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HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of David

Executive Summary

June 2020

Final Report

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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 report has been written in line with the terms of reference for the independent investigation into the care and treatment of David. 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.

Events which may occur outside of the timescale of this review will render our report out-of-date.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.

This is a confidential report and has been written for the purposes of NHS England alone under agreed framework terms. No other party may place any reliability 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 Report' should be regarded as definitive.

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1 Executive Summary

1.1 This is the executive summary of the final independent investigation report which was presented to NHS England in April 2020.

1.2 Following the completion of the independent investigation, David's family requested that the full report was shared with relevant stakeholders to enable lessons to be learned, but that this summary only is published.

1.3 David was 16 years old and lived in Wigan with his Mum. On 29 October 2016, he left a party he was attending, telling his friends that he was going for a walk. His Mum told the investigation team that when he left the party, he removed the fancy dress outfit he was wearing and placed it under a bush in a nearby garden. He made a 999 call and spoke to the operator as he made his way to the train track. The operator tried to engage him in conversation, find out what his concerns were and dissuade him from going to the track right up to the moment that he was hit by the train.

1.4 Alerted by the 999 call the police began a search for David and attended his home address to speak to his Mum. While the police were at his home speaking to his Mum, they received a call from the British Transport Police informing them of a fatality on the train tracks close to the address of the party and David's home. It was later identified that this was David.

1.5 We would like to express our condolences to David's Mum, Dad, siblings, wider family and friends, and thank his family for their valuable contribution to the investigation.

1.6 Following his death, David's family had expressed concerns about the quality of his care, the process and quality of the internal investigation report, and the conduct of North West Boroughs NHS Foundation Trust (the Trust hereafter) towards the family. NHS Wigan Clinical Commissioning Group (CCG) had also raised a number of concerns about the internal report, however, this was eventually accepted as closed. An agreement was reached between NHS Wigan CCG, NHS England Cheshire & Merseyside, and the North regional NHS England patient safety team that an independent investigation should be commissioned.

1.7 NHS England North commissioned Niche Health and Social Care Consulting (Niche) to carry out the independent investigation into the care and treatment of David. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.8 This independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) (SiF) and Department of Health guidance[2] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.

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[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*

[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

Brief chronology and mental health history

1.9 David had been referred to the Child & Adolescent Mental Health Service (CAMHS) in 2013 by his GP. This referral was not accepted by the service because it did not identify any mental health problems that he needed support with as he already was accessing support with anger management through school and the Youth Offending Team.

1.10 In June 2015 David was again referred to CAMHS due to low mood and suicidal thoughts. This referral was for counselling but, at triage by the single point of referral for CAMHS in Wigan, it was transferred to Tier 3 CAMHS.[3] David was assessed and allocated a care coordinator. An assistant practitioner from CAMHS provided David with therapy around anger management in December 2015 and January 2016. Two safeguarding referrals were made at this time because David had written letters containing plans to kill another young person at Wigan Youth Zone (WYZ).[4]

1.11 David was also assessed by a consultant paediatrician and diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) in December 2015. This resulted in him being prescribed medication.

1.12 In February 2016 David's mood had deteriorated and he was taken to A&E by his family. He was admitted to the Rainbow Unit[5] and, following an assessment of his mental health, he agreed an informal admission to the Fairhaven Unit.[6] Following requests to leave the Fairhaven Unit he was assessed under the Mental Health Act (MHA)[7] and detained under Section 2 MHA.[8]

1.13 Whilst an inpatient David was diagnosed with moderate depression with underlying emotional dysregulation. He was prescribed antidepressant medication. David was discharged from Section 2 MHA and he chose to remain on the ward. However, he took his own discharge before the planned discharge care programme approach (CPA)[9] review could be held. An ad-hoc discharge CPA meeting was held as the discharge plan had been previously agreed with CAMHS and the Specialist Health and Resilient Environment (SHARE) Service.[10] In the community he was under the care of CAMHS and SHARE.

