide staff to care for the young person based on the assessment of all needs and risks.

TEWV response 4 & 7 combined:

Alongside the developments described above, the work around care planning continues to be a priority and is overseen by the Quality and Safety Programme Board as well as the Clinical Strategy Board.

Significant work has been undertaken over the past 18 months to make sure care plans are developed with a young person and their family or carer, and that these are trauma-informed, recovery-focused, autism aware and meaningful for the children and young people themselves. The Trust is working hard to progress this as quickly as possible, with the programme of work subject to ongoing review and evaluation.

To make sure care plans developed for young people in CAMHS include evidence-based practice, we use what is known as a 5P formulation structure, to organise assessment information when children and young people come into the service. The 5Ps are: current Presentation, Pre-existing, triggers for current issue (Precipitating), any maintaining (Perpetuating) factors, and the Positives to understand what is going well. The 5P formulation structure is a standard format utilised in mental health services nationwide approved by the British Psychological Society.

We have found that this is a useful way of organising information and for children, young people and their families and carers, to develop a shared understanding and language with the clinical staff, to make sure it was patient-centred and easy to follow, and that the care plans are completed together in way which the young person and their parent / carer also understands.

Using this method to assess people, means decisions about an individual's care is made with them and their family or carers. We have often received feedback from people who use our services that they don't like having to repeat their stories. Developing a shared 5P formulation also helps with consistency for sharing relevant information and avoid having to do this.

In addition to the above, a quality improvement event was held in March 2022 to focus on the clinical model of care planning across the Trust. The event was well attended by people we support in our services, carers, professionals from across the Trust's geographical area

Consensus from the event was that care planning must be owned by the patient and contributed to by the care network involved in a person's care.

Outcomes from the event included additional training sessions which took place in April and May 2022 to make sure staff have the appropriate skills to co-create meaningful, goal-orientated care plans. Awareness sessions were arranged for people we support in our services, carers, and our partners to facilitate a shared understanding of the changes. The event also looked at which parts of the care plan review could be stopped to reduce duplication and free up staff time to care.

The introduction of the Trust's new electronic patient record system will also enhance the care planning process.

Recommendation 3

TEWV and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) must ensure that any young person with a recent history of self-ligature has a written care plan that identifies how staff (or families in the case of a community setting) are to care for the young person and mitigate the risks of fatal self-ligature.

TEWV response:

As the Trust no longer provides inpatient services for children and young people, our response is focused on community services. In the community, staff would not be caring for young people directly. Therefore, it is standard practice for community CAMHS to make sure parents / carers are advised how to provide close supervision for young people who are at risk of self-harm, including self-ligature, to maximise safety. This is routinely recorded in the risk assessment documents (safety summary and safety plan). Daily supervision and consultation are available for staff where required.

Recommendation 6

TEWV must ensure that decisions about observation levels are clearly recorded and that all interventions are clearly documented.

TEWV response:

To strengthen the recording of mental health observations, the Trust's policy around supportive observation and engagement was reviewed in December 2020. A new competency-based assessment was introduced for all clinical staff prior to the policy going live, to make sure staff understood it and what was required of them.

In January 2021, the Trust held a five-day quality improvement event to make sure robust systems were in place to assess and mitigate patient risk, including the management of observations and observation levels. The aim was to develop a simplified and streamlined framework to enable effective assessment, risk assessment, care planning and care delivery.

The outcome was a ‘plan on a page’ framework, which simplified the electronic patient record in the form of the safety summary and safety plan, leave plan, observation plan and care plan.

Staff took part in training sessions to recognise and understand:

- areas of harm and the need to take immediate action,
- working collaboratively with the multi-disciplinary team (MDT) and the patient when determining observation levels,
- how to review static and dynamic risk factors that may affect potential harms,
- the importance of maintaining simultaneous records, and;
- clarity of roles and responsibilities in relation to observation levels

Clinical risk assessment and management guidance was provided to clinical staff to support their practice in line with the Trust’s revised Harm Minimisation policy (clinical risk assessment and management). MDT huddles were introduced in inpatient areas and outcomes are now recorded in clinical records. This includes discussion on observation levels. Following this, a quality assurance (QA) programme was introduced and includes the following:

- **Assurance self-declaration:** a fortnightly assurance tool reviewing all patients on inpatient wards. The tool monitors compliance with completion and updating of safety summaries, safety plans, incident reporting, leave and observation plans as well as associated documentation. The tool was updated on 23 October 2021 to provide a more focused and detailed review of the quality of patient records and clinical record keeping.
- **Modern matron quality review:** a monthly review of quality indicators and information in inpatient areas. It includes 33 standards relating to safety summaries, safety plans, patient carer involvement, leave plans, and observations plans. Each ward or team have developed continuous improvement plans based on intelligence gathering from reviews and case note reviews.
- **Practice development review:** a monthly assurance tool led by the practice development team. The practice development practitioners (PDPs) observe MDT discussions in relation to risk, leave, level of observations, mental state, medication compliance and effectiveness of medication regime and whether everyone in the MDT is felt to have a voice. PDPs now work with staff across both inpatient and community services focusing on completing robust risk assessments and ensuring the quality of mental state examinations and record keeping, including observation levels.

The quality assurance programme has provided evidence that observation and engagement plans, for both day and night, were present in 99% of cases. It also showed that patient observation levels documented in the clinical records matched the paper sheets and visual control board. There was 100% compliance with allocation sheets being fully completed, specifying the named member of staff responsible for carrying out observation and engagement for each specified time-period.

Recommendation 8

TEWV must ensure that trauma-informed therapy is a routine aspect of a young person's care provision where there are any considerations of previous trauma, not just diagnosed post-traumatic stress disorder (PTSD), and that there are sufficient staff with the requisite skills to provide this.

TEWV response:

To address this recommendation, we have approached this in two parts; trauma informed approaches to care and trauma focused therapeutic approaches.

Trauma Informed Approaches

CAMHS adopts trauma informed approaches (TIA) across our services, where we guide staff to consider what may have happened, or be happening, in someone's life to understand why they are presenting in distress. As part of Trust-wide developments, there has been a CAMHS training programme on trauma informed care (TIC) for all staff, including clinical, managerial and administrative colleagues. Training was developed using the evidence base.

The trauma awareness training is offered to all staff including clinical, managers, administration and reception staff. The training is a continuous rolling programme that new and existing staff can access, with refresher training offered three times a year. Requests for bespoke training for individual teams can be accessed as and when needed, by contacting the trauma informed care lead for CAMHS.

The start of a young person's journey with the Trust is designed to be trauma informed. Clinicians will ask the appropriate person about adverse childhood experiences and trauma to take this into consideration with regards to signposting and further assessment.

Trauma-focused Therapeutic Interventions

When a young person has identified considerable adverse childhood experiences and trauma-related symptoms, they can access the complex developmental trauma pathway, post-traumatic stress disorder (PTSD) pathway, co-occurring difficulties, or Disorders of Severe Impact.

Each of the CAMHS pathways have been designed to be autism and trauma aware. This includes formulating and re-formulating points at which possible alternative underlying causes such as trauma are considered, especially if progress is not being made as would be expected. This includes trauma, which is fully or partially disclosed, or that which may be present but undisclosed. The pathways also take into consideration the young person and their family's needs, and how the impact of trauma may affect their ability to access support as well as previous solutions they may have adopted to feel safe in past dangerous environments.

