Serious Case Review concerning the young person 'Clare'

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Contents

Part 1 – Introduction

1. The subject of this Serious Case Review (SCR) is Clare[1] who died on the 19th March 2017 aged seventeen, whilst an in-patient at Hospital 1 in Norfolk . She was found with a dressing gown cord tied around her neck as a ligature, which she appeared to have placed there herself.

2. Clare was born, brought up and attended schools in West and North Yorkshire. She was an only very young child when her parents separated. Her father met a new partner when Clare was aged 5 and later married, subsequently having two children. Clare remained with her mother but contact with her father continued as did contact with his new family. Clare's mother met a new partner who had a child. Both joined the mother's household.

3. Clare began to experience emotional and mental health difficulties in early adolescence that required intervention from Child and Adolescent Mental Health Service (CAMHS). Her difficulties escalated into episodes of self-harm and suicidal ideation as she got older, this continued following the move to live with her father and his family, in June 2015.

4. Following a suicide attempt in November 2015, she was admitted to Hospital 2 in Sheffield as an informal in-patient for a four-week assessment of her emotional and mental health needs. The purpose of the assessment was to determine whether Clare could return home safely, receive support from community CAMHS and resume her schooling.

5. Clare's presenting behaviours increased whilst at Hospital 2 and she was sectioned under the Mental Health Act, 1983 in both January 2016 (section 2) and February 2016 (section 3). Such were the perceived increased risks of self-harming and suicidal ideation that she was transferred in early December 2016 to Hospital 1, a low secure unit for adolescent in-patients where, tragically, she died on the 19th March 2017.

6. A criminal enquiry was started by Police 1 into Clare's death and a file was sent to the Crown Prosecution Service which in June 2018 decided there was insufficient evidence for a prosecution.

7. Both the Care Quality Commission (CQC) and the National Health Service (NHS) England have undertaken their own investigations into Clare's death. Niche Consulting [2] was also commissioned by Hospital 1 group to produce an independent report into the circumstances.

8. The North Yorkshire Safeguarding Children Board (NYSCB) was notified of Clare's death on the 28th March 2017 and in April 2017 commissioned this SCR.

[1] Not her real name. Changed to protect her identity

[2] Niche Health and Social Care Consulting Ltd is an independent consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents (https://www.nicheconsult.co.uk/)

9. Family Structure[3]

Clare	17 at the time of her death
Anne	Clare's mother
Patrick	Clare's father
Sue	Clare's step-mother
Michael	Anne's partner
Paternal grandparents	
Patrick and Sue have two children younger than Clare	
Michael has one child younger than Clare	

10. What was Clare like?

Despite the tragic content of this Serious Case Review, Clare had many positive aspects to her character. Her parents describe her as fun loving, witty, caring, easy going with a big heart, being intelligent, artistic, a wonderful girl, articulate, having opinions on the world, sociable, somebody who loved animals and nature. She wanted to save all the animals of the world.

Part 2 - Aims and Objectives, Terms of Reference and SCR Process Issues

See Appendix 1

Part 3 - Background and Agency Involvement

This section of the report seeks to set out the narrative and does not attempt to make judgements about decisions, actions and practice. This is done in the later sections of analysis and findings.

11. Clare was born on the 14th December 1999 and died on the 19th March 2017. She was the only child of her mother (Anne) and father (Patrick) who separated prior to her first birthday. Anne moved to Leeds and Clare lived with her during the week and with Patrick at the weekends and occasionally during the week when she was very little. Clare started to go to her father's every other weekend at age 11 until age 13 when she requested not to anymore. Sometime later Anne formed a relationship with a male (Michael) who already had a child. The family continued to live in Leeds until Clare moved to live with Patrick, Sue, and Clare's half-siblings in North Yorkshire in June 2015. Clare attended a secondary school (S1) in North Yorkshire whilst living in Leeds and a further school (S2) on moving to her father's.

12. The parental separation had a significant impact on Clare's emotional and mental wellbeing from an early age. Anne, from CAMHS 1 records, had bonding and attachment problems with Clare since Clare's early childhood. Clare was seen by her GP aged four

[3] The family's names have been changed to protect identities.

years old as Anne had noted she frequently cleared her throat for no apparent reason. The GP recorded this as possibly a nervous habit.

13. Patrick and Sue had a child (the first of two) in 2009 when Clare was nine years old. This triggered feelings in Clare that the baby's arrival meant her father would not also care for her. Both Clare and Anne were referred by the GP to the CAMHS 1 team[4] and received therapeutic and parenting services between December 2009 and June 2010.

14. At fourteen, Clare was again referred to CAMHS 1 in February 2014 for attempted suicide and reported anxiety and self-harm during the previous summer. Clare and Anne then received community based therapeutic services (including individual, dyadic[5] and family therapies) from CAMHS 1 between June 2014 and March 2015. Clare's school (S1) was not informed by the GP or CAMHS 1 of her emotional or mental health issues, and had no record of parental communication about this or her self-harming. This represents a missed opportunity to support Clare and her family.

15. Shortly after starting treatment with CAMHS 1, Clare was admitted to Hospital 3 emergency department on the 10th July 2014 following ingestion of paracetamol the previous evening. It was recorded that Clare indicated she did not want to kill herself. The reported trigger for the overdose was *'low mood, frustration at low mood and anxiety at not being taken seriously'*. Professionals considered this a significant suicide attempt which was recorded as the first of several.

16. Following discharge from CAMHS 1 in March 2015, Clare and Anne were again referred by their GP to the same agency in April 2015 for Anne's report of deterioration in Clare's emotional wellbeing. No intervention by CAMHS 1 took place due to waiting times of the service. Clare subsequently moved out of area to live with Patrick, Sue and half-siblings in June 2015. Claire was subsequently referred to CAMHS 2.

17. Shortly after the move, on the 6th July 2015, Clare was reported to Police 2 by a member of the public as she was walking on the hard shoulder of the A19. She was found later by the Police and subsequently returned to her father's home.

18. Clare started at a new school (S2) on the 7th July 2015. The disruption involved in moving schools gave rise to challenging behaviour and truanting in the following autumn term[6]. There was poor communication between School 1 and School 2 about Clare's educational background and poor emotional wellbeing. School 1 was unaware of CAMHS 1' involvement, and School 2 only became aware of Clare's suicidal ideation on the 18th September 2015 when staff were informed by Patrick. Clare left School 2 in late November 2015 following admission to Hospital 2.

19. Clare attended the Accident and Emergency department at Hospital 4 on the 12th November 2015 following an overdose of 30-40 paracetamol tablets. She was admitted for assessment and seen by a psychiatrist from the CAMHS 2 who was concerned about

[4] CAMHS 1

[5] Therapy involving two people.

[6] September to December 2015

Clare's mental health. Clare remained on the paediatric ward and was seen the next day for a psychological assessment by CAMHS 2. Clare said she did not regret the attempt on her life and wished her suicide attempt had succeeded. She returned home on the 14th November 2015 subject to a safety plan and a referral to 'CAMHS 2'[7], on the 16th November 2015.

20. Clare was seen by the Psychiatric team at CAMHS 2 on the 16th November 2015, where she met with her care co-ordinator. Significant concerns around her self-harm and suicidal ideation were identified by the psychiatric team and the option of an in-patient admission was discussed. The option was a referral to the inpatient CAMHS service. This took a little time to set up she was seen there on the 19th November and in the meantime was assessed as ok to return home on a short term basis under a safety plan, pending going to CAMHS Inpatient Service 1 on the 19th November. CAMHS Inpatient Service 1 recommended a four-week in-patient assessment. A safety plan for a short-term return home was developed prior to the option of admission to CAMHS Inpatient Service 1.

21. On the 19th November 2015 the CAMHS Inpatient Service 1 suggested Clare be admitted. Clare and her parents were unsure about this option and wanted further time over the weekend to consider both it, and the potential alternative of local community based out-patient (Tier 3) services.

22. The family was informed by the CAMHS 2 care co-ordinator on the 23rd November 2015, that there was no longer a bed available at CAMHS Inpatient Service 1 and other options needed to be explored. A community CAMHS option to meet Clare's need was not viable because of the degree of risk she presented as well as there being no assertive outreach service to offer crisis intervention or support. Patrick and Sue said they wanted to proceed with an in-patient admission as they felt they were not in a position to manage Clare's risk at home long term.

23. Clare was admitted as an informal patient to the Hospital 2 on the 25th November 2015. She was later detained under Section 2 of the Mental Health Act, 1983 on the 8th January 2016 and under Section 3 of the Mental Health Act, 1983 on the 3rd February 2016 due to Claire's refusal to return to the hospital after a family outing. Clare later transferred to the Psychiatric Intensive Care Unit (PICU)[8] on the 15th February 2016 due to her increased risk of self-harming and aggression towards staff. She was diagnosed with an emotionally unstable personality disorder, although parents recall that this diagnosis was not shared with them at that time.

24. Whilst in the PICU Clare continued to have suicidal ideations and was at risk of self-harming. Such were the risks that she was allocated one to one nursing observation in April 2016. In May 2016, she underwent an Autistic Spectrum Assessment (ADOS) which found she did not meet the criteria, though she did show signs of having some autistic traits. In June 2016, a multi-disciplinary team decided to refer Clare to a Mental Health

[7] Adolescent Mental Health, Tier 3, CAMHS 2 outpatient unit in York.
[8] The term PICU is in line with national specification.

Low Secure Unit as she had not been engaging in therapy, meaning managing her risk in the PICU was problematic.

25. Clare attended Hospital 5 on the 22nd September 2016 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 absconded from her escorts and ran out in front of a car, resulting in a car-versus pedestrian collision leaving her with a fractured pelvis.

26. Clare was transferred to Hospital 1 (a low secure mental health facility)[9], on the 6th December 2016 under Section 3 of the Mental Health Act, 1983 which was seen as more appropriate option for a long term patient. She was given the diagnosis of (emerging) borderline personality disorder and initially subject to Level 4 supportive observation[10]. However, this was later stepped down to Level 2 supportive observation[11]. Clare refused to take medication and did not take part in education. She was selective in her engagement with staff at the Hospital. Clare had eight self-harm incidents between admission and her tragic death on the 19th March 2017. There were two Care Plan Approach's[12] held on the 18th January 2017 and 16th March 2017 respectively. Both involved working with Clare towards a step-down move to a support unit, with a view to discharge and eventual return home.

27. Clare returned to Hospital 1 following her two-day Section 17[13] Mental Health Act 1983 leave at her mother's; returning on the 12th March 2017. Clare had left a suicide note in her room at Hospital 1 which was found by staff on the 11th March 2017, who noted deterioration in her mood and demeanour on her return. Staff also discovered Clare had smuggled vodka in a cola bottle into her room. On the 16th March 2017, at the Care Plan Approach meeting it was agreed to work with Clare to accept some treatment, to help her 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.

28. On Sunday the 19th March 2017, Clare was found in her room at Hospital 1 unconscious with a dressing gown cord tied around her neck; it having been used as a non-suspended ligature. She had been on Level 2 intermittent observation of four observations per hour i.e. at 15 minute intervals. However, on nine occasions between 20:30 on the 18th March 2017 and 01:57 on the 19th March 2017, she was not observed within the specified fifteen minutes as per the local Hospital 1 Observation Protocol for Level 2 intermittent observations. The largest gap was of fifty-seven minutes between 01:00 and 01:57, when she was discovered. Clare was taken by the Ambulance Service 1 to Hospital 6 where she was pronounced dead on the 19th March 2017 at 04:18.

[9] A Tier 4 Low Secure Hospital which is an independent provider.
[10] Constant observation of the patient by up to two staff.
[11] Observation Levels 1-4; Level 1-Interact once per shift with patient; Level 2-Intermittent checks at least four times per hour; Level 3-Close proximity observations, one to one staff to patient; Level 4-Close proximity observations, two staff per patient.
[12] A Care Plan Approach (CPA) is a package of care for people with mental health problems.
[13] Section 17 of the Mental Health Act 1983 allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital and is the only legal means by which a detained patient may leave the hospital site.

29. A police enquiry into the death was started by Police 1. The post mortem recorded Clare's death as *hypoxic ischaemic brain injury*[14] *and ligature compression of the neck*.

Part 4 - Suicide and Self-Harm-Definition and Context

(See Appendix 3)

Part 5 - Children and Adolescent Mental Health Policy: The National Context

(See Appendix 4)

Part 6 – Analysis

30. What follows is an analysis of practice, actions taken and decisions made against the five terms of reference. Key findings, learning[15] and current agency developments are set out in Part 7.

Terms of References 1/2/4

(See appendix 1)

Assessment, Planning and Service Provision of Clare's Needs and Risks and Multi-Agency Working Together

Clare in Leeds: January 2014 - June 2015

Health Agencies

31. Whilst living with her mother in Leeds between January 2014 and June 2015 when she moved to her father's in North Yorkshire, Clare and her mother were involved with three Leeds health agencies: Clinical Commissioning Group 1 via Clare's general practice (GP) service, CAMHS 1 via community CAMHS, and Hospital 3 through Clare's attendance at Hospital Emergency Department in July 2014 following paracetamol ingestion.

32. Clare's first contact with a health provider was with the GP in late January 2014 following episodes of self-harm. Clare had been using a blade at school to inflict superficial cuts to her thighs since the previous summer. The GP diagnosed *that she was experiencing some stresses at home and at school with workloads, which seemed to be underlying her self-harm*. Clare was referred to CAMHS 1 in early February 2014. However, given the long waiting list for CAMHS it was suggested that contact be made in the interim with 'Leeds Market Place'[16].

[14] Deprivation of oxygen to the brain.
[15] Given the closure of Hospital 1 Norfolk in December 2017, all lessons and actions for improvement in parts 7 and 8 are directed at the Huntercombe Group.
[16] The Market Place is a young people's support centre that provides a range of support services in Leeds, especially for mental health, sexual health and crisis support. Young people can self-refer as well as access the drop in centre.

33. CAMHS 1 triaged the referral as urgent on the 3rd February 2014 due to Clare self-harming and the anxiety she was suffering. An 'opt in' letter was sent on the 17th February 2017. Anne contacted the service via a duty call on the 3rd March 2014. She was signposted to additional agencies and advised to make contact again if needed, all prior to a CAMHS appointment being offered.

34. An appointment letter was sent on the 6th May 2014. Clare and Anne were seen for by the CAMHS care co-ordinator on the 25th June 2014 and an initial assessment was undertaken. It included information on family history, significant events, relationships and presenting difficulties. The next appointment was on the 9th July 2014 and was attended by Clare and Anne. Therapy modalities, including Cognitive Behavioural Therapy (CBT) were explored and a follow up was arranged.

35. Clare was admitted to Hospital 3 Emergency Department on the 10th July 2014 at 08:44, having taken a paracetamol overdose (approximately 40) on the 9th July 2014 at 19:00 and had not told anyone. Anne was made aware of this when one of Clare's friends told her that Clare had taken an overdose. Anne then took Clare to hospital and Clare was treated to prevent long-term damage from the overdose. She was seen by a Paediatric Physician in the Emergency Department and admitted as an in-patient overnight, pending a standard CAMHS review before being considered for discharge. Clare denied any suicidal intent to the Paediatrician but disclosed *'frustration and low mood'*.

36. Whilst on the ward Clare was seen by the *'on call'* Doctor with lead responsibility for her care during the admission. Anne and Michael were present during the stay. Clare told the doctor that the trigger for the overdose was *'low mood, frustration and anxiety at not being taken seriously'*. Clare denied suicidal intent or any previous overdose incidents, about which Anne was said to be *'dubious'*. There was no recorded exploration by the Doctor with Clare or Anne into the background and circumstances leading up to the overdose, or Anne's *'dubious'* comment.

37. As outlined within the local guidance[17] Clare was reviewed at 15:45 the next day by the duty hospital CAMHS worker before being discharged. A mental state examination was completed. Clare repeated that the trigger for the overdose was *'low mood, frustration and anxiety at not being taken seriously'* and that a factor had been her CAMHS session on the 9th July 2014. However, Clare had been feeling low for some months, during which time she had been considering taking an overdose and had been storing paracetamol for the purpose. Professional opinion was that the incident was a significant suicide attempt, given the delay (over 12 hours) in treatment. The CAMHS worker's observation was that *'research into method (of overdose) is of concern'* as was Clare's storing paracetamol.

38. Liaison was made with Clare's named CAMHS 1 worker who was apprised of the incident. Safety and monitoring strategies were discussed with Anne prior to Clare's discharge on the afternoon of the 11thJuly 2014. Clare was given a follow up appointment

[17] Leeds Safeguarding Children Board Self-harm and Suicide Behaviour Protocol

within two weeks. CAMHS 1, GP and Specialist Community Public Health Nurse (School Nurse)[18] were notified of the admission and the incident.

39. Clare had no previous involvement with the 5-19 Healthy Child Service (School Nursing Service) prior to the overdose in July 2014. On notification on the 15th July 2014, the School Nurse contacted Clare and Anne to offer support, though she was aware of on-going CAMHS 1 involvement. Clare and Anne chose not to take up the offer of support and there was no further contact with this service.

40. Clare and Anne attended a CAMHS session on the 23rd July 2014 with Clare's named care co-ordinator and a psychologist who had seen her in hospital during her admission. An in-depth exploration took place into the mother/daughter relationship and systemic factors were considered. Following this a referral for psychotherapy with a psychiatrist was made.

41. Clare's behaviour was assessed as being, in part, '*a function of her early experiences of parental separation and associated attachment/relational difficulties, compounded by her mother's own insecure parenting as a child*.' Clare's position as a child in the wider family of her half-siblings from her father's second marriage and the arrival of her mother's partner's child, seemed also to have produced uncertainties and insecurities for Clare. It seemed to CAMHS professionals that, *'there was a strong sense of systemic factors regarding connection, relationships and bonding'*[19]. A structured programme of twelve inter-personal therapeutic (IPT) sessions involving individual, dyadic and family therapy was arranged, running from September 2014 to January 2015. Clare was reported to be ambivalent towards attending which was explored by the therapeutic team who sought to offer her appropriate therapeutic interventions, namely from interpersonal therapy to family therapy.

42. The GP was notified and information was shared, including practitioner discussions with Clare and Anne about safety and minimising future risk of self-harm and suicidal ideation. This was in line with official guidance.[20]

43. Anne told practitioners at a session in January 2015 that '*there had been some improvement in the relationship with Clare and that they were planning a holiday together'*, although things had become strained with Michael. There had been no further incidents of self-harm according to Anne. Clare decided to discontinue the therapeutic work with CAMHS 1 in January 2015 stating that *'she and her mother had worked things out and their relationship had improved'*. It was agreed to wait six weeks before making a formal discharge to allow Anne an opportunity to call back in the event of any deterioration in Clare's emotional well-being. The GP was informed.

[18] Part of the North Yorkshire 5-19 Healthy Child Service.
[19] LCH SCR report, page 14, paragraph 9.7
[20] Department of Health (2007), 'Best Practice in Managing Risk'.

Discussion

Delay and Waiting Times

44. The delay of nearly five months (early February 2014 to 25th June 2014) before the first CAMHS 1 appointment offered was not to Clare's advantage. Although Clare and Anne were signposted on the 3rd March 2014 to additional agencies, which *may* have been able to offer support in the interim period. It would have been beneficial had she received a quicker and more timely response from CAMHS 1, notwithstanding demand pressures on services.

45. Long delays and a lack of timely intervention for young people from the full range of Children's Mental Health Services, including CAMHS[21], are recognised nationally by Government[22] and professionals[23]as being detrimental to children and young people's mental well-being[24]. *'Unfortunately, all too often, children and young people have a poor experience of care or they struggle to get timely and appropriate help ('Right care at the right time') that meets their needs'*[25].

