Serious Case Review concerning 'Clare'

Executive Summary

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1. Introduction

The Serious Case Review (SCR) concerning 'Clare' was commissioned by North Yorkshire Safeguarding Children Board (NYSCB)[1] in April 2017 following her untimely tragic death in a mental health unit. The review was commissioned in line with statutory guidance at that time (HM Government, 2015) and covered the period from 01/01/2014 to 30/03/2017.

The independent author of the review was asked to specifically consider five key themes:

1. Assessment of Clare's needs and risks
2. Service planning and provision
3. The voice of the child and parents in assessment, planning, implementation and review
4. Multi-agency working together
5. Compulsory intervention and out of area placements

Reports from fifteen agencies involved with Clare and her family were submitted for the purposes of the review.

Four multi-agency SCR panel meetings were held throughout the review, along with a learning event involving front line practitioners and managers.

Clare's family has been involved in the review process and contributed their views and perspective.

All the names in the review have been changed to respect the privacy of Clare and her family.

It is of note that during the duration of this SCR, there were police investigations into Clare's death. In June 2018, the Crown Prosecution Service decided that no prosecutions would be brought.

2. Who was Clare?

Clare had a multitude of positive aspects to her character. Her parents describe her as 'fun loving, witty, caring, easy going with a big heart, very intelligent, artistic, a wonderful girl, articulate, having opinions on the world, sociable in surroundings, a young person who loved animals and nature. She wanted to save all of the animals of the world. At times Clare has anxiety and found new situations stressful and did not like changes in environments.

[1] At the time of publication NYSCB is now known as North Yorkshire Safeguarding Children Partnership (NYSCP)

3. Clare's Story

Clare was born in December 1999, the only child to her mother (Anne) and father (Patrick). Her parents separated prior to her first birthday and Clare remained living with her mother in Bradford then moving to Leeds.

Patrick moved to North Yorkshire, where he later remarried and had two children with his second wife, Sue.

Clare's mother entered a new relationship with Michael, who also had a child. The family continued to live in Leeds until Clare moved to live with her father and his family in North Yorkshire in 2015.

By all accounts, the parental separation had a significant impact on Clare's emotional and mental wellbeing from an early age. Information presented to the review also highlighted that Anne had experienced difficulties with Clare in her early childhood due to her social, emotional and mental health needs.

The arrival of Patrick and Sue's first child in 2008 triggered feelings for Clare (aged 8) that her father would no longer care for her. Clare and Anne were referred to the Child and Adolescent Mental Health (CAMHS) team and received therapeutic services between December 2008 and June 2010.

In February 2014, Clare was again referred to the CAMHS service for unresolved issues around parental separation, anxiety and self-harming and along with her mother, received various community-based therapeutic services until March 2015. Clare's school at this time (S1) did not receive information from CAMHS practitioners or the GP about her emotional wellbeing and mental health, and had no record of parental communication about these issues and her self-harming.

In July 2014, Clare was admitted to hospital following an overdose. It was recorded that Clare had expressed 'low mood, frustration at low mood and anxiety at not being taken seriously.' The family felt that Clare was not listened too by CAMHS and had no one else to turn too.

Having been discharged from CAMHS in March 2015, in the following month Clare and Anne were again referred by their GP to the service and placed on the waiting list. The family were signposted to alternative sources of support whilst they were awaiting a first appointment with CAMHS.

Around the same time, the school support officer contacted Anne following a period of Clare's absence from school. It was agreed that Clare would be offered a place in the school's nurture unit which supports vulnerable students. Her programme noted weak literacy skills and significantly low self-esteem. The school were unaware of her previous overdose or that a referral to CAMHS had been made by the GP.

Before Clare could be offered services from CAMHS, she moved to live with her father and his family in June 2015.

Back in North Yorkshire, Clare started at a new school (S2) in July 2015. The review noted a lack of communication between schools around Clare's educational background and emotional wellbeing.

On 6 July 2015, Clare was found by the police walking on a main road near her father's home – she stated that she was trying to walk to her mother's home in Leeds. At this time, she did not present as being at risk and was not displaying self-harming or suicidal behaviour.

In the autumn term of 2015, Clare presented at S2 with challenging behaviour and truanting.

In November 2015, Clare was admitted to York Hospital having taken a second overdose. Clare expressed that she felt suicidal and there was clear evidence of healed self-harm wounds. A psychiatric assessment during this admission highlighted significant concerns about her mental health. She was discharged home with a safety plan and referred to the North Yorkshire community CAMHS team, where she was seen two days later. Significant concerns around her self-harm and suicidal ideation were identified and the option of an in-patient admission was discussed. A safety plan for a short-term return home was developed prior to the option of admission to the local in-patient CAMHS unit.

Clare and her parents wanted to consider their options over the weekend. However, over the same weekend the situation at the CAMHS in-patient unit changed, such that no bed was available for Clare. At this time, it was felt that Clare's needs and risks were too high to be managed within a community CAMHS setting and there was no assertive outreach service available to offer crisis intervention or back-up to the family. Supported by Patrick and Sue, Clare was then admitted as an informal patient in Hospital.

