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

## November 2022

## Final Abridged Report

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

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

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

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

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

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

Events which may occur outside of the timescale of this investigation will render our report out-of-date.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

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

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# Summary

## About this Investigation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Investigation limitations

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

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

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

## Parallel processes

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

1.18 There may also be enquiries by HM Coroner.

## Contact with Christie's family

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

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

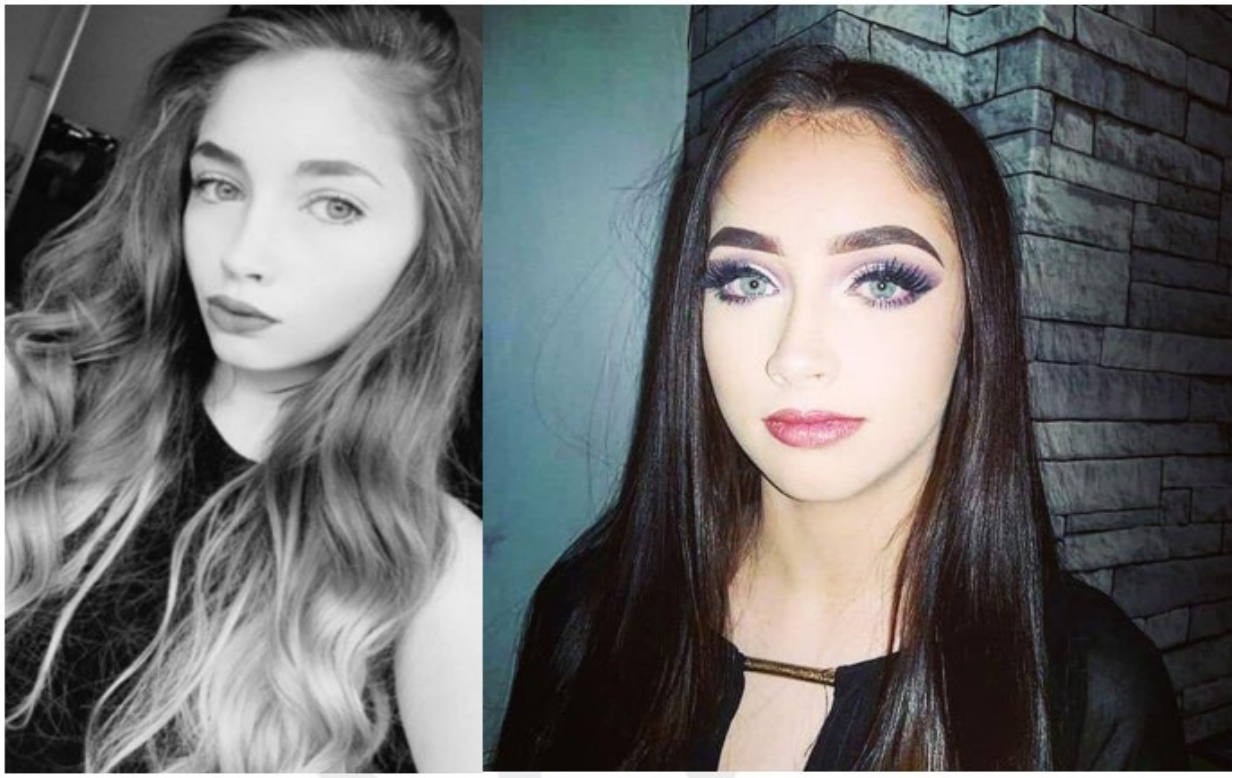
us much valuable information. They also provided a list of questions which we answered, wherever possible within our full investigation report.

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

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

## About Christie

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



**Christie, 13th February 2002 – 27th June 2019**

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

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

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

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

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

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

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

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

## Chronology

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

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

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

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

**Table 1: Dates of hospital admission or placement for Christie**

## Early years

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

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

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

## January – May 2017

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

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

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

## May 2017 to January 2018

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

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

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

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

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

## January and February 2018

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

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

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

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

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

## March to October 2018

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

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

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

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

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

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

**The Westwood Centre (19 March - 11 October 2018)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### The Newberry Centre (11 October - 26 October 2018)