1.14 Between April and August 2016 David and his family were supported in the community by CAMHS and SHARE. During this period, they were supported through outpatient appointments, cognitive behavioural therapy (CBT) and family therapy

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[3] *Tier 3 services are usually multidisciplinary teams or services working in a community mental health setting or a child and adolescent psychiatry outpatient service, providing a service for children and young people with more severe, complex and persistent disorders. https://www.icptoolkit.org/child_and_adolescent_pathways.*

[4] *Wigan Youth Zone is a purpose built, state-of-the-art youth facility in Wigan town centre which opened in June 2013. https://www.wiganyouthzone.org*

[5] *Wrightington, Wigan and Leigh NHS Foundation Trust children's ward. https://www.wwl.nhs.uk/Specialities/Child_Health/rainbow.aspx*

[6] *Fairhaven Young Person's Unit is a young person's mental health unit in Warrington.http://www.nwbh.nhs.uk/aboutus/Pages/Fairhaven-alders.aspx*

[7] *Mental Health Act (1983). http://www.legislation.gov.uk/ukpga/1983/20/contents*

[8] *Section 2: admission for assessment for up to 28 days. http://www.legislation.gov.uk/ukpga/1983/20/section/2*

[9] *Care Programme Approach: www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx*

[10] *SHARE Service aims to implement a model of supporting young people at risk of becoming engaged with statutory social care services as a result of complex emotional and behavioural problems in Wigan. https://www.gov.uk/government/publications/wigans-share-service-project*

sessions. At the beginning of August 2016 David was referred to the Young Persons Drug and Alcohol Service (YPDAS)[11] because of his self-reported use of illicit drugs.

1.15 David's mood dipped in September 2016 and this continued into October 2016. There were a number of incidents involving David that resulted in a professionals meeting being convened on 10 October 2016. The agreement from the meeting was for David and his family to be seen in a CAMHS outpatient appointment the following day. SHARE and YPDAS were to attend this outpatient appointment. At this time David was no longer attending Wigan and Leigh College and his Mum was looking for an alternative education setting for him.

1.16 Also on 10 October 2016, he took an overdose and burnt his face. He was assessed in A&E and sent home. He was seen in outpatients on 11 October 2016. The plan from this outpatient appointment was for David to continue to receive support from CAMHS and SHARE, with more contact with his SHARE key worker. David and his family were reminded that if they were unable to keep him safe, they were to go to A&E.

1.17 This was the last contact that David and his family had with CAMHS. David and his family continued to receive support from SHARE. In the week before his suicide David also had contact with YPDAS.

Trust response to family complaints

1.18 The family made three complaints to the Trust in March 2017, August 2018 and January 2019 raising concerns about the care and treatment provided to David.

1.19 The family made an initial complaint to the Trust in March 2017. The family described their concerns under three broad headings: care and support, the internal incident investigation and a potential breach of patient confidentiality. Upon reflection the family took the decision not to pursue the complaint at that time and asked that the Trust look at the complaint when the Coroner's Inquest into David's death was concluded.

1.20 The Coroner's Inquest concluded on 9 March 2018. The Trust did not make contact with the family because the Trust was expecting the family to make contact with them. The Trust believed that the last communication they had with the family about the complaint was an email stating that the family would contact the Trust after the Inquest. The family told us that in a telephone call to the Trust they asked them to make contact with them following the Inquest.

1.21 The family contacted the Trust again in August 2018 requesting that the Trust complete an investigation into the original complaint. In addition, they asked the Trust to review the behaviour of Trust staff at the Inquest as they believed that the behaviour of staff had been inappropriate.

1.22 The Trust offered the family a meeting with two members of staff. The offer was declined by the family because one of the staff had attended the Inquest. The family then asked that the Trust place the complaint on hold while they explored with NHS England the option of an independent investigation into David's care and treatment.

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[11] *Drug and alcohol treatment for young people in Wigan.*
http://fis.wigan.gov.uk/kb5/wigan/fsd/service.page?id=XyCfytyhTj0&familychannel=6

1.23 The family attended a meeting on 30 November 2018 with representatives from NHS England, NHS Wigan CCG, NHS Knowsley CCG and the Trust. At this meeting handwritten notes were taken. There was no intention on the part of the Trust, NHS England or the CCGs that these notes were to be formal minutes of the meeting. This was not made clear to David's family at the meeting. When they received typed notes for this meeting from the Trust the family were unhappy with the content and did not believe that they reflected the discussion. When the Trust was challenged about these notes, they were unable to provide the handwritten notes taken in the meeting. The handwritten notes were destroyed once they had been typed up. Best practice would have been to await the approval from the family.