We have developed a trauma stabilisation pack with material from the trauma informed care programme and guidance for staff who are not trained in trauma-focused treatments to enable them to safely work with children and young people. This pack is accessed when someone is identified as experiencing post-trauma symptoms and helps them to understand what is happening to them. This is a very useful intervention to help prepare and stabilise

people before they start the trauma-focused (TF) therapy. This is currently being evaluated and informal feedback is positive.

Ensuring that there is provision of trauma-focused psychological therapies is a second area of focus for workforce development. This is a specialist area of therapy and requires staff to be trained at a secondary level. We continue to train and support staff to deliver trauma-focused interventions through provision of expert clinical supervision and continuous professional development (CPD) opportunities. We are also aware of the need to continue to train staff to develop the skills to work with complex trauma presentations, and to provide the supervision and CPD required to sustain skills. We are not yet able to offer the level of provision that we would like and continue to focus on this aspect of workforce development.

As the needs of the young person increase, staff can access specialist services to support their work. Specialist services including Forensic CAMHS, intensive home treatment services, intensive positive behaviour support services and crisis services who use trauma informed approaches and are available throughout the Trust.

Our trauma informed approaches are cocreated with survivors of trauma, working alongside our peer support workers and cocreation leads, as well as the Trust's lived experience directors, including our involvement members who are services users and carers. This has proved invaluable in improving and developing these approaches.

Recommendation 9

Health and social care agencies must provide appropriate challenge where there are concerns about unsafe discharge arrangements from Tier 4 inpatient care, including appropriate escalation up to chief officers where concerns for children's safety are high.

TEWV response:

As providers of community care for children and young people we would work with our partners and the young person to ensure there is a safe discharge. Where known to the Trust, our community clinicians would remain involved with a young person throughout their inpatient stay in another hospital and attend discharge planning meetings. We are therefore aware of the importance of multi-agency and multi-disciplinary working, and to appropriately and robustly challenge where our staff are concerned about patient safety.

Where a professional agreement could not be reached and the Trust had concerns about unsafe discharge arrangements, then we would escalate this through our operational and safeguarding processes. We fully endorse this approach and can provide recent examples where this has been actioned.

Recommendation 10

Local Authorities and Health providers must ensure that there is clarity about the roles and responsibilities of each agency in the planning and delivery of care to

young people in Tier 4 CAMHS provision where they are in the care of the Local Authority to ensure that support is holistic and meets the educational; social; physical health and emotional needs of children and young people as well as their mental health needs.

** We have provided some detail on actions we are taking to address these important issues, working alongside colleagues in the local authorities and health care providers.*

TEWV response:

The Trust and all the local authorities across our geographical area have signed up to implementing iTHRIVE (detailed in the overarching context section), meaning that progress is being made with all our partners, and describes a whole-system approach. This is an important and positive change to our approaches to joint working with targeted support.

We are also working closely with our partner agencies to improve how we work together to support children, young people and their families. In Durham, we have been developing multi-agency decision making following a whole-system pathway development. This work has been led by the Trust over the past three years. Family hubs are also being developed in Consett, County Durham, Billingham, Stockton-on-Tees and in North Yorkshire and York. Included in the whole-system approach, we have also been developing an integrated multi-agency approach for high risk, vulnerable young people with joint accountability. Using this approach, risk assessment and management plans, safety plans are cocreated- between agencies and young people, their families and carers. Support comes from all sectors including family, social, activity, education and employment to enable the children and young people to settle back into their life in the community. Intensive home treatment (IHT) teams provide planned support which is tailored and bespoke for each individual, and this support is available in the Durham and Tees areas. There are also dedicated 24/7 CAMHS crisis teams across the Trust. The IHT and crisis teams work together with the multi-agency network, including CAMHS, to support children and young people when they leave inpatient accommodation.

TEWV have an active working group for 16-25's, which led by an Associate Director of Therapies supported by a project manager. The working group oversees the transition process for CAMHS, AMHS and learning disability services. Transition panels are in place for each AMHS team. Active planning for the transition starts at six months prior to the young person's 18th birthday, with a discussion with the young person and their parent / carers which is recorded in the transition plan on electronic care records. Monthly reports are provided by team managers which are overseen by modern matrons, to check this happens. The last transition audit was completed in April 2020. An audit of transition planning formulations for complex presentations is planned for the next audit cycle.

For young people who are more vulnerable, we start to make links with adult mental health when a young person is 17 years and a quarter, with transition plans in place at 17 years and six months. We know that this transition time can be particularly difficult, especially for people in the care of the local authority, so we make sure that this is proactively done through preparation and follow-up actions. Multi-agency working across the transition time can be complicated, and it is recognised that young people often require additional support

because of this. Our policies and procedures are based on previous CQUIN standards set by NHS England.

Recommendation 12

TEWV and CNTW must ensure the organisational approach to safeguarding young people proactively involves and informs the relevant local Safeguarding Children's Partnership of all instances where a young person is placed at risk, including the use of unregulated and unsupported accommodation in the community.

As providers of community care for children and young people we would work with our partners and the young person to ensure there is a safe discharge. Where known to the Trust, our community clinicians would remain involved with a young person throughout their inpatient stay in another hospital and attend discharge planning meetings. Our responsibility is to work with local authority colleagues who are responsible for the safe transfer of individuals to appropriate accommodation. Where this cannot be met for any reason, the Trust will provide challenge and would escalate this through our operational and safeguarding processes.

Health and social care agencies must provide appropriate challenge where there are concerns about unsafe discharge arrangements from Tier 4 inpatient care, including appropriate escalation up to chief officers where concerns for children's safety are high.

We fully endorse this approach and can provide recent examples where this has been actioned.

Recommendation 13

TEWV must ensure that services consider and document robust risk management processes to safeguard children where threats have been made to harm them by older family members who are also service users.

TEWV response:

The thorough risk assessment and management processes which consider harm to self and others, within the context of the persons family life, includes consideration of risk to younger siblings. Swift action is taken to address any threats to harm a child by others, which would be reported and referred to the appropriate local authority. Consultation with Forensic CAMHS is available for additional support and guidance. These processes are supported by the safeguarding lead within each CAMHS team.

Recommendation 17

TEWV should ensure there is much greater detail and understanding of the patterns and instances of harm within services through the regular reporting and interrogation of data, when required, to inform both individual patient clinical care planning, and Trust and service understanding of safety and quality issues.

TEWV response:

The Trust recognises the importance of using clinical incident data to inform patient care and to improve quality and safety. From the learning that has been gained, a series of training sessions have been provided to operational staff around how they can better use the Trust's integrated information centre (IIC), which provides a range of information and reports on the quality and safety of care. This training covers how to use IIC effectively to understand the patterns and instances of harm at an individual and service level, and this analysis helps staff to identify any themes and trends. This information is used to inform individual plans of care, as well as enabling us to take improvement actions across services.

To make sure that there is greater ownership and oversight of individual patient safety incidents by each service, the Trust is placing the responsibility of incident management back to operational services. This will ensure that they are able to get greater detail and understanding of the patterns and incidence of harm in their clinical teams and use them for learning and safety purposes. Over 90% of our wards are actively using this, and we are continuing to support the embedding of this practice.

Whilst the Trust is in a period of transition from a centralised process to one of ownership and oversight by operational services, the central approval team continues to monitor repeated attempts of harm within our services.

