A system-wide independent investigation into concerns and issues raised relating to the safety and quality of CAMHS provision at West Lane Hospital, Tees, Esk and Wear Valleys NHS Foundation Trust

March 2023

Final Report – Advisory Notice

This report deals with difficult subjects relating to self-harm, the use of restraint and the treatment of young people. Limitations exist on the extent of publication of information on suicide and self-harm (Safety Alert NatPSA/2020/001/NHSPS published 03/03/20). Direct quotes from families, young people and staff are used to provide a first-hand description of events and we see it as important that those views are directly included. Whilst we have made efforts to use quotes which are not unduly descriptive about the mechanisms of self-harm we do advise caution in those who may be triggered by reading such information, particularly, that they are supported to read this report in a safe and supported way.

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Final Report March 2023

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

Our Report has been written in line with the terms of reference as set out in our Proposal of March 2020. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out of date.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

This is an independent report which has been prepared for NHS England and has been written for the purposes of publication. No other party may place any reliability whatsoever on this report, as this report has not been written for their contractual purposes.

Different versions of this report may exist in both hard copy and electronic formats, and therefore only the final signed version of this report should be regarded as definitive.

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Documents and reference materials: We have used an extensive amount of written evidence for the purpose of this review. This index can be made available on request.

Part 1 – Executive summary

Introduction

1.1 Niche Health and Social Care Consulting (Niche) were commissioned by NHS England in November 2019 to undertake an independent investigation into the governance at West Lane Hospital (WLH), Middlesbrough between 2017 up to the hospital closure in 2019. The terms of reference for this review do not include, unless for providing context on chronology, consideration of governance processes today or any remedial action taken by the Trust since 2019.

1.2 WLH was provided by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and delivered Tier 4 child and adolescent mental health services (CAMHS) inpatient services.

1.3 This review initially incorporated the care and treatment review findings of two index case events for Christie and Nadia who both died following catastrophic self-ligature at the unit. The Trust subsequently agreed to include the findings of the care and treatment review of Emily which related directly to her time at West Lane Hospital, even though Emily did not die at this site. This is to ensure that optimal learning could be achieved from this review.

1.4 Niche is a consultancy company specialising in patient safety investigations and reviews. The independent investigation follows the good practice described within the NHS England Serious Incident Framework[1] (March 2015).

1.5 The main purpose of an independent investigation is to ensure that serious and catastrophic incidents can be investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required, which could help prevent similar incidents occurring.

1.6 The terms of reference for this investigation are detailed in full within the Appendices of this report. They include but are not limited to:

- consider if there were effective and appropriate arrangements in place for the escalation of concerns and the resolution of family concerns and complaints;

- taking into account the size and geographical spread of the Trust, reviewing and assessing the efficacy of the Trust's clinical governance arrangements and processes, and the reporting of the same to the Trust Board, including whether the Board had a 'clear line of sight' of individual service areas/departments and any presenting issues;

- analyse the impact of the Trust being a New Care Model and how the Trust managed their responsibility to provide assurances to NHS England that patients in their services were in receipt of safe and high-quality care, and to assess the efficacy of NHSE assurance arrangements and processes with regard to this; and

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[1] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

- determine and test the robustness of overall governance, review and assurance processes of the Trust, NHS England local and the commissioner (CCG).

1.7 We would like to thank those who have contributed to this governance review and who assisted us with openness and candour during our fieldwork, even though this might have been distressing for them.

About this report

1.8 We have aimed, through this report, to safely surface the truth. However, we accept that there are instances where this report might be difficult to read, particularly for people who have used these services themselves and for their families. We also acknowledge that there were many staff who have been deeply affected by these events.

1.9 Many previous patients, families and staff have contributed quotes to this report. We have made all efforts to protect identities and to produce a report which is non-attributable and respects privacy. However, the families of Christie, Nadia and Emily have expressed their preference for us to use the first names of their daughters. The three girls were known to each other and were friends. All other quotes from families and staff have been anonymised.

1.10 We do not wish to cause the families of Christie, Nadia or Emily or any of the other families who contributed to our work, any distress through the process and the way in which we write our report. If, in the course of our work we are or have been responsible for causing any additional distress, we offer our most sincere apologies.

1.11 There is significant learning within the pages of this report, particularly in relation to the role of NHS boards, their oversight and accountability, the information they receive and the action they take in response to that information alongside key stakeholders. This report outlines the consequences of poor leadership and the combination of services which develop closed cultures, and the relationship of individual staff towards that culture.

1.12 The challenge of this report is to relate care and treatment decisions delivered within WLH to the evidence of fragmented oversight and poor or insufficient decision-making. During the period of care there were an exceedingly large number of care interventions, and many of these have been addressed in individual investigation reports. We use the basis of the combined care and service delivery problems to understand the deficiencies in governance relating to WLH which were abundant between 2017 up to the hospital closure in 2019.

1.13 This report involves multiple agencies spanning health, social care and education across a large geographical footprint. There is extensive learning to be gained in relation to inter-agency liaison, particularly between the local authority designated officer (LADO), the Care Quality Commission (CQC), Ofsted and local authorities in regard to the care and treatment of young people experiencing mental ill-health, autism and trauma.

1.14 The following summary provides an abridged overview of the key findings. The evidence which supports the summary findings is detailed extensively within the report pages. The summarised findings should not, therefore, be read in total isolation of the main report.

Summarised findings

Background and index events

1.15   TEWV provided Tier 4 CAMHS services from WLH until its closure. Tier 4 services offered included: specialist assessment and treatment for children and young people who have severe and complex mental health conditions and eating disorders that require treatment in hospital.

1.16   Forty-two of the Trust's 858 beds were children's mental health beds and were split across three wards:

Location	Ward name	Number of beds	Summary of service
West Lane Hospital	The Newberry Centre	14	Assessment and treatment for serious mental health problems (12 – 18 years)
West Lane Hospital	The Westwood Centre	12	Low secure (12 – 18 years)
West Lane Hospital	The Evergreen Centre	16	Specialist eating disorder treatment

1.17   On 7 November 2018 a young person complained of being inappropriately restrained in the Westwood Centre. This resulted in CCTV footage being reviewed, which supported the complaint "the index event". Following this, all CCTV footage of all restraints from the preceding four weeks was reviewed. Eighteen incidents of inappropriate restraint, predominantly involving three patients being dragged along the floor, were identified. This resulted in 33 members of staff being removed from duty and eight subsequently disciplined.

1.18   13 of the 33 staff were alleged to have observed but failed to prevent the inappropriate restraints. These staff were initially put on special leave and then suspended. Several staff were referred to the LADO after complaints from children and management raised concerns, and there were additional complaints from families. However, from the disciplinary hearings held in 2019, nine staff were then found to have "no case to answer" and no dismissals occurred.

1.19   The restraint issues in 2018 and resultant handling by the Board and leadership of Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) created an operating and care environment which was often, through our review, described as "chaos". A deteriorating spiral of poor care delivery ensued in the nine months between the suspensions and the receipt of the closure notice from the Care Quality Commission in August 2019.

1.20   This was, however, not until after the tragic deaths of two young people, Christie and Nadia, partly as the result of the care and misapplied controls at WLH. The third young person, Emily, died whilst in receipt of adult services at TEWV although this report also refers to the care she received at WLH.

1.21   Christie was a young person with complex mental health needs as well as autism and was a "looked-after" child. She had been receiving treatment in the Newberry Centre, WLH, Middlesbrough at the time of her death. She sadly died on 27 June 2019, after a series of brain stem tests demonstrated that she had irreversible brain damage following a self-ligature incident four days earlier.

1.22   Nadia was an inpatient in the Westwood Centre at WLH and on the morning of 5 August 2019, less than six weeks after Christie died, Nadia tied a fatal ligature and died on 9 August following a series of brain stem tests. Nadia had a diagnosis of autistic spectrum disorder (ASD).

1.23   Emily had been an inpatient in Newberry Centre until July 2019, and then moved to Ferndene, managed by CNTW. She was transferred to a TEWV adult acute ward in February 2020 when she turned 18 and took her own life one week later.

1.24   Niche Health and Social Care Consulting (Niche) were commissioned by NHS England in November 2019 to undertake an independent investigation into the governance at WLH, Tees, Esk and Wear Valleys, NHS Foundation Trust, Middlesbrough.

Service user experiences

1.25 During our review, we spoke to many families and invited substantial feedback from previous service users; some of this feedback is captured within this report and is, we are aware, difficult to read.

1.26 Our analysis of service user feedback[2] identified a striking and pervasive theme of insufficient attention and importance being applied to risk. Young people talked about how they perceived that the environment facilitated self-harm. This risk was often exacerbated by a lack of staff, and particularly skilled staff, in order to respond with appropriate methods when young people were self-harming. Service users did not feel confident that they were safe.

1.27 The unit was not structured and managed in a way that enabled service users regular and consistent access to the therapies they needed to recover, nor was there a planned, systematic, and individualised approach to care planning. Christie did not receive any targeted treatment for her diagnosis of emotionally unstable personality disorder (EUPD) or for her diagnosis of underlying post-traumatic stress disorder (PTSD).

1.28 Young people told us they were often treated in an uncaring way, and that verbal interactions were experienced as judgemental and at times felt abusive. Rather than simply being uncaring, some staff were perceived to be intentionally negative, and several interviewees described this as a form of bullying. The typical response to self-harm and suicidality was described by several interviewees as negative and punitive.

1.29 Every parent who spoke to us was unhappy with treatment of their young person at West Lane, we are aware that this will not represent the entirety of views about this service over several years of operation. Many views cited a lack of structure and therapy, a feeling that staff were not paying attention and that risks were not being managed. Family members and carers frequently described an environment in which they felt they could not safely raise concerns about the care their loved one was receiving. Many parents we spoke to felt actively judged and undermined by staff and others reported feeling a fundamental lack of confidence that raising concerns would result in positive change. There was a fundamental and consistent failure to inform parents about incidents involving their children under Duty of Candour (DoC).

The management of inappropriate restraint and the aftermath

1.30 Views from staff on the Trust's response to the November 2018 index incident ranged amongst interviewees from those that felt that the Trust dealt with an unprecedented situation in the best way possible, to those that felt there was a distinct lack of grip and oversight from Trust leaders. It is clear that this was a very complex situation to manage. The decision-making process applied to the mass suspensions in the wake of the 2018 inappropriate restraint incidents was, we found, widely criticised and we identified the lack of a clear audit trail to support the decision-making around disciplinary action. Equally, we found a lack of evidence to describe how decisions

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2 We conducted a series of interviews with ex-patients of WLH after we were contacted directly by those who wanted to be interviewed in relation to their experiences. Interviews were transcribed and then coded in order to identify common themes.

were re-visited, monitored and recalibrated; there was a lack of a clearly accountable leadership at all levels.

1.31 Following the suspensions, the WLH staff team was supplemented from elsewhere in the Trust, including Adult Mental Health Services (AMHS), Forensic, and Rehabilitation service. Time spent on the unit by senior leaders, including executive directors was also increased. Ward managers and modern matrons brought into the unit came from predominantly adult mental health services and there was a feeling that AMHS approaches became dominant during this time. We were repeatedly told that there were frequent differences of opinion and, at times, tension between CAMHS and AMHS staff: "the management structure of the unit changed, and the working ethos of the unit changed when the adult staff came in bringing the adult mental health care models". This was a view reflected by several staff.

1.32 There was a consistent failure to put the young people at the heart of care through access to qualified, experienced and compassionate CAMHS professionals.

Managing risk

1.33 One of the long-standing challenges facing the unit was an inconsistent workforce. Several service users and staff pointed to staff attrition as one of the factors that made the unit feel 'chaotic and unsafe' as it was often described. Young people lamented the lack of continuity of care, with some noting that having new staff undertaking interventions such as observations only heighted their sense of distress and vulnerability. New staff or staff who only worked on WLH wards intermittently did not know the individual needs of patients, which significantly undermined their ability to build and sustain a rapport and manage complex behaviour. We found no evidence that the impact of constantly changing staff on patients was acknowledged and effectively mitigated by the Trust's leadership.

1.34 There were repeated missed opportunities to respond to ligature risk at WLH, despite risks being identified via a variety of mechanisms such as safety alerts, near-misses, the Board's risk register, and post-incident debriefs. Examples include:

- Service-level risk registers did not capture known ligature risks and this fostered a tacit acceptance that ligature risks were simply part of the WLH environment.

- Incidents and near-misses highlighted potential ligature risks, including a failure to assess ligature points and implement effective ligature management training at WLH; however, there was a failure to act in response.

- An NHS safety note – Estates and Facilities Alert[3] – regarding ligature risk in September 2018 led to changes to the Suicide Prevention Environment Survey and the Risk Assessment Procedure, but this appears not to have been promptly and effectively translated into practice at WLH.

- Training to effectively respond to ligatures had not been undertaken at WLH.

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[3] **Estates and Facilities Alert EFA/2018/005: "Assessment of ligature points" (19 September 2018), produced in response to a Coroner's Prevent Future Deaths Report sent to NHS England after a patient killed themselves using a low-level ligature in an inpatient unit.**

- We also found that ligature risk assessment, review and monitoring was not meaningfully integrated into the Trust's governance structure for monitoring and oversight.

1.35   The Trust's failure to robustly address environmental risks at WLH created an over-reliance on observations to keep children and young people safe. There were several issues with observations at WLH, which led to the development of 'local' observation rules that were inconsistent with established Trust-wide policy. Observations were intrusive, often degrading and not applied in an individualised way.

1.36   Like observations, the use of anti-tear clothing was also frequently used in lieu of proactive behavioural reinforcement methods. This also was degrading to young people.

1.37   The concept of 'least restrictive practice' was broadly misunderstood and inconsistently implemented at WLH, and the impact of this on young people cannot be underestimated. Staff reported feeling unclear about what was acceptable practice. For example, staff reported that they were told not to intervene in incidents of self-harm until the situation became life-threatening. The reality of this was that children and young people would be allowed to cause harm to themselves before staff stepped in. Patients felt that they had to be alert to others self-harming and did not trust staff to keep them safe.

1.38   Young people were also allowed to decide whether they attended lessons and were not always stopped from bringing inappropriate high-risk and potentially lethal items onto the wards. There was confusion about what items should and could be restricted on the ward.

1.39   The Trust had developed an organisation-wide oversight group to implement a 'reducing restrictive practice' initiative. The implementation of this lacked a measured planned approach. Staff told us that ways of working would be changed overnight and communicated in handovers. They also note that a lack of a consistent staff group made it very difficult to make changes and support young people on working with new approaches.

1.40   The outcome as expressed by staff, parents and young people was that rules and boundaries became lacking, and wards felt chaotic. Examples of this are that school attendance dropped dramatically, and staff would be reluctant to intervene if there was challenging behaviour for fear of criticism for being overly restrictive. Young people would be in their pyjamas all day watching daytime TV and staying up at night on the internet or watching films.

1.41   Parents and young people told us that the boundaries about access to smart phones were changed. This meant that young people had unmanaged access to their smart phones, and so they could access inappropriate websites, such as those for self-harming, share pictures of other patients who had self-harmed and spend hours on the internet at night.

1.42   The use of and access to smart phones was seen as being compliant with ECHR (the European Convention on Human Rights) *Right to respect for private and family life* (article 8) as the devices facilitated family communications. However, access to smart phones became a blanket non-restriction for all young people on the unit, without

considering their individual needs and the needs of other people. Without 'care-planned' control of access to smart phones and certain websites the risks to some young people were exacerbated.

1.43   The use of restraint at WLH was excessive, inappropriate, and ultimately damaging to patients, as well as staff. The reasons for the poor deployment of restraint as a first-line intervention are complex and multifaceted. Staff told us that there was a general acceptance at WLH that T4 CAMHS patients needed to be restrained to be fed or to protect themselves.

1.44   Regular restraint was poorly identified and responded to at WLH. There was a consistent failure to identify when care and treatment provided at WLH was inappropriate and, at times, misapplied. There was a failure to put in place controls and checks to recognise when restraint was inappropriate or causing harm (as well as iatrogenic harm[4]). There was a lack of recognition that patients' right to be safeguarded under the Children Act 1989 was paramount.

1.45   Staff were struggling to cope with the complexity and demands of this patient cohort, and there is an argument to suggest that both patients and staff were experiencing trauma responses to how these frequent and distressing situations were managed. Little support was given to staff to assist in de-escalation, and it is likely that this contributed to an over-reliance upon regular and sustained restraint as a method of coping.

1.46   Many interviewees cited 'rising acuity' as one of the key factors behind the challenges at West Lane: "more young people were being admitted with increased acuity and a range of complex problems. This resulted in many more disturbed young people and a significant increase in acuity which was not appropriately responded to." Staff from other care environments emphatically rejected this claim, stating: "from my perspective that they were not alone in having those issues – they weren't singled out, and every other service had been running smoothly with an inflow and outflow of staff and a level of acuity (rising nationally) that was being managed effortlessly".

Care culture at WLH

1.47   WLH was described with striking frequency as a "closed culture" by interviewees. When we interrogated over what was meant by this description, we were told that the unit did not feel like an integrated part of the Trust: it could be hard for new staff to feel welcomed and integrated, and local practices could be developed which were not always consistent with Trust-wide policy. It was regularly characterised as "geographically isolated" in that it was not connected with any other inpatient areas, which reduced opportunities for staff to engage with those from other parts of the Trust.

1.48   Several staff recalled the same experience of being surprised at the lack of collaboration between the three wards at WLH. One member of staff described

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4 *the harm caused inadvertently by the process of treatment. This may manifest as uncertainty and anxiety caused to the patient by a failure of staff to provide them with important information regarding diagnosis, treatment, or discharge planning; adverse reactions to drugs; negligence; or unnecessary treatment resulting from a psychiatrist's decision.* Sarah Markham: Dealing with iatrogenic harm in mental health – The BMJ.

moving from Newberry and being told that they could not sit and eat with the Westwood staff at mealtimes.

1.49 Additionally, a lack of robust service-level leadership was repeatedly cited as one of the key contributory factors underpinning the dysfunctional service-level culture. There was an absence of effective leadership at WLH, which meant that the tendency of the service to be inward-looking remained unchecked, practices at odds with Trust policy and values were not challenged, and the managerial line of sight to the service was fractured.

1.50 Ineffective escalation mechanisms and fundamental weaknesses in the function of key meetings resulted in a failure of corporate oversight of quality and safety at WLH. We found numerous missed opportunities for concerns about care and treatment at WLH to receive the attention and response they required from those responsible for governance and oversight at the Trust.

Corporate governance

1.51 We found evidence to suggest that the Board was overly accepting of verbal reassurance in relation to quality and safety across T4 CAMHS. We also found a failure to identify contradictions between verbal reassurances and other sources of information linked to WLH. The Quality and Assurance Committee (QuAC) assurance report received by the same meeting noted that the service remains under pressure, in part due to the need to integrate new staff. The Board were not cognisant of the unintended consequences associated with bringing in new staff to a service.

1.52 There was insufficient curiosity regarding the culture at WLH: at the same meeting the Board discussed the impact of retirement on staffing levels and the need to focus on retire and return "in order to maintain the balance of experienced and newly qualified nurses". There is no evidence that board members sought to understand the underlying reasons for high staff attrition at WLH. Asking the right questions might have revealed that staff were leaving due to stress and reduced wellbeing, which is indicative of a service in potential distress.

1.53 The Executive Management Team (EMT) was too far removed from WLH to identify the escalating risks associated with operations, quality and safety. A review of EMT minutes and papers in the two years prior to the 2018 inappropriate restraint incidents found the oversight of locality and service-based issues to be superficial with an over-reliance on verbal summaries from the Director of Operations regarding the most pressing issues.

1.54 The Trust's governance framework placed disproportionate emphasis on operational performance rather than quality and safety. In the years leading up to the closure of WLH, there was an organisational preoccupation with the numbers of reportable issues, as opposed to meaningful interrogation of themes and trends in order to identify and respond to emergent risks and ensure safe and high-quality care for patients.

1.55 Incident reporting gave false assurance about the true nature of incidents at WLH and focused on the quantity of incidents rather than what they indicated about the quality and safety of care and treatment. For example, the Patient Safety Group (PSG) Quarterly Quality Report (Reporting Period: 1 January 2019 to 31 March 2019)

reports that the "number of incidents reported at West Lane Hospital has decreased" (referring to 1,069 incidents). Similarly, the report for the following quarter (1 April 2019 to 30 June 2019) reports the "number of incidents reported at West Lane Hospital has decreased" (referring to 991 incidents). This does not concur with the incident numbers reported on Datix. Our analysis shows that there were 1,348 incidents reported on Datix between January and March 2019, and 1,415 incidents between March and June 2019.

1.56   There was a tolerance amongst leaders of high numbers of incidents at WLH coupled with poor benchmarking and insufficient professional curiosity regarding incident levels. Several interviewees spoke of a pervasive attitude that high restraint incidents were to be expected for a service like T4 CAMHs. We found no evidence of effective assurance seeking in relation to the underlying causal factors for increasing level of self-harm incidents at WLH.

1.57   The Board Assurance Framework (BAF) (used by the Board) was detached from the reality of the organisation. The BAF presented to the Board at the end of July 2019, for example, made no reference to the CQC enforcement notice received a month earlier. The minutes of this meeting show that, whilst the BAF was discussed, Board Members (BMs) did not identify this significant omission. The BAF was also only updated to reflect risks associated with WLH in December 2019, three months after the closure of the site.

1.58   Reporting was disjointed between each level of the Trust's governance structure, a feature exacerbated by a tendency towards introducing multiple new reports and dashboard formats without these being properly tested or embedded. We also found that management information was often presented at an aggregate Trust level which provided insufficient 'line of sight' to emerging risks in WLH, where, under deeper scrutiny, red flags were evident. The ability of the Board to 'drill-down' into service-level data was lacking as was the responsiveness to the clear information presented.

Inter-agency working and regulatory oversight

1.59   Working Together[5] guidance stipulates that "there is a shared responsibility between organisations and agencies to safeguard and promote the welfare of all children in a local area". However, there is no evidence that there was a collaborative effort by the Trust or its partners to ensure that there was a robust safeguarding framework in place to protect children and young people at WLH. The lack of clarity regarding commissioning responsibility and quality oversight in relation to T4 CAMHS extended to safeguarding; the impact of this was that, prior to November 2018, there was little scrutiny of safeguarding processes or risks at WLH by commissioners, the LADO or the CQC.

1.60   Minutes reveal the primary safeguarding focus was on training across the organisation and meeting key performance metrics, rather than safeguarding associated with care and treatment. We were told that there was an awareness amongst locality leadership that WLH was an area of concern for the safeguarding team from 2018 onwards; however, attempts to work with the Trust's safeguarding service were often met with resistance from WLH staff.

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5 Working Together to Safeguard Children 2018 (publishing.service.gov.uk)

1.61   We were told that there was a robust process to safeguard any under 18 patients who were admitted to adult wards. However, it was found during the course of the review that this process was not consistently followed and, therefore, under 18s were sometimes admitted to adult wards without the Trust's safeguarding team being involved.