46. The CQC report states that Community CAMHS nationally needs to improve waiting times. Many local CAMHS services, in conjunction with their local commissioners, set their own waiting time targets. This can result in considerable variation that can lead to a, *'post code lottery'* for timely service provision. The CQC report noted that crisis care was limited because of availability only during normal office hours (9:00-17:00) or that out of hours support was provided by adult psychiatrists who do not specialise in children and young people's mental health. The CQC report identifies the importance of easily accessible crisis care and gave an example of a team being co-located in the emergency department of a local acute hospital operating seven days per week from 08:00 to 23:00.

47. 'Future in Mind' 2015, the governmental blue print for a step-change in mental health services for children and young people has an aspirational target that by 2020, *'In every part of the country, children and young people have timely access to clinically effective mental health support when they need it'*[26]. With additional funding, this would be delivered by a five-year programme to develop a comprehensive set of access and waiting times standards bringing the same rigour to mental health as in physical health. An additional objective involves improving care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible[27].

48. The Leeds Local Transformation Plan 2015[28] is a five-year strategic plan aiming to deliver whole system change to children and young people's emotional and mental health

[21] This refers to the full range of children and young people's mental health services, from Tier 1 (Universal), Tier 2 (Schools and Third sector), Tier 3 Community CAMHS and Tier 4 In-patient, CAMHS
[22] 'Future in Mind' 2015 and the Green Paper on Mental Health Services for Children, December 2017
[23] CQC report, 'Review of children's and young peoples' mental health services, phase one report October 2017; Children's Commissioner 2017)
[24] 39% of specialist community CAMHS are rated as requires improvement and 2% as inadequate according to CQC (see CQC, October 2017, 13) regarding waiting times.
[25] CQC, 2017, pg 2
[26] Future in Mind, 2015, pg 14
[27] Future In Mind – Objective 6 pg 15
[28] Leeds Local Transformational Plan for Children and Young People's Mental Health and Wellbeing: 2015

support and service provision. It incorporates priorities from primary prevention through to specialist provision and focuses on improving children and young people's experiences and outcomes. It is overseen by the Clinical Commissioning Group 1 Partnership, the Health and Well-being Board, the Family Trust Board and is a key programme in the Leeds Children and Young People's Plan (2015-2019)[29].

49. Part 6.1.1 of the plan (Access to Services) states that '*following consultation with local children and young people about their experiences of CAMHS 1 services, concerns were noted at the length of waiting times*.' A specific request for support during the wait, such as self-help, peer support and on-line support was made. This SCR, however, notes that despite this, there appears to be no waiting time target included in the Leeds Local Transformation Plan. The CAMHS 1 website (at 6th April 2018) states that *'We aim to see children and young people waiting for a first consultation clinic appointment within 12 weeks. Unfortunately, we are experiencing longer wait times than the normal 12 weeks. We apologise for this and are working hard to try and ensure that wait times are reduced as quickly as possible'.* As of February 2018, 90% of the children and young people attending a first consultation clinic appointment were seen within 27.2 weeks with an average wait of 9.3 weeks[30].

Education – School S1

50. Although living with her mother in Leeds, Clare had attended Secondary School (S1) in North Yorkshire since 2011, having previously attended a Leeds Primary School. Clare had been a good student at School 1 with an acceptable attendance record, who presented no real concerns until January 2015. School 1 reported that it was not aware of her involvement with CAMHS 1 or her previous self-harming and suicidal ideation in 2014. There is no recorded communication with Clare's GP or CAMHS 1 and no recorded communication between School 1 and Anne regarding Clare's difficulties. However, there is a discrepancy in accounts. Anne states that she had spoken to a member of School 1's staff the day after Clare's first self-harm episode. Anne said the staff member did not take the incident seriously and she did not feel listened to. She also said that she had informed School 1 of Clare's involvement with CAMHS 1.

51. In January 2015, Clare was involved in a fire alarm incident where she and another girl set off the school fire alarm and was excluded for one day. This was seen as a *'one -off'* episode. A re-integration meeting was held with Clare and Anne in late January 2015, but no mention was made of the recent CAMHS involvement or Clare's emotional wellbeing. A bespoke career interview was conducted with Clare during which it was identified that she '*lacked motivation'* to do well in her studies, although there were no other concerns noted.

52. Uncharacteristically, Clare was absent for seven days in April 2015, which resulted in the school's support officer contacting Anne. It transpired that she had been staying with her

[29] The Integrated Commissioning Executive (ICE) functions as the formal commissioning sub-group of the Health and Well-being Board.
[30] Information given in e mail (30.04.18) from Clinical Commissioning Group 1

maternal grandparents. The episode had coincided with a referral by the GP to CAMHS 1. This referral was not known by or notified to the school which, as mentioned above, had made no record of being made aware by Anne of any underlying emotional or mental health difficulties regarding Clare. Following discussions with Anne, Clare was offered a place in the school's nurture unit that offered support to vulnerable students. Clare took this up in late April 2015. Her programme noted weak literacy skills and significantly low self-esteem. Interventions aimed to re-engage her with the school, strengthen her learning given this was an important pre-GCSE year, increase her motivation and support for her anxiety over exams.

53. Despite support from the nurture unit, Clare's attitude and mood deteriorated to the extent that the school advised Anne to visit Clare's GP with a view to making a referral to CAMHS. Unbeknown to the school the family GP, at Anne's request, had already re-referred Clare to CAMHS 1 in mid-April 2015 due to concerns about Clare's self-reported depression. There was a delay in CAMHS seeing Clare due to waiting times. She was again signposted to another support agency in the meantime. Anne had indicated that Clare was not self-harming at that time. Clare was not seen by CAMHS 1 as by June 2015 she had moved to live with her father in North Yorkshire.

54. Several contacts took place between Anne and the School's Support Officer (School 1) in May 2015 and early June 2015 when they discussed what progress had been made with a CAMHS referral. Clare's last day at School 1 was on the 10th June 2015. The school received a phone call from Sue (Clare's step-mother) on the 15th June 2015 informing them that Clare was living with them in North Yorkshire. Patrick and Sue met with the school on the 19th June 2015 to discuss Clare's future education but no decisions were made. Clare started at a local secondary school (School 2) in North Yorkshire on the 7th July, nine days before the end of term. She was taken off School 1's roll on the 17th July 2015.

Discussion

55. March 2015 to mid-June 2015 was a critical time for Clare and her family. There appeared to be a notable deterioration in her emotional and mental health, possibly related to changes in family dynamics leading to her move to her father's home in North Yorkshire. Notwithstanding the length of service waiting lists a timelier and early intervention in spring 2015 by CAMHS 1 could have been to Clare's advantage. CAMHS 1 has pointed out that this was a routine referral, and that even if the service could have met the standard waiting time the earliest Clare would have been seen was mid-July 2015, by which time she had moved to her father in North Yorkshire. Additionally, the move to a new school (School 2) came at a very significant and potentially negative point in Clare's education.

56. School 1 reportedly had not been informed by the GP, the School Nurse or CAMHS 1 of Clare's emotional wellbeing difficulties, or her previous self-harming/suicidal ideation[31]. Without this information sharing, and given it held no record of the information Anne claims she had shared with School 1, the school did not take these issues into consideration in planning and offering pastoral support for Clare's mental health needs. Steps had been taken to address her academic educational needs through inclusion in the nurture unit. Clare's father recalls that she was spending the entire school day in 'safe house' classroom with her head in her hands although this had not been communicated with him at that time. There should have been an attempt, with parental consent, to undertake a more multi-agency approach between School 1, GP, CAMHS 1, School Nursing and the family via an Early Help assessment, seeking to meet Clare's needs for therapeutic and pastoral support. Consideration by any of these agencies should have been given, if circumstances warranted, to make a referral to Local Authority 2 with a view to assessing her as a possible 'Child in Need' under Section 17 of the Children Act, 1989.

57. Had there been a record made that Clare's mother had informed School 1 about her daughter's emotional wellbeing, behavioural troubles and recent involvement with two key health agencies, this may have led to School 1 providing extra pastoral and educational support whilst Clare was on CAMHS 1 waiting list from April to June 2015.

North Yorkshire: Mid-June 2015 to 25 November 2015

58. Following the move to her father's Clare remained with him, Sue and her half-siblings, from mid-June 2015 to the 25th November 2015 when she was admitted on an informal basis to Hospital 2 in Sheffield. During this time, Clare was involved with six agencies:

- School 2
- Police 2
- Local Authority 1
- Hospital 4
- CAMHS 1
- CAMHS 2

School 2

59. Clare started at School 2 on the 7th September 2015 and remained there for eleven weeks until the 11th November 2015. Regardless of having started there in July 2015 there was no record of Clare's school files being formally requested from School 1, despite there being a process in place to facilitate this. The agency report from School 2 states that key staff had left prior to the start of this SCR and that there was some difficulty in both accessing information and locating records. We must conclude there was a problem with vital record keeping at School 2, certainly in relation to Clare.

[31] Although a GP letter referring to Clare's anxiety and depression was sent directly to the exam board in mitigation of her absence of the 16 April 2015 when she missed a GCSE PE assessment. The letter was not made available to the school (S1).

60. The transition of Clare's records from School 1 to School 2 fell short of required standards. Formal records were not shared between schools. A phone conversation was held between the schools about Clare, but there were no records of the content of that discussion, what information was shared, or what actions were agreed regarding support for Clare. Given School 1's reported lack of knowledge of the extent of Clare's vulnerabilities via her parents or health agencies, School 2 also remained unaware of these until the 18th September 2015 following e-mail communication with Clare's father; he mentioned Clare's previous self-harm and suicidal ideation. However, Sue reported that she had already discussed Clare's issues with the school in previous meetings'. Patrick's disclosure was the result of Clare's challenging behaviours and problematic attitude to School 2's staff. She was placed in *'isolation'*, in line with the school's behavioural policy, and given an opportunity to discuss her behaviour with the school's Assistant Head Teacher.

61. Following the disclosure by Patrick, School 2 staff met Clare's step-mother, Sue on several occasions, none of which were recorded, thus falling short of acceptable practice. Legally, at this stage Clare's mother Anne should also have been consulted by School 2 given she retained parental responsibility under the Children Act, 1989. In any event, the outcome of the discussions with Sue was the organisation by School 2 of a work placement for Clare and a bespoke timetable when in school. There was no attempt by School 2 to follow up the information from Patrick regarding Clare's self-harm and suicidal ideation and the implications of one or both for her safety and wellbeing as well as her behaviours in school.

Discussion

62. This episode was a missed opportunity for School 2 and other agencies to share crucial information and develop a co-ordinated plan to address Clare's needs. More effective information sharing between School 1 and School 2 would have supported a more holistic assessment of Clare's needs, and consideration by School 2 and other agencies of any additional actions necessary to support Clare and her family. The NYSCB Vulnerability Checklist was available and could have helped the school determine Clare's level of need, but was not used.

63. Clare's mood and behaviour in school did not improve as the term progressed. She then opted out of involvement in the work experience placement. Her last day at School 2 was on the 11th November 2015 prior to a missing episode and her leaving a suicide note at home on the 12th November 2015.

Discussion

64. Clare's social, emotional and mental health (SEMH) needs were not adequately considered or assessed by School 2 due to several factors including: failure by School 2 to request formal pupil transfer information from her previous school, a lack of effective

recording of telephone calls and meetings with Sue, a failure to follow up with health agencies, including the Healthy Child 0-19 Service, 'Compass Reach'[32] programme on learning from Patrick about Clare's previous self-harm and suicidal ideation, a lack of holistic assessment processes or consideration of any additional actions necessary to support Clare.' Arguably, she was viewed as a troubling adolescent with challenging behaviour rather than a troubled young person with significant and serious emotional and mental health issues that underlay her behaviours.

65. Due to the non-availability to the reviewer of relevant key School 2 staff, who have left since Clare's death, it has not been possible to gain an understanding of why systems and processes designed to facilitate pupil transfers and assessments of individual needs, including SEMH, were not functioning as the law requires between July 2015 and November 2015. This was a critical time for Clare, involving significant changes in her life around family, school, location and friends. This review concurs with the comment in the relevant agency report that, *'A more structured approach (from S2) may have enabled more evidenced based interventions to be sought by the school with greater involvement of outside agencies'.*

North Yorkshire Agencies

66. Clare had two contacts with Police 2, the first in the early hours of the 6th July 2015 when she was located walking on a main road near her father's home, attempting to walk to her mother's home in Leeds. The police considered she did not present as being, *'at risk',* nor was she displaying self-harming behaviour or suicidal ideation. Because her step-mother had reported her absence from home after she was found by the Police, the incident was not logged as a missing episode. In policing protocol terms there was no need to institute a *'Missing from Home'* process. The Police ensured that she was safe, re-united her with her mother Anne, informed Patrick and Sue of the situation and recorded the incident for future reference.

67. The next contact with Police 2 was on the 12th November 2015 when Patrick reported Clare missing as he found a suicide note indicating what he considered was a serious intention to kill herself. Clare was located at the end of the street and re-united with her very concerned father and step mother as Sue had found the suicide note. Clare agreed to attend Hospital 4 with Patrick and Sue and a referral was made to Local Authority 1 by the Police on the 20th November 2015.

68. Clare was taken by Sue to the Emergency Department at Hospital 4 and admitted at 20:38 on the 12th November 2015. Four hours later Clare told a Psychiatric Senior House Officer (a Junior Doctor from the CAMHS 2) that she had taken 30-40 paracetamol tablets (500mgs) the previous day at around 15:00. Clare said that she felt suicidal and continued to have such thoughts. This disclosure was made whilst Sue was waiting outside the

[32] This provides a service to children and young people aged 9-19 in relation to emotional well-being and mental health issues. Also included are individuals with moderate or high levels of need in regard to substance misuse/alcohol and /or sexual health.

room. Evidence was found of healed self-harm wounds and Clare said that she had been in a low mood feeling 'awful', for some months. She expressed no regret at taking the overdose and wished that she was dead.

69. The Nurse in the Emergency Department telephoned the Local Authority 1 Duty Team (EDT) to establish whether Clare was known to Children & Families Services and was advised to send in a referral. There is no written evidence this was done, or any recording that the Emergency Department staff had discussed this referral with ward staff. Moreover, there was no evidence the hospital staff had discussed with Sue the option of support for her to manage Clare's behaviour through the Local Authority's Prevention Service.

70. The psychiatrist assessed Clare as at high risk of suicide and self-harm given her presenting behaviour and self-reporting. There were also concerns for her mental health. A decision was made to admit her to the paediatric ward for further CAMHS 2 risk assessment and treatment for the paracetamol overdose. Clare was assessed in the late morning of the 13th November 2015 by two clinical psychologists who obtained a history of her previous involvement with CAMHS 1.

71. The assessment concluded that the episode had been a serious attempt to end her life, which she had planned for over a week. Clare had e-mailed the school pretending to be her father stating that she would not be in school that day. She had bought the medication online and had written a note which included music that she wanted playing at her funeral.

72. Clare was kept on the paediatric ward overnight and was assessed the next morning, following blood tests which showed that her paracetamol levels had normalised, thus indicating that she was medically fit for discharge. She was seen by the on-call psychiatrist in the afternoon and discharged at 19:30 on the 14th November into the care of her step-mother and father under a safety plan[33] and given an outpatients' appointment to attend CAMHS 2 at on Monday 16th November at 09:30.

Discussion

73. The evidence shows Clare's physical and emotional/mental health needs were well met by staff at CAMHS 2 and Hospital 4 in the Emergency Department and on the paediatric Ward. Her paracetamol overdose was treated appropriately. There was a thorough assessment of her mental health and risks of further self-harm and suicidal ideation prior to her discharge into the care of her paternal family. An early CAMHS outpatient appointment was secured in compliance with the North Yorkshire Pathway of Support for Children and Young People who deliberately self-harm.

[33] This involved the removal by Clare's father and step-mother of all medication from her bedroom and bathroom and to be moved to a safe place. An emergency number and contacts were given in the event of any further incidents.

74. It is not known why a referral was not made to Local Authority 1 Children's services by the hospital staff, or why the option of exploring the possibility of support from the Prevention Service was not pursued with Clare's paternal family. This SCR would judge such practices as unacceptable and not in Clare and her parent's best interests.

75. Key learning from this practice episode is that agencies should formally follow up concerns with a referral to the Local Authority 1 Children's Services in line with already established organisational and partnership policies.

76. Clare, Patrick, Sue and Anne met with the CAMHS 2 care-co-ordinator on the 16th November 2015 as arranged. The ensuing assessment raised significant concerns regarding previous self-harm, recent suicidal incidents and Clare's on-going suicidal ideation. Options were discussed involving an in-patient admission to the CAMHS Inpatient Service 1 facility in York for further assessment, to which Clare and her parents agreed. A safety plan was developed to manage the risk in the interim. It involved Patrick and Sue keeping Clare under constant supervision at home advice was given to remove as many objects as possible which Chare could use to harm herself. The family were also asked to undertake one hourly observation during the night. The family reflect that this was difficult to deliver with other commitments e.g. work and other children, as well as damaging the relationship between Clare and parents. The care co-ordinator made the necessary arrangements for admission to a Tier 4[34] service and scheduled a further assessment for the 19th November 2015 at CAMHS Inpatient Service 1.

77. Local Authority 1 Children and Families Prevention Service received a referral on the 20th November 2015 from Police 2 following the missing incident of the 12th November 2015. The eight-day interval between making the referral and the Prevention Service receiving it was caused by the shift pattern of the attending Police Officer. This meant the service standard of completing a return interview within 72 hours was not met. However, the Missing from Home Care Protocol was followed as the family were contacted on the 18th November 2015 and offered an interview. This was declined by Patrick as Clare was due to be admitted to CAMHS Inpatient Service 1 for a four-week in-patient assessment the next day and appropriate support was therefore being offered. The family was advised how to request future support from the Prevention Service and the case was closed. There was no further involvement from this service.

78. In April 2017, as part of developments in the Safeguarding Unit, the missing process was reviewed. The Police now notify the Safeguarding Unit when a child goes missing and make a further notification when they are found; this prevents delays.

79. The CAMHS Inpatient Service 1 assessment of the 19th November 2015 concluded that a four-week in-patient admission could be beneficial for Clare. This followed the

[34] A Tier 4 service involves admission of an individual as an in-patient. Since 2013, NHS England has had commissioning responsibility.

commissioning principles of identifying the least restrictive environment as close to home as possible. It was noted, that due to previous changes in her life a further move could have had a de-stabilising effect on her. The care plan's purpose was to seek to understand the causes of her difficulties, providing an opportunity for further assessment around Clare's risks of self-harm and potential suicide, seeking to understand the underlying causes of her emotional instability and establish what could be done to address, reduce and manage risks. This would enable further therapeutic work in the community, endeavouring to keep her safe.

80. The admission would be informal and would not require recourse to compulsory admission under the Mental Health Act, 1983. An important element was development of a therapeutic relationship with Community CAMHS, to progress future treatment and support after the in-patient assessment.

81. At Clare's parents' request an alternative option was offered involving a community care package from CAMHS 2, entailing weekly/fortnightly sessions with the care co-ordinator, involvement with a psychiatrist and the availability of a duty clinician in the event of future concerns. Patrick and Sue recall that there was an expectation that parents would be with Clare on a 1:1 basis all day, every day to reduce the risk of self-harm which would be difficult to achieve for working parents with other children. However, there was no facility at the time for the provision of an assertive, out of hours, outreach/crisis service. Clare and her parents said that they would like the weekend to think about their options.

82. On the 23rd November 2015, Clare and her parents were informed by the CAMHS 2 care co-ordinator that there was no longer a bed available at CAMHS Inpatient Service 1 because of acuity factors, with five young people on 1:1 observations. This prevented the planned admission. Clare's parents did not feel in a position to safely manage Clare's behaviour whilst waiting for a bed. Given the already agreed and identified risks, they were not in a position to agree to the community package over the longer term. They wanted CAMHS 2 staff to look for a bed elsewhere. It was not recorded what Clare's views were.