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

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

## October to November 2018

### The Daltons (26 October - 29 November 2018)

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

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

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

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

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

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

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

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

**Tunstall Ward (23 – 30 November 2018)**

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

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

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

## December 2018

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

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

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

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

**Slough (12 December – 20 December 2018)**

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

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

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

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

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

**Tunstall Ward (30 – 31 December 2018)**

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

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

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

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

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

## January 2019 to June 2019

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

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

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

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

### Ferndene PICU (13 January – 1 March 2019)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**The family home (8 May – 20 May 2019)**

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

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

**Cypress Grove, Newton Aycliffe (20 May onwards)**

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

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

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

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

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

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

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

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

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

**The Newberry Centre (28 May to 23 June 2019)**

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

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

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

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

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

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

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

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

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

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

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

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

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

## Events on the evening of 23 June 2019

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

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

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

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

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

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

# 2 Analysis of Christie's Care and Treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

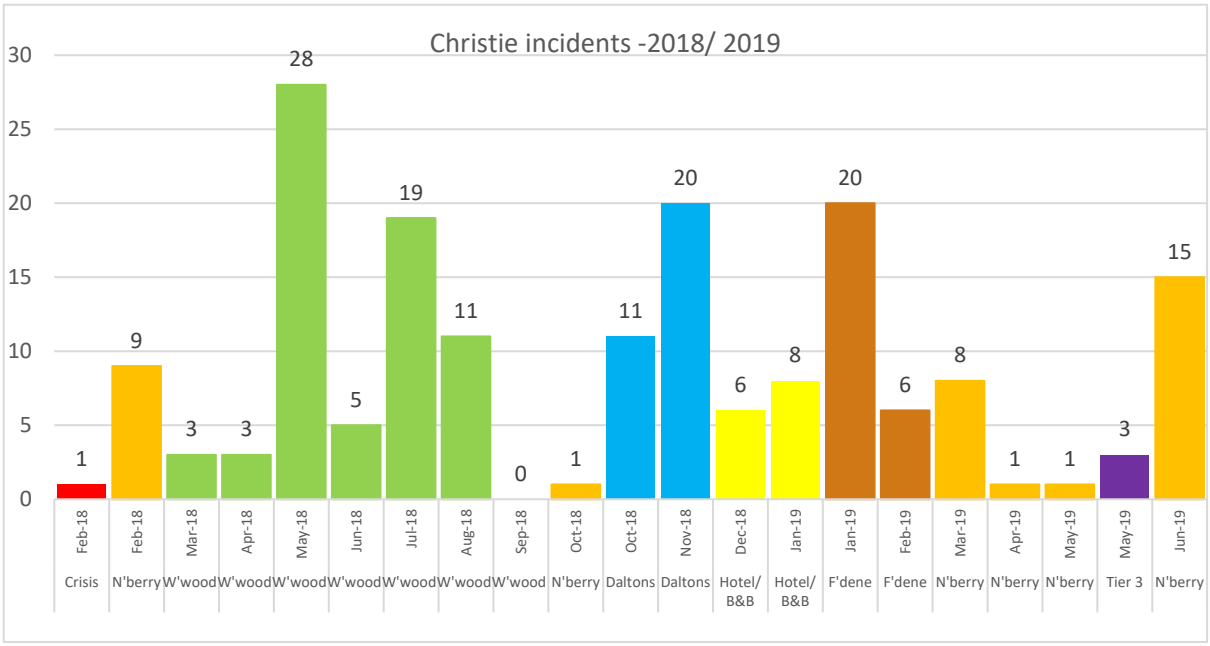
undertaken on 3 May 2019, but this did not inform the Trust's approach to managing low level ligature risks, which were being addressed in response to the NHS Estates and Facilities Alert (EFA/2018/005) Assessment of Ligature Points. This meant that there was little consideration of the risks posed by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

