f

Suffolk Safeguarding Children Board

www.suffolkscb.org.uk

Serious Case Review

Young Person C

Overview Report

Independent Overview Report Writer: Briony Ladbury

July 2015

Table of Contents

Acknowledgements

I would like to acknowledge the cooperation and support of Young Person C's mother, who allowed me to speak with her at length about her experiences prior to the death of her daughter and of the front line practitioners at the St Aubyn Centre in Colchester, who were the last service in touch with Young Person C before her death in August 2014.

I would also like to give my thanks to members of Suffolk Local Safeguarding Children Board (LSCB) Serious Case Review Reference Group, who have given me generous access to their notes and procedures and to the LSCB Board Manager and Business Support Coordinator who have coordinated the SCR on behalf of the partnership.

Representation on the Serious Case Review Reference Group was as follows:

Designation	Agency
Assistant Director of Nursing and Named Nurse for Safeguarding & Professional Standards	Norfolk and Suffolk Foundation Trust (NSFT)
Head of Safeguarding	North Essex Partnership NHS Foundation Trust
Detective Superintendent, Protecting Vulnerable People Directorate	Suffolk Constabulary
Professional Advisor for Safeguarding in Education	Suffolk County Council Children and Young People Services
Strategic Manager for Learning and Improvement	Suffolk County Council Children and Young People Services
Head of Safeguarding and Quality Assurance	Suffolk County Council Children and Young People Services
LSCB Manager	Suffolk Local Safeguarding Children Board
Designated Doctor for Safeguarding Children	West Suffolk and Ipswich and West Suffolk Clinical Commissioning Groups

Independent Overview Writer

The Independent Overview Writer for this case is Briony Ladbury RN, RM, HV cert, FP certificate, BA (Hons) Protecting Children, ENB Specialist Practitioner Award (Child Protection), MSc in Inter-professional Practice (Society, Violence and Practice).

Briony has a background in safeguarding children work in the NHS both in strategic and practice contexts, producing and quality assuring NHS contributions to Serious Case Reviews and leading on developing NHS participation in Serious Case Reviews for NHS England. She completed the taught modules for the Social Care Institute for Excellence Learning Together Systems Training in 2012 and undertook the DfE funded Course for Improving the Quality of Children's Serious Case Reviews in 2013. She is also trained in the NHS Root Cause Analysis Approach.

Currently Briony is working as an Independent Safeguarding Professional. She was appointed by Suffolk Local Safeguarding Children Board in January 2015 as the Independent Overview Writer for this case.

1. Introduction

1.1. Purpose of a Serious Case Review (SCR)

1.1.1. An SCR is commissioned under statutory guidance issued by HM Government in Working Together 2015 to provide a sound analysis of what happened in a particular case and why, and what needs to happen in order to reduce the risk of recurrence.

1.1.2. Working Together (DfE 2015) stipulates that a SCR should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way that data is collected and analysed;
- Makes use of relevant research and case evidence to inform practice.

1.1.3. This SCR has been undertaken with these principles in mind. It aims to give an understanding of who did what, the reasons why, and the factors that were influencing decisions and actions within a specified time prior to the incident.

1.1.4. The review includes personal reflections from some of the professionals closely involved with Young Person C and her family to explain how their organisations operated at the time of the incident and how and why they acted as they did in relation to her needs.

1.1.5. The mother of Young Person C also agreed to meet with the overview writer and the LSCB Board Manager giving a valuable picture of her daughter prior to and during the two years leading up to her death. She also gave a full account of what it was like to be in receipt of services during the time of her daughter's mental health illness. We are incredibly grateful for her time and willingness to discuss this most devastating and life changing event.

1.1.6. The report will outline the lessons learned during the investigation and make recommendations as to how they can be translated into practice improvements.

1.2. Commissioning Rationale

1.2.1. On 18th August 2014 the Suffolk Local Safeguarding Children Board (Suffolk LSCB) SCR Panel was alerted to the death of a young person which had occurred on 4th August 2014 in Suffolk.

1.2.2. Young Person C aged 17 years and 7 months undertook actions that caused her own death by injecting herself with a veterinary antibiotic preparation. At the time of this incident she was with her father at his farm in Suffolk on 5 hours home leave from the St Aubyn Centre, a specialist Child and Adolescent Mental Health (CAMHS) facility in Colchester Essex.

1.2.3. Clarification was sought by the Chair of the Suffolk LSCB SCR Panel as to the legal status of Young Person C when she died and confirmation was received on 22nd September 2014 that she was accessing Section 17 Leave of Absence whilst being detained under Section 3 of the Mental Health Act (1983). It was therefore agreed by the LSCB Independent Chair that the case met the criteria for a Serious Case Review according to Chapter 4 of Working Together to Safeguard Children (2013) which states 'an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 1983'.

1.2.4. Regulation 5(2)(b)(i) includes cases 'where a child died by suspected suicide'.

1.2.5. The organisations participating in this SCR are as follows:

Organisation	Description	Commissioning Arrangement
GP	Primary Care Provider	Independent Contractor NHS England
Ipswich High School	Independent School (Girls 3 to 18 years) member of the GDST network of Independent Girls' Schools	Independent School
4YP Suffolk Young People's Health Project	Community based young people's health project charity. Offers a range of services including a Short Term Counselling Service which was accessed by Young Person C.	Short Term Counselling Service commissioned by NSFT Suffolk Wellbeing Service (SWS)
Suffolk Referral and Assessment Team	Children and Young People's Service (CYPS)	Suffolk County Council
CAMHS	Norfolk and Suffolk Foundation Trust (NSFT)	Ipswich East Clinical Commissioning Group (CCG) and West Suffolk CCG
Priory Hospital	Eating Disorder Service (Chelmsford)	NHS England
St Aubyn Centre	North Essex Partnership University NHS Foundation Trust, Acute , Intensive and Secure Adolescent Mental Health Unit	NHS England, 4 beds for Suffolk children

Organisation	Description	Commissioning Arrangement
Essex Constabulary	Territorial Police Force/CAIT	Devolved budget from Essex Police and Crime Commissioner (PCC) (additional victim services are commissioned via the OPCC).
Colchester Hospital University NHS Trust	Acute Provider Trust Accident and Emergency Services	North East Essex CCG
West Suffolk NHS Foundation Trust	Acute Provider Trust Accident and Emergency Services	Suffolk CCG

1.3. Methodology

1.3.1. The SCR Reference Group agreed that the purpose of this SCR would be to:

- **Review the circumstances leading to the incident** that caused the death of this young person and establish what lessons are to be learned from the case about the way in which local **professionals and organisations work individually and together** to safeguard and promote the welfare of children.
- **Assess the adequacy of risk assessment and consideration of safeguarding issues,** and review the relevant documents that make up the Trust's internal investigation to assess the adequacy of its findings and recommendations.
- **Identify clearly what those lessons are** both **within and between agencies**, how and within what timescales they will be acted on and what is expected to change as a result.
- **Involve the family of Young Person C** as considered appropriate and in accordance with their wishes and feelings.

1.3.2. It was decided that the SCR would cover the period from when the school first reported an issue suggesting that Young Person C may be having difficulties at home, to the day that Young Person C died when on home leave from the St Aubyn Centre.

1.3.3. Therefore, the timescale covered by this report is **14th October 2012 until 4th August 2014**.

1.4. Data and Evidence Base

1.4.1. Single agency chronologies of agency involvement were compiled and merged into one integrated multi-agency chronology document of over 300

events. This was a main data source for this review. The SCR Reference Group oversaw the preparation of the chronologies, and interviewed some of the staff as the chronologies were compiled. The SCR Reference Group members provided the leadership role for their specific agencies and undertook to seek out, prepare, provide and clarify data as the SCR progressed. The chronology colour-coded by agency gave an excellent account of Young Person C's journey through the system, of what services she engaged with and at what time.

1.4.2. By the time the Suffolk Safeguarding Children Board (Suffolk LSCB) SCR Panel had agreed to undertake a review and commissioned an Independent Overview Writer, the North Essex Partnership University NHS Foundation Trust had already completed a Serious Incident (SI) internal investigation in relation to their services, including interviewing their staff about the incident. It was not considered appropriate or necessary by Suffolk LSCB for the Trust to re-investigate or re-interview mental health staff who were understandably traumatised at the news of Young Person C's death.

1.4.3. Norfolk and Suffolk Foundation Trust (NSFT) were also asked to research and summarise their activity and add it to the North Essex Partnership University NHS Foundation Trust Serious Incident Report.

1.4.4. This combined mental health services report is the only report that the Overview Writer has received for this review. No additional Internal Management Reviews (IMR's) have been submitted.

1.5. Timeline

1.5.1. The timeline was drawn from the multi-agency integrated chronology of events. It consists of three distinct periods of care (care episodes) upon which the investigation and analysis concentrates:

1. The multi-agency care received in the community prior to admission to The Priory Hospital - 14th October 2012 to 16th January 2014;

2. Care following the admission to the Priory Hospital (Tier 4 CAMHS), Chelmsford from 17th January 2014 until 20th February 2014;

3. Care received from statutory agencies whilst a patient at St Aubyn Psychiatric Intensive Care Unit (Tier 4 CAMHS) Colchester from 21st February 2014 until 4th August 2014.

1.6. Narrative Chronology

1.6.1. A narrative chronology, prepared by the Overview Writer was drawn from the merged chronology document and the reports that were supplied. It describes Young Person C's journey through the system during the timescale of the review.

1.6.2. The detail of every aspect of practice for every event has not been included in the narrative chronology on the basis that they were of no relevance to the decisions and actions that influenced Young Person C's care plan.

1.7. Additional Documentation Requested

- Selected Clinical Notes
- Social Work Records
- Organisational Polices NEPFT
- Organisational Policies NSFT
- Organisational Policies and Procedures (Priory Hospital)
- Organisational Policies and Procedures (NEPFT/St Aubyn Centre)
- CQC Report (NEPFT/St Aubyn Centre)
- CQC Report (NSFT)
- CQC Report (NEPFT)

1.8. Additional Interviews

1.8.1. The Suffolk LSCB Manager and Overview Writer conducted supplementary interviews with key staff at the St Aubyn Centre in Colchester on the 25th and 26th February 2015 as they were the service that were engaged with Young Person C and her family immediately prior to the incident.

1.8.2. An interview also took place with Young Person C's Mother on the 5th March 2015.

1.9. Reflective Practitioner Learning Events

1.9.1. On 28th April 2015 the first reflective practitioner learning event took place that included members of the SCR Reference Group and front line practitioners. It was facilitated by the Suffolk LSCB Board Manager and the Overview Writer. The aim of this whole day event, which took place away from the work place, was to enable professionals involved in the care of Young Person C to learn more about the SCR process and purpose, reflect on their practice and clarify any gaps or misinterpretations of the data. It also gave an opportunity for agencies to discuss the early findings and the lessons that were emerging. The second practitioner learning event took place on May 21st 2015.

1.9.2. Most, but not all of the agencies, were represented at the reflective practitioner learning events. The practitioners were pleased to be able to speak freely and openly about the case from their perspective and they learnt a lot from each other. An opportunity was also given to them to make notes about any aspect of the review for attention of the Overview Writer. Formal evaluation forms were filled out at the end of Event 1 and it evaluated very well indeed.

1.10. Analysis

1.10.1. Where possible the analysis has utilised a systems approach to enable a view of what happened and why staff took the actions that they did, but the

nature of the data and evidence submitted has not always facilitated an analysis based on systems principles.

1.10.2. Government Strategy, inspection data and current research has been mentioned when it is of relevance to the analysis.

1.11. Findings

1.11.1. Findings from the analysis are set out in terms of single and multi-agency contributory factors, including any factors that could be categorised as root causes.

1.11.2. Issues of practice identified in the chronology that require single agency improvement are also included in the findings as 'incidental learning'. They are considered not to have impacted directly on the care received or influenced the outcome for Young Person C, but could, if left unchanged in the system create systemic weaknesses in the future.

1.11.3. Themes that apply to more than one agency have also been identified.

1.12. Recommendations

1.12.1. Recommendations relevant to Suffolk LSCB Terms of Reference are made based on the findings from the analysis. They are designed to inform the single and multi-agency actions that will be necessary to secure systems improvement.

1.13. Learning and Improvement

1.13.1. The strategy for embedding the learning across the partnership will be locally determined and agreed by the members of Suffolk LSCB. In addition this SCR has outlined the importance of single agency action planning and wider assurance arrangements, including the responsibility for the LSCB to hold agencies to account on any required improvements.

1.14. Strengths and Weaknesses of Methodology

1.14.1. Overall coordination of the SCR process and materials and the organisation of meetings was successfully undertaken by the Suffolk LSCB Board Manager. Papers and draft reports were circulated in good time for comment from participating agencies. Periodic progress reports were made by the Suffolk LSCB Board Manager to the Chair of the SCR Panel, a sub-group of the Suffolk LSCB.

1.14.2. Two meetings of the SCR reference Group took place to evaluate, triangulate and analyse some of the information received, and two practitioner reflective events as described above were also organised.

1.14.3. There have been some identifiable weaknesses with the chosen methodology which will inform the Learning and Improvement Framework for the County in the future.

1.14.4. The Suffolk LSCB Case Review Panel decided that IMR's would not be necessary from most of the organisations involved in Young Person C's care unless the SCR Review Reference Group Members judged an IMR to be necessary. In this case the relevant Reference Group Member would arrange for an IMR to be written. Agencies were asked instead, to submit a comprehensive chronology of their involvement, to include an analysis of what they perceived their key practice and learning points to be.

1.14.5. During the course of the SCR investigation it became clear that the data submitted to the overview writer concentrated only on what had happened against what should have happened, and in a clinical rather than a safeguarding context. The information had not been systematically analysed by the agencies involved and did not provide clarity about why practitioners acted as they did, or what was influencing their actions at the time.

1.14.6. As the review developed it became apparent that taking evidence and information from the integrated chronology led to difficulties in interpreting the data using systems principles, particularly when practitioners or reference group members were unable to attend the reflective practitioner learning events to clarify the meaning.

1.14.7. To mitigate some of the risk that this posed to the integrity of the report, a decision was made within the SCR Reference group for the Suffolk LSCB Board Manager and Overview Writer to undertake interviews with some of the practitioners delivering care to Young Person C immediately prior to the incident using an appropriate systems technique to elicit why decisions and actions were taken. The interviews were very much appreciated by the practitioners and the managers that took part.

1.14.8. It has not been possible to interview or re-interview all of the practitioners in this way and this may have affected the accuracy and comprehensiveness of the SCR final report. The reason for the overall lack of focus on systems investigative techniques was probably due to an assumption by the LSCB that systems methodology for safeguarding was fully understood and familiar practice for the members of the SCR Panel Reference Group. This finding will be factored into the recommendation to review the Learning and Improvement Framework for the County.

2. Case Background and Context

2.1. Introduction to Young Person C

2.1.1. A sense of Young Person C was drawn from conversations with her parents and many of the staff who looked after her. The wishes feeling and views of Young Person C, according to the verbal accounts of staff, were central to the professional interventions undertaken as part of her treatment, but in general they were poorly represented in the documentation provided as evidence for this review.

2.1.2. We learned that Young Person C's parents were married but had separated soon after Young Person C's birth. She was the only daughter of that marriage. Her father is a sheep farmer in Suffolk, and farming was an

important part of her life. Young Person C had three adult step brothers. Two of her step brothers, who were much older than Young Person C, lived abroad and had occasional contact with her, including during the timescale of this review.

2.1.3. Following her parents' separation, Young Person C stayed with her mother and was the subject of a residence order, although contact with her father was maintained throughout her early years. By the summer of 2011 Young Person C made a choice to live with her father on the farm. This arrangement however broke down in May 2012 and Young Person C moved back to her mother's house with her father's agreement. As a very busy farmer and an older parent, Young Person C's father realised he had little experience and was not coping well with meeting the needs of a teenage daughter.

2.1.4. The loss of both of Young Person C's grandparents within a few weeks of each other when she was fourteen years old had a profound effect on her. Young Person C's mother also struggled to cope with the loss of her parents and Young Person C felt particularly isolated at this time.

2.1.5. Young Person C's parents were able to, and often did, arrange private healthcare for various ailments during Young Person C's childhood, and especially following a skiing accident when she sustained a broken leg. She also attended an independent school in Suffolk as a day pupil.

2.1.6. We have heard consistent descriptions that Young Person C was a likeable, bright, intelligent, and popular young person, who was a perfectionist and somewhat impatient by nature. She enjoyed sport and the outdoors and was a successful long distance runner.

2.1.7. We also heard that Young Person C had high expectations of herself and became easily frustrated and disappointed if she failed to achieve the goals she had set herself. Changes to friendship groups and actions of peers at school also affected her deeply and perceived disloyalty caused her great anguish.

2.1.8. Farming was a constant and important factor in her life. She was interested in and knowledgeable about rearing livestock and training sheep dogs and she was a popular and active member of the local Young Farmers Association.

2.1.9. Young Person C hoped to assume a career in farming, agriculture or veterinary science and was working hard at school to achieve this, successfully attaining good grades in her GCSE examinations in the summer term of 2013.

2.2. View of the Family

2.2.1. The reference group agreed that Young Person C's parents should be approached to participate in this SCR, to give a view of the services that Young Person C received during her illness.

2.2.2. The complexity of the family dynamics between Young Person C and her parents is a continuous feature in the SCR chronology and reports. Despite obvious relationship difficulties there was also ample evidence that both her mother and father loved her deeply, but they admitted that they found the challenges of looking after Young Person C demanding and difficult. During the acute phases of Young Person C's illness she projected a lot of anger and negativity onto her parents, particularly her father, but in the periods of improvement she appeared well attached to both of them.

2.2.3. Both parents engaged with the various treatments and therapy options that were put in place, expressing concerns as they arose on behalf of their daughter and generally wanting very much to secure a good outcome for her.