83. The care co-ordinator and the NHS England case manager (see next paragraph) went through the process of sourcing a suitable Tier 4 in-patient placement in another hospital by working their way through the list of available beds across the country, starting with those with any proximity to Clare's home. The option of an in-patient facility in Leeds was explored but the facility was full. Clare was eventually admitted to Hospital 2 in Sheffield on the 25th November 2015 as an informal patient. Her CAMHS 2 care co-ordinator remained involved as the responsible professional throughout her time there, and later whilst she was placed at Hospital 1.

84. The NHS England Yorkshire and Humber Specialised Commissioning team had a role in commissioning admission to Hospital 2. The allocated NHSE case manager (Mental Health Commissioning Manager (MHCM)) works with local services and the Tier 4 provider, in

this case the CAMHS 2 care-co-ordinator and Hospital 2 staff. Their role is crucial in ensuring that an individual's needs are addressed and links are maintained with the home area. This is especially important given individuals placed in secure units can spend lengthy periods away from their families, increasing the risk of losing significant relationships. This was the case with Clare.

Hospital 2, Sheffield: 25 November 2015 – December 2016 and November 2015 to February 2016

85. Clare was admitted on an informal basis to the Hospital 2 in Sheffield on the 25th November 2015 and placed on a general adolescent unit. Hospital 2 is an independent specialist mental health hospital[35] providing low secure and locked rehabilitation services for women and children, and adolescent mental health services for males and females aged between 11 and 18 years. Two wards serve adolescents: a 15-bed mixed gender acute general adolescent ward and a 12-bed mixed gender Psychiatric Intensive Care Unit (PICU).

86. Clare's admission was due to concerns regarding potential risks of being unable to manage her safely in her home community. The aim was to undertake a four-week assessment to gain a better understanding of her mental health needs, including the risks she presented, to establish a plan with the home community mental health team (CAMHS 2) to enable a successful discharge. More specifically, CAMHS 2, as the referring agency[36] wanted Hospital 2 to undertake an assessment of risk regarding Clare's self-harming and also consider an Autistic Spectrum Condition (ASC) assessment.

87. Clare's stated aim was to gain a better understanding of *'Why I am feeling this way?'* Her parents' aim was to work together to understand Clare's difficulties and agree how to support her. Hospital 2 recognised that *'Clare and her family ultimately need to address her difficulties by developing a therapeutic relationship with the community adolescent mental health team, namely the CAMHS 2'.*

88. It was recognised by Hospital 2 that Clare needed a safe environment in which to engage in the assessment work but that she had also recently experienced unsettling changes in school and home locations in her move of home between parents. The further move to Sheffield, albeit ostensibly for only four weeks, could potentially have had a further de-stabilising effect, as could being in an in-patient setting. In the event, Clare's stay at Hospital 2 was for 54 weeks after which she was transferred on the 6th December 2016 under Section 3 of the Mental Health Act, 1983 to Hospital 1, around 200 miles away from home.

89. Following her admission on the 25th November 2015 Clare was given a preliminary diagnosis of a severe depressive episode with suicidal ideation. Her consultant

[35] The hospital is run by Hospital 2 Limited and part of Universal Health Services (UHS), the largest provider of behavioural health care in the USA.

[36] NHS England (Yorkshire and Humber Specialised Commissioning Team) also had a role in the commissioning and oversight of the placement at Hospital 2- see later paragraphs.

psychiatrist had identified a key risk as being her contemplating running out in front of road traffic.

90. Clare continued to engage in self-harm from early on in the admission. This escalated to the point where it was beginning to have a significant detrimental impact on her life, starting on the 6th December 2015 when a TV remote battery from her room went missing. It was suspected she had secreted it with the possible aim of swallowing it. Clare declined to discuss the incident. There was no mention of the incident in the risk assessment/care plan, which was not updated to consider this new factor.

91. Following a ward round on the 22nd December 2015, Clare was allowed unescorted home leave to her mothers, which was to take place on Boxing Day. There were no details in hospital records of the planned duration, time or location of the leave. Nor was there a recorded risk assessment regarding the potential for Clare's self-harm or suicide.

92. Clare was noted as finding it difficult to engage in the care and treatment plan during this early phase at Hospital 2. She had also started to neither eat nor drink. This was seen as self-neglect and deemed symptomatic of her self-harm. Her resulting physical health needs were then met by the Physical Health Care Team. They oversaw her self-neglect/feeding issues and sought advice from Children's Services regarding safeguarding. They treated her self-harming injuries, undertook blood testing and liaised with the local GP and hospitals when required.

93. In response to Clare's ongoing deteriorating behaviour, a decision was taken by Hospital 2 professionals to the PICU on the 8th January 2016 under Section 2 of the Mental Health Act, 1983. This was undertaken without any recorded consultation with Clare or her parents. The Section provided hospital detention for up to 28 days and for a further assessment following her first ligating incident earlier that day. The assessment was completed 'in house' by the ward clinical team[37]. No record was evidenced that included the ligating incident and no update was made to her care plan and risk assessment. Her transfer to the PICU meant she experienced a change of clinical team. This would likely to have been experienced as yet another set of significant transitions, albeit her psychologist and schooling remained the same. Arguably, these changes would likely not have benefitted Clare's condition or facilitated Hospital 2 assessment of her needs and attempts at a therapeutic intervention with the aim of addressing the underlying reasons for her emotional distress and the reduction self-harm and suicidal behaviour.

Discussion

94. Clare's section on the 8th January 2016 marked a further critical phase in her pathway through the adolescent mental health system, having entered Tier 4 CAMHS services on a voluntary basis through admission to Hospital 2 on the 25th November 2015, where she was compulsorily detained under the Mental Health Act, 1983, after a process in which her parents had not been consulted.

[37] Section 2 requires the approval of two doctors and an approved mental health practitioner.

95. The CAMHS 2 care co-ordinator, at Hospital 2's request, contributed information regarding the Mental Health Act assessment. She also received weekly reports and meeting minutes on Clare's progress at Hospital 2, albeit there was no evidence that she had attended - or been invited to attend - any of the multi-disciplinary meetings such as a Care Programme Approach (CPA).[38]

Discussion

96. Hospital 2 was proactive in ensuring Clare's physical safety, seeking to meet her physical health needs and managing her self-harming behaviour, during the initial four weeks prior to her being detained under Sections 2 and 3 of the Mental Health Act, 1983. However, there was little evidence of what, if any, purposive work was being done with her and the parents on the aims and objectives of the original four-week admission. Good practice indicates professional intervention, whilst needing to ensure a young person's safety and well-being, should also engage with the individual and attempt to understand underlying reasons for self-harming and suicidal ideation.

97. Sullivan (2017) suggests a correlation between a person's behaviour and the degree of control they exert over their environment. The greater the degree of environmental/external control, the more likely an individual will engage in reactive and protest behaviour (flight or fight) to try to regain control. This can result in a negative feedback loop of interaction resulting in ever more challenging behaviour which is then matched by a regime of ever increasing control and coercion by the institution. The focus of intervention then becomes ensuring the individual's safety through enhanced control, at the cost of forming constructive, and trusting relationships designed to address underlying problems and work towards solutions and positive outcomes. Sometimes there is a tendency for agencies to focus on the 'troubling teenager' and their behaviour, rather than trying to engage with the adolescent and their underlying issues.

98. The evidence provided by Hospital 2 raises questions about the balance between care and control, the engagement of Clare and the need to ensure her safety. In short, was there an over focus on control at the expense of engaging her through the development of a constructive and trusting relationship?

99. With regard to consultation with Clare and her parents about going to an out of area facility, there is little indication in the reports from CAMHS 2 and Hospital 2 as to how much discussion there was about the admission. Albeit that there was agreement that Clare needed in-patient intervention, and commissioners had tried without success to place her nearer to home. In addition, there was little or no evidence of the care co-ordinator communicating with and keeping Clare's parents up to date with developments during her stay at Hospital 2. In this respect communication fell significantly short of acceptable standards. Patrick, in a subsequent contact with the Author, described the

[38] The CPA is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems.

poor communication as a fundamental failing that made things very difficult and upsetting for him and Sue'

100. It is documented that Clare did not want to be at Hospital 2. She wanted to return to her mother or live with her maternal grandparents, which at the time was not a safe option because of difficulties in managing her risk at home. Clare was clear she was unhappy living with her father.

101. In any event, it would seem the original aims and objectives of the four-week assessment were not met, partly for reasons to do with the hospital's approach to Clare; her escalating presentation of self-harming behaviours and limited engagement with staff.

102. Hospital 2 and the CAMHS 1 care co-ordinator co-operated in relation to the provision of reports and minutes of multi-disciplinary meetings, input into Clare's compulsory detention under the Mental Health Act, 1983 and the Autism Diagnosis Observation Schedule (ADOS) assessment. However, the care co-ordinator should have taken a more proactive role, for example in attending some CPA meetings whilst Clare was at Hospital 2. Given this was an out of area placement this only served to emphasise the key pivotal and linking roles that should have been played by the CAMHS 2 care co-ordinator between Clare, Hospital 2, family and home agencies, including the Local Authority Children Services[39], this latter being especially important given Clare was compulsory detained under the Mental Health Act, 1983.

Commissioners and Regulators: NHS England and the Care Quality Commission (CQC)

103. This SCR notes that NHS England (NHSE) started a single item Quality Surveillance Group in December 2015, focusing on three hospitals belonging to Alpha Hospital of which Alpha Sheffield was one. Hospital 2 Group acquired Alpha Hospitals on the 19th August 2015. The Quality Surveillance Group are part of the quality monitoring and assurance system used by NHS commissioners and other stakeholders, including Local Authorities and regulators[40], specifically where there are concerns regarding a provider. The group was convened due to escalating concerns regarding Hospital 2 Sheffield. Several key themes were identified including the hospital's understanding of its core business, the climate and effectiveness of organisational learning, leadership, embedding governance and staff retention.

104. Following acquisition of Alpha Hospital by Hospital 2 Group a new board structure was put in place, along with a mechanism of introducing and implementing improvements to Hospital 2's processes. The Quality Surveillance Group looking into Hospital 2 closed in March 2017 as it was deemed sufficient progress had occurred to remedy commissioner and CQC concerns. Throughout the process there was increased surveillance on the service by the Yorkshire and Humber Specialised Commissioning Team and NHS England case managers. This involved carrying out service reviews with key lines of enquiry

[39] There was a legal duty for Hospital 2 and CAMHS 2 to notify Local Authority 1 of Clare's placement at Hospital 2 once she had been there for three months (i.e. at the end of February 2016)
[40] (namely, the Care Quality Commission, CQC)

relating to CQC concerns and NHS England case managers attending Multi-disciplinary team and Care Programme Approach meetings. Quarterly contract meetings to review and monitor quality and safety were carried out and further supported by attendance at monthly Hospital 2 governance meetings.

105. It is noted that Hospital 2 was subject to four CQC inspections in February 2015, January 2016, June 2016 and August 2017. Five requirement notices [41]were issued by the CQC in February 2015 because the hospital was failing to meet regulatory standards within the safe domain. A rating was not given.

106. In response to concerns from the CQC and NHS England in regard to ongoing issues in child and adolescent mental health services, Hospital 2 commissioned an external Independent review of the child and adolescent wards in December 2015. A CQC action plan was developed, and reviewed at the next inspection in January 2016. The Inspection team was assured that all actions were completed against the plan. A rating was not given. The subsequent report issued on the June 2016 identified that the hospital was in breach of Regulation 13 HSCA (i.e., *'Safeguarding service users from abuse and improper treatment'),* namely that, *'Informal young people were not able to leave the ward at will'*.[42]

Hospital 1: 15th February to 7th July 2016

107. Clare was made the subject of Section 3 of the Mental Health Act, 1983 on the 3rd February 2016, providing for detention and treatment in hospital for up to six months. It is not known what either she or her parents thought of this. Nor is it clear what their involvement was in any consultation as no records were produced. We must conclude none were made, or kept, that would have evidenced this. Likewise, it is not known what involvement the CAMHS care co-ordinator had in the decision, albeit she continued to receive weekly updates from Hospital 2.

108. A Care Programme Approach (CPA) meeting was held on the 4th February 2016 involving the Clinical Team from the adolescent ward, Patrick, Anne and Sue. Neither the NHS England case manager nor the care co-ordinator from CAMHS 2 were present, nor was Clare. These absences, especially that of Clare, fell short of good practice (as admitted by the Hospital 2 report at page 10) and did not respect her participation rights or afford her a direct voice in decisions about herself. The Clinical Team had assessed that the ward could not meet her emotional and mental health needs because of both the acuity of her clinical presentation and the severity of her risk-taking behaviour.

109. Clare was engaging in almost daily self-harm and her involvement with the assessment and therapeutic programme[43] was mixed. Reportedly she often remained silent, spoke infrequently or did not attend. It was agreed she should move to the PICU to meet her

[41] This requires an agency to take actions to address the shortcomings in services identified by the CQC inspection.
[42] In breach of regulation 13 (4) (b) (5).
[43] (this included a range of individual and group interventions)

treatment needs and better manage her risks. The move happened on the 5th February 2016.

110. Due to the absence of any supporting documentation, it is not known precisely what the care plan and risk assessment were whilst Clare was on the PICU. It would seem the focus was on the containment and control of her increased risk of self-harm. Arguably such behaviour can function as a means of emotional regulation and/or as a coping mechanism in response to environmental factors. This should have featured in her plan, but it did not. Indeed:

'*Enforced interventions to stop patients injuring themselves are likely to produce a confrontational rather than a therapeutic environment that increases levels of distress and reduces the chance of a positive outcome in the longer term……Many individuals who self-injure have a history of abuse or trauma and preventative measures may increase their feelings of powerlessness and in extreme cases result in additional trauma and therapeutic alienation'* (Sullivan: 2017)

111. The NHS England case manager attended a CPA meeting in March 2016 which sought to identify and support Clare's future pathway following her transfer from wards within Hospital 2. The least restrictive options, including going to CAMHS Inpatient Service 1 or a facility in Leeds (neither of which had a PICU), were considered. However, the clinical consensus was that Clare's level of risk militated against a transfer back to a General Assessment Unit (GAU). It is recorded by NHS England that the family agreed with this, although Clare's views were not known. The care plan presented at the CPA, according to NHS England felt, '*clinically appropriate'*. A new NHS England case manager was allocated to Hospital 2 Sheffield which included Clare's case.

112. The negative spiral of interaction between Clare and the staff at Hospital 2 continued. Clare was frequently involved in several self-harming incidents ranging in seriousness from aggravating and picking at pre-existing wounds, inserting foreign objects in wounds, fresh cuttings, ligating on two occasions in January 2016 and May 2016 and running out in front of vehicles on two occasions. Clare attended the Emergency Department at Hospital 5 overnight on the 12th February 2016 for a self-harm wound to her wrists. Emergency treatment was provided and a plan put in place for follow up at the Trust's specialist hand centre. On the 27th May 2016, having jumped out in front of a car, she was assessed as having not sustained any injuries and returned to the care of Hospital 2.

113. Clare's care co-ordinator from CAMHS 2 met with her on two occasions in late May 2016 and completed an autism assessment[44] in conjunction with Hospital 2 staff. This concluded that Clare did not meet the criteria for the disorder. Of note, Clare reported to staff in May about an episode that had taken place whilst at the Leeds primary school where she had reportedly told a member of staff that something had happened to her. However, there was no commentary regarding this in Hospital 2's documentation.

[44] An ADOS (Autism Diagnostic Observation Schedule) was undertaken.

114. In any event the task for the hospital, which proved problematic, entailed balancing Clare's safety whilst seeking to engage her in assessment and purposive therapeutic work. The hospital's response became increasingly focused on risk management, restrictions of liberty and control of her behaviour, involving allowance of a restricted number of items in her room, the use of items under close supervision, the use of restraint, time in the enhanced care suite, 3:1 observation, seclusion and restrictions of Section 17 of the Mental Health Act, 1983.

115. By the summer of 2016, it was clear to Hospital 2 that Clare's stay was having a minimal impact on alleviating her emotional and mental health wellbeing. A clinical decision was made that the risks were too high either to proceed to a '*step down'* to a general adolescent ward or, even more unlikely, discharge into her home community. The stalemate position on the Hospital 2 ward was deemed not in her interests and unsustainable. In light of the non-availability of other options a recommendation was made on the 7th July 2016 for Clare to be treated in a Tier 4 Low Secure Unit[45].

Discussion

116. Whilst acknowledging the challenges of working with Clare, it must be noted that interventions by Hospital 2 were unsuccessful in engaging her in the aims of assessing her risks, understanding underlying reasons for her self-harming and suicidal ideation, or working towards positive outcomes of community and family rehabilitation. The hospital did succeed in preventing her ending her life whilst she was a patient. However, the evidence indicates that the levels of self-harm and suicidal ideation increased to the point where the Hospital 2 team felt it could not safely manage the risks to Clare. This resulted in the multi-disciplinary team's decision to seek a transfer to a low secure unit.

117. In analysing the reasons for the above, several factors can be identified. As acknowledged in Hospital 2 agency report for this SCR, there were a number of internal practices that did not meet the required standards and a number of organisational issues that did not facilitate positive outcomes for Clare.

118. The first was with regard to care planning. The care planning structures and processes in operation were predominantly nursing plans which had limited input and review by the wider multi-disciplinary team. This raises questions of professionals' involvement and how effective the assessment was of Clare's wider holistic needs, risks, the quality of planning, implementation and review: in essence, the quality of the CPA process.

119. Two sets of care plans ran simultaneously, with contradictory aspects. For example, the observation levels outside Hospital 2 were recorded as 3:1 in one plan and in another, 2:1. Clearly, there should have been only one plan. The existence of two reflects a lack of co-ordination, communication and collaboration within the multi-disciplinary team working with Clare.

[45] See definition and criteria for admission.

120. Secondly, poor recording within Clare's patient record is noted. Care plans were produced electronically with communication mainly via e-mail both internally and externally in providing updated care plans, risk assessments and reports. However, the plans were not copied or placed in Clare's patient record, making it difficult to understand what information had been shared by the multi-disciplinary teams, with whom, or when. Compounding this is that previous versions of plans were overwritten when individual members of the multi-disciplinary team came to update and review the patient record. This resulted in a lack of clarity for staff as to whether Clare's care plan and current risk assessment had been updated and amended to reflect changes in her presentation, or following key events such as the two ligature episodes in January and May 2016 (see below).

121. There was no effective process for updating the care plan and risk assessment following a significant event or incident. Of concern in light of the manner of Clare's death at Hospital 1, the two ligature incidents did not result in the completion of an incident form as per Hospital 2 Policy, nor an up-dated risk assessment included in the care plan. There are also questions about the accuracy of recording of these incidents, which were described as *historic*. There was no contextual detail or analysis surrounding the ligature events or what was meant by 'historic'. These were serious events requiring, in one instance, the use of a knife to release Clare from the ligature tie. Both these and other self-harming events were viewed in isolation and not analysed and understood within a wider dynamic risk context for Clare.

122. Of significant concern, there is no evidence to show these two critical ligature incidents were included in the referral information sent to Hospital 1 in December 2016.

123. The record keeping and documentation practices did not provide an accurate or up to date assessment of Clare's complex needs and risks. Moreover, the infrequent care plan reviews compounded the ineffectiveness of the whole APIR (assessment, planning, intervention and review) process, resulting in a lack of an accurate up to date understanding of Clare's circumstances and her *'bigger picture'*.

124. Thirdly the operation of the fortnightly '*ward rounds'*, is of concern, as incidents occurring in the previous two weeks were not discussed with the wider multi-disciplinary team (MDT). This meant there was only partial information input into the ward rounds concerning Clare's care and treatment, all of which could result in an incomplete understanding of her needs, risks and progress and therefore a misdirection of practice in her case. Such practice also raises the question as to which professionals were present on the ward rounds and why the full Multi-disciplinary team was not in attendance.