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

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

## Christie's self-harm incidents

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




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

## Family complaints (August 2018)

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

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

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

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

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

## Care and service delivery problems

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

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

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

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

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

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

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

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

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

# 3 Conclusions and recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

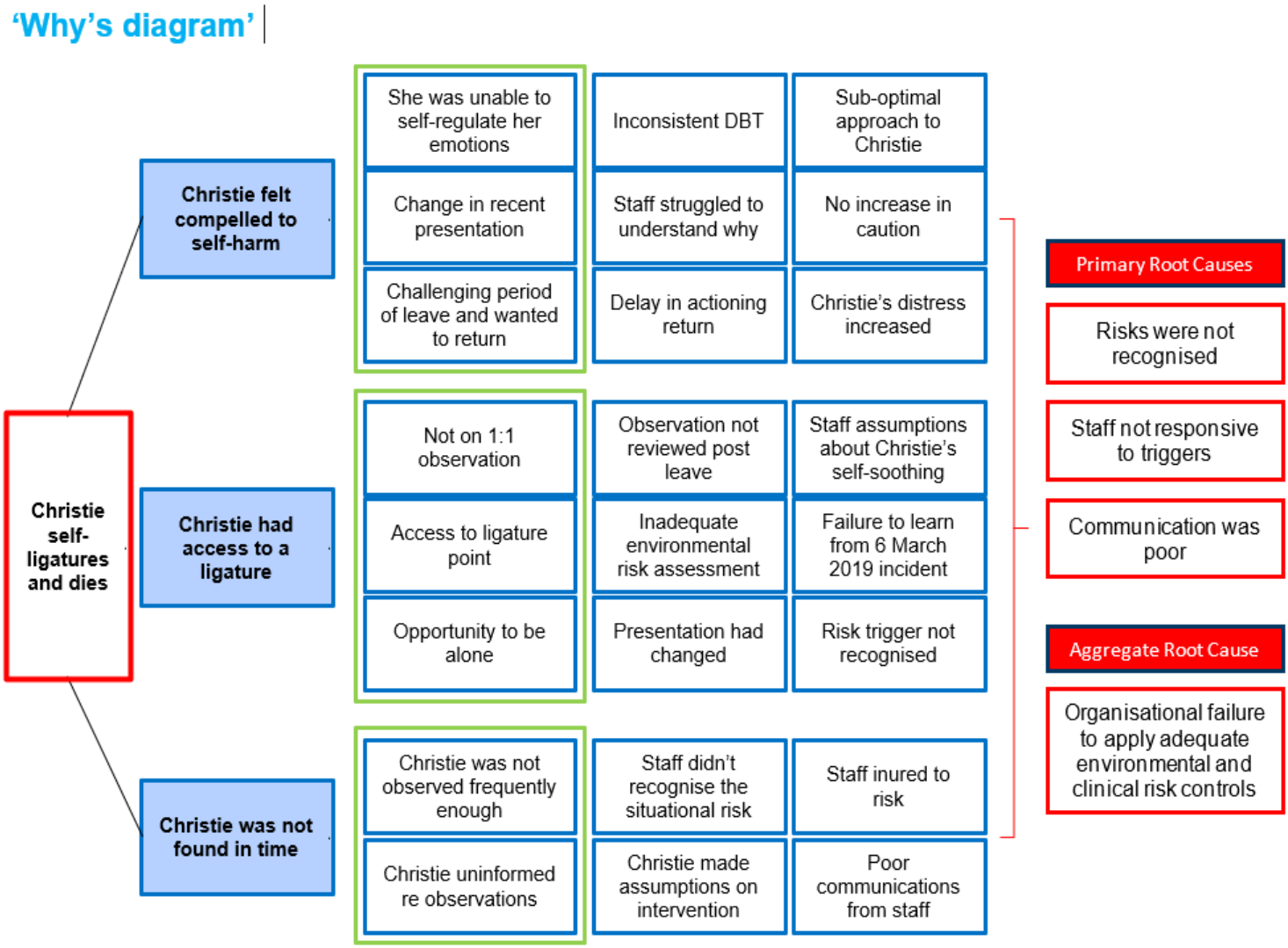
1. Factors leading to an increase in her risk (uncertainty, instability, and the recent move to her new home etc.) were not fully recognised.
2. Trauma-informed care and psychological therapy was not provided.
3. There was a lack of local authority commissioned services to support Christie in the community.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

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

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

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

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



## Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Good practice

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

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

# Appendix A – Terms of Reference

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

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

Purpose of the investigation/commission

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

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

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

Involvement of the affected family members/patients and staff groups

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

Investigation

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

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

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

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

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

Determine any further lines of enquiry from an investigative perspective.

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

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

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

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

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

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

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

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

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

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

**Deliverables**

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

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

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

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

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

Contribute towards a multi-agency media/publication strategy.

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

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

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

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

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

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

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

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

## Appendix B – Glossary of acronyms

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

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