1.62   There were "quite fundamental disagreements" about the respective roles and responsibilities of the LADO and the Trust in the investigation of allegations and the requirement to share information. After a review of the communication between the Trust and the LADO in response to the August 2018 referral in relation to Christie's care, we found significant deficiencies in the Trust's response, as well as a lack of assertiveness from the LADO given the severity of the allegations.

1.63   The quality of care provided to children and young people at WLH was undermined by a complex and frequently disparate commissioning landscape. Interviewees frequently raised the issue of a lack of role clarity between NHSE as the specialised commissioner and the local CCGs. A lack of clarity about the statutory functions of commissioning bodies involved in WLH directly resulted in a failure to ensure the safety and quality of services provided.

1.64   The CQC had been aware of risks to the care and treatment of children and young people over 12 months prior to their issuing of the closure notice. We found evidence that suggests that prior to November 2018, the CQC's scrutiny of safety at WLH lacked rigour, for example – the CQC sought information on StEIS-reportable incidents. The focus on only StEIS incidents gave a subjective view of safety at the unit, as it was overly reliant on self-reporting. In July 2018, the CQC received a complaint about the use of restraint in the service, however this did not trigger a more extensive review of service-wide incidents. Greater depth of scrutiny would have alerted the CQC to the concerning pattern of restraint incidents, coupled with the evident lack of analysis and learning on the part of the Trust.

1.65   The Trust created an action plan to address the concerns raised by the CQC in June 2019. However, we found no evidence that this action plan was subject to Board-level scrutiny at this time. This is particularly surprising given that Christie died on 21 June, when the CQC had been on site only two days before.

New Care Models

1.66   The Trust was awarded New Care Models[6] (NCM) 'wave 1' pilot status for T4 CAMHS in September 2017 and was also included as a 'wave 2' pilot site in partnership with NTW (now CNTW). The purpose of the pilot was to reduce the number of children and young people being admitted to out-of-area inpatient beds and to redivert funding to prevention strategies in community CAMHS.

1.67   Interviewees voiced their support for the strategic aims of NCM; however, several felt that the operational implementation of NCM at WLH lacked strategic clarity and many shared the view that the pilot increased risk at WLH. Many perceived that patient

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[6] In January 2015 the NHS invited local health partnerships to apply for 'vanguard' status for the new care models programme, as an early step towards delivering the NHS *Five year forward view* and supporting service integration and improvement. Over 260 health and social care partnerships expressed interest in developing one of the models to transform the delivery of care for their local populations.

acuity increased significantly as a consequence of NCM. Whilst we acknowledge the challenge in evidencing a direct causal relationship between NCM and patient acuity, many staff held the view that the drive to keep patients close to home, coupled with a national shortage of specialist beds, led to, arguably, a more complex patient mix at WLH, as less were being sent to specialist placements. We also acknowledge the complexity of understanding iatrogenesis in mental health, particularly in young people and how this might contribute to rising acuity.

1.68   An unforeseen consequence of NCM was lower engagement between staff at WLH and NHSE Specialised Commissioning, this diluted opportunities for external scrutiny of the service in the lead up to the index incident. The shift towards managing patients closer to home wherever possible led to more local management of cases, which was typically led by the Heads of Service (HoS) rather than NHSE Specialised Commissioning case managers, thereby reducing professional contact.

1.69   We have made a number of recommendations both for TEWV and a number of agencies discussed within this report. Where recommendations have multiple components, these are classed as 'compound elements'. It is important to note that the Trust no longer provides T4 CAMHs services. The following recommendations have been made because they have relevance to other services provided by the Trust, to the Trust's wider governance framework, or to the effectiveness of partnership working across the local health economy. We recommend strongly, that a multi-agency assurance review is undertaken in 6-12 months to assess progress on the changes arising from this work.

Summary of recommendations

Recommendation 1 (TEWV): It is clear from our research that patients and their families (and some staff) were ignored and that their concerns and complaints are now found to be, on the whole, justified. The Trust must seek assurance that complaints, concerns and feedback are taken seriously and managed in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 particularly in relation to recording receipt of a formal complaint. Additionally, feedback and concerns on a service must be comprehensively reported and reviewed on a frequent basis, and importantly, that feedback is acted upon.

Recommendation 2 (TEWV): Formal corporate decision-making processes and outcomes were difficult to trace and evidence. The Trust should seek assurance that there is a ratified minute of key organisational decisions.

Recommendation 3 (TEWV): Action plans relating to West Lane Hospital were not connected to improvement programmes or risk registers. The Trust should ensure that there is strategic oversight of actions through the Board, Committee or working group where multiple interventions are involved. This will ensure that actions are not duplicated with other activities or overlooked. Using a programme approach around improvement plans and risk registers increases the accountability and enforceability around actions.

Recommendation 4 (TEWV): There were issues with the consistent application of Duty of Candour at the Trust. The Trust should seek assurance that there are now mechanisms in place to assess that the Duty of Candour Policy is effectively implemented. Additionally, where there has been a death in a service, whether

through self-harm/suicide or homicide, that families are given appropriate, meaningful, timely and compassionate family liaison and support through personal contact with a nominated officer of the Trust.

Recommendation 5 (TEWV, CNTW, North East & North Cumbria ICB, Middlesborough Council, NHSE and provider collaborative, and CQC): TEWV, CNTW and System Partners need to seek assurance that they have resolved the problems associated with the clinical transitions phase (between services and child to adult). A compound recommendation is required to address this deficit:

a) TEWV must provide assurance that a full gap analysis between the 2018 Healthcare Safety Investigation Branch (HSIB) investigation and its own position has been completed. As the Trust still delivers Tier 3 CAMHS services they should expedite a review of processes and procedures in relation to transitions.

b) CNTW need to expedite a review of processes and procedures in relation to transition of CNTW young person inpatient to adult services.

c) Patient as well as stakeholder feedback associated with transitions between CAMHS and other services (such as AMHT) should be sought and incorporated into service redesign by all parties.

d) Effective governance surrounding transitions was not always in place. The good practice relating to transitions which is described within NICE Guidance should be translated into practice and delivered by all parties.

e) Where a young person is in receipt of T4 care and transferring back to T3, there must be a joint response between health and the relevant local authority children's services (in this case Middlesborough Council) so that the young person is prepared for life in the community and can be properly supported and their risks appropriately managed.

f) ICBs, NHSE and provider collaboratives must ensure that providers with a PICU have a written protocol that details the pathway for discharge, including timescales for involving in arrangements, the families and the young person. This will ensure that, wherever possible, a young person is not suddenly transferred without adequate preparation.

Recommendation 6 (TEWV): There was a gap between the development and successful implementation of important care initiatives (such as least restrictive practice), plans and evidence-based changes to practice. The Trust must seek assurance that there are implementation plans for new initiatives, policies or procedures and that these are evidence-based, being implemented correctly within services and monitored appropriately.

Recommendation 7: There was a lack of systematisation in relation to the identification, mitigation and actioning of known risks at a ward, service and corporate level. A compound recommendation is required to address this deficit:

a. TEWV must ensure that risk assessments for young people in CAMHS are based on a psychological formulation and are developed by a multidisciplinary team in conjunction with the young person and their family.

b. TEWV must ensure that proper training is provided to staff around clinical risk management and how to ensure that action is taken consistently.

c. TEWV must provide assurance that it meets the requirements of the new Patient Safety Incident Response Framework by 2023.

d. The North East & North Cumbria Integrated Care Board (ICB), NHSE, and provider collaborative must seek assurance that TEWV has a robust environmental and ligature risk assessment process and the ability to respond effectively and urgently to mitigate risks identified through this process (including risks identified on Tunstall Ward).

e. North East & North Cumbria Integrated Care Board must assure themselves that CNTW are following the NHS Child and Adolescent Mental Health Services Tier 4 (CAMHS T4): General Adolescent Services including specialist eating disorder service specification and the QNIC standards for use of mobile phones and social media access in inpatient environments.

f. The application of robust risk assessment forms part of the CQC regulatory framework. The CQC should routinely examine the quality and consistent application of TEWV's clinical risk assessment, clinical risk training and the relationships to local and corporate risk registers.

Recommendation 8 (TEWV): The function of Executive team meetings in terms of operational involvement lacked clarity. The Executive team meetings must clearly define and record actions which they are directly responsible for, or, where actions have been delegated. The ET should recognise that it has the mandate to form task and finish groups.

Recommendation 9: Safeguarding between mental health providers and system partnerships was insufficient to protect young people in West Lane Hospital. Despite the availability of Working Together Guidance, responsibilities and obligations internally and externally between agencies (providers and system colleagues) were confused, interpreted differently by individuals and consequently gaps developed. A compound recommendation is required to address this deficit:

a. NHS England Specialised Commissioning, the North East & North Cumbria ICB and provider collaborative and the South Tees Safeguarding Children Partnership Board and LADO should now all reflect upon matters raised within this report and determine whether further internal review is required to ensure proper learning occurs within each respective agency. All relevant Safeguarding Children's partnerships need to ensure that there are sufficient mechanisms in place to prevent a recurrence of the same.

b. The North East & North Cumbria ICB and provider collaboratives should obtain assurance that provider organisations have sound systems and processes to safeguard young people in mental health facilities, and these provide regular robust assurance to NHS England Specialised Commissioning of effective working.

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

d. Local Authorities and Health providers must provide appropriate challenge where there are concerns about unsafe discharge arrangements from Tier 4 inpatient care, including appropriate escalation up to chief officers where concerns for children's safety are high.

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

f. North East and North Cumbria Integrated Care Board and the Provider Collaborative must consider the impact and risks on Tier 4 CAMHS if a local Safeguarding Board is found to be weak or inadequate, or a local provider is found to have a major staffing issue.

g. Where Safeguarding concerns are raised about a child, these must include a formal consideration of other vulnerable family members for the lifespan of care.

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

Recommendation 10 (TEWV): Reporting structures were disconnected between various tiers of governance, and this prevented the 'drill-down' required for effective oversight and effective learning. The Trust must ensure rounded reporting arrangements to support proper Board assurance consisting of both hard evidence and soft intelligence. This should include a 'trigger tool' when a ward or department is experiencing 'stress', such as failing to complete training, debriefs, high sickness absence, low staff morale and this should be viewed alongside patterns of incidents, harms and complaints.

Recommendation 11: There were gaps in relation to both the commissioning of effective services and in relation to the regulatory oversight in relation to West Lane Hospital. Assurance seeking activity was weak with a lack of sufficient scrutiny of both hard and soft intelligence. A compound recommendation is required to address this deficit:

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

b. NHS England Specialised Commissioning, the provider collaborative and the North East & North Cumbria ICB, should work together with the Directors of Children's Services in the North East region. This is to ensure that services are commissioned which will meet the needs of the growing number of young people with complex needs and challenging behaviours that require integrated health and social care responses.

c. A demand and capacity review (under the provider collaboratives programme and in association with each local authority) should be undertaken to ensure services have the appropriate capacity locally to minimise placing children out of area and to ensure the availability of suitable specialist care.

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

Recommendation 12: (NHS England) A full assurance review of progress against the recommendations contained within this report must be completed in 6-12 months. This should include all recommendations and all participant bodies.

Part 2 – Investigations and governance review

Approach to the individual investigations and governance review

2.1   This review was commissioned by NHS England North East and Yorkshire regional team and follows the NHS England Serious Incident Framework (March 2015) – this is now the Patient Safety Incident Response Framework (PSIRF). The terms of reference for this investigation are given in full in Appendix A. This review follows three in-depth investigations of young people in receipt of Tier 4 services at TEWV who were able to catastrophically self-ligature.

2.2   The three cases all relate directly to care delivered at WLH, whilst it was Christie and Nadia who died at the site. We would like to thank all three families for their participation in the investigations, which have provided significant areas of evidence for this broader review of governance.

2.3   The governance review team at Niche comprised:
- Kate Jury, Partner responsible for the governance review
- Nick Moor, Partner responsible for the individual care and treatment reviews
- Carol Rooney, Associate Director
- Sophie Stephenson, Governance Specialist
- Danni Sweeney, Senior Consultant

2.4   We have used procedural information and clinical records provided by Tees, Esk and Wear Valleys NHS Foundation Trust.

Interviews and quotes

2.5   We conducted over 100 staff interviews via Microsoft Teams; key interviews were recorded and transcribed, with transcripts returned to the interviewees for review. We conducted a further 16 interviews with previous inpatients and families, which were recorded and transcribed. We also met with the families of Christie, Nadia and Emily several times during the course of fieldwork.

2.6   Staff interviewed were selected on the basis that they either had direct interaction with Christie, Nadia and Emily, or, were involved in the governance and management of the unit or of the Trust more broadly.

2.7   We have used several verbatim quotes through the course of this review, and we acknowledge that these quotes contain some emotive language. Previous service-users and family members who were interviewed or provided their quotes were more likely to express strong deficit-based views to the review team; those views are valid and important. We have reflected only a small sample of the broader comments which were often not appropriate for publication. We were not contacted by individuals expressing positive views of this service and we accept that different views may exist about this service. In order to provide, where possible, a balance of view we compared views expressed about this service to views expressed about other services within the Trust.

2.8   These views and quotes remain the working property of Niche Health and Social Care Consulting to retain privacy. We have also consulted broadly with other experts in commissioning not directly related to this case.

2.9   For the purposes of this report, individual health and social care professionals have been referred to by their post title or code to protect the identities of individuals still in practice.

Investigation quality control

2.10   Interested parties are given the opportunity to provide factual inaccuracy responses to a draft investigation report, and individuals, where needed, have been provided with a right to reply through their representative organisations. These are carefully documented along with any changes which result from feedback. No party has the right to amend or dictate our work in any way, regardless of bill-payer.

2.11   At Niche we have a rigorous approach to quality standards. We are an ISO 9001:2015 certified organisation and have developed our own internal single operating process for undertaking independent investigations. Our final reports are quality assured through professional standards review (PSR) process and approved by an additional senior team member to ensure that they have fully met the terms of reference for review. This report has been extensively peer reviewed within Niche by experienced mental healthcare professionals prior to distribution.

Part 3 – Overarching timeline of events

Pre-2018

3.1   TEWV was created in April 2006 as a result of the merger of County Durham Council and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust. In July 2008 the Trust was awarded foundation trust status under the National Health Service Act 2006.

3.2   In June 2011 and as part of the Transforming Community Services (TCS) initiative, the Trust adopted the contract to provide mental health and learning disability services to the people of Harrogate, Hambleton and Richmondshire, and in October 2015, TEWV adopted the contract to provide mental health and learning disability services to the Vale of York.

3.3   Prior to the closure of WLH, TEWV offered Tier 4 CAMHS services, which included specialist assessment and treatment for children and young people who have severe and complex mental health conditions and eating disorders that require treatment in hospital.

3.4   Forty-two of the Trust's 858 beds were children's mental health beds and were split across three wards:

Location	Ward name	Number of beds	Summary of service
West Lane Hospital	The Newberry Centre	14	Assessment and treatment for serious mental health problems (12 – 18 years)
West Lane Hospital	The Westwood Centre	12	Low secure (12 – 18 years)
West Lane Hospital	The Evergreen Centre	16	Specialist eating disorder treatment

3.5   The Trust was managed via a locality structure. Until August 2016, T4 CAMHS sat within the Yorkshire locality when it then transferred to the Tees locality. The rationale for this was primarily due to the location of the inpatient CAMHS service; WLH is based in Middlesbrough, which sits within the Tees locality footprint.

Christie ('Christie') – case precis

3.6   Christie was a young person with complex mental health needs and was a looked-after child. She had been receiving treatment in the Newberry Centre, West Lane Hospital, Middlesbrough at the time of her death. She sadly died on 27 June 2019, after a series of brain stem tests demonstrated that she had irreversible brain damage following a self-ligature incident four days earlier.

3.7   Christie had a troubled early life and had a complex and emerging mental health disorder, with emotional dysregulation leading to serious self-harm and violent assaults on other people, most often perpetrated when being restrained to prevent

her self-harming. Christie was admitted as a mental health services inpatient on 10 occasions in total. She was detained under the MHA on 11 occasions, seven under Section 2 MHA, three under Section 3 MHA and once under Section 4 MHA. In total she spent 556 days as a detained patient in just under three years. She did not receive any specialised inputs to help her deal with her past trauma and diagnosed PTSD and very little targeted support with her diagnosis of borderline personality disorder (BPD). Christie was also strongly suspected to have ASD, but this was never formally assessed.

3.8   During Christie's mental health treatment, she was placed multiple times in adult inpatient units, acute placements and, more concerningly, a range of hotels. This was often due to a lack of availability of age-appropriate beds but also because at least one provider had refused to allow her to return to her placement. This was also due to the impact of staff suspensions on capacity at WLH.

3.9   After her admission to Ferndene and then the Newberry Centre, she was eventually placed in her own rented accommodation by social services. She was 17 years old and had not been given any support in learning the skills required to live on her own. The impact that this instability and recent or frequent change had on Christie was never fully understood, yet it was clear that shortly after any admission or significant change, Christie's self-harm behaviour escalated. We can see that the move to living alone in May 2019 led to an escalation in Christie's self-harming and believe that this change and its impact failed to trigger sufficient concern with the care team.

3.10   In March 2019 the clinical team at the Newberry Centre changed their approach to Christie in line with the TEWV Protocol for the Reduction of Harm in Young People With BPD, which recognised that there were risks associated with admission and heightened observations for Christie. As a response, a 'less is more' approach to her care was agreed, where she would be supported to take more personal responsibility.

3.11   However, her risks never reduced, and she continued to use multiple mechanisms for self-harm. The biggest risk to her life was from self-ligature and yet there was nothing in her care plan to address approaches to managing this risk. At the same time, TEWV were also responding to an NHS Estates and Facilities Alert (EFA) from 2018 which highlighted concerns about low-level ligature risks. We found no evidence that these risks were addressed adequately despite prior opportunities for learning. This oversight presented the opportunity and mechanism for Christie's fatal self-ligature.

3.12   Our investigation identified 31 care delivery problems which occurred during or just after Christie's care in WLH, and 20 service delivery problems. These problems were multifaceted and systemic and included insufficient staffing, low staff morale, ineffective management of change, lack of leadership, aggressive handling of disciplinary problems and failures to respond to concerns from patients and staff alike. This was all set within the context of weak safeguarding, a lack of suitable placements and a unit which was struggling to cope with rising patient acuity.

Nadia ('Nadia') – case precis

3.13   Nadia was an inpatient on the Westwood unit at WLH, under the care of TEWV. On the morning of 5 August 2019, Nadia tied a fatal ligature and died on the 9 August following a series of brain stem tests. Nadia had been under the care of the TEWV community CAMHS since 2012. She was initially referred due to problems in school, and psychology reports showed a learning difficulty.

3.14   In April 2016 she was diagnosed with ASD[7] by a multi-agency autism assessment team. There were concerns raised about her aggression towards family members and controlling behaviours at home, which had become worse over the previous year.

3.15   Nadia had a series of periods of care in WLH, including on Newberry and Westwood wards. Her first admission to West Lane was to Newberry ward in November 2016, and she was transferred to a psychiatric intensive care unit (PICU) in Bury for seven months. In under three years Nadia was subject to 10 different placements including (latterly) an adult placement.

3.16   From December 2018 Nadia was living in her own flat and was provided with an individual package of care by Thornbury Community Services[8]. The clinical records show that as risks increased, she was admitted back to a hospital environment for short periods. The funding and resources for the Thornbury Community Services package of care remained in place, and the intention was for her to move back to her flat.

3.17   During the three years of care that Nadia received we found that there was a consistent and insufficient recognition of risk, compounded by the fact that autism-targeted care was not consistently provided to Nadia. She was also receiving care from members of staff who were not experienced in CAMHS, and there was insufficient training in risk management protocols.

3.18   We have identified 26 care delivery problems during her care, and 20 service delivery problems that occurred in her care, across the various agencies. These problems were multifaceted and systemic and included insufficient staffing, low staff morale, ineffective management of change, lack of leadership, aggressive handling of disciplinary problems and failures to respond to concerns from patients and staff alike. This was all set within the context of weak safeguarding, a lack of suitable placements and a unit which was struggling to cope with rising patient acuity.

Emily ('Emily') – case precis

3.19   Emily did not die at West Lane Hospital as with Christie and Nadia, however, we have included the case of Emily because she received significant care at the site during two episodes; January to February 2018 and March to July 2019.

3.20   Emily was 18 years old when she died. She tied a fatal ligature just after 2pm on 13 February 2020, while an adult inpatient at Tunstall Ward, Lanchester Road Hospital,

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

[8] Thornbury Community Services is an independent provider of healthcare services. https://www.thornburycommunityservices.co.uk/

Durham (TEWV). CPR was commenced and she was transferred to University Hospital of North Durham by ambulance, however, she sadly died two days later on 15 February 2020 after a series of brain stem tests.

3.21 On 10 January 2018, a referral was made for a Tier 4 CAMHS inpatient bed.[9] Following an extended period of community-based care and therapies aimed at reducing her self-harm (predominantly cutting and overdosing). Emily was admitted to Newberry Ward on the 11January and after her initial assessment her observation levels were set at six observations per hour and three engagements per shift with a plan to maintain home visits.

3.22 Emily's discharge date was set for the 25 January with planned crisis support arranged within the community. Emily's parents felt that the discharge was too soon and that her risks of self-harm were too high with too little progress. Emily's parents were reassured of the approaches but relationships between the ward and the family started to disintegrate from here on in.

3.23 For almost the next year Emily was supported in the community, however, her low mood and incidents of self-harm continued. Emily was admitted to Newberry Ward again in March 2019, after being detained under Section 2 MHA. In April 2019 the Section 2 MHA was converted to Section 3 MHA with a working diagnosis of emotionally unstable personality disorder (EUPD).

3.24 During her periods of care on Newberry Ward staff were working to a protocol which stated that "Young people [with borderline personality disorder] are [much] safer when they take responsibility for their own actions instead of relying on others or on services to keep them safe. Clinical teams should convey through their words and actions that the young person with a diagnosis of BPD+ is able to, and does, hold responsibility for their wellbeing. The protocol also states that "optimal care for young people with a diagnosis of BPD+ involves providing just enough intervention".

3.25 Our investigation found that a key issue relating to this guidance is that it was consistently open to misinterpretation, and consistent, experienced CAMHS staff would be required for the protocol to be effectively implemented. These staff were not consistently available during Emily's second admission in 2019.

3.26 Emily's family consistently expressed frustration that staff did not intervene straight away to stop their daughter, rather than trying to encourage her to stop by using her own coping techniques (as the protocol had suggested). Emily's family were increasingly concerned that the ward was unable to keep her safe and wanted her placed in a room where she was unable to access any mechanisms of self-harm. Emily's de-escalation box whilst on the ward contained significant high-risk items which could allow her opportunities to cause self-injury.

3.27 Emily was regularly restrained whilst on Newberry Ward in response to her escalating risks. Medications were also given under restraint, including rapid tranquilisation when lorazepam failed. Emily was transferred to Ferndene Ward in July 2019 and then onto an adult ward where she fatally self-ligatured; those transitions were managed badly.