125. Hospital 2's agency report indicates that there was a lack of multi-disciplinary team oversight of the whole care package and planning process. What passed for planning was completed by the nursing team in a uni-disciplinary manner that lacked input from the wider team. This may explain the re-active focus on day to day risk management of Clare (perceived as a troubling individual) at the expense of a more proactive attempt to

address her underlying emotional and mental needs and consider her longer-term welfare, post discharge.

126. A further factor was the poor quality of transition between the two Hospital 2 wards in mid-February 2016.There was no formal process for transitioning patients from one service (general adolescent ward) to another (PICU). The lack of a record of a formal handover meeting and effective information sharing between the two clinical teams did not make for a smooth transition. Crucially, there was no evidence that *risk incidents* identified on the adolescent ward, such as the ligature episode of early January 2016, had been noted or addressed by the PICU. Moreover, the two clinical teams had different consultant psychiatrists and nursing staff. The change in care regimes and the more restrictive care environment would have been problematic for Clare to negotiate, given her developmental history of a lack of secure attachments and trust within her family.

127. High staff turnover was an issue identified by Patrick and Sue and in the August 2017 CQC report (see below.) Patrick and Sue stated they *'Never saw the same consultant'* when attending CPA meetings. They noted that at one CPA meeting the consultant was helpful and suggested the family communicate with him directly but two weeks later he had moved positions. Communication with staff was very poor. The family claimed Clare did not have a key worker and felt it was impossible to get through to the ward via telephone to speak with her.

128. They stated that *'Clare felt she wasn't cared for in Sheffield and any staff member she did get close to would eventually move jobs'*. High staff turnover would not have facilitated the development of constructive therapeutic relationships given Clare's needs for healthy emotional attachment to caring adult figures, a sense of continuity, existential security and the development of trusting relationships.

129. Of significant concern was the lack of effective action by staff in regard to two safeguarding incidents which were not properly documented by the hospital or shared with the appropriate agencies.

Care Quality Commission (CQC)

130. Deficits and sub-standard practices identified above in respect of Clare's experiences at Hospital 2 were systemic. Evidence of this is found in the CQC inspection reports of December 2016 and August 2017[46]. The former reported on a visit in late June/early July 2016 which rated Hospital 2 Sheffield as '*Requires Improvement'*. Regarding the category *'Are child and adolescent mental health wards safe?*' it was found to be '*Inadequate'.* Parents recall that they we not made aware of the outcome of the CQC inspection result. The August 2017 report in respect of the PICU identified several issues and shortfalls that gave rise to significant concerns for the health and wellbeing of patients. As a result, the CQC sent an urgent letter of concern to the provider requesting them to provide assurance about what actions were to be taken. The PICU ward was closed for further

[46] Based on an inspection carried out in July 2017 following a serious incident on Haven ward.

admissions by the provider to allow for the implementation of an improvement action plan.

131. Some of the key findings, mirrored by evidence in this SCR, included:

- Shortfalls to the processes of individual risk assessments and limited information in care records about patient's warning signs.
- Records and care plans not always including known risks relating to the patient.
- No consistent system to inform staff about all newly admitted patients to the ward.
- The operation of two alternate shift groups at night with the same staff working in each shift.
- Differences in how staff found out background information about patients when they were not on shift.
- Shortfalls in the reporting and learning of incidents which although documented and described were not always entered on the incident reporting system.
- Learning from incidents was not shared with staff at ward level. No staff routine feedback about incidents unless they were serious. Post incident debriefs did not always take place.
- Safeguarding procedures did not protect patients from the risk of exposure to harm. Staff not identifying safeguarding incidents and logging them. Not all staff were knowledgeable about the ways they could report safeguarding matters, in particular when they occurred out of hours.
- Management of environmental risks was not robust; it was unclear what ligature risk assessment staff were expected to follow. Risks in the environment, such as access to screws in fixtures and fittings which had led to repeated incidents of self-harm by patients.

132. The most recent CQC report of November 2017, following an inspection visit in August 2017, rated the hospital still as *'Requires Improvement'* overall. The category of 'Are child and adolescent mental health wards safe?' *resulted in* '*Requires Improvement'*.

7th July 2016 to 6th December 2016

133. A referral was made by the hospital on the 7th July 2016 for a low secure placement. This was agreed to by Hospital 2 staff, CAMHS 2 and NHS England (as the commissioner of Tier 4 services). It is not known if Clare and her parents were asked for their views about the transfer. Patrick and Sue reportedly felt that they did not want her to move again, despite previous incidents, as they believed that any change would be disruptive for Clare. They only became aware of the move to Hospital 1 Norfolk on the 6th December 2016 on receipt of a 'Welcome pack', from the hospital. Clare's views were not known or recorded, although her father reported that she wanted to move back to a voluntary ward and no longer to be the subject of a Section under the Mental Health Act, 1983.

134. Tier 4 low secure settings are subject to complex commissioning arrangements by NHS England and at the time of Clare requiring a transfer there was an increased demand for Low Secure Services, which impacted on the waiting time. She was considered by two

low secure units and eventually provided with a place at the low secure setting of Hospital 1 in Norfolk some 200 miles from North Yorkshire. She was admitted on the 6th December 2016.

135. Clare's situation continued to deteriorate during the five months prior to her transfer to Hospital 1. The focus of professional intervention continued to be around containment and control of Clare's self-harm and suicidal ideation. Such was the frequency and seriousness of her self-harming injuries during the period (often involving the insertion of foreign bodies into her arm) that they necessitated admission to hospital and treatment during August and September 2016. The latter admission involved Clare being taken to the Emergency Department at Hospital 5 by a 3:1 nursing escort from Hospital 2. Unfortunately, she absconded and ran in front of a car incurring further injury and the attendance of officers from Police 3, resulting in a week's in-patient stay. There is no record of how such an absconding incident happened given 3:1 supervision was in place from Hospital 2.

136. Of some significance, the named professionals for Safeguarding Children at Hospital 5 identified that during this period there were significant numbers of young people from Hospital 2 attending the Emergency Department, each of them with self-harming injuries. Concerns were escalated to the Designated Nurse for Safeguarding Children, Clinical Commissioning Group 2 on the 24th October 2016 and were subsequently escalated to NHS England.

Discussion

137. There were difficulties of inter-agency working between Hospital 2 and Hospital 5 regarding Clare's self-harming injuries. An example of this was Clare's admission to Hospital 5 in September 2016. The acute staff had limited understanding of Clare's mental health needs, albeit they were aware that she was subject to Section 3 of the Mental Health Act, 1983. There was a lack of information sharing about Clare between the two health providers and poor if any evidence of a shared collaborative care plan to meet her physical and mental health needs and risks whilst in the care of both providers. There was no effective discharge planning and inter-agency planning. This pattern creates serious concerns

138. There were also gaps and deficits in the transfer of information about Clare from Hospital 2 to Hospital 1. The Hospital 2 report presented as part of this SCR noted that the health records did not evidence clearly what information was shared with Hospital 1 on Clare's discharge from Hospital 2. There was a deficit regarding the storage of records and a lack of clarity on what information had been either shared or documented. The additional information should have included at least the following: current care plans, risk assessments and management plans. These were absent.

Hospital 1, Norfolk

6th December 2016-19th March 2017

139. Hospital 1 in Norfolk was a Tier 4 Child and Adolescent Mental Health (CAMHS) hospital providing low secure and psychiatric intensive care (PICU) for 30 young people aged between 12 and 18 years of age. It was part of the Huntercombe Group, an independent provider of hospital services to the NHS with facilities throughout the UK. The hospital provided services to young people with a range of mental health disorders, detained under the Mental Health Act, 1983. However, following CQC inspections in 2017 and other considerations, the Huntercombe Group deemed that the hospital was not meeting the expected standards of service provision. It took the decision to close Hospital 1 in December 2017.[47]

140. What follows draws heavily from two sources, firstly the September 2017 independent investigation and report undertaken by NICHE[48] at the behest of Hospital 1, consequent to Clare's tragic death on the 19th March 2017. The investigation used the NHS England (NHSE) Serious Incident Framework of March 2015. Secondly, this review relies on the Police 1 case summary of the force's inquiry into Clare's death.

Assessment and Management of Risk and Care Planning

6th December 2016 to 10th March 2017

141. Clare was transferred from Hospital 2, Sheffield, to Hospital 1 on the 6th December 2016 under Section 3 of the Mental Health Act, 1983 to a low secure ward. She arrived with a diagnosis of (emerging) Borderline Personality Disorder and an implication from Hospital 2's clinical notes that she was also depressed, though no formal diagnosis of depression was made. Clare said she had suffered an episode of depression which had led to her current admission. She felt that she had recovered from this and no longer needed either to be subject to a Section 3 of the Mental Health Act, 1983 or be on medication.

142. On the 7th December 2016 a clinical risk inventory was completed. It was informed by information from the referral and handover from Hospital 2. Clare was noted not to have engaged with staff regarding treatment. The inventory considered: violence and aggression, suicide, vulnerability, other risks and precipitants. Identified risks included: self-harm by cutting, inserting objects into wounds, head banging, absconding, jumping in front of cars (sustaining a fractured pelvis) and physical aggression to staff. Of significance, no mention was made of the two ligature episodes at Hospital 2 because this information had not been passed onto Hospital 1. Indeed, none of Hospital 1 staff interviewed by the NICHE investigator showed any awareness of the previous ligature history. Non-sharing of information, and a lack of such knowledge, are both causes of concern for this review.

[47] See letter from Huntercombe Group medical director to NYSCB (14 September 2018)

[48] 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. The author of the report into the death of Clare was Ms. Sue Denby. Expert clinical advice was provided by Dr. Leahy, consultant psychiatrist for inpatient adolescent psychiatry.

143. The resultant initial care plan assessed Clare as being subject to Level 3; that is two-to-one intermittent observations. She also had a CGAS (Children's Global Assessment Score) of 31, placing her in the category of having serious emotional, self-harming and suicidal ideation problems, major impairment in several areas and being unable to function in one area.

144. The ward round notes of 15th December 2016 stated that the observation level had, on the authority of the responsible clinician, RC1, been reduced to Level 2, which according to custom and practice at Hospital 1 meant an observation of no more than 15 minutes should pass between checks. The NICHE report took the view that the decision to reduce from Level 3 to Level 2 observations was appropriate as Clare was reported not to be presenting with psychotic symptoms or prolonged periods of low mood. Anne had reported that Clare had made good progress since her admission and a recent short family visit from her mother had gone well, including Clare having unescorted leave with her family.

145. Whilst at Hospital 1 Clare was reportedly difficult to engage and deemed secretive, refusing sessions with the assistant psychologist and not attending education. She refused medication and did not talk to ward staff about her difficulties. However, on a positive note, she developed relationships with two support workers with whom she was able to express some of her thoughts and feelings.

146. There were eight self-harming incidents which included cutting and inserting objects into her wounds whilst at Hospital 1. In addition, Clare brought alcohol onto the ward in a Coca-Cola bottle following home leave on the 10th and 11th March 2017.

147. The overall care plan was understood by support workers to be '*helping Clare to find different ways of coping so that she could live somewhere less restrictive, to be discharged either to an open unit or home leave*.' The use of Section 17 leave was dependent on the level of risk Clare presented at any one time. The Named Nurse perceived the care plan as indicating Clare wanting to go to an open unit. Reportedly, Clare did not want to return to live with Anne, preferring to move to Social Care provided supported accommodation. The responsible clinician (RC1) had told her that the quickest way to move back closer to her family was for a transfer to a step down unit in the area where she wished to live. Clare did not want to return to the York area. Given her equal reluctance to return to her mother's in Leeds, she acknowledged that her preferences reduced the options open to her.

148. The RC1 identified that an external Local Authority Social Worker would be required to enable the step down plan and eventual discharge to supported accommodation and/or return home. This led to a request for the Hospital 1 Social Work Department to facilitate the plan with the Local Authority. The NICHE report noted that there were no timescales recorded for these plans. Early discussion of a step down took place at the first CPA on the 18th January 2017 at which Clare was present, with involvement from Anne via conference call. The RC1 indicated the need for the CAMHS 2 care co-ordinator to liaise with the Community CAMHS 1, the GP and the Local Authority. This step down appeared

to be the objective of Clare's care plan until her home leave on the 10th and 11th March 2017.

149. This changed on her return to hospital on the 12th March 2017, when she was discovered on the ward with vodka in a coca cola bottle. This in part led to a suspension of step down. The following week was a sustained period of cumulative and escalating risk, evidenced by her low mood, the finding of a suicide note, conversations with support workers around suicidal intent, ongoing difficulties with her mother, the news that her grandparents could not take her, her mother's expressed concerns for her safety and Hospital 1 decision to suspend step down.

Events from the 10th-19th March 2017 leading up to Clare's self-ligature and death

150. Whilst Clare was on Section 17 home leave on the 10th & 11th March 2017, Hospital 1 staff found a suicide note in her room on the 11th March at 03:00 stating: *'F**k you all, I'll just do it……. f**k you all, I will, just you wait'*. The letter was not specific about when Clare intended to take her life, although on her return to Hospital 1 she told staff she would have attempted to end her life if the opportunity had arisen during her home visit.

151. The letter caused concern for Clare's two support workers who reported it to the nurse in charge who contacted the doctor on call for advice. The support workers wanted someone to check on Clare. Given it was 03:00 the doctor advised to document the letter in her case notes and hand it over in the morning to the day staff, who would contact Clare at home and ascertain her wellbeing.

152. Anne was contacted later that morning. It is recorded that Clare had been in a positive mood, that they had made dinner together and watched some films on the previous evening and were planning to go out for the day. The suicide note was not discussed with Anne because it was felt not to be the right timing. She was therefore not warned about the issues Hospital 1 staff considered were of concern.

153. On Clare's return on the 12th March 2017 she was searched by staff who made no mention of a dressing gown cord being seen or found during that search. It is believed Clare was given the dressing gown as a gift following home leave. Items thought to have been a ligature risk were restricted by the hospital. There was no indication from the police investigation that a dressing gown cord was, as it should have been, on the hospital's list of ligature risk items[49]. Clare was overheard that evening telling another patient that there were no razors around when she was on home leave but if there had been she would have used them.

154. Later that night she was found by staff with the coca cola bottle containing vodka. She was observed to be giggling and slurring her words. She had to be restrained in order for staff to retrieve the bottle and to prevent her from self-harming as she had started to bang her head against the wall. Her room was searched again and all risk items (save,

[49] The police investigation was not able to produce the list as it was not seized initially with subsequent requests having found it was not available.

crucially, the dressing gown cord) were removed on the 14th March 2017. A datix incident form[50] was completed.

155. On the 13th March 2017, during a one to one conversation with Clare and support worker 1 about the note she had left on her bed, she said '*that she had written it because she had generally meant it*.' She implied there was another note she had written for staff, which could be found by them in the event that she did not return. Clare told Support Worker 1 she had given up and if the right opportunity had arisen when on leave she would have ended her life, but her mother was a light sleeper which meant she could not do anything whilst at home.

156. On the 14th March 2017 Clare was noted to be in a low mood and seemed to have stopped eating and drinking. She told Support Worker 2 that she had spoken earlier that day to her mother on the phone which had been a difficult conversation. Anne followed this up by phoning the ward to raise her concerns about Clare's behaviours and presentation.

157. In light of Clare's deterioration, a STAR[51] risk assessment was carried out on the 14th March 2017, jointly by the RC1, the staff nurse, the clinical team leader and the ward manager. The risk assessment concluded that:

- She remained at current risk of self-harm and that she had done so in the past;
- She had been a suicide risk in the past;
- She had self-neglected in the past and that these risks had remained;
- She had been at risk of self-cutting and ligaturing in the past and was currently at risk of head banging;
- She had been at risk of overdosing in the past.

158. None of the columns identified the severity or frequency of various hazards. None had been marked (1-5), except for *'Jumping in front of vehicles'*, which was recorded as 5 (severity) and 1 (frequency). The risk assessment documented that, '*Clare appears to self-harm impulsively without pattern, unknown if risk increased but staff have noticed low moods, particularly after leave'.* The responsible clinician (RC1) told Clare that in light of recent events the proposed move to a *Step down* less secure environment was being suspended.

159. Of significance, in the light of the nature of Clare's death, the NICHE report noted that there was a 'Medium' grading risk recorded for suicide, with ligature use identified as a risk prior to admission to Hospital 1, having previously occurred at Hospital 2.

160. The identified mitigating factors that could lessen the risk of suicide were: staff support and good therapeutic relationships, positive peer relationships, psychology sessions, restriction of potential risk items, detention under Section 3 Mental Health Act, 1983 and

[50] Datix is a patient safety software product used in the NHS for recording incidents.
[51] Salford Tool Assessment of Risk.

a safe and secure placement. There was no mention of increasing the observation levels or consideration of ligature use as a potential risk.

161. On the 15th March 2017, during a session with support worker 1, Clare said that she could not pretend to be okay any more when she felt so low. Clare reported that her home leave had been *'rubbish'* because her mother was careful with what she left around the house and was a light sleeper. If she had tried to get out of the house her mother would have noticed. On being asked how she got on with her mother, Clare said that '*she was not her mother*.' On further questioning Clare said that *'Her mother had played a part in what had happened to her in earlier life but there was more than one reason'*[52].

162. Clare told Support Worker 1 that although she did want to talk to someone about the reasons for ending her life, she was reluctant to do so as she would want that person to stick with her and not leave. She felt staff on the unit could not give her that support. Support Worker 1 asked her to think about speaking to someone with whom she felt most comfortable with. Clare said she would think about it but was pretty sure her mind was already made up.

163. Clare had asked her grandmother if she could live with her but this was declined on the grounds that her grandfather's health was not good – a response which Clare saw as another rejection. She took the news badly and was reportedly upset. She said that she wanted a mother figure to care for her. Even though she was 17 years old she felt unable to look after herself because she felt too *'shit'*.

164. The Care Planning Assessment (CPA) meeting of the 16th March 2017 included Clare's mother and the care co-ordinator from CAMHS 2, both via conference call. Clare refused to attend as she was upset at the decision to stop future Section 17 Home leave and the move to a *Step Down*. The NHS England Case Manager had not been invited and had not participated in any of the previous CPA meetings. It was understood that Clare did not want to return to her mother's straight away and would eventually need a supportive placement somewhere in North or West Yorkshire. The step down, assuming it was to happen given recent concerns*,* would involve transfer to a unit at the hospital to prepare for discharge. The 16th March 2017 CPA noted that some progress had been made since the last CPA that included periods of more settled behaviour. On reflection Patrick and Sue felt that there was a lack of consultation and communication around the proposed step down process.

165. A team handover briefing took place at 20:30 on the 18th March 2017 to cover the weekend and bank holiday. In compliance with the agreed staffing model at Hospital 1 and identified patient needs (see paragraphs 3.123 to 3.164 of NICHE report) there were eleven nurses on duty on the ward, comprising of one registered (agency) nurse and ten support workers. The agency nurse was also the Designated Nurse in Charge of the ward night shift of the 18th March 2017.

[52] NICHE report, paragraph 3.207

166. The Designated Nurse in Charge had previously worked at Hospital 1 on both day and night duty and had received an induction. This consisted of being shown the staff handbook, fire exit locations, medication times and familiarising himself with the patients. Of significance, the Nurse in Charge role, according to the CAMHS safe and consistent staffing policy, placed responsibility and accountability for the decision to delegate supportive observation to other staff members, in this case Support Worker 4; and for ensuring that staff were sufficiently competent and knowledgeable to carry out the task. The Clinical Team Leader (CTL1) was also present at the handover meeting. It was their first shift following a period of leave.

