# An independent investigation into the care and treatment of Emily at Tees, Esk and Wear Valleys NHS Foundation Trust and Cumbria, Northumberland, Tyne and Wear 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 Emily and her family;

3 Emily was legally an adult at the time of her death and her right to privacy extends beyond death;

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Events which may occur outside of the timescale of this investigation will render our report out-of-date.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

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# 1 About this Investigation

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

1.2 This investigation was commissioned by NHS England and NHS Improvement as an independent investigation into Emily's care and treatment by Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW). A serious incident such as Emily's death would normally be subject to an internal (Level 2) investigation.

1.3 After the closure of West Lane Hospital in October 2019, NHS England commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake a review of the governance and management of West Lane Hospital by TEWV. Emily's father had raised serious concerns about West Lane Hospital when she was an inpatient and continued to raise concerns about her care by TEWV, along with other parents.

1.4 After Emily's death in a hospital managed by TEWV, NHS England agreed that the investigation of her care and treatment should be conducted independently. The terms of reference were added to Niche's existing work and an independent (level 3) investigation was commissioned, with the agreement of Emily's family.

1.5 The terms of reference (ToR) for our investigation are set out in full in Appendix A and were developed following consultation with Emily's parents. These ToR include Emily's care in West Lane Hospital at their request.

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

1.7 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 the confidentiality of 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).

1.8 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.

1.9 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.

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

- Dr Carol Rooney (lead author) BA, Registered Nurse (Mental Health), MSc, DProf Prac.
- 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, Postgraduate Certificate in Teaching and Learning in Higher Education, Fellow of Higher Education Academy, Registered Nurse Teacher (NMC Approved), MA Clinical Education.
- Nic Hull, BA (Hons), CQSW.
- Sharon Conlon, RMN, RNLD, MA Adult Safeguarding, MA Child Care Law and Practice, BSc (Hons) Community Health Specialist Practitioner.
- Dr Mark Potter, BmedSci, BM, BS, MRCPsych.
- Nick Moor, MBA, PGDip (Law).

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

1.11 To review the care and treatment provided to Emily 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;
- University Hospital of North Durham
- The Care Quality Commission (CQC);
- River Tees Multi-Academy Trust; and
- North East Ambulance Service (NEAS).

1.12 We reviewed many pages of documents, clinical records, policies and procedures, and meeting notes, including policies and procedures from TEWV and CNTW. We also reviewed written accounts of what happened from some of the staff involved. We also carried out over a hundred interviews, and a site visit to West Lane Hospital and Tunstall Ward.

1.13 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 Emily received, and to identify any care and service delivery problems, contributory factors and possible root causes.

1.14 A full list of all documents reviewed is available upon request.

1.15 The draft report was sent to relevant stakeholders for factual accuracy checks. This provided the opportunity for those organisations that had contributed significantly and those whom we interviewed, to review and comment on the content. We considered the comments and corrected factual inaccuracies where relevant.

## Investigation limitations

1.16 Overall, our investigation took 18 months to complete, which is significantly longer than the anticipated six months. We understand the additional distress that this has caused to Emily's family and to staff involved, and we are very sorry for this.

1.17 In addition, this report was 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

1.18 An inquest has been opened and adjourned by the Durham Coroner's Office, and we understand it will be reconvened following completion of this independent investigation report.

## Contact with Emily's family

1.19 We initially met Emily's parents at their home in July 2020. We have had several meetings with them, and we interviewed them formally as part of the investigation. Her parents were very clear that their main concerns centred on the care Emily received from TEWV, both before and after the period of care at Ferndene. For these reasons, her care from her first contact with Child and Adolescent Mental Health Services (CAMHS) has been included.

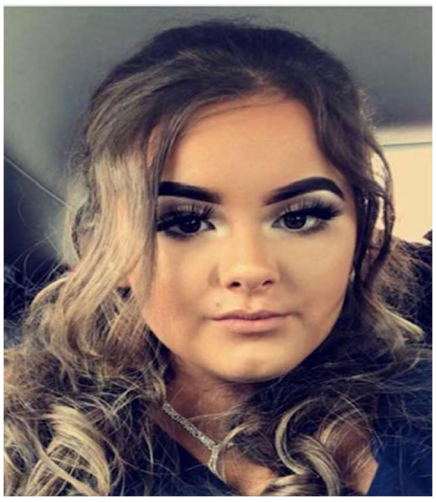
1.20 The family contributed to the questions we asked at interviews, and we have updated them regularly about the progress of the investigation. The family also shared a further series of questions following their review of the full first draft of the report, these have been answered in detail within the full report.