1.24 The quality of the notes from this meeting was the basis of the third complaint made in January 2019. An agreement was reached that a review of the Trust management of the three complaints would be part of this investigation.

1.25 We have concluded that the Trust did not follow their own Complaints Policy and Procedure when managing these complaints. Furthermore, the complaints were not managed within the spirit of the Complaints or Being Open Policies.

Independent investigation

1.26 The investigation was completed by Elizabeth Donovan, Niche, with expert advice provided by Dr Andrew Leahy, consultant child and adolescent psychiatrist. Christopher Gill provided education expertise, and Sharon Conlon provided safeguarding expertise. The report was peer reviewed by Dr Carol Rooney, Deputy Director, Niche.

1.27 The investigation was commissioned to review David's care and treatment, the internal investigation undertaken by the Trust, the CCG assurance process for the internal investigation and the Trust management of the complaints made by his family.

1.28 This independent investigation has drawn upon the internal investigation and has studied clinical information and policies. The team has also interviewed staff who were responsible for David's care and treatment. We have provided a review of the care and treatment provided to David, with particular emphasis on the period after his discharge from the Fairhaven Unit in March 2016.

1.29 We have provided a review of the internal investigation, including the oversight by NHS Wigan and Knowsley CCGs of the serious incident (SI) report.

1.30 We have provided a review of the Trust's management and responses made to the three complaints raised by David's family.

Summary and findings

1.31 We have listed below the findings that we have developed through our analysis of the care and service delivery issues, and our subsequent recommendations.

Predictability and preventability

1.32 As part of the terms of reference we were asked to provide a view as to whether David's suicide was predictable or preventable.

1.33 Predictability is ‘the quality of being regarded as likely to happen, as behaviour or an event’.[12]

1.34 We have considered predictability based on David’s behaviour on that day. We believe, given his history of self-harm and his reported thoughts and plans of suicide, the risks clearly identified and known, it was predictable that at some point David would attempt to take his own life but not on that day.

1.35 Prevention means to ‘*stop or hinder something from happening, especially by advance planning or action*’[13] and implies ‘anticipatory counteraction’; therefore, for a suicide to have been preventable, there would have to be the knowledge and opportunity to stop the incident from occurring.

1.36 In its document on risk, the Royal College of Psychiatrists scoping group observed that: ‘Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. Risk, however, cannot be eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person’s behaviour’.[14]

1.37 In considering these we have asked two key questions:

- Was it reasonable to have expected those caring for David to have taken more proactive steps to manage the risks presented by him?
- Did they take reasonable steps to manage these known risks?

1.38 We have concluded that it would have been reasonable to expect the professionals caring for David to have taken more proactive steps to manage the risks presented by him, and that reasonable steps were not taken to manage the known risk.

1.39 We have tried to avoid the bias of hindsight in considering whether his suicide was avoidable. However we have reviewed David’s care and treatment, with particular reference to risk assessment and risk management, and have concluded that David’s suicide was predictable.

1.40 The meeting on 10 October made the decision that David would not benefit from admission to the Fairhaven Unit. This was a reasonable decision made in good faith based on his reaction to the previous admissions. However, there was no clear plan put in place to manage him in the community beyond that he was to be offered additional contact with his SHARE key worker.

1.41 We have concluded that the plan at the time agreed by services was sufficient to monitor David’s risk and keep him safe.

1.42 We consider that there should have been an increase in interventions to try to keep David safe in the period following the outpatient review in October 2016. This should have mitigated the subsequent increase in suicide risk.