167. The NICHE report noted that three members of the night shift on the ward had accompanied a patient for admission to a general hospital. One patient was on 2:1 observation with another on 1:1. Clare was on a Level 2 observation, namely every fifteen minutes. The shift planner detailed that nurses were allocated to Level 2 observations every hour between 20:30 on the 18th March to 08:30 the following day (i.e. over a 12 hour shift). It was hospital policy to have hourly change of allocation in order to avoid staff strain and to maintain levels of attention.

168. According to the National Institute for Clinical Excellence (NICE) guidelines (2005); Principles of Supportive Observations[53] , '*It is the nurse in charge of the unit who is to take responsibility to ensure visits are accrued out by the nomination of people commensurate with their skills. They should be familiar with the patient's history, risk factors, background and be aware of the unit, its policies and environmental risks. They should be familiar with significant events since the patient's admission, the care plan and initiate one to one interaction particularly where the patient is uncommunicative*'.

169. Notwithstanding staffing demands of the shift, the NICHE report concluded at paragraph 3 (163) that *'The systems in place for safe staffing are adequate, there were no concerns about the competency of their staff and staffing issues did not impact adversely on Clare's care and treatment'*.

170. Crucially, both the Clinical Team Leader and the Nurse in Charge were unaware of current concerns and escalation of risk regarding Clare that had emerged during the previous week. Neither was briefed on these concerns at the handover meeting. The Nurse in Charge told the NICHE enquirers that he had been informed at handover that Clare was on a Level 2 observation due to risk of self-harm. Of great significance and concern was that no information was passed on about her active suicidal thoughts, plans and intentions. It is not known why this had not occurred, given it was very important information which could have improved staff vigilance and risk management during the shift, especially in regard to observations. In the event, Clare was understood to have presented as *'Medium'* risk, in line with prevailing assessments and plans.

171. She was found at 01:57 on the 19th March 2017 in her room with a dressing gown cord tied around her neck as a non-suspended ligature. The ligature was cut, emergency services called for and Clare was taken by ambulance to the Hospital 6 where she was

[53] NICE guidelines (2005) in dealing with disturbed and violent patients in A and E and psychiatric units

pronounced dead at 04:18 on the same day. The post mortem recorded the cause of death as hypoxic ischaemic brain injury and ligature compression of the neck.

Discussion

Care Delivery Problem 1

172. The NICHE investigation identified two key care delivery problems underpinning the circumstances surrounding Clare's death. The first identified that: 'Clare was not observed on nine occasions between 20:30 and 01:57 on the 18th and 19th March 2017 within the specified 15 minutes as per the Hospital 1 local protocol for Level 2 intermittent observations, *with the biggest gap being 57 minutes between 01:00 and 01:57'*[54].

173. Given the importance of Level 2 observations at 15 minute intervals it is not known why this did not happen. It is clear the Nurse in Charge had the responsibility to ensure Clare was seen at intervals of no longer than 15 minutes. Support Worker 2 had spoken to Clare earlier in the shift and subsequently mentioned to the Nurse in Charge at 01:29 that she had talked *of 'going under the covers and killing herself as staff did not check*.' CCTV evidence from Hospital 1 showed 58 minutes had passed since Clare's last checked by staff. At least three or four visits were missed before the final check took place at 01:57. The Police enquiry indicated that the Nurse in Charge had signed the observation sheets to show all checks had been made. However, CCTV evidence in possession of Police 1 proves this not to be the case[55]. Poor practice at handover, and the fact that the realities of missed 15-minute checks required on Clare's care plan do not match the records signed by the Nurse in Charge as if they had in fact taken place, are matters of grave concern to this review. However, the ongoing police enquiry[56] has prevented the lead reviewer speaking to the Nurse in Charge and other Hospital 1 staff to find out why the agreed protocol was not followed.

174. The NICHE investigation identified several contributory factors that precipitated Clare's death. Firstly, there was a discrepancy between the Huntercombe Group Supportive Observation Policy and the local Hospital 1 policy in use at the time. The former document itself out of date and in need of review, stated that *'observations should be carried out for example, at 5 minute, 10 minute, but not exceeding 30 minute intervals'*. The local protocol set out a requirement of observations at least five times in a one-hour period, undertaken at random intervals, 10 to 15 minutes apart but with never more than 15 minutes between checks.

175. Staff, and the hospital's custom and practice at the time[57] meant that nurses understood Level 2 intermittent observations to be every 15 minutes. This was the level of checking to which Clare was subject to. Both the Groups Policy and the local Hospital

[54] (Niche report, September 2017, page 8)

[55] This may have been after the event and is the subject of the Police inquiry. See Police report, page 10 and NICHE paragraph 3.226/3.227 and page 17.

[56] Currently being conducted by Police 1.

[57] The local protocol was reportedly revised on 14 June 2017.

1 Protocol stated *that 'the timing and interval should be explicit in the care plan, risk assessment and reviews'*. The NICHE report found that the exact timing required for intermittent observations of Clare was not explicitly stated in her health and wellbeing or risk care plan. This was a significant gap in Clare's care and a breach of practice guidelines both within this setting and across the Group. This is a matter of serious concern.

176. As previously noted, CCTV evidence of the 18th & 19th March 2017 indicated that there were nine occasions between 20:30 and 01:57 when Clare was not observed as per the local protocol. The longest gap was 57 minutes between 01:00 and 01:57. The intervals of over 15 minutes between checks were 20, 26, 30, 20, 20, 23, 27, 33 and 57 minutes. In compliance with the local Hospital 1 Observation Policy, there should have been 28 checks over the 12-hour shift. Only 14 were completed. Again, this is a matter for serious concern.

177. A significant finding by the NICHE report was that the Supportive Observation Policy template for intermittent observations did not allow for the exact time of the observations to be recorded. This meant there was no accurate, timed, written record of observation intervals for Clare on the night shift of the 18th and 19th March 2017. Moreover, there was a discrepancy between the record of engagement form and the template shift planner. The former had pre-set observation intervals of 15 minutes for every hour starting on the hour. This did not correspond with the latter, which had pre-set times for allocating staff to observation gaps of 15 minutes across every hour, starting on the half hour.

178. The NICHE report at paragraph 1.44 noted that '*The combination of the differences in the Groups and Hospital 1 Norfolk supportive policy and local protocol, plus the template for intermittent observations not allowing for the exact time of the intermittent observations undertaken to be recorded, and the lack of correlation between the pre-set observations levels and the shift planner pre-set times of allocating staff to observations may have allowed for human error to occur. The agency nurse-in-charge allocated to observing Clare between the hours of 00:30 and 01:30 told us, and recorded, that he had last observed Clare at 1.30 a.m. However, CCTV indicated that he had last observed her at 1.00 a.m.'*

179. This led to false assumptions by Support Worker 4 who took over the allocated observations for Clare at 01:44, that the interval for the last observation had been 14 minutes rather than the actual time of 44 minutes. Support Worker 4 undertook the last observation at 01:57 on the assumption that Clare had last been observed at 01:30, some 27 minutes previously, when in fact it was 57 minutes since the last observation. Even if it had been 14 minutes, according to the local Hospital 1 Protocol there should have been a check no longer than 15 minutes after. This both begs the question of why this did not happen, and must lead to questions about whether the outcome for Clare could have been different had observations been both better and more frequently carried out, and recorded as they should have been.

Care Delivery Problem 2

180. The NICHE report identified that '*There was no evidence of a comprehensive multi-disciplinary review of risk or aligning risk assessment and management of levels of observations for Clare. This meant that Clare remained on Level two intermittent observations. The exact timing of the intermittent observations for Clare were not explicitly stated in her health and well-being or risk care plan, neither were they recorded as being discussed in the ward round or CPA minutes of the 16th March 2017, despite an apparent cumulative and escalating risk following her return from leave on the 12 March 2017'*[58].

Discussion

181. By way of contributory factors, the following were identified.

182. The CPA of the 16th March 2017 was a key opportunity to review the care plan and update the risk assessment. This opportunity was missed. Moreover, there should have been some consideration of firstly, whether in light of Clare's recent deterioration, a change of intermittent observation levels was warranted; and secondly, what the appropriate actions should be to support the eventual aim of discharging Clare back into the community. Neither discussion took place.

183. The NICHE report noted that communication between multi-disciplinary team members responsible for Clare's care was not effective. This resulted in the reports submitted to the CPA meeting on the 16th March containing no detailed up to date risk information regarding her discussions with Support Workers 1 and 2 between the 13th – 15th March 2017, which included very significant information about both her emotional state and suicidal intent. Moreover, the risk assessment did not include consideration of her previous eight self-harm episodes.

184. As noted by the NICHE report, the Groups Risk Assessment Policy[59] should have been, but was not, based on Department of Health frameworks for best practice in managing risk. Additionally, the nursing report for the CPA was completed on the 2nd March 2017 and did not contain up to date information, or crucial commentary, on Clare's home leave, simply stating that *'She has accessed unescorted leave back home which she has used appropriately'*. This lack of commentary represents a further missed opportunity.

185. In addition, there was no evidence of a formal psychiatric mental health assessment being undertaken at Hospital 1 with Clare, in response to the hospital's knowledge of her suicidal intent on return from home leave. The NICHE investigator's view was that this was '*Essential in the light of her deteriorating mood and increase in risk issues. Had this been done it could have contributed to the discussions on risk at the CPA meeting*'[60].

Use of Ligatures

[58] Paragraph 1.47

[59] It was due for review in September 2016

[60] Albeit that the NICHE report notes that it could not say with certainty that a mental state examination would have made a material difference to the outcome because of Clare's unwillingness to discuss her mental state.

186. An important finding of the NICHE report was that there was a lack of clarity regarding Clare's risk history in relation to her use of ligatures whilst at Hospital 2. None of the staff interviewed seemed to know that there was a known history of the use of ligatures, despite it being identified as a past risk in the self-harm and suicide risk assessment on the 13th January 2017. Clare's use of ligatures had not been recognised as a possible contemporaneous element of potential risk by the time of the 16th March 2017 CPA meeting. It is not known why such a fundamental gap in knowledge existed. In the opinion of this SCR lead reviewer such a gap should not have been present. Clare's previous use of ligatures and the not uncommon occurrence of ligation at Hospital 1 *'should have indicated that self-ligature may have been a method of choice'*[61], for her, as tragically was the case. Ligature incidents at Hospital 1 were running at 2.5 per day and 1.8 per night being the commonest means of self-harm[62]. Compounding this issue was the lack of recognition of the potential risks of ligature use. The NICHE report found, after reviewing nursing records, that risky items had been locked away on the evening of the 16th March 2017, but that the dressing gown cord had not. The Groups Policy document on Rescue from ligature and use of ligature cutters does not explicitly include dressing gown cords in its list of restrictive items.

The CPA Meeting of the 16th March 2017

Discussion

187. The minutes from the CPA meeting held on the 16th March 2017 do not record any discussion about the risks and concerns regarding the level of observation to which Clare was to be subjected. The NICHE report noted that the responsible clinician indicated in an interview that this was discussed in the meeting and a team agreement was made for Clare to remain on Level 2 intermittent observations. Given previously mentioned professional concerns for Clare after home leave, it must be questioned as to whether there was a realistic and accurate assessment of the risk level in regard to her situation in the week prior to her death. In particular, it must be asked whether the decision for her to remain on Level 2 intermittent (15 minute) observation a reasonable one in all the circumstances. That the routine involved was then not followed is also, clearly, at issue, given gaps of almost an hour between observations were recorded by the CCTV system at Hospital 1.

188. The NICHE report indicates at paragraph 1.51 that all staff were aware of an increase in Clare's risk profile. It remains debateable as to whether the full range of risks, including Clare's sessions between the 13th – 15th March 2017 with Support Workers 1 and 2, were sufficiently taken into consideration by the STAR risk assessment on the 14th March, 2017 which graded Clare as 'Medium' risk of suicide, and the CPA meeting of the 16th March 2017. It would certainly have been helpful for the two support workers to have been at the CPA meeting to report on their sessions with Clare, or alternatively for a written

[61] (see paragraph 1.61 of NICHE report),
[62] See Niche report at paragraph 3.118

report by them to have been presented. Neither happened, representing a further missed opportunity to join up professional practice in support of Clare.

189. The NICHE report identified no evidence of a comprehensive multi-disciplinary review of risk, or of aligning risk assessment and management plans for Clare with levels of observation. It states that had this been done it '*Might have led to a different outcome'* and that *'Although Clare's risks were compounded by her unwillingness or inability to engage in any form of treatment, we believe that there were opportunities to intervene in terms of reviewing and increasing Clare's observation levels'*[63].

190. Regarding observation levels and risk management, the NICHE report noted that Clare's risk plans to manage and reduce her self-harm did not contain either specifics of levels of observation to be applied, or evidence that these levels or risks were consistently reviewed or updated following incidents. There was no evidence of discussions of reviews of supportive observations in clinical records. Moreover, at Hospital 1 there were separate care plans for Clare's health, wellbeing and risks; none of which were integrated into an overall care plan. Health and wellbeing were not joined up with assessment and management of risk, presenting gaps through which Clare could, and in the end did, fall.

191. The investigators concluded that, '*Without the agreement, the observation intervals and the rationale aligned with the escalating risk being recorded, it is difficult to consider whether the decision for Clare to remain on Level 2 intermittent observations was reasonable'*[64].

192. The NICHE report concluded that:

'*In our view this (CPA meeting) was a missed opportunity to review the care plan and observation levels aligned with the risk. A decision to increase the level of observation*[65] *could potentially have protected Clare until she was more settled. However, we are aware that increasing observations to a one-to-one observation level is very intrusive and believe that this is a balanced decision that can only be made by the team at the time to ensure that the risk management plan is consistent with the long-term treatment strategy'*[66].

This SCR concurs with this conclusion.

CQC Inspection of Hospital 1, Norfolk-2017

193. The CQC inspection on the 13th and 14th March 2017[67] gave an overall rating to Hospital 1 of *'Requires Improvement'* and under the category of *'Are child and adolescent mental health wards safe?' an 'inadequate'*, judgement. It identified many of the shortcomings in practice and policy highlighted in the NICHE report, and found by this review in Clare's case. These shortcomings included: the review of supportive observations, wards left

[63] (page 10, paragraph 1.50)
[64] (page 34, paragraph 3.74)
[65] To level 3, one-to one, observation for a period of time, as stated at page 35, paragraph 3.75 of NICHE report.
[66] (page 11, paragraph 1.57)
[67] Published on the 19.05.17

with no registered nurse for a short period, deficiencies in risk management, staff not consistently reviewing and updating care plans following risk incidents, care plans not reflecting multi-disciplinary team goals, staff not being aware of ligature audits or environmental risk areas for each ward, a vacancy rate of 51% for registered nurses across the site and 23% for support workers, mitigated by the use of agency staff and out of date policies (e.g. supportive observations). The hospital was required to take improvement action by the 31st August 2017 but was closed down by the Group in December 2017.

194. Given this section of the SCR has been extensively informed by the NICHE Report and the case summary of the Police 1, it makes no commentary on any additional findings or lessons learned from those set out at pages 12-13 of the NICHE report (see appendix 2i of this report). The seven recommendations made by NICHE (see appendix 2ii of this report) also serve as those from this SCR to the Group.

Multi-Agency working

Discussion

195. There was minimal evidence of multi-agency working between Hospital 1 and any external agencies. Both the NHS England case managers and CAMHS 2 care co-ordinators had little or no involvement with either Clare or her parents despite both having important roles in overseeing her care and maintaining regular contact. The CAMHS 2 care co-ordinator did not see Clare whilst she was at Hospital 1 and her direct participation at meetings was limited, albeit she did receive regular reports. More involvement could have provided a stronger and more proactive link with Clare's parents and local agencies (GP, CAMHS and both Local Authorities) particularly in regard to the proposed post discharge planning. The appropriate Local Authority should also have been notified of Clare's placement at Hospital 1, in compliance with Section 85 of the Children Act, 1989. This did not occur.

196. The CAMHS 2 report noted that there were no policies and procedures in place at the time concerning the role of the care co-ordinator in regard to young people placed out of area. Self-evidently there needs to be clear guidance provided by the Trust regarding the roles, responsibilities and remit of the care co-ordinator in relation to children and young people placed at out of area CAMHS 2 facilities.

197. NHS England was not involved whilst Clare was at the hospital. This is regrettable and a cause for concern, given its attendance at the March 2017 CPA, '*Would have provided a wider representation of professionals that had involvement in Clare's case, in order that her needs were examined, understood and addressed when deciding her future pathway'*[68].

[68] (NHSE agency report, p.14)

TOR 3 - How well were the voices of Clare and her parents heard and included in the Assessment, Planning, Intervention and Review (APIR) process? Was the process sufficiently child focused, if not, why not?

Leeds Agencies

198. There was a mixed record of Clare and her parent's views being heard and included in decision making and actions then being taken by the three Leeds agencies[69]. The GP spoke to Clare and Anne in late January 2014 following an episode of self-harming. However, prior to the referral to CAMHS 1 in early February 2014, there was no recorded evidence of Clare having had a conversation on her own with the GP about her wishes, feelings and views on the options available to help her. Such a discussion was her right, and should have taken place.

199. On the several occasions when she was seen by various GPs in 2014 to address physical ailments, professionals did not ask about her emotional health or wellbeing. Given her history of self-harm and involvement with CAMHS 1 it should have been expected that exploration of her emotional wellbeing would have happened. Anne told the lead reviewer that Clare felt that the GP '*Laughed it off*' and that she *'Wasn't taken seriously'*, in the early part of 2014. Clare presented well and according to Anne, the GP believed that Clare was '*Ok and put it down to being a teenager'*. Anne said that Clare found it hard to express her feelings and to communicate with others.

200. However, Clare did speak to her GP in April 2015 and disclosed that she did not find her previous experience with CAMHS 1 helpful. Anne said the weekly one-hour family therapy sessions were not enough and that Clare felt they were ineffective. As a working professional it was sometimes difficult for Anne to get time off in the week to attend the sessions and she felt home sessions might have been more useful.

201. CAMHS 1 stated in their report prepared for this SCR that there was evidence of both Clare and her parent's views being heard and included in assessment, planning and review. Any changes in therapeutic interventions were based on family reports, with Anne making most of the contact with the therapist and Clare's level of engagement being, '*ambivalent'*.

202. Clare's Accident and Emergency admission to Hospital 3 in July 2014 did not involve Clare being seen on her own, but always with her mother. The Leeds Teaching Hospital agency report noted that there was a missed opportunity for Clare to have spoken with a doctor on her own, especially given the context of her self-harm, suicidal ideation, low mood and anxiety. There was a tendency at the time to rely on CAMHS 1 to do this work. Action has since been taken by CAMHS 1 to upskill appropriate staff with a bespoke training package that seeks to encourage discussion with adolescents about their wider emotional and mental health issues.

[69] Clinical Commissioning Group 1, CAMHS 1, Hospital 3

The Schools

207. Although there was discussion between Clare, her parents and both schools about her behaviour, motivation and educational development, there was no evidence of dialogue regarding her emotional wellbeing and mental health needs in either setting. Previous mention is made in this report regarding Anne's account that she had spoken to School 1 immediately after Clare's first self-harming episode in July. The school in her view did not take the incident seriously. Anne also said that she shared with School 1 the CAMHS involvement. Additionally and as already reported, School 2 did not contact Anne about Clare at the point of transfer, despite Anne having legal parental responsibility.

North Yorkshire Agencies

203. Clare and Anne were seen by the Specialist Public Health Nurse in July 2014 following the overdose and A & E admission to Hospital 3. The agency report states that Clare was given an opportunity to be heard by a different professional as she was involved with CAMHS 1 at the time, and was provided with links to other agencies that could have offered an alternative approach.

204. Clare's initial contact with Police 2 in July 2015 resulted in her being spoken to by an Officer and providing some background information. The Police facilitated Clare in speaking to her mother in accordance with her wishes. Anne and Patrick were spoken to for background information which was recorded on Police systems for future reference. On the second occasion in November 2015 Clare did not engage with the attending police officer and Patrick was informed that she had been located. Clare agreed to attend Hospital 4 with Patrick and Sue.

