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

November 2022

Final Abridged Report

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

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

2 It contains private information about Nadia and her family;

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

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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 Nadia. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose. We have aimed to remove all sensitive, triggering, personal third-party information from this report.

Events which may occur outside of the timescale of this investigation will render our report out-of-date.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

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

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1 Summary

About this investigation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Investigation limitations

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

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

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

Parallel processes

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

1.16 There may also be enquiries by HM Coroner.

Contact with Nadia's family

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

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

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

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

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

About Nadia

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

Nadia, 1st February 2002 – 9th August 2019

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

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

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

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

Prepared by her family

Summary Chronology

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

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

Early years

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

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

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

2012 - 2019

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

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

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

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

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

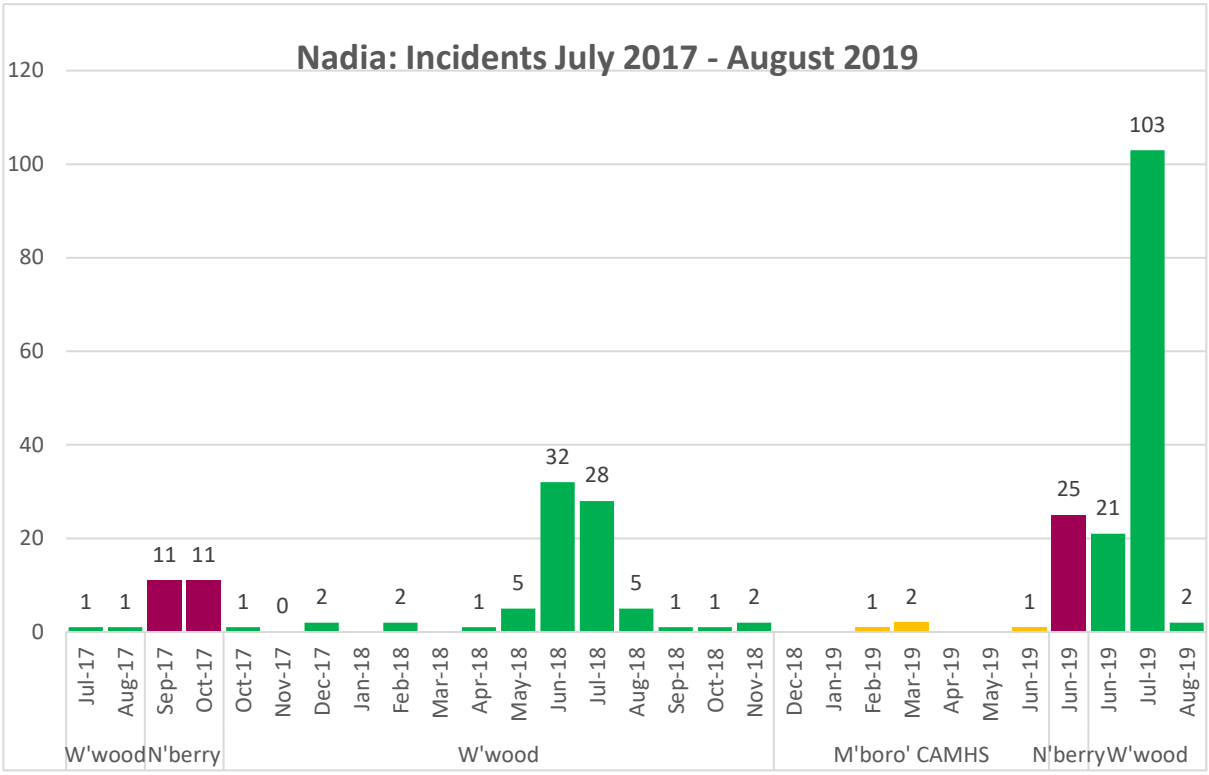
1.32 From December 2018 Nadia was living in her own flat and was provided with an individual package of care by Thornbury Community Services (TCS)[2]. The clinical records show that as risks increased, she was admitted back to a hospital environment for short periods. The funding and resources for the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

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

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

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

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



Events leading up to Nadia's death

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

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

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

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

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

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

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

2 Analysis of Nadia's care and treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Care and service delivery problems