A daily patient safety huddle takes place to review any new incidents where safety and quality may have impacted on patient care. Clinical services are requested to attend in order that a deeper understanding of the circumstances and any immediate learning can be actioned. There are a range of ways in which we use our information to identify patterns of harm and inform learning across our services. Information on incidents and complaints are shared at a weekly care group patient safety meeting, to identify any areas of immediate concern and enable timely actions to be taken. Through our governance systems we have a range of reports that measure key aspects of patient care, for example restrictive intervention, patient experience and patient safety incidents. Since 2019, we have introduced the use of statistical charts, and through these, we are able to better identify any areas of concern.

Recommendations 18 & 21 -have been combined - responses are outlined below and should be considered together.

Recommendation 18 & 21

Recommendation 18 - TEWV must redesign its response to incidents and patient safety to provide robust clinical governance, so that it conforms with the NHS England Serious Incident framework (SiF), its successor policies and other relevant

guidance and best practice, so that it is assured that all relevant incidents are investigated thoroughly, and organisational learning can be quickly put in place.

Recommendation 21 - TEWV should review the Duty of Candour Policy and ensure that it is monitored through the relevant Board subcommittee processes. As part of this it must ensure that where there has been a death in a service, whether through self-harm/suicide or homicide, that families are given appropriate and regular family liaison and support through personal contact with a nominated officer of the Trust.

TEWV response:

The Trust's Serious Incident Framework (SIF) have been updated, and significant improvement work has been undertaken to strengthen its serious incident processes since 2019. This has included quality improvement and a 'deep dive' event involving feedback from service users, families and carers. Following the Trust's final serious incident review panel, learning is distributed Trust-wide via a learning bulletin. If there are any urgent patient safety issues arising as part of the rapid review process, and to make sure there is swift action and early learning, these will be disseminated via a Trust-wide patient safety briefing. All staff can access these briefings via the patient safety learning library on the staff intranet. Any assurance obtained from associated actions is stored in the learning database.

We have undertaken an in-depth review of key themes from incidents dating back several years. This has enabled us to make measurable improvements and identify areas where further work is needed to embed learning. We are using our quality assurance schedule to inform this, to help develop and transform our organisational response to incidents, and the Trust is working towards the implementation of the new national patient safety incident response framework (PSIRF) by September 2023.

To build on this work, the Director of Quality Governance commissioned a quality improvement event called 'Improving the experience of patients, families, and staff during serious incident reviews (SIRs)'. The event took place in July 2021, and the aim was to share with internal and external stakeholders the work that had been undertaken in the patient safety team in collaboration with families, patients and operational services, to:

- Improve the quality and safety of the care we provide.
- Improve the experience of patients and families throughout the serious incident review process.
- Improve the efficacy of our patient safety incident investigations by moving towards a systems-based approach identifying interconnected causal factors and systems.
- Address causal factors to prevent or minimise repeat patient safety risks and incidents.
- Measure the impact of actions taken to reduce repeat patient safety risks and incidents.
- To increase stakeholders (notably patients, families, carers, and staff) confidence in the improvement of patient safety through demonstrating the impact of learning from incidents.

A project manager was appointed to drive the continued delivery of this improvement work.

A further event was held in February 2022 with the NHS England support team and the patient safety team, where four additional work streams relating to the serious incident process and incident reporting were identified, including:

- The incident report process.
- Triaging patient safety incidents.
- Revisiting the duty of candour.
- The Trust's final assurance panel for signing off serious incident reports.

On 20 May 2022, following completion of these workstreams with the relevant stakeholders, and in line with our improvement plan in Our Journey to Change, a further event called 'Co-creating for Patient Safety' took place. The event was attended by 70 people including bereaved families, carers, clinical services, members of the executive management team and commissioners. It focused on sharing details of the improvement work and facilitated full engagement with all relevant stakeholders.

The Incident Reporting and Serious Incident Review policy is being reviewed and updated to incorporate all outcomes of the improvement work.

All our current serious incident reviewers have received specialised training in serious incident investigation via the PSIRF approved trainers or the healthcare safety investigation branch (HSIB).

We have modified our rapid review response template, which is used for incidents categorised as near miss, moderate and above, to incorporate a section on duty of candour. This places the initial responsibility on clinical services to contact the patient or relevant other to apologise for the harm caused and to share information known at the time.

We recognise that staff in clinical services would benefit from some training in holding difficult conversations as well as the duty of candour, which has been captured in the Trust's training needs analysis. The policy will be reviewed and revised to incorporate service improvements.

In addition, we will be commencing a review of our duty of candour processes in January 2023.

Recommendation 20

TEWV should ensure that it improves its response to complaints, so that complaints are managed in line with NHS England best practice guidance – tracking and reporting this through the relevant Board subcommittee processes.

TEWV response:

The Trust is working to improve its complaints process in line with NHS England best practice and guidance.

This includes introducing a more empathic approach into daily practice and improve culture and better outcomes for our patients, carers and their families. An ongoing programme of externally delivered empathy training in dealing with complaints and incidents has been undertaken since 2019. The Trust's patient advice and liaison services (PALS) have also attended this training and have made changes in line with this.

A monthly report tracking complaint response times is reported through to the Trust's Board Quality and Assurance Committee, Executive Quality Improvement Sub-Group, as well as the Trust's two care group Quality Improvement Sub-Groups.

The Trust is due to start a full end-to-end review of the PALS and complaints' function in November 2022, which is being led by the Trust's lived experience directors, which is scheduled to complete in January 2023. This will explore a more restorative approach to PALS and complaint resolution. The review will involve services users, families and carers, Trust services as well as partners including those in the voluntary and community sector to cocreate and shape what these services look like in the future.

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TEWV response to NHS England independent investigation – Emily Moore

The following assurance statements have been produced as a response to the Niche independent investigation into the care and treatment of EM by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and Cumbria, Northumberland, Tyne, and Wear NHS Foundation Trust (CNTW), commissioned by NHS England. (EM)

The independent investigation made a total of 13 recommendations.

This section addresses recommendations 1, 2, 3, 10, 12 and 13 in order as made by the report.

Recommendation number 4, 5 ,6, 7, 8, and 9 relate to other organisations and are therefore not included in this assurance statement.

Recommendation 11 is a joint recommendation for TEWV, CNTW, NHS England and Durham County Council. This statement provides only the TEWV response.

Introduction

We would like to apologise unreservedly for the unacceptable failings in the care of Emily which the report clearly identifies.

We accept in full the recommendations made in the report – all the improvements required are being made where applicable to our services.

Following a governance review in March 2021, and the comprehensive public engagement exercise that followed, a new TEWV organisational and governance structure was put in place from 1 April 2022 with simplified governance processes and strengthened reporting from teams through two new care groups directly to the Trust's Board, embedding increased line of sight and oversight from ward to Board.

As part of this, we have recruited two lived experience directors into our leadership team to make sure patient voice is heard at the very highest level in the organisation.

Importantly, all the necessary changes are being made to the services we deliver, with the knowledge and oversight of the CQC and NHS England and reviewed by them monthly at an external Quality Assurance Board, chaired by NHS England.

In the three years since these tragedies, we've made significant improvements – how we assess the risks to our patients, how we organise and staff our services, and how we more closely involve the families and loved ones themselves.