205. Hospital 4's report stated that Clare's voice was heard on admission and staff acted in accordance with her stated wishes. However, it was difficult to conclude with any certainty whether her voice was heard consistently. Clare was described as quiet with poor eye contact. There was no written record of any reference to her mother.

206. The in-patient CAMHS 1 involved Clare, Anne, Patrick and Sue. It was not documented whether Clare was seen on her own, or was able to speak freely. The agency reported that both Clare and her parents as actively involved in decision making and planning about the option of an in-patient admission for treatment to address her self-harming and suicidal ideation.

207. CAMHS 2 states in its report for this SCR that the voices of Clare, Anne and Patrick were heard during the assessments conducted by the Trust prior to admission in November 2015. The options of in-patient and community care were explained by the care co-ordinator. Patrick and Sue commented in an interview with the SCR Chair that the care co-ordinator's input was *'useful'*. They said that she had communicated with them very well in an inclusive manner and had provided objective advice and support. They said that for the first time it seemed that they had been listened to and that someone wanted to help them. After considering the available options for Clare, the family concluded that

a four-week local in-patient assessment admission was in her best interests. It was unfortunate that having made the decision, a local bed was not available, for reasons already given. The care co-ordinator located an out of area bed at the Hospital 2. It was not clear from the CAMHS 2 records as to how much discussion took place with Clare and her parents about this. Clare's mother told the lead reviewer that she was still unsure how a bed was originally offered in York but that Clare ended up in Sheffield.

Hospital 2

208. Hospital 2 state that there was generally good communication with Anne, Patrick and Sue who were reportedly invited to attend ward rounds and CPA meetings and provided with updates following incidents. Conversely, Patrick and Sue's view was that *'communication with staff was very poor'*. High staff turnover meant that they never saw the same consultant twice, which they say was a major factor in poor communication. They cited an example of attending a CPA meeting where they met a consultant who was very helpful by suggesting that the family communicate directly with him. However, two weeks later he had moved positions and they did not see him again.

209. Patrick and Sue maintained that Clare did not have a key worker and felt it was *'Impossible to get through to the ward via telephone to speak with Clare'*. They believed difficulties in contacting Clare made it problematic to stay in touch with her. Hospital 2 admits that there were some occasions when the parents were not invited to meetings. Patrick and Sue have reflected that there was a lack of consistent communication with parents who hold legal parental responsibility. The parents made two sets of complaints which were upheld.

210. Concerning Clare, Hospital 2 state health records evidence her inclusion in discussions and plans about her care and treatment (albeit she did not always engage in them). She was encouraged to participate in the process but only signed a couple of care plans. She did not attend ward rounds although the hospital states that *'her thoughts were obtained beforehand and the outcomes were relayed back to her'*, albeit that there were sometimes delays. The hospital acknowledged that there was a need for more timely and consistent feedback from the ward rounds.

211. Patrick maintained that his daughter had only attended one CPA and that staff did not explain their roles or the purpose of the meeting. He felt that *'she was not included in decision making'*. He also thought that *'the CPA meetings were ineffectual'* and at one meeting he noted that none of the staff introduced themselves. Apparently, there was a high staff turnover thus making it difficult for him and Sue to understand what the professional roles were. There was *'lots of talking at us'*. The parents did not have sight of meeting minutes in a timely way, often getting them handed out after the meeting and none were received at all when they were unable to attend, despite Clare being the subject of the meetings concerned.

212. Hospital 2 state that Clare was regularly offered advocacy which she declined. She had her legal rights read and recorded monthly although there were four times when this was

not done. She was also legally represented during a Mental Health Act 1983 tribunal process.

213. It is not known how far Clare and her parents were involved in the decision for her to leave Hospital 2 and move to Hospital 1. Anne maintains that it was minimal.

214. Regarding Clare's admissions to the Hospital 5, the trust states that recording shows *'Clare's wishes and views were respected regarding both her acceptance and refusal of care'*. Given that she was 16 years old all decisions regarding her physical care would have been discussed with her. Any contact or sharing of information with her parents-there was none-would have only been completed with Clare's informed consent. However, in this case no contact or information was shared with her parents.

Norfolk-Hospital 1

215. Given the distance involved between North/West Yorkshire and Norfolk, communication between Hospital 1 and the parents was problematic. Anne was able to take part in the two CPA meetings via conference call. There was no known contact with Patrick and Sue. According to Patrick, neither he nor Anne wanted Clare to be moved, despite the previous incidents, as they believed that any change would be disruptive for her. They perceived that Clare was seeking to move back to a non-secure ward on a voluntary non-section basis. It is not known how far Patrick and Sue participated in the decision to move their daughter to Hospital 1. Indeed, they only became aware of the move on receipt of a, *'Welcome Pack'* from the hospital. That said, Anne told the lead reviewer that her daughter seemed more settled at Hospital 1 and appeared to be relatively positive about her situation.

216. The NICHE report at paragraph 3.112 notes that *'there seemed to be little active attempt to engage with the parents, (indeed, there is no record of any contact with Clare's father at all), with no documented face to face clinical meetings or any reference to a need for them*'. Parental involvement appeared minimal save for Anne's involvement at the two CPA meetings via conference call. There was no evidence that she had been signposted to the appropriate local authority (Leeds) for a carer's assessment or evidence that the NICE[70] guidance had been followed in providing help on the management of self-harm during Clare's Section 17 Home Leave. Patrick had no contact with his daughter for over a year which the authors of the NICHE report found concerning. The SCR would concur with this view.

Discussion

217. The lack of family involvement was a critical and at times a deeply concerning and negative issue in the care and treatment of Clare. As referenced by the NICHE report: *'The role of the family in the treatment of young people with borderline personality disorder is critical to consider. Issues with the family, both past and present, are likely to be highly relevant to the development or maintenance (or both) of the young person's*

[70] See NICE guidance on self-harm in the over 8s-long term management (2009).

problems'[71]. As noted by the NICHE report: *'Family involvement was essential and not an 'Add on', given the reported nature of the difficulties. Albeit that the family may have declined invitations or that Clare may have refused to meet with them, but this is not documented'*. This SCR would strongly agree with the above views.

ToR 5 - Why was compulsory intervention under the MHA 1983 and Out of Area placements necessary?

25 November 2015 - Informal Admission to Hospital 2, Sheffield

218. The rationale and reasons for Clare's admission to Hospital 2 have been set out and analysed above at paragraphs 82-83.

8 January 2016 - Hospital 2, Sheffield: Section 2 Mental Health Act, 1983

219. This episode marked the start of Clare's patient experience as a young person compulsorily detained under the Mental Health Act, 1983 in a Tier 4 setting. She was placed under Section 2 of the Act because of her escalating self-harming behaviour which the hospital deemed could not be managed within her status as an informal patient. This allowed for a 28-day assessment to be undertaken. (See above at paragraphs 92-92 for more detail)

3rd February 2016 - Hospital 2, Sheffield: Section 3 Mental Health Act: 1983

220. Clare's self-harm and suicide ideation continued to escalate to the point where the Hospital 2 multi-disciplinary team felt that the attendant risks could not be managed on a general adolescent ward. In consultation with the NHS England case manager, Clare was made the subject of a Section 3[72] on the 3rd February 2016 and transferred to the Haven ward (a PICU) on the 5th February 2016. (See paragraph 106)

Transfer to Hospital 1, Norfolk: Low Secure Unit

221. By the summer of 2016, little progress had been made by the Haven ward in addressing Clare's need and managing the increasing risks. A stale mate position was reached[73]. In conjunction with the CAMHS 2 care co-ordinator and the NHS England case manager, the multi-disciplinary team at Hospital 2, on the 7th July 2016, assessed that a transfer to a Low Secure Unit (LSU) was deemed necessary and proportionate. This was compliant with the least restrictive option principle in order to better manage Clare's risks and seek to address her underlying problems through treatment over a longer term.

222. Two mental health tribunals were held in July and October 2016 which upheld her Section 3 status.

223. Despite a search by NHS England for a local secure unit none could be found in the Yorkshire region or the North East/West region of England. A suitable placement was

[71] (NICE guidance on borderline personality disorder, 2009).

[72] detained for up to 6 months

[73] see paragraph 140

eventually found at Hospital 1 in Norfolk on the 6th December 2016, some 200 miles or so from her home. Lack of available bed capacity within the entire Northern region prevented Clare's admission being closer to home. Best practice indicates that she may have been better served had she been placed in a local secure unit as close to home as possible for reasons already mentioned. On this occasion such a close placement was not possible.

224. The shortage of Tier 4 local secure unit places nationally has been well documented (Frith, July 2017)[74]. Such problems are exacerbated by the speciality, age factors and a geographical disparity in the distribution of beds. The Royal College of Psychiatrists has proposed a proxy measure of appropriate bed numbers as between 2 and 4 beds per 100,000 of the population[75]. The average for England is 2.5 (at the lower end of the range) with the number for Yorkshire and Humber being 1.6 per 100,000[76], the second lowest in England after the South West at 1.1 per 100,000[77].

225. A 2014 NHSE Review of CAMHS Tier 4[78] capacity concluded that,

'The overarching aim should be that all children and young people in England are able to access age-appropriate services as close as possible to where they live. Some of these services may be at a greater distance from home because of their specialised nature (sub-speciality) but they should nonetheless still be accessible through having a defined catchment area'.

226. This SCR agrees strongly with this statement, given that Clare's case illustrates it starkly, as reflected in this report.

Current Developments with NHS England, Yorkshire and Humber Region

227. In 2014[79] the NHS England National CAMHS Review identified insufficient Tier 4 in-patient CAMHS beds in the Yorkshire and Humber region. Some immediate steps were taken to increase capacity. A Mental Health Programme Board is presently leading the process and a service review is being locally directed and driven so services can come to meet the needs of the local population. There are plans in place to work with providers to ensure sufficient capacity for in-patient services in the Yorkshire and Humber region. This will increase the capacity of Local Secure Unit beds in the North of England and mean Yorkshire and Humber will have its own Local Secure Units service.

228. Over the past two years significant work has been undertaken describing the context of the CAMHS Care Pathway, including the inpatient aspect but focussing more importantly and clearly on local and community provision. Publication of the CAMHS Tier 4 Report (2014) and Future in Mind (2015) have led to the development of local

[74] See Frith. E, 'Inpatient Provision for Children and Young People with Mental Health Problems', (July 2017), Education Policy Institute.
[75] See Frith (2017,7, note 7)
[76] Data provided in House of Commons written answer. 9 February 2016 in Frith (2017,17)
[77] The North East has the highest at 3.0/100,000.
[78] Quote from the NHSE report for this SCR.
[79] See the NHSE report provided for this SCR.

transformation plans in each locality, which articulate how local pathways will work more effectively.

229. NHS England indicates that this future provision for Yorkshire and Humber is based on NHS England's National CAMHS Tier 4 need and capacity exercise. This supports taking forward key objectives and recommendations in relevant mental health strategy and policy. A key driver has been a lack of capacity in some areas, which has led to out of area placements. The proposed changes in bed numbers aims to address this and ensure that services will include having the right number of General Adolescent Units (GAU) beds and Psychiatric Intensive Care Unit (PICU) beds available to meet demand in each area. As these services are specialist, there is a national oversight of this process, but with a strong emphasis on local engagement. The Yorkshire and Humber region commenced procurement of General Adolescent and Psychiatric Intensive Care Inpatient Services ahead of national timescales. In 2017, Humber NHS Foundation Trust was successful in their bid to provide General Adolescent Service and Psychiatric Intensive Care In- patient Services. This will be a new build, and will be operational in 2019

230. NHS England is collaborating with local commissioners on CAMHS Tier 4 bed changes in the Yorkshire and Humber region to ensure interdependencies between localities which are managed effectively, for example, Psychiatric Intensive Care Inpatient Services provision in West Yorkshire and South Yorkshire. NHS England has now identified and confirmed a new commissioning model for eighteen General Adolescent beds and four Psychiatric Intensive Care In-patient beds within West Yorkshire.

Part 7 - Findings, Key Lessons and Current Agency Developments since Clare's death TORs 1/2/4

Leeds Agencies (LEEDS 0-19, Hospital 3, Clinical Commissioning Group 1)

231. Clare's physical, emotional and mental health needs and risk issues were appropriately assessed and adequately met by the three Leeds health agencies, although there was an issue about waiting times in with CAMHS 1. Clare's needs and risks were well met and managed by professionals during her admission at the Hospital 3 in July 2014.

232. Risk issues around potential significant self-harm were effectively considered and appropriately managed internally by CAMHS 1. There was a reasonable balance between working with and managing the risks presented by Clare, addressing her therapeutic needs and being mindful of safeguarding concerns.

233. The delay of nearly five months before the first CAMHS 1 appointment was not to Clare's advantage. Ideally, and whilst acknowledging the demand pressures on services at the time, it would have been beneficial had she received a quicker and timelier response.

234. A key lesson and improvement action for the Clinical Commissioning Group 1 and the CAMHS 1, identified by this practice episode, is for waiting times for an initial consultation appointment with CAMHS to be within the stated target of 12 weeks, with an aspiration to

lower the target time further as resources allow. This SCR endorses the Children Commissioner's (October 2017) recommendation at Part 2 in relation to Clinical Commissioning Group 1[80] and suggests that this is implemented.

Current Developments with the Leeds/West Yorkshire Local Transformation Plan

235. CAMHS 1 report that over the coming months and as part of the West Yorkshire Mental Health Service Collaborative, they will be working together to improve Child and Adolescent Mental Health Services. This project called *'New Model of Care'* launched on the 1st April 2018, means that across West Yorkshire agencies will be working together and seeking to make better use of money that pays for inpatient beds for young people. Many professionals believe better support can be offered to young people and their families in communities so as to save money by using less 'bed days'. From the 1st April 2018, CAMHS 1 was awarded, on behalf of the region's partners, the budget to manage the local community investment in Children's Mental Health Services.

236. Work will continue on this new model of care with a plan to invest the money into four main elements:

- 24/7 care for children and young people achieved through provision of responsive crisis services.
- Community intensive services working extended hours.
- Access to non-clinical 'safe space' as an alternative to hospital.
- Care Navigators based across West Yorkshire; to act as children and young person advocates, working with professionals involved in their care. This is to develop strong local relationships and ensure local options for further support are explored before a bed is considered.

237. If a hospital bed is still required, the shared aim is for the child or young person to have the shortest length of stay possible, in a modern, fit for purpose facility. To support this, funding has also been secured to build a new facility in Leeds for children across the region.

Inter-agency working and communications

238. Communication and information sharing was effective and of an expected standard in promoting Clare's safety and welfare and supporting her mother. The agencies liaised appropriately in addressing Clare's physical, emotional and mental health needs and monitoring her treatment.

239. A key piece of more generalised learning is for CAMHS, the GP service and all other relevant agencies to consider firstly, whether a multi-agency support approach (e.g. an Early Help or a Child in Need assessment) would benefit the child. Secondly, to consider seeking informed consent from both the child or young person (if Fraser competent) and parents to share information with third parties such as a school or a Local Authority Children's Service. In the event of non-consent, consideration should be given to

[80] See page 7/8 of the Children's Commissioner's report.

dispensing with it in the best interests of the child whilst bearing in mind the need for the young person to exercise control as far as possible in the decision making process, with a view if necessary to interventions at Child in Need[81] or Child Protection[82] levels, subject to Local Safeguarding Children Partnership threshold and vulnerability frameworks[83].

School 1

240. School 1 had not been informed by the GP, the School Nurse or CAMHS 1 of Clare's emotional state, or her self-harming and suicidal ideation[84]. Although steps had been taken to address Clare's educational needs through inclusion within the nurture unit, S1 was not in a position to take Clare's emotional state, self-harming and suicidal ideation into account as a result. It was therefore unable to offer Clare appropriate pastoral support.

School 2

241. The transition of Clare's records from School 1 to School 2 fell far short of excepted and required standards. Formal records were not shared between the schools, a serious shortcoming.

242. Support made available to Clare by School 2 focussed on her academic needs around entry to Year 11. Her social emotional and mental health (SEMH) needs were not considered or assessed by School 2 due to several factors set out previously in paragraphs 63-64. The emphasis was on Clare's responsibility for her own behaviour, rather than on an effort being made to support her to seek and address the reasons for it. A more structured and supportively pastoral approach from School 2 may have enabled more evidenced based interventions to be undertaken, with greater involvement of outside agencies.

243. There was a missed opportunity for both schools to have made enquiries with Clare's GP, CAMHS 1 and the North Yorkshire 5-19 Healthy Child Service. Had this been done it may have been possible for School 2 to have re-assessed Clare's wider SEMH needs in addition to her educational requirements. If necessary, consideration could have been given to making a referral to North Yorkshire Children and Families Service with a view to an Early Help or, if appropriate, a Child in Need multi-agency intervention.

244. Key learning from this episode include:

- A robust and formally required process for the timely exchange of written records when students transfer between schools.

[81] Section 17 Children Act 1989

[82] Section 47 Children Act 1989

[83] For instance, the North Yorkshire Vulnerability Check list/Threshold document (see NYSCB website www.safeguardingchildren.co.uk)

[84] Although a GP letter referring to Clare's anxiety and depression was sent directly to the exam board in mitigation of her absence of the 16th April 2015 when she missed a GCSE PE assessment. The letter was not made available to the School. This is disputed by Clare's mother.

- A robust and equally formally required system of written recording of significant events, conversations and meetings with parents, students and school staff (both within and out with the school), with a record of actions taken to follow up concerns.
- The need for all staff to be vigilant and to share any concerns with the school's designated safeguarding lead. All concerns must be followed up in compliance with agreed safeguarding procedures.
- Systematic use by schools of the 'Compass Reach Service' provided by North Yorkshire Healthy Child Service.
- A more systematic and better informed use by pastoral staff of the statutory threshold document Vulnerability Check List/ Threshold document as per Working Together 2018.
- A process for schools to support early identification of pupil's SEMH needs.
- The development of a school Self-harm and Suicide Prevention Policy that includes the North Yorkshire Pathway of Support for Children and Young People who deliberately self-harm[85].
- Where appropriate, seeking student and parental consent for information sharing with other agencies.
- Being consistent with the parameters of information sharing, regarding rules of confidentiality, data protection and the circumstances when consent can be overridden in the best interests of the child or young person.

Current Social Emotional Mental Health Developments in North Yorkshire

245. There is widespread recognition of the vital role schools play in the mental health and wellbeing of their students[86] Schools are well placed to identify the earliest signs of mental health problems and provide appropriate support and counselling to pupils when needed. This SCR would commend and urge the appropriate agencies in North Yorkshire to have regard to the Children's Commissioner's Report of October 2017. This recommends that '*as part of a whole systems approach to the provision of mental health services to children and young people, schools should:*

- *Establish a positive environment which promotes children's wellbeing.*
- *Teach children of all ages about mental health and wellbeing.*
- *Have a lead professional and a clear mental health policy.*
- *Be an access point for early support for children with emerging problems, such as short courses of therapy. Where possible, this should be provided within the school, with local authority and NHS budgets helping to fund these services.*
- *Where students have more serious needs, schools should be a referral point into specialised services (e.g. CAHMS)*'.

[85] See the suicide prevention charity 'Papyrus' and it's very useful, 'Building Suicide-Safer Schools and Colleges-A Guide for teachers and staff', 'Save the class of 2018', at www. Papyrus-uk.org. Also, see the 'North Yorkshire Pathway of Support for Children and Young People who deliberately self-harm', North Yorkshire Children's Trust.
[86] (CQC Report, October 2017; Future in Mind, 2015).