1.21 We have facilitated a meeting between the investigation team, the other bereaved families and their legal representative.

1.22 We would like to express our sincere condolences to the family of Emily. 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.

## About Emily

1.23 Emily's family have provided the following description of their daughter:



**Emily, 4th February 2002 – 15th February 2020**

*"Born in Bishop Auckland, County Durham, a beautiful daughter to David and Susan and sister to Ben. Emily grew up and lived in the current family home in Shildon. At a young age she attended brownie's, gymnastics, swimming and also ballet lessons all of which she enjoyed and was keen to attend and spent a lot of weekends going out with her Mam and Grandma Barbara who she was very close to. The schools Emily attended were Timothy Hackworth primary school and Sunnydale/Greenfield Comprehensive, she was a well-liked pupil with a fairly large group of friends and very bright, again attending many after school activities and did very well in her exams considering her mental health at the time.*

*Emily loved shopping from as far back as we can remember and was an animal lover with many pets throughout her short life and loved elephants, but we stopped at only allowing Guinea pigs and cats! Holidays and TV were a big part of her life also growing up and ironically our daughter passed away on the same day as the TV presenter Caroline Flack who she loved watching on Love Island one of her favourite programmes.*

*Emily had her whole life ahead of her, she really did, sadly taken by mental health issues and lack of proper professional care.*

*We miss you every single day 'Our Emily'*

*Always in our hearts and never forgotten.*
*Love*

*Mam, Dad and Ben x"*

# Summary Chronology

## Contact with mental health services 2017 – 2020

1.24 An extensive chronology is provided in the full, unabridged version of Emily's report. The contents of that chronology are deemed private and not suitable for publication. Additionally, Emily was an adult when she died and her rights to privacy extend beyond death.

1.25 Emily's contacts with mental health services in the three years before her death are detailed in the table below. Local community mental health services were provided by Tees, Esk and Wear Valleys Foundation NHS Trust (TEWV) and Emily was under the care of the South Durham CAMHS service. West Lane Hospital and Tunstall Ward were both TEWV services.

1.26 The Ferndene unit where Emily moved to in July 2019 is provided by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW).

1.27 Emily had been under the care of the TEWV community CAMHS after taking an overdose in February 2017. She had two periods of inpatient care in West Lane Hospital from January to February 2018 and March to July 2019.

1.28 She was transferred to Ferndene from West Lane Hospital in July 2019, and then to TEWV adult services at Lanchester Road Hospital when she turned 18.

1.29 She was an inpatient under the care of TEWV Adult Services (Tunstall Ward) when she took her own life.

| Service | Date admitted | Date discharged |
|---|---|---|
| South Durham CAMHS | February 2017 | January 2018 |
| Newberry Ward | January 2018 | February 2018 |
| South Durham CAMHS | February 2018 | March 2019 |
| Newberry Ward | March 2019 | July 2019 |
| Ferndene PICU | July 2019 | September 2019 |
| Ferndene Stephenson | September 2019 | February 2020 |
| Tunstall Ward | February 2020 | |