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[9] On the NHS England Form 1.

3.28   Our investigation found 8 Care Delivery Problems, 5 of which relate directly to West Lane Hospital and 6 Service Delivery problems, 3 of which relate to West Lane Hospital. Again, these problems were multifaceted and systemic and included insufficient staffing, low staff morale, ineffective management of change, lack of leadership, aggressive handling of disciplinary problems and failures to respond to concerns from patients and staff alike. This was all set within the context of weak safeguarding, a lack of suitable placements and a unit which was struggling to cope with rising patient acuity.

October and November 2018 'index' incident overview

3.29   On 7 November 2018 a young person complained of being inappropriately restrained in the Westwood Centre. This resulted in CCTV footage being reviewed, which supported the complaint. Following this, all CCTV footage of all restraints from the preceding four weeks was reviewed. Eighteen incidents of inappropriate restraint, predominantly involving patients being dragged along the floor and involving three patients, were identified. This resulted in approximately 33 members of staff being removed from duty and 18 were subsequently disciplined.

3.30   13 of the 33 staff were alleged to have observed but failed to prevent the inappropriate restraints. These staff were initially put on special leave and then suspended. The disciplinary hearings held over the next six months created fear and anxiety amongst staff, who were fearful of losing their job, their Nursing and Midwifery Council (NMC) registration, and even contact with their own children[10]. Several staff were referred to the LADO after complaints from children and management raised concerns, and there were additional complaints from families. However, from the disciplinary hearings held in 2019, nine staff were found to have "no case to answer".

3.31   We have referred to this event as the "2018 inappropriate restraint incidents" throughout the report.

Combined care delivery problems

3.32   There were clear synergies between care failings delivered to Christie, Nadia and Emily, which are summarised below:

- Care plans were not sufficiently targeted at individual need; they were too generic.
- Care plans were often incomplete, with regular use of 'copy and paste'.
- Lack of positive behavioural support (PBS) focus in care plans.
- Appropriate and sometimes basic psychological interventions were not available.
- There was frequent poorly planned and implemented transitions between services (discharge, CAMHS and adult).
- There was insufficient ongoing close liaison with the local authorities relevant to each young person.
- Documentation was often incomplete, with observations not recorded or notes not made on a contemporaneous basis.
- Staff did not always record their involvement in incidents of restraint.
- Risk assessments were often incomplete or poorly described.

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[10] Because the allegations were harm to a child.

- Poor translation of identified risk into risk management plans.
- Reassessment of risk was weak.
- Risk mitigations were not always implemented (contraband items found).
- Lack of triangulation of information to inform safeguarding, and lack of safeguarding escalation.
- Family felt that they were not heard, and services were not always inclusive.
- Breakdown in trust and relationship allowed to develop between staff and families.
- Duty of Candour was not applied after incidents, and this was not checked. Families were often not informed following incidents.

Combined service delivery problems

3.33 There were clear synergies between service failings for Christie, Nadia and Emily which are summarised below:

- Key protocols unclear to staff. Guidance is not always clear and well-articulated (i.e. how to remove ligatures/access to social media).
- Lack of skills and training in BPD and trauma-informed CAMHS approaches. This was detrimental.
- Consistent lack of analysis of patterns of harm.
- Investigations were not always conducted, and learning was not followed up.
- Known environmental risks were not fully mitigated through remedial activities.
- There was poor introduction of new practices.
- There was a poor response to concerns raised by staff, patients and families.
- Learning lessons was consistently inadequate.
- Safeguarding protocols were not always followed through (particularly allegations about staff).
- There was a mismanagement of incident responses.
- The environment was not appropriate or supportive for ASD.
- Lack of staff, lack of expert staff, lack of consistent staff.
- Lack of training in de-escalation.
- Insufficient triangulation of data on care quality.

Combined system problems

3.34 There were consistent issues relating to 'the system' identified in all three cases:

- A lack of shared clarity about the statutory functions of commissioning bodies.
- Insufficient oversight of incidents from commissioners, one commissioner stating: 'we didn't commission the service'".
- The CCG and NHSE Specialised Commissioning confusion around quality monitoring and safeguarding assurance.
- NHSE and CQC focused predominantly on incident reporting provided via StEIS, rather than seeking more thorough incident assurance and analysis.
- NHSE Specialised Commissioning lacked responsiveness to signs of escalating risk at WLH prior to the November 2018 incident.
- NCM increased acuity and risks at WLH.
- Communication between the CQC and LADO was insufficient in response to concerns.

- CQC provided inadequate scrutiny and received simplified explanations from the Trust.
- Inadequate safeguarding provision/safeguarding deferential to health.
- Confusion around the police investigations' interaction with the Serious Incident Framework.
- Poorly managed transitions between services.
- Risks of unregulated accommodation and lack of Ofsted oversight.
- Lack of whole pathway commissioning and inter-agency working.

Impact

3.35   It is important to attempt to quantify the impact of healthcare incidents – not only the immediacy of the incidents of harm themselves, but also the broader impact which extends significantly outside of the families and services themselves, in this case these include:

- The impact upon the families and friends of these young people who have catastrophically self-harmed cannot be measured. This is not only immediate family members but also extended family, friends, teachers and the many people who were involved in the lives of these young people.
- We also, in this case, recognise the impact upon the staff who were working to deliver care in often difficult circumstances.
- There were consequences in terms of other service users as a result of the closure of this hospital, and this exacerbated an already very challenging regional problem with the availability of CAMHS beds.
- The reputation of the Trust has been affected and will continue to be affected, which can result in a loss of public confidence, although this is harder to quantify.
- The reputation of CAMHS services nationally will likely face greater scrutiny as the result of this case, although it is important that the learning from this case is cross-referenced with multiple CAMHS, specialist and private services.
- There has been a cost to the public purse not only through the funding of this investigation but also the costs of service closure, diverting resources and legal fees associated with defending claims.

Recommendations

We have provided a full list of recommendations in 1.27. We have only made recommendations where we feel there are still residual gaps despite the closure of the unit.

Part 4 – Service-level governance

Putting young people first

Listening to young people – service user feedback

4.1 Our analysis of service user feedback[11] identified a striking and pervasive theme running throughout all interviews: that of insufficient attention and importance being applied to risk. Under this theme, young people talked about how the environment facilitated self-harm, a risk often exacerbated by a lack of skilled staff and a lack of staff in general to respond effectively when young people were self-harming. Attitudes of staff were perceived as uncaring and judgemental. The often-perceived dismissive attitude of staff to young people and their condition/s added to interviewees' sense that WLH was a risky environment in which to be an inpatient.

Key themes we identified in the feedback from young people:

Powerlessness

4.2 This was a feature of all interviews, and we identified four core components to this theme:

- Embodied distress – this concept refers to the way in which young people's distress became manifested in their physical state. Some felt that their need to self-harm (often cutting or headbanging) increased following their admission, as a direct result of the environment, culture and patient mix.

- Repressed feelings – young people shared the sense that their feelings could not be expressed during their inpatient spell, often due to a lack of confidence that staff were willing or able to listen and respond appropriately.

- Indignity – a striking feature of the experiences that young people described was the experience of being treated with a lack of dignity.

- Concerns for the safety of other patients – several young people spoke about their lack of confidence that fellow patients were safe, which created an additional pressure of feeling responsible for one another.

> "They let me do a degree of harm to myself which I know now should not have been possible."
>
> "They made me feel that I'm just a waste of a bed."
>
> "Men would restrain me when I was completely naked."
>
> "I would have to wait for staff to take me to the toilet but they never came; it led to me having to go to the toilet on a towel and a bucket."
>
> "… at a mealtime when all the staff were down in the dining room and I had to cut off another patient's ligature because there were no staff and they wouldn't come down. They said it's protected mealtimes, if you want to do those things to yourself that's not our problem".

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[11] We conducted a series of interviews with ex-patients of WLH after we were contacted directly by those who wanted to be interviewed in relation to their experiences. Interviews were transcribed and then coded in order to identify common themes.

Concerns about skills and resources

4.3 There was recognition of 'good' staff at WLH from several interviewees who cared and tried to do their best, despite the pervading challenges at WLH. The lack of staff, coupled with increasing reliance on agency staff and staff with limited CAMHS experience, reduced patients' confidence that they were safe.

> *"There were a lot of good staff there, and they were trying really hard to support the bad staff."*
>
> "There was never enough staff; there was constant agency staff on my observations who didn't know what they were doing. I was left with nobody that I knew."

Staff attitudes

4.4 Young people told us they were often treated in an uncaring way, and that verbal interactions were experienced as judgemental and at times abusive. Rather than simply being uncaring, some staff were perceived to be intentionally negative, and several interviewees described this as a form of bullying. The typical response to self-harm and suicidality was described by several interviewees as negative and punitive.

> "Some were helpful and would try to sit with you but the majority would just leave you to it in the room. They wouldn't do anything about it most of the time. They would either walk off and say, 'You need to stop doing this' and leave and not come back for an hour or two."
>
> "I remember so many staff members said to me, 'Well, it's not tight enough yet [the ligature] so we'll intervene when it's tight enough.' I would just be left, sat there waiting for it to get tighter and waiting for it to actually have an effect before they would intervene."
>
> "I was called a maniac, a stupid little girl – lots of comments like that. I was told, if you really wanted to kill yourself, you would be dead by now."
>
> "A lot of the time, no one would do checks, so the observations were very ad hoc and, even if you were on five-minute checks, they wouldn't happen."
>
> "… they were very strict on searches [in another hospital], whereas the Newberry, you could get anything you wanted – absolutely anything in there."

Person-centred care

4.5 Service user and family/carer feedback (see sections 4.13 and 4.21) highlighted that there were some dedicated and skilled staff who went above and beyond to help young people at WLH. We found, however, aspects of the culture at WLH to lack sufficient emphasis on the individual and allowed behaviour which could be uncaring and ultimately unsafe to go unchecked. Often described by staff as "chaotic", the unit was not structured and managed in a way that enabled service users regular and consistent access to the therapies they needed to recover, nor was there a planned, systematic and individualised approach to care planning.

4.6 Care at WLH was more often than not described by staff and service users alike as reactive, rather than planned. This was symptomatic of the "chaotic"

characterisation of the unit, as found in all three individual investigation reports. Care plans tended to be generic rather than tailored to individual needs, and we found several examples of 'copy and paste' entries between care plans, as well as examples of incomplete care plans and oscillation between the use of the 1st person and 3rd person.

4.7 Care plans should be co-authored, and yet we found several examples of care plans being jargonistic and using language that a young person would not use. Poor care planning and care plan documentation makes it difficult for all members of the healthcare team to pick up and follow the support plan, and fundamentally undermines the clinical impact of care plans.

4.8 There were attempts to embed PBS[12] into care planning; however, the service never achieved a consistent, embedded PBS practice. We were told that there was a "lack of understanding" over how PBS could be used effectively in an inpatient setting and that there was a lack of training for ward staff in a PBS approach. This further contributed to the sense of reactivity that was endemic on the ward.

4.9 Appropriate therapies, including those which we would describe as basic psychological interventions, were not always made available to young people at WLH. It was recommended, for example, that Christie be provided with dialectical behavioural therapy[13] (DBT) and trauma-focused therapy, and there was a six-month period during 2019 that it was repeatedly flagged that Christie both wanted and would benefit from psychological support. Whilst there were initial attempts to provide DBT, we found no evidence that appropriate trauma therapy was provided. We recognise that this may in part have been due to Christie's willingness to engage with therapies; however, there is no evidence that the provision of such therapy was given sufficient urgency and attention. This was likely exacerbated by sporadic gaps in psychology provision due to vacancies.

4.10 There was a lack of engagement in training to support patients, such as Nadia, with specific needs, which further impacted the extent to which staff knew how to manage and respond to individual needs. For example, Thornbury Community Services staff visited Nadia regularly whilst she was admitted to Westwood and offered to train Westwood staff in autism-specific approaches as well as spend time with Nadia on the ward. Both offers were refused, ostensibly due to operational pressures.

4.11 There were limited activities provided to young people at WLH, and the profile of occupational therapy (OT) was very low, despite the OT suite at WLH being well-resourced. Several interviewees also made the connection between the lack of ward-based activities, an increase in boredom and an increase in acuity. We would expect to see a consistent programme of skills groups, as well as entertainment

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[12] PBS is "a person-centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge. It is a blend of person-centred values and behavioural science and uses evidence to inform decision-making ... Behaviour that challenges usually happens for a reason and may be the person's only way of communicating an unmet need. PBS helps us understand the reason for the behaviour so we can better meet people's needs, enhance their quality of life and reduce the likelihood that the behaviour will happen."

[13] Dialectical behaviour therapy, or DBT, is a psychological treatment to help:
people who may have difficulties managing their emotions; and
those displaying borderline personality traits who may be using coping strategies that have a negative impact on their lives, e.g. self-harm, chaotic and risky behaviours.

and enrichment activities to enhance the wellbeing of young people, prepare them for life after their inpatient spell, and ultimately help them to reach their recovery goals. The May 2019 Positive and Safe Steering Group, a forum designed to monitor the implementation of the reducing restrictive practice initiative, was informed that feedback from young people was that there is a lack of activities on the unit and minutes document it being agreed that work would be done to address this. There is, however, little evidence that changes were made before the closure of the unit.

4.12 One of the long-standing challenges facing the unit was an inconsistent workforce. However, we have found no evidence that the impact of constantly changing staff on patients was acknowledged by the Trust's leadership. Several service users and staff pointed to staff attrition as one of the factors that made the unit feel chaotic and unsafe. Young people lamented the lack of continuity of care, with some noting that having new staff undertaking interventions such as observations only heighted their sense of distress and vulnerability. New staff or staff who only worked on WLH wards intermittently did not know the individual needs of patients, which significantly undermined their ability to build and sustain a rapport and manage complex behaviour.

Listening to family and carers – feedback about their experiences

4.13 It was striking how frequently family members and carers described to us[14] an environment in which they felt they could not safely raise concerns about the care their loved one was receiving at WLH. Many parents we spoke to felt actively judged and undermined by staff at WLH. Others reported feeling a fundamental lack of confidence that raising concerns would result in positive change.

4.14 A theme running throughout the interview feedback was parents'/carers' cynicism about attitudes to accountability at WLH, which included: not being told or having things explained when they went wrong; being ignored if they raised concerns; or receiving an unsatisfactory response to concerns raised and complaints made. This, in turn, fostered the perception that there was often no likely benefit from engaging with staff, asking questions and raising concerns.

4.15 Key comments made by parents and carers in relation to a poor accountability culture included:

> "It seemed like they didn't want parents to mix, in case we were all thinking the same, I think. Nobody would take any responsibility or accountability for anything that happened, including the Ward Manager".
>
> "There [was] no visibility of senior managers on that unit."
>
> "Where were the managers and how did they not recognise the unit was not being managed well and the lack of care for the patients and parents, for that unit to get so bad? What are we paying people for? They either ignored it or, in my opinion, never came on to the ward and ensured the right care was being received."

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[14] We interviewed a sample of 16 parents, family members and carers to seek their perspectives on how effectively the Trust engaged with them, listened to their concerns and enacted change where required. We deployed the same approach as that used with ex-patients of WLH to that in interviews with parents, families and carers of young people who had been cared for at WLH. Paragraph 2.5 outlines more detail in relation to this exercise.

Feeling bullied and judged

4.16 One of the most consistent experiences of parents was the degree to which they felt undermined, undervalued and had their opinions discounted. Parents told us there was little respect for the perspective of parents on their children's care, and a sense of being judged because their children were in hospital. We identified three core components to this theme:

- parents/carers feeling bullied;

- parents/carers being made to feel culpable in their children's admission and/or condition; and

- parents/carers not feeling listened to.

> "We felt we were being manipulated into not making more fuss about things, by [senior manager name] being nice to us."
>
> "I was asking how staff could allow two patients to fight with each other. She manipulated it to make it sound like, if we took it any further, [name] would be dragged in, the police might be involved, and X, Y and Z. It would be more of an assault charge, and that felt threatening to us."
>
> "West Lane made me feel like the shittiest mother about. I just used to sob, and sob, and sob, and sob. I was thinking, they are going to take her away from me, they are going to make up something."
>
> "Don't attack the parent. When they can't find a fix, it is the parent's fault. Not all of us are abusers."
>
> "The consultant was very dismissive of any views that we had. He had his own ideas around not wanting to try to get any form of diagnosis. We wanted some kind of answers, and he even wrote that in one of their reports: 'parents obsessed with their need for a diagnosis'."
>
> "From start to end we were just regarded as a nuisance. We'd book visits, we'd turn up for visits and then, more often than not, some reason why the visit couldn't take place."

Poor management of self-harm

4.17 A lack of confidence in how staff may have prevented self-harm, how they reacted to it and the management of the self-harm incident, was related by every parent that we spoke to. Of particular concern was regarding how the communication about an injury was managed and the treatment and care provided.

> "A lot of the comments and the impressions that I had were that they saw these children as a nuisance."
>
> "Laughing at him, taking the mick out of the way he talked, and the way he dressed. It was just brushed underneath the carpet."
>
> "It was a major incident. They basically just said to me it's my fault." [Parent]
>
> "I had many conversations with [senior staff] about ligatures […] their motto was – and they were very open about it – it's tough, you tie a ligature, it's only important when you pass out."

Concerns about care and treatment

4.18 Every parent who spoke to us was unhappy with treatment of their young person at West Lane. The ways in which this was expressed was as a lack of structure and therapy, a feeling that staff were not paying attention and that risks were not being managed.

> "We sat down and agreed an action plan, with dates on, and none of it was ever followed through, it was just left, really."
>
> "It was like *Lord of the Flies*: they would all be in a cohort either just watching telly or running round."
>
> "He was expected to get reasonable GCSEs, pass however many, and they were just not interested. They've stolen his life. He has no education now."
>
> "They never got [name] up at a sensible time in the morning. They let him stay up until God knows when at night."
>
> "The whole of her forearm was red, swollen, hot, and I remember I looked at it and said to her, 'Oh my God, that's infected, are you on antibiotics?' She said, 'no'."

Concerns about skills and staff attitudes

4.19 Parents reported that there were some skilled and well-intentioned staff; however, their overriding sense was of a staff cohort that lacked the skills and experience to effectively care for their children, with some reporting the sense that staff afforded young people insufficient attention. Parents also recalled a growing sense of unease throughout 2019 due to an increase in agency staffing and an increasing sense that staff did not know their children sufficiently well to provide effective care.

> "The dietician was really good, and the psychologist was excellent. Without those two, I don't know what we'd have done, really."
>
> "Staff would be in their office with the door closed."
>
> "Another thing that happened there was that they were so short staffed and there were a lot of agency staff. That impacted on the level and continuity of care, and also on the morale of people working there."
>
> "When we were told about the dragging incident, they said that instead of having a longer-term talking-down regime that you might want to have, that wasn't always possible due to staff shortages and so on."

4.20 The Trust was aware that there was a weakness in its approach to listening to parents and carers prior to the closure of WLH; however, we found little evidence to suggest that this was effectively addressed. In August 2018, the Executive Team received a presentation in a 'time-out session' titled: "What issues are being uncovered in serious incidents and how should we address them?" This identifies a theme of families and/or carers not being involved sufficiently; however, there was no corresponding action, nor have we seen evidence that this weakness was closely monitored by the Executive Team following this session. Over one year later, another Executive Team time-out session considered the Teeside Patient Safety Report, which again identified the need to improve family and carer

engagement following incidents, and again limited action was identified to address this issue.

4.21 Several young people experienced care at Ferndene after they were inpatients at WLH. Whilst acknowledging that there were also issues at Ferndene, parents and carers were struck by the improved levels of compassion and care that both young people and they received in comparison to WLH. The following comments were made in interviews:

> "Completely different, completely different. There was more compassion, more understanding […] keeping you involved. They cared. You weren't a number."
>
> "Completely different care, completely. Half of me thinks, if he went to Ferndene at the very beginning, the outcome would have been a hell of a lot different."
>
> "[X] from Ferndene was amazing. What a fantastic consultant he was. Any questions, he would ring you, regular contact with you all the time. I would email him and he would email me back."

(Recommendation 1)

Response to the 2018 inappropriate restraint incidents

4.22 Views from staff on the Trust's response to the November 2018 restraint incident ranged amongst interviewees from those that felt that the Trust dealt with an unprecedent situation in the best way possible, to those that felt there was a distinct lack of grip and oversight from Trust leaders. The decision-making process applied to the suspensions in the wake of the 2018 inappropriate restraint incidents was widely criticised and we found a lack of clear audit trail to support who made the decision and on what basis. Accounts of the way in which the decision was made varied significantly amongst interviewees. The role of executive directors in the decision to suspend 33 members of staff is explored further in section 5.3.

(Recommendation 2 and 3)

4.23 The Trust acknowledged that its disciplinary policy was designed for individual cases, and not for cases such as the mass suspensions and disciplinaries that occurred after the CCTV footage was examined. We understand the Trust has now updated its disciplinary policy to ensure its applicability in the future.

4.24 The majority of staff were critical of communication with CAMHS staff as the CCTV was being analysed and staff suspended or being asked to take special leave. We understand that the suspensions took place over a two-week period; this was the time it took for CCTV to be reviewed and a decision about individual staff involvement made. The Trust maintains that it was unable to communicate effectively with staff during this time due to the ongoing disciplinary process; however, there was acknowledgement from some interviewees that "we didn't manage that time [immediately after November 2018] very well".

4.25 We were told that staff would simply be removed from the wards, and there was no explanation regarding whether this was due to sickness or due to the Trust determining culpability in relation to inappropriate restraints. This caused significant anxiety and distress for the remaining staff working on the unit. The Trust also described the incident initially as a "moving and handling incident"; this added to the confusion about what had happened.

4.26 Many staff were angry, as they were told by the staff originally involved that they were using "agreed practices". Staff described being in a constant state of anticipation about whether they would be next to be suspended, and equally felt a sense of loyalty and defensiveness towards their colleagues, who many felt had been unfairly treated by the Trust.

4.27 Staff were critical of the Trust's approach to communication in the aftermath of the 2018 inappropriate restraint incidents. We were told that the Trust did not inform staff why colleagues had been suspended, what the outcome of a disciplinary was, or whether and when staff would be returning to their jobs. This resulted in information that we would expect service management to relay, such as the imminent return to work of a colleague, being shared on social media, as well as incorrect information about the circumstances of suspensions further strengthening the view that the staff involved had been "hard done by".

4.28 Many ward staff felt "hurt" by the lack of a clear message from management about the 'manual handling' (restraint) incident and what it was as well as the incremental suspension of staff. They felt there was a completely inconsistent application of new initiatives on reducing restrictive practice.

4.29   The view that suspended staff had done nothing wrong was felt by several interviewees to have created a division between long-standing staff on the unit, and staff drafted in to support the wards following the 2018 inappropriate restraint incidents. This led to differences of opinion in relation to decisions taken on the unit and a perceived cultural divide. One interviewee summed this up by stating that "the staff were angry that their colleagues had been suspended, that they had done nothing wrong, so they were never going to accept anybody else coming in because they just wanted their staff back".