246. The Government Green Paper, *'Transforming Children and Young People's Mental Health Provision'* December 2017, has set out proposals for consultation around:

- *A designated mental health lead in every school by 2025.*
- *Mental health support teams working with schools and colleges offering support to young people with mild to moderate mental health issues such as anxiety, low mood and behavioural difficulties; acting as the link between schools and the NHS.*
- *Shorter waiting times with the aim of four weeks for children to obtain treatment*.[87]

247. The Clinical Commissioning Group 3, Local Transformation Plan for Children and Young People's Emotional and Mental Health 2015-2020[88] at page 5 sets out its plan to develop a whole school approach at Local Priorities 1 and 2. The aim by 2018 (with a two-year extension) is to have dedicated mental health workers aligned to all school clusters, a named mental health lead in each school and a named link mental health worker for each GP surgery. The stated outcomes include; training staff to recognise and respond to pupils with difficulties (advice/seek help) and supporting pupils through interventions either individually or in groups to feel they can cope and have strategies to do so. In addition, GPs and surgery staff will have direct access to advice about individual patients and strengthened links to schools.

248. The current North Yorkshire Children's Trust, SEMH strategic cross service implementation plan (2017-2020)[89] 'nests' within the wider Local Transformation Plan in covering Local Priorities 1 and 2, a whole school approach. Its key priorities include, '*ensuring that there is a co-ordinated and coherent system for SEMH across, health, education and social care; and that the services commissioned meet the needs identified locally*.'

249. The SEMH strategy in North Yorkshire involves several local initiatives such as: Compass Reach and Compass Buzz, The Thrive Approach, The Academic Resilience Framework and Back on Track. Details of these initiatives and progress regarding implementing of the SEMH strategy can be found in the Local Authority 1 SEMH briefing paper and note of 2017. The strategy is currently being reviewed in order to strengthen it further, particularly with regard to the need to ensure earlier help and intervention.

North Yorkshire Agencies

250. There was effective inter-agency co-operation between Police 2, Hospital 4 and Community CAMHS 2 in responding to Clare's self-harming and suicidal episode as well as promoting her safety and welfare. Clare's physical, emotional and mental health needs were well met by the staff at Hospital 4. Clare's parents were well supported.

[87] To be piloted in some areas.

[88] In line with Future in Mind, 2015

[89] This is overseen by the North Yorkshire Children's Trust Board.

251. Clare's emotional, mental health needs and risks were appropriately assessed and addressed by both CAMHS teams (i.e. CAMHS 2 and CAMHS Inpatient Service 1. Options involving both an in-patient and a community approach were considered. There was effective liaison and information sharing between the two CAMHS teams which promoted Clare's welfare and safety. Her parents were supported through the episode and informed of the options for the care of their daughter.

252. It is generally to a young person's advantage to receive in-patient intervention as close to home as possible. Reasons include continuity, ease of contact with family which in Clare's case was a significant issue, relative familiarity with the young person's locality, effective communication and liaison with local services, including the local authority, schools and the responsible health agency, particularly in regard to Section 17 home leave and eventual discharge planning and support. For reasons of acuity at CAMHS Inpatient Service 1 in York, it was unfortunate that Clare was not able to be admitted to this local facility as an in-patient. At the very least, her admission would have facilitated family involvement, continuity of schooling and liaison with community social, educational and health agencies.

253. A critical deciding factor for Anne, Patrick and the professionals in opting for an out of area placement was the absence at that time of a crisis/assertive outreach service.

254. Key lessons from this practice episode include:

- Consideration of the design, development and use of an intensive home intervention service that seeks to maintain them in the community and is consistent with the young person's safety and wellbeing.
- Consideration of devising and implementing a robust, early intervention based multi-agency approach that includes: the school, Children's Services and other relevant agencies within a statutory framework.
- In the event of an in-patient admission, placement as close to the young person's home and family as possible.

Current Developments

255. CAMHS 2 was identified[90] by NHS England within the *'New Model of Care'* project as one of the selected providers covering both the North East Region and North Yorkshire. This started in October 2016, with an aim to provide the incentive and responsibility to put in place new approaches, which will strengthen care pathways to:

- *'Improve access to community support;*
- *Prevent avoidable admissions;*

[90] Information provided for this SCR by CAMHS 2

- *Reduce the length of in-patient stays and;*
- *Eliminate clinically inappropriate out of area placements.'*

256. Early indications are that the additional support offered to children and young people within the community reduces the number of young people requiring admission to hospital and reduction of the length of stay in CAMHS Tier 4 settings.

257. CAMHS 2 now provide a crisis intervention/intensive home treatment[91] service for children and young people within North Yorkshire. Had this been in operation in November 2015 it is possible that a place at CAMHS Inpatient Service 1, York may have been found. In the longer term it may have provided favourable circumstances for pursuing a community, multi-agency approach, including children's services assessing Clare as a Child in Need, enabling professionals to meet Clare's needs and manage her risks, without recourse to later Out of Area Placements at Sheffield and Norfolk. Indeed, it was the NHS England case manager's belief in the NHS England report for this SCR that had a home treatment or crisis team been available as an interim support at the time of the referral to CAMHS Inpatient Service 1, this could have provided an alternative to the admission to Hospital 2.

Hospital 2

258. There was little evidence to show that any purposive work was done with Clare and her parents on the objectives of the intended four-week admission. Professionals could not engage Clare in assessing her risks, understanding the underlying reasons for her self-harm and suicidal ideation or working towards positive outcomes of re-integration to her home in Yorkshire. That said, the hospital did succeed in preventing her ending her life whilst she was a patient.

259. Multi-agency working was not evident. There was no indication that the NHSE Care Manager or the CAMHS 2 care co-ordinator were present at the Care Programme Approach (CPA) meetings The CAMHS 2 care co-ordinator had a pivotal role in linking Clare, the hospital, the family and home agencies, including the Local Authority Children and Families services[92]. This was especially important given Clare was compulsorily detained under the Mental Health Act, 1983.

260. Clare's level of self-harm and suicidal ideation increased along with the attendant risks, leading to the multi-disciplinary team's decision to seek a transfer to a low secure unit.

261. There were sub-standard internal practice and organisational issues that did not facilitate positive outcomes for Clare, and that this review concludes contributed to her poor and eventually tragic outcomes. These are set out in paragraphs 116-128.

[91] Provided between 10a.m to 10p.m

[92] There was a legal duty under section of the Children Act 1989 for Hospital 2 and CAMHS 2 to notify Local Authority 1 Children's Care Services (i.e. the home authority) of Clare's placement at Hospital 2 once she had been there for three months (i.e. at the end of February 2016)

262. There were significant elements of unsafe practice operating on and between the two wards during Clare's time at Hospital 2. There was an absence of critical fundamental systems and processes, a lack of triangulation of recording systems, no updating of care plans or risk assessments, ineffective intervention by the multi-disciplinary team, and a failure by staff to comply with existing agency policies and procedures, for example in not acting on safeguarding issues. The SCR viewed this catalogue of deficits as unacceptable and concludes that the hospital's practice and overall care of Clare fell far short of acceptable standards.

263. These matters are cause for serious concern, and raise questions regarding the degree of management grip, and the patchy involvement of senior hospital management, in overseeing the quality of practice and positive outcomes for Clare and the effectiveness of clinical governance oversight and audit.

264. The dysfunctional organisational environment is clear from the reports provided to the reviewer, and was unlikely to have fostered either a developing and necessary sense of security in Clare, or the building of trusting relationships with key staff. Both were essential conditions if she was to be helped to address her emotional state of mind and depression.

265. Many service improvements identified as needed by this SCR are similar to those set out in the CQC reports in 2017. The practice under analysis in this report occurred two years prior to the publication of the CQC report and in the interim period the hospital was subject to a closely monitored service improvement initiative by both the CQC and NHS England. Notwithstanding these regulatory developments, this SCR concludes that Hospital 2 needs to pay particular attention to the following issues and ensure that, if not already addressed, they are now tackled, and improvement in each area listed is proven.

266. These are:

- Individual care plans should be holistic, comprehensive and address need, treatment, objectives, desired outcomes and risk. They should be wider than just nursing plans and include inputs from the entire multi-disciplinary team.
- Care plans should be updated regularly, especially after significant events and risk episodes.
- There should be only one plan for each patient and duplication should be avoided.
- The hospital should use an electronic recording system that will allow for regular updating, especially after risk incidents, by all members of the multi-agency team. This system should not be enabled to overwrite previous entries.
- The hospital should ensure that all significant incidents (especially suicidal, self-harm and ligature episodes) are recorded, and clear to all members of the multi-agency team.
- The hospital should undertake dynamic assessments that recognise the changing nature of risk, as opposed to static assessments that do not.
- Staff should be trained to see patients' needs and risks in their historical context so their treatment can be undertaken within a bigger picture of their lives and histories.

- Ward rounds should include regular reviews of care plans and risk assessments, with the direct involvement of the full multi-agency team and patients.
- Effective transition arrangements should be put in place between wards (general adolescent ward and PICU), and there should be a system for both better information sharing, and recorded handover meetings.
- The hospital should ensure better continuity of care and minimisation of disruption to patients, both within a ward, and at any transition points.
- Recruitment and retention of high-quality staff is needed, to help the hospital to achieve consistency. Less staff turnover and use of agency workers should be the aim.
- Each patient should have a named key worker.
- Staff should be trained to be familiar with safeguarding procedures, including any instances where they should be reporting and referring to Children's Services.
- The hospital should ensure greater involvement of external agencies, NHS England, commissioning CAMHS and Local Authority Children's Services in patients' care.
- The hospital should commit to, and ensure, greater involvement of parents/carers.
- The hospital should ensure better recording of the involvement wishes and feelings of subject children and young people in their care/treatment plans and discharge arrangements.

267. There were issues of inter-agency working between Hospital 2 and Hospital 5 that between them dealt with Clare's self-harming injuries. In addition, there was sub-standard transfer of information from Hospital 2 to Hospital 1.

268. Key lessons from this episode include:

- The need for effective communication, information sharing and joint service planning by the two providers through the production of a care pathway and protocol regarding treatment and risk management of adolescent patients presenting with self-harming behaviour.
- Hospital 2 has the responsibility to share information (i.e. mental health issues, presenting behaviours, current risk assessments of self-harm) with the acute agency on admission in order for the provider to ensure the patient's continuing safety.
- Documentation in the patient's medical and nursing care plans should include notes on the triggers and type of self-harm typically demonstrated.
- All involved should lead to more effective joint provider planning and co-ordination of the patient's discharge back to Hospital 2.
- The need for Hospital 2 to ensure that it has a robust patient information sharing and transfer system when young people are discharged from its care.

Huntercombe Group

269. The key findings and learning have been set out in the NICHE report which this SCR supports in full. (See appendices 2i and 2ii of this report)

CAMHS 2 and NHS England

270. Clear guidance is required and once in place should be followed through, on the role, responsibilities and remit of CAMHS 2 care co-ordinators towards children and young people placed at out of area CAMHS facilities, including links with parents/carers and external agencies (local CAMHS, GPs and the Local Authority Children's Services)

271. Clear guidance is also required on the role, responsibilities and remit of case managers (NHSE) towards children and young people placed in out of area CAMHS facilities, including links with parents/carers and external agencies (local CAMHS, GPs and the local authority children's services). N.B. The review was told by the NHSE representative on the 17th September 2018 that clear guidance is now in existence and is being implemented as standard operational procedure in respect of the above learning point.

TOR 3

Leeds Agencies

272. There was a mixed record of Clare and her parents having their views heard and included in decision making and actions taken by the three Leeds agencies.

273. **The key lesson here is that the agencies involved all need actively to facilitate the maximum possible participation of children, young people and their parents or other legal carers in decisions about themselves, including consideration of their wishes and feelings**.

The Schools

274. There was a lack of inter-agency information sharing either between, or by other agencies with, the two schools regarding Clare's self-harming and suicidal ideation. Thus, although there was discussion between Clare, Anne, Patrick, Sue and the schools about her behaviour, motivation and educational development, there was no dialogue regarding her emotional wellbeing and mental health needs.

275. **The learning from this practice episode indicates the need for schools to become more aware of their students emotional and mental health needs and having improved their awareness, to respond to them appropriately. Involvement in the North Yorkshire Children's Trust SEMH strategy and its current review, and in other current local initiatives, should address this issue. (See paragraphs 247-248).**

North Yorkshire Agencies

276. In general, there was a good record of these agencies listening to Clare and her parents taking on board their wishes and feelings. However, there were questions raised as to how well the parents were informed as to why Clare went to Hospital 2 in Sheffield rather than being offered a place in York, as originally intended.

Hospital 2

277. Hospital 2 state that there was generally good communication with Clare's parents. Conversely, Anne, Patrick and Sue's view was that communication with staff was very

poor. High staff turnover, the use of bank and agency workers and the consequent lack of staff continuity meant that they never saw the same consultant/professional, which they say, was a major factor making for poor communication. Clare's mother told the lead reviewer that she had no involvement in decision making.

278. The learning from this episode is covered at paragraph 265.

Hospital 1 Group

279. There was little effort by Hospital 1 to engage with Anne and Patrick. Anne participated by conference call in the CPA meeting of the 16th March 2017 and her father had no contact. The distance between Norfolk and Yorkshire did not facilitate easy direct contact with the family. Clare was dis-engaged with the staff and chose not to participate in CPAs and ward rounds. Her mother felt that there was poor staff continuity and no named professional to liaise with. In her view, there was a lack of verbal communication and she often felt disconnected.

280. The learning from this episode highlights the crucial importance of every effort being made by hospital staff to encourage the maximum degree of participation and involvement by young people and their careers in the planning and decision making processes. Self-evidently, young people should have a voice in their treatment and post discharge planning though involvement in ward rounds, CPA meetings and other relevant fora' See also paragraph 303 below.

TOR 5

281. Clare was unable to go to CAMHS Inpatient Service 1 in York because of acuity problems at the time of her proposed admission. Due to a lack of capacity of nearby Tier 4 facilities she was found a place at Hospital 1 Sheffield.

282. She was sectioned under the Mental Health Act, 1983 because her escalating self-harming and suicidal behaviour necessitated it in the judgement of the Hospital 2 multi-disciplinary team and NHSE.

283. She was transferred to Hospital 1 in Norfolk because her behaviour in the summer of 2016 required a low secure unit (LSU) facility to safely manage her risk. There were no suitable LSU units in Yorkshire/Humber or the North of England due to lack of capacity which resulted in her going to Hospital 1.

Part 8 - Improvements and Challenges

284. All agencies named below are challenged by this SCR to consider what actions are needed to translate the following learning points and improvements into positive outcomes, so as to enhance the safety and well-being of children and young people who have emotional and mental health needs.

Leeds Agencies

LCH-CAMHS, Clinical Commissioning Group 1, Leeds Safeguarding Children Partnership[93]

285. Within the context of the, 'New Model of Care' the LCH (CAMHS) and Clinical Commissioning Group 1 (as commissioners of CAMHS and GP services) should address:

286. The importance of early recognition, intervention and treatment of children and young people with mental health issues; in the home/locality, or as close to it as possible, '*The right care at the right time in the right place'*.

287. There is a need to reduce waiting times for a first consultation CAMHS clinical appointment to within a realistic stated target date.

288. CAMHS 1 and the Clinical Commissioning Group 1 need to consider the potential importance of a multi-agency approach (Early Help and/or Child in Need), by involving other agencies and in particular, schools, in promoting the safety and well-being of children and young people in their care.

289. There should be annual reporting to the Leeds Safeguarding Children Partnership by the relevant agencies/Boards on progress made on implementing the Local Transformation Plan and New Model of Care.

290. The Leeds Safeguarding Children Partnership should be made aware of this report, especially regarding those agencies mentioned above.

North Yorkshire Agencies

291. School 2 and if necessary, all schools in North Yorkshire, should ensure they can prove they are addressing and implementing the nine learning points at paragraph 243.

292. The Clinical Commissioning Group 3 should be made aware of this report. Following consultation, it should take steps to assure the North Yorkshire Safeguarding Children Board that progress is being made on the effective implementation of the Local Transformation Plan, including the North Yorkshire Children's Trust SEMH implementation plan (2017-2020)[94], paying special regard to the development of a whole school approach (see paragraphs 246-248 above). Thereafter, there should be an annual progress report made to the NYSCB.

293. CAMHS 2 should address (through the LTP and NHS E, '*New Models of Care'* initiative, see paragraphs 254-256 above) the importance of early recognition, intervention and treatment of children and young people, with mental health issues; in the home/locality, or as close to it as possible, as per the '*The right care at the right time in the right place'*, initiative.

294. Through the LTP the need to reduce waiting times for a first consultation CAMHS clinical appointment to within a realistic stated target date.

[93] Formerly the Leeds Safeguarding Children Board (LSCB).

[94] Overseen by the NY Children's Trust Board.

295. CAMHS 2 and LYPFT should assure the NYSCB by annual reporting that good progress is being made in effectively implementing the New Model of Care agenda, especially the Crisis Intervention/ Intensive Home Treatment initiative.

Sheffield Agencies

Hospital 2 and Hospital 5

296. In addition to the service improvement initiatives required by the CQC and NHS E, the Hospital 2 Sheffield should address and implement the learning points at paragraph 265.

297. The Hospital 2 and STHFT should address and (where relevant), implement the learning at paragraph 267.

298. The Sheffield Safeguarding Children Board should be made aware of this report, especially in reference to the two agencies mentioned in this section.

Huntercombe Group

299. The Huntercombe Group should address and implement the recommendations (see appendix 2ii) of the NICHE report in a timely manner.

300. The Group should report on progress and effective implementation of the action plan to both the NYSCB and Norfolk Safeguarding Children Board within the next six months of the approval of this report.

301. Norfolk Safeguarding Children Board should be made aware of this report and should seek assurance on the safety and well-being of children and young people resident at any Huntercombe Group facility in the county.

Police 1

302. A copy of this report should be provided to Police 1 for coronial purposes.

All Agencies

303. All agencies involved in this SCR should consider how best to maximise the voices of young people and their parents/carers/ families in decision making processes, especially as regards admission to in-patient care, Care Planning Approach, considerations around Section 17 leave and planning for community discharge.

Claire's Parents Suggestions for Service Improvement[95]

304. Agencies should give due regard to the following points;

- 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 i.e. Single Point of Contact (SPOC).

[95] Obtained from the lead reviewer's visit to Anne.

- Connections with families: parental involvement as much as possible.
- Early Intervention with Schools.
- CAMHS involvement – more involvement and the opportunity to offer a professional who could visit the home i.e. home care professional.
- Tier 4 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 – Anne said that there is limited support for parents and has paid for her own. This is only once a week and is limited due to the cost.

Glossary

A and E	Accident and Emergency
APIR	Assessment, Planning, Implementation, Review
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CC	Care Coordinator
CGAS	Children's Global Assessment Score
CiN	Child in Need
CPA	Care Plan Approach
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CTL	Clinical Team Leader
DSH	Deliberate Self-Harm
GAU	General Adolescent Unit
GP	General Practitioner
IPT	Interpersonal Therapeutic
LTP	Local Transformation Plan
LSU	Low Secure Unit
MDT	Multidisciplinary Team
MHA 1983	Mental Health Act 1983
NiC	Nurse-in-charge
NHS England	National Health Service England
NICE	National Institute of Clinical Excellence
NYSCB	North Yorkshire Safeguarding Children Board
PICU	Psychiatric Intensive Care Unit
RC	Responsible Clinician
SCR	Serious Case Review
S1	Secondary School 1
S2	Secondary School 2

SEMH	Social Emotional Mental Health.
SPOC	Single Point of Contact
SSO	School Support Officer
STAR	Salford Tool Assessment of Risk

References

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National Confidential Inquiry into Suicide and Homicide by People with Mental Illness; May 2016; Suicide by Children and Young People in England

NICE, Self-Harm, Quality Standards, 2017

NICHE; September 2017; An Independent Investigation into the Care and Treatment of a Young Person who was a Mental Health Service User in Hospital 1, Norwich.