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[12] *http://dictionary.reference.com/browse/predictability*

[13] *http://www.thefreedictionary.com/prevent*

[14] *CR201 (Royal College of Psychiatrists, 2016) https://www.rcpsych.ac.uk/members/supporting-you/assessing-and-managing-risk-of-patients-causing-harm*

1.43 However, it is clear that his risk behaviours escalated after this meeting and the response to them was uncoordinated:

- On 19 October David told SHARE staff that everything was getting on top of him and he wanted to kill himself.
- On 22 October he spoke to SHARE about feeling guilty about assaulting his Mum, and that he could not forgive himself.
- On 22 October Mum called SHARE twice and said that she felt unable to keep him safe.

1.44 We have concluded that SHARE should have communicated David's escalating risk to CAMHS in late October 2016. Based on the action taken by CAMHS in the past (April 2016 and the beginning of October 2016) we believe that had they known about David's escalating risk, they would have convened an urgent outpatient appointment and/or professionals meeting.

1.45 Had SHARE communicated this information to CAMHS there could have been a plan for both CAMHS and SHARE to more effectively monitor his change in risk and to consider a response to the risk of harm to himself. Furthermore, it would have been an opportunity to consider an inpatient admission.

1.46 We cannot say for certain whether a change in his plan of care would have prevented David's suicide. However, we consider that it is much more likely that had there been an increase in interventions to try to keep David safe following the disclosures made by David and his Mum on 19 and 22 October 2016, his suicide risk would have been greatly reduced.

1.47 In our opinion we consider that there was the knowledge and opportunity within the healthcare system around David to stop the incident from occurring. The terms of reference require us to 'determine through reasoned argument the extent to which this incident was either predictable or preventable, providing a detailed rationale for the judgement'. Referencing the definition above, we have outlined the 'anticipatory counteraction' that we believe should have taken place to prevent David's suicide. David's mother made SHARE aware that she was not able to keep David safe, and there were concerns about his escalating risk. SHARE had this knowledge, and the existing knowledge of his high-risk markers for suicide.

1.48 In the past when his risk of suicide escalated, there were mitigating plans put in place. After the meeting on 10 October, there were plans made but these were not robust, and did not respond to an escalation in risk. It is on this basis that we consider the system around David had the knowledge and opportunity to prevent his suicide.

Summary

1.49 David was supported by a loving family, who did everything they could to support him.

1.50 It is clear that David experienced many challenges in his life, including low mood, a learning difficulty, and feelings of loss and abandonment. He often presented an image of a young man who was more capable than he was. He was a teenage boy trying to assert his independence and did not recognise that he needed more protection and support than the average teenager because of the challenges in his

life. This would result in him pushing against the boundaries that his parents imposed on him. His parents were concerned about the life choices that David made and the consequences that they might have for his future.

1.51 David made a number of disclosures to staff from November 2014 onwards about involvement with gangs and using illicit drugs. Whilst this self-reporting resulted in safeguarding referrals being made, we question the outcomes from these referrals. In our view there was a lack of professional curiosity by all of the professionals involved with David and there was no proper exploration of the validity of his reports. In addition, there was an over reliance on the parental narrative that David lacked the opportunity and finances that would have allowed him to use illicit drugs or take part in the gang activity he reported.

1.52 In 2016 both David and his family felt the benefit of the 'wrap around' support that they received from SHARE, and the more limited support from CAMHS.

1.53 However, we have concluded that the support from SHARE lacked a sense of purpose and direction with the therapies being provided not following any particular model, no outcome measures being used and staff not being able to adequately describe the way in which they adapted their communication style to meet David's needs.

1.54 With regard to CAMHS we have concluded that the relationship between CAMHS, David and his family was not as good as it could have been. The CAMHS Consultant Psychiatrist who David had regular appointments with, acknowledged that she could have been more direct with the family about her view of David's diagnosis. This was one of emotional dysregulation rather than depression. The Care Coordinator saw her role as one of supporting the outpatient appointments and left care and support to SHARE. SHARE was always the family's first point of contact in a crisis.

1.55 David was subject to care under CPA. CAMHS did not support David with a formal CPA care plan, relying on the outpatient letters to the GP, and they did not complete a formal risk assessment.

1.56 SHARE completed regular risk assessments but as they identified escalating risk there was no change to management plans.