2.2.4. Young Person C's father declined to meet with the Overview Writer but he did share some thoughts with the Suffolk LSCB Board Manager during the course of two telephone conversations. We heard from the County Safeguarding Manager who chaired the SUDIC meeting (Sudden Unexpected Death in Childhood) that he was totally distraught by the actions of his daughter and it is understandable that he did not want to revisit this traumatic event.

2.2.5. During one of the telephone conversations he expressed disappointment that the St Aubyn Centre had not taken steps to increase his awareness about self-harm in general. He felt that had he understood more about the psychology of self-harm, how it could manifest and how he should behave in terms of supporting his daughter, he would have been more prepared to manage the visit to the farm that day. Material submitted to the SCR reference group records several instances when Young Person C's father reported his concerns to providers when he was worried about their effectiveness in meeting his daughter's needs.

2.2.6. The Suffolk LSCB Board Manager and the Independent Overview Report Author met with Young Person C's mother at her home on March 5th 2015. She gave us a useful insight from her own perspective into the services and interventions that Young Person C experienced and the impact of those services on herself as Young Person C's main carer. She confirmed that she had accompanied Young Person C to all of her arranged appointments, and maintained contact with her daughter during her admissions.

2.2.7. Ipswich High School maintained contact with the family and in the main Young Person C's parents felt they acted on the information that was being relayed to them. She was concerned that details of Young Person C's illness may have been inappropriately discussed with her peer group; however, school records suggest that this was not the case and that they put measures in place to ensure that the detail of Young Person C's illness were kept confidential.

2.2.8. She was hugely grateful for the support she received from her GP. He was consistently helpful, acting as an advocate for Young Person C and her family to enable Young Person C to access support to manage her illness. He communicated with numerous service providers on their behalf and provided listening support on many occasions.

2.2.9. Her view of the 4YP Service was mixed. Whilst she agreed the Counsellors were well meaning, and actively listened, she felt they did not provide Young Person C with the expertise and techniques to manage her increasingly negative feelings.

2.2.10. The encounter with the NSFT CAMHS community based services was also mixed. Young Person C's mother had some concerns as to how the CAMHS service communicated with the family and specific issues relating to telephone messages and written communication are mentioned in the body of the report.

2.2.11. She described one consultation during the initial assessment as lacking overall compassion and of under-estimating her parental anxiety. She also felt that the choice of language the member of staff chose when talking to Young Person C aggravated her daughter's feelings of worthlessness. Whether this was the case or not cannot be determined, particularly as Young Person C may have felt more vulnerable anyway due to having divulged details that were painful and personal to her. There is no evidence to suggest this is a generalised culture within the initial CAMHS assessment service but compassion in practice is a cornerstone of the new strategy for nursing and midwifery in Britain and any report of lack of compassion should be taken seriously. The matter, which is not for the SCR to manage, has been passed to NSFT to make further enquiries.

2.2.12. The Bury St Edmunds CAMHS team providing family therapy was perceived as helpful and responsive, skilfully managing their complex family relationships and the re-introduction of Young Person C's father into family therapy sessions. Young Person C's mother told us however that the service suddenly disappeared. This comment is further explored in the body of this report.

2.2.13. The NSFT CAMHS Youth Pathway Service eating disorder team that provided short term support when Young Person C's anorexia nervosa became evident, and prior to the admission to the Priory Hospital, was very highly regarded. Young Person C's mother was extremely impressed by a nurse in the team who sensitively directed and advised her daughter about improving her food intake at a time when she was seriously underweight.

2.2.14. The experience at the Priory Hospital was described as being useful in regard to her daughter's eating disorder, but Young Person C's escalating self-harm posed challenges beyond the scope of their service, a view that the Priory Hospital would agree with. The timing of moving her daughter 'upstairs' caused Young Person C's mother to wonder if the act of changing Young Person C's routine and her proximity to other patients she had made friends with may have triggered an increase in the rate and severity of her daughter's self-harming behaviour. This issue is considered later in this report.

2.2.15. The support and attention Young Person C's mother witnessed at the St Aubyn Centre in Colchester was greatly appreciated. She mirrored the evidence given by staff at St Aubyn that C was showing significant and sustained improvement when decisions were being made to extend home

leave. We were shown photographs of Young Person C taken the day before she died during an overnight stay with her mother and pictures of Person C with her mother and father whilst she was at the unit. The pictures showed a healthy, happy, smiling, relaxed young person. She also related how her daughter's mood could change suddenly, and how she would self-harm on impulse, which was extremely difficult to understand or manage.

2.3. HM Coroner's Inquest

2.3.1. The Coroner's Inquest took place on 2nd April 2015. The Assistant Coroner described a narrative conclusion acknowledging the events that happened on the day of Young Person C's death and her significant history of mental illness. It was indicated that there was insufficient evidence to be sure that Young Person C had intended to take her own life at the time of the incident and that her action may have been a cry for help. The cause of death was confirmed as toxicity from the animal medication.

3. Narrative Chronology of Young Person C's Journey Through the System

3.1. Care Episode 1: Multi-agency care received in the community from 14th October 2012 to 16th January 2014

3.1.1. Ipswich High School Head of Pastoral Care was made aware by Young Person C's mother on 14th October 2012 of a heated exchange at home which caused Young Person C to be upset.

3.1.2. In early December 2012 Young Person C visited her GP. The GP observed that she was sad and tearful but clinically not exhibiting symptoms of a mental health disorder. She was receiving private counselling at this time.

3.1.3. On 13th December 2012 Young Person C was referred to the NHS Suffolk Wellness Service who arranged support from the 4YP counselling service. She was discharged from the 4YP service on 24th April 2013 when she began accessing CAMHS.

3.1.4. The GP saw Young Person C again on 21st January 2013 after her 16th birthday. She gave an account of difficulties at home and relationship issues with her parents.

3.1.5. Young Person C's father made contact with Ipswich High School to report his own serious concerns about Young Person C's mental health on 31st January 2013.

3.1.6. Young Person C was seen the next day on 1st February 2013 by the school Health Care Practitioner and a Section 47 child protection referral was sent to Suffolk CYPS.

3.1.7. A social worker saw Young Person C alone at school on 1st February 2013 and her parents were interviewed on the same day. A decision was made for the family to be referred for a Team Around the Child (TAC) approach.

3.1.8. On 12th February 2013 C's mother contacted the GP again because Young Person C had been reading information on a web-site about ways to commit suicide. A referral was made to Norfolk and Suffolk Foundation Trust CAMHS service for an urgent triage assessment.

3.1.9. The CAMHS referral was accepted on 13th February 2013 and NSFT CAMHS triage team contacted Ipswich High School for information. On the same day a consent form to undertake an assessment under Common Assessment Framework (CAF) criteria was sent by CYPS to the family.

3.1.10. On 14th February 2013 a letter was sent from NSFT CAMHS to Young Person C's mother offering an appointment for a specialist assessment. The school was informed of the outcome of the referral.

3.1.11. On 19th February 2013 Young Person C attended the specialist CAMHS appointment accompanied by her mother. Checks were also made with SCYPS (Suffolk Children and Young Peoples Services) at this stage and the school was made aware of the CAMHS assessment outcome.

3.1.12. The GP received a letter about the outcome of the CAMHS assessment on 22nd February 2013. Investigations were undertaken as recommended by the CAMHS psychiatrist.

3.1.13. Four telephone messages were left for the CAMHs team by Young Person C's mother, two on 21st February 2013 and one on 23rd and 25th February 2013 respectively. A CAMHS follow-up appointment occurred on 28th February 2013.

3.1.14. Young Person C was seen again by the CAMHS specialist Assessment Team 14th and 27th March 2013.

3.1.15. On 28th March Young Person C's mother asked the GP to arrange individual therapy for Young Person C as she had been advised there was a waiting list for an NSFT CAMHS service.

3.1.16. On 15th April 2013 Young Person C was seen by a practice nurse at her GP surgery with a scald to her arm. The scald was assessed and treated and dressed in another two appointments with the nurse.

3.1.17. Young Person C attended for a specialist NSFT CAMHS appointment on 16th April 2013 when the family were referred to the NSFT Family Therapy Service.

3.1.18. Family therapy service provided by NSFT CAMHS commenced on 25th April 2013. They saw the family for a total of five sessions. The last attended session the family attended was on 12th July 2013.

3.1.19. The family also discontinued individual support from the private clinical psychologist and the 4YP in June 2013.

3.1.20. On 16th July 2013, the GP was contacted by Young Person C's mother expressing concerns that her daughter had a negative body image, was

exercising and watching her weight. She also thought that Young Person C had stopped taking her medication.

3.1.21. The GP saw her again on 20th July 2013 for nutritional and dietary advice.

3.1.22. The family cancelled a CAMHS family therapy appointment on 31st July 2013 and failed to attend the re-booked appointment on 23rd August 2013.

3.1.23. On 23rd August 2013, Young Person C was seen at the West Suffolk NHS Foundation Trust Accident and Emergency department, complaining of chest pain. She was diagnosed with costochondritis (inflammation of the joints between the ribs and breast bone) a condition associated with strenuous exercise. The GP was notified about the attendance.

3.1.24. The CAMHS Family therapist attempted to make contact on Young Person C's mother's answer-phone on 6th and the 20th September 2013 to arrange further appointments.

3.1.25. On 4th October 2013, the family spoke to Young Person C's mother on the telephone. The family no longer thought that family therapy was necessary.

3.1.26. On 3rd December 2013 Ipswich school noted that Young Person C was losing weight.

3.1.27. On 6th December 2013 a final attempt was made by the CAMHS service to re-engage the family by means of two telephone calls. The single agency chronology states that messages were left asking the family to make contact, however the Mother of Young Person C has told us that she cannot recollect being aware of any messages.

3.1.28. On 9th December 2013 a letter was sent to the family informing them that the case would be closed if they did not make contact, again, feedback from the Mother of Young Person C was that as far as she was aware, the family did not receive the letter.

3.1.29. Young Person C was also seen by the GP on 9th December 2013 to follow up Young Person C's apparent weight loss. Investigations by means of blood tests that were initially declined were taken one week later.

3.1.30. The GP received the results of the investigations on 19th December 2013 and referred Young Person C immediately to the Priory Hospital eating disorders unit for an urgent private consultation.

3.1.31. The Priory Hospital Outpatients Department in Chelmsford saw Young Person C as a private patient, on 7th January 2014 a few days following Young Person C's 17th birthday. The psychiatrist recommended NSFT provide urgent dietetic input and eating disorder therapy and informed the GP of his findings. The notes also recorded a history of self-harm.

3.1.32. Two days later on 9th January, the GP referred Young Person C to NSFT CAMHS for an urgent assessment and response.

3.1.33. The NSFT CAMHS eating disorder team accepted the referral and supported the family through telephone consultations from 9th January.

Five days later on 13th January 2014, Young Person C attended for an outpatient appointment with the NSFT CAMHS eating disorder team. By this time Young Person C was substantially underweight. The CAMHS team concluded she needed in-patient care.

3.1.34. A bed became available at the Priory Hospital in Chelmsford and an NHS funded admission was arranged for four days later on 17th January 2014.

3.2. Care Episode 2: Care received as an inpatient at Priory Hospital (Tier 4 CAMHS Service), Chelmsford from 17th January 2014 to 20th February 2014

3.2.1. The Priory admission on 17th January 2014 was to offer intensive support for Young Person C's diagnosis of anorexia nervosa. Her condition was assessed and a treatment programme put in place.

3.2.2. For the first two weeks of her admission Young Person C struggled with her eating and treatment plans and continued to try to manage her negative feelings.

3.2.3. On 2nd February 2014, one day after returning to the Priory Hospital from home leave Young Person C deliberately burnt herself on a hospital radiator and started to express suicidal ideation with intent.

3.2.4. Between 2nd February 2014 and 10th February 2014 the unit noted five attempts at self- harm.

3.2.5. On 10th February 2014 Young Person C was discovered in a hospital bathtub with a scarf hooked over the curtain rail and tied tightly round her neck. She also burnt her leg on a hot radiator despite increased observation levels on the same day.

3.2.6. On 12th February 2014 Young Person C again burnt her leg on a radiator.

3.2.7. On 13th February 2014 consideration was given as to whether hospitalisation was hindering her recovery at that point. Suffolk CYPS were contacted by the Priory to check for any previous child protection history.

3.2.8. The SCYPS responded on 13th February by confirming that a Section 47 assessment had been undertaken which was unsubstantiated. Section 47 of the Children Act 1989 places a duty on LAs to investigate and make inquiries into the circumstances of children considered to be at risk of 'significant harm' and, where these inquiries indicate the need, to decide what action, if any, it may need to take to safeguard and promote the child's welfare

3.2.9. 9 further attempts at self-harm were noted between 14th and 18th February 2014. Young Person C's mental health was deteriorating rapidly and the self-harm attempts were increasing in number and severity. She was also judged to be suicidal with intent.

3.2.10. On the 19th February 2014 Young Person C was found with a ligature (scarf) round her neck. She was seriously disturbed and needed restraint.

3.2.11. Young Person C was placed under Section 2 of the Mental Health Act (compulsory admission for assessment and treatment, for duration of up to 28 days) by Essex County Council on 19th February 2014.

3.2.12. A bed at the St Aubyn Centre in Colchester was secured and Young Person C was transferred for Psychiatric Intensive Care on 21st February 2014.

3.3. Care Episode 3: Care received as an inpatient at St Aubyn Centre Psychiatric Intensive Care Unit (Tier 4 CAMHS Service), Colchester from 21st February 2014 to 4th August 2014

3.3.1. On admission, St Aubyn assessed Young Person C as high risk due to her increasingly self-destructive behaviour and severe depression. Visits to Colchester Hospital Accident and Emergency Department occurred four times between 2nd and the 21st March in relation to self-inflicted injuries.

3.3.2. On 14th March 2014 Young Person C was re-graded to Section 3 of the Mental Health Act (detained for treatment for duration of up to 6 months).

3.3.3. On 11th April 2014 escorted leave was agreed at a Care Programme Approach (CPA) meeting. However it ended by Young Person C running into the road in front of a car, no injuries were sustained. The Essex Constabulary were informed of and logged the incident.

3.3.4. Young Person C attended Colchester Hospital Accident and Emergency Department on 12th March complaining of double vision. A head scan revealed no injury.

3.3.5. A CPA meeting held on 30th may 2014 noted that Young Person C had improved sufficiently enough to move towards a programme of support to move her towards discharge planning.

3.3.6. At the beginning of June 2014 Young Person C applied for a mental health tribunal.

3.3.7. By early July 2014 Young Person C showed signs of sustainable change. Periods of supervised leave were increased as part of her care plan. The application for a tribunal was withdrawn.

3.3.8. On 24th July 2014 Young Person C remarked in a ward review that despite having access to farm medications, she was able to resist using them as a method of self-harm. A risk assessment was undertaken and this issue is considered in more detail later in the report.

3.3.9. On 29th July 2014, Young Person C's mother contacted NSFT CAMHS. She reported that her daughter was self-harming, suicidal and distressed at the thought of returning to hospital. A plan was made for NSFT to inform the St Aubyn Centre.

3.3.10. A ward review undertaken at the St Aubyn Centre on 31st July 2014 updated Young Person C's leave plan. Leave opportunities increased to include a combination of unescorted leave, escorted leave and accompanied leave,

including an outing to an agricultural show. The mother and father of Young Person C were at this meeting and agreed that on the trip to the show they would 'have to be like a shadow, always together to ensure her safety'

3.3.11. On 3rd August 2014 Young Person C spent an overnight leave with her mother with no adverse effect. She then went back to St Aubyn Centre before going on a 5 hour home leave to her father's farm.

3.3.12. On the morning of 4th August 2014 Young Person C injected herself with a powerful animal medication and ran into the fields. Emergency services were summoned.

3.3.13. Despite a prolonged resuscitation attempt Young Person C died in West Suffolk Hospital later that day.

4. Analysis & Findings

4.1. There is no doubt from the evidence submitted that during the period investigated for this review Young Person C was living in complicated and complex family circumstances that she found difficult to cope with at times, but this was not an entirely new situation for her as we learned that her parents had lived apart since she was an infant and that relationship difficulties had surfaced at other times during her childhood.

4.2. There is no evidence that suggests Young Person C was ever deliberately harmed, although her emotional health was adversely affected by the tensions at home in her adolescent years. Many young people living in similar households are able to manage living in stressful environments by developing a resilience which protects their emotional wellbeing, but others are less well able to cope.

4.3. An evidence base drawn from academic research suggests that this difference between individual children may be reflected in the biological structure of their brains and changes during adolescence. Research into the development of the adolescent brain (S.J. Blakemore et al) is relatively new; however, it has been proven through cognitive neuro-scientific experiments and MRI imaging that the adolescent brain undergoes remarkable biological development during the teenage years. How far biological brain development is responsible for adolescents experiencing some kind of psychiatric or psychological disorder during adolescence is still subject to research. A 'Positive for Youth' Summit that took place in 2011 started the debate about the policy implications for the Government in response to the research, particularly with regards to preventative measures and building adolescent resilience.

4.4. However, this is work in progress and as far as this review is concerned the focus is not to try to analyse why C developed a mental health problem or why it escalated at the pace that it did. The focus is to look at the care given by the agencies working with the family for the duration of her illness.

Care Episode 1: Multi-agency care received in the community from 14th October 2012 to 16th January 2014

4.4.1. Analysis

The following analysis will concentrate on the quality and outcomes of the most significant interventions undertaken by community providers in Suffolk to support Young Person C during her illness.

4YP Suffolk Young People's Health Project

4.4.1.1. The confidential counselling service 4YP is provided by a Charity in partnership with the NHS. It is sub-contracted by Norfolk and Suffolk Foundation Trust to deliver part of their preventative programme and provides a short-term, solution focused confidential counselling service. Young Person C was referred to the 4YP service by Norfolk and Suffolk NHS Foundation Trust after Young Person C came to the attention of the 'Suffolk Wellbeing Service'.

4.4.1.2. Prior to this Young Person C was attending family counselling sessions with her mother and father provided by 'Suffolk Relate'. It was the Relate service that initially thought that Young Person C would benefit from some support of her own and they advised mother accordingly.