These improvements are being delivered through our five-year change programme "Our Journey to Change", which sets out why we do what we do, driven by three big goals to create a great experience for our patients, carers and their families, for our staff, and for our partners.

This includes an unrelenting focus on patient safety, with clear priorities set out in our patient safety strategy – this is our absolute priority.

This is supported by a quality assurance programme, and our quantitative and qualitative data shows that we have made considerable progress, and these are continually measured, evaluated, and reported upon.

We are working hard to put patients and carers at the centre of everything we do – treating everyone with respect and compassion and taking responsibility for our actions.

These assurance statements outline the improvements we have made in response to the report recommendations.

Recommendation 1

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) must ensure that young people in Child and Adolescent Mental Health Services (CAMHS) have a clear plan of care incorporating evidence-based practice.

TEWV response:

The Trust's work around care planning continues to be a priority and is overseen by the Quality and Safety Programme Board as well as the Clinical Strategy Board.

Considerable work has been undertaken over the past 18 months to make sure care plans are developed with a young person and their family or carer, and that these are trauma-informed, recovery-focused, autism aware and meaningful for the children and young people themselves. The Trust recognises this is a work in progress and is subject to review and evaluation.

To make sure care plans developed for young people in CAMHS include evidence-based practice, we use what is known as a 5P formulation structure, to organise assessment information when children and young people come into the service. The 5Ps are: current Presentation, Pre-existing, triggers for current issue (Precipitating), any maintaining (Perpetuating) factors, and the Positives to understand what is going well. The 5P formulation structure is a standard format utilised in mental health services nationwide approved by the British Psychological Society.

We have found that this is a useful way of organising information and for children, young people and their families and carers, to develop a shared understanding and language with the clinical staff, to make sure it was patient-centred and easy to follow, and that the care plans are completed together in way which the young person and their parent / carer also understands.

Using this method to assess people, means decisions about an individual's care is made with them and their family or carers. We have often received feedback from people who use our services that they don't like having to repeat their stories. Developing a shared 5P formulation also helps with consistency for sharing relevant information and avoid having to do this.

In addition to the above, a quality improvement event was held in March 2022 to focus on the clinical model of care planning across the Trust. The event was well attended by people we support in our services, carers, and professionals from across the Trust's geographical area

Consensus from the event was that care planning must be owned by the patient and contributed to by the care network involved in a person's care.

Outcomes from the event included additional training sessions which took place in April and May 2022, to make sure staff have the appropriate skills to co-create meaningful, goal-orientated care plans. Awareness sessions were arranged for people we support in our services, carers, and our partners to facilitate a shared understanding of the changes. The event also looked at which parts of the care plan review could be stopped to reduce duplication and free up staff time to care.

The introduction of the Trust's new electronic patient record system will also enhance the care planning process.

Recommendation 2

TEWV must ensure that risk assessments for young people in CAMHS are based on a psychological formulation and are developed by a multidisciplinary team in conjunction with the young person and their family.

TEWV response:

In addition to the information provided above, the Trust has developed new safety summary and safety plan documents. These support a psychological formulation approach to risk assessment with children, young people, their families and carers. The documents require a consideration of a young person's history regarding what has happened to them, and any patterns to help understand when they have been better or become more unwell. The risk assessment and management plans need to be developed alongside a thorough understanding of the young person within their context. It is therefore an integral aspect of their care, and building on the assessment, formulation and shared decision-making process described above.

These were introduced into CAMHS in April 2021. Our Quality Assurance Programme currently shows that 96.8% of children in treatment have a safety summary and safety plan in place across the Trust. We continue to work with clinicians to enhance the quality of these documents and have established processes to support this via caseload supervision, clinical supervision and daily discussions (huddles). We have assurance processes including fundamental standards and peer reviews in place to ensure clinicians have a variety of sources of support.

Recommendation 3

TEWV must ensure that the management of restrictive interventions (including contraband items) is part of an agreed philosophy and approach, with clear protocols embedded to guide practice.

TEWV response:

We have made significant progress in the management of restrictive interventions and have a Trust-wide agreed philosophy and approach, enhanced by our supporting behaviours that challenge policy to guide good practice.

We have clear aims to reduce all forms of restrictive practices across inpatient areas and we are delivering this by focusing on a number of areas. These are outlined below.

Training

In April 2021, the Trust updated mandatory training for all staff working in an inpatient setting, to improve our response to behaviours that challenge. Our new competence-based Positive and Safe Care training courses focus on prevention, human rights and trauma-informed care. They are nationally accredited by the Restraint Reduction Network and comply with the Mental Health Units (Use of Force) Act.

In line with the national standards, we have extended the length of training for new staff and all staff are now required to update their training annually. Training is delivered trust-wide. A number of our trainers have experience of mental illness and can share their insights, to show colleagues the impact that restrictive interventions can have on individuals. This puts patient experience at the very heart of the way we deliver care.

We have worked alongside our partners from Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) and University of Cumbria to develop post-graduate training in the field of reducing restrictive intervention. The training has now been completed by 45 multi-professional staff. The aim is to develop leaders in the field of service improvement and reducing restrictive interventions. The 18-month long course is now recognised nationally and the third cohort of 40 students will commence study in September 2023.

Behaviour support plans

Creating good quality and collaboratively developed behaviour support plans for all patients continues to be a key priority within our improvement plan for reducing restrictive practice. We have worked alongside the regional positive behaviour support coalition to make master's level training available for specialist practitioners in this area. In 2021, 26 staff across the Trust achieved their post graduate certificate in Positive Behaviour Support.

In 2021, we changed the way we record and store our behaviour support plan in Paris, our electronic patient recording system. We now have designated care documents that are collaboratively developed and easily available for staff to access which supports the practice to become more embedded.

Pilots

Whilst it is always our priority to prevent incidents from occurring, it is essential that we take all reasonable steps to learn and improve when incidents do happen. To support this process, we are currently piloting the use of body worn cameras across 10 of our inpatient wards to support post incident reviews for staff and patients.

In 2021, NHS England worked in partnership with the Restraint Reduction Network to develop an audit toolkit for the use of restrictive practices and blanket restrictions. We have recently piloted this tool across 14 wards in our secure inpatient services, which has enabled us to identify issues and make improvements. We have developed service improvement plans including new training programmes for frontline staff and the recruitment of additional behavioural specialists to support teams. We are currently reviewing the use of this tool across all inpatient areas, including ways it can be incorporated into our procedures and governance frameworks for reducing the use of restrictive practice.

HOPE(S) model

Since June 2022, the Trust has been working with partner organisations to support people through the introduction of the HOPE(S) model, a human rights-based approach that has enabled us to reduce restrictive interventions, supported by external expertise. This model has now been adopted by NHS England and therefore endorsed as a national approach to reducing restrictive interventions.

Recommendation 10

TEWV must provide assurance that clinical records are kept to expected standards.

TEWV response:

In June 2021, the Trust introduced a new quality assurance programme focusing on the quality of clinical record keeping in relation to key clinical records including care plans, observation records, risk assessment and management plans recognising that high quality documentation is an enabler to good patient care. This is in line with national clinical record keeping policy and professional guidance for record keeping.

These audits are completed monthly and are verified through a peer review process. Results from Jun-21 to Jun-22 activities demonstrate consistent practice standards are being achieved across the organisation in terms of implementation of the minimum standards, in line with the Good Practice Guidance for the safety summary / safety plans, observation and engagement plans, and leave documentation within the patient electronic care record system. The Practice Development Practitioners continue to monitor compliance and to facilitate areas where focussed improvement work is required in collaboration with clinical teams.