4.30   Re-enactment and reflection sessions of the restraint were held in November and December 2019 (and later in January 2020) to describe to staff why the restraint was inappropriate conduct, 12 months after the initial incident. The sessions included a presentation and a summary paper of themes. It was only after the re-enactment of the 2018 inappropriate restraint incidents that there was a greater appreciation of the need for management to act. Several interviewees lamented the amount of time that lapsed between the suspensions and the re-enactment and felt that this promulgated "myths" that destabilised the culture of the unit.

4.31   The reason for a 12-month delay between the incident and re-enactment remains unclear and represents a key failing in the Trust's response to the incident.

Impact of the 2018 inappropriate restraint incidents

4.32　Following the suspensions, the WLH staff team was bolstered elsewhere in the Trust, including Adult Mental Health Services (AMHS), Forensic, and Rehabilitation service. Time spent on the unit by senior leaders, including executive directors was also increased. Ward managers and modern matrons brought into the unit came from predominantly adult mental health services and there was a feeling that AMHS approaches became dominant during this time. We were repeatedly told that there were frequent differences of opinion and, at times, tension between CAMHS and AMHS staff: "the management structure of the unit changed and the working ethos of the unit changed when the adult staff came in bringing the adult mental health care models". This was a view reflected by several staff.

4.33　A key example given repeatedly by staff interviewed was the approach to least restrictive practice: we were told that AMHS staff encouraged as much autonomy as possible and would state that patients needed to take responsibility for their actions. Access to mobile phones and adherence to set bedtimes was generally relaxed as a consequence. Some CAMHS staff felt that this approach portrayed a lack of understanding of the needs of children and young people and an under-appreciation of the need for stricter boundaries than would be found in an adult inpatient setting.

4.34　The managers who were "parachuted in" from AMHS were aware that they were all seen as lacking the skills to deal with young people and several describe this period as being "the hardest job they have ever done". They also felt they were doing a job of, according to one interviewee, trying to 'steady the ship' within the confines of no plan and no supporting leadership.

4.35　There was a lack of organisational oversight of the risks associated with amalgamating staff from different backgrounds with different skillsets onto a ward with a complex patient cohort. Given the severity of the incidents and the turmoil that the unit had been through in the ensuing months, we were surprised to find that there had been relatively little involvement from the Trust's organisational development (OD) team, however a return to work process was in place for the staff suspended or on special leave that was facilitated by the nursing and Governance Team along with Safeguarding, Organisational Development and Head of Nursing. Staff were, however, made aware of the Employee Support Service and we understand that the Trust's Health and Wellbeing Lead and the Head of Organisational Development increased their presence at WLH in the aftermath of the incident and provided some one-to-one and group sessions, that also included sessions on the Trust values, resilience, raising concerns, and whistle blowing. The Trust also commissioned an independent listening exercise with all staff to reflect on their experiences.

4.36　The unit was repeatedly described as "chaotic" in the months after the November 2018 restraint incident. Some staff who were asked to work at WLH at this time reported feeling "shut out" and described it as a "closed culture".

Duty of Candour

4.37　We found three key failings in the Trust's approach to its DoC, namely:

- The Trust's DoC policy has a weak interpretation of national regulation, lacking in detail and specificity (we explore this further below).

- We found examples of a minimalistic interpretation of DoC requirements which often lacked compassion and consideration of the readers' feelings and circumstance.

- The Trust did not have a governance process to ensure DoC requirements were being adhered to, to assure the Board of its compliance, and to proactively identify and address any areas of weakness/non-compliance.

Duty of Candour policy

4.38 We have reviewed the Trust's DoC policy in place at the time of the index incidents[15]. We found several weaknesses in this policy, namely:

- Responsibility for DoC compliance is delegated to clinical teams, referred to as "MDT"; however, this is not defined or clarified, which raises the risk that responsibility is not well understood.

- The timescale by which written communication should be made to a family is not defined.

- The policy is silent on the governance process to monitor the compliance, including the relevant Board committee responsible for seeking assurance on DoC policy compliance.

- The policy contains no guidance to the reader on how different approaches should be deployed with different patient and family groups. We would expect a robust DoC policy to include consideration of those with learning disabilities, cognitive impairment, language or cultural considerations and any specific communication needs.

4.39 The Trust's Incident Reporting and Serious Incident Review Policy[16] also makes reference to DoC; however, similar issues apply. For example, the policy lacks specificity in relation to who is responsible for complying with DoC when it states: "The Ward/Team/Unit Manager will ensure the Duty of Candour/culture of candour processes are implemented in line with the Duty of Candour policy." Later in the policy, it states that "the HoS is notified of requirement to undertake a review and any required actions monitored by the Quality Assurance Group (QuAG) and if Duty of Candour has been fully implemented".

DoC oversight

4.40 We found there to be a material gap in the Trust's oversight of DoC compliance. Not only was there no central recording system which enabled the Trust to record and track DoC notifications, but there was no clearly defined and understood process to provide ward-to-Board assurance that DoC requirements were well understood and followed in practice.

4.41 We also found missed opportunities for those responsible for governance at the Trust to strengthen DoC. In March 2018, Quality and Assurance Committee (QuAC) received the output of a clinical audit on DoC. The minutes of this meeting note that "the group acknowledged that the audit results were concerning and agreed that further work on the policy was required. It was agreed that a re-audit would take place." We can see that the Patient Safety Group assurance reports

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[15] CORP-0064-v1.1 DoC policy Being Open, Honest and Transparent, 2016.
[16] Incident Reporting and Serious Incident Review Policy, Ref CORP-0043-v8.2.2017.

received throughout 2018 include the same sentence: "work is ongoing to ensure appropriate protocols are in place for demonstrating compliance with DoC". It is not clear what this work was or how its impact was understood.

4.42 In November 2018, Board of Directors' meeting minutes state that "assurance was provided that the learning from the incidents would examine the reasons why the Duty of Candour and Freedom to Speak Up processes had not been implemented"; however, we found little evidence that this was followed up on.

4.43 A document entitled Early Learning Themes Report, dated February 2020, highlights that DoC requirements were not being fulfilled although the report remains silent on why this was the case or what would be done to remedy the deficiency.

DoC application

4.44 The TEWV policy on DoC[17] states that, "we must act in an open, honest and transparent way with service users and/or relevant persons in relation to care and treatment provided whilst carrying out a regulated activity". It goes on to specify that it "applies to any unintended OR unexpected notifiable safety incident that could have or did lead to harm for anyone to whom we provide care and treatment". We note that the definition of a notifiable incident in the Trust's policy is too narrow when compared to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20(2), however, we understand that this has now been addressed.

4.45 The separate investigations into the care and treatment of Christie, Nadia and Emily found a number of ways in which DoC requirements were not complied with or where compliance was superficial and at odds with the spirit of DoC; this is outlined in more detail in Table 1.

Table 1: Summary of DoC application to Christie and Nadia particularly *and the November 2018 restraint incident*.

Date and summary of incident	Detail	Meets DoC criteria?	Complied with DoC
November 2018 Nadia involved in a dragging incident	There is no evidence that Nadia's parents were informed of the incident. The subsequent internal investigation noted that *"DoC was observed"*.	Yes.	No. There is no evidence of communication with Nadia's parents. It is also unclear from Nadia's notes whether this incident was determined as notifiable under the policy; however, it should have been communicated as part of being *"open and transparent"*.

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[17] Duty of candour 20(1) A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. (2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must (a) notify the relevant person that the incident has occurred in accordance with paragraph (3), and (b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20

June 2019 Death of Christie	Five days after Christie's death, staff visited Christie's family at their home. The HoS sent a letter dated 30 August 2019 to Christie's parents. This offered an apology, condolences, stated an internal investigation would be carried out, and provided the HoS's contact number should the family need further information and support. We noted that the letter was dated on the same day as the letter sent to Nadia's parents.	Yes.	Yes, however, we found the response to lack the compassion that is intended by DoC. Simply providing a contact number in a letter of condolence for the family for if they needed help is insufficient where there has been the death of a young person. The TEWV DoC policy says that: *"Appropriate support and assistance should be offered to the bereaved family or carer, for example informing them where and how they can get help from the Chaplaincy and Funeral Directors."* We have not seen any evidence that this happened. The letter was wrongly addressed, and we understand that it arrived with Christie's parents because the postman recognised their name. We also believe that the two-month delay between Christie's death and the date of the letter to be indicative of a tokenistic attitude to DoC compliance. There is no record in Christie's notes of an intention to contact the family as part of DoC requirements.
August 2019 Death of Nadia	The HoS sent a letter also dated 30 August 2019 to Nadia's parents. This offered an apology, condolences, stated an internal investigation would be carried out and provided the HoS's contact number should the family need further information and support.	N/A	Yes, however, the content of this letter was identical to that sent to Christie's family outlined above, suggesting a lack of compassion and personalisation. We believe that a family grieving the death of a young person requires greater support than the HoS's contact number. Like Christie, there is no record in Nadia's notes of an intention to contact the family as part of DoC requirements.

4.46 We found the Trust's commitment to the DoC requirement to be "open and transparent" to be lacking in their communication with families. In March 2020, both Christie and Nadia's families received a further letter of apology from the Trust's Medical Director, alongside the Early Learning Themes Report. The report did not contain any analysis of staff actions or specific events surrounding both Christie and Nadia's deaths, which left parents questioning whether staff had done everything they could have done. The families were expecting an investigation report that would address their questions and were not made aware that the Early Learning Themes Report was not intended to do this.

4.47 The Trust's belated response to complaints and concerns from families will have compounded their distress, and we also found that the handling of responses could have been more personal and sensitive. The report prepared for the family of Nadia contained the name of Christie in the section which was offering condolences to the family; this is extremely inappropriate.

4.48 Christie's family received a response to their complaint over 17 months after they originally made the complaint, which was shortly followed by a copy of the Early Themes Report. We are not aware of any personal contact being made by a senior member of staff from the Trust, after her death, or in the following months.

(Recommendation 4)

Managing risk and learning lessons

Observations

4.49 The Trust's failure to robustly address environmental risks at WLH created an over-reliance on observations to keep children and young people safe. The effectiveness of observation as a mitigating control was hampered by numerous factors, namely:

- a lack of consistent staff with the experience;

- high patient acuity and therefore a high need for observations including enhanced observations;

- insufficient staffing, which left staff without enough capacity to undertake the recommended level of observations;

- high usage of temporary staff with limited knowledge of individual patient's needs;

- poor record-keeping about observations or decisions, resulting in changes to observation and engagement; and

- WLH developing its own rules around observation which were inconsistent with Trust-wide policy.

4.50 In section 4.160, we outlined the Trust's failure to respond to known environmental risks, such as bathroom hardware. Interview feedback was unequivocal that the mismanagement of environmental risks placed additional prominence on observations as the primary intervention to prevent self-harm and suicide rather than proactive care and behavioural support methods.

4.51 The May 2019 the Suicide Prevention Environmental Survey and Risk Assessment for Newberry notes that: "All patients are risk assessed and suicidal/self-harm

behaviours are managed through individual intervention plans. Each patient has engagement and observation needs included in their intervention plans detailing the level of intervention they require to remain safe on the unit. Any increase in risk would instigate a further risk assessment and subsequent review of intervention plan, which may include enhanced observation and engagement in bathroom area."

4.52   We also note that there were observational blind spots in the seclusion suite on Westwood which resulted in Nadia being able to tie a ligature whilst under enhanced observation. This directly contradicted the Trust's policy on seclusion, which states seclusion areas should have no observation blind spots.

4.53   Care plans and intervention plans did not consistently or clearly articulate what decisions had been made about the nature or frequency of observations, nor did they robustly capture whether observations had been deployed in line with plans. For example:

- The recording of observation levels for Nadia in August 2019 was confusing and plans are not clear about the agreed frequency. The frequency of observations, for example, could be read as 12 or 4 per hour.

- Records for Christie and Nadia do not state whether observations were carried out as prescribed.

- Plans referred to a set number of observations and engagements per shift, but not the definition of what an engagement or a shift is. For example, Christie was to have "six engagements per shift", but there is no record of what these engagements were, at what frequency they were deployed, or how a shift was defined. It is also not clear if this means the new 12-hour shift in place at that time, or the previous shift pattern used at WLH.

4.54   Documentation was often incomplete, with observations not recorded or notes not made on a contemporaneous basis, and this is likely to have reduced the accuracy of records made. Within Emily's clinical records the references to increasing observations, planning interventions and responding to increases in risk are disjointed and are mostly reactive. Records of self-harm incidents are incomplete: for instance, the need to have stitches removed or medical attention would be referenced, but the outcome or treatment is then not recorded. The clinical records do not clearly indicate who had been allocated to observe her during a shift, and we have not seen observation-recording documents.

4.55   The language used to describe observations in documentation could be unclear and indicates a lack of specificity on what observations were used for. Intervention plans frequently framed actions as patient needs. For example, Christie's care plan describes engagement and observations during the day as a patient need, but the true need was to maintain patient safety, which is enabled by regular engagement and observation.

4.56   In Section 4.168 we explore our findings in relation to the culture of WLH. One aspect of this is the frequent characterisation of the unit as a "closed culture" in that it was perceived by many to function and feel very differently to other parts of the Trust. One of the frequent examples cited in this regard was the local practice of observation at WLH. We were told by interviewees that WLH informally adopted a policy of 12 observations an hour; however, this is at odds with the Trust's policy.

4.57 A review of the Trust's observation policy led to this being revised to provide more clarity and a shared understanding of the purpose and approaches to patient observations and engagement. There is now mandatory training and a competency-based assessment in place for all ward-based staff, including bank staff. We have been told that the Trust will support and monitor the effectiveness of these changes to patient observation through a programme of clinical audit.

4.58 The confusion surrounding the 'right' approach to observations was exacerbated by the actions taken in the aftermath of the 2018 inappropriate restraint incidents. Following the publication of guidance from CQC[18,] there was a movement away from 'blanket restrictions', such as set bedtimes for patients and open access to certain areas. This was not, however, supported by an improvement in documented observation and engagement levels for individual patients. Staff told us that the result of this was ultimately confusing and led to inconsistent practice. At this time, observations were also one of the top three concerns escalated to the attention of the Tier 4 Quality Assurance and Governance (T4QuAG) meeting (March 2019). Blanket restrictions are explored more fully in section 4.183.

4.59 We found that the communication between WLH and families was lacking when it came to the topic of observations, and specifically changes to observation levels. Whilst we found examples of positive communication with families in relation to some aspects of care, such as medication changes, interview feedback strongly suggests that it was not customary and practice to communicate changes to observation levels. This led to families not having up-to-date information about the assessed risk of their family member. More concerningly, we found no evidence of action of serious consideration on the part of the Trust in response to concerns raised by families in relation to the frequency of observations. For example, Christie's family raised concerns about the low level of observations and the corresponding high number of opportunities Christie had to self-harm.

4.60 A key factor that limited the effectiveness of observations at WLH was staff capacity. The SBARD[19] briefing undertaken at WLH following the complaint from Christie's grandmother points to staffing levels being the main reason that enhanced observations could not be used effectively and resulted in staff deploying other techniques to keep patients safe, such as the use of anti-tear clothing and the removal of clothing.

4.61 This was corroborated in the interviews with some interviewees, who confirmed that anti-tear clothing was used in lieu of observations. Whilst we recognise the role that anti-tear clothing can sometimes have in keeping patients safe, it is unacceptable that common practice at WLH was to use anti-tear clothing simply because there was insufficient staffing to undertake effective observations. We found no evidence to suggest that the issue of using anti-tear clothing rather than observations was escalated to more senior levels of Trust management.

4.62 Staffing on the unit also enhanced the pressure on handovers; the need for a clear and thorough handover was even more important than it would ordinarily be due to the lack of familiarity of bank and agency staff with patients on the unit. The Trust's

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[18] https://www.cqc.org.uk/sites/default/files/20191125_900767_briefguide-blanket_restrictions_mental_health_wards_v3.pdf

[19] SBARD briefing: situation, background, assessment and recommendations decision – a way of sharing important information in a shortened and easily accessible form that relays the salient points.

Supportive Engagement and Observations Procedure[20] states that the nurse in charge must ensure that the staff involved in observations, including agency and bank staff, have been briefed on the service user's history, background, specific risk factors and the needs of the intervention plan, as well as being clear on how to positively engage with that service user, including preferred communication style. A handover is unlikely to give time to do this in a comprehensive manner.

4.63   The lack of well-documented clinical decision-making around factors such as observation, placed additional pressure on handovers as the main method of communicating key clinical information about individual patients. We were told repeatedly in the interviews that handovers were an area of clinical weakness due to the chaotic and highly pressured environment at WLH, exacerbated by frequent changes to practice, such as observation levels, which required extra time to bring staff up to speed.

4.64   Staffing pressures on the unit and subsequent use of agency and bank staff resulted in temporary staff being used to undertake observations. The Supportive Engagement and Observations Procedure referred to above states that agency staff should not do observations unless they have the relevant skills and knowledge. We were repeatedly told that the relevant nurse in charge did not have time to thoroughly check the skills and competency of agency staff and make adaptations to the management of patients accordingly. The Early Learning Report also noted that the use of unfamiliar staff to carry out observations left young people feeling either distressed or frustrated.

4.65   Feedback from families revealed concerns that young people came to harm despite being on high levels of observations and showed their related lack of confidence in staff attitudes to observations. Some said that staff could display a dismissive, uncaring, and ultimately unsafe approach to observation. Concerns were also expressed that the culture on the ward allowed staff ostensibly undertaking observations to be on their smartphones without challenge or repercussion:

> "A lot of the time no one would do checks, so the observations were very ad-hoc and, even if you were on five-minute checks, they wouldn't happen."

Transitions

4.66   'Transitions' refers to the points at which a young person turns 18 and is therefore no longer eligible to be an inpatient in a CAMHS unit. Transitions require careful planning between staff and the young person and other agencies involved such as social care and families. It should be "a co-ordinated, purposeful, planned and patient-centred process that ensures continuity of care, optimises health, minimises adverse events, and ensures that the young person attains his/her maximum potential. It starts with preparing a service user to leave a child-centred healthcare setting and ends when that person is received in, and properly engaged with, the adult provider".[21]

4.67   Badly managed transitions have the potential to significantly increase an individual's risk profile. This is particularly the case for transitions between an inpatient and a community setting, and also between CAMHS and AMHS. The current (from 2019) TEWV document Admissions, Transfers and Discharge

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[20] Supportive Engagement and Observations Procedure CLIN-0017-001 v2.3.

[21] . Coleman EA, Berenson RA. Lost in transition: challenges and opportunities for improving the quality of transition of care. *Ann Intern Med.* 2004;141:533–6. [PubMed] [Google Scholar]

Framework states that the discharge planning process will allow time for those involved to ensure that a smooth, safe and efficient transition from hospital to community or to another facility is implemented. We have also seen a copy of the Trust's latest transitions protocol: Child and Adolescent to Adult Services/Primary Care.

4.68   There were a number of areas of significant weakness in WLH's approach to transitions. For example:

- Christie's transitions between home and WLH typically preceded a period of deterioration in her mental health.

- Christie's transfer from a PICU to the Newberry Centre was very sudden and there is no evidence that a robust transition plan was in place. Christie had a diagnosis of BPD, and the associated NICE guidance suggested that changes in treatments and services can illicit strong reactions from people with BPD; despite this, we noted that Christie's transfer from the PICU to the Newberry Centre was very sudden and there was no evidence of a robust transition plan in place.

- The loss of placement at Belford Terrace[22] and subsequent lack of communication from agencies involved likely led to an increase in Nadia's compulsion to self-harm.

- Emily was transitioned into adult services in a way which was not tailored to her needs.

4.69   We found some isolated areas of good practice in TEWV's approach to transitional care planning. Nadia, for example, was identified for post-discharge, six months in advance of her 18th birthday, which is an area of good practice. We also found discussions in T4 QuAG meeting minutes that evidence proactive efforts on the part of the Trust to identify a placement for a young person due to turn 18. These discussions appear to take place on a case-by-case basis, however, rather than as part of a planned, systematic, and consistent approach to transition.

4.70   The Trust identified the need to improve its internal management of transitions several years ago, particularly in relation to CAMHS patients transitioning to AMHS. The 2016/17 Quality Account included four key priorities, one of which was to "improve the clinical effectiveness and patient experience at times of Transition". This remained a key quality priority for the Trust for 2017/18, 2018/19 and again in 2020/21.

4.71   Subsequent annual reports have outlined the myriad actions that the Trust has sought to implement to improve transitions, such as implementing transitions panels across all localities, an engagement plan with key partners and a thematic review of patient stories to produce plans to improve the transition experience of young people. We found no evidence that these actions were in place at WLH.

4.72   There was a fundamental fracture between the strategic profile of transition and the scrutiny, planning and action taken at service-level within WLH. Despite being consistently recognised as an organisational priority over the previous five years, this was not translated into service and locality-level actions, nor was there a

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[22] Belford Terrace was the residential placement identified for NADIA in the spring of 2018. Staff at Belford Terrace terminated the placement because they felt that they could not keep Nadia safe after episodes of aggression requiring restraint.

systematic approach to monitoring the effectiveness and quality of transitions. There was very little attention afforded to the effectiveness and risks of transitions at each tier of governance. For example, we found little reference to the service's approach to transitions at T4 QuAG; instead, there is some evidence of transitions being discussed on an occasional, case-by-case basis. The Patient Experience Group (PEG) and QuAC also gave little scrutiny to assurance relating to transitions, despite transitions being a quality priority for the Trust.

4.73   The HSIB published the findings of its investigation into how young people are supported in the transition from CAMHS to AMHS in June 2018. We understand that the Trust was intending to undertake a gap analysis against the recommendations in this report; however, we have found no reference to this exercise at QuAC, the Locality Management Governance Board (LMGB) or the T4 QuAG.

4.74   The Trust put in place a number of service-level processes to try to strengthen its management of transitions. A transitions panel was piloted in September 2017 in order to more proactively manage the continuity of care for young people shortly before they turn 18 years old. The transitions panel Terms of Reference included representatives from CAMHS, LD CAMHS, ALD and AMHS (affective and psychosis teams) and includes the following in the list of its responsibilities:

- "provide assurance to the relevant QuAG that all young people are appropriately discussed and transition plans agreed";

- "discuss, briefly, every young person open to CAMHS and LD CAMHS who are 17yrs 3 months old, regardless of whether they currently look like they need transition to adult mental health services or not"; and

- "discuss, in detail, every young person open to CAMHS and LD CAMHS who are 17yrs 6 months old. This includes review of the Transition Plan."

4.75   We have also seen a transitions panel checklist which includes such prompts as: "does the Transition Plan include jointly agreed personal transition goals?" and "if transitioning to another service, does the young person have a named case worker or dedicated contact for that team?".

4.76   Despite the ToR and checklist, including prompts to capture and report information on the effectiveness of transitions, we found no evidence that these processes worked effectively in practice. For example, no assurance reports from the transitions panel to T4 QuAG were provided throughout 2017 to 2019. We also found no mention of transitions at all in T4 QuAG meetings for the entirety of 2019.