4.4.1.3. 4YP engaged with Young Person C to offer initial support. She attended regularly at first and sporadically after a period of approximately one month when her condition worsened and NSFT CAMHS took over. Out of 14 sessions offered Young Person C attended 7. The proposed 14 sessions were over and above 4YP's normal offer, to ensure support was available during the time Young Person C was engaging with the NSFT CAMHS service. 4YP discharged Young Person C on 25th April 2013.

4.4.1.4. 4YP reported that they often gave Young Person C's mother advice about accessing specialist services, but I have not seen any documentation to support this. There is no evidence of 4YP formally communicating with any other agency during their involvement with Young Person C and neither is there evidence that 4YP received any information from other agencies as and when they became involved.

4.4.1.5. At the time that 4YP were seeing Young Person C, the NHS was in a period of reform and were implementing enormous structural changes to commissioning and provider arrangements. 4YP have commented that at the time they were involved with Young Person C, the information sharing pathways and the systems and people that were key to communication were not fully in place which affected their ability to send or receive information effectively. This was not peculiar to Suffolk. The impact of the reforms inevitably caused systemic confusion both locally and further afield.

4.4.1.6. There has been a great deal of confusion expressed during the course of this review about the accountability arrangements for the 4YP service. Members of the SCR Reference Group initially gave mixed and

confused messages about the commissioning and contractual arrangements for this service. On asking about assurance arrangements for the 4YP service, I was reassured by the Designated Health Professionals that the LSCB requires all agencies to describe how they oversee their commissioned services in their annual Section 11 self-assessment as part of the wider LSCB learning and improvement framework. The assessment is further scrutinised by Suffolk LSCB. The LSCB Learning and Improvement Group has identified that the data being presented against Section 11 criteria in Suffolk needs to improve to include all providers of services to children in the area.

4.4.1.7. The recent Independent Inquiry into Child Sexual Exploitation in Rotherham 1997 - 2013 (Alexis Jay OBE) commented how the NHS reforms and the complexity of new NHS commissioning and provider structures had implications for accountability. In the context of this review, it is important for the overall safety of children residing in the county of Suffolk that there is absolute clarity about the NHS commissioning and provider arrangements for all of the children's services in the Suffolk area.

Ipswich High School

4.4.1.8. Ipswich High School is a large all girls Independent high school taking children from the age of three up to eighteen years of age. A comprehensive up to date safeguarding children policy, and safeguarding children procedure is displayed on the school website which suggests a high level of commitment to safeguarding and promoting the welfare of the students. The organisational structure includes the appointment of designated and deputy safeguarding leads and a lead governor. The school also employs its own school health team consisting of qualified health professionals, nurses and doctors.

4.4.1.9. The school was first made aware of Young Person C's difficulties in October 2012 following a telephone call from Young Person C's mother explaining that Young Person C had been upset after a family argument. The school began to monitor her when the information about Young Person C came to their attention, to ensure that her school performance didn't suffer.

4.4.1.10. Further concerns emerged following a conversation with Young Person C's father at the end of January 2013, when he alerted the school head to his worries about Young Person C's mental health. The content of the call was passed to the school head of pastoral care who decided that Young Person C might be in need of safeguarding. She asked the health team to urgently assess Young Person C's health and wellbeing. A Health Care Practitioner saw Young Person C alone the next day. Young Person C was asked about the problems she was having at home.

4.4.1.11. The Health Care Practitioner did not follow a formal risk assessment model to inform her decision but was convinced that the threshold for risk of significant harm had been reached. Young Person C had told her

she was being pushed around by her father, was witnessing arguments and felt unsafe at home. Based on what she had observed and heard, the health care practitioner decided to make an urgent child protection referral to the SCYPS Access and Assessment Team. The rationale being that a referral would clearly be in Young Person C's best interests.

4.4.1.12. In principle it is good practice to gain consent from a young person to pass on information they have given in confidence. Seeking consent allows the young person to retain some control over their situation; however, consent is not strictly required and if it is not given the child should be informed (unless this increases their risk) that their information will need to be shared to safeguard them. Recording the interaction enables the voice of the child and their wishes and feelings about the referral to be put on record.

4.4.1.13. The school has a procedure for requesting or overriding consent from young people, but there is no evidence in the school files about how the decision to make the referral was discussed with Young Person C, although a one-word note in the social-work record suggests that Young Person C was 'unaware' that a child protection referral was being made about her.

4.4.1.14. Similarly, documentation held by SCYPS indicates that during the process of referring C, the school Health Care Practitioner asked the social worker specifically that C's mother should not be informed about the referral without C's consent. This remark suggests that the matter of C's mother needing to know about the referral had not been discussed or explained to Young Person C prior to the referral either.

4.4.1.15. Sensitively informing Young Person C that her mother would need to be involved ahead of the referral being made would have been good practice, unless by doing so it increased Young Person C's risk. Practising in this way takes proper account of parental responsibility and prepares the young person, parent and social care professionals for the conversations and activity that may follow. Should there be reasons for not informing a parent, these should be carefully documented by the practitioner. It is unclear due to the lack of written documentation which agency took the responsibility for informing Young Person C's mother about the referral, either in school notes or the record made by SCYPS.

4.4.1.16. On reflection, the Health Care Practitioner realises that failing to record and follow up the referral in writing, was an omission on her part and that recording child protection matters fully is very important. She has no idea why she did not record the detail of her encounter with Young Person C that day; one possible explanation may be that she may have been so overwhelmed with the intensity and urgency of the situation that it slipped her mind. Either way the decision to make the referral was sound on the basis that she wanted to protect Young Person C from harm.

4.4.1.17. Ipswich High School should, however, check that their internal safeguarding systems and processes with regards to recording actions

and outcomes, including those relating to consent are included in the improvements that they have already implemented.

4.4.1.18. The initial decision by SCYPS not to proceed to an initial assessment was not acceptable to the medical practitioner who was sufficiently concerned to say that she would not allow Young Person C to return home that day on the basis of what C had told her. A further telephone contact was made and the school Health Care Practitioner reiterated that she was convinced that Young Person C's description of being 'pushed around by her father' and of 'feeling unsafe' was enough to warrant an immediate child protection investigation. On hearing this additional information SCYPS agreed that they would initiate a Section 47 child protection investigation that afternoon and assess Young Person C at school.

4.4.1.19. The use of a safeguarding risk assessment model to explain the rationale for a child protection referral assists social workers in their decision making for follow on action. Ipswich High School may wish to adopt a risk assessment model that is specifically designed to clarify a child's circumstances in terms of risk or need, they are also useful for providing clarity about threshold and consent requirements. Suffolk Children and Young People's Services are leading the use of a Signs of Safety model for risk assessment in the County, supported by the Suffolk LSCB, and the school should explore how they can use this this model within their organisational context.

4.4.1.20. A short time after the referral to SCYPS, the GP made a professional referral to the NSFT CAMHS, and Young Person C began to receive mental health services. There is evidence of a contact between NSFT CAMHS and the school at the time of Young Person C's initial mental health assessment but inter-professional communication throughout Young Person C's period of treatment with NSFT CAMHS was not sustained. Most of the school's information regarding Young Person C's progress came from conversations with Young Person C's mother.

4.4.1.21. Young Person C did not return to school after 10th May 2013, and the school closed for the school holiday on 10th July 2013. Ipswich High School is staffed all year round and communication with them during holiday periods should be no different than in term time. The school received little in the way of communication from any other agencies involved in Young Person C's care, the family being the main source of information as to what was going on.

4.4.1.22. Professional information sharing between agencies is the bedrock of safeguarding practice and is essential for effective care planning. Ipswich High school should introduce a system that enables and encourages staff to proactively seek information from others in the professional network about students who have been identified as having additional needs. This will enable them to contribute to the assessment and planning processes if necessary and appropriate.

4.4.1.23. There is evidence that shows that Ipswich High school were communicating effectively with St Aubyn Psychiatric Intensive Care Unit following Young Person C's admission and throughout the summer

holiday. Telephone conversations and written communications from St Aubyn are recorded in school records and the school participated in one Care Programme Approach meeting held in July 2014.

4.4.1.24. At the reflective practitioner event some agencies suggested there were difficulties in general about relaying information to schools out of term time; however this view was not upheld by the education practitioners attending the reflective event. The issue was considered, and the practitioners concluded that this is more likely to be an issue of perception for some of the children's workforce. The notion of schools totally shutting down at the end of term is not true, and all schools can be contacted if need be.

4.4.1.25. Suffolk LSCB together with partner agencies may wish to explore ways to reassure the children's network that communication with schools during the holiday periods is possible and should be encouraged. In particular Ipswich High School wished to remind Suffolk LSCB that following a serious incident, the school should be involved as soon as possible to enable them to put strategies in place for supporting other students, parents and staff who may be affected.

4.4.1.26. It is clear that Ipswich High School takes its safeguarding role very seriously and that their approach is child centred. They acted in Young Person C's best interests when problems arose, recording information pertaining to C's progress that was relayed to them by her mother and by St Aubyn when Young Person C was admitted. However, as with many independent providers, they have not always been regarded as part of the children's sector. This has been improved and strong links to the SCYPS designated professional officer for safeguarding now exists, with the result that the school is now more closely aligned to the Suffolk LSCB and a plan is in place to improve their inter-professional relationships with other agencies in the professional network. Suffolk LSCB have initiated regular meetings with the Independent Schools Sector with a view to closer relationships with the LSCB leading to Head Teacher representation on the Board at a future date.

Suffolk Children and Young People Services (SCYPS)

4.4.1.27. Young Person C was brought to the attention of the SCYPS for the first time on 1st February 2013, when the child protection referral to the Access and Assessment Team was made.

4.4.1.28. The referral process between Ipswich High School and SCYPS appears not to have gone entirely smoothly at first. Follow up telephone calls were made to ensure that immediate action was taken. SCYPS agreed to accept the referral as the level of professional concern and the rationale for the referral was more fully explained. The CareFirst record of the initial contact and decision is recorded in some detail.

4.4.1.29. The referral was accepted as meeting the threshold for an urgent section 47 investigation on the basis that Young Person C's father may have been violent towards her. Assessments for C and her parents were arranged for the same day. A social worker from the 12 + team met with Young Person C at school. She was happy to talk to the social

worker and was interviewed alone. The social worker interviewed her parents later at the family home.

4.4.1.30. All the interviews were undertaken on the day that the referral was made, which is an appropriate response on the basis of the circumstances described. The assessment was thorough and properly balanced between clarifying the report of possible physical abuse and assessing Young Person C's emotional wellbeing and family functioning. The CareFirst record of the assessment reflects the discussion with Young Person C and confirmed that Young Person C was unhappy at home but had never been physically abused by either of her parents.

4.4.1.31. Young Person C's parents agreed that the family was struggling with their relationships, but they wanted very much for the family dynamics to change and improve, realising that the home situation was having an adverse effect on their daughter. Having assessed the situation, the social worker was assured that there was no evidence to substantiate that Young Person C was suffering or likely to suffer significant harm or that her health and development were being impaired. The conclusion was that the risk to Young Person C was low and that C and her parents had sufficient insight and willingness to accept and also to participate in a support programme that would improve the family's relationship difficulties by helping Young Person C's parents to understand Young Person C's emotional needs and how to meet them.

4.4.1.32. The decision made by the social worker, based on a sound and reasonable judgement, was to step down the referral from the child protection threshold and instigate an early help arrangement designed to support children with additional needs who do not meet the 'child in need' threshold for specialist services. This type of early intervention in Suffolk is delivered through local integrated teams who define the needs by means of the Common Assessment Framework (CAF) process introduced in England and Wales in 2004. Interventions are then delivered through a multi-disciplinary 'team around the child' (TAC) service.

4.4.1.33. The plan following the assessment was to seek consent from Young Person C's parents for permission to instigate a TAC arrangement. It is unclear from the documented evidence if the plan for an early help service was ever discussed with C to ascertain her own wishes and feelings about the proposal, and it is equally unclear if the plan was raised with C's parents during their preceeding assessment.

4.4.1.34. The recommendation to offer support by means of a CAF/TAC approach was signed-off as authorised by the social work practice manager on 12th February 2013.

4.4.1.35. The final outcome of the social worker's assessment was never communicated to the school Health Care Practitioner who initiated the referral; this left the school somewhat in the dark as to what had been decided.

4.4.1.36. Reporting on the outcome of a referral to the referrer has been written into child protection procedures for some time. It is unclear from the evidence given to the SCR why the practitioner did not let the school know the outcome of the assessment. A recent audit undertaken by the Suffolk Multi-agency safeguarding hub (MASH) has identified that this issue needs general systems improvement and an action plan is in place to enable this to happen. The Suffolk LSCB will hold SCYPS to account with regards to improving the system.

4.4.1.37. Enabling a voluntary TAC arrangement relies on service-user consent. Twelve days after the assessment a CAF consent form was dispatched to C's mother to enable the plan to progress. There is no evidence submitted that confirms C's own right to consent to the proposal was included as part of the consent procedure.

4.4.1.38. The CAF consent form was never returned and there was no system in place to follow up the families where consent had not been given or the forms were not returned. In subsequent discussions with the Mother of Young Person C, she has stated that she did not receive the CAF consent form that was posted.

4.4.1.39. The demand for early help TAC services is high in Suffolk and they are entered into by families through an entirely voluntary arrangement, delivery being through integrated multi-disciplinary teams operating below the Section 17 of the Children Act (1989) Child in Need threshold. The responsibility is placed firmly with the family to consent and participate.

4.4.1.40. SCYPS had, and still has no formal system in place to follow up CAF consent forms that have not been returned, meaning that some children deemed to be in need of an early intervention TAC approach may not receive the early help necessary to meet their additional needs. As it stands, social care would not know that a child has not received a service, and neither would any other agency.

4.4.1.41. SCYPS in the practitioner learning event, reflected on the current system that does not enable follow up of CAF consent forms, as to whether it could disadvantage some children and young people from accessing the early help they require to prevent their needs from escalating further. There was agreement in principle that a follow-up process could be beneficial for some families and indeed more child centred, but that any systems change to enable this to happen would need to be effective and robust in the long term. There was concern that such a systems change could create pressures elsewhere in the system.

4.4.1.42. SCYPS should consider the feasibility and benefits of following up unreturned consent forms, bearing in mind the impact that any such change would have on capacity and demand and the ability of the service to respond.

4.4.1.43. After the posting of the CAF consent form, SCYPS did not come into contact directly with Young Person C or her family again. The service does feature later in the story however, by responding to an enquiry

from the Priory Hospital in February 2014 about the outcome of the child protection referral in February 2013, and also when they received the Section 85 (Children Act 1989) notification in July 2014 from the St Aubyn Centre, after Young Person C had been an in-patient there for more than three months. No further contact was made with SCYPS until they were notified of Young Person C's death.

4.4.1.44. The St Aubyn centre work to a standard protocol that was recommended by Essex Safeguarding Children Board following a SCR. The expectation is that when a section 85 notification is sent by St Aubyn, with due consideration to consent, the Local Authority undertakes an assessment of their needs.

4.4.1.45. This is not the system in Suffolk at present, where the response to a section 85 notification is to undertake an assessment nearer to the date of the young person's discharge. The consensus of the practitioners at a learning event was that Suffolk should operate the protocol that St Aubyn have implemented. Suffolk LSCB will need to formally request the protocol from Essex LSCB to enable this to happen.

Primary Care GP Service and Minor Illness Clinic

4.4.1.46. The GP works from a large and busy group practice covering a wide geographical area and a population of approximately 17,500 people. He knew and supported Young Person C's family well and there is ample evidence that proves continuity of care and thoughtful interactions and advocacy for Young Person C and her parents whilst she was living at home. Overall the care and attention that Young Person C and her family received from the GP were of a high standard.

4.4.1.47. Young Person C saw the GP alone and also with her mother when she accompanied Young Person C to her appointments. Young Person C was clearly very comfortable explaining her feelings and symptoms to him. He was aware of the relationship problems C had with her parents which she discussed freely, but he did not suspect that C was suffering abuse or was in need of protection.

4.4.1.48. In early December 2012 Young Person C was taken to the surgery by her mother. Young Person C was tearful but in the GP's opinion she was not exhibiting signs or symptoms of a mental health disorder. He decided after seeing her again on 13th December 2013 to refer her to the local NHS Suffolk Wellness Service that offered talking therapy and self-help for people suffering from anxiety or stress. The 4YP service picked up the referral for ongoing support.

4.4.1.49. He saw Young Person C again on January 21st 2013. Young Person C was experiencing difficulties relating to her parents which was causing her to be stressed and anxious. He did not consider she was at risk of significant harm from her parents, but did suggest 'time-out' as a school boarder might be a way of alleviating the situation at home, however the family did not pursue this option. His decision was made by drawing from his clinical experience and knowledge of the family rather than by using a formal safeguarding risk assessment tool. Such practice aids have not been widely used by primary care settings in the past.

4.4.1.50. A formal risk assessment model might have been useful for the GP to clarify Young Person C's risk or need in her particular circumstances. SCYPS are leading on the Signs of Safety risk assessment model in the County, supported by the LSCB, and NHS partners specifically the Named GP, may wish to explore how this model could be introduced into GP practice.

4.4.1.51. On 12th February 2013, the GP took a telephone call from Young Person C's mother. The call alluded to the fact that C had been looking at websites about committing suicide. The outcome of this conversation led the GP to make an urgent CAMHS referral. From the information received it appears that Young Person C was neither asked to consent, nor informed of the decision to make this referral. However, the GP made this referral based on the perceived risks associated with her behaviour. It was not considered appropriate to delay a psychiatric assessment by seeking consent and the decision was made clearly in Young Person C's best interest. The action did not appear to affect the willingness of Young Person C or her mother to accept psychiatric help.

4.4.1.52. Following the appointment, the GP followed instructions from the psychiatric report that was faxed to him. He arranged for tests to be undertaken and prescribed medication according to the recommendations from the psychiatrist.