## Emily's death

1.30 Emily harmed herself using a ligature on 13 February 2020 and sadly died on 15 February 2020.

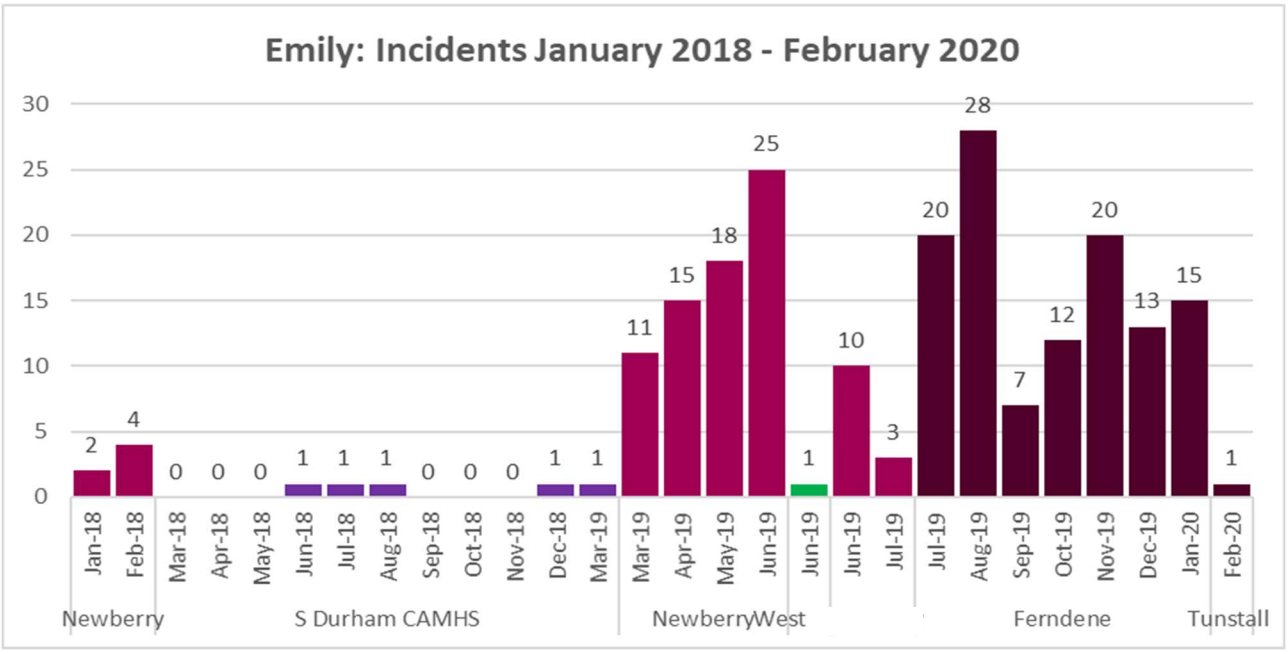
# 2 Analysis of Emily's care and treatment

2.1 Emily first presented to secondary mental health services in 2017 with low mood and feelings of hopelessness and low self-worth.

2.2 The community Child and Adolescent Mental Health Services (CAMHS) team initially treated Emily as experiencing a severe depressive episode. As she began to refer to hearing voices in 2017, she was assessed by the Early Intervention in Psychosis (EIP), who thought she could be at risk of developing a psychosis.

2.3 After Emily's admission to Newberry Ward in March 2019 the working diagnosis was emotionally unstable personality disorder (EUPD). This diagnosis was also confirmed after her transfer to Ferndene later in 2019. Emily did not agree with this diagnosis. Efforts were made to explain it to her and her parents, but she remained very unhappy with it.

2.4 Because harm to herself was a feature of her presentation from January 2018, the chart below shows the number of incidents of self-harm by year, month and service between 2018 and February 2020.




## Care and Service delivery problems

2.5 Care Delivery Problems (CDPs) are problems that arise in the process of care, usually actions or omissions by staff. Service Delivery Problems (SDPs) are acts or omissions identified during analysis but are not associated with direct care provision. They are associated with procedures and systems that are part of the process of service delivery.

2.6 Following our analysis of Emily's care and treatment, a range of CDPs and SDPs were found.

2.7 There is no evidence that a functional analysis was carried out to develop the initial Positive Behaviour Support (PBS) plan, although there is a more person-specific narrative provided by Emily. We have not found evidence of a consistent approach to embedding this within her PBS care plans on Newberry Ward.

2.8 Emily's care plans in Newberry Ward were fragmented, incomplete and inconsistent with the recommendations for access to evidence-based interventions in inpatient settings.

2.9 In May 2019, a care planning meeting went ahead without the Social Worker present in case this exacerbated the situation, and the Social Worker agreed noting that they had not met either the family or Emily.