4.77   We did find ad hoc references in T4 QuAG minutes to the issues associated with transitions in spring 2018. For example, minutes describe one of the "top concerns" raised by representatives of the Westwood Centre as delayed transfers when young people turn 18, and delayed transfers for young people who need specialist placements, such as autism-specific placements. The minutes note that the issue of transition for young people, particularly those with autism, as under "escalation to LMGB". However, we found no evidence in corresponding LMGB minutes that this matter was highlighted.

4.78   The vast majority of references to transition at T4 QuAG are made in the context of the CAMHS Inpatient to Adult Care CQUIN, which was introduced in 2017. This was first noted in January 2017 followed by a comment during the April 2017

meeting that there was a "lot of discussion around the CAMHS transitions CQUIN target and ensuring that we improve … It was noted that community teams who hold care co-ordination should be doing this."

4.79   The Trust also put in place a CAMHS transitions CQUIN steering group in June 2017. We have seen the ToR for this meeting, which fail to articulate where in the Trust's governance framework the steering group sits and whom it reports to. The result of this is that any risks associated with transitions identified by the group would not easily be escalated and monitored. We also note that the ToR focus purely on the achievement of the CQUIN and do not reference the need to monitor the patient experience or clinical effectiveness aspects of transition.

4.80   The following table provides a summary of oversight and focus around transitions:

Table 2: Transitions oversight

Level of governance	Meeting	Commentary
Service	T4 QuAG	T4 QuAG referred to Transitions on an occasional, case-by-case basis, rather than as a consistent area of focus for the service.
	SDG	SDG minutes contained the most references to Transitions; however, this was almost exclusively in the context of performance against a Transitions CQUIN running in Tier 3 services. SDG May 2018 cites "The full payment for Transitions CQUIN had been achieved. L highlighted that there had been a couple of Serious Incidents relating to transitions, further detailed work to be carried out around this" The May 2018 CQUIN meeting notes that following a transitions audit, in 20% (11/56) of cases, there was no evidence of a meeting taking place between professionals six months (or within one month if new to service) before transfer. It was noted that Panel Meetings are taking place across the Trust and staff are discussing young people at these meetings before they reach the age of 17.5. However, it was found that staff are not documenting the outcome of the panel meetings on PARIS. Throughout 2018, it was repeatedly noted that there was poor attendance by representatives from AMHS, which would have undermined attempts to improve CAMHS-to-AMHS transitions.
Locality	LMGB	Whilst we found the occasional reference to Transition Panels at LMGB meetings, there is no evidence to suggest that there was robust locality-level governance in relation to transitional care. We are also not aware of the organisational focus on transition as represented in the Quality Account cascading to locality or service-level via LMGB or T4 QuAG meetings.

		We also noted that in June 2018, QuAG discussed escalating to the LMGB the issue of delayed transfers to AMHS when young people turn 18, as well as delayed transfers of young people needing specialist placements. A review of LMGB minutes found scant reference to transitions, and no meaningful discussion about actions to be taken to address this potential area of service risk.
Trust	QuAC	Despite QuAC receiving a quarterly report summarising progress against Quality Account priorities, we found that reporting on Transitions provided poor assurance about the status of the process, residual risks and outstanding actions. For example, the report noted that 100% of QI actions were 'green' as at December 2017, whereas the Quality Account for 2017/18 notes that there remains a need to "further improve the clinical effectiveness and patient experience at times of transition from CYP to AMH services in 2018/19."
	PEG and PSG, both sub-groups of QuAC	Neither discussed nor received reporting on Transitions between 2018 and 2020.

(Recommendation 5 and 6)

Least restrictive practice

4.81 It is a principle of mental health law that care should be provided in the least restrictive setting possible, which maximises independence.[23] The MHA Code of Practice also set the expectation that mental health practitioners would commit to reducing restrictive interventions, such as restraint, seclusion, and the use of blanket restrictions[24]. The concept of "least restrictive practice" gained significant prominence nationally following the publication of the CQC's State of Care in Mental Health Services 2014 to 2017, which found that care for some patients could often be overly restrictive. The 2015 MHA Code of Practice also set the expectation that mental health practitioners would commit to reducing restrictive interventions, such as restraint, seclusion, and the use of blanket restrictions. [25]

4.82 A Quality Improvement (QI) initiative was established in the Trust in mid-2018, commonly referred to as the Reducing Restrictive Practice (RRP) Pilot. This was in

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[23] Mental Health Act 1983 Code of Practice (2015)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
[24] Blanket restrictions are rules or policies that restrict a patient's liberty and other rights, which are routinely applied without individual risk assessments to justify their application. As a consequence, they can potentially violate Article 8 of the European Convention on Human Rights (ECHR) – the right to respect a person's private life. **Blanket restrictions: Policy on the use of Global Restrictive Practices (Blanket Restrictions) in In-Patient Units** Ref: CLIN-0089-v2; https://www.tewv.nhs.uk/content/uploads/2021/12/Blanket-Restrictions-Policy.pdf
[25] A focus on restrictive intervention reduction programmes in inpatient mental health services (cqc.org.uk)

response to a national RRP pilot, and all three WLH wards were selected to be part of the pilot. The remit of the Trust's pilot covered topics such as reducing blanket restrictions, strong clothing, observation, and seclusion.

4.83   A RRP steering group had its first meeting in January 2019. The steering group was chaired by the T4 CAMHS Clinical Director (CD), and attended by the Head of Service, Service Manager, modern matrons, ward managers, PBS Lead and Consultant Psychologist. Meeting minutes document that the Executive Director of Nursing (DoN) was the designated executive sponsor. We have been unable to clarify where and with what regularity the RRP steering group reported in the Trust's governance structure.

4.84   The implementation of least restrictive practice principles lacked coherence and coordination from the inception of the QI pilot. Several interviewees attributed this in part to the churn in staff on the unit, which made it difficult to embed consistent clinical changes and communicate new approaches. The intention in adopting least restrictive practice was to allow patients more choice and independence. At WLH, this meant that there was a drive to reduce some of the 'blanket' restrictions that had previously been in place, such as an observation practice (five-minute observations), limits to the use of smart phones and social media and fixed bedtimes.

4.85   Instead, we were repeatedly told that young people were allowed to stay up later at night, or to spend all day watching television in their pyjamas, to not attend school and to self-ligature under observation. A typical comment from one interview was: "What we tended to find with West Lane, it would never quite seem to embed, if that makes sense, so you would get a couple of champions and they'd do some really good work, we'd see some really nice bits, but then it would get lost for a few months; one of the champions would perhaps go onto long term sick leave." Many interviewees were highly critical of the apparent oscillation between the embedded use of blanket restrictions at WLH, to the RRP approach, which was interpreted by many staff as "no blanket restrictions". Most staff we spoke to felt strongly that RRP had been implemented in the absence of clear guidance, a framework of support, clear communication, and review processes.

4.86   We have not been able to locate a TEWV policy on an approach to the use of social media amongst young people in hospital. We were told that "least restrictive practice" meant that staff were also unable to restrict access to mobile phones on Westwood. The relevant Trust policy on mobile phone usage states "no use of the recording or photography facility because of the potential risk for the violation of the privacy and dignity of other patients, staff and visitors and may constitute a security risk". However, social media content is now a much more prevalent risk which does not appear to have been addressed in any meaningful way.

4.87   This mean that, in turn, staff were left to negotiate this complex terrain and to try to accommodate parents and fulfil their duties to keep the young people safe. Mobile phones and access to social media was a primary issue which was poorly handled and caused mistrust and concern amongst families and patients, whereas previously there had been good relationships.

4.88   Mobile phones can, on one hand, be a protective factor, enabling young people to maintain regular contact with family and friends. However, the risk is that smartphones can also be harmful to this cohort of patients who might access inappropriate social media – sites supporting eating disorders, self-harm and

suicide are easily available – and this may cause significant detriment to mental health.

4.89   Initially, families thought the idea of restricting mobile usage was positive in principle, but when implemented, they did not agree to their child not being able to contact them, especially if they had had a prolonged admission. This meant mobile phones (often smart phones) were allowed, even though staff disagreed with their use and were battling with the consequences of access to inappropriate content.

4.90   We were told by families (and some staff) about the way that bringing in changes to practices on the wards "lost the families" and could have been managed better. A negative social media campaign by one patient and their family gathered momentum in January 2018 at around the same time as the staff disciplinaries hit the press. More and more parents made their concerns public.

4.91   We were also informed that staff were "stalked" on Facebook, had witnessed people standing outside the hospital staring at them and had verbal abuse and objects thrown at their cars when leaving the hospital.

4.92   We have not been able to locate a TEWV policy on an approach to the use of social media amongst young people in hospital. We were told frequently that "least restrictive practice" meant that, in practice, staff were unable to restrict access to mobile phones on Westwood. The absence of guidance meant that young people could be exposed to inappropriate content on social media.

4.93   The link was also made to the lack of visible and effective leadership on the unit; there was broad consensus that this issue pre-dated the 2018 inappropriate restraint incidents but gained prominence due to differing views amongst ward leaders about how least restrictive practice applied in a CAMHS setting. We were told that some AMHS staff tended to encourage the same level of independence and low level of intervention that they would deploy on an adult ward; this created a tension with CAMHS staff, who generally held the view that there needed to be more boundaries for children and young people.

4.94   The adverse impact on children and young people of a least restrictive practice approach which lacked clarity, consistency and leadership cannot be understated. Staff reported feeling unclear about what was acceptable practice. We were also told that staff were so afraid following the 2018 inappropriate restraint incidents and the lack of clear guidance that they would telephone the executive DoN for guidance on whether they could restrain an individual when the patient needed to be prevented from harming themselves.

4.95   We were frequently told that staff were told not to intervene in incidents of self-harm until the situation became life-threatening. The TEWV Protocol for the Reduction of Harm Associated with Suicidal Behaviour, Deliberate Self-harm and its Treatment (for Young People with a Diagnosis of Borderline Personality Disorder and Related Conditions), was approved in May 2016 (and reviewed in April 2020).

4.96   The scope of this protocol is stated as applying *"to young people who have a diagnosis of borderline personality disorder (BPD) and to young people challenged by similar long-term issues of self-harm, suicidal thinking and behaviour, emotional difficulties, and difficulties with relationships. Such individuals may have one or more of a range of personality disorder diagnoses. The term BPD+ will be used as shorthand for this group".*

4.97   The Protocol sets out 8 principles:

- Principle 1: Purposeful Interventions

- Principle 2: Formulation

- Principle 3: Precision in thinking and communicating about self-harm and suicidal behaviours

- Principle 4: Multidimensional risk assessment

- Principle 5: Patient responsibility

- Principle 6: Consensus decision-making

- Principle 7: Least intrusive intervention

- Principle 8: Defensible documentation"

4.98   The protocol contains practice guidance in the above areas. There are however areas of focus that we believe are open to misinterpretation, and contain language that has the potential to be seen as judgemental, which we would not normally expect to see in a protocol including: "For most young people with a diagnosis of BPD+, the road to recovery begins when they see the possibility of taking adaptive action to end their own misery, instead of continuing to invest entirely in unrealistic hopes that others can take away their pain".

4.99   The protocol also states that "optimal care for young people with a diagnosis of BPD+ involves providing just enough intervention". The protocol goes on to explain that the word "intervention" is used in preference to "care" as it better conveys the sort of skills building, autonomy building, resilience building approach required.

4.100 The reality of this ambiguity was that children and young people would be allowed to cause harm to themselves before staff stepped in. Patients felt additional anxiety because of witnessing harm which was not stopped and felt that they had to be alert to others self-harming, as they did not trust staff to keep them safe. The impact of this trauma upon young people cannot be discounted as a potential for iatrogenic harm.

4.101 The issues outlined earlier in relation to differing clinical views on restrictive practice had an impact on young people's access to education. Some staff strongly believed that it was their role *in loco parentis* to ensure young people had structure to their day and were woken up at a set time, and were encouraged to access education, whereas other staff felt that young people themselves needed to determine whether or not they attended education. It is the local authority (LA) which has the responsibility to "arrange suitable, full-time education (or as much education as the child's health condition allows) for children of compulsory school age who, because of illness, would otherwise not receive suitable education"[26]. Whilst we know that the Trust monitored education attendance for each patient at WLH, we are unaware of action taken as a consequence, or engagement with the LA, to manage low attendance.

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[26] https://www.gov.uk/government/publications/education-for-children-with-health-needs-who-cannot-attend-school

4.102 The governance framework which was put in place to support the implementation of least restrictive practice at WLH and across the Trust was unclear. We found that:

- Policies used differing terminology to describe the principle. The Protocol for the Reduction of Harm Associated with Suicidal Behaviour, Deliberate Self-harm and its Treatment (for Young People with a Diagnosis of Borderline Personality Disorder and Related Conditions), which was in place between May 2016 and withdrawn in April 2020, referred to the "least intrusive intervention", whereas the Admissions, Transfers and Discharge Framework states that the least restrictive option must always be considered first.

- Trust-wide strategies refer to "a restrictive intervention reduction plan" introduced in 2015; however, most interviewees referred to mid-2018 as the point at which this initiative was launched. This suggests low visibility and impact of these strategies at WLH prior to 2018.

- Individual clinical records, such as PBS plans, rarely made reference to consideration of least restrictive options, and there continued to be a heavy reliance on the use of restrictive physical intervention.

- Monitoring and escalation of least restrictive practice was ineffective. As stated, whilst there was a RRP steering group introduced in January 2019, we have been unable to evidence where this reported to in the Trust's governance structure.

4.103 A Positive and Safe dashboard was developed in early 2019 to capture metrics such as numbers of restraint incidents and PBS plans in place across the Trust. This could have been a useful tool to help WLH to better understand its use of restrictive practice; however, it was not effectively used at ward-level, nor was it seemingly used to test the impact of interventions such as PBS plans on the use and frequency of restrictive interventions.

4.104 The Trust was involved in The National Quality Improvement Reducing Restrictive Practice project involving all three wards in WLH from October 2018, which was run by the Royal College of Psychiatry. The Executive Director of Nursing was the identified lead for the Trust. The CD for inpatient CAMHS, was the lead for WLH working alongside the ward managers for implementation.

4.105 There was consistent interview feedback that the momentum behind the RRP initiative quickly dissolved. Minutes from the RRP steering group in April 2019 – attended by the DoN and Positive Approaches team (PAT) Lead, six months after the 2018 inappropriate restraint incidents – state that "the service is looking at setting up sessions for staff on how to manage self-harm and giving staff some guiding principles, e.g., when to intervene/when it would be safe not to". This suggests that a lack of clarity about when to intervene remained a live issue at WLH long after the 2018 inappropriate restraint incidents.

4.106 The Trust established a WLH-specific Positive and Safe steering group in May 2019 which met monthly and reported into the Service Development Group. The remit of this forum included oversight of WLH's involvement in the national Reducing Restrictive Practice pilot, monitoring the Blanket Restrictions Register and a ward-by-ward focused discussion. We found evidence of positive discussions about how handovers could be enhanced as well as how post-incident reviews

could be more effectively undertaken on the ward. There was, however, frequent non-attendance by leaders at service, locality and corporate level.

(Recommendation 6)

Prevention and management of violence and aggression

4.107 The use of restraint at WLH was excessive, inappropriate, and ultimately damaging to patients, as well as staff. The reasons for the poor deployment of restraint as a primary rather than a tertiary intervention are complex and multifaceted. We have sought to illustrate the environment in which this was enabled below:

Inappropriate use of restraint was not identified or challenged **because**

There was a lack of positive role-modelling, leadership, training and clarity about what 'good' restraint looks like **because**

Leaders were not sufficiently present, nor did they provide a consistent message about restraint.	There was failure to respond promptly and transparently to allegations of inappropriate restraint.	Lack of structure and stimulus exacerbated behaviour that required restraint as an intervention.	There was a lack of guidance about how to intervene in self harm such as headbanging or ligatures.
There was a lack of CAMHS focus on prevention / management of violence and aggression training.	An inconsistent workforce prevented there from being a team-based approach to change.	There was a tacit acceptance that restraint was needed and insufficient emphasis on de-escalation.	Patients lacked de-escalation and crisis plans developed with their input, and input from the PAT team.

4.108 Staff told us that there was a general acceptance at WLH that T4 CAMHS patients needed to be restrained, particularly on the Evergreen Centre, where this was sometimes necessary to save lives. A typical comment from an interview was "the sense was from the paediatrician who was involved was that if we do not feed these children they will die, and that was the message that was consistently given". One staff member who refused to restrain a child for NG feeding was told by senior clinical staff that [they] "had just killed that child". Although this was not a life-threatening situation, this statement left the staff member feeling responsible and as though there was no acceptable alternative to restraint.

4.109 There was broad consensus amongst ex-WLH staff that they were instructed to use restraint and Naso Gastric (NG) feeding to protect patients; however, there was a failure to put in place controls and checks to recognise when restraint was inappropriate or causing harm. This is a high-risk intervention, although we have seen little evidence of the presence of this on any risk registers.

4.110 Staff at WLH had resigned themselves to the belief that this patient cohort would always need to be frequently restrained, to a degree that, in any other clinical setting, would prompt challenge and scrutiny. There was a lack of recognition that a patient's right to be safeguarded under the Children Act 1989 was paramount.

4.111 Several interviewees shared the view that restraint became normalised due to the transfer of patients from Evergreen, where they were treated for eating disorders and therefore often restrained to be nasogastric (NG) fed. NG-fed, to Westwood, where a similar level of restraint continued. The Trust has a nasogastric insertion and management policy, which includes a brief reference to NG and restraint; however, there is no reference to consent, capacity, the MHA, nor guidance on how staff should respond if there is reluctance or refusal. The policy refers to the MDT as being responsible for the decision to administer NG feeds, and there is no requirement for a discussion with the patient, or their family. We would typically expect to see well-communicated and understood guidance about decision-making, documentation, and review in relation to NG feeding and restraint. We are also not aware that any training was provided in relation to NG feeding under restraint. A CYPS Board presentation in March 2019 showed that the majority of WLH restraints were for refusal of food/feeding. NG feeding involves a fine bore tube passed via the nasal passage into the stomach to administer nutrition.

4.112 NICE guidance on eating disorders[27] states that "feeding people without their consent should only be done by multi-disciplinary teams who are competent to do so". The use of NG tubes to provide nutrition is a skilled procedure, and some of the risks are misplacing the tube, which may then enter the lungs, and of refeeding.[28] The risk of misplacing the tube is reduced by routinely checking that the tube is in the correct place by checking the acidity levels of the stomach. The placement of the tube should always be checked before feeding starts, and monitored during the process, which is obviously very challenging under restraint.

4.113 Regular restraint was tolerated and there was a failure to identify when care and treatment provided at WLH was inappropriate and misapplied. Nadia was identified as having two periods of 'dragging' as part of the review of CCTV in November 2018. Despite identifying her in the inappropriate restraint incident, there is no mention of this in Nadia's clinical records, or at meetings where her care was discussed. There was an agreement at a LADO meeting on 23 November 2018 that Nadia's parents should be informed of the incident and a safeguarding referral submitted. We could not find evidence of either action having taken place. The Trust have informed us that her parents were contacted by telephone, but there is no record of this.

4.114 Staff recalled their frustration that repeated restraint was deployed at WLH without sufficient planning and resource being applied to the root causes of the behaviour that resulted in restraint. One interviewee told us: "I think we were keeping them physically safe but, psychologically, I don't think we were scratching the surface." Another key comment from the interviews was: "there was a real sense on physical containment rather than emotional containment. It was not understanding distress, trauma, it was very much focused on stopping." As well as the lack of stimulus in

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[27] NICE 2017, Eating Disorders: Recognition and Treatment. https://www.nice.org.uk/guidance/ng69
[28] Refeeding syndrome consists of metabolic changes that occur on the reintroduction of nutrition to those who are malnourished or in the starved state. The consequences of untreated refeeding syndrome can be serious, causing hematologic abnormalities and may result in death. NICE CG32 Refeeding Guidelines

the form of planned activities, therapy and education provided to patients described earlier, the physical environment of the wards was described as noisy and chaotic.

4.115 There was a lamentable lack of support given to young people in the aftermath of restraints. The Trust's policy on physical restraint[29] requires there to be an immediate debrief post-restraint and states that the patient should be offered the opportunity to discuss their experiences with staff who were not party to the restraint. It also states that staff should consider whether the PBS plan or other aspects of the patient's care plans need to be revised or updated in response to the information from the post-incident debrief.

4.116 The requirement for and impact of regular, repeated restraint was not a standard part of care planning or care review. We found this to be the case for Christie, Nadia and Emily. There was a failure to document when restraint had occurred in care records, including which staff were involved in a restraint and what their specific role was. We found only one write-up of a physical restraint in Nadia's notes during her admission to Westwood; however, we know that she was frequently physically restrained to prevent self-harm.

4.117 We also found little acknowledgement of the impact of restraining patients on staff. Interviewees described a working environment in which restraint was commonplace: "I recall the Nadia incident and coming out of that after I had resuscitated her and within seconds having to go back into an incident to remove a ligature. That was how it worked. It was difficult to describe unless you were there. It was just like you turned every corner and there was another traumatic event." The trauma of restraining and observing regular restraints on staff was evident in many interviews and we understand that a psychologist on-call process was introduced. Despite this, staff reported that there was a lack of effective and well utilised support system in place for those staff for whom restraint was a daily part of their professional lives, despite the Trust's awareness that WLH was an organisational outlier in relation to the number of restraints.

4.118 In 2014, *Mind* published a report titled Building on the Mental Health Crisis, which identified the Trust as a high user of restrictive intervention. This resulted in the Trust developing a restraint reduction plan which was approved by the Trust Board in January 2015. The plan, which became commonly referred to as the Force Reduction Project, centred on initiatives such as PBS and Safewards. It is unclear how this project links to the RRP, if they overlapped or one superseded the other, or if the same staff were involved.

4.119 The Force Reduction Project did not achieve its goals at WLH. PBS never became an embedded approach at WLH. Efforts to implement the Safewards[30] initiative were generally characterised as initially enthusiastic but ultimately tokenistic by interviewees. We were told that staff had "not been given any extra resources" to train and plan accordingly. The lack of a stable, consistent workforce at WLH also dramatically undermined attempts like this to change practice.

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[29] TEWV Safe use of Physical Restraint techniques – CLIN-0019-002 v1
[30] Designed to "influence rates of conflict and containment on their wards at every level: by reducing or eradicating the conflict originating factors; by preventing flashpoints from arising out of them; by cutting the link between the flashpoint and conflict, i.e. the flashpoint occurs but does not lead to a conflict event; by judiciously choosing not to use containment on occasions when it would be counterproductive; and by ensuring that containment use does not lead to further conflict when it is used."

4.120 The PAT, also known as the Positive and Safe Team, was borne out of the Force Reduction Project. It was operationally managed by a lead senior nurse who reported to the Deputy DoN. Staff from the PAT had been intermittently involved at WLH for several years since the publication of the Mind report.