4.4.1.53. Young Person C's mother telephoned the GP at the end of March 2013 reporting that her daughter had not received individual Cognitive Behavioural Therapy (CBT) that the psychiatrist had recommended because the waiting list for an NHS CAMHS service was in the order of three months long. She asked the GP if this could be arranged privately. The GP offered her the details of a private clinical psychologist after he had checked that she would be an appropriate person to offer C support. The clinical psychologist accepted the referral and saw C until the end of June 2013. This may have minimised the delay for C but remains a problem for most children in Suffolk whose parents cannot afford to pay privately.

4.4.1.54. In mid-April 2013 Young Person C, accompanied by her mother, attended the GP surgery Minor Illness Clinic to see a nurse practitioner for treatment of a scald. There was no delay in seeking treatment and neither mother nor Young Person C alluded to self-harm as the cause. An explanation was sought and the nurse acted on the history she was given, that Young Person C had spilt boiling water from a kettle on to her forearm. The nurse practitioner considered the explanation was consistent with the minor injury that was being presented. Her decision and follow up action was to treat and dress the scald over a series of three appointments based on clinical need.

4.4.1.55. There is no information that either confirms or denies that the nurse read the historical information pertaining to Young Person C's mental health issues, but having reflected on the case with her practice colleagues, the nurse has said she would not have done anything differently at the time. The action to treat the scald on clinical need alone was entirely understandable in terms of the information and

explanation she was given. Scalds are common injuries and the explanation did not sound suspicious or indicative of anything other than an accident**.** Whether a direct enquiry by the nurse about self-harm in light of Young Person C's recent history would have changed the explanation or enabled Young Person C to reveal her need to self-harm cannot be determined.

4.4.1.56. When reflecting on this event at the SCR practitioner learning event, a question was raised regarding the level of professional understanding in general about the issue of self-harm. The most common perception of self-harm is one of people 'cutting' themselves. As a learning point from this review, the LSCB may wish to look at reflecting on the work they have already undertaken on improving the knowledge and skills base of the partnership to promote greater awareness of the different ways and means that people inflict harm upon themselves.

4.4.1.57. The GP explained that the minor injuries clinical staff worked independently within the practice environment and did not routinely link with the practice GPs or other members of the primary healthcare team. As with most primary care teams in early 2013, there was no system in place within his GP surgery that regularly enabled all of the healthcare staff delivering services within the practice to come together to discuss vulnerable patients.

4.4.1.58. Since 4th April 2013, safeguarding children responsibilities have been reinforced by NHS England and a great deal of work has been undertaken by commissioners, clinicians and inspectors to improve the way primary care teams identify and respond to people who are at increased risk, including changing the culture to include the social as well as the medical model of practice, but this is very much work in progress.

4.4.1.59. The designated professionals for safeguarding in Suffolk CCG reported that they have successfully trained GPs in Suffolk to level 3 competencies outlined in 'Safeguarding Children and Young people: roles and competences for health care staff (2014)' and are training other clinical practitioners to the same level. They are also in the process of implementing local guidance loosely based on the RCGP/NSPCC 'Safeguarding Children Toolkit for General Practice Safeguarding Issues (2014)' for primary care teams in Suffolk to follow.

4.4.1.60. The toolkit requires that GPs hold regular whole-practice meetings where vulnerable patients are discussed as a standard agenda item. This is to ensure that all non-clinical and clinical staff are aware of any emerging issues that should influence their approach to practice. The GP practice involved in this case is currently implementing a new system to meet this requirement.

4.4.1.61. The CCG Designated Professionals should review the guidance they are developing for the County to ensure it includes an expectation that regular whole practice meetings are implemented and minuted and that the agenda includes a discussion about vulnerable patients as standard.

4.4.1.62. Overall, the evidence obtained shows that the GP communicated well with other professionals in order to secure the best outcome for C. For example, he wrote a letter to the school to alert them to the possible effects that C's condition could have on her examination performance and facilitated access to a private clinical psychologist for C when NSFT CAMHS service could not provide the individual therapy that C and her family wanted.

4.4.1.63. Signs of Young Person C's eating disorder and excessive exercise regime began to manifest in the summer months of 2013, disguised very much by the fact she was training to compete in a cross country run. The GP heard concerns from Young Person C's mother that alluded to Young Person C indulging in obsessional exercise and dieting. The GP considered the information on the basis that as Young Person C was motivated and had sufficient stamina to train for a major sporting event, and an eating disorder had not been raised before, she was probably well. He was also reassured by the fact that a family therapy appointment was imminent and the family could discuss their concerns during that session. The GP did not know, in the absence of being formally notified, that the family had stopped attending family therapy appointments.

4.4.1.64. He saw Young Person C for a consultation four days later and she asked specifically for dietary advice; the issue of an eating disorder was not raised. The GP referred Young Person C to an osteopath with a sports science qualification for nutritional advice in relation to her exercise regime. No evidence has been received in relation to the advice she was given by the osteopath.

4.4.1.65. The GP made an assumption that the concerns that Young Person C's mother had raised would be properly addressed in a forthcoming family therapy session. The GP has acknowledged that he made an assumption, on the basis that at the time he had no reason to believe otherwise. On reflection he agrees that relaying the concerns directly to the family therapist would have been a more appropriate action.

4.4.1.66. On 19th December 2013, Young Person C's weight loss was so apparent that the GP made an urgent private referral to the Priory Hospital eating disorders clinic. There are no notes that relate to either gaining or overriding consent from Young Person C for this referral.

4.4.1.67. The GP received a letter from the psychiatrist who recommended urgent dietetic input. He gave the GP immediate instructions about Young Person C's management and a fuller psychiatric report was received and filed in the GP notes suggesting she may need inpatient services.

4.4.1.68. One instruction for the GP was for Young Person C to be referred urgently for local support for her eating disorder as getting to the Priory Hospital was logistically difficult. The GP sent an urgent referral as instructed to the NSFT CAMHS Access and Assessment Team which was received two days later. Again, there are no notes that relate to either gaining or overriding consent from Young Person C for this referral.

4.4.1.69. The rights of a competent young person to be consulted and give consent is an important aspect of safeguarding practice. Consent should be recorded and where this has not been possible, justification for overriding consent should be noted in full. NHS partners should reinforce the importance of young people consenting to referrals and treatments as part of their learning the lessons events following this SCR.

4.4.1.70. Young Person C continued to deteriorate rapidly and the GP made an urgent and appropriate referral to enable an NHS admission for a re-feeding programme. The admission occurred on 17th January 2014.

4.4.1.71. During the course of this review, the GP has expressed the stressful period of time he spent personally trying to secure a tier 4 CAMHS bed for Young Person C when she was dangerously underweight. He also described the adverse effect this had had on his availability for his other patients.

4.4.1.72. The issue of tier 4 provision is a long standing problem, and NHS England in 'Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report' (July 2014) reported on the action required to improve the access to specialised mental health services for children and young people. The report resulted in the setting up of an NHS England taskforce to develop a national strategy for children's mental health services in general. The strategy entitled 'Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing (2015)' will involve local participation.

4.4.1.73. Further notes regarding C's deterioration and admission to the St Aubyn Centre are appropriately filed in the GP notes. The GP did not see Young Person C again in surgery, but maintained a good level of support to her parents throughout Young Person C's admissions and after Young Person C died on August 4th 2014.

Norfolk and Suffolk Foundation Trust Child and Adolescent Mental Health Services (CAMHS)

4.4.1.74. The first contact with the NSFT CAMHS service was on 13th February 2013. An emergency referral was faxed to the service from the GP after Young Person C's mother had found her daughter viewing on-line suicide websites at home. The referral was accepted by the NSFT CAMHS triage service the following day and Young Person C's mother was contacted for consent to start a mental health triage assessment.

4.4.1.75. The triage assessment consisted of collating information from relevant professionals about Young Person C's health and wellbeing. Information was gathered from Young Person C's head of pastoral care and the school Health Care Practitioner at Ipswich High School, who expressed great concern about Young Person C's demeanour. The school Health Care Practitioner reported that Young Person C was 'expressing suicidal ideation on a daily basis' and was probably not receiving the level or type of support services that she needed.

4.4.1.76. The nurse made an immediate decision that Young Person C should be treated as a priority and an appointment for a specialist CAMHS assessment was requested. During the conversation the school Health Care Practitioner was given instructions about how to access the CAMHS emergency pathway via the local Accident and Emergency department should Young Person C require emergency assistance.

4.4.1.77. A letter informing the GP of the outcome of the triage assessment was sent to the GP the following day and a similar letter was sent to the school explaining that an emergency specialist CAMHS assessment had been requested. The letter alluded to a possible diagnosis of severe depression with a danger of self-harm.

4.4.1.78. The triage assessment was undertaken promptly and efficiently and the time interval between referral and the booked out-patient appointment is reasonable. The Trust have secured the provision for more acute presentations via an arrangement with the local hospital Accident and Emergency department and it was entirely sensible and appropriate for the nurse to talk the doctor through the process of where and how to access this emergency care should Young Person C's needs become more acute.

4.4.1.79. To complete the triage process, the nurse wrote letters to the professionals who had contributed to the assessment to inform them of the plan. This is a good example of inter-agency communication and information sharing. Copies of the letters were filed in the NSFT notes.

4.4.1.80. By the 14th February 2013, two days after the initial referral, the request for an urgent assessment had been received and a specialist CAMHS appointment was arranged for five days later on 19th February 2013. Details of the appointment were posted to Young Person C's mother along with documents for Young Person C and herself to complete ahead of the appointment, including strengths and difficulties questionnaires (SDQs) designed to help Young Person C and her mother to think about the aspects of C's life that were impacting on C's health and wellbeing, and to help them both articulate their feelings.

4.4.1.81. The first specialist CAMHS appointment, which occurred on 19th February 2013 as planned, consisted of an assessment by a psychiatrist and a nurse. Young Person C attended with her mother bringing the necessary completed documents and the SDQs with them to inform the assessment. A full history was taken from Young Person C and her mother. The decision by the locum psychiatrist was to continue to review Young Person C at the clinic with a view to prescribing medication for her anxiety and depression and to decide if Cognitive Behavioural Therapy might be an option for her.

4.4.1.82. Following the assessment the GP was advised by means of a letter from the psychiatrist about the outcome, and instructions were given about the tests that the GP would need to undertake before the next appointment. A contact was also made with SCYPS to check if Young Person C had ever come to their attention as a child in need of services. The outcome of the CAMHS enquiry confirmed that Young Person C had been subject to a Section 47 child protection assessment earlier

that month which was unsubstantiated and that CAF consent was being sought. This outcome was recorded in the notes. The decision and action to contact CYPS and record the result is a further example of good practice.

4.4.1.83. The second outpatient appointment on 28th February 2013 resulted in anti-depressant medication being prescribed. Cognitive Behavioural Therapy (CBT) was considered to be a suitable future treatment option. Further appointments to review Young Person C's progress were recommended. A letter was posted to the GP giving a comprehensive account of the assessment that had taken place.

4.4.1.84. According to chronological data, Young Person C and her mother were seen by the specialist CAMHS service at approximately two weekly intervals until their care passed primarily to the CAMHS Family Therapy Team. In all they attended five specialist CAMHS appointments between 19th February and the 16th April 2013, the last being prior to the family therapy team becoming involved.

4.4.1.85. The GP was properly and appropriately advised by letter of the outcome of the first two consultations on the 19th and 28th of February 2013, but not about the outcomes of the remaining three. The reason for this is not clear, but it suggests that either a system does not exist or the system for NSFT specialist CAMHS professionals to pass information to other relevant professionals in the children's network providing care to the family is not working.

4.4.1.86. A pattern emerges shortly after the family has engaged with the CAMHS service, of Young Person C's mother leaving messages on the answer phone at the specialist CAMHS clinic reporting that all was not well with her daughter. The messages left between February 21st 2013 and the 4th March 2013 (a period of eleven days) were written down on receipt and passed to the psychiatrist or nurse for their attention. The messages indicated a high level of parental anxiety and related to increasing concerns about Young Person C's suicidal ideation and self-harm. One message described how Young Person C had tried to jump out of her mother's moving car. In all, five telephone messages were left for the team about Young Person C's difficulties and worsening behaviour. Whilst there is evidence that the detail of the messages was passed to the team for action there are no records in the professional notes that record what the professionals did in response to the information that they received.

4.4.1.87. A further four telephone calls were made by Young Person C's mother between 4th March 2013 and 14th March 2013 when the family were due to be seen. These calls resulted in direct telephone support from the psychiatrist or the nurse. The calls provided a useful holding arrangement to support Young Person C before her next appointment on the 14th March 2013.

4.4.1.88. There were a combined total of 9 telephone contacts initiated by Young Person C's mother, five as messages and four where there was a telephone consultation. The subject of the telephone discussions ranged from confirming appointment times to asking for advice on how

to manage Young Person C's continuing deterioration and escalating self-harm. On one occasion the conversation included talking to Young Person C directly.

4.4.1.89. The nature and outcome of some of the telephone interactions were recorded in the NSFT CAMHS case notes. From the evidence however, it appears that the information was not shared with other professionals who should have been informed. In particular the family GP seems not to have been told about the difficulties that Young Person C's mother was encountering when trying to cope with her daughter at home.

4.4.1.90. The specialist CAMHS face to face consultations that took place on the 14th and 27th March 2013, despite the mounting evidence and accounts of self-harm and compulsive eating habits, did not seem to address or probe the issue of self-harm as a primary concern, in fact the notes from both consultations allude to 'no self-harm or suicidal thoughts' in the case record. This completely contradicts the intelligence that was being passed to the team by telephone about Young Person C's escalating self-harming behaviour, the detail of which was known and recorded.

4.4.1.91. The reason why there seems to be a lack of focus on important issues, about self-harm in particular, that were known and recorded remains unexplained. From the information supplied in the chronology it appears the matter was noted as a discrepancy. The Trust's acknowledgement of a disparity between the reports of self-harm on 12th March 2013 and the assessment of 14th March 2013 needs to be further explored as it may be connected to a systems failure. Any subsequent findings and recommendations should be included in the NSFT single agency action plan for the LSCB.

4.4.1.92. The chronology suggests that the next consultation of 27th March 2013 focussed on exploring how the family relationship difficulties were impacting on Young Person C. The outcome and plan, which was entirely reasonable was to refer the family for family therapy. There is no evidence to confirm whether CBT was discussed at this juncture as something that might help with Young Person C's urges to self-harm. However the GP notes confirm that the day after this specialist CAMHS appointment Young Person C's mother contacted him. She told the GP that she had been informed that the wait for CBT from Suffolk CAMHS could be up to three months long. In response to this, Young Person C's mother requested that the GP arrange for a private clinical psychologist to provide her daughter with the individual support she wanted.

4.4.1.93. Long waiting times for CAMHS therapy appointments is the focus of a national debate; it is by no means peculiar to Norfolk and Suffolk NHS Foundation Trust.

4.4.1.94. The House of Commons Health Committee 'Children's and adolescents' mental health and CAMHS' Third Report of Session 2014–15 (October 2014) outlines a national increase in waiting times for therapy services linked to increased demand and reduced funding. The report acknowledges the strain that this can put on families and young

people, and this was certainly an issue for Young Person C and her family. A recommendation is in place to develop, implement and monitor a national minimum service specification and audit of spending for CAMHS services and another for a Department of Health/NHS England taskforce to support the national policy directive to improve service access, quality and funding for CAMHS tier 3 interventions. The NHS members of the Suffolk LSCB should ensure that the findings of this report are translated into a local context and keep the Suffolk LSCB appraised of any local strategies or developments being considered to meet the needs of children and young people in Suffolk. They should also consider what immediate remedial action could be implemented to alleviate the situation.

4.4.1.95. On 16th April 2013 an account of Young Person C's self-harm was recorded by a locum psychiatrist seeing Young Person C in the clinic, this being the day after Young Person C had sustained a serious scald from pouring hot water onto her arm. Family therapy had been arranged by this time and was due to commence later that month.

4.4.1.96. Family therapy appointments were attended as planned during the months of April, May, June and early July 2013 and by the end of June 2013 Young Person C was able to re-engage with her father and the whole family were joining in the sessions. The introduction of Young Person C's father into the family therapy sessions and his subsequent participation was skilfully and sensitively managed, indicating that the approach had been effective and had achieved a positive outcome for Young Person C and her parents. The private psychologist delivering individual and private support to Young Person C joined in one of the multi-disciplinary discussions about Young Person C's progress and the school was contacted to discuss the possible impact of her illness on her revision plans for her forthcoming GCSE examinations. A note was also made for the nurse to contact SCYP about the outcome of the child protection referral earlier in the year. This shows good attention to inter-professional practice, however there is no evidence available to show that the action to carry out the SCYPS enquiry ever happened.

4.4.1.97. Young Person C decided to discontinue her individual sessions with the private clinical psychologist on June 17th 2013 and a letter dated 25th July 2013 was sent from the clinical psychologist to the GP after completing 7 sessions. The clinical psychologist described a huge improvement in Young Person C's mood and her relationship with both of her parents, possibly because she no longer felt stressed about her examinations. The letter was not copied to any of the clinicians involved in her care at NSFT CAMHS.

4.4.1.98. At the end of June 2013 Young Person C's mother telephoned the specialist CAMHS service to report that Young Person C was no longer taking her medication; this is recorded in the file. It is not clear however, if the matter of Young Person C discontinuing her medication was ever formally passed from the specialist CAMHS team to the family therapist team so it could be discussed during the family therapy session and there is no mention of the issue in the family therapy notes.

4.4.1.99. Two weeks later on 12th July 2013, the whole family arrived for their family therapy appointment as usual. The family therapist recorded that the family's relationship difficulties 'on the surface had notably improved'. Young Person C and her parents were feeling much more optimistic about the future. Young Person C had done exceptionally well in her GCSEs which was a great relief to them all and family outings taken together had been problem-free and thoroughly enjoyed.

4.4.1.100. The appointment of the 12th July 2013 turned out to be the last family therapy session that the family ever attended. The family failed to attend two further appointments offered in August 2013, although there is a question as to whether the family were aware of these two new appointments as C's mother cannot recall receiving any information about them.