1.57 David's self-reported illicit drug use and involvement with gangs did result in safeguarding referrals to the local authority. When managing the safeguarding referrals, the local authority relied on the services supporting David to manage the issues.

1.58 In the context of David's life, the move from a small independent school to a mainstream college was always going to be a challenge. At Red Rose School he was supported for the whole of the school day, whilst at Wigan and Leigh College he was supported in the classes and was responsible for his own time management for the remainder of the day. He was unaccustomed to this amount of unstructured time.

1.59 SHARE and CAMHS were aware that David found transitions difficult and did not consider providing any additional support during this period. David stopped attending Wigan and Leigh College at the beginning of October 2016 and an alternative education provision, Fir Tree Fisheries, was found for him. He was due to start there on 31 October 2016.

1.60 Our findings are listed below under the headings of care planning and treatment, risk assessment and management, substance misuse and involvement with gangs, care

coordination and clinical leadership, delays in referrals, safeguarding, education and transition, NICE guidance, Trust serious incident (SI) and report, and CCG oversight.

Findings and recommendations

Findings 1: Care planning and treatment

1. There was no care plan in place in the community that described the care to be provided by the different agencies and how communication between the agencies would be managed.
2. There were no outcome measures used for monitoring the impact of the CBT or family therapy provided by SHARE.
3. There were no outcome measures used by CAMHS to monitor the impact of the treatment provided to David.
4. Although there was a review meeting on 11 October 2016 David's care and treatment plan remained the same, this was in the face of a deteriorating presentation.
5. The use of outcome measures would have supported focused discussions between services, David and his family about his treatment needs.
6. The Care Coordinator did not complete a CPA for David while he was in the community. She told us that she considered the outpatient letter sent after each appointment to be the care plan. This is not in line with Trust policy.
7. The Care Coordinator relied on SHARE to coordinate David's care and the responses to his episodes of crisis.

Findings 2: NICE Guidance

1. Whilst the CAMHS Consultant Psychiatrist's approach to prescribing could be considered cautious, it is within the boundaries of acceptable practice for a young person with David's presentation.
2. The CAMHS Consultant Psychiatrist was correct to take advice about the impact that illicit drug use may have on the efficacy of prescribed medication.
3. The guidance states that questionnaires should be used as an adjunct to clinical judgement. The CAMHS team chose not to use questionnaires to monitor David's mood because of his learning difficulty and the CAMHS Consultant Psychiatrist explained to us that she relied on her clinical judgement when assessing David. However, the use of questionnaires could have provided additional evidence of the patients' mood.
4. David had demonstrated on other occasions that he was able to make use of questionnaires to identify his mood and feelings, including during his initial CAMHS assessment. The decision to discontinue the use of questionnaires should have been recorded in the clinical notes, along with the rationale for doing so.
5. The guidance requires services to monitor young people receiving treatment using outcome measures, SHARE and CAMHS did not use outcome measures to monitor David's progress.

6. There is little evidence of David being seen on a 1:1 basis by the Care Coordinator or the CAMHS Consultant Psychiatrist; more often than not he was seen in the company of his family. This might have been a barrier to the CAMHS team building a therapeutic relationship with David.
7. CAMHS did not give any consideration to David's capacity to make decisions and how this might have impacted on his mental health.
8. We have been unable to conclude that robust safeguarding procedures were followed by CAMHS and SHARE with regard to David's self-reported illicit drug use, gang activity and violence as none of the referrals made had resulted in any further action, e.g. a strategy meeting or escalation in the Trust.
9. We have been unable to conclude that the CAMHS staff had an agreed approach to communication with David that met the needs of his receptive language difficulties and informed the approach to his treatment.
10. There was a failure on the part of the CAMHS Consultant Psychiatrist to adequately describe to David and his family their conclusion about this diagnosis. She believed that his diagnosis was one of emotional dysregulation but chose to describe this to the family using terms such as David's 'ups and downs' or 'difficulty controlling his emotions'.
11. The informal complaints made to CAMHS were not adequately managed.
12. There was a lack of clarity about which service had overall responsibility for David's care and support.
13. There was a lack of leadership in both CAMHS and SHARE.
14. Delays in the referral to YPDAS delayed services getting an understanding of David's illicit drug use.
15. The Care Coordinator did not support the psychology sessions during his inpatient stay or CBT in the community as planned.