2.10 There were gaps in psychology provision for the ward which limited any opportunity to consult on or to review care and the PBS plan. Lack of consistent and regular individual psychology sessions meant assessment of Emily's motivation to engage with her formulation and take responsibility for her safety and recovery, and to review her psychological progress was fragmented.

2.11 The clinical team did not have effective risk management plans in place for Emily from May 2019. This was a missed opportunity to develop a formulation and understanding of her self-harm and to engage her family in understanding the treatment approach.

2.12 From April to July 2019, Emily's father raised concerns regarding the multiple self-harm incidents despite Emily being on increased observations. However, there is little evidence of these concerns being considered in accordance with multi-agency procedures. There is no evidence that a strategy meeting was conducted to determine if the threshold for a Section 47 investigation[1] had been met. There was an over-reliance on the internal complaint investigation by the Trust with no evidence of scrutiny and challenge from external partners.

2.13 Although regular meetings were arranged and efforts were made to listen to Emily's parents' concerns, a complete breakdown of trust occurred.

2.14 There is a TEWV Protocol for the Reduction of Harm Associated with Suicidal Behaviour, Deliberate Self-harm and its Treatment (for Young People With a

[1] A Section 47 enquiry means that Children's Social Care must carry out an investigation when they have "reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm." https://www.scie.org.uk/publications/introductionto/childrenssocialcare/childprotection.asp#:~:text=Section%2047%20investigations,suffer%2C%20significant%20harm'1.

Diagnosis of Borderline Personality Disorder and Related Conditions). This was approved in May 2016 and reviewed in April 2020. In our view the language used is open to misinterpretation, and skilled interpretation by consistent, experienced CAMHS staff would be required for the protocol to be effectively implemented. Such staff were not consistently available during Emily's admission in 2019.

2.15 The TEWV policy for standards for clinical record keeping states that documents should be fully completed to identify the staff involved and must be signed and dated. The expectation is that each staff member should make an entry on their own login to the system, which acts as the digital signature. Most Newberry Ward entries did not comply with this standard.

2.16 Whilst on Ferndene, Emily had alleged that staff at Newberry Ward would shout and swear at her when she harmed herself. Ferndene staff also raised concerns that risk items had been found in her 'self-soothe' box on transfer from Newberry Ward. There is no evidence that any further action was taken in relation to these concerns. A safeguarding referral should have been made, this would have enabled the local authority to triangulate information and maintain oversight of the care and treatment of young people on Newberry Ward at West Lane Hospital.

2.17 In August 2019, Emily was assessed as being able to move to the LSU, but no bed was available. Her risks indicated that she could not transfer to an open unit. It was inappropriate to keep her on the PICU, so a decision was made for Emily to step down to Stephenson Ward in September 2019.

2.18 In January 2020, a Consultant Social Worker employed by Durham County Council audited this case and noted that during the period of their involvement, which started in March 2019, until the change of Social Worker in July 2019, the social work provision was "wholly inadequate". The report noted that Emily and her parents were not seen until June 2019. An assessment had been completed in May 2019 without any involvement from Emily or her family. There was no involvement with other professionals, no family involvement, meetings, plans or management oversight during this period.

2.19 On Tunstall Ward, risk items were found in Emily's property after transfer from Ferndene. Although we do not wish to diminish the concerns of her parents, it would not be routine practice on admission to a ward to search Emily on return from leave or to carry out regular property searches. The initial search of her property was noted at admission. There was a record that some contraband items had been removed at admission, but the detail was not recorded.

2.20 There is a TEWV protocol in place to guide the transition from CAMHS to Adult Services[2]. The expectation is that where a young person is in a CAMHS inpatient service and is approaching the age of 18, contact and planning should start at least three months before their birthday. Although plans for her transition from a CAMHS service were developed six months before she was due to turn eighteen, no suitable provider was identified. There was no provision for an alternative, clinically appropriate, placement after the specialist provider turned down the referral.

2.21 It is clear from the records that Emily was unable to keep herself safe in a secure unit with fewer beds and high numbers of specialised CAMHS staff. These facts were lost in the system expectation that she must leave the care of CAMHS.