4.4.1.101. The family therapist was rightly concerned about an apparent disengagement from the service and the fact that the family had not completed the proposed course of therapy designed for them. An effort was made to contact Young Person C's mother twice in the month of September 2013 to try to re-engage them with the service.

4.4.1.102. In October 2013, ten weeks following the last appointment that they attended together Young Person C's mother spoke to the family therapist on the telephone. She described how the family functioning had improved to such an extent that they no longer felt the need for family therapy services. Young Person C's mother acted as the spokesperson for the decision of the family to discontinue their contact with the service. It appears that Young Person C, who was the principle recipient of the CAMHS offer, was not asked about the matter. Talking directly to Young Person C as the professionals involved in her care may have allowed Young Person C to reflect on the decision and reconsider the choice that had been made to stop CAMHS support entirely.

4.4.1.103. The detail of how much effort was made to persuade the family to finish their family therapy sessions, or whether issues of sustainability or relapse were discussed, has not been presented in the evidence for this review but closing a case is a common consequence of patient disengagement because it is difficult to deliver a therapeutic service without full cooperation. It was decided that the family therapy service should discontinue its involvement and that the specialist CAMHS psychiatrist would be informed of the decision.

4.4.1.104. There is no record to confirm that the action to inform the psychiatrist took place, and the notes do not record if, how or when it was done, if at all. From the evidence it appears that the psychiatrist may not have known that the service was no longer available to Young Person C as part of her treatment programme. The GP was not informed either at the time of the failed appointments, nor when the family gave notice that they would not be resuming their family therapy sessions.

4.4.1.105. Despite the improvements noted by the family therapist and reported by Young Person C's parents, in July 2013 new observations were coming to the attention of the GP via Young Person C's mother

suggesting that Young Person C was beginning to indulge in obsessional exercise, was dieting and had stopped taking her medication.

4.4.1.106. A combination of the GP's assumption and belief that Young Person C's symptoms would be discussed during a forthcoming therapy session and the fact that he was never formally notified of their failure to attend that or any subsequent family therapy appointments offered to them, led to a false sense of security and missed opportunities for the GP to raise the matter of disengagement during his consultations and professional interactions with the family.

4.4.1.107. In December 2013, twelve weeks after the family were last seen by the CAMHS service, a final attempt was made by the NSFT CAMHS service to contact the family by means of two telephone calls and a letter to Young Person C's mother which was copied to the family GP. This was in line with the Trust's policy to close a case. Young Person C who, by this time, was almost 17 years old does not appear to have been included in these communications about finally discharging her. No response from the family was forthcoming. The family was finally and formally discharged from the NSFT CAMHS service on December 20th 2013.

4.4.1.108. The potential harm to children and young people when professionals fail to communicate in a timely and effective way has been well documented and it is a standard component of any safeguarding children training programme for health professionals from any discipline. In this case from the evidence submitted, it appears that NSFT CAMHS services did not pay sufficient attention at the time to the importance of informing professional colleagues both inside and outside of the organisation.

4.4.1.109. CAMHS must ensure that systems are in place that facilitate information sharing and that a culture is promoted that expects psychiatrists, therapists and other mental health professionals to share information with colleagues. This approach should include a system to notify professional colleagues in the community when there are concerns about young people stopping medication or suddenly disengaging from services. In these circumstances it is also important that efforts are made to talk to any competent young person about the decisions being made about discontinuing their care programmes to ensure that their views are taken into account.

4.4.1.110. The current NSFT Policy document entitled 'Non-access visits and Missed/Cancelled Appointments (2014) indicates that GP's should be notified of worrying circumstances when vulnerable patients fail to attend or cancel appointments. I have not seen the policy that was available for staff in 2013, but it seems that the matter of informing the GP is now recognised as an important staff responsibility. NSFT need to ensure that this becomes embedded into practice.

4.4.1.111. There is very little in the CAMHS data that represents Young Person C's experience of the services she received or which gives a sense of Young Person C's own wishes and feelings to influence her own care

plans. Young Person C was Gillick competent at the time she was receiving care, although at 16/17yrs of age would have been assessed under the Mental Capacity Act. In the evidence received for this review, frequent detailed references to conversations and contacts with Young Person C's parents can be found, indeed, the voice of the parents seems to be far more prominent than the voice of Young Person C herself. Consideration needs to be given as to whether consciously or unconsciously, the care plans for this case were over influenced by the wants and needs of Young Person C's parents and whether the wishes and feelings of Young Person C were given equal weighting.

4.4.1.112. The comment made by Young Person C's mother for this SCR alluding to the family therapy service suddenly disappearing was discussed at the SCR practice learning event. Young Person C's mother never suggested that she actively tried to re-engage with the service or that she had difficulty in doing so, although she has stated clearly that she did not receive some of the messages and letters offering her appointments, and that she would have followed advice if she had received it. She did feel that something changed with regards to the local mental health provision she had been accessing, although could not articulate why.

4.4.1.113. Reflecting on the meaning of this comment, members of the SCR reference group remembered a period of complete confusion when the services were restructuring to a new model of delivery. The services never disappeared as such, but this could very well have been the public perception. For future learning the Suffolk LSCB should consider how assurance can be obtained about safe transitional arrangements when services that have a major impact on children and families enter a phase of re-organisation.

4.4.1.114. On 9th January 2014, less than three weeks after the case was formally closed by NSFT CAMHS, the family was re-referred to the service following an urgent referral from Young Person C's GP for an eating disorder. The action was recommended by a psychiatrist at the Priory Hospital following a private consultation where Young Person C was found to be severely underweight. The referral was picked up quickly by the NSFT CAMHS Youth Pathway Team and by the 11th January 2014 inpatient treatment was being recommended.

4.4.1.115. Young Person C was sensitively and extremely well supported by the NSFT CAMHS eating disorder team in the short period between the re-referral to CAMHS and her admission. Young Person C and her mother were instructed about strategies to improve Young Person C's calorie intake, and the directive approach taken by the staff was hugely appreciated. The notes of the professional contacts, most of which were done over the telephone, were appropriately recorded, although there is little written evidence as to whether professional communication did or did not occur with Young Person C's GP regarding their advice.

4.4.1.116. Following a week of intense activity by NSFT CAMHS and the GP to support Young Person C in the community and also to locate an inpatient facility, a bed became available at the Priory Hospital eating disorders unit and arrangements were made to admit her.

4.4.1.117. On 3rd February Young Person C's GP wrote to NSFT to bring to their attention a problem reported to him by C's mother. Young Person C had apparently not been able to access individual therapy at the Priory Hospital and this was causing her distress. NSFT did not respond to his letter.

4.4.1.118. The NSFT CAMHS eating disorder nurse continued to participate in Young Person C's care throughout the time she was a patient in the St Aubyn psychiatric intensive care unit by attending multi-agency CPA meetings and recording the outcomes from those and other meetings held at St Aubyn. She acted as the NSFT care coordinator for Young Person C which demonstrates good practice in relation to multi-agency working.

4.4.1.119. Norfolk and Suffolk Foundation Trust provides mental health, substance misuse and learning disability services across a wide geographical area including CAMHS provision. A Care Quality Commission inspection undertaken in October 2014, shortly after Young Person C's death, was published in February 2015. It has resulted in a stringent improvement plan in relation to the findings.

4.4.1.120. The 'NSFT Specialist Community Mental Health Services for Children and Young People Quality Report (2015) that formed part of the inspection was judged as 'requires improvement' in four out of five of the quality standards; the Trust received 'good' in the domain of caring. Ipswich and Bury South Integrated Delivery Teams are described in detail in the body of the report and did not receive an inadequate rating. The CQC findings have been read in relation to this SCR to triangulate findings.

4.4.1.121. Many of the CQC findings were similar to some of the incidental learning points identified in this SCR. For example, whilst examples of good practice and compassionate care were clearly evident, issues relating to updating risk profiles and the lack of a joined up approach of records systems, leading to a reliance on young people or carers needing to pass on relevant information, are mentioned in the CQC findings. The negative impact of the Trust's reorganisation of services for children and young people is also mentioned. The action plan that has been designed to meet the findings of the CQC report incorporates issues which have also been highlighted within this SCR.

4.4.2. Findings (Care Episode 1)

4.4.2.1. For this time period which spanned approximately 15 months there were 118 interagency interactions identified in the chronology consisting of face to face, written or telephone consultations. This large number of events show that the needs of Young Person C were both recognised and acted upon and in general the sector worked together to meet the needs of Young Person C as her mental health issues began to emerge.

4.4.2.2. The written evidence reviewed shows several examples of effective interagency communication and information sharing but there were also

examples where information sharing was poor or inconsistent. Similarly evidence was seen that showed good attention to recording information relating to care given and actions taken but this was not always the case.

4.4.2.3. Agencies should reflect on the practice issues identified in this report that relate to their services and ensure that any weaknesses in their organisational systems and processes are subject to an improvement plan. Plans should enable practitioners to safeguard young people safely and effectively within their agency and across the wider partnership. Suffolk Safeguarding Children Board should hold the agencies to account by seeking assurance that improvements have been implemented.

4.4.2.4. It has been difficult to extract the 'voice of the child' from most of the documentation relating to Young Person C's care in the community. References and explicit accounts of her family and school life and her view of how they had affected her can be found in some records, but the sense of how she was included in the decisions being made about her or the detail of how she was invited to participate or was informed about her care are not represented in the material. For example, there is no evidence that I have seen in the NSFT CAMHS addendum or chronology that allude to Young Person C agreeing to, signing or being given a copy of a care plan. The 'voice of the child' should not only be used to inform a clinical decision, it should wherever possible be represented within that clinical decision.

4.4.2.5. The views of Young Person C's parents are represented, and rightly so, but care needs to be taken to ensure that the voice of a young person is also present in everyday practice for care planning and also when organisations are producing evidence for an internal or multi-agency investigation.

4.4.2.6. None of the practice issues identified in this care episode would have changed the course of action that Young Person C took on 4th August 2014, but some important incidental learning has been identified that suggests that there need to be some system changes to improve practice for the future.

4.4.3. Root Causes

No root causes were found that have would have had a direct link to or caused Young Person C to inject herself with animal medication that resulted in her death.

4.4.4. Contributory Factors

There were no factors identified in the evidence reviewed that had a major influence or impact on the course of her illness or recovery or that either directly or indirectly contributed to the action taken by Young Person C on 4th August 2014.

4.4.5. Incidental Learning

The analysis suggests that some systems in Suffolk require improvement to enable children and young people to be more effectively safeguarded. Actions in relation to the incidental learning should be set out in either in a single agency SCR action plan or as additional actions for to any other improvement plans in place for submission to the Suffolk Safeguarding Children Board when requested. Action plans should include the following:

Ipswich School

- Review internal systems and processes with regards to making and recording referrals based on an established needs/risk assessment model; specifically considering the signs of safety model.

- Review the internal policy relating to gaining or overriding the consent of students to incorporate the consent pathway when making a child protection referral.

- Review the internal policy to encourage staff to proactively follow up information about students from professional colleagues in the network.

- Establish regular contact with the SCYPS safeguarding in education and strengthen relationships with the Suffolk LSCB.

Suffolk Children and Young People Services (SCYPS)

- Provide assurance data to the Suffolk LSCB regarding the actions being taken to improve the feedback loop for notifying the outcome of a referral to the referrer.

- Review the system and consider the feasibility for pro-active follow-up of non-responses to CAF consent forms within the capacity and demand constraints of the service.

NHS Primary Care (GP) Service

- Incorporate into training programmes greater awareness of the ways and means that young people inflict harm upon themselves;

- Establish whole practice meetings to enable the sharing of information about vulnerable people.

NSFT Suffolk CAMHS

- Develop an action plan to improve communication and information sharing between teams and with other professionals in the children's sector, including GPs, particularly when children and young people disengage from the service and to raise the standard of recording keeping

- NSFT should ensure that a robust system is in place for receiving and forwarding telephone messages that can provide an audit trail of what is sent to whom and the response or outcome.

- Review and strengthen the NSFT Non-access Visits and Missed/cancelled Appointments Policy (2014) and develop a system whereby professional colleagues in the community are notified of when vulnerable young people suddenly disengage from services.

- Inform mental health staff of the Trust's expectation that children's 'voices' must be explicit in case plans, case files, files and documents submitted for single or multi-agency investigations.

- Implement a standard whereby Gillick competent young people are copied into letters that are sent to their parents about discharging them from services, unless there is a good reason not to do so.

- Explore the disparity between the reports of self-harm on 12th March 2013 and the assessment of 14th March 2013 and 27th March 2013.

All Agencies

- Should ensure the 'voice of the child' (particularly for competent children) is sought and recorded in relation to care proposals or care plans, unless it is considered not to be in their best interests.

4.5. Care Episode 2: Care received as an inpatient at Priory Hospital (Tier 4 CAMHS Service), Chelmsford from 17th January 2014 to 20th February 2014

4.5.1. Analysis

4.5.1.1. The Priory Hospital in Chelmsford is an independent hospital that offers Tier 4 CAMHS treatment and behavioural management programmes to adolescents with eating disorders. A recent Care Quality Commission Inspection Report of the unit (March 2014) undertaken shortly after Young Person C was discharged from their care judged the service to have met all of the inspection standards including those for safeguarding patients from abuse and providing a safe environment.

4.5.1.2. The Priory Hospital CAMHS unit was also granted an international accreditation for meeting a range of quality standards set by the Royal College of Psychiatry's Quality Network for Inpatient CAMHS (QNIC). This was after the date that C died, but the CQC report and the accreditation award suggests on balance, that the organisation took its responsibilities seriously with regards to keeping children safe at the time Young Person C was a patient.

4.5.1.3. The first contact Young Person C made with the Priory Hospital was via a private referral from the GP. The appointment took place on 7th January 2014 and Young Person C's mother accompanied her to the appointment. The psychiatrist faxed a comprehensive report to the GP on the day of the appointment recommending a review of her medication, urgent one-to-one eating disorder therapy and a re-feeding programme.

4.5.1.4. Initially a suggestion was made that the local NSFT CAMHS eating disorders unit could pick up her care in the community as the hospital was some distance away from the family home. However, Young Person C's mental health continued to deteriorate and on 15th January 2014 a request was made from NSFT CAMHS for inpatient treatment.

4.5.1.5. Two days later, on the 17th January 2014, Young Person C was admitted as an informal NHS funded patient to the Priory Hospital Tier 4 CAMHS eating disorder unit with a diagnosis of anorexia nervosa and depression.

4.5.1.6. On admission Young Person C received a thorough examination and assessment of her physical and psychiatric needs, and clinical review of her progress was undertaken on a daily basis thereafter. The record of her admission is comprehensive although the electronic admissions form filled in by the admitting doctor was incomplete in parts.

4.5.1.7. Deliberate self-harm, self-neglect and non–compliance with treatment featured in her initial risk assessments and risk plan, but she denied suicidal thoughts or ideation at the time she was admitted and expressed a wish to get better. Young Person C chose her mother to be her main family contact at this time.

4.5.1.8. Within the first few days of her admission, Young Person C was judged to be seriously ill and in need of a high level of support to cope with her pre-occupation with negative feelings about her body image and her relationships with her parents.

4.5.1.9. Treatment plans were drawn up to improve her self-esteem and resilience in order for her to gain control over her serious eating disorder and regain a healthy body weight, and care plans were written primarily to help Young Person C manage and recover from her weight loss and to challenge the voices that were telling her to self-harm. The plans included close monitoring of her weight and physical condition, meal plans, dietary advice, and individual supervision from nursing staff. Various group activities were also available to Young Person C, and she very much enjoyed creative therapy group-work.

4.5.1.10. Young Person C was initially considered high risk and arrangements were made for someone to be with her for 24 hours a day and within arm's reach as a means of keeping her safe and compliant with treatment.

4.5.1.11. Individual therapy that Young Person C very much wanted to help her to control her invasive thoughts was not initially offered as part of her treatment programme at the Priory Hospital. By 31st January 2014 the lack of individual support was causing Young Person C some anxiety and her mother spoke to the GP to express her dismay about the lack of individual attention for her daughter.

4.5.1.12. On 3rd February 2014 Young Person C's GP raised the concerns of the family with the psychiatrist at the Priory Hospital. The delay in

arranging individual cognitive therapy for C was due to staff leaving the service and new staff joining and the issue was resolved within two weeks of the initial complaint.

4.5.1.13. Young Person C's views and feelings were consistently well recorded in detail in the case notes and she received copies of her care plans that she was invited to sign. Nursing arrangements and risk plans were adjusted regularly to ensure she had adequate observation, supervision and support. The consistent attention to care planning and frequent re-evaluation of risks suggests that the overall ethos in the unit was one of working in a coordinated way to promote the safety and welfare of young people; however, decisions about the support of the wider family including the details about family contact arrangements were sometimes not paid sufficient attention.

4.5.1.14. In the context of family contact, on 23rd January 2014, an issue arose about a potential visiting arrangement that caused Young Person C a great deal of anxiety and distress. Young Person C was led to believe by a receptionist that her father could visit her on the ward when he wanted to, and this was not in accordance with her wishes. The incident was recorded in the notes.

4.5.1.15. When seeking clarification about this event the SCR investigating officer for the Priory Hospital was unable to clarify exactly what had happened. Assurance was given to the SCR reference group that a robust visiting policy was and still is in place. Visitors report to reception area initially and are escorted onto the ward by a member of staff. Whilst the policy is robust as a corporate document, it does not cover the detail that may be necessary at a local level and a procedure to supplement the policy developed with local arrangements would be useful.

4.5.1.16. On 23rd January 2014 the notes also record that Young Person C had taken laxatives that she had concealed on admission. She also admitted to having harmed herself, although it is unclear from the evidence whether this pertained to deliberate self-harm prior to admission or afterwards. The laxatives were subsequently handed to the staff and the incident was recorded in her notes. An organisational accident/incident form was not completed as would have been expected. There is no explanation as to why the staff omitted to follow the required procedure for logging accidents and incidents and the Priory Hospital may wish to review the system to check that the process is well known and easy for staff to manage. Accident and incident reporting systems are essential for keeping organisations safe by continually identifying and managing organisational risks. It is important that this process is adhered to.