Findings 3: Risk assessment and management

1. SHARE and CAMHS did not develop a shared, agreed understanding of David's risks. This is evidenced by each team completing their own risk assessments. There is no evidence available that these risk assessments were shared or discussed.
2. The SHARE and CAMHS risk assessments do not identify risk triggers or relapse indicators that would have allowed services to identify and respond to changes in risk.
3. SHARE identified David's risks as red in all risk domains, apart from implementation of physical violence, i.e. the need to restrain David in October 2016. A review meeting was held but this did not result in a revised risk plan.
4. David did have a risk safety plan in place, his family were able to describe this to us and there is evidence that they used it. This plan was for David and his

family to keep him safe using distraction techniques, to contact SHARE and if unable to keep him safe to go to A&E.

5. Services were responsive to David's increasing risks in October 2016 and convened a professionals meeting to discuss the recent events. However, no revised plan came from this meeting or following his outpatient appointment. The plan was for services to continue to provide support to David.
6. The risk assessments do not demonstrate any exploration or understanding of David's risks with regard to illicit drug use or gang involvement.

Findings 4: Substance misuse and involvement with gangs

1. Services failed to get a true understanding of David's illicit drug use.
2. There was a lack of professional curiosity about David's self-reported illicit drug use because his family stated that he did not have the opportunity or the resources to access illicit drugs. His family reported that he lived in a fantasy world.
3. However, there were occasions when he was not where his family believed him to be and there were texts and internet searches that suggested he was involved with illicit drugs. On the only occasion a drug test was completed he tested positive for cannabis.
4. There was a delay in making a referral to YPDAS. The Care Coordinator recorded that she was considering making a referral in August 2015, but a referral was not made until August 2016. This delay prevented services from developing a true understanding of his illicit drug use and the impact that this was having on his mental health.
5. There was a lack of professional curiosity about David's self-reported involvement with gangs. There was limited exploration of the Heretics when SHARE spoke to the police, but no consideration was given to his wider friendship groups. Services lacked curiosity about David's friendship groups (rugby, boxing, WYZ); only considering potential gang activity to be linked to the Heretics.
6. We consider that a well-managed safeguarding referral might have supported a proper explanation of the situation.

Findings 5: Safeguarding

1. The response from the local authority to the safeguarding concerns raised was not sufficient. The referral in March 2016 that included concerns about David's involvement with gangs should have resulted in a strategy meeting to explore the validity of the claims with all of the professionals supporting David and the police. This was the second safeguarding referral with regard to gang involvement, one had previously been made in November 2014.
2. David's potential involvement with gangs was referred to again in the safeguarding referral made by the Care Coordinator on 4 October 2016.

3. All of the agencies involved with David, including the police in January 2016, placed a lot of reliance on the information shared by his family, without seeking corroboration from other sources.

4. There was a lack of longitudinal review of David's safeguarding risks.

5. The response from the local authority to the safeguarding concerns raised was not adequate and CAMHS did not escalate concerns about the local authority response through the Trust safeguarding procedures.

Findings 6: Care coordination and clinical leadership

1. David was subject to formal CPA.

2. The Care Coordinator did not build a therapeutic relationship with David, relying on contact in outpatient appointments and multi-disciplinary meetings.

3. The Care Coordinator did not complete a CPA assessment or review for David while he was in the community. She told us that she considered the outpatient letter sent after each appointment to be the care plan. This is not in line with Trust policy.

4. The Care Coordinator relied on SHARE to coordinate David's care and the responses to his episodes of crisis.

5. The family relied on SHARE for care and support. There was a poor relationship between David's family and CAMHS. They did not see CAMHS as the first port of call when there was a crisis or they needed additional support.

6. The poor relationship was discussed with the Care Coordinator on two occasions and with SHARE. An open discussion about the relationship might have provided an opportunity to improve communication between David, his family and CAMHS.

7. There was a lack of leadership in CAMHS, with the Consultant Psychiatrist and Care Coordinator describing a multi-disciplinary approach to care and treatment in line with New Ways of Working. Neither accepted overall responsibility for David's care and treatment.