2.22 We asked if there had been a particular focus on the progress of care for former West Lane patients who were approaching 18 in 2019/2020 and 2020/2021. We were informed that there was no such oversight, but that TEWV have since developed a structure which provides oversight and communications as the young people concerned approach the age of 18.

2.23 The lack of suitable placements in the community for young people with this level of risk-taking behaviour was again highlighted. Given the lack of a community option it is difficult to see what other course of action could have been taken by Children's Services during this period.

2.24 A national safety alert was issued by NHS bodies in September 2018 regarding assessment of ligature points[3]. This alert was not new guidance; the aim was to clarify existing guidance and emphasise the importance of considering multiple factors in assessing the risk posed by ligature points. Part of the shared learning was that current risk assessments be reviewed.

2.25 A programme of ligature review and subsequent action planning was undertaken across the Trust in 2019. It was noted at the time that the previous Tunstall Ward Suicide Prevention Environmental Survey was out of date. En-suite furniture was identified as a low level ligature risk in 2019.

2.26 There were no actions to change the design of the en-suite bedroom furniture, and no revision to the survey which emphasised these as risk areas. Following Emily's death, the design of the toilets was changed to reduce the risk of ligatures.

2.27 TEWV care plans for observation levels should specify whether the staff member should enter the room or not, based on the person's presentation.

[2] Transitions Protocol Child and Adolescent to Adult Services / Primary Care CLIN-0023-v10. August 2019

[3] Assessment of ligature points, Estates and Facilities Alert, EFA/2018/005.19 Sept 2018.

2.28 The Trust have installed a system called Oxehealth[4]. Each bedroom on Tunstall ward has a camera installed which can show if it is occupied, whether the person is in bed or not, and note their vital signs. There is a dashboard in the nursing office which shows green, amber or red depending on the person's state of health, and there is an electronic tablet version so nurses can have this with them as they work around the ward.

2.29 If this had been in place when Emily was an inpatient, staff would have been able to tell whether she was in the room or not, but good practice would still to be to open the door to check. In our view, care plans for observation levels should specify whether the staff member should enter the room or not, based on the person's presentation.

2.30 The 15 care delivery problems, and 9 service delivery problems which occurred during Emily's care are shown in the tables below:

| | Care Delivery Problems identified for Emily | |
|---|---|---|
| | **Assessment, care planning and care delivery** | |
| 1. | TEWV and CNTW | PBS care plans incomplete, and not based on a functional analysis. |
| 2. | TEWV | Gaps in psychology provision. |
| 3. | TEWV | Fragmented incomplete care plans inconsistent with the recommendations for access to evidence-based interventions. |
| 4. | CNTW | A low secure bed was not available, and Emily stayed on the PICU longer than was clinically necessary. |
| 5. | TEWV/NHSE /CNTW | The system expectation was that Emily had to leave the inpatient CAMHS service at aged 18, regardless of her treatment needs. |
| | **Local authority social care** | |
| 6. | DCC | After the referral in March 2019, her parents were not seen until after the assessment was completed |
| 7. | TEWV/DCC | Planning for discharge was arranged without the input of a social worker. |
| 8. | DCC | A Section 47 investigation into her parents' concerns was not conducted. |
| | **Record keeping** | |
| 9. | TEWV | Clinical record keeping was not completed to expected standards. |
| | **Risk assessment** | |
| 10. | TEWV | Lack of effective risk management plans. |
| 11. | TEWV | Contraband items were found in Emily's property on transfer. |
| 12. | CNTW | Details of the contraband found on admission were not recorded. |
| | **Safeguarding** | |
| 13. | CNTW | A referral to the LADO should have been made by Ferndene, after Emily's allegations about Newberry staff. |