In January 2016, Clare's mental health had deteriorated such that she was detained under Section 2 of the Mental Health Act (1983) and again under Section 3 of the same Act in February 2016.

In February 2016, Clare was transferred to the Psychiatric Intensive Care Unit (PICU) due to her increased risk of self-harming and aggression towards staff. She was recorded as having an emotionally unstable personality disorder. Whilst in the PICU, Clare continued to have suicidal ideation and was at risk of self-harming.

In May 2016, an assessment for Autistic Spectrum Disorder found that whilst Clare did display some autistic traits, she did not meet the diagnostic criteria for this condition.

In June 2016, a multi-disciplinary team decision was made that Clare's needs would best be met in a Mental Health Low Secure Unit as she had not been engaging in therapy, and managing her risk in the PICU was problematic. She continued to self-harm and show suicidal ideation.

However, in September 2016 before a bed was located, Clare attended Hospital to receive treatment on her arm where she had inserted a screw. She did not allow the doctor to examine her and was later discharged. Clare managed to abscond from her escorts and ran out in front of a car, sustaining a fractured pelvis.

In December 2016, Clare was transferred to Mental Health Low Secure Unit under Section 3 of the Mental Health Act (1983), with a diagnosis of (emerging) borderline personality disorder.

Whilst at this Hospital Clare refused to take medication or to take part in education. She was also selective in her engagement with staff at the hospital. Between December 2016 and March 2017, Clare had eight incidents of self-harm.

Two multi-disciplinary Care Plan Approach meetings were held which identified a plan for Clare to work initially towards a step-down move to a support unit, with a view to discharge and eventual return home.

On the 10 March 2017, Clare went to stay with her mother on a two-day leave under Section 17 of the Mental Health Act (1983). On 11 March, staff at the hospital found a suicide note that Clare had left in her room and noted that on her return (12 March) she showed a deterioration in mood and demeanour. It was also discovered that Clare had smuggled some alcohol into her room.

On 16 March 2017, a Care Plan Approach meeting was held where it was agreed to work with Clare to accept some treatment and progress towards a more settled mental health state and eventual discharge. It was also agreed to revisit Clare's prescribed medication which she was not taking.

On Sunday 19 March 2017, Clare was found unconscious in her room at the Hospital with a dressing gown cord tied around her neck. She had been placed on Level 2 intermittent observation of four observations per hour. However, it was found that there were nine occasions between 20.30 on 18 March 2017 and 01.57 on 19 March 2017 when this protocol had not been adhered to, and one period of fifty-seven minutes when she had not been observed which immediately preceded her death.

Clare was taken by ambulance to an acute Hospital where she was pronounced dead at 04.18 on 19 March 2017.

4. What is the key learning from this Review?

Areas of good practice:

Clare's physical, emotional and mental health needs were appropriately assessed and adequately met by the three Leeds Health agencies and there was good communication, information sharing and support offered to Clare's mother.

Risk issues around potential significant self-harm were effectively considered and appropriately managed internally by CAMHS, although there was an issue about waiting times.

There was effective inter-agency cooperation between Police, Hospital and CAMHS service in responding to Clare's self-harming and suicidal episode as well as promoting her safety and welfare.

Clare's physical, mental health needs and risks were well met by the staff at Hospital, and Clare's parents were well supported.

Clare's physical, mental health needs and risks were appropriately assessed and addressed by both CAMHS teams and there was effective liaison and information sharing between the teams which promoted Clare's welfare and safety. Clare's parents were supported through the episode of care and informed of the various options for care of their daughter.

Areas where practice development has already taken place:

Use of CAMHS intensive home intervention services – such services seek to maintain young people in the community. Such services were not available as an option for Clare and her parents in 2015, hence her admission to a specialist mental health Hospital. It is of note that CAMHS services do now

provide a crisis intervention/intensive home treatment service for children and young people in North Yorkshire.

In-patient CAMHS admissions – where possible, it is beneficial for in-patient CAMHS admissions to be close to the young person's home and family. This is more likely to facilitate family involvement, continuity of schooling and liaison with community social, educational and health agencies. Following the National CAMHS Review conducted by NHS England in 2014, work is underway with providers to ensure that there is sufficient capacity for in-patient CAMHS services within the Yorkshire and Humber region.

Management of 'missing' notifications by police – the review highlighted a gap of eight days between the police becoming aware that Clare had gone missing, and this information being shared via a referral to Children's Social Care. This situation arose due to shift patterns and days off. However, since this time, police officers and staff are required to submit such referrals prior to finishing a tour of duty.

Areas where practice development is required:

The importance of holistic assessment – the review highlighted several times how robust information sharing within and between agencies could have led to a more holistic assessment of Clare's needs taking in the views of Clare and also the family. Opportunities to both share and seek relevant information about Clare were missed and as a consequence, Clare's social, emotional and mental health needs were not always adequately considered and assessed. A more robust assessment could have been used at an early stage to signpost to appropriate services and sources of help and support.