8. There is little evidence of David being seen on a 1:1 basis by the Care Coordinator or the CAMHS Consultant Psychiatrist. More often than not he was seen in the company of his family. This might have been a barrier to the CAMHS team building a therapeutic relationship with David.

9. When interviewed SHARE staff told us that they adopted a multi-disciplinary approach to David's care and treatment, with decisions being made through the weekly team meeting. No one member of the team had overall responsibility for David's care and treatment.

10. We acknowledge that there is considerable value to be found in a multidisciplinary team approach but ultimately there needs to be someone in a leadership role and accepting responsibility for the decisions made about care.

11. We have also concluded that neither CAMHS nor SHARE accepted overall responsibility for David's care and support.

12. It is our opinion that this responsibility lay with CAMHS through the CPA.

13. We have concluded that there were failings of care coordination.

Findings 7: Delays in referrals

1. Earlier referrals to YPDAS and Forensic Child and Adolescent Mental Health Services would have allowed the professionals supporting David and his family to obtain a clearer picture of David in the light of parental reports that he lived in a fantasy world. Also, the professional belief that he was a 'Walter Mitty' character and that his accounts were 'stories'.
2. The delay in making a referral to YPDAS was a missed opportunity for David's use of illicit substances to be explored with him by a practitioner with experience in this field.
3. An earlier referral to YPDAS would have allowed for regular drug screening that would give the professionals a better picture of David's self-reported drug use.
4. The YPDAS worker also gave David advice about smoking cessation and safe sex. Discussions of these topics that would have been important to a young person are absent from records of his discussions with other professionals.

Findings 8: Education and transition

1. The final Education Health Care Plan (EHCP) was delayed because of a late start to the process. This was due to poor engagement with the EHCP coordinator by Red Rose School, and a delay in obtaining supporting information from CAMHS and SHARE. It was not available to Wigan and Leigh College until David started his course.
2. We have concluded that the support available to David from Red Rose to explore post 16 education was not in line with the statement the school made to the local authority. David was not supported by the school to visit colleges, attend induction/taster days etc. David was reliant on his family for this support.
3. David attended late in the academic year for his interview at Wigan and Leigh College. The EHCP was not available at this time and there was insufficient time for the Learning and Support coordinator to gather supplementary information.
4. CAMHS and SHARE demonstrated in the clinical notes an understanding that David found the transition to high school difficult. SHARE noted in August 2016 that David would require additional support during the transition to post 16

education. However, neither service provided additional agreed structured support during September 2016.

5. The CAMHS contribution to the EHCP was scant and not provided until July 2016.
6. The SHARE contribution to the EHCP was more detailed but not provided until July 2016.
7. We believe that better information sharing by Red Rose School, SHARE and CAMHS would have resulted in a more information rich EHCP that would have allowed Wigan and Leigh College to make a better-informed decision about the support provided to David.
8. How David would cope with moving from a small school with classes of no more than eight, where he was supervised and supported throughout the school day, into a large college with support only provided in the classroom with no supervision at other times was not explored with David and his family. CAMHS and SHARE did not help David and his family explore the pros and cons of the move.
9. CAMHS and SHARE did not communicate with the Learning and Support coordinator at Wigan and Leigh College until the placement at the college had broken down.
10. The responsibility for supporting David to make choices about his post 16 education was left to his Mum. Access to better support to consider schools, colleges, apprenticeships, internships etc. in a structured way could have resulted in a placement better suited to David and his needs.
11. The health and social care contribution to David's transition to post 16 education was not managed well.

Findings 9: Trust SI and report

1. The SI investigation commissioned by the Trust was described as concise. This was not in line with the recommendations of the NHS England SiF. We consider that there were complex issues with regard to David's care and treatment that warranted a comprehensive investigation.
2. We have concluded that the Trust did not allocate a lead investigator for the Trust SI with the skills and knowledge needed to complete the investigation.
3. The terms of reference for the investigation were generic in nature and did not identify the scope of the investigation sufficiently. The family were not involved in the development of the terms of reference.
4. The investigation did not have access to all of the records required to complete the investigation. As a result, there was insufficient information available to support an understanding of David's care and treatment and the circumstances surrounding his death.
5. The investigation report does not demonstrate appropriate use of Root Cause Analysis techniques. As a result, the conclusions reached by the investigation about care and delivery problems are flawed.