[4] https://www.oxehealth.com/applications/patient-safety

| | | |
|---|---|---|
| 14. | DCC | Social workers did not explore Emily's perspectives on the concerns raised with the CQC. |
| | **Family involvement** | |
| 15. | TEWV | A complete breakdown of trust occurred between the Trust and Emily's parents. |

| | **Service Delivery Problems identified for Emily** | |
|---|---|---|
| | **Capacity and skills** | |
| 1. | TEWV | The language of the BPD+ protocol is open to misinterpretation and requires consistent experienced CAMHS staff, which was not the case during Emily's second admission to Newberry. |
| | **Clinical governance** | |
| 2. | TEWV | Clinical record keeping was not completed to expected standards. |
| | **Risk management** | |
| 3. | TEWV | Lack of oversight of the risks of former West Lane patients who were approaching 18. |
| 4. | TEWV | Remedial actions were not carried out to address all ligature risks identified on Tunstall ward in 2019. |
| 5. | TEWV | TEWV care plans for observation levels should specify whether the staff member should enter the room or not, based on the person's presentation. |
| | **Service provision** | |
| 6. | CNTW | A low secure bed was not available and Emily stayed on the PICU longer than was clinically necessary. |
| 7. | TEWV | No provision for an alternative, clinically appropriate, placement on transition after age 18. |
| 8. | TEWV/NHSE /CNTW | The system expectation was that Emily had to leave the inpatient CAMHS service at age 18, regardless of her treatment needs. |
| 9. | DCC | There is a lack of suitable placements in the community for young people with this level of risk-taking behaviour. |

# 3 Conclusions and recommendations

3.1 Emily's parents were particularly concerned about the quality of her care at West Lane Hospital and felt very strongly that her care and treatment in West Lane should be part of this review. The strength of their feelings about this was influenced by the deaths of two young girls which occurred at West Lane before it closed.

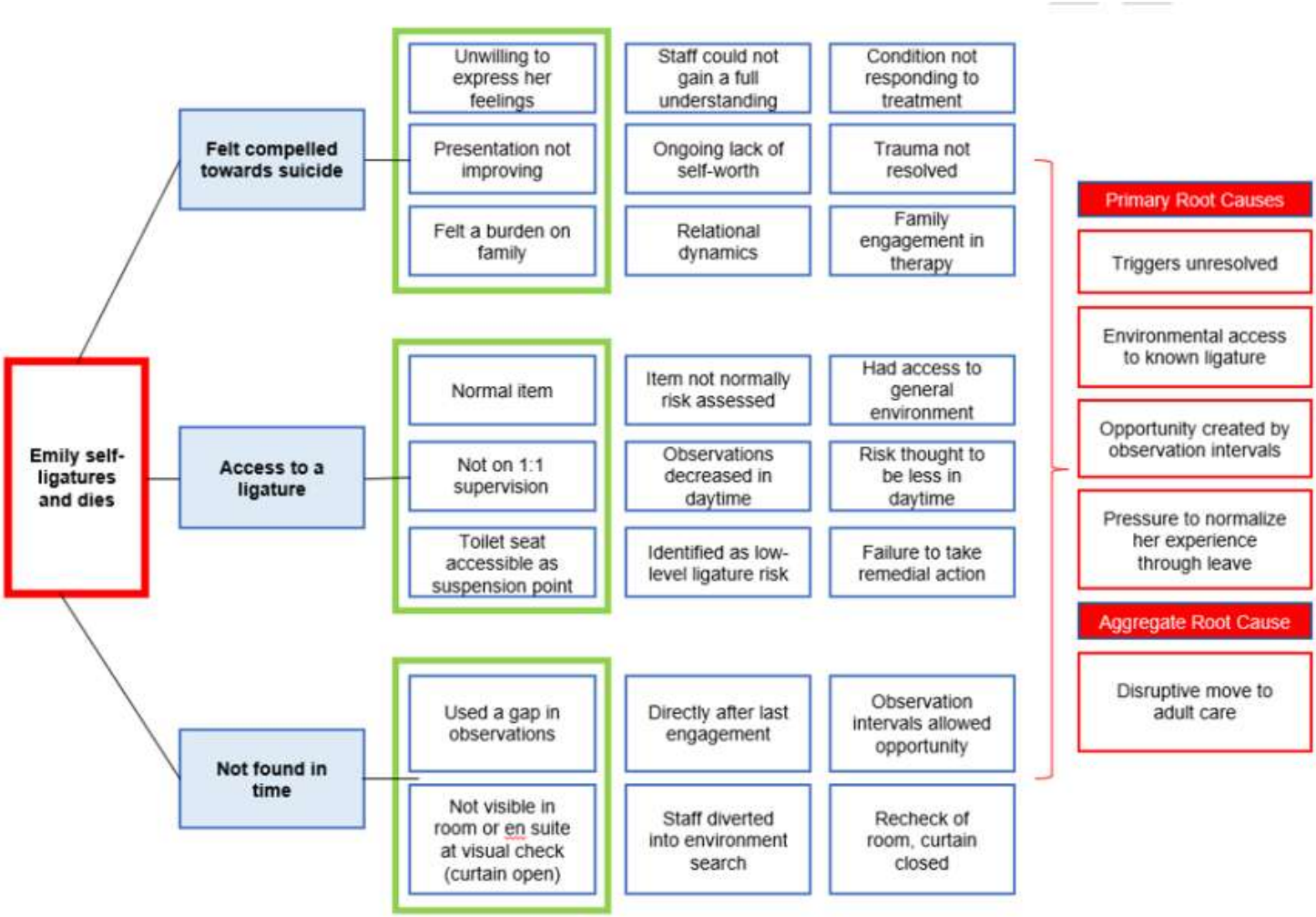
3.2 However, Emily had not been an inpatient at West Lane since July 2019, and the issues at West Lane cannot be seen to have been immediate contributory factors in her death.