4.5.1.17. Young Person C continued to struggle with the re-feeding programme throughout the admission and required high levels of support from the staff to manage her distress, but her weight did improve slightly and it continued to improve. By the end of January 2014 patient leave opportunities were discussed with Young Person C which she initially declined. Leave arrangements were made later in her admission

when she decided she was ready and was observed to be less anxious about leaving the ward.

4.5.1.18. On the 30th January 2014, Young Person C was moved to a bedroom 'upstairs' as a new sleeping arrangement. There is no rationale or reason recorded in the Priory Hospital notes as to why the decision was made. Young Person C's mother expressed in her interview for this SCR that she felt the move had a negative effect on Young Person C by causing her to feel isolated and separated from friends she had made on the unit.

4.5.1.19. Looking at a timeline, it does appear that very shortly after this move Young Person C's self-harming behaviour increased markedly. This would suggest that the timing of the move may not have been in her best interests. However, the internal reviewing officer for the Priory Hospital has explained that the practice of moving a young person upstairs is typical for young people like Young Person C who are showing an improvement in their condition. The bedrooms are fully staffed at night, and during the day activities, treatments and therapies continue as usual downstairs for the whole in-patient community.

4.5.1.20. The reviewing officer also explained that the act of being 'moved upstairs' is commonly associated with increased anxiety levels. A decision to move a patient upstairs is applied on the basis of a recognised improvement in their condition. Young Person C would have known that being selected to move upstairs meant she was getting better and this in itself may have brought the inevitability of being considered for discharge into sharp focus. The thought of being discharged and of having to assume full responsibility for controlling and managing her own feelings and urges, combined with feelings of loss about the people and routines she had established in the unit may very well have diminished Young Person C's confidence and increased her anxiety.

4.5.1.21. Moving patients in this way is an unavoidable but necessary means of managing the throughput of patients coming to and leaving the unit. Bed management is a constant issue for the unit and when the demand is high decisions may need to be taken quickly. The decision to move Young Person C was taken on the basis of assessing the risk and clinical needs of all the patients on the unit. She was assessed as being the patient most able to make the change. Under those circumstances it is unlikely that any other outcome would have been possible.

4.5.1.22. Reflecting on how the process of moving a young person is managed, the Priory Hospital reviewing officer thought that the way the staff communicate and explain the reasons to young people for relocating them upstairs should be reviewed, to see if it can be improved in any way to reduce the level of anxiety it causes.

4.5.1.23. Young Person C was seen harming herself whilst on home leave on 1st February and deliberately burnt herself on a hospital radiator on 2nd February 2014. As her weight increased thoughts and acts of self-

harm and suicidal ideation seemed to take over as the main focus of her illness in response to being unable to restrict her food intake.

4.5.1.24. Numerous attempts to harm herself were observed and recorded by staff and the methods were extreme and varied. The self-harm attempts were recorded in full in the patient notes, but not always logged as an accident/incident according to the procedure that the Priory Hospital requires as part of its organisational risk management and learning and improvement framework.

4.5.1.25. By February 5th 2014, Young Person C's risk assessment escalated to deliberate self-harm and suicide ideation with intent. The staff tried hard to manage the risk to Young Person C by increasing her supervision and observations, for example one-to-one supervision when awake and 6 checks per hour at night. Items that she could harm herself with were removed.

4.5.1.26. Nevertheless on 10th February Young Person C was found with a ligature (scarf) round her neck. Young Person C was examined by a doctor immediately. This action was to assess any immediate medical needs and was entirely appropriate. Staff comforted Young Person C and her mother was called, who travelled to the unit to be with her daughter. Young Person C was re-assessed as a suicide risk and monitoring was increased to one-to-one within eyesight at all times

4.5.1.27. Young Person C's mental health continued to deteriorate and consideration was given to whether hospitalisation was aggravating Young Person C's sense of hopelessness. Reaching a point where hospitalisation in itself becomes a risk is not uncommon. As Young Person C's mother had reported that Young Person C often became distressed at the thought of returning to the unit after home leave, it seems reasonable to have incorporated this as a factor in her risk assessment.

4.5.1.28. A decision was made to contact the NSFT eating disorder team with a view to Young Person C being supported in the community. During the conversation the NSFT eating disorders unit mentioned the previous child protection referral one year earlier, but could not give any detail of the outcome. The Priory Hospital contacted SCYPS who confirmed that a referral had been made but abuse had been ruled out. Nevertheless, this raised a question about Young Person C's safety should she return home. In addition, Young Person C's mother was finding Young Person C's behaviour increasingly difficult to cope with. Based on a combination of a remote but possible safeguarding issue and the impact of discharge on the emotional wellbeing of Young Person C's mother, the proposed plan for discharge with community support was stood down.

4.5.1.29. The Priory Hospital felt that their service was not the right environment to manage Young Person C's escalating and serious deliberate self-harm. The notes record in full the various ways and means that Young Person C employed to hurt herself, and despite numerous risk assessments and plans it was clear that the hospital was struggling to keep her safe. By the 17th February the Priory Hospital made the

decision that Young Person C needed to be in a more secure environment and the plan was communicated to her parents.

4.5.1.30. Young Person C's parents were understandably concerned by this decision, which could involve their daughter being moved to a unit many miles away. Both parents expressed a wish to be involved to support their daughter through this most traumatic time.

4.5.1.31. In the early hours of the 19th February 2014 Young Person C became extremely agitated and disclosed that she was struggling to control the urges to kill herself. At 03.35, Young Person C was found once again to have tied a ligature tightly round her neck. The ligature had restricted her breathing slightly and she was placed on oxygen. The examining doctor took immediate advice from an Ear Nose and Throat specialist about Young Person C's immediate care, ensuring that her medical needs were met in full.

4.5.1.32. Young Person C's mother was informed about the incident and was advised about the urgent need for a Mental Health Act Assessment (1983), following which a telephone call was placed with NHS England (NHSE) that commissions intensive care provision to request funding for a bed in a more appropriate setting. The NHSE case manager was in agreement with this decision.

4.5.1.33. Arrangements were made for Young Person C to have Mental Health Act (1983) assessment with an Approved Mental Health Professional (AMP) from Essex County Council and later that day Young Person C was appraised of her rights in line with the MHA code of practice. The assessment was undertaken and Young Person C was placed under Section 2 of the Mental Health Act (1983) on 19th February 2014 and the associated documentation was completed in full.

4.5.1.34. On 20th February a referral was sent to the St Aubyn Secure Centre in Colchester, a Tier 4 Psychiatric Intensive Care Unit, and arrangements were made by The Priory Hospital with agreement from NSFT to transfer Young Person C into the unit. NSFT and C's mother were informed of the transfer that would take place the next morning.

4.5.1.35. The arrangements to transfer Young Person C from the Priory Hospital to a more appropriate unit took less than 48 hours. The process followed was thorough and well-coordinated; however there is little information in the evidence provided that gives a sense of how Young Person C was prepared for this move, apart from a reference to her being extremely agitated, restrained and sedated.

4.5.2. Findings (Care Episode 2)

4.5.2.1. Evidence submitted for this review was by means of a comprehensive chronology and participation in a practitioner reflective workshop. 97 key events recorded in the Priory chronology were reviewed, covering the duration of her stay which was slightly over one month long. The chronology gives a good account of what happened, when and what should have happened, but is limited to the level of analysis it can provide and therefore does not give any rationale for why decisions or

actions were taken by the staff and what the factors were that influenced their practice.

4.5.2.2. The 'voice of Young Person C' and a sense of her journey as a patient in the Priory Hospital is present to a large extent in the information received. Young Person C's views and feelings were described and recorded fully and frequently indicating that an appropriate person centred approach was taken. She was clearly able to input, agree, and sign her own care plans and was given a copy to keep. This acknowledges her right as a young person to be involved and demonstrates that she was included in decisions being made about her care.

4.5.2.3. Young Person C made the decision that she only wished to see her mother during the stay at the hospital and that she would be her main source of family support. In line with this arrangement Young Person C's mother was kept informed of her progress and notified without delay when serious incidents occurred. However there were some omissions with regard to routinely recording the detail of the family contact arrangements in her notes, an important part of Young Person C's overall care planning.

4.5.2.4. The standard of nursing and medical record keeping for a majority of the time was good, clinical activity and observations were recorded in detail. On a few occasions outcomes of risk assessments were not always translated into care plans, and the details about the actions taken were missing in a few places.

4.5.2.5. There was, however a generalised issue with regards to complying with the hospital accident/incident organisational risk policy. Serious occurrences were not always reported on the organisation's accident/incident forms. Such reporting enables organisations to review incidents and monitor the overall safety of the care they deliver, and to put in remedies to mitigate against organisational risks. The Priory Hospital should reinforce with their senior staff that this is an important management responsibility that should be undertaken seriously whenever a patient or a member of staff is involved in an accident or incident.

4.5.2.6. Young Person C did manage to improve and sustain her weight gain, which suggests that the treatments and therapies offered in the Priory Hospital eating disorders unit were effective. However, as Young Person C's weight improved the episodes of deliberate self-harm intensified in number and severity and at an alarming pace. The interval between risk assessments escalating from 'risk of self-harm' to 'serious suicidal thoughts with intent' was approximately 10 days.

4.5.2.7. Despite frequent risk assessments and attempts to keep Young Person C safe, the service at the Priory Hospital was clearly not able to meet her complex needs and arrangements were quickly made for Young Person C to transfer to a more secure unit.

4.5.2.8. There was multi-agency communication and information sharing toward the end of Young Person C's stay in the hospital. Contacts

were made with SCYPS, NSFT and NHS England, particularly around the time she was to be sectioned under the Mental Health Act (2003), but there was no evidence of contact with the GP during the month she was an inpatient. This might have been helpful to the GP who was supporting Young Person C's parents during the admission.

4.5.2.9. The findings for this episode of care when Young Person C was a patient at the Priory Hospital in Colchester would not have had an impact on the incident that led to this SCR. However, some learning points have emerged from the evidence they have submitted. The Priory Hospital has given a detailed account of the care they delivered whilst Young Person C was an in-patient and has been extremely open and cooperative during the SCR process, participating in a practitioner event. They are keen to learn any lessons from the review and their single agency action plan will need to include the incidental learning points outlined below. The action plan will need to be submitted to the Suffolk Safeguarding Children Board for review.

4.5.3. Root Causes

No root causes were identified from the services that Young Person C received in the Priory Hospital that directly link to her death.

4.5.4. Contributory Factors

There is no evidence that events in the Priory Hospital directly or indirectly contributed to the action taken by Young Person C on 4th August 2014.

4.5.5. Incidental Learning

- The Priory Hospital Visiting Policy should be supplemented by the formulation of a local procedure which would include explicit local arrangements, individual responsibilities etc as required and the right of competent young people to decide on who their contacts and visitors will be should be made explicit in the Policy;

- A record audit should be undertaken with regards to:
  - Family contact arrangements being routinely updated in care plans;
  - Identified risks being translated into risk management plans;
  - Outcomes and actions being recorded in full detail.

- The Priory Hospital should reinforce to senior staff and managers that all accidents or incidents should be reported according to the Priory policy.

- The Priory Hospital should consider criteria and develop a system to inform GPs about progress or sudden changes in the condition of their patients receiving care in the unit.

4.6. Care Episode 3: Care received as an inpatient at St Aubyn Centre Psychiatric Intensive Care Unit (Tier 4 CAMHS Service), Colchester from 21st February 2014 to 4th August 2014

4.6.1. Analysis

St Aubyn Psychiatric Intensive Care Unit

4.6.1.1. Young Person C was admitted to the St Aubyn Centre (SAC) on 21st February 2014 from the Priory Hospital. The St. Aubyn Centre is an NHS Adolescent Acute and Intensive Care (AIC) unit located in Colchester Essex provided by North Essex Partnership University NHS Foundation Trust. It provides care for young people between the age of 11 and 18 who are experiencing acute, complex and/or severe mental health, emotional and psychological problems. A CQC unannounced inspection in March 2014 concluded that St Aubyn met all of the standards including for safeguarding patients from abuse and respecting their human rights.

4.6.1.2. Young Person C was extremely ill when she arrived at the unit. On the day of admission she was expressing suicidal thoughts. The staff were astonished by her determination to harm herself, commenting that she would self-harm whenever the opportunity arose. The initial assessment of her condition on 21st February 2014 concluded that she was not psychotic but was suffering from severe depression and anorexia nervosa.

4.6.1.3. During the admission Young Person C's mother informed staff that historically there had been significant conflict between Young Person C and her Father. She alluded to the section 47 child protection referral being closed by SCYPS. A safeguarding allegation recording form was completed. The form is part of an internal system to collect formation relating to safeguarding, for example historical information or partial disclosures. It ensures that the information is in one place, is easily accessible and does not become lost within the mass of clinical information that is recorded. The information informs the agenda of regular safeguarding clinics where safeguarding issues for young people and any other safeguarding issues are discussed. The information is pre the threshold for child protection referral, but is used to inform child protection referrals if necessary. This is a robust system that facilitates good safeguarding and child protection practice.

4.6.1.4. Young Person C was treated as a high risk patient and subject to level 4 observation, the highest level of supervision defined by NICE: Clinical Guideline 25: Violence -The short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments (2005). Occasionally Young Person C's care would involve her wearing protective clothing and being nursed at ground level to prevent her from inflicting injuries upon herself. When considered necessary staff, consisting of trained nurses working with trained healthcare assistants, would restrain Young Person C to keep her safe. Young Person C was allocated a key worker that was

responsible for coordinating her care plans and for arranging meetings such as her Care Programme Approach meetings.

4.6.1.5. The necessary interventions to keep Young Person C safe were undertaken using the 'less restrictive' principle to take account of her rights. Her observations and supervision arrangements followed a very robust and comprehensive Trust policy and guidance document (NEPFT In-Patient Observation and Engagement Policy) implemented in March 2014. The document, which suggests an organisational culture of good Governance, explains the principles of good practice and the responsibilities of staff. It focuses primarily on the safety and rehabilitation for users also giving guidance about rights of their parents or carers. The documentation presented to the SCR and information from the interviews held with staff demonstrates clearly that the unit put the young people at the centre of their practice and were compassionate when supporting their parents.

4.6.1.6. Young Person C settled into the St Aubyn Centre which despite being a psychiatric intensive care unit (PICU) has been designed to be as homely as possible. Her care followed the established daily regime in the unit designed for high risk and complex young people. The activities and observations of the staff immediately after Young Person C's admission were primarily focussed on harm reduction and on defining and managing the risks that were presenting. The protocols and procedures for staff enabled them to adjust the levels of observation for Young Person C depending on her needs without undue delay and this would clearly have been in Young Person C's best interest.

4.6.1.7. Formally recorded care plans and risk management plans were written on a daily basis by the nurse in charge of her care with senior management and clinical oversight. Nursing notes and observations were then updated three times a day at nursing handover meetings when one shift ended and another began. Young Person C's mental health status, treatment, activities and parental visits were reported during handover meetings to ensure clinical and social information were shared to provide continuity of care.

4.6.1.8. An overview of Young Person C's progress was discussed during daily ward reviews and weekly multi-disciplinary team (MDT) meetings. Monthly MDT meetings were also held. These were informed by the wishes, feelings and views from Young Person C that had been ascertained separately the day before at a smaller pre-review meeting with nursing staff. The pre-review meetings with young people are considered a good way to enable them to participate in their care without being overwhelmed by a larger group of professionals.

4.6.1.9. Minutes of the weekly review and monthly MDT meetings were regularly sent to the NSFT care coordinator to keep her updated. Contact with Young Person C's school was also maintained. Multi-agency Care Programme Approach meetings arranged by Young Person C's Key worker commenced in April 2014 and three were held in all. An approved mental health professional (AMP) attended all CPA meetings and there is evidence of NSFT attending on two occasions

and the school also attended once. Notes were kept and circulated, although not to the GP, and Young Person C's voice was represented in the discussion. Independent advocacy was available to the young people, usually on a Wednesday.

4.6.1.10. Three weeks following admission, on 14th March 2014, it was decided at an MDT meeting that the highest level of observation (level 4) should continue as Young Person C was harming herself at an alarming rate, some injuries requiring treatment at Colchester Hospital. At this meeting the professional judgement based on a clinical assessment and including the opinion of an approved mental health professional was that Young Person C should be detained for treatment under Section 3 of the Mental Health Act. She was re-graded accordingly. The care coordinator at NSFT CAMHS was informed. Young Person C's medication was reviewed and a psychological assessment was recommended. Young Person C was encouraged to attend school and ward activities if she felt she could participate.

4.6.1.11. Young Person C's first CPA meeting was undertaken on the 11th April 2014. Young Person C was judged to have made a small amount of progress. She had been attending school sessions, her observations had been reduced from level 4 to level 2 in social areas and level 3 in isolated areas and she had reached and maintained her target weight. The records also noted that her self-harming episodes were decreasing in intensity and frequency. Two hours escorted leave was granted. This seemed a reasonable decision to make on the information at hand.

4.6.1.12. During the escorted leave Young Person C ran into the path of a slow moving car that stopped instantly. However she threw herself onto the bonnet of the stationary car observed by two members of staff. They were certain she had not hit her head. Staff checked her for any physical injuries and concluded that as she was relatively unscathed they would not take her to hospital.

4.6.1.13. However the next day on 12th April 2014, Young Person C complained of double vision. She was taken immediately to Colchester Hospital where they did a full examination and sent her for a head scan. The reason for the complaint of double vision is not fully explained other that it may have been caused by Young Person C's frequent head banging as a means of harming herself. It is highly unlikely that it would have been as a result of the incident with the car. The decision not to take her to hospital was therefore justified.

4.6.1.14. All of the adverse incidents occurring to Young Person C whilst she was in the unit were appropriately entered on the Datix risk management system.

4.6.1.15. The CPA meeting of 11th April 2014 that reported an improvement in Young Person C's condition preceded a period of deterioration in her mood and ability to cope and an increase in her self-harming behaviour. Once again it appears that Young Person C being faced

with the reality that she was improving triggered an anxious and negative reaction.