4.121 We were told that the PAT undertook a review and refresh of Trust policies in relation to restraint in 2017. We found, however, several areas in which these could have been clearer and more in line with good practice. The Safe Use of Physical Restraint Techniques procedure focuses on the process of restraint, rather than the prevention and management of violence and aggression, which is addressed separately in a Supporting Behaviours that Challenge Policy.

4.122 If this is a policy purely about the process of restraint, it would be helpful to have clarity about what training is expected before the staff member can use PAT techniques. The policy states: "All staff within the Trust should be trained in undertaking physical restraint and the risks involved." However, training such as should be delivered on a targeted basis, whilst knowledge of the appropriateness of this intervention should be widespread so that staff are able to discern good from poor practice. The policy also did not include guidance on how to move a young person under restraint, or how to restrain a young person to have an NG tube inserted.

How practice is monitored

4.123 The audit and monitoring section of this policy states: "The organisation regularly provides a report to the National reporting and learning system (NRLS) of all incidents associated with patient safety. If trends or unusual activity become apparent, the Positive & Safe Team will seek clarification and strategies to address the issues from the appropriate service manager." There is no reference to local monitoring or learning, or how the CAMHs and PAT teams should engage.

4.124 The governance section states: "Training will be reviewed on a yearly basis by the Director of Nursing and Governance and programmes will be amended accordingly." We found no evidence of compliance or monitoring of compliance in this area.

4.125 Appendix 3 to the Supporting Behaviours that challenge policy refers to "pathways"; however, we would expect this to be specific about how such pathways are CAMHS-friendly, and what CAMHS-appropriate approaches are used. This is also an area of weakness in the Trust's restraint policy.

4.126 The Supporting Behaviours that Challenge Policy also references the "Mental Health Units Use of Forces Act (2019)"; the correct reference is Mental Health Units (Use of Force) Act 2018. The policy does not, however, reference how this is being applied at the Trust.

4.127 The Patient Safety Quality Report for 2017 identified 42 instances of prone restraint within CAMHS within a three-month period. Prone restraint is a highly contentious practice. Trust policy states that: "If services become aware that a patient has been restrained in prone position on more than 2 to 3 occasions, services are expected to seek the support of the Positive Approaches Team (PAT) for support and guidance." We are not aware of the PAT being proactively engaged in relation to prone restraint.

4.128 Training in the prevention and management of violence and aggression (PMVA), including restraint, was provided by the Trust's PAT. The Trust undertook a review of PMVA training at the same time as launching the new Safe Use of Physical Restraint Policy. WLH staff did not receive effective PMVA training because it was not tailored for children and young people. We were told that at this time, some staff requested CAMHS-specific restraint training, but this was not acted upon. We also found evidence from May 2016 that there was an appetite for T4 inpatient staff to have bespoke PMVA training specific to the needs of young people – however, this was never acted upon. We were also told that those responsible for restraint training in the PAT had little-to-no experience in a CAMHS setting.

4.129 Given the profile of children and young people at WLH, we were surprised to find that staff did not receive trauma-informed training that also recognises the physical differences and vulnerabilities of children and young people compared to adults. This is particularly the case given the extremely low body weight and associated health conditions of WLH patients. Crucially, we were also told that the PAT did not undertake any work in relation to restrictive practice used when undertaking NG feeding.

4.130 We were told by several parents that their autistic child's sensory needs were not considered during times of distress, aggression, or self-harm, and we have no evidence that the PAT supported approaches to young people with autism or sensory needs.

4.131 Interview feedback also suggested that WLH's approach to identifying training needs was arbitrarily focused on a target number of staff to provide Management of Violence and Aggression (MOVA) training and did not sufficiently consider people's needs, the nature of T4 CAMHS or the transient workforce at the unit. A training needs analysis (TNA) for WLH was led by the Trust's central workforce team and we were told that there was limited input from WLH staff and no input from the PAT. We understand that this process has now changed and there are multiple sources of information used to compile service specific TNAs, including staff surveys and staff focus groups. We have not been provided with the TNA for WLH.

4.132 We have not seen any evidence that such support or guidance from the PAT was sought or provided as a direct consequence of the 2018 inappropriate restraint incidents. We were also told that HR did not request the support of the PAT during the reintegration of staff suspended or on special leave in early 2019.

Iatrogenesis

Iatrogenic harm refers to *the harm caused inadvertently by the process of treatment. This may manifest as uncertainty and anxiety caused to the patient by a failure of staff to provide them with important information regarding diagnosis, treatment, or discharge planning; adverse reactions to drugs; negligence; or unnecessary treatment resulting from a psychiatrist's decision*. Sarah Markham: Dealing with iatrogenic harm in mental health – The BMJ.

4.133 In 2014 the CAMHS Tier 4 Report states that "admission to hospital can also have an iatrogenic effect, particularly for people with chronic suicidality and self-harm, and this is recognised in the NICE guidelines on the Treatment and Management of BPD (NCCMH, 2009). This phenomenon is also described by CAMHS Tier 4 clinicians in that admission can lead to a spiral of worsening symptoms and increased suicidality in some young people."

4.134 Several studies have attempted to establish a link between the use of mental health inpatient services and iatrogenic harms, particularly within the cohort of patients with personality disorder diagnosis. The task within the inpatient setting when young people are admitted because of risk to themselves is to keep the young person safe whilst carrying out a comprehensive, holistic assessment and providing treatment for any underlying disorder. Ensuring safety will require adequate staffing and an appropriate environment. Care should be provided according to the principles of the least restrictive environment possible.

4.135 The final report of the Independent Review of the Mental Health Act 1983 (December 2018) was clear that "for some, detention [under the MHA] left them worse not better off [all] interventions, and being detained under the MHA is an intervention, which may have side effects. We can only help reduce these outcomes if we accept they happen (Department of Health and Social Care, Modernising the Mental Health Act: increasing choice, reducing compulsion, p5).

4.136 Iatrogenesis can be a polarised debate, which is underpinned by the limited data available. It seems the logic model applied to extended inpatient stays for this patient group relates more to controlling risk than extending function (preventing further deterioration or death).

4.137 The key features of care which may engender an outcome of iatrogenic harm within an inpatient setting include:

- Trauma from the act of restraint itself (causing PTSD-type symptoms).

- Trauma from the loss of liberty and absence of protective factors.

- Extrapyramidal side effects from medications.

- Increase in self-harm by virtue of being on wards with other emotionally unstable patients and learning new methods of self-harm.

- Loss of dignity, loss of autonomy.

- For people who have self-harmed, staff attitudes are often reported as contributing to poor experiences of care. Punitive or judgemental staff attitudes can be distressing for people who have self-harmed and may lead to further self-harm. (NICE 2013 QS34 – Self Harm Quality Standard).

4.138 Harm caused by environmental factors. Not only in respect of poor ligature risk management but also in respect of the design of the built environment causing over stimulation: loud alarms and frequent situations with high emotional content. Many of the young people directly observed distressing, loud and invariably frightening incidents. This is particularly prevalent for young people who had additional needs for calm and stability, Christie, and Nadia, for example, with ASD.

4.139 Without clear counter-factual evidence for each case, iatrogenic harms are difficult to definitively diagnose. However, there is now extensive evidence to suggest that this is a material factor in deterioration and one which was not considered meaningfully in either of the cases described (although there was some recognition of this in the care planning for Christie). A greater awareness of iatrogenic factors can be extremely useful in underpinning care planning and in ongoing recognition of risk, but this needs to be translated into risk plans and acted upon in a coherent way.

Acuity[31]

4.140 Rising acuity in adolescent mental health is a national challenge and one which Tier 4 units and units catering for young adults are struggling to tackle. There are several reasons why acuity might rise, which include:

- Iatrogenic factors and worsening presentation within the healthcare environment.

- Greater numbers of adolescents with more complex mental healthcare needs.

- Lack of access to therapies.

- Lack of early, effective and targeted interventions.

- Lack of close liaison between schools, LA and health.

- Lack of implementation of the 'triangle of care' and parents and carers who are sometimes ostracised.

- Access to social media and untoward communications.

4.141 Many interviewees cited "rising acuity" as one of the key factors behind the challenges at West Lane: "more young people were being admitted with increased acuity and a range of complex problems. This resulted in many more disturbed young people and a significant increase in acuity which was not appropriately responded to". However, staff from other care environments emphatically rejected this claim, stating: "from my perspective that they were not alone in having those issues – they weren't singled out, and every other service had been running smoothly with an inflow and outflow of staff and a level of acuity that was being managed effortlessly".

4.142 However, rising acuity was used as an explanation for not completing training, poor incident management and the failure to learn lessons. Trust training on the removal of ligatures had not been provided at WLH due to "high levels of patient acuity". Similarly, resuscitation debriefing was also not given for the same reason.

4.143 Staff were struggling to cope with the complexity and demands of this patient cohort and there is an argument to suggest that both patients and staff were experiencing trauma responses in how these frequent and distressing situations were managed.

4.144 The Trust Board were aware of the issues at WLH, and the lack of response may well have led to a state of 'learned-helplessness' amongst staff, including the view: "it's just how it is". In these cases, staff can become apathetic about escalating concerns as nothing is done, contributing further to the daily pressure and lack of resilience on the ward. For example, the complaint raised by Christie's grandmother resulted in an undated SBARD briefing. This identified the high patient acuity at the Westwood Centre. It also identified staff reporting that they did not feel sufficiently trained and were using anti-tear clothing rather than enhanced observations due to the lack of availability of extra staff.

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

Ligature risk

4.145 There were repeated missed opportunities to respond to ligature risk at WLH, despite risks being identified via a variety of mechanisms such as safety alerts, near-misses and post-incident debriefs. Examples include:

- Service-level risk registers did not capture known ligature risks. This points to fundamental inadequacies in the service's risk culture explored more fully in Section 5.1, but they also fostered a tacit acceptance that ligature risks were simply part of the WLH environment.

- Incidents and near-misses highlighted potential ligature risks, including a failure to assess ligature points and implement effective ligature management training at WLH; however, there was a failure to act in response.

- Between 6 March 2019 and 28 June 2019 there are 12 Datix reports identifying self-ligature using bathroom hardware by three patients.

4.146 CQC (2017) guidance[32] suggests that inspectors request and examine the provider's ligature risk reduction policy and procedure. There does not appear to be a specific policy or procedures within the TEWV Trust for dealing with ligatures. Some trusts are developing specific guidelines on dealing with ligatures; however, even with those developments, there is very little guidance on dealing with people who self-ligature by unusual mechanism.

4.147 The TEWV Suicide Prevention Environmental Survey and Risk Assessment Procedure[33] indicates that surveys should be completed annually at a minimum, and when there is a new build and when an incident has occurred, but we have not seen evidence of this occurring. This then goes to the local QuAG for sign off in September and to the Operational Management team in November.

4.148 This programmed approach is intended to enable the comparison of services and the identification of trends, issues and hot spots whilst ensuring a consistent approach.

4.149 Four main and en suite bathroom hardware ligature risks were identified via risk assessment at WLH in 2018 and 2019.

4.150 The risk assessment documents include a section titled "How is risk being managed". An example of a response included under this section for WLH is: "all patients are risk assessed and suicidal/self-harm behaviours are managed through individual intervention plans. Each patient has engagement and observation needs included in their intervention plans detailing the level of intervention they require to remain safe on the unit.

4.151 To maintain privacy and dignity and promote therapeutic engagement, patients with agreed stay safe plans may have "bathroom privacy in the context of an enhanced observation intervention plan". As previously outlined, we found significant weaknesses in the unit's approach to observation and engagement, the provision of effective therapies and the accuracy and robustness of individual care plans.

4.152 In September 2018, a national EFA[34] was issued by the Department of Health (DH) regarding the assessment of ligature points. This alert was not new guidance;

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[32] CQC (2017) Brief Guide: Ligature Points (for inspection teams).
[33] Suicide Prevention Survey Procedure. HS-0001-014-v2. January 2019.
[34] Assessment of Ligature Points, Estates and Facilities Alert, EFA/2018/005, 19 September 2018.

rather it sought to clarify existing guidance and emphasise the importance of considering multiple factors in assessing the risk posed by ligature points. Part of the shared learning was that current risk assessments be reviewed: "… multi-disciplinary in situ risk assessments to identify ligature points, no matter what their height, in areas where patients are admitted, assessed, or receive treatment … This particularly relates to the provision of fixtures and fittings in rooms/spaces where service users may not be observable by staff.

4.153 A programme of review and subsequent action planning was undertaken across the Trust in 2019. As a result, the Newberry Centre was re-assessed on 30 January 2019.

4.154 The review asked four questions regarding safety on the Newberry Centre around unobserved areas, building infrastructure, mountings and fittings, to complement the updated survey.

4.155 There followed a detailed list of risks, which identified specific items of bathroom hardware, amongst several other items, as a low-level ligature risk. A document listing very specific remedial actions was developed, however, there were no actions to change the specific items of bathroom or en suite hardware, despite these having also been identified as a low-level ligature risk in the prior survey in January 2019.

4.156 We were told that, following Christie's self-ligature attempt in March 2019, the specific items of bathroom hardware were changed three months later in May 2019. However, as we discuss later in section 5, this incident was not investigated properly and does not appear to have informed the Trust response to the EFA which was being reviewed at that time. There appeared to be no urgent remedial action taken. A report was provided to the EMT by the Director of Estates and Facilities at the end of April 2019 (over a month after the serious incident (SI)) which discussed the retrofitting of sensors onto specific items of bathroom hardware in all bathrooms at WLH – which were awaiting approval on costs.

4.157 TEWV also has a Policy for Harm Minimisation[35]. Section 5.1 of the policy states: "Suicide Risk Mitigation: The fundamental importance of clinical risk assessment and management in the prevention of suicide is well documented. All clinical practitioners should ensure they are familiar with contemporary information about suicide indicators, potential high-risk areas for self-harm and suicidal behaviour and clinically effective risk interventions for the prevention of suicide relevant to the client groups likely to be in your care." Despite the high and increasing risk of ligatures in WLH, we saw no evidence that the Policy for Harm Minimisation was cross-referenced with the Suicide Prevention Environmental Survey and Risk Assessment. This would have ensured clinical staff were aware of the potential high-risk areas for self-harm and that this knowledge informed care planning and an organisational response (such as reducing access to mechanisms of ligature).

4.158 Training to effectively respond to ligatures had not been undertaken at WLH. Trust-wide training in response to ligatures included the removal of ligatures using ligature scissors and cutters, which goes beyond the Resuscitation Council guidelines. In addition to this, the training included participating in 'scenarios' where trainers arrive on a ward with a mannequin and press the alarm and expect staff to

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[35] Policy for Harm Minimisation: A recovery-orientated approach to clinical risk assessment and management. Ref CLIN-0017-v7.

respond. Staffing levels and patient acuity meant that this training had not been provided at WLH.

4.159 Individual care plans were not adequately updated to reflect contemporary information on known ligature risk, and case review meetings often did not refer to self-ligature risk even when this was a known feature of an individual's pattern of behaviour. Christie did not have a care plan relating to self-ligature even though this was a known risk.

4.160 We also found that ligature risk assessment, review and monitoring was not meaningfully integrated into the Trust's governance structure. For example, ligature risk and alerts were managed by the Environmental Risk Group. There is an example of the EMT being informed of the ligature safety alert, and they agreed to establish a working group to address issues. However, the EMT appeared to lose sight of the topic after that. This led to fractured organisational oversight of ligature risk identification and management. This is explored in more detail in section 5.

4.161 Environmental risk audits were also presented to the EMT, and they also received locality risk registers; these, however, did not reflect ligature risk in relation to WLH and there was insufficient curiosity applied to the absence of this.

4.162 Individual incidents were a key point where learning could have been joined up. For example, there were instances with Christie where, despite the Trust identifying environmental risks, we were unable to identify any resultant attempts to manage these environmental risks. Instead, a generic position stated was that: "all patients are risk assessed and suicidal/self-harm behaviours are managed through individual intervention plans. Each patient has engagement and observation needs included in their intervention plans detailing the level of intervention they require to remain safe on the unit. Any increase in risk would instigate a further risk assessment and subsequent review of intervention plan, which may include enhanced observation and engagement in bathroom area."

4.163 There were repeated missed opportunities to develop a centralised and systematic approach to the management of ligature risks. Oversight of this issue was fragmented and there were examples of mitigating activities being commenced with no mechanism of holding to account for completion.

(Recommendation 7)

Culture and leadership

Service-level culture

4.164 WLH was described with striking frequency as a "closed culture" by staff interviewees. When we interrogated them over what was meant by this description, we were told that the unit did not feel like an integrated part of the Trust; it could be hard for new staff to feel welcomed and integrated, and local practices could be developed which were not always consistent with Trust-wide policy. It was regularly characterised as "geographically isolated" in that it was not connected with any other inpatient areas, which reduced opportunities for staff to engage with those from other parts of the Trust.

4.165 The relationship, or lack thereof, between the three wards at WLH was a topic raised repeatedly in staff interviews. Staff would move between wards at WLH in order to plug urgent operational gaps caused by absence and to provide support with feeds and restraints; however, this typically lacked planning and

communication. Several staff recalled the same experience of being surprised at the lack of collaboration between the wards. One interviewee remarked: "there wasn't really any sharing and there wasn't any opportunity to work as a service. Each ward, each MDT, worked very independently. The Service never worked cohesively." Notably, several staff interviewees independently shared not tackling service cohesion and collaboration as one of their key regrets.

4.166 It was not uncommon for WLH staff to live close to the unit, to socialise with colleagues, and we are also aware of staff being related. This contributed to the impression of a close-knit culture: "It was a very emmeshed, entrenched group. I think there was no sense of divide or split between the people who were working on the floor with the patients. They described themselves as a family."

4.167 Most Trust services are for adults. This fostered a perception amongst some WLH staff that T4 CAMHS was not well understood by other staff. One staff member noted that "there was a general narrative around [WLH] that it was a highly specialised, highly complex service, and it absolutely was, but [the Trust] had lots of highly specialised, highly complex services". Several interviewees, including those from WLH, felt that there was also a resistance embedded in the culture of WLH to views from elsewhere in the Trust and a reluctance to seek specialist expertise, such as safeguarding or support from the Positive and Safe team. Another staff interviewee summarised this when they said, "there was a sense in the organisation that West Lane was insular and there was a sense at West Lane that the organisation doesn't understand us".

4.168 Interviewees repeatedly referred to staff turnover, sickness absence and use of agency and bank staff when discussing the culture of the unit. The transience of the workforce was used to partially explain the unit's failure to embed key service changes, such as the RRP initiative: "What we tended to find with West Lane, it would never quite seem to embed, if that makes sense, so you would get a couple of champions and they'd do some really good work, we'd see some really nice bits, but then it would get lost for a few months, one of the champions would perhaps go onto long-term sick leave."

4.169 The lack of a consistent workforce was a known challenge for the unit; however, we found a failure to identify this as a risk to the quality of care and treatment of the children and young people on the unit. Continuity of care is a crucial element of providing high quality and safe care to the type of patients admitted to WLH. However, we found evidence that there was an attitude of acquiescence to the subject of consistent staffing on the unit. We were told that the chaotic nature of the unit meant that handovers were often ineffective, a risk heightened by the reliance on temporary staff with limited knowledge of the unit. There was also limited time for ward managers to assess the training and experience of agency staff and little evidence to suggest that mitigating actions were put in place when gaps in experience and training were identified.

4.170 The quality of rostering at WLH was criticised by many staff interviewees and cited as a contributory factor to the chaotic atmosphere of the unit. Prior to the 2018 inappropriate restraint incidents, self-rostering was used, and we were told that there was little intervention from ward managers and modern matrons in the management of the roster. The impact of this was that there was little oversight of the amount of overtime staff members were undertaking and the subsequent impact on their own wellbeing: rosters were not always accurate, with staff movements between the wards not reflected on the roster, and there was a

fundamental lack of granular understanding of the staffing needs and gaps on the unit.

4.171 Staff sickness was also not reflected on the roster, which gave further false assurances to senior managers that staffing numbers were adequate.

4.172 There was consensus amongst interviewees that the dynamic between staff on the ward shifted significantly after November 2018. The response to the 2018 inappropriate restraint incidents is explored more fully in section 4.23, and the impact on the culture of the ward was multifaceted:

- Myths about staff culpability, or lack thereof, in the 2018 inappropriate restraint incidents pervaded amongst staff on the ward, creating an atmosphere of distrust and defensiveness.

- Differences in clinical opinion between CAMHS and AMHS staff were not openly discussed, mediated, and resolved, resulting in inconsistent approaches to the care of young people on the wards.

- The underlying sense of chaos increased, which reduced the safety of young people and put staff under additional pressure.

- Poor management of business continuity[36] processes involving frequent and inadequately communicated changes to practice.

4.173 There was a stark division in interview feedback from staff who worked at WLH at the time of the 2018 inappropriate restraint incidents, in comparison to AMHS staff who began working at the hospital in the aftermath of the incident. CAMHS staff reported feeling tainted by association and most shared the view that their clinical opinion and CAMHS-specialism was disregarded by AMHS. This issue was raised repeatedly in the context of the management of restraint, restrictive practices, and observations.

4.174 AMHS staff were also broadly in consensus that CAMHS staff were strongly resistant to new ways of working and were actively unwelcoming to AMHS staff who joined the unit: for example, by not acknowledging their presence on their first day on the ward. Key comments made in the interviews included:

> "You couldn't raise issues because there was a sense of this is CAMHS, this is how we do it – what would you know? You are adult staff."
>
> "I was told constantly prior to November 2018 that it was 'different in children', and my rationale back to that was that it was not different – they were smaller people, but the principles were the same, and good practice was the same wherever we worked."
>
> "It was quite overt that they weren't happy and that they didn't want to change."
>
> "My reflection was that neither side understood each other."

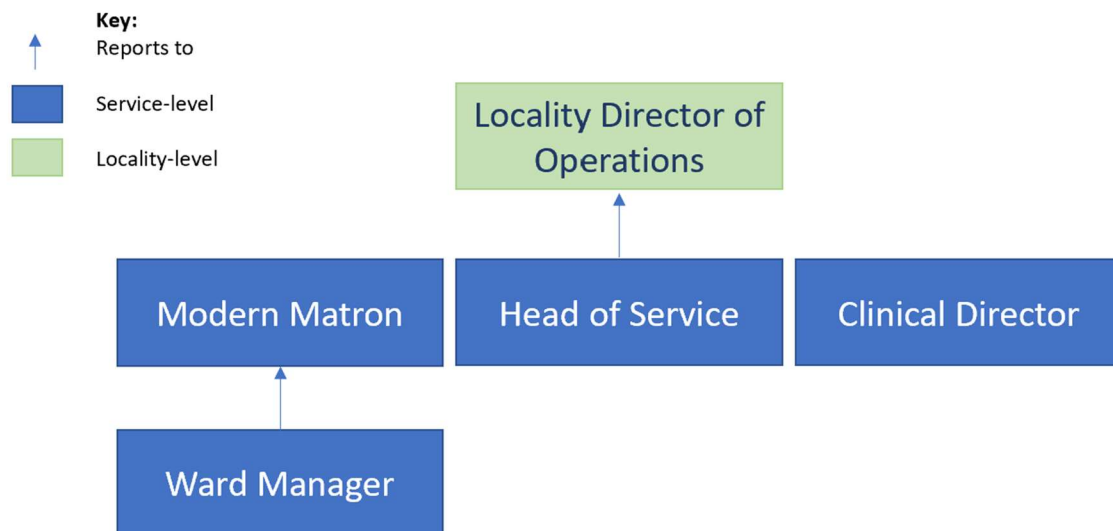### Service leadership

4.175 A lack of robust service-level leadership was repeatedly cited as one of the key contributory factors underpinning the dysfunctional service-level culture outlined

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[36] From TEWV Business Continuity Policy. CORP-0048-v4.1."Business Continuity: Creation and validation of a practiced logistical plan for how an organisation will resume and continue delivery, partially or completely, of interrupted critical functions within a predetermined time after a disaster or disruption."

above. There was an absence of effective leadership at WLH, which meant that the service's tendency to be inward-looking remained unchecked, practices at odds with Trust policy and values were not challenged and the managerial line of sight to the service was fractured.