In addition, clinical risk assessment and management guidance is provided to clinical staff to support their practice in line with the Trust's revised Harm Minimisation policy (clinical risk assessment and management). Multi-disciplinary team (MDT) huddles were introduced in inpatient areas and outcomes are now recorded in clinical records. The quality assurance (QA) programme that was introduced in June 2021 includes the following:

- **Assurance self-declaration:** a fortnightly assurance tool reviewing all patients on inpatient wards. The tool monitors compliance with completion and updating of safety summaries, safety plans, incident reporting, leave and observation plans as well as associated documentation. The tool was updated on 23 October 2021 to provide a

more focused and detailed review of the quality of patient records and clinical record keeping.

- **Modern matron quality review:** a monthly review of quality indicators and information in inpatient areas. This includes 33 standards relating to safety summaries, safety plans, patient carer involvement, leave plans, and observations plans. Each ward or team have developed continuous improvement plans based on intelligence gathering from reviews and case note reviews.

- **Practice development review:** a monthly assurance tool led by the practice development team. The practice development practitioners (PDPs) observe MDT discussions in relation to risk, leave, level of observations, mental state, medication compliance and effectiveness of medication regime, and whether everyone in the MDT is felt to have a voice. PDPs now work with staff across both inpatient and community services focusing on completing robust risk assessments and ensuring the quality of mental state examinations and record keeping, including observation levels.

The quality assurance programme has provided evidence that observation and engagement plans, for both day and night, were present in 99% of cases. It also showed that patient observation levels documented in the clinical records matched the paper sheets and visual control board. There was 100% compliance with observation recording forms being fully completed, specifying the named member of staff responsible for carrying out observation and engagement for each specified time-period.

Recommendation 11 *

TEWV, CNTW, NHS England and Durham County Council must provide assurance that all transitions between services for children and young people are completed in line with the NICE guidance on the Transition of Children and Young people.

** We have provided some detail on actions we are taking to address this important issue, working alongside colleagues in the local authorities and health care providers.*

TEWV response:

The Trust and all the local authorities across our geographical area have signed up to implementing the iTHRIVE system framework. This is recognised nationally as a way of promoting good practice, and its pathways follow evidence-based National Institute for Clinical Excellence (NICE) guidance and have been developed by staff using the available evidence-base and clinical expertise. This means that progress is being made with all our partners and describes a whole-system approach. This is an important and positive change to our approaches to joint working with targeted support.

We are also working closely with our partner agencies to improve how we work together to support children, young people and their families. In Durham, we have been developing multi-agency decision making following a whole-system pathway development. This work has been led by the Trust over the past three years. Family hubs are also being developed in Consett, County Durham, Billingham, Stockton-on-Tees and in North Yorkshire and York. Included in the whole-system approach, we have also been developing an integrated multi-

agency approach for high risk, vulnerable young people with joint accountability. Using this approach, risk assessment and management plans, safety plans are co-created between agencies and young people, their families and carers. Support comes from all sectors including family, social, activity, education and employment to enable the children and young people to settle back into their life in the community. Intensive home treatment (IHT) teams provide planned support which is tailored and bespoke for each individual, and this support is available in the Durham and Tees areas. There are also dedicated 24/7 CAMHS crisis teams across the Trust. The IHT and crisis teams work together with the multi-agency network, including CAMHS, to support children and young people when they leave inpatient accommodation.

TEWV have an active working group for 16-25's, which is led by an Associate Director of Therapies supported by a project manager. The working group oversees the transition process for CAMHS, Adult Mental Health Services (AMHS) and learning disability services. Transition panels are in place for each AMHS team. Active planning for the transition starts at six months prior to the young person's 18th birthday, with a discussion with them and their parent / carers which is recorded in the transition plan on electronic care records. A monthly report for team managers, overseen by modern matrons, provides assurance. The last transition audit was completed in April 2020. An audit of transition planning formulations for complex presentations is planned for the next audit cycle.

For young people who are more vulnerable, we start to make links with AMHS when a young person is 17 years and a quarter, with transition plans in place at 17 years and six months. We know that this transition time can be particularly difficult, especially for people in the care of the local authority, so we make sure that this is proactively done through preparation and follow-up actions. Multi-agency working across the transition time can be complicated, and it is recognised that young people often require additional support because of this.

Recommendation 12

TEWV must provide assurance that that all ligature risks identified in Tunstall Ward in 2019 have been addressed.

TEWV response:

The Trust established an environmental risk group in January 2020 to oversee a comprehensive ligature reduction programme across the Trust. This included the replacement of ensuite bathroom furniture and fittings across all adult inpatient assessment and treatment wards to an agreed standard. This work was completed on Tunstall Ward in September 2020.

We have invested over £5m in our ligature reduction programme to date, with a further £2.8m due for completion by March 2023.

A comprehensive door replacement programme is also underway across the Trust. As part of this, ensuite doors were replaced on Tunstall Ward in April 2022. Installation of new bedroom doors will be completed in November 2022.

Where ligature points cannot be removed or are in low-risk areas of the ward, these are managed as part of individual and ward risk assessments. Staff are aware of these risks, and they are discussed as part of the daily ward safety reviews.

An annual assessment of ligatures within the ward environment is undertaken in accordance with the Trust's Suicide Prevention Environmental Survey and Risk Assessment Procedure. This was last completed on 22 July 2022.

In addition, since the time of this incident, Oxevision has been installed in a number of wards, including Tunstall Ward. This system supports clinical teams and enhances patient safety by using contact free, vision-based monitoring technology to monitor a patient's vital signs and high-risk activity. This offers safe and unobtrusive care, which is respectful of people's privacy, and we are developing and evaluating our services to ensure we embrace the benefits of this assistive technology.

Recommendation 13

TEWV must ensure that the Supportive Observation and Engagement Procedure requires that care plans specify whether to enter the individual's room if they cannot be observed from the doorway.

TEWV response:

The Trust's Observation Policy has been updated to specify that care plans should include whether to enter the individual's room if they cannot be observed from the doorway.

To strengthen the recording of mental health observations, the Trust's policy around Supportive Observation and Engagement was reviewed in December 2020. A new competency-based assessment was introduced for all clinical staff prior to the policy going live, to make sure staff understood it and what was required of them.

In January 2021, the Trust held a five-day quality improvement event to make sure robust systems were in place to assess and mitigate patient risk, including the management of observations and observation levels. The aim was to develop a simplified and streamlined framework to enable effective assessment, risk assessment, care planning and care delivery.

The outcome was a 'plan on a page' framework, which simplified the electronic patient record in the form of the safety summary and safety plan, leave plan, observation plan and care plan.

Staff took part in training sessions to recognise and understand:

- areas of harm and the need to take immediate action,
- working collaboratively with the multi-disciplinary team (MDT) and the patient when determining observation levels,
- how to review static and dynamic risk factors that may affect potential harms,
- the importance of maintaining simultaneous records, and;
- clarity of roles and responsibilities in relation to observation levels

In addition, clinical risk assessment and management guidance is provided to clinical staff to support their practice in line with the Trust's revised Harm Minimisation policy (clinical risk assessment and management). Multi-disciplinary team (MDT) huddles were introduced in inpatient areas and outcomes are now recorded in clinical records. The quality assurance (QA) programme that was introduced in June 2021 includes the following:

- **Assurance self-declaration:** a fortnightly assurance tool reviewing all patients on inpatient wards. The tool monitors compliance with completion and updating of safety summaries, safety plans, incident reporting, leave and observation plans as well as associated documentation. The tool was updated on 23 October 2021 to provide a more focused and detailed review of the quality of patient records and clinical record keeping.