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

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

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

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

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

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

3 Conclusions and recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

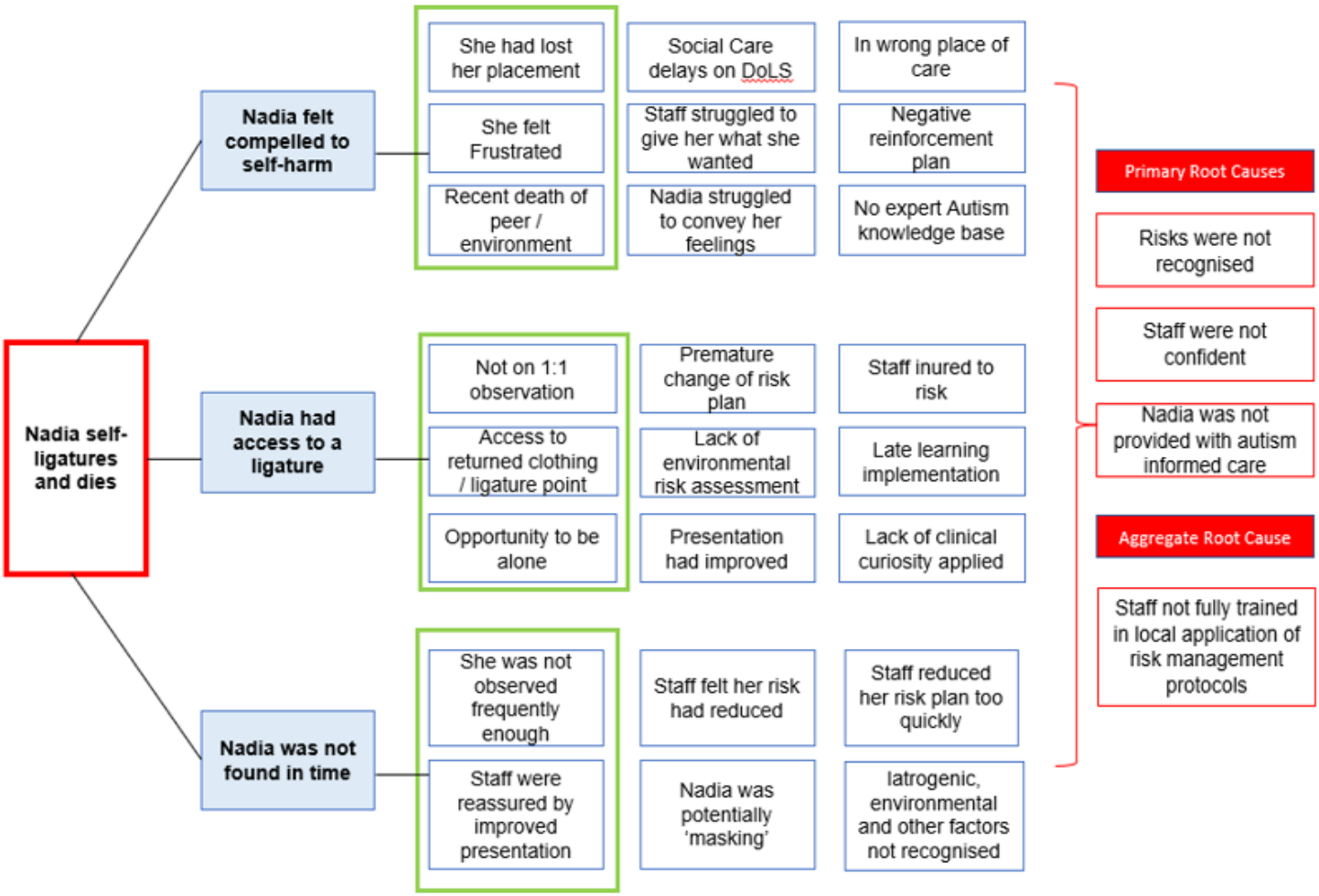
3.12 This was all set within weak internal and external systems of safeguarding governance, as well as systemic pressures due to the lack of appropriate places (both NHS and social care) for young people nationally.

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

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

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

Why's diagram



Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Good practice

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

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

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

Appendix A – Terms of reference

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

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

Purpose of the investigation/commission

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

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

Involvement of the affected family members/patients and staff groups

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

Investigation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21. Determine how effectively the transitions between services, care settings, care providers and localities were managed. This should include but not be limited to:
    - How were these transitions coordinated and communicated across providers and localities?
    - How were these arrangements recorded, reviewed, and evaluated?

22. How effective were Looked After Child Reviews processes, including Health Assessments, in identifying and understanding holistic assessment of needs?

23. How well did Trust staff understand the specific needs of a Looked After Child in their care and how well did non-Trust staff understand the specific needs of Nadia while she was detained under the Mental Health Act?

24. Were Deprivation of Liberty Safeguards considered during the periods that Nadia was not detained under the Mental Health Act, and should they have been?

25. Did the clinical assessments and behavioural monitoring processes adequately assess risk, and was escalating risk effectively identified and acted upon?

26. How were the challenges of inter-organisational communication and sharing of confidential information managed after Nadia's admission to acute services?

27. What areas of good practice have been identified?

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

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

29. Consider whether parental perspectives regarding mental health state informed clinical decision making including whether a Psychiatric Intensive Care Unit (PICU) placement would have been appropriate.

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

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

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

Appendix B – Glossary of Acronyms

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

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