3.3 Part of the terms of reference is to “identify any actions that could have led to a different outcome for Emily.” In our view there are two systems issues that had a direct impact on Emily’s death:

- The transition from CAMHS to Adult Services which was based entirely on age and did not take Emily’s clinical needs into consideration; and
- The failure to address the low-level ligature risks identified in en-suite bathrooms on Tunstall Ward in 2019.

## Why’s Diagram

3.4 The following diagram should be read from left to right. It contains an ascending flow of causes with the ultimate aims of establishing root causes (in the right-hand boxes). This diagram is known as a ‘Why’s Diagram’.



## Recommendations

3.5 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 13 recommendations to address the issues identified in this investigation. This report also makes recommendations about the governance issues

3.6

**Recommendation 1:** Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) must ensure that young people in Child and Adolescent Mental Health Services (CAMHS) have a clear plan of care incorporating 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 (MDT) in conjunction with the young person and their family.

**Recommendation 3:** TEWV must ensure that the management of restrictive interventions (including contraband items) is part of an agreed philosophy and approach, with clear protocols embedded to guide practice.

**Recommendation 4:** Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) must ensure that where risk items are found in a patient's possession, there is clear recording and appropriate care planning to address the risk identified.

**Recommendation 5:** Durham County Council must ensure that social workers are directly involved in planning for a young person's discharge from an inpatient environment.

**Recommendation 6:** Durham County Council must ensure that responses to referrals are completed within expected time frames, and subsequent assessments always incorporate the views of the family and young person.

**Recommendation 7:** Durham County Council must respond formally to serious concerns raised about the care and treatment of a young person under their care and explore those concerns with the family and young person.

**Recommendation 8:** CNTW must provide assurance that there are protocols in place for Local Authority Designated Officer (LADO) referrals and ensure that these are understood and followed by all staff on Ferndene.

**Recommendation 9:** NHS England Specialised Commissioning and the North East region Integrated Care Systems (ICSs), as system leaders, should work with the Directors of Children's Services in the 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. Durham County Council and CNTW/TEWV must work together to secure effective joint Section 117 aftercare packages. Where children are looked after by the Local Authority, Durham County Council and the North East & North Cumbria Integrated Care System must provide suitable placement options to support discharge arrangements.

**Recommendation 10:** TEWV must provide assurance that clinical records are kept to expected standards.

**Recommendation 11:** TEWV, CNTW, NHS England and Durham County Council must provide assurance that all transitions between services for children and young people are completed in line with NICE guidance on the Transition of Children and Young people.

**Recommendation 12:** TEWV must provide assurance that all ligature risks identified in Tunstall Ward in 2019 have been addressed.

**Recommendation 13**: TEWV must ensure that the Supportive Observation and Engagement Procedure requires that care plans specify whether to enter the individual's room if they cannot be observed from the doorway.