- **Modern matron quality review:** a monthly review of quality indicators and information in inpatient areas. It includes 33 standards relating to safety summaries, safety plans, patient carer involvement, leave plans, and observations plans. Each ward or team have developed continuous improvement plans based on intelligence gathering from reviews and case note reviews.

- **Practice development review:** a monthly assurance tool led by the practice development team. The practice development practitioners (PDPs) observe MDT discussions in relation to risk, leave, level of observations, mental state, medication compliance and effectiveness of medication regime and whether everyone in the MDT is felt to have a voice. PDPs now work with staff across both inpatient and community services focusing on completing robust risk assessments and ensuring the quality of mental state examinations and record keeping, including observation levels.

The quality assurance programme has provided evidence that observation and engagement plans, for both day and night, were present in 99% of cases. It also showed that patient observation levels documented in the clinical records matched the paper sheets and visual control board. There was 100% compliance with observation recording forms being fully completed, specifying the named member of staff responsible for carrying out observation and engagement for each specified time-period.

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TEWV response to NHS England independent investigation – Nadia Sharif

Tees, Esk and Wear Valleys NHS Foundation Trust response to the recommendations in the Niche Health and Social Care Consulting independent investigation (NS)

The following assurance statements have been produced as a response to the Niche independent investigation into the care and treatment of NS in West Lane Hospital by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), commissioned by NHS England.

The independent investigation made a total of 12 recommendations.

This section addresses recommendations 1, 2, 3, 6, 7, 8 and 11 in order as made in the report.

Recommendations 4, 5,10 and 12 relate to other organisations and are therefore not included in this assurance statement.

Recommendation 9 is a joint recommendation for TEWV, NHS England and Middlesborough Council. This statement provides only the TEWV response.

Introduction

We would like to apologise unreservedly for the unacceptable failings in the care of Nadia which the report clearly identifies.

We accept in full the recommendations made in the report – all the improvements required are being made where applicable to our services.

TEWV has not delivered CAMHS inpatient services since September 2019. CNTW provides these inpatient services to children and young people from the West Lane Hospital site - this arrangement was formally put in place by NHS England in September 2020 and opened to admissions in April 2021.

Following a governance review in March 2021, and a comprehensive public engagement exercise that followed, a new TEWV organisational and governance structure was put in place from 1 April 2022, with simplified governance processes and strengthened reporting from teams through two new care groups directly to the Trust's Board, embedding increased line of sight and oversight from ward to Board.

As part of this, we recruited two lived experience directors into our leadership team to make sure patient voice is heard at the very highest level in the organisation.

Importantly, all the necessary changes are being made to the services we deliver, with the knowledge and oversight of the CQC and NHS England and reviewed by them monthly at an external Quality Assurance Board, chaired by NHS England.

In the three years since these tragedies, we've made significant improvements – how we assess the risks to our patients, how we organise and staff our services, and how we more closely involve the families and loved ones themselves.

These improvements are being delivered through our five-year change programme "Our Journey to Change", which sets out why we do what we do, driven by three big goals to create a great experience for our patients, carers and their families, for our staff, and for our partners.

This includes an unrelenting focus on patient safety, with clear priorities set out in our patient safety strategy – this is our absolute priority.

This is supported by a quality assurance programme, and our quantitative and qualitative data shows that we have made considerable progress, and these are continually measured, evaluated, and reported upon.

We have completely overhauled the community services we provide to young people in Child and Adolescent Mental Health Services (CAMHS) to provide safe and kind care, today and every day.

Improvements we have made in CAMHS have been acknowledged by the CQC in a recent inspection, where services had improved – they said our senior management team had responded promptly to address issues identified at the previous inspection - we recognise there is still work to do, however we are moving in the right direction.

We are working hard to put patients and carers at the centre of everything we do – treating everyone with respect and compassion and taking responsibility for our actions.

These assurance statements outline the improvements we have made in response to the report recommendations.

Overarching context

To provide additional and important context, the following information provides details about service developments that have been underway within TEWV CAMHS over the last few years. This demonstrates that specific recommendations have been considered and acted upon and provides additional assurance regarding the fundamental changes to our services that are underway.

Service development work has been undertaken in CAMHS to improve care for young people and their families and carers. We began with a detailed analysis of the data based on different levels of need. This included the development of principles of care for people with the most complex presentations, with specific guidance for multi-agency and multi-disciplinary working.

During 2021-22 a significant programme of work got underway to develop evidence-based pathways of care using what's known as the iTHRIVE system framework, which is recognised nationally as a way of promoting good practice. These pathways follow evidence-based National Institute for Clinical Excellence (NICE) guidance and have been developed by staff using the available evidence-base and clinical expertise. Pathways include guidance on assessment, formulation, re-formulation, treatment approaches and care planning, with

shared decision making considered with children, young people and their families and carers. All pathways include guidance for any adjustments which may need to be made for autistic people.

These new clinical pathways are due to be launched in November 2022 with a clear plan for evaluation, review and continual improvement based on feedback from young people parents, carers and clinicians.

Recommendation 1

TEWV must ensure that plans of care for young people in Child and Adolescent Mental Health Services (CAMHS) incorporate evidence-based practice.

TEWV response:

The Trust's work around care planning continues to be a priority and is overseen by the Quality and Safety Programme Board as well as the Clinical Strategy Board.

Considerable work has been undertaken over the past 18 months to make sure care plans are developed with a young person and their family or carer, and that these are trauma-informed, recovery-focused, autism aware and meaningful for the children and young people themselves. The Trust recognises this is a work in progress and is subject to review and evaluation.

To make sure care plans developed for young people in CAMHS include evidence-based practice, we use what is known as a 5P formulation structure, to organise assessment information when children and young people come into the service. The 5Ps are: current Presentation, Pre-existing, triggers for current issue (Precipitating), any maintaining (Perpetuating) factors, and the Positives to understand what is going well. The 5P formulation structure is a standard format utilised in mental health services nationwide approved by the British Psychological Society.

We have found that this is a useful way of organising information and for children, young people and their families and carers, to develop a shared understanding and language with the clinical staff, to make sure it was patient-centred and easy to follow, and that the care plans are completed together in way which the young person and their parent / carer also understands.

Using this method to assess people, means decisions about an individual's care is made with them and their family or carers. We have often received feedback from people who use our services that they don't like having to repeat their stories. Developing a shared 5P formulation also helps with consistency for sharing relevant information and avoid having to do this.

In addition to the above, a quality improvement event was held in March 2022 to focus on the clinical model of care planning across the Trust. The event was well attended by people we support in our services, carers, professionals from across the Trust's geographical area

Consensus from the event was that care planning must be owned by the patient and contributed to by the care network involved in a person's care.

Outcomes from the event included additional training sessions which took place in April and May 2022 to make sure staff have the appropriate skills to co-create meaningful, goal-orientated care plans. Awareness sessions were arranged for people we support in our services, carers, and our partners to facilitate a shared understanding of the changes. The event also looked at which parts of the care plan review could be stopped to reduce duplication and free up staff time to care.