4.6.1.16. Over the next two weeks Young Person C continued to self-harm but the risk management plans drawn up for her still included escorted ground leave. This adheres to the principle of taking therapeutic risks to ensure protective or intrusive care would not lead to inappropriate dependence.

4.6.1.17. By mid-May 2014 there had been a noticeable improvement in C's condition. Young Person C was described as more positive and optimistic about future plans. Escorted leave which included her mother was increased to 30 minutes at a time. Young Person C was participating well in the Unit's groups and activities and was described as jovial at times, but this was tempered by periods when her mood lowered considerably.

4.6.1.18. Young Person C became frustrated and disappointed with the pace of her improvement, but her determination and belief that her illness was resolving quickly was considered to be a risk and staff encouraged her not to have such high expectations and allow herself to progress more slowly. They explained that this approach would enable her to achieve real and sustainable change.

4.6.1.19. A letter was sent to SCYPS on 28th May 2014 notifying them Young Person C had been a patient since 21st February 2014, a period of three months which complies with Section 85 of the Children Act 1989. A copy of the letter was filed.

4.6.1.20. Family therapy which involved Young Person C and her mother at first started towards the end of May 2014. By this time Young Person C was also receiving individual psychotherapy on a weekly basis and attended other sessions with a clinical psychologist.

4.6.1.21. At a multi-agency CPA meeting that was convened for the 30th May 2014, Young Person C agreed that her father should join the family therapy sessions. Notes recorded that as she had made considerable progress an increasing home leave plan should be designed to move her towards discharge planning.

4.6.1.22. A leave plan was drawn up for Young Person C that included a combination of escorted leave with staff within the local area, accompanied ground leave with her mother, a once per week three hour escorted leave period to undertake an activity with her mother and five hours escorted leave to visit her mother's home or her father's farm. Risk assessments were undertaken prior to leave arrangements being taken.

4.6.1.23. Throughout the spring the staff caring for Young Person C gave consistent accounts of her overall improvement whilst in the unit, but she frequently protested at the pace of her rehabilitation. The unit continued to proceed with caution on the basis that Young Person C was being far too over-optimistic in terms of her recovery, observing

that her progress was tempered by bouts of self-doubt, hopelessness, suicidal ideation and impulsive self-harm.

4.6.1.24. Young Person C was not very happy with the leave arrangements set out in a plan dated 12th June 2014. She felt that they were unnecessarily harsh and restrictive. By this time she had successfully re-engaged with her father and felt she was being unnecessarily detained in the hospital. The staff were constantly challenged by her insistence she was well.

4.6.1.25. Later in the evening of 12th June 2014 Young Person C deliberately and seriously burnt herself on the filament of a food trolley for which she required first aid and a trip to hospital. This impulsive action was to set a pattern of self-harm that reflected both her frustration when she thought care plans were unreasonable, and also the guilt she felt about letting people down. Her observation levels were increased following this incident.

4.6.1.26. Young Person C's fluctuating and unpredictable reactions to decisions about her care supports the professional judgements being made not to rush towards discharge planning. A slow but steady approach based on risk assessment continued to ensure new challenges were only offered when she was considered ready and well enough to manage them.

4.6.1.27. The month of June 2014 was turbulent for Young Person C and the apparent deterioration of her condition was painful to her mother. A decision was made for St Aubyn to refer Young Person C's mother for a carer's assessment which would be undertaken by the NSFT care coordinator. Young Person C continued to feel unhappy that staff were being too overcautious about her progress. She applied for a mental health tribunal to review her reasons for being detained. This application was later withdrawn, and it is not clear in the evidence why this decision was made.

4.6.1.28. In July 2014 Young Person C's condition was again showing signs of improvement and leave opportunities that were granted proceeded with no adverse effects or incidents. Young Person C was receiving regular visits from both her parents and the staff on the unit remarked on how well they were all getting on. At a multi-agency CPA meeting on 11th July 2014 her parents expressed how pleased they were with their daughter's progress, how helpful and supportive the staff had been and how they had appreciated being involved in Young Person C's care plan. At the same meeting, Young Person C spoke optimistically about her future, outlining reasons why she should refrain from hurting herself. She talked about running her own farm and going to agricultural college, and was pleased by the improving relationship with her father.

4.6.1.29. Following this meeting Young Person C's demeanour continued to improve markedly. Staff described her as being a pleasure to have around, helpful and happy. She was joining in a range of group activities and she was clearly enjoying her parents' company. Due to likely sudden changes of mood staff continued to follow a cautious

approach. But leave plans were acceptable to her and she no longer objected to the decisions being made by staff or resorted to self-harm as a result of disagreements or inability to change an outcome. Her relationship with her parents was visibly improving, and the staff spoke about her parents bringing Young Person C's dogs to the unit for her to see from the window of her room, and pots with flowers were brought from home and placed in the garden outside her room.

4.6.1.30. The school in the unit had closed for the summer holiday, presenting a challenge to the unit with regards to occupying the young people. It is important that young people do not feel bored or oppressed by the sudden change in routine when school activities are no longer available. Leave options are considered in terms of therapeutic benefit under these circumstances.

4.6.1.31. During a ward review of 24th July 2014, the risk to Young Person C from livestock medication and chemicals on her father's farm was discussed. This came up because Young Person C had a conversation with staff where she explained that despite being able to access dangerous substances, she had no intention of doing so. A risk assessment was undertaken which centred on psychological risk assessment criteria taking into account Young Person C's psychological risk and protective factors. These included her improved relationship with her father, successful previous visits, optimistic plans for the future and compliance with therapy and dietary requirements. A leave plan was drawn up following the assessment which included farm visits. An environment risk assessment was not included in the plan.

4.6.1.32. By the time of the next review scheduled for 31st July 2014 Young Person C had spent several leave opportunities on her father's farm that she loved. Young Person C had vast experience of the farming industry having been exposed to the family farm and watching and later working alongside her father. It was a very important part of her life and was the career she wanted to pursue. Young Person C was highly skilled in undertaking complex farming work and whilst on leave enjoyed several farming related activities such as driving a combine harvester, shepherding and horse riding which were second nature to her. She had enjoyed the trips to the farm immensely and they had all passed without incident.

4.6.1.33. Many staff on the unit admitted they had no personal experience of farming or the hazards that a farm presents. One member of staff alluded to not being aware that animal antibiotics could be lethal to humans, and another admitted that farms and the countryside are often portrayed as healthy places to spend time; the thought of the farm that Young Person C loved causing C harm did not cross her mind. In addition they had not factored in the amount of knowledge Young Person C had about the farming industry. She would have known exactly what could cause her harm and where it would be.

4.6.1.34. When Young Person C was a patient leave risk assessments were completed immediately before any young person left the unit. Risk

management plans were explained and agreed and a copy would be signed by and given to the parent who would be supervising the visit..

4.6.1.35. The organisational policy that underpinned leave arrangements was contained in the policy 'In-Patient Observation and Engagement Policy (March 2014). Point 6.4 of that policy refers to considering risks that present outside of the ward environment for patients on escorted leave whilst on enhanced observation levels 3 and above, but there was no references to environmental risk for any other leave arrangement.

4.6.1.36. Risk assessments prior to Young Person C's leave were all appropriately carried out according to the relevant policies and procedures in place at the time and it is entirely possible that had the risk assessment taken full account of the environmental dangers, it may still have not have prevented Young Person C's impulsive action that led to her death on 4th August 2014.

4.6.1.37. On reflection following Young Person C's death, staff realised that they could have been better aware of the specific risks a farm environment posed, and have moved quickly to the position that environmental risks must be considered formally alongside psychological risks when any leave is being contemplated.

4.6.1.38. NEPFT have already amended their policy to reflect this finding and it now includes environmental risk as a component of an assessment for home leave. The St Aubyn Centre have also moved quickly and a system has embedded that includes environmental risk when leave plans are being developed for their patients. These risks are now explicit and discussed with the supervising parent before they leave the unit.

4.6.1.39. The NSFT evidence for this review implies that a clinical psychologist passed information given to her by Young Person C's mother ahead of the multi-disciplinary review to be held at St Aubyn on 31st July 2014. The information was important and raised concerns that Young Person C was self-harming and feeling suicidal at the thought of returning to hospital. A record of this information does not feature in the notes of the meeting held on 31st July 2014. I have seen no evidence that either confirms that this information was communicated by NSFT or that it was received by St Aubyn, and staff at St Aubyn have consistently said they were unaware of this information, so the significance of how or if it influenced the decisions and actions with regards to assessing Young Person C's risk shortly before her death remains unclear.

4.6.1.40. Notwithstanding, any information indicating a high level of parental anxiety and suicidal thoughts about a young person must be passed on effectively and factored into care plans. This intelligence might have made a difference by influencing the risk assessment and/or the conversation with Young Person C's father about the level of supervision he should provide.

4.6.1.41. The reason for this missed opportunity remains unknown. Had evidence been obtained that illuminated the system failure that led to

this important information being missed, it would have been a contributory factor. Both organisations should check their systems to ensure there is a process for logging the passing and receiving of information.

4.6.1.42. A decision was made at the meeting on 31st July 2014 to increase Young Person C's leave. This would include 5 hours accompanied and closely supervised home leave including to the farm, plus a 5 hour escorted leave to the Unit's beach hut. Daily unescorted leave confined to the hospital grounds for periods of fifteen minutes and a 12 hour leave to attend a farming event on 1st August 2014 supervised by her father at all times, and an overnight leave to her mother's home were also sanctioned. Both parents were present and actively involved in the discussions at this meeting on 31st July 2014 and the notes of the meeting record that both parents agreed to the plan and understood that there needed to be a high level of supervision at all times to keep C safe.

4.6.1.43. Risk assessments were undertaken immediately before C left the unit to commence leave, as required by policy and procedure. She took her daily leave opportunities as planned and returned to the unit as agreed. She thoroughly enjoyed the farming event with her father that passed without incident. She also managed the overnight stay with her mother remarkably well.

4.6.1.44. On 4th August 2014 Young Person C prepared for the five hour supervised leave arrangement on the farm with her father. The nurse on the unit had no reason to feel worried about her presentation or the need to re-evaluate her risk to a higher level prior to her leaving the unit. . In her professional judgement it was safe for Young Person C to undertake the five hour leave period on her father's farm, supervised by him at all times. She was collected and staff watched her leave with her father feel unconcerned for her safety. On interview, the senior staff member on duty that morning reflected and confirmed that there was no reason to change her risk status and no reason to stop her from commencing that period of leave with her father.

4.6.1.45. Whilst on the farm Young Person C managed to access and inject herself with a veterinary medication designed for sheep after which she ran into the fields pursued by her father. Paramedics were called and Young Person C was transported to hospital where she died from the effects of the medication.

4.6.1.46. The introduction of leave was a justifiable risk to take and was successfully planned for Young Person C and her family using the processes in place at the time. Neither her parents nor the staff had reason to believe that Young Person C would harm herself catastrophically on 4th August 2014. The staff undertook the necessary risk assessments prior to leave being taken and Young Person C's parents signed up to supervising Young Person C at all times whilst she was away from the ward. Clearly this was not sufficient to protect C that day from acting on impulse and injecting herself with animal medication.

4.6.1.47. A member of staff told us at the SCR interview that Young Person C's father had expressed a wish to learn and know more about self-harm, including what drives people to do it and how it manifests. He clearly wanted to understand more about the problems his daughter struggled with. The St Aubyn Centre unit were considering setting up a FLASH (Families learning about self-harm) training course at the time that Young Person C was a patient, but funding was not identified to enable this to happen. The unit may wish to consider this again in the future.

Norfolk and Suffolk Foundation Trust (NSFT)

4.6.1.48. Whilst Young Person C was an inpatient in St Aubyn Centre, The NSFT CAMHS eating disorder nurse was nominated as Young Person C's care coordinator for the Trust. This is an appropriate action and enables all parties involved in her care to keep abreast of changes and progress. A letter was faxed to St Aubyn Centre to inform them of the decision on 14th March 2014.

4.6.1.49. The care-coordinator received copies decisions and outcomes of the St Aubyn MDT and weekly review meetings and they were duly filed in Young Person C's record. However they were not always noted or used to update the risk profile on the ePEX electronic case record as part of the Trust's ongoing risk, identification, assessment and contingency planning process.

4.6.1.50. The care coordinator received invitations to multi-agency CPA meetings arranged by the key worker at St Aubyn. She attended one on 11th April 2014 and a second on 30th May 2014. The NSFT care coordinator arranged to meet Young Person C prior to the 11th April CPA meeting and this would be good practice, but there is no record in the NSFT notes that confirms that the meeting took place or what was discussed.

4.6.1.51. A social circumstances report was prepared by the NSFT CAMHS care coordinator on 2nd June 2014 in preparation for a mental health tribunal review, highlighting that the risk of suicide should Young Person C be discharged. This would have been essential should the tribunal have taken place, but the application for the tribunal was withdrawn by Young Person C just over two weeks later on 17th June 2014.

4.6.1.52. Young Person C was visited by the NSFT care coordinator on 13th June when she learned of Young Person C's increasing self-harm and deteriorating condition generally. It was around this time that Young Person C's mother was also showing signs of distress about her daughter's deterioration and sense of hopelessness. A telephone call was received by the NSFT coordinator from St Aubyn Centre to request that NSFT CAMHS undertake a carer's assessment for C's mother. It is unclear from the NSFT documentation whether the care coordinator responded or that an assessment followed. The NSFT care coordinator was unable to attend the CPA meeting of 11th July 2014 due to transport problems and the St Aubyn Centre were informed by telephone the day before.

4.6.1.53. On 29th July 2014, a week before Young Person C's death, Young Person C's mother spoke an NSFT clinical psychologist on the telephone. Young Person C's mother had noted during Young Person C's home leave periods that she was distressed and had thoughts of suicide prior to returning to the St Aubyn unit in Colchester. Young Person C's mother concluded that having to return to the intensive care environment and being surrounded with very unwell young people was having a negative effect on daughter. She wondered if Young Person C would benefit from being moved to another unit and asked if this could be arranged. The likelihood of suicide was judged to be low but the clinical psychologist along with Young Person C's care coordinator agreed that the team at St Aubyn Centre needed to know about mother's concerns.

4.6.1.54. The plan was for Young Person C's clinical NSFT psychologist to telephone St Aubyn Centre to tell them about the conversation with Young Person C's mother and for the NSFT care coordinator to raise the concerns at C's next CPA meeting. The telephone call was not made by the clinical psychologist on 29th July due to 'telephone problems' and I have not been able to clarify what those telephone problems were.

4.6.1.55. The NSFT Serious Incident investigation report alludes to the content of mothers's conversation being passed to the St Aubyn Centre by the NSFT psychologist, stating that the issues were addressed on 31st July 2014. This event is not recorded in the NSFT chronology and there is no mention or record of this information being received in the evidence or chronology provided by the St Aubyn Centre.

4.6.1.56. The next CPA meeting would be scheduled for a date in August 2014 but Young Person C died before the meeting was held. The discussion with Young Person C's mother was the last time that NSFT were involved in Young Person C's case, and it appears from the evidence from NSFT and the record from the St Aubyn Centre that the important content of mothers conversation on 29th July 2014 relating to suicidal ideation may not have been shared or considered at the meeting on 31st July 2014.

Colchester Hospital

4.6.1.57. Young Person C attended Colchester Hospital Accident and Emergency department five times between the 2nd March and 11th April 2014. Four visits were in relation to self–inflicted injuries, and one for a routine wound dressing appointment. The clinical notes contain a full medical and social history giving a good account of Young Person C's injuries and proposed treatment. Young Person C's voice does not feature in the clinical notes.

4.6.1.58. The safeguarding aspects of the accident and emergency documents were not consistently applied as required by hospital policy. This meant that some of the information was not passed to the hospital safeguarding team for their attention. It was also noted that one of the attendances was recorded using an adult rather than a paediatric

record card. This is not uncommon in general Accident and Emergency departments where there is often confusion about the age of medical consent (16) and the age of 18 which applies to safeguarding. The CQC during an inspection became aware that this might be an issue for the department and the hospital are already taking measures to improve the way in which young adults are approached in the department. Suffolk LSCB will inform Essex LSCB of this finding.

Essex Constabulary

4.6.1.59. The incident that involved Young Person C running into the road was reported to Essex police by the staff at the St Aubyn Centre. They took the details of the incident and recorded them as information only. A decision was made not to pass the information to the Social Care team as a child coming to police notice because officers did not have direct contact with Young Person C. This seems a reasonable decision under the circumstances and is how many police services operate.

4.6.1.60. In some areas however, all children whether they are seen or not, who come to police attention are formally entered on police intelligence systems as children coming to police notice. The rationale for this is to ensure the intelligence is retained in a place that is easily accessible, in case the young person comes to their attention again.

4.6.1.61. The view of the SCR Reference Group is that as a minimum, Essex constabulary should flag any highly vulnerable young person coming to their notice who is receiving psychiatric intensive care on the appropriate intelligence system. Suffolk LSCB will communicate to Essex LSCB for the attention of their police partners. Suffolk Police already record all children coming to police notice on their intelligence system.

West Suffolk Hospital (West Suffolk Foundation Trust)

4.6.1.62. West Suffolk Hospital were involved with Young Person C twice during the SCR period. Once on 23rd August 2013 for a complaint of chest pain, and again when Young Person C injected herself with animal medicine on 4th August 2014. Her mother accompanied her on the first attendance and both parents were present at the second.

4.6.1.63. The clinical notes of the first visit diagnosed costochondritis. It was documented that Young Person C was a 'keen athlete' (this condition can be associated with exercise). They also mentioned that C had felt stressed by her exams. She was prescribed analgesia and sent home. The safeguarding procedures for the Trust require every child under 18 years to have an assessment that includes documenting any child protection concerns or parenting factors that may influence the subsequent care of the patient or any professional actions taken. The history for this presentation was 'sudden chest pain whilst walking the dog this morning.' No child protection concerns were identified so the decision to treat and discharge C was reasonable.