NHS England (July 2014); Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report; CAMHS Tier 4 Steering Group.

NHS England, 2015; Five Year Forward Plan for Mental Health

IRISS Insights, July 2013, no 21

Papyrus, 2018; Building Suicide- Safer Schools and Colleges- A Guide for Teachers and Staff.

Royal College of Psychiatrists (2014); Managing Self-Harm in Young People

HM Government; 2017; Transforming Children and Young People's Mental Health Provision

Working Together, 2015; HM Government

Appendix 1 Aims, Terms of Reference and SCR Process

Aims

1. The overall purpose of this SCR is set out in Working Together to Safeguard Children (2015) namely to undertake a rigorous, objective analysis that will:

- *"Look at what happened in this case, and why, and what action needs to be taken to learn from the Review findings.*
- *Action results in the lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm.*
- *There is transparency about the issues arising from this case and actions which the organisations are taking in response to them.*
- *Including sharing the overview report with the public"* (WTSC 15, pg 72)

Terms of Reference (ToR)

2. This SCR and the overview report have been undertaken in relation to the following terms of reference, namely;

Key Themes

Assessment of Clare's Needs and Risks

1. Critically analyse and evaluate the effectiveness and extent to which Clare's needs (emotional and mental health, physical health, safeguarding and welfare and educational) and risks of self-harm and suicidal behaviour, were met by agencies.

Planning and Service Provision

2. How effective was service planning and provision in addressing Clare's self-harming and suicidal behaviour and as far as possible, promoting her safety and wellbeing?

The Voice of the Child and Parents in Assessment, Planning, Implementation and Review (APIR)

3. How well was the voice of Clare and her parents heard and included in the APIR process? Was the process sufficiently child focussed, if not, why not?

Multi-agency working together

4. How effective was multi-agency working together in regard to,

- Information sharing and communication of concerns
- Multi-agency meetings
- Promoting the safety and welfare of Clare
- Supporting her parents
- Impact on multi-agency working
- Support to schools

Compulsory Intervention and Out of Area Placements

5. Why was compulsory intervention under the Mental Health Act 1983 and Out of Area placements necessary? How well did they promote Child MT's safety and well-being regarding risk management from harm and meeting her emotional and mental health needs?

Scope of SCR

3. The time-frame under examination is from 01.01.2014 to 30.03.2017. This covers the period from Clare and her mother's involvement with Leeds CAMHS to just after her tragic death in mid-March 2017. It should be noted that this SCR is an examination into agencies' involvement with Clare and her family over the above time period and not a determination of who (if anyone) may have had responsibility for her death. This is the job of the police investigation or inquest, in the event that one is held.

Methodology

4. The following documents, meetings and events underpinned the SCR;

- Integrated chronology.
- Fifteen agency reports from Leeds, North Yorkshire, Sheffield, South Yorkshire and Norfolk agencies involved with Clare and her family.
- Preparation meeting between lead reviewer and agency authors.
- Reports from NHS England, Care Quality Commission, NICHE and Norfolk 1.
- The NICHE report was commissioned by Hospital 1 Norfolk and was used extensively by the Lead Reviewer.
- Discussion and analysis at four panel meetings. Learning event involving front line practitioners and managers: November 2017.
- Conversations with mother, father, step-mother.
- Reference to the five ToRS
- Liaison with the Police 1 Senior Investigation Officer (SIO) and Crown Prosecution Service (CPS)
- Sight of all relevant documents
- The adoption of a broadly,' Systemic', approach to the understanding and analysis of the case within an organisational context of professionals' actions and decision making at the time.
- A focus on learning and not blame

The Panel

5. The Panel comprised of senior representatives from the following agencies;

SCR Panel Chairs	Ms. Dallas Frank (May 2017-February 2018). Business Manager, North Yorkshire Safeguarding Children Board

	Mrs. Elaine Wyllie (September 2018 - Publication). Designated Nurse Safeguarding Children and Children in Care, North Yorkshire and York.
Lead Adviser, Vulnerable Learners, Education and Skills	Local Authority 1
Director of Quality	Hospital 1, Norfolk
Head of Safeguarding, Children and Families	Local Authority 1
Designated Nurse Safeguarding Children	CCG 4
Senior Designated Safeguarding Nurse	CCG 1
Senior Designated Safeguarding Nurse	Hospital 3
Head of Service, Safeguarding	CAMHS 1
Detective Superintendent	Police 2
Lead Reviewer	NICHE
Mental Health Lead (Yorkshire & Humber)	NHS England
Associate Director of Nursing	CAMHS 2
Senior Nurse	Hospital 2
NYSCB Board Manager	NYSCB
Leadership Support Officer	NYSCB (Non-member)

6. The independent lead reviewer was Mr. Paul Sharkey (MPA)[96]. He had no previous connection with either the NYSCB or any of its partner agencies, including those involved in the SCR. He has a professional background in statutory and third sector safeguarding of over thirty years at senior management level. He has authored/chaired more than seventeen SCRs since 2002 and has attended several DfE/NSPCC courses on improving the quality of SCRs over recent years.

Confidentiality

[96] Master's in Public Administration (2007) from Warwick University Business School. CQSW and M.A (Keele University) in Child Care Law and Safeguarding.

7. In compliance with Government guidance this SCR has respected the right to anonymity of Clare, her family and the professionals involved in the case. All names have been changed.

Family Involvement

8. Clare's mother, father and step mother took part in discussions with the lead reviewer and SCR Chair.

Race, Religion, Language and Culture

9. Clare and family are English speakers of white British heritage.

Parallel Proceedings

For most of the duration of this SCR there was an ongoing police investigation undertaken by Police 1 into the death of Clare. The Crown Prosecution Service decided in June 2018 that no prosecutions would follow her death. An inquest took place in November 2019 with the conclusion of Suicide.

Appendix 2i -NICHE Findings (Root Causes)

1. We 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. These included:

- Poor communication between multi-disciplinary team members about information pertaining to risk.
- Lack of review of Clare's mental state following her return from leave 12 March 2017
- Out of date multidisciplinary reports provided to the CPA meeting 16 March 2017 not containing the detailed information from the support workers 1 and 2 on 13,14 and 15 March 2017 following her return 12 March 2017 from two day's section 17 leave with her mother.
- Lack of comprehensive multi-disciplinary review of risk, aligning risk assessment and management with levels of observation.
- Lack of a documented agreement arising from the CPA meeting 16 March 2017 regarding Clare's observation intervals and an explanation of the rationale aligned with the escalating risk.
- Lack of an explicit statement of the timing of the intermittent observations for Clare in her health and wellbeing or risk care plan.
- Lack of an awareness that ligatures could be a risk for Clare coupled with The Huntercombe Group policy 'Rescue from Ligature and use of Ligature Cutters Policy' restrictions list not including dressing gown cords.
- The lack of consistency between The Huntercombe Group and guidelines, policies and procedures for intermittent supportive observations.
- The record of engagement form for intermittent observations not allowing for the time of the observation to be recorded and creating the opportunity for human error to occur.

- Inadequate adherence to the HHN stated 'custom and practice' of undertaking intermittent level two supportive observations.
- The record of engagement form timings not correlating with the shift planner staff allocation timings making it complicated for the systems to work together.
- Support Worker 3 being allocated the intermittent observations from 01.29am for Clare but attending the emergency at 01.35am on 19 March 2017 with other staff leading to a delay in the intermittent observations for Clare.
- Support Worker 3 then being asked by Support Worker 4 to take over the allocated two-to-one observations allocated to the agency nurse-in-charge to enable the nurse-in-charge to deal with the emergency on the ward leading to further delay of 44 minutes in the intermittent observations for Clare.
- The agency nurse-in-charge recording in error that he had undertaken the intermittent observation on Clare at 1.30am when in fact it was at 1.00am according to the CCTV footage.
- Support Worker 4 taking over the intermittent observations believing that observations for Clare had been completed 14 minutes rather than 44 minutes previously.
- A further delay of 13 minutes in Support Worker 4 undertaking the intermittent observations due to talking to both the nurse-in-charge and the Support Worker that was feeding back the information about her earlier conversation with Clare.

Appendix 2ii NICHE Recommendations

1. The Huntercombe Group must align the current CAMH service inpatient supportive observation policy and the HHN local protocol for supportive observation and review the current template for the record of the engagement reflecting on whether the exact timing of the engagement can be recorded to avoid human error. The revision of the policy must meet the NICE quality standard QS 34 for the monitoring of self-harm and a process for regular multidisciplinary team review of the rationale and the level of supportive observation, recorded in the clinical records and the care plan. The policy must be clear that the staff allocated supportive observations must continue to do so unless instructed otherwise by the nurse-in-charge.

2. The Huntercombe Group must review the risk assessment policy based on current Department of Health best practice guidance and ensure that the critical importance of the family is recognised, the role of the formal mental state assessments, provides guidance on the assessment of cumulative and escalating risk factors and aligns with a review of the supportive observations.

3. To ensure that practice is embedded, HHN must ensure that an annual audit cycle is in place and includes audit of adherence to the supportive observation, CPA and risk assessment and management policies. The audit cycle and subsequent audit reports must be approved and scheduled into the local quality governance arrangements.

4. HHN must ensure that there is a process in place to ensure that NICE self-harm in over 8's long term management clinical guidance CG 133 for the involvement of carers and

family members is in place and includes ensuring the carer is appropriately signposted to the Local Authority for a carers assessment, is provided with information on the management of self-harm and is offered information, including contact details, about family and carer support groups and voluntary organisations.

5. HHN must ensure that the current practice of completion of the shift planner by a Support Worker is reviewed so that the allocation of duties does not limit the responsibility of the nurse-in-charge to discharge their responsibilities effectively.

6. The Huntercombe Group and HHN must review the care planning documentation to ensure that it is clear and that it allows for the alignment of care and risk management plans.

7. Given the culture in the Huntercombe Group and HHN CAMH inpatient services of tying ligatures, risk assessments must always assume that this is a potential risk that requires management. The Huntercombe Group and HHN must consider how best to reflect and balance the management of ligatures risks in the revision of the risk assessment policy both from an individual risk assessment basis and by managing the environment and through having a list of restricted items.

Appendix 3 - Suicide and Self-Harm - Definition and Context

1. Suicide can be defined as ‘*‘A deliberate intent to end life….. (and)…. attempts to stop distress by ending life’*[97],(Furnivall 2013). Deliberate non-fatal self-harm can be understood as ‘*An intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent’*[98].(Furnivall 2013) with adolescent deliberate self-harm understood as ‘*A way of managing an underlying distress by a young person’*[99]. Motivations for deliberate self-harm vary with individuals. Furnivall 2013 [100] identifies that self-harm is used for the relief of negative emotion, intensively difficult feelings and a desire for punishment. Participants describe overwhelming sadness and frustration before the self-injury followed by a sense of relief and calm afterwards. It may be that the release of distressing feelings in itself, through deliberate self-harm can likely reinforce the behaviour.
2. Bywaters and Rolfe (2002) suggest that the motivations of young people to begin and continue to self-harm fall into three main categories. These are, managing events, managing emotions and contextual factors. Managing events refers to traumatic episodes in the young person’s life such as loss, abuse or family discord. Managing emotions through self-harm can be understood as a means of dealing with stress and regulating painful feelings. Contextual factors such as living in a residential setting where

[97] See article by Furnivall. J in the Institute for Research and Innovation in Social Services; IRISS insights, no 21, pages 1 and 2, July 2013
[98] This definition is quoted in the Furnivall article cited above and taken from the Royal College of Psychiatrists 2010 definition, IRISS insights, no 21, page 2, July 2013
[99] IRISS, July 2013
[100] Ibid

the young person has little control over events or where other residents regularly engage in self-harming behaviour may also contribute to starting and maintaining the behaviour.

3. It is suggested that *'responding to underlying distress is more important than focusing on stopping the self-harm (and that) assessment is essential but should focus on the needs of young people as well as their current level of risk'*. (Furnivall, 2013, 1)
4. Suicidal intent can increase with the frequency of self-harm and a young person's motivation for suicidal intent can be located within three core categories (Furnivall 2013). These are: *avoidance*, where suicide is perceived as a rational and realistic option in avoiding ongoing overwhelming distress or in averting an impending intolerable experience; *communication*, as a way of signalling to others the very painful feelings being experienced by the young person. Finally, *suicide as a means of taking control in a powerless situation*, either over others who have power or as a means of the young person themselves regaining control over their destiny.
5. Albeit a relatively rare event with young people, suicide is one of the main causes of mortality[101] and the second most common cause of death in this group[102].The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Report[103] (May 2016) found that there were 145 suicides and probable suicides by children and young people in England between January 2014 and April 2015, of which 66 were under 18 years old. The suicide rate in this age group (under 20 years) is low overall but the highest rate within late teens, with 70% male deaths and 30% female deaths. The majority of the deaths (54%) had indicated their risk through previous self-harm[104], and around a quarter (27%) had expressed suicidal ideation in the week prior to their death. Almost two-thirds (63%) of the 145 suicides were by hanging.
6. Risk factors include: mental illness, self-harm and suicidal ideation, drug or alcohol misuse, abuse and neglect, bereavement, bullying (online), academic pressures and social isolation. The most common method of death was by hanging/strangulation for both males and females. People who have self-harmed have a 50-100-fold higher likelihood of dying by suicide in the 12-month period after an episode than those who do not self-harm[105].
7. Numerous experiences and stresses contribute to suicide and it is rarely caused by one factor.[106] There are likely to be several antecedent risk factors including: long-standing family adversity/dysfunction, difficulties in other areas of life, social isolation and withdrawal; all complicated by mental health problems, especially depressive disorder. A pattern of cumulative risk may then lead to a, *'final straw'* event, often a broken relationship or exam stress.

[101] Source: 'National Confidential Inquiry into Suicides and Homicide by People with Mental Illness' (May 2016, p4); Office for National Statistics in the UK, 2014 Registrations, Statistical Bulletin 2016: 1-33
[102] See Royal College of Psychiatrists, 'Managing self-harm in Young People', October 2014, College Report CR192
[103] 'Suicide by Children and Young People in England'
[104] Cutting and self-poisoning (overdosing) being the most common.
[105] (NICE; Self-Harm; Quality Standard, 2017, Published: 28 June 2013
[106] Source from note 19.

8. The study concludes that '*Improved services for self-harm and access to CAMHS are crucial to addressing suicide risk but the antecedents identified in this study make clear the vital role of schools, primary care, social services and youth justice'*[107].

Appendix 4 - Children and Adolescent Mental Health Policy: The National Context

1.'*If mental health is the Cinderella service of the NHS, then child and adolescent mental health services (CAMHS) is the Cinderella service of the Cinderella service'*[108]. This comment from Norman Lamb (MP), the then Minister of State for Care and Support in the coalition government of 2010-2015 reflected widespread professional and political opinion at the time. Nationally, the CAMHS service was *'dysfunctional and crying out for a complete overhaul'*[109], underfunded and inadequately meeting the emotional and mental health needs of children and young people.

2. The Minister set up a taskforce to shake up the service and make recommendations for change and improvement. At the same time in November 2014, the House of Commons Health Select Committee into Children's Mental Health found that *'The lack of reliable and up to date information about children's and adolescent's mental health and CAMHS means that those planning and running CAMHS services have been operating in a fog*'. These developments led to the publication of the seminal report, 'Future in Mind' in March 2015 and NHS England's, 'Five Year Forward View for Mental Health' (February 2016), both of which provided a blueprint for the modernisation of CAMHS services, backed up by an additional £1.4 billion over the five years to 2020.

3. The reforms were translated locally by the publication of NHS England 'Local Transformation Plans for Children and Young People's Mental Health and Well-being' in August 2015. This set out guidance for local area Clinical Commissioning Groups working closely with their Health and Well-being Boards and partners from across the NHS (including NHS England Specialised Commissioning), Public Health, Local Authorities, Youth Justice and Education sectors on the development of Local Transformation Plans to support improvements in children and young people's mental health and well-being.

4. The key themes from, 'Future in Mind', that underpinned the National and local plans were fivefold, namely:

- Promoting resilience, prevention, early intervention and a joined up approach with clear pathways for children and young people to navigate;
- Improving access to effective support by simplify structures-a system without tiers;
- Care for the most vulnerable;
- Accountability and transparency;
- Developing the workforce.

[107] (Ibid at note 21; 2016,16)
[108] (Independent newspaper, 19 August 2014)
[109] (ibid),

5.The Vision set out was that by 2020 children and young people in every part of England would have timely access to clinically effective mental health support when needed. The five-year programme would include a comprehensive set of access and waiting time standards that would bring the same rigour to mental health as seen in physical health. There was to be a step change in the delivery of care moving away from a system based up a 'Tiered' model of service provision [110], towards one built around the identified needs of children, young people and their families. The aim was to ensure that they would have easy access to the right support from the right service at the right time. This was to be achieved by collaborative commissioning approaches between Clinical Commissioning Groups, Local Authorities and other partners with the development of a single integrated plan.[111]

6.Planning includes localities having a '*one stop shop'* of services that provide mental health support and advice to young people in the community, improving communications and facilitating access to support through every area, having named points of contact in specialist mental health services and schools, including the integration of schools and GP practices. In addition, there is provision for the development of clear pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to in-patient care.

7.The recently published Government Green Paper[112] builds on 'Future in Mind' and notes that, *'In some cases, support from the NHS is only available when problems get really serious, is not consistently available across the country, and young people can sometimes wait too long to receive that support. Support for good mental health in schools and colleges is also not consistently available'* (HM Government, December 2017). The Green Paper consultation with stakeholders and sets out proposals seeking to achieve earlier intervention and prevention, a boost in the support for the role played by schools and colleges and better/faster access to NHS services[113].

8.It has three key elements:

- Every school and college to identify a Designated Senior Lead for Mental Health to oversee the approach to mental health and well-being;
- The funding of new Mental Health Support Teams supervised by NHS CAMHS staff to provide extra capacity for early intervention and ongoing help. The teams would be linked to groups of primary and secondary schools and colleges, providing supportive interventions to children with mild to moderate needs and the promotion of good mental health and wellbeing;
- Trialling a four week waiting time for access to specialist NHS CAMHS services.

[110] Tiers 1 and 2 are provided at Universal and Early Help levels (e.g. through existing school and voluntary sector counselling services). Tier 3 is CAMH's community based, out-patient service provision and Tier 4 is CAMH's in-patient hospital service.
[111] I.e. The Local Transformation Plan.
[112] Transforming Children and Young People's Mental Health Provision (December 2017)
[113] See page 3, Executive summary of above reference at 14 for a list of government commitments and achievements.

9. The approach is envisaged to be rolled out to at least a fifth to a quarter of the country by 2022/23, securing funding after 2020/21, depending on future spending review decisions.

10. Criticism from the Children's Commissioner (October 2017) has highlighted the limited and '*unacceptably slow*' progress made over the last few years in improving CAMHS services. It notes that nearly 60% of local areas are failing to meet NHS England's own benchmarks for local area improvement and over 55% of local areas are not meeting those standards on providing crisis care in Emergency Departments in hospitals and other settings.

11. A recent Care Quality Commission (CQC) thematic review (October 2017) on CAMHS services concluded with the following key messages which are relevant to this SCR:

- The system for CAMHS is complex and fragmented with different parts of the system not always working together in a joined up way. It is highly fractured because of the many organisations that commission and provide services across the four tiers of services;
- Poor quality data prevents a clear understanding of demand and access patterns across England, although the available data suggests that demand is rising across the system;
- Early opportunities to provide support are being missed because staff working in primary care settings and schools lack the necessary skills in mental health;
- This is placing specialist services under increasing pressures and children are having to wait longer for admissions;
- Most NHS specialist services are rated as good or outstanding, albeit there is variation in the quality of care;
- Safety remains the CQC's biggest overall concern about specialist services, followed by staffing matters and a lack of person-centred care approaches in some services.