The introduction of the Trust's new electronic patient record system will also enhance the care planning process.

Recommendation 2

TEWV must ensure that risk assessments for young people in CAMHS are based on a psychological formulation and are developed by a multidisciplinary team in conjunction with the young person and their family.

TEWV response:

In addition to the information provide above, the Trust has developed new safety summary and safety plan documents. These support a psychological formulation approach to risk assessment with children, young people, their families and carers. The documents require consideration of a young person's history regarding what has happened to them, and any patterns to help understand when they have been better or become more unwell. The risk assessment and management plans need to be developed alongside a thorough understanding of the young person within their context. Risks of harm to self and others are considered including where there are younger siblings present in the family. This forms an integral aspect of care planning building on the assessment, formulation and shared decision-making process described above, and includes consideration of risk to others. Safeguarding policies are in place and are followed where required.

These were introduced into CAMHS in April 2021. Our Quality Assurance Programme currently shows that 96.8% of children in treatment have a safety summary and safety plan in place across the Trust. We continue to work with clinicians to enhance the quality and have established processes to support this via caseload supervision, clinical supervision and daily discussions (huddles). We have assurance processes including fundamental standards and peer reviews to ensure clinicians have a variety of sources of support.

Recommendation 3

TEWV must provide assurance that race and ethnicity, gender and religious issues are routinely addressed in Care Programme Approach (CPA) needs assessment and care planning as per the Trust's policy.

TEWV response:

The Trust addresses race, ethnicity, gender and religious issues in Care Programme Approaches in the following ways:

- To reduce any language barriers and ensure patients and families have access to information in a language they understand, the Trust uses a contracted interpretation and translation service called Everyday Language Solutions (ELS). This information is available on the staff intranet and is supported by an interpretation and translation policy. This service can be accessed by clinical staff to support patients and family members.

- To ensure there was better uptake of the offer from ELS, in 2022, we asked ELS to deliver Working with Interpreters training for our staff. The aim of the session was to give clinical staff more knowledge and a better understanding of how to use the interpretation service and how to work with interpreters.

  In addition, the Trust's Equality, Diversity and Human Rights (EDHR) team reviews all interpretation and translation usage. They contact teams directly to make sure colleagues are aware of the service, the policy that supports it and best practice including how often people should be offered it.

  Since 2019, the use of ELS translation service has nearly doubled from seven to 13 a month, and the use of the interpreter service has gone from 182 to 265 requests per month.

- The Trust assesses and develops all policies, procedures and service changes to ensure that people from protected characteristic groups are not negatively impacted and that our services are inclusive.

- The Trust's training offer has increased to make sure colleagues understand race and ethnicity, gender and religious issues and can take action to address them. This includes:

  - Mandatory EDHR training for all staff.

  - Equality and Diversity training.

  - Human rights training - the EDHR team recently ran a human rights training programme for senior staff to embed human rights models into decision making. This helps clinicians to ensure care is person-centred.

  - The EDHR team has developed and now delivers Compassion, Respect, Responsibility and Race training, to increase staff's awareness of the experiences of people from a BAME (black, Asian and minority ethnic) background.

- The Trust also holds human rights supervisions, where staff can work through real life scenarios using human rights models and share good practice, including reverse mentoring.

Recommendation 6

TEWV must provide assurance that there are protocols in place for safeguarding and Local Authority Designated Officer (LADO) referrals, and that these are understood and followed by all staff caring for young people.

TEWV response:

The Trust's Safeguarding Children Policy was last updated in July 2022 and is available to all staff on the Trust intranet. This policy and related training reflect the protocols to be followed in relation to Local Authority Designated Officer (LADO) notification, where the member of staff works with children and an allegation is made.

To ensure that the correct procedures are followed, the Safeguarding Public Protection and Human Resources teams must be informed alongside the local authority. This means that the referral process has been considerably strengthened since 2019, and all referrals are checked by the safeguarding team before submission, to make sure that they contain all the relevant information needed.

The Trust's safeguarding team is fully aware of the LADO procedures and ensure that allegations are escalated to the senior nominated officer in accordance with policy. To support staff to fulfil their safeguarding responsibilities, training for registered staff is refreshed every three years to ensure it meets both their practice and what's required. It incorporates both adult and children safeguarding and is delivered via a mixture of e-learning, a workbook and virtual meetings. Additional bespoke training is provided as required. Safeguarding training compliance for CAMHS Clinicians is currently 88% and safeguarding leads in each CAMHS team provide support and supervision to front line staff. This is monitored via staff appraisals and safeguarding audit to ensure implementation of policies.

Recommendation 7 *

Where a young person is in receipt of T4 care and transferring back to T3, there must be a joint response between health and Middlesbrough Council children's services so that the young person is prepared for life in the community and can be properly supported and their risks appropriately managed.

** We have provided some detail on actions we are taking to address this important issue, working alongside colleagues in the local authorities and health care providers. T3 or Tier 3 relates to community CAMHS services, and T4 of Tier 4 relates to inpatient CAMHS services.*

TEWV response:

The Trust and all the local authorities across our geographical area have signed up to implementing iTHRIVE (detailed in the overarching context section), meaning that progress is being made with all our partners, and describes a whole-system approach. This is an important and positive change to our approaches to joint working with targeted support.

We are also working closely with our partner agencies to improve how we work together to support children, young people and their families. We continue to work on multi-agency and multidisciplinary models of care within the Middlesbrough area. Family hubs are also being developed in Consett, County Durham, Billingham, Stockton-on-Tees and in North Yorkshire and York. Included in the whole-system approach, we have also been developing an integrated multi-agency approach for high risk, vulnerable young people with joint accountability. Using this approach, risk assessment and management plans, safety plans are co-created- between agencies and young people, their families and carers. Support comes from all sectors including family, social, activity, education and employment to enable the children and young people to settle back into their life in the community. Intensive home treatment (IHT) teams provide planned support which is tailored and bespoke for each individual, and this support is available in the Durham and Tees areas. There are also dedicated 24/7 CAMHS crisis teams across the Trust. The IHT and crisis teams work together with the multi-agency network, including CAMHS, to support children and young people when they leave inpatient accommodation.

TEWV have an active working group for 16-25's, which led by an Associate Director of Therapies supported by a project manager. The working group oversees the transition process for CAMHS, Adult Mental Health Services (AMHS) and learning disability services. Transition panels are in place for each AMHS team. Active planning for the transition starts at six months prior to the young person's 18th birthday, with a discussion with the young person and their parent / carers which is recorded in the transition plan on electronic care records. A monthly report for team managers, overseen by modern matrons, provides assurance. The last transition audit was completed in April 2020. An audit of transition planning formulations for complex presentations is planned for the next audit cycle.

For young people who are more vulnerable, we start to make links with AMHS when a young person is 17 years and a quarter, with transition plans in place at 17 years and six months. We know that this transition time can be particularly difficult, especially for people in the care of the local authority, so we make sure that this is proactively done through preparation and follow-up actions. Multi-agency working across the transition time can be complicated, and it is recognised that young people often require additional support because of this.

Recommendation 8

TEWV must provide assurance that clinical records are kept to expected standards.