4.176 The structure of service-level leadership at WLH is illustrated below:

4.177 The Modern Matron, Head of Service (HoD) and CD were commonly referred to as the 'supercell group', denoting that they were the key leadership team for WLH. Despite this, we were told that the supercell did not meet on a regular basis; there was no dedicated supercell meeting for T4 CAMHS. We were told that the only scheduled opportunity for the service leaders to meet to discuss issues was at the T4 QuAG meeting, which often had a full agenda, a much wider membership and also only occurred monthly.

4.178 One interviewee told us: "There were identified leaders nominally. You were a head of service, you were a clinical director, but there wasn't a sense of leadership team, so I think when we talk about collective leadership there wasn't that element of collective leadership." We would typically expect for the service triumvirate to meet weekly, as a minimum, to discuss emerging operational issues and the status of actions, to share information, and crucially, ensure that there was consensus about key decisions that could impact the operational and strategic direction of the unit. Meetings of this type ideally take place on site to aid visibility with ward staff.

4.179 There was a significant amount of churn in service-level leadership roles from 2017 onwards, particularly that of ward manager. This was in addition to the transient nature of ward staffing in general, as detailed earlier. There were significant inconsistencies in how service leadership was described at different times by interviewees. Whilst we recognise that this could partially be attributed to the passage of time, the level of inconsistency suggests that service-level leadership was not clearly communicated and understood at times: "the leadership team across site changed because we had lots of new people, understandably because of what happened and what continued to happen, but I think the dynamic there changed. I am sure people have said people probably didn't know what their role was anymore or where they fitted in, or how their communication went, so I think there was some chaos at times."

4.180 The appointment of new modern matrons and ward managers in the aftermath of the 2018 inappropriate restraint incidents was an opportunity to identify and address the myriad of problems that had built up at WLH. The likelihood of this happening in practice, however, was immediately reduced due to the lack of clarity with which new leaders were appointed. Several told us that they were "asked to support WLH"; however, some were given the title of Modern Matron or Ward Manager. This led to confusion and misaligned expectations about what the new leadership roles were there to resolve and to achieve.

4.181 We were told that leaders brought into the unit after November 2018 had a divisive style, whereas others felt that leadership titles were bestowed without sufficient power and autonomy; for example, it was reported that new ward leaders were not permitted to appoint staff they had previously worked with, which undermined the extent to which they felt they could rapidly enact change. There was no single person in overall charge of the unit, which also led to confusion and diluted accountability.

4.182 There was broad consensus that the HoS portfolio was too large to enable the post-holder to be fully effective. The HoS role is key in connecting the service with the rest of the organisation. The impact, therefore, of the portfolio being unwieldy was that the post-holder was unable to be as present on the wards, which was therefore a missed opportunity to identify and escalate key service risks. The extent to which the post-holder could collaborate with other leads, namely the clinical directors, was limited, and their attendance at key meetings was not as consistent as we would expect. This was recognised by the Trust and the role was split to ensure a HoS with responsibility only for Tier 4 CAMHS.

4.183 A common theme running throughout the interviews was the lack of physical presence of leaders, from ward managers to CDs to the locality operations director at WLH. We understand and were told that this was in part due to the location of management offices on the site – these are not on or adjacent to the wards and therefore reduced the visibility of leaders on the wards. This was also seen by many to have been exacerbated by the administrative burden faced by managers in response to managing sickness and agency staff; this significantly reduced the time available to simply be on the wards. However, criticism was also levied at the perceived willingness of the locality managers, HoS, CDs, and other key service leaders, to spend time on the wards.

4.184 We were told that the Locality Manager (who reported to the HoS) and Modern Matron would meet daily to discuss operational issues such as incidents and staffing. These meetings were not minuted to our knowledge, nor did they have a high profile with ward staff. We also understand that there was a weekly WLH performance meeting with representation from the three wards and periodic attendance from the HoS. Again, the focus of this meeting was staffing, incidents and admissions/discharges. Whilst not minuted, the information discussed at this meeting would be presented on a board in the corridor at WLH.

4.185 Clinical leaders were also generally described as not visible or "hands off". Staff told us that there was an absence of senior clinical direction in relation to aspects of young people's care, such as when and how to use restrictive practice. This created a culture in which inappropriate restraint was not well understood and not challenged. As outlined earlier, this allowed for situations to develop in which staff felt that restraint was essential to keep patients safe. The structure and development of clinical leadership roles was criticised repeatedly throughout the

interviews. Leadership roles tended to be assigned without clear indications about expectations and parameters.

4.186 We have not seen any evidence that CDs at WLH were provided with training or a robust induction, nor were job plans updated to reflect the additional responsibilities. The link between the CD role and the strategic direction of the service was characterised as vague by several interviewees: "There was a sense that we were all talking about the same things, but it was not clear who was doing what."

4.187 The quality of supervision on the unit was also criticised by several interviewees. The pressurised environment of the wards coupled with the low visibility of leaders led several to share the view that "thinking about clinical standards and clinical practice, there wasn't a great supervisory element on the ward". Records of clinical supervision were insufficient.

4.188 There were isolated examples of leadership interventions that, had they been sustained and supported more broadly and at the highest levels of the Trust, may have reduced the level of clinical risk at WLH. In 2016, a WLH psychologist provided a presentation titled: "How incidents became more about compassionate leadership in sustaining compassionate care". This references several issues which we found to be 'live' issues at the unit prior to its closure, such as:

- CAMHS as an outlier in relation to numbers of incidents.

- The need for shared understanding and support re incident management.

- Collective, collaborative, compassionate leadership to sustain compassionate care.

- Model of compassionate leadership and the benefits for service users and staff.

4.189 The same presentation went onto say that "Barriers to compassionate care being: insufficient time/breaks when patients challenging; high levels of acuity, incidents, multiple demands; 12-hour shifts; no time to process emotion; task focus, negative approaches; feeling incompetent or threatened, stress, negative judgements, lack of relationship and mistrust; medical model; staffing; audits and external quality assurance."

4.190 We were also told by several interviewees that there was a dysfunctional relationship between some service leaders. The culture of the unit during and following the return to work of suspended staff was further exacerbated by the inconsistent and, at times, remote presence of leaders on the unit.

4.191 Leaders in place at WLH after the 2018 inappropriate restraint incidents spoke of the high number of meetings that they were required to attend as the organisational and, eventually, specialised commissioning and regulatory focus on the unit increased. Most felt that this inhibited the extent to which they could meaningfully engage, lead, and enact change on the wards.

The role of the multi-disciplinary team

4.192   There was mixed feedback about the effectiveness of multi-disciplinary team[37] (MDT) meetings at WLH with variations between the three wards. Newberry was generally regarded to have the most robust approach to MDT meetings, whereas we were told that there was a lack of clarity about how MDT meetings should work and an inconsistency in how they operated in practice on Westwood and Evergreen. As outlined earlier, we found that the three wards, including their respective MDTs, worked separately with little communication and engagement.

4.193   We found that there was not one clear definition of what an MDT was, which resulted in variation of practice and inconsistency. In addition to MDTs, interviewees referred to think tank sessions, case conferences, grand rounds, report outs and daily action meetings in an interchangeable way, akin to the generally accepted definition of an MDT meeting. The absence of terms of reference, definition and, frequently, records of these meetings contributed to the confusion and use of interchangeable terminology.

4.194   We found the role of nursing staff in MDTs to be a point of significant weakness. Several interviewees said that nurses either did not see themselves included or were considered as part of the MDT. This is evident in Nadia's care when there was an MDT "think tank" session with no nursing staff in attendance (although they were heavily involved in her care planning on the ward). This is particularly shocking given the high level of restrictive intervention being used on Nadia at the time. Some interviewees described the ethos surrounding MDTs on Evergreen and Westwood as "split" either between nurses and other clinicians, or between psychology and psychiatry. We also note that the profile of occupational therapists (OTs) at WLH was very low, and they do not appear to be an integrated part of the MDT approach. The effectiveness of MDT meetings further deteriorated in the aftermath of the 2018 inappropriate restraint incidents; we were told that decisions made at MDTs would often be reversed by ward leaders, which undermined the role of MDTs and led to confusion amongst staff.

4.195   We also found evidence that the MDT failed to comply with the Trust's policy on DoC. Nadia's death, for example, was a "notifiable safety incident" and met the criteria for a DoC notification. The policy lists seven steps that must be followed next, the first of which is that a "senior member of the MDT must notify the person the incident has occurred … if the patient has died a condolence letter and the initial apology for what has happened will be sent out from the Head of Service". Further steps include giving the notification in person, giving an apology, advising of next steps and making a record of what has been said and to whom in the care record. This responsibility was delegated to the MDT without clarity in the policy and without a clear assurance mechanism to ensure that MDTs function as intended. Further findings in relation to DoC compliance are outlined in more detail in section 4.37.

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[37] "Multi-disciplinary team working – how health and care professionals work together to support people with complex care needs that have been identified through risk stratification and case finding." NHS England Report Template 1 - half page cover photo

4.196 We were frequently told about "Stop the Line" meetings held in relation to the index cases. Originating in the car manufacturing industry, Stop the Line[38] refers to the creation of a culture in which every staff member feels empowered to stop the literal or metaphorical assembly line if they notice something is wrong. It is designed to be a rapid reaction, an opportunity to identify a problem at the earliest possible stage and act accordingly. We found:

- No formal definition or protocol for a Stop the Line meeting at TEWV.

- Stop the Line meetings which took place up to a week or two after they were first suggested, which significantly undermines the impact of the meeting as a decisive and rapid intervention.

- Evidence that there was a lack of leadership of Stop the Line meetings, resulting in unclear next steps and a failure to agree on how any action taken would be assessed.

[38] Sugimori Y, Kusunoki K, Cho F, *et al.* Toyota production system and kanban system materialization of just-in-time and respect-for-human system. Int J Prod Res 1977;**15**:553–64.doi:10.1080/00207547708943149

Part 5 – Corporate, regulatory and system elements

Corporate elements

Board-level oversight

5.1 Ineffective escalation mechanisms and fundamental weaknesses in the function of key meetings resulted in a failure of corporate oversight of quality and safety at WLH. We found numerous missed opportunities for concerns about care and treatment at WLH to receive the attention and response they required from those responsible for governance and oversight at the Trust. There were numerous meetings which, if functioning effectively, should have identified the extent of risks at WLH.

5.2 Appendix D illustrates the Trust's governance structure. However, the following corporate meetings are constitutionally responsible for stewardship at WLH:

- the Board of Directors (the Board) – has the ultimate responsibility for the work of the Trust;

- the QuAC, which reported to the Board – has the delegated responsibility for matters of quality and safety;

- the Resources Committee; and

- the Mental Health Legislation (MHL) Committee both have a corporate duty to report on matters of significance.

5.3 Most Board-level interviewees stated that the first time they were alerted to the severity of pressure within the service was in the aftermath of the 2018 inappropriate restraint incidents. There were, however, clear warning signs reported to QuAC, the membership of which contained several Board members. Issues with the effectiveness of the Board and Board's committees, the quality of reporting and escalation all culminated in WLH not being identified as an area of significant risk.

5.4 Prior to the 2018 inappropriate restraint incidents, WLH was most frequently referenced in the Board's Resources Committee. This was exclusively in the context of NCM, a national initiative to implement a new approach to inpatient CAMHS care in the pursuit of providing care closer to a patient's home and saving costs. We found there to be a preoccupation with the financial performance of NCMs at WLH and little evidence that Board members sought robust assurance about the impact of this initiative on quality and safety at the unit.

5.5 'Red flags' in relation to quality, safety, and performance at WLH were present in reporting to QuAC several years before the closure of the unit. At the November 2016 committee meeting, reports documented myriad issues associated with T4 CAMHS, namely escalating acuity, staffing shortages and recruitment, bed pressures, high levels of self-harm, high levels of restraint and problems with the Force Reduction Project. These issues arose in individual reports and were not robustly triangulated, and there is no evidence that their collective weight was noted in the meeting itself. Specifically:

- Committee members [are] informed via the LMGB Assurance Report that "clinical demands and complexities on wards remain high and difficult to manage" and there are "increased incidents, particularly on Westwood".

- The Quality Strategy Scorecard gave CYPS a 'red' rating for myriad metrics including complaints, patient engagement in care planning, compliance with statutory and mandatory training and staff friends and family scores.

- The Tees locality risk register is presented and includes a high risk (T-CA4-241) which relates to the risk to clinical service delivery at WLH posed by inadequate staffing levels.

5.6 The assurance report from the PSG, a sub-group of QuAC, highlights increasing control and restraint numbers in Tier 4 CAMHS as one of the key issues across the organisation. The report details that in June 2016, 41% of the total restrictive interventions were in T4 CAMHS, with Westwood and Evergreen being described as "outlier areas". This was despite T4 CAMHS comprising only 5 per cent of Trust-wide inpatient beds.

5.7 The November 2016 Board meeting is subsequently informed via the QuAC Assurance Report that "acuity on the Wards continued to be a growing problem, particularly […] at West Lane" and it is noted in the report that this is an area to be escalated to the Board's attention. A review of minutes arising from the November 2016 Board meeting does not evidence that this issue was discussed by BMs.

5.8 Triangulation of issues relating to T4 CAMHS at QuAC was further hampered by the committee's full agenda, a characteristic which several interviewees felt reduced its ability to interrogate issues and seek assurance.

5.9 Further examples of WLH being brought to the attention of BMs as an area of concern in the years prior to the 2018 inappropriate restraint incidents include:

- May 2016 – QuAC receives a paper titled "Force Reduction: Inpatient CYPS". This outlines in detail the context for the use of restraint in T4 services and the specific challenges faced by T4 services in reducing restraint, such as turnover of staff, complexity of patients, rising acuity and the impact of transfers between CAMHS and AMHS.

- December 2017 – QuAC is alerted to the fact that Newberry and Evergreen are outliers in relation to restraints, with Westwood showing increasing levels of restraint. This is not highlighted in the preface to the PSG report to QuAC and is only apparent on reading the detailed appendices to this report.

- February 2018 – QuAC is informed of increased levels of complexity and acuity across all three wards, as well as an increase in formal and informal complaints relating to communication and inadequate staffing, and increasing numbers of incidents, namely those relating to NG feeding.

- July 2018 – QuAC receives a presentation titled "Restraint and Physical Interventions in T4 CAMHS Services". The minutes note that members are concerned about this issue and would like the topic to feature in a future Board seminar. The minutes do not identify a timescale for this action and we have no evidence that it did take place in practice.

5.10 The Board is also supported by the Non-Executive chaired MHL Committee, which met quarterly. Notably, this did not feature in any responses from interviewees when we asked about the Board's oversight of safety and quality at WLH. Standing items at this meeting included: a seclusion report including ward-level data; a mental capacity and deprivation of liberty (DoLs) report; and a

discharge from detention report. A review of minutes from 2016 onwards found that much of the meeting focused on AMHS, with little scrutiny of CAMHS, including T4 services. In the 12 months after the 2018 inappropriate restraint incidents came to light, we found only two high-level references to WLH in meeting minutes: one in the context of one escalation from Newberry in the Section 132 report, and a further reference following the presentation of the CQC report in July 2019.

5.11   We also found evidence to suggest that the Board was overly accepting of verbal reassurance in relation to quality and safety across T4 CAMHS. For example, the minutes of the November 2017 meeting note a question regarding "the pressure on WLH". The response is a generic reassurance that an influx of qualified nurses, coupled with improvements triggered by the NCM for T4 CAHMS "has reduced pressure". We also found a failure to identify contradictions between verbal reassurances and other sources of information linked to WLH. The QuAC Assurance Report noted that the service remains under pressure, in part due to the need to integrate new staff. The Board were not cited on the unintended consequences associated with bringing in new staff into a complex CAMHS environment. This is likely exacerbated because these issues were not being addressed under a dedicated improvement risk register.

5.12   The Board's scrutiny of WLH after it was informed of the 2018 inappropriate restraint incidents was significantly lacking. Whilst the Board was promptly briefed on the incident at its meeting in November 2018, there is little documented challenge in relation to the circumstances of the incident nor evidence that further assurance was sought regarding any 'make-safe' actions. Board minutes recorded valid questions in relation to DoC and Freedom to Speak Up (FtSU) processes; however, we found that subsequent meetings did not provide adequate responses to these questions.

5.13   The Board should have prioritised the issues at WLH following 33 staff being investigated and taken out of duty, given that this was an almost existential risk to clinical care and matters of reputation.

5.14   Concerningly, risks that were raised by staff did not seem to penetrate to the Board's attention. For example, an email sent by a staff nurse at WLH following the suspensions states: *"I wanted to express my concerns in regards to the staffing levels that we are being expected to manage on currently. As a result of the poor staffing, the level of therapeutic intervention and quality of care has become extremely low as we are mostly having just enough staff to perform visual checks on the young people. We have also had to not go ahead with planned interventions such as supporting the young people with leave or running ward activities. In addition, we are very rarely managing to have breaks which is leading to the staff getting burnt out. I have been nurse in charge today and I must say I have found it extremely difficult and stressful trying to manage the staff and ensure that the safety of everyone is maintained. I have also not been able to complete the daily nursing tasks and have had to do the bare minimum for the shift. I think it's also important that you know that the young people have reported to staff that they feel that their care is suffering as a result of the staffing situation. I personally feel like we have been in situations where there have not been sufficient numbers of staff left on the ward to manage an incident should it arise and this has been a concern of many of the other staff also."*

5.15 The email goes on to say: "*today we had two young people needing to attend A&E and really struggled to manage this. We actually had to use a parent to help with the A&E visit. I appreciate on paper the figures for the staffing on site may look OK but I feel that it's important that we are sharing that actually when you factor in response, planned interventions and meetings along with the continuous observations we are not coping on the Newberry Centre … A lot of staff are also struggling with the lack of management presence as well. I think with our manager supporting another ward and being mostly based on another ward the band 6 management days are vital to offer a senior presence to give support and supervision to the staff as we are having a really hard time … I think with everything that's happened on site recently the message has been very clear that we have a responsibility as staff to raise these concerns, so I thought it was important that I communicated this to you."*

5.16 This extensive and at times pleading email was met with, in our view, a platitudinous: "*Thank you for raising your concerns. We are busy recruiting more staff to strengthen the staffing rotas. I will ask modern matrons to review the daily requirements for each ward so we can better ensure we are supporting staff to carry out what they need to do. I am sorry there are no quick fixes and I really do appreciate how hard staff are working in these difficult circumstances. If you let me know when you are on duty I will call in to catch up with you".*

5.17 The lack of attention given to WLH by the Board continued until the Trust received the CQC enforcement notice in June 2019. The minutes of the June 2019 meeting evidence that NEDs requested a retrospective analysis of how the service had reached the present position. This was an overdue but positive step towards identifying the scale of risk and dysfunction at WLH; the findings were presented to a Board seminar on 8 August 2019. This seminar contained a chronology of events and actions taken at WLH since the November 2018 restraint incident. It is concerning that at the same session (eight months after the incident) that it was still "unknown at present, how and when the inappropriate practice of moving and handling had developed". A review of the documentation used for this seminar showed that the Board were assured that there were "no immediate safety concerns", which is a direct contradiction to the concerns raised in the June 2019 CQC enforcement notice only two months earlier.

5.18 In July 2019, the Board also received a presentation on the key issues facing the Tees locality. Minutes capture some Board-level discussion in relation to T4 CAMHS, namely in relation to the impact of NCM on funding for WLH as well as benchmarking data in relation to restraint. However, we found there to be a concerning lack of focus from the Board on the current quality and safety of services provided to T4 patients.

5.19 It is our view that the lack of prompt and assertive remedial actions from the Board in relation to WLH are due, at least in part, to aspirational assurances given at that time which helped to develop a sense of confirmation bias.

5.20 These include:

- The Board were told at the August 2019 seminar (above) that there was daily monitoring and oversight of staff numbers and that there was currently sufficient staffing, without an acknowledgement of the continuity, quality and fragility of those establishment numbers.

- The notes from that session also indicate that, despite the QRP event on 6 August 2019 raising concerns associated with incident management, "the Trust considered that its present processes were appropriate taking into account guidance and practice elsewhere". There is no evidence of NED challenge in relation to this stance. Notes also state: "whilst it was recognised that the CQC had evidence to require the closure of the Hospital, the risks of this, notwithstanding the recent SI, had receded over the last couple of weeks". It is not clear on what basis this assertion is made.

- The July 2019 Board was provided with assurance "as a result of the [NCM] programme that funding to services at West Lane Hospital had increased and had been used to provide additional staffing. An example of this was the establishment of the children's crisis services in North Yorkshire and York which would further contribute to reducing inpatient admissions."

5.21 There was also insufficient curiosity regarding the culture at WLH: at the same meeting the Board discussed the impact of retirement on staffing levels and the need to focus on retire and return "in order to maintain the balance of experienced and newly qualified nurses". There is no evidence that BMs sought to understand the underlying reasons for staff attrition at WLH. This would have revealed that staff were leaving due to stress and reduced wellbeing, which is indicative of a service in potential distress.

5.22 Directors' visits are a less formal component of the governance and oversight framework at the Trust. A programme of directors' visits has been in place for several years. This involves an executive or non-executive director visiting a designated site or service at the Trust. We were told that visits were 'themed'; for example, one visit to WLH had an 'estates' theme during which ancillary areas of the site were visited, such as the boiler room and the kitchen. We are not aware of any directors' visits to the clinical areas of WLH being undertaken and reported since 2017.

5.23 The purpose of the directors' visits was and continues to be vague; some interviewees described their function as providing an insight into the work of individual services, whereas others described them as a key Board assurance mechanism. We found no evidence of a formal reporting mechanism following directors' visits, which raises the risk that issues identified during a visit are not widely known nor acted upon and that opportunities for learning are missed.

5.24 Those undertaking visits were supported via a 'typical questions' document which included a range of suggested topics from safe staffing levels, checking whether staff know how to raise concerns and the effectiveness of communication with management. This document, however, did not include indicative questions that would have necessarily highlighted some of the challenges associated with working at WLH and may have benefited from some simple additions such as "What is the most challenging aspect of working on this ward?" We also note that questions pertaining to multi-disciplinary team working and capturing the views of patients and carers were omitted from the question list (however, these were addressed in a 2020 update to the document).