## Good practice

3.7 We have identified several examples of good practice, all which relate to Emily's care on Ferndene:

- Emily's move to Stephenson Ward was the least restrictive option and kept continuity within the same service with the Consultant Psychologist.
- The Consultant Psychologist devised a matrix for Emily to complete to explore her self-harm in more detail. Using these tailored methods gave Emily the opportunity to explore and express her experiences in a safe and supportive way.
- A detailed psychological formulation of the maintaining factors and the purpose of Emily's self-harm was handed over to the new care team and assessments of continued risk and the absence of understanding of triggers were shared.
- The multidisciplinary team (MDT) increased Emily's leave to meet the family's hope that Emily could go on holiday in July 2019, and to facilitate

time with family at Christmas overnight in Ferndene, with some time spent in the family home.

- The team were aware at admission that there had been a difficult relationship between Emily's parents and the West Lane team and made every effort to develop open and positive communication.

# Appendix A – Terms of reference

Terms of reference for Independent Investigations in accordance with Appendix 3 of NHS England's Serious Incident framework 2015.

The following terms of reference for an Independent Investigation into the care and treatment of Emily provided by Tees, Esk and Wear Valley NHS Foundation Trust (TEWV), have been drafted by NHS England and NHS Improvement.

The terms of reference will be developed further in collaboration with the investigative supplier, Emily's family and key stakeholders.

**Purpose of the investigation/commission**

To commission an independent investigation with recognised subject matter expertise to scrutinise and assess the effectiveness of Emily's care and treatment specifically following transfer from Child and Adolescent Mental Health Services (CAMHS) services at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) to Adult Mental Health Services (AMHS) within Tees, Esk and Wear Valley services, with particular scrutiny of the assessment and management of risk.

Additional lines of enquiry in response to family questions are included.

**Involvement of the affected family members**

It is expected that Emily's family are fully informed of the investigation and the investigative process and that they understand how they can contribute to the process.

**Investigation**

Determine a comprehensive chronology, which includes care delivered within Cumbria Northumberland Tyne and Wear and Emily's transition from CAMHS to Adult Services.

Undertake a critical review and analysis of the care and treatment of Emily, identifying, but not limited to, any gaps, deficiencies or omissions in the service and individual care and treatment.

Consider and comment on the assessment and management of care in the time leading up to the incident (including whether due consideration was given to relevant risk history and the needs of the patient).

Include input from Emily's family for further scrutiny of care and determine whether the statutory Duty of Candour was appropriately applied.

Review the appropriateness of Emily's treatment in the light of identified health needs, identifying both areas of good practice and areas of concern with reference to supporting expert evidence.

Determine any further lines of enquiry from an investigative perspective.

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

Examine the effectiveness of Emily'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
- the effectiveness of multidisciplinary team (MDT) working.

Identify any areas of best practice, opportunities for learning and areas where improvements to services are required.

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

Establish what lessons are to be learned 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.

Cross reference and correlate any emerging themes, findings and learning with the systemwide investigation commissioned by NHS England and NHS Improvement.

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

**Deliverables**

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

Provide an executive summary and a learning case study.

Provide an opportunity for Emily's family to receive supported feedback related to the findings.

Based on investigative findings make organisational specific, outcome focussed recommendations which may include NHS England. Recommendations are to include 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 Clinical Commissioning Group (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 NHS Improvement that will be shared with stakeholders and will be made public.

## Appendix B – Glossary of acronyms

| | |
|---|---|
| BPD | borderline personality disorder |
| CAMHS | Child and Adolescent Mental Health Services |
| CCG | Clinical Commissioning Group |
| CNTW | Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust |
| CQC | Care Quality Commission |
| EIP | Early Intervention in Psychosis |
| EUPD | emotionally unstable personality disorder |
| LADO | Local Authority Designated Officer |
| LSU | low secure unit |
| MDT | multidisciplinary team |
| NEAS | North East Ambulance Service |
| PBS | Positive Behaviour Support |
| PICU | Psychiatric Intensive Care Unit |
| SI | serious incident |
| SIF | Serious Incident framework |
| TEWV | Tees, Esk and Wear Valleys NHS Foundation Trust |

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