TEWV response:

In June 2021, the Trust introduced a new quality assurance programme focusing on the quality of clinical record keeping in relation to key clinical records including care plans, observation records, risk assessment and management plans recognising that high quality documentation is an enabler to good patient care. This is in line with national clinical record keeping policy and professional guidance for record keeping.

These audits are completed monthly and are verified through a peer review process. Results from Jun-21 to Jun-22 activities demonstrate consistent practice standards are being achieved across the organisation in terms of implementation of the minimum standards, in

line with the Good Practice Guidance for the safety summary / safety plans, observation and engagement plans, and leave documentation within the patient electronic care record system. The Practice Development Practitioners continue to monitor compliance and to facilitate areas where focussed improvement work is required in collaboration with clinical teams.

In addition, clinical risk assessment and management guidance is provided to clinical staff to support their practice in line with the Trust's revised Harm Minimisation policy (clinical risk assessment and management). Multi-disciplinary team (MDT) huddles were introduced in inpatient areas and outcomes are now recorded in clinical records. The quality assurance (QA) programme that was introduced in June 2021 includes the following:

- **Assurance self-declaration:** a fortnightly assurance tool reviewing all patients on inpatient wards. The tool monitors compliance with completion and updating of safety summaries, safety plans, incident reporting, leave and observation plans as well as associated documentation. The tool was updated on 23 October 2021 to provide a more focused and detailed review of the quality of patient records and clinical record keeping.

- **Modern matron quality review:** a monthly review of quality indicators and information in inpatient areas. It includes 33 standards relating to safety summaries, safety plans, patient carer involvement, leave plans, and observations plans. Each ward or team have developed continuous improvement plans based on intelligence gathering from reviews and case note reviews.

- **Practice development review:** a monthly assurance tool led by the practice development team. The practice development practitioners (PDPs) observe MDT discussions in relation to risk, leave, level of observations, mental state, medication compliance and effectiveness of medication regime and whether everyone in the MDT is felt to have a voice. PDPs now work with staff across both inpatient and community services focusing on completing robust risk assessments and ensuring the quality of mental state examinations and record keeping, including observation levels.

The quality assurance programme has provided evidence that observation and engagement plans, for both day and night, were present in 99% of cases. It also showed that patient observation levels documented in the clinical records matched the paper sheets and visual control board. There was 100% compliance with observation recording forms being fully completed, specifying the named member of staff responsible for carrying out observation and engagement for each specified time-period.

Recommendation 9

TEWV/NHS England and Middlesborough Council must provide assurance that all inpatient care for young people with a diagnosis of autism have care provided that is in line with the NICE guidance on autism spectrum disorder in under 19s: support and management.

TEWV response:

We do adhere to this national guidance. A Trust-wide Autism Project has been providing training to clinical and corporate staff across all specialties, including adult inpatient services. Health Education England have developed the core capabilities framework standards and our training is aligned with this. It includes consideration of the impact of autism and consequent reasonable adjustments that staff may need to make when caring for and supporting an autistic child, young person or adult. This includes sensory considerations, social and environmental considerations and communication needs ensuring that care is individual to the response and responsive to their needs.

We have undertaken environmental checklists (recommended in NICE guidance) and this programme is underway for all wards. This creates a baseline of understanding of the sensory environment which then enables personalisation when autistic people are present on the ward.

We have also provided training for the estates department to ensure they are aware of the needs of autistic people.

From September 2020, the autism project has also offered consultation and supervision for clinical staff working with an autistic child, young person or adult accessing TEWV services in the community and as an inpatient. Reasonable adjustment workshops have been delivered (co-facilitated) in all adult mental health community teams across the trust.

In July 2022, a two-day scoping event was held to map out a significant piece of work looking at the reasonable adjustments needed specifically within our adult mental health inpatient services. Following this event, a number of themes were identified including communication needs, sensory considerations, staff training needs, environment and cultural change. With the support of the Autism Project team, each TEWV inpatient site will have a steering group to ensure the changes that were identified during the event are delivered. This group will be made up of key members of the service as well as Experts by Experience and people we support in our services. They will develop an implementation plan for their site which will be supported and monitored by the Autism Project team with clear timeframes for actions and outcomes.

Recommendation 11

TEWV Serious Incident processes must meet the expectations of the Serious Incident Framework and Duty of Candour.

TEWV response:

The Trust's Serious Incident Framework (SIF) have been updated, and significant improvement work has been undertaken to strengthen its serious incident processes since 2019. This has included quality improvement and a 'deep dive' event involving feedback from service users, families and carers. Following the Trust's final serious incident review panel,-learning is distributed Trust-wide via a learning bulletin. If there are any urgent patient safety issues arising as part of the rapid review process, and to make sure there is swift action and early learning, these will be disseminated via a Trust-wide patient safety briefing.

All staff can access these briefings via the patient safety learning library on the staff intranet. Any assurance obtained from associated actions is stored in the learning database.

We have undertaken an in-depth review of key themes from incidents dating back several years. This has enabled us to make measurable improvements and identify areas where further work is needed to embed learning. We are using our quality assurance schedule to inform this, to help develop and transform our organisational response to incidents, and the Trust is working towards the implementation of the new national patient safety incident response framework (PSIRF) by September 2023.

To build on this work, the Director of Quality Governance commissioned a quality improvement event called 'Improving the experience of patients, families, and staff during serious incident reviews (SIRs)'. The event took place in July 2021, and the aim was to share with internal and external stakeholders the work that had been undertaken in the patient safety team in collaboration with families, patients and operational services, to:

- Improve the quality and safety of the care we provide.
- Improve the experience of patients and families throughout the serious incident review process.
- Improve the efficacy of our patient safety incident investigations by moving towards a systems-based approach identifying interconnected causal factors and systems.
- Address causal factors to prevent or minimise repeat patient safety risks and incidents.
- Measure the impact of actions taken to reduce repeat patient safety risks and incidents.
- To increase stakeholders (notably patients, families, carers, and staff) confidence in the improvement of patient safety through demonstrating the impact of learning from incidents.

A project manager was appointed to drive the continued delivery of this improvement work.

A further event was held in February 2022 with the NHS England support team and the patient safety team, where four additional work streams relating to the serious incident process and incident reporting were identified, including:

- The incident report process.
- Triaging patient safety incidents.
- Revisiting the duty of candour.
- The Trust's final assurance panel for signing off serious incident reports.

On 20 May 2022, following completion of these workstreams with the relevant stakeholders, and in line with our improvement plan in Our Journey to Change, a further event called 'Co-creating for Patient Safety' took place. The event was attended by 70 people including bereaved families, carers, clinical services, members of the executive management team

and commissioners. It focused on sharing details of the improvement work and facilitated full engagement with all relevant stakeholders.

The Incident Reporting and Serious Incident Review policy is being reviewed and updated to incorporate all outcomes of the improvement work.

All our current serious incident reviewers have received specialised training in serious incident investigation via the PSIRF approved trainers or the healthcare safety investigation branch (HSIB).

We have modified our rapid review response template, which is used for incidents categorised as near miss, moderate and above, to incorporate a section on duty of candour. This places the initial responsibility on clinical services to contact the patient or relevant other, to apologise for the harm caused and to share information known at the time.

We recognise that staff in clinical services would benefit from some training in holding difficult conversations as well as the duty of candour, which has been captured in the Trust's training needs analysis. The policy will be reviewed and revised to incorporate service improvements.

In addition, we will be commencing a review of our duty of candour processes in January 2023.

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