4.6.1.64. West Suffolk Hospital's Emergency Department managed the resuscitation attempt for Young Person C on 4th August 2014 and took measures to follow the county SUDIC protocol for managing sudden or unexpected deaths in childhood. Police were in attendance and the coroner was informed. The department also involved the Hospital Chaplain who supported the parents during the resuscitation attempt and after C had died.

4.6.2. Findings (Care Episode 3)

4.6.2.1. At the time of the incident St Aubyn was fully staffed. However some of the staff described a very hectic working environment at times when the needs of the young people were particularly demanding. The information reviewed and data from staff interviews demonstrated that practice followed a number of embedded organisational protocols and processes to enable constant monitoring of the patients in their care.

4.6.2.2. Young Person C was clearly central to her care and involved in decisions and care planning processes. Observations and interventions delivered by St Aubyn followed the least restrictive option to uphold Young Person C's rights and her care plans were influenced, agreed and signed by Young Person C. Notes record her wishes, feelings and responses, not always positive, to the care plans that had been drafted for her.

4.6.2.3. Young Person C's mother and father were supported well by the team at St Aubyn, although one member of staff feels Young Person C's father particularly could have benefited formal training about self-harm.

4.6.2.4. The staffs on the St Aubyn Centre appear to take their safeguarding responsibilities very seriously indeed. Risk planning and risk management for Young Person C was frequent and effective, in the knowledge that risks for young people with severe mental health disorders can never be mitigated entirely. Therapeutic risks were only taken following a robust assessment. Supervision was regularly available to staff, taken seriously and based on an organisational acknowledgement of the emotional impact of the work.

4.6.2.5. CPA and multi-disciplinary meetings were well attended and well documented demonstrating a willingness to work together with all interested parties. Evidence shows that St Aubyn Centre kept the care coordinator at CAMHS NSFT and the school informed of Young Person C's progress during her stay.

4.6.2.6. Record keeping was consistently good with decisions, outcomes and communications about Young Person C carefully documented. However, communication with the GP did not feature and this may be an issue that needs further exploration to ensure enough information is known by the wider children's sector to ensure the family can be supported adequately.

4.6.2.7. Staffs at St Aubyn were not entirely sure about the role and function of a Local Safeguarding Children Board. Currently membership is

through the Trust Head of Safeguarding. In relation to this finding the Head of Safeguarding for North Essex Partnership Foundation Trust will include a feature on LSCB responsibilities locally and nationally in the newsletter she prepares and circulates to staff on a regular basis.

4.6.2.8. Although there were several positive actions in relation to Young Person C's support, findings for NSFT mirror those in care episode one. Information sharing was poor or inconsistent and outcomes and responses were not always recorded adequately for example and the Trust system to record an ongoing risk profile on the electronic record was not updated as expected. An explanation as to why systems did not support record keeping or the sharing of information was not forthcoming from the evidence put forward to this review, but clearly there needs to be an organisational shift towards a much more robust approach.

4.6.2.9. The evidence pertaining to the attendances at the Accident and Emergency departments of Colchester Hospital and West Suffolk Foundation Trust was taken from the integrated chronology. For the recorded visits prior to 4th August 2014 the safeguarding elements of practice at Colchester Hospital were consistently poor.

4.6.2.10. The one visit to West Suffolk Foundation Trust prior to C's death followed the Trust's established child protection procedures. The practice following Young Person C's collapse was handled well both clinically and in safeguarding terms.

4.6.2.11. No root causes have been identified that suggest any agency was directly responsible for Young Person C injecting herself with animal medication or that any agency could have prevented what happened on that day. However there may be some contributory factors during this episode that may have indirectly and unintentionally influenced the outcome.

4.6.2.12. The findings for this episode of care have focussed mainly on the services delivered at St Aubyn in the five months prior to Young Person C's death, but lessons can be learned by all of the other agencies involved during this time, many being incidental to the outcome. Actions in relation to the incidental learning should be included in the single agency action plans developed for this SCR and submitted to the Suffolk LSCB when required.

4.6.3. Root Causes

No root causes were identified for any of the services or agencies involved with Young Person C between the 21st February 2014 and August 4th 2014.

4.6.4. Contributory Factors

Evidence and reflective practice by the staff at St Aubyn have identified that the risk assessment process undertaken prior to leave being taken did not focus enough on the environmental factors and the likelihood of harm.

Staffs at the St Aubyn Centre were not sufficiently culturally aware of risks and issues presenting in a farming environment.

If there was evidence to confirm that the information held by the NSFT Clinical Psychologist on Mrs C's concerns was passed to The St Aubyn Centre, or indeed evidence that the Unit at St Aubyn's had received it, then the lack of consideration of this information in the risk assessment could be presented as a contributory factor. Unfortunately the lack of evidence meant that the overview writer was unable to attribute this system failure as a contributory factor for either of the mental health trusts involved. However the issue of communication features in the recommendations for each of those organisations.

4.6.5. Incidental Learning

NEPFT (St Aubyn Centre)

- The Designated Nurse (North East Essex) for NEPT should work with The St Aubyn Centre to improve their understanding of the work of the LSCB and explore how to improve their links to their LSCB to ensure they are recognised as an important part of the safeguarding community.

- The St Aubyn Centre should ensure that robust systems are in place for receiving and sending information to other agencies, providing an audit trail of what is sent to whom and when.

Norfolk and Suffolk Foundation Trust

- NSFT should ensure that Care Coordinators meet their responsibility to update the ePEX electronic case record as part of the Trust's ongoing risk identification, assessment and contingency planning process.

- NSFT care coordinators should notify GP's of the progress of their registered patient as part of the care coordination process.

- NSFT should ensure that robust systems are in place for receiving and sending information to other agencies that can provide an audit trail of what is sent to whom and when.

Colchester Hospital

- Colchester Hospital Accident and Emergency Department should improve their systems for safeguarding young people between the ages of 16 and 18 years of age.

- A CQC action plan for safeguarding is in place regarding the safeguarding systems in Colchester Hospital and assurance regarding the implementation of that plan should be shared with Suffolk LSCB.

North East Essex CCG

- Commissioners for NEPFT should ensure that there are appropriate and sufficient services in place to enable support and training for parents/carers of young people who self-harm

Suffolk Local Safeguarding Children Board (LSCB)

- LSCB to consider utilising/developing a version of the Essex LSCB protocol regarding admission of young people to inpatient psychiatric units – this includes reference to assessment of a young person under s85 of the Children Act 1989.

Suffolk Children and Young Person Servies (SCYPS)

- CYPS to ensure they are complying with s85 of the Children Act 1989 in undertaking an assessment of the child/young person's needs on receipt of notification from the CCG that the young person has or will be accommodated by the CCG for three months or more.

5. Internal Investigation Process

5.1. One of the terms of reference for this SCR was to review the NHS Trust's Serious Incident Investigation Report submitted for this review to assess the adequacy of the findings and their recommendations.

5.2. North Essex Partnership University Foundation Trust (NEPFT) submitted a Serious Incident (SI) investigation report that was written on 27th August 2014 before the SCR process commenced. Norfolk and Suffolk Foundation Trust supplied an addendum to the NEPFT SI investigation report about their involvement dated 12th September 2014. This combined document was submitted to the SCR as a key data source.

5.3. The combined NEPFT/NSFT SI report indicates that a standard NHS root cause analysis approach was taken. The content focusses on clinical practice outlining what happened, when and what should have happened according to the Trust's policies and procedures. The information pertaining to why staff acted as they did and what was influencing their practice is not identifiable in the document. The findings pertain only to clinical practice and do not include safeguarding in its widest sense.

5.4. There are some references to Young Person C's presentation that describe her demeanour in relation to clinical decisions and actions, but neither NEPFT or NSFT give a sense of Young Person C, or explain why professionals acted or did not act, or address the inter-professional / multi-agency responsibilities for safeguarding and promoting the welfare of children.

5.5. In short, the NHS Serious Incident process has not suited the purpose for this SCR. A recent NHS England Policy Document 'Serious Incident Framework' (2015) has acknowledged that the Serious Incident process, which is designed primarily for incidents that occur in healthcare settings, is not necessarily useful for investigations that interface with other sectors and processes which have very different aims and purposes. The document concludes that there needs to be a coherent multi-agency approach and methodology agreed by LSCB partners that enables single agency accountability assurance and governance, whilst meeting the requirements of a SCR.

5.6. The standard NHS Root Cause Analysis (RCA) systems approach for clinical incidents can be loosely adapted for multi-agency reviews. RCA is designed to identify the factors that contributed to an incident, and seeks to understand the underlying causes and environmental contexts in which an incident happened. However it is essential that the leadership responsibility for collating data and providing evidence to the SCR is undertaken by NHS safeguarding professionals who fully understand the context of a safeguarding incident in terms of NHS and inter-professional practice.

5.7. Suffolk LSCB should ensure that it's Learning and Improvement Framework clearly sets out their expectations for SCR participation and also enables NHS providers to meet their own accountability, governance and assurance requirements.

5.8. NHS Trusts will need to be flexible and adapt their investigation processes to meet the Terms of Reference and timescales of the SCR and avoid duplication such as interviewing staff more than once and so on.

6. Conclusion

6.1. This SCR has looked at how organisations worked individually and together to safeguard and promote the welfare of Young Person C as whilst she was being treated for a mental health problem for a period of approximately twenty two months between October 2012 and August 2014 when she tragically died. Most of the evidence has been drawn from a comprehensive integrated chronology for ten agencies consisting of 320 key events.

6.2. The author has also reviewed the combined North Essex University Partnership Trust and Norfolk and Suffolk Foundation Trust Serious Incident Investigation Report that was undertaken immediately following Young Person C's death to check that the safeguarding elements were properly covered and to see whether the report could inform this SCR.

6.3. On close scrutiny areas of practice in need of single agency improvement were discovered for most of the organisations involved, although plenty of good practice was identified as well. None of this incidental learning would have had an impact on the final outcome for Young Person C or her family.

6.4. None of the agencies have been found to have caused the conditions whereby Young Person C was able to access and inject herself with animal medication during a visit to her father's farm.

6.5. The SCR has concluded, however, that the risk assessment process undertaken prior to Section 17 Leave of Absence for a restricted patient may have increased the likelihood of harm by not formally including the hazards of the environment that Young Person C was going to. An underlying reason for this was that the staff working in the psychiatric intensive care unit at the time were unfamiliar with farming practices and culturally unaware of farming life in general.

7. Themes

7.1. Some generalised themes have emerged in the analysis that apply to more than one agency. Suffolk LSCB will need to incorporate these themes as lessons learned from this review into its strategy for embedding the learning across the county.

7.2. Throughout the period of this review the NHS in Suffolk and nationally was in a state of transition as the reformed commissioning and provider structure was implemented. The change from long standing established systems to new arrangements and sudden changes of key personnel inevitably caused a period of confusion within health and the wider children's workforce.

7.3. Recommendation 8 of Professor Munro's review of child protection (2011) urged the Royal Colleges for Paediatrics, Child Health and GPs to research the impact of health reorganisation on safeguarding to ensure that children's safety would not be compromised, but this is work in progress.

7.4. Several practitioners involved in this review recalled that the unfamiliarity of the new systems and processes did introduce an element of risk as they tried to understand how systems would work in the new NHS landscape, and there is a sense that confusion still exists for some health practitioners and professionals from other agencies.

7.5. The accountability and assurance arrangements for safeguarding in the NHS are becoming clearer, but it is important that all of the Suffolk LSCB partners have a good understanding of what the local arrangements are now and what they may look like in the future, for example the Suffolk LSCB should ensure they are sighted on the transformation plans for children and young people's mental health and wellbeing which will articulate the local offer for the NHS England Taskforce 'Future in Mind' project.

7.6. Poor record keeping, information sharing and communication between mental health professionals occurred more than once in the analysis. This may be attributable to individual practitioner errors or systemic or cultural issues and is worthy of a closer look. Some practitioners participating in a reflective learning event thought that psychiatric staff are traditionally poor communicators with any professionals other than those from their own discipline. This generalisation suggests a possible systemic or cultural problem within the profession itself which is out of scope for this review, but NHS partners should wish to explore this issue to see if it is true for mental health services delivery in Suffolk Children and report back to LSCB.

7.7. The voice of Young Person C was not prominent in the evidence provided. There is little feel for how she engaged in her care or was able to influence it, and little in relation to how her rights as a young person were upheld. For example, attention to consent was poor in places. In contrast the sense of the needs of her parents was strongly represented. Professionals in Suffolk must ensure that practice is truly child centred. This issue has been identified as incidental learning for single agency attention.

7.8. Several of the agencies suggested that there needs to be more awareness in the children's workforce about the stigma of mental illness and recognition that more

effort needs to be made to support young people and their parents when mental illness, eating disorders or deliberate self-harm becomes a feature of their lives.

7.9. The last thematic finding for this review concerns agency participation in the SCR process. Many agencies and professionals were unclear of their role and responsibilities for the review and were unfamiliar as to how a systems approach is applied to a multi-agency SCR context. This is not surprising as there is little guidance available as to the best way to achieve this. Suffolk LSCB should review their current Learning and Improvement Framework and agree a process for the County that gives clarity to participating agencies as to what is expected and why when participating in a SCR.

7.10. Some of the systems changes that have been identified in this review have already been implemented or are in the process of being implemented as part of individual agency action plans. Suffolk LSCB should hold agencies to account for the implementation of the recommendations in this review. All agencies should undertake future safeguarding practice audits to ensure that improvements have been sustained.

7.11. Learning the lessons from this review will need to be undertaken across the children's sector. A plan, including a range of activities or events to embed the learning should be designed and agreed by Suffolk LSCB member agencies, monitored by the LSCB to ensure that the lessons have been distributed widely.

8. Recommendations

The recommendations take into account lessons learnt from closely analysing the evidence submitted for this SCR. Some of the lessons that emerged were 'incidental' and remote from the events that lead to Young Person C's death. They are however relevant to safeguarding children practice more broadly. The incidental learning is grouped for the agencies to rectify as part of their overall internal safeguarding responsibilities. Suffolk Safeguarding Children Board will require assurance that the incidental lessons and learning have been dealt with as part of agency improvement plans.

Some lessons however were directly linked to the outcome for Young Person C in some way and these are termed as contributory factors. In this review no root causes have been identified. However some of the lessons are described as contributory factors, due to their relevance to the final incident outcome.

Finally, there are recommendations that relate to thematic learning arising from this review, and recommendations for monitoring implementation for the attention of Suffolk Local Safeguarding Children Board, both intended to assist sustained improvement for the children's sector as a whole.

RECOMMENDATIONS	
	Incidental learning: All agencies
1	Within three months all of the individual agencies involved in this SCR should develop an action plan and audit the incidental learning attributed to their organisation (including those that apply to 'all agencies') in this report to ascertain whether the issues are generalised across their service provision or attention is required in one part of the system only.
	Contributory Factor NEPFT
2	Within six months NEPFT should enable staff working in Tier 4 Psychiatric Services to undertake cultural awareness training which includes issues relating to rural communities.
3	Within three months NEPFT should review and update the 'In-Patient Observation and Engagement Policy (March 2014)' to add as standard an environmental risk assessment prior to home leave being taken.
	Contributory Factor NSFT
4	Ensure that robust plans are in place to improve communication and information sharing between teams and with other professionals in the children's sector, including GPs, particularly when children and young people disengage from the service and to raise the standard of record keeping and provide an audit trail.
5	Ensure a robust system is in place for receiving and forwarding telephone messages that can provide an audit trail of what is sent to whom and the response or outcome
	Thematic: NHS Commissioners NHS England / Suffolk CCG
6	Within three months, the NHS commissioning partners (NHS England and Suffolk CCG) should provide assurance to Suffolk LSCB that the arrangements for all sub-contracted services delivering care to children and young people in Suffolk are mapped, clear and considered in Section 11 and practice audit arrangements.
	Thematic: Suffolk LSCB
7	Within three months, Suffolk LSCB should review its current Learning and Improvement Framework to ensure it sets out the expectations for SCR participation and enables all partners to meet their own accountability and assurance requirements.
8	By October 2015 the Suffolk LSCB should hold the agencies involved in this SCR to account by reviewing the single agency action and implementation plans developed in relation to the incidental learning identified in this SCR.
9	At least every six months, until they are assured that actions are complete, Suffolk

	LSCB should seek periodic assurance from the agencies involved in this SCR that lessons learned specific to their agency have been disseminated to the workforce.
10	Suffolk LSCB should agree an 'embedding the learning' plan to ensure the thematic lessons from this SCR reach a wide range of practitioners in the children's sector

9. References

Blakemore, S.J and Choudhury, S (2006) *Development of the Adolescent Brain: implications for executive function of social and social cognition*. Journal of Child Psychology and Psychiatry 47:3 (2006), pp 296–312.

House of Commons Health Committee (October 2014) Third Report of Session 2014 –15 Children's and adolescents' mental health and CAMHS. House of Commons London.

Intercollegiate Document 'Safeguarding Children and Young people: roles and competences for health care staff (2014)' RCPCH.

Jay, A (2014) Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013. Rotherham Council, p1.

Munro, E (2011) The Munro Review of Child Protection: Final Report A child-centred system. Department for Education Great Britain.

NHS England taskforce (2015) Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health.

NHS England Patient Safety Domain (2015) Serious Incident Framework: Supporting learning to prevent recurrence. Policy Document NHSE.

NICE Clinical Guideline 25 (2005) Violence: The short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. National Institute for Clinical Excellence.

Norfolk and Suffolk Foundation Trust (2014) *Non-access Visits and Missed/cancelled Appointments*. Policy Document.

North Essex Partnership University Foundation Trust (2014) *In-Patient Observation and Engagement Policy, version11.* Policy Document.

Primary Care Child Safeguarding Forum (2014) Safeguarding Children and Young People: The RCGP/NSPCC Safeguarding Children Toolkit for General Practice. RCPCH/NSPCC.

Turnell, A and Edwards, S (1999) Signs of Safety: A solution and safety oriented approach to child protection. Norton.