Communication between schools – there was a lack of good communication between S1 and S2 in relation to Clare's educational background and emotional wellbeing. This transition period was a time of significant changes for Clare around family, school, location and friends and the review concluded that the systems and processes designed to facilitate pupil transfers and the assessments of individual needs were not functioning at that time.

Communication between health professionals and schools – S1 had not been informed by the GP, School Nurse or CAMHS about her emotional state, previous self-harming or suicidal ideation. Such communication could have contributed to the school's holistic assessment of Clare and the provision of appropriate pastoral or other support.

Transfer of records – the review found that the transfer of records between S1 and S2 fell short of expected and required standards since no formal records were shared between the schools.

Documentation – within the schools, there was a lack of any robust system for the written recording of significant events, conversations and meetings with parents, students and school staff with a clear record of actions taken to follow up concerns. There were also a number of failings of accurate documentation noted in respect of specialist mental health Hospital.

CAMHS waiting times – Clare waited nearly five months before her first CAMHS appointment. Whilst the demand pressures on services at that time are acknowledged, a more timely response would have been beneficial. The stated target for waiting times is now 12 weeks, with an aspiration to lower this as resources allow.

Care provided by the specialist mental health Hospital, Sheffield – there were a number of sub-standard internal practice and organisational issues that, in the opinion of the lead reviewer, did not facilitate positive outcomes for Clare and probably contributed to her poor outcomes. Unsafe practice included an absence of critical fundamental systems and processes, a lack of triangulation of recording systems, no updating of care plans and risk assessments, ineffective intervention by the multi-disciplinary team and a failure by staff to comply with existing agency policies and procedures.

Many of the issues identified in the SCR reflected those set out in a subsequent report by the Care Quality Commission (CQC) in 2017. The hospital is subject to a closely monitored service improvement initiative by both the CQC and NHS England.

Care provided by the specialist mental health Hospital, Norfolk – care provided to Clare was the subject of a separate investigation commissioned by NHS England. This investigation 'found it difficult to determine a single root cause and concluded that a number of factors aligned which created the opportunity for failure to occur and resulted in Clare taking her own life.' Two key issues were specifically highlighted: the first was around the implementation of the 'Supportive Observation Policy', and the second was around the apparent lack of a comprehensive multi-disciplinary review of risk. The report made a number of recommendations for service improvement.

The Hospital closed in December, 2017. However, the findings from the NHS England investigation and from this SCR will still be taken forward by the hospital group.

Communication between health professionals – there was a lack of effective communication between professionals at the specialist mental health Hospital and acute Hospital, and also between both the specialist mental health Hospitals. The review recognised the need for effective communication, information sharing and joint service planning between health provider organisations through the production of care pathways and protocols regarding treatment and risk management of adolescent patients presenting with self-harming behaviour.

Multi-agency intervention – the review found opportunities where various agencies, using a robust assessment of need, could have considered initiating a coordinated multi-agency approach to supporting Clare and her family. This could have been via an Early Help or Child in Need Assessment with consent from Clare and her parents. Guidance published by the LSCB could have supported professionals in determining Clare's level of need.

The voice of the child and parents – a key lesson from the review was that agencies need to facilitate the maximum possible participation of children, young people and their parents in decisions about themselves, including consideration of their wishes and feelings.

The review found that there was a mixed record of Clare and her parents having their views heard and included in decision-making and actions taken by the agencies. In general, there was a good record of North Yorkshire agencies listening to Clare and her parents and taking on board their wishes and feelings.

There was discussion between Clare, her family and the schools regarding her behaviour, motivation and educational development. However, there is little recorded dialogue about Clare's emotional wellbeing and mental health needs.

The view of Clare's family is that communication with both the specialist mental health Hospitals was poor. Lack of staff continuity was a significant factor in this.

Clare's parents made a number of suggestions for service improvement which were included in the SCR. These included:

- Communication between hospitals and parents; professionals need more regular contact with families particularly for those placed out of area.
- Named professional to be identified who knows the patient and can liaise with families.
- Connections with families: parental involvement as much as possible including step parents.
- Early intervention with schools.
- CAMHS involvement – more involvement and the opportunity to offer a professional who could visit the home.
- In-patient CAMHS placements: the wards are not homely and felt that they were more like a prison. Needs to be an offer of a nurturing therapeutic environment.
- Bereavement support is limited, also need to acknowledge the wider family and siblings.

Clare's family have reflected that a lack of communication and support were recurrent themes experienced by themselves and by Clare throughout her story' and this was supported by the findings of the review.

The North Yorkshire Safeguarding Children Partnership are grateful to Clare's family for their contribution to the review process.

5. Next steps

The findings from this SCR will be disseminated across those agencies in North Yorkshire involved with supporting children and young people so that the lessons can be widely learned.

The review will also be shared with Safeguarding Children Partnerships[2] in Leeds, Sheffield and Norfolk since the findings have relevance in those areas.

An action plan in relation to the key learning points will be developed and monitored by the Learning and Improvement Sub-Group of the Safeguarding Children Partnership.

References

HM Government (2015) 'Working Together to Safeguard Children'

[2] Prior to 29th Sept – Safeguarding Children Boards