6. The final report does not flow. It addresses the terms of reference and family concerns but these findings do not follow through to the analysis, conclusions and recommendations.

7. Two of the recommendations related to two members of staff. This is not in the spirit of the SI Framework which advocates a ‘no blame’ approach. Furthermore, the recommendations do not support wider learning, service change and the prevention of future deaths.

Findings 10: CCG oversight

1. There was incomplete paperwork for the Incident Report Evaluation (IRE) meeting. Whilst the action columns in the IRE were completed the other columns (responsibility, date completed and documents) were not.

2. The CCG would have been able to provide more robust assurance for the investigation and report had they used the Closure Checklist available in the NHS England SiF. Completion of the checklist would have enabled the CCG to identify the weaknesses in the investigation and report.

3. When requesting further evidence to support the assurance of the investigation and report the CCG accepted a narrative from the Trust; a more robust approach would be to request sight of the actual documentation.

Findings 11: Complaints

1. The Trust communicated with the family using three different methods – letter, email and phone call.

2. The Trust has not been able to provide us with a log of how communication with the family was recorded and monitored.

3. Furthermore, the Trust was not able to provide us with details of one member of staff who was identified as being responsible for managing the complaint. As a result, the family did not have one named contact at the Trust. They had contact with several members of Trust staff with regard to the complaints.

4. The use of more than one method of communication, poor record keeping and no one member of staff identified as a primary contact for the family resulted in a misunderstanding about who was to initiate communication about the first complaint following the Inquest.

5. When the family made contact with the Trust in August 2017 they initially declined to meet with the Trust because one of the members of staff identified to meet with them had attended the Inquest. This led to a delay in arranging a meeting.

6. The situation was compounded by the family pursuing a parallel process with NHS England, which resulted in a further delay in the Trust investigating the family’s complaints.

7. The Trust placed an over-reliance on the complaint process being driven by the family.

Recommendations

Based on our findings we have made nine recommendations, which we have listed in themes:

Theme 1 Care plans and risk assessment

Recommendation 1

All patients must have risk assessments and care plans which comply with Trust and national standards, and the Trust should develop an assurance framework that evidences compliance.

Recommendation 4

All patients should have a risk assessment which addresses triggers and relapse indicators and includes assessment and management plans if there is an escalation in risk.

Theme 2 CAMHS Pathway

Recommendation 3

The Trust must demonstrate that the CAMHS pathway has identified and implemented the requirements of the NICE guidance into the 'iThrive'[15] pathways, and that this is monitored.

Recommendation 5

All young people under the care of the CAMH service must have a named practitioner with responsibility and oversight of their care in line with the Trust Care Coordination Policy and Lead Professional Policy, and this must be included in the implementation of the 'iThrive Model' in Wigan.

Theme 3 Partnership working

Recommendation 6

All young people who are under the care of CAMHS who have an EHCP must have their EHCP referenced in the CPA care plan. The Care Coordinator must liaise with the EHCP coordinator.

Recommendation 2

The Trust must develop an approach to the quality assurance of care plans that addresses communication with other agencies for patients with complex needs. This must include assurance that appropriate communication plans are in place.

Theme 4 SI & complaints process

Recommendation 7

The Trust and NHS Wigan CCG must ensure that all investigations and SI reports meet national quality requirements, to include particular reference to engaging with and listening to families.

Recommendation 8

NHS Wigan CCG and NHS Knowsley CCG must ensure that all systems for 'sign off' of Trust SI reports provide quality assurance that the requirements of the NHS England SiF are met.

Recommendation 9

The Trust must complete the review of the complaint handling process and implement the recommendations from the review, incorporating particular reference to engaging with and listening to families.

[15] *http://implementingthrive.org/wp-content/uploads/2019/03/THRIVE-Framework-for-system-change-2019.pdf*

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