5.25 The oversight of WLH by the Council of Governors (CoG) was heavily skewed by the quality of Board oversight. Governors were generally briefed soon after the Board identified an issue. However, the failures in Board governance outlined

above ultimately impacted on the completeness and accuracy of information provided to governors.

5.26   In February 2020, the Board established a NED-chaired WLH project committee, which met monthly. The ToR outlines that this reports directly to the Board and includes both Executives and NEDs in its membership. The purpose of the committee is "to oversee all the activity related to WLH with a focus on learning from incidents arising from internal and external reviews [and] there is a WLH Delivery Group reporting into the Project Committee.

5.27   The impact of the WLH committee was initially adversely impacted by the emergence of the Covid-19 pandemic; this is evident in meeting minutes and the lack of detail included in reports to the committee between March and October 2020. For example, the committee received a report titled "Driving improvements in the quality and safety of care through learning from West Lane Hospital" in November 2020. Most of the content of this report was derived from the Early Learning Themes report which was published 10 months earlier in February 2020. We also note that several areas for improvement identified in the report did not have a corresponding remedial action, nor was it clear how the efficacy of identified actions would be assured.

5.28   We were told that in spring 2021 there had been renewed focus into the committee. Minutes show that an action log was implemented in March 2021 at the suggestion of the CEO. An organisational learning task and finish group was also established in early 2021, which aimed to share learning (both from the events leading to the closure of WLH and in general) across the Trust.

Executive team oversight

5.29   The EMT has met weekly for several years. The focus of meetings alternates between performance, business development and strategy, across a 'standard' agenda which tends to cover a broad range of issues. EMT meetings are typically attended by locality directors of operations (DoO). Minutes regularly capture DoO verbally escalating key issues from each locality.

5.30   The EMT was too far removed from WLH to identify the escalating risks associated with operations, quality and safety. A review of EMT minutes and papers in the two years prior to the 2018 inappropriate restraint incidents found that the oversight of locality and service-based issues to be superficial with an over-reliance on verbal summaries from the DoOs regarding the most pressing issues. There was also insufficient triangulation and interrogation of quantitative data. Examples of concerns associated with the resilience and capacity of T4 CAMHS being brought to the attention of the EMT include:

- Throughout 2017, the EMT is alerted to rising CAMHS referrals/rising demand for CAMHS inpatient services. We also found minutes capturing concern that CAMHS pressures are not being consistently raised at the Safeguarding Children's Board.

- In July 2017, EMT notes a Never Event associated with a CAMHS patient being held on Cedar Ward (a PICU). It is agreed that there would be a review of how this situation arose with a report back to the EMT in four weeks' time; however, we found no such evidence that this was received, nor that there were robust systems in place to trigger alerts (and statutory escalations to the CQC) around CAMHS patients being cared for in adult units.

- In September 2017, the EMT is informed that "there are significant difficulties both clinically and with staffing at West Lane currently, across all Tier 4 services for different reasons". There is a brief discussion about moving staff to help strengthen the service, but it is not clear how and if the EMT will monitor this situation.

5.31 Despite being designated as the most senior operational forum in the Trust in relation to the oversight of incidents and risks, we found little evidence to suggest that EMT afforded these crucial issues sufficient time nor analysis. For example, the Director of Quality Governance (DoQG) would frequently report numbers of incidents to EMT, but there was little 'business as usual' intelligence provided on the themes, trends and associated learning arising from SIs. This is explored further in the incident section. Similarly, we found EMT's oversight of operational and corporate risk to be significantly lacking – see section 5.

5.32 The response of the EMT to the 2018 inappropriate restraint incidents lacked urgency and rigour. The EMT were promptly alerted to the "significant safeguarding concern in respect of a patient on Westwood" on 14 November 2018, with a further update on 28 November 2018 clarifying that concerns now extended to "the movement of other patients […] by a large number of staff". After this point, there is very little reported to the EMT regarding the outcome of an internal investigation, referrals to the LADO, liaison with the police, and crucially, how staffing on the unit was being safely managed whilst investigations were being undertaken. There was a perception amongst some service-level staff that "there was very little interest in the service, apart from in taking young people that needed extra care".

5.33 Several interviewees stated that the decision to suspend WLH staff in the wake of the 2018 inappropriate restraint incidents was taken by the EMT. However, we found no evidence in EMT papers or minutes that this decision was agreed by this group; we are told that they were verbally briefed. We understand that the DoN was on leave at this time and so the deputy made this decision along with HR.

5.34 However, the opportunity cost and risk analysis around this decision was insufficient and we would expect there to be a clear governance framework and decision-making audit trail in relation to an action of such magnitude. Other interviewees described that the decision-making process around suspensions and staffing at WLH was too informal in relation to executive involvement. Comments made included:

> "It was a conversation at director level, exec-level and [with] HR."
>
> "People like the Chief Executive and the Chief Operating Officer would have been informed."
>
> "Discussions took place in the senior exec team [and] there were concerns expressed about moving away from the suspension investigation route."

5.35 Between January and May 2019, there are surprisingly few references to WLH in EMT minutes. Despite some executives sharing the view that "we had good discussions on a regular basis with the execs about how things were developing, what the issues were and what the emerging information was", there is little evidence to support this in EMT minutes. We found a reference in May 2019 to the EMT agreeing for WLH to enter into intensive OD support and an action to

bring back a proposed intervention plan by the end of November 2019. Additionally, the Head of Governance attended the Trust Board in September 2019 and WLH wards are referenced in the Head of OD report. The reason for a six-month gap between the identification and completion of this action is not clear, and given the severity of issues at WLH, we find this response to be wholly inadequate. There is little in the way of documented discussion or assurance in relation to assimilation of new staff, the return of CAMHs staff post-suspension/special leave, insights gained from leaders who were physically present on the site or the outcome of OD involvement at WLH.

5.36 The line of sight from EMT to WLH continued to be a fundamental weakness throughout 2019 until the point that the unit was closed at the end of August 2019. Whilst we were told that SIs, such as Christie's self-ligature attempt in March 2019, were discussed by the EMT, we only found evidence that the group was informed in April 2019 of a "near-miss"; there is no indication that the seriousness of the incident and its context were relayed and discussed by the EMT.

5.37 The Board recognised the weaknesses in its governance and escalation framework in 2019. EMT discussed the need to improve the flow of assurance from services to localities and then EMT, QuAC and the Board. Led by the DoQG, work was undertaken to ensure the agendas of QuAGs, LMGBs and QuAC were more aligned; this was reported to the EMT in May 2019. We welcome this focus. However, there remains scope to strengthen both the consistency with which issues are escalated up the operational governance structure and the robustness applied to actions associated with escalated issues.

(Recommendation 8)

Locality and service oversight

5.38 In 2017-2019, the Trust was split into four geographically based localities: County Durham Council and Darlington, North Yorkshire, and York and Selby. T4 CAMHs has been positioned within the Tees locality since August 2016; prior to this it was managed in the North Yorkshire locality. There was broad consensus from interviewees that the reorganisation resulting in T4 CAMHS being moved to the Tees locality was positive as it meant that inpatient and community CAMHS were reunited. The large geographical footprint and the size of the Trust's localities was also cited regularly as important and a challenging context for the governance applied to WLH.

5.39 Each locality has a LMGB which is the primary oversight mechanism for each service. Each service has a QuAG which feeds into the LMGB. The Trust also has organisation-wide specialty development groups (SDG), clinician-led forums focused on clinical effectiveness. Appendix D illustrates the Trust's operational governance structure in respect of T4 CAMHs.

5.40 We found numerous weaknesses in the locality-level oversight of T4 CAMHs, namely:

- LMGB agendas were repeatedly described as overly full and did not allow for sufficient scrutiny of escalated concerns and emerging risks; issues arising from the T4 QuAG meeting.

- There was a perception that the LMGB did not exert parity of attention to T4 CAMHS in comparison to other services, and a held a dismissive attitude

towards the service, which reduced the scrutiny applied to quality and safety. Some interviewees also reported that there was inconsistent attendance from T4 CAMHS representatives (particularly ward managers) at LMGB meetings, which further reduced the likelihood of robust discussions about the service.

- Some reported feeling that LMGB meetings were not meetings in which concerns could be aired freely and that agendas were often too heavy to invite a focus upon priority risk areas.

- Escalation from the service to the LMGB was not robust. QuAG minutes evidence frequent discussions about what issues to escalate to the attention of the LMGB. Given that the LMGB is the gateway through which service concerns are raised to the attention of the EMT, QuAC and then ultimately the Board, this is a key failure of governance.

5.41 Service-level issues, such as staffing pressures, regularly surfaced at QuAG meetings; however, the process by which these issues were escalated to, and then responded to by the LMGB, was fundamentally flawed. For example, QuAG minutes and papers as far back as 2016 contain clear concerns associated with staffing numbers, experience and capability, sickness, staff caseloads, pressure on staffing because of patient acuity, observations and the effects of repeated restraint on staff. We found that such matters were not evidently discussed by or highlighted to the attention of LMGB members. A typical comment from the interviews was "there wasn't that governance structure where information goes up, information comes down, people are looking, scrutinising it, thinking about what are our themes, how we are going to respond to that".

5.42 Further examples of missed opportunities to escalate concerns associated with WLH from service to locality level and beyond include:

- April 2017: QuAG noted that the LMGB and SDG should be alerted to the "high level of incidents, especially aggression to staff, on Newberry, as well as Newberry being used as a PICU ward".

- July 2018: QuAG discussed the challenges of reporting and analysing the use of restraint at WLH. It was agreed that QuAG would receive a report from the Heads of Nursing on restraint, and feedback would be provided to the LMGB; a review of the effectiveness of this process was planned for September 2018 but we found no evidence that this happened in practice.

- January 2019: QuAG discussed the "fragility of staffing" at WLH and identifies this as one of the top concerns to escalate to the LMGB. We found no evidence to suggest there was a resultant discussion or action identified at LMGB.

5.43 The ToR for both the LMGB and service-level QuAG meetings are explicit about their role in overseeing patient safety; however, we found there to be significant gaps in how this was done in practice. For example, neither the LMGB nor QuAG robustly scrutinised the use and risks associated with NG feeding, one of the highest risk interventions deployed by the Trust. Oversight of incidents was also significantly lacking with lengthy delays between incidents and their reporting to QuAG, coupled with a lack of analysis of incident information at LMGB-level and beyond.

5.44　We found that similar weaknesses also applied to the SDG, which failed to calibrate and respond to the escalating level of risk at WLH. SDG is a specialty-specific forum which, per its ToR, was responsible for overseeing the work of the Positive and Safe Advisory Group as well as:

- developing and leading agreed patient pathways and protocols;

- providing thought leadership on the development of excellent quality services and standards of practice;

- commissioning reviews of areas of practice, patient experience, clinical safety and effectiveness, service development, and improvement and governance as indicated by local, regional or national drivers; and

- promoting a positive culture […] of person-centred compassionate care.

5.45　Despite the remit of the SDG, we found little evidence of scrutiny afforded to key areas of clinical risk in T4 CAMHS, such as use of restraint, restrictive practice, NG feeding. For example:

- SDG is alerted to the high levels of restraint used at WLH; however, minutes note that there is an "increase in use in CAMHS across the country", which downplayed the seriousness of the clinical risk associated with repeated restraint.

- Transitions received focus from SDG; however, this was most frequently in the context of CQUIN performance, rather than an analysis of how transitions were being effectively managed, what the associated patient experience was and further areas for improvement. This is explored further below.

- We also found no explicit reference to the specific staffing and staff wellbeing challenges faced by staff in the T4 service. Again, information was not sufficiently granular to identify locality issues. Interviewees also suggested that there was a lack of engagement from T4 CAMHS representatives in the SDG at times.

Risk management

5.46　Risk identification was a significant failing in the Trust's oversight of WLH. Whilst a RR (risk register) for T4 was maintained and regularly presented at QuAG, it was not an accurate reflection of the risks known to exist in the service. QuAG minutes suggest that the word 'risk' was frequently associated with the WLH service, but discussions did not meaningfully translate to items on the RR (examples are NG feeding, restraint, and newly qualified staff).

5.47　The Trust had an Organisational Risk Management Policy[39] which was ratified in January 2018. This defined the way in which risks should be identified, managed and, where necessary, escalated through the governance structure to the Board. In summary, each service is expected to maintain its own RR, which is reviewed at QuAG meetings; from this, 'high' risks are elevated to a locality RR which is reviewed at LMGBs and also at the EMT. Both the LMGB and EMT are supposed to calibrate risk and propose which are the most material risks for inclusion on the Corporate Risk Register (CRR).

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[39] Policy Template (tewv.nhs.uk)

5.48   The Board's responsibility per the policy was to consider:

- "The BAF, in its entirety, twice per year (including to report the outcome of the fundamental review following the approval of the Business Plan).

- In the intervening months, produce reports providing:

- A summary of the positions of risks contained in the BAF.

- The profiles for risks contained in the BAF where approval of significant changes is required or those with mitigating actions due/behind plan.

- A schedule (by exception) of mitigating actions behind the plan for those risks contained in the CRR.

- Any new strategic risks identified by the Board's committees or the EMT for potential inclusion in the BAF."

5.49   The Board's use of the BAF was detached from the reality of the organisation. The BAF presented to the Board at the end of July 2019, for example, made no reference to the CQC enforcement notice received a month earlier. The minutes of this meeting show that, whilst the BAF was discussed, BMs did not identify this significant omission. The BAF was also only updated to reflect risks associated with WLH in December 2019, three months after the closure of the site.

5.50   The Board received an RR in October 2017 that stated, "harm could be caused to patients and staff if we fail to reduce levels of violence and aggression on inpatient units". The narrative notes that there is a gap in control of "MOVA training and practice needs to be more closely aligned to PBS approaches". It also notes a Rapid Process Improvement Workshop (RPIW) is planned for the end of November 2018 to consider how restrictive interventions are recorded. The team continues to provide more intensive support to 10 services including Tier 4 CAMHS.

5.51   A summary of the risks on local risk registers (LRR) formally identified in relation to T4 services is shown below in Table 3.

Table 3: T4 CAMHS Risk Summary

Date identified	Date closed	Risk description and ID	Inclusion on LRR?	Inclusion on CRR?
September 2015	November 2016	Risks to patient care posed by nurses not revalidating or re-registering (245)	N	N
August 2015	July 2017	Adequate staffing levels (241)	Y	--
April 2016	May 2017	Safeguarding implications if patients older than 18 are cared for in CAMHS beds (240)	N	N
May 2016	May 2017	Access to education in inpatient areas (248)	Y	--
March 2017	--	Evergreen achieving its Quality Network for Inpatient CAMHS accreditation	N	N
March 2017	--	A high level of inexperienced workforce	N	N

February 2019	--	Staff perceive that there aren't enough staff and this is causing anxiety	N	N

5.52 For a large part of 2017 and all of 2018, there are only two 'live' risks on the RR relating to WLH: these were Evergreen's QNIC accreditation, and the use of inexperienced staff. During this time, there are known pressures at WLH associated with the acuity of patients, restraint, restrictive practice, blanket restrictions, observations, NG feeding and transitions; however, there is no sign that there was a holistic discussion about the cumulative risk at WLH.

5.53 Incidents were not translated into risks, which can be broadly attributed to a failure to investigate incidents properly and objectively in the spirit of learning and improvement, and also due to a culture which was not supported by a proactive approach to risk identification. For example, there was no formal identification of rising acuity as a key risk for WLH, yet this was by far one of the prevailing risks that interviewees brought to our attention. We note that on June 2019 BAF includes the following risk: "There is a risk to patient safety if the Trust fails to identify, share and embed learning from death". This was rated as "Very High". Despite this risk, we found that the escalation of incidents, including near-misses and deaths, through the Trust's governance structure to be inadequate, and there is insufficient evidence to show that the Trust meaningfully captured learning from such events.

5.54 The process by which risks relevant to WLH were closed is also cause for concern. Risk 241, for example, relates to adequate staffing levels and is closed in July 2017, at a time when staffing pressures across T4 services are regularly discussed at QuAG meetings and occasionally escalated to the attention of the LMGB. Risks are live for an extended period (regularly one year) and the more serious risk of adequate staffing levels is live for two years with static risk scores. Even if the risk cannot be fully resolved we would expect mitigating actions to manage the risk 'down' through firm and decisive intervention.

5.55 The risk of safeguarding implications if patients older than 18 are cared for in CAMHS beds (240) does, again, not describe what the actual risk is. There is also not reciprocal risk identified for CAHMS patients cared for in adult beds which, arguably, carries more severity and risk impact.

5.56 The presentation and use of RRs was found consistently through our review to not aid the clear identification and escalation of risk:

- RRs presented to QuAG were not consistently completed. For example, the live risks presented to the September 2017 QuAG meeting did not contain a Datix ID number or a risk score; rather, risks were described as "high", "medium" or "low".

- The RR format at QuAG did not include any indication of controls, mitigations or actions to manage risks, nor any rationale for 'closed' risks on the RR. The LRR only introduced high-level references to controls and gaps in controls in summer 2018; however, this approach was not applied to the T4 RR. This is indicative of a weak risk management culture which places insufficient emphasis on the efficacy of controls and the identification of remedial action.

- Risk descriptions were too high-level and did not articulate the actual risk and impact manifesting on patient safety and quality. For example, there are

myriad implications of the risk associated with "an inexperienced workforce"; however, there is little evidence that these are acknowledged, reviewed, and incorporated into the management of the risk.

- The time afforded to scrutinise the LRR at LMGBs was minimal and insufficient to have a meaningful discussion about the locality's risk profile. Minutes rarely demonstrate any triangulation between the content of the LRR and the rest of the LMGB meeting.

- Whilst the Trust's Organisational Risk Policy clearly states that the CRR was to be presented regularly at the EMT, we could not find evidence that this was done in practice.

5.57 The description of the risk identified in February 2019 and use of the word "perceive" in particular, also betrays an organisational dismissiveness towards the concerns of staff in relation to staffing levels. The issue of staffing levels, both numbers and skill mix, has been repeatedly raised at all tiers of governance since 2016; however, the risk is worded in a way that indicates that staffing is not an area for concern. In fact, "*fragility of staffing*" is one of the top concerns escalated from QuAG to the LMGB in January 2019. The fact that staffing levels is one of the contributory factors to the CQC enforcement action in June 2019 illustrates that the Trust's response to this risk was inadequate.

Quality and safety governance

5.58 The Trust's governance framework placed disproportionate emphasis on operational performance rather than quality and safety. In the years leading up to the closure of WLH, there was an organisational preoccupation with the numbers of reportable issues, as opposed to meaningful interrogation of themes and trends in order to identify and respond to emergent risks and ensure safe and high-quality care for patients.

5.59 The oversight of incidents was poor and led to those charged with governance being screened from the scale, nature and human story associated with incidents. We also found a lack of triangulation between SIs, incidents, and complaints (both formal and informal). We would typically expect this to be within the remit of the QuAC; however, we found no evidence that this is done on a systematic basis.

5.60 These issues have not been newly uncovered by this governance review. The need to strengthen the Board's oversight of quality governance, in particular the analysis of incidents, processes to share learning, and risk management, were key features of the Grant Thornton review in 2017. The repeated identification of similar issues which are fundamental to a Board's ability to discharge its statutory oversight duty raises key concerns about the Trust's ability to respond to known areas of weakness and sustain improvement between 2017 and 2019.

5.61 The Trust uses Datix to capture incident data. T4 CAMHS incidents were classified into six categories until mid-2019: physical intervention use; prone intervention use; rapid tranquilisation use; seclusion and segregation use; tear-proof clothing use; and mechanical restraint use. Datix is also calibrated to capture the reason for restrictive intervention incidents: refusal of food/feeding; self-harm attempt/actual; attempt/actual assault towards staff/patient/property.

5.62 The incident reporting culture at WLH lacked transparency and did not support effective and personalised care planning; there is strong evidence to suggest that

not all incidents were captured via Datix. For example, staff were compelled to call 999 to respond to a ligature incident relating to Christie in 2018; however, there is no corresponding entry on Datix. This approach undermined the Trust's ability to identify rising ligature incidents on the unit.

5.63 Incidents were not consistently and adequately documented and there is little evidence to suggest that the service used incidents to proactively adapt care plans. We found numerous examples of individual care plans not referencing incidents, which is a significant weakness in a service's ability to adapt to the specific needs and risks associated with individual patients.

5.64 Incident data was not used to full effect to manage wards. It was not custom-and-practice for incident numbers to be reviewed systematically by the ward team or the ward manager; this was the case even after the 2018 inappropriate restraint incidents and subsequent suspensions. We were told that it was late June 2019 before there was a systematic ward-based review of incidents reported, and that prior to this, management's attention was consumed by staffing issues.

5.65 Prior to November 2018, the Trust did not use CCTV footage to corroborate or investigate reported incidents, a further missed opportunity to identify poor restraint practice. In 2021, the Trust invested in body cameras for staff to aid the analysis of incidents.

5.66 Incident data was also not used holistically to identify areas of systemic risk. Notably, the Trust had not calibrated Datix to capture ligature incidents until after Nadia's death in August 2019. Interviewees consistently told us that ligature incidents were becoming more commonplace in the two-to-three years prior to the closure of WLH; however, there was an absence of qualitative data to objectively analyse and respond to this risk. This was set against an underlying attitude that a service like T4 CAMHS is inherently likely to have high numbers of incidents.

5.67 Whilst the Trust's Incident Reporting and Serious Incident Review policy states that HoS reviews (completed for moderate harm and 'near-miss' incidents) should be reported to QuAG within an eight-week timeframe, we found numerous examples of this timescale being exceeded, such as Christie's serious ligature incident in March 2019 which involved an inpatient spell in an intensive therapy unit (ITU) in a coma. This incident was identified as requiring a HoS review, but there were significant delays in this taking place. The Trust also failed to report this incident to the Strategic Executive Information System40 (StEIS); had this been done, Trust management and commissioners may have been alerted to WLH at an earlier stage.

Incident escalation, analysis and learning

5.68 We found numerous significant weaknesses in the Trust's approach to incident management and oversight:

- There was inadequate incident analysis in assurance reports to key governance forums that did not adequately present the themes and trends. The Trust's Incident Reporting and Serious Incident Review Policy (2017, updated 2020) notes the devolved responsibility from Board to QuAC in relation to monitoring clinical risk management, as well as the role of the EMT in overseeing incidents. For example, EMT agendas contained a standing

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40 StEIS: Strategic Executive Information Systems – the NHS national database for reporting serious incidents.

agenda item titled "What is out-patient safety data telling us?" which was typically presented by the DoQG. We could not evidence that this provided any more than an update on how many SIs had been recorded at the Trust over the previous month.

- Incident reporting gave false assurance about the true nature of incidents at WLH and focused on the quantity of incidents rather than what they indicated about the quality and safety of care and treatment. For example, the PSG Quarterly Quality Report (Reporting Period: 1 January 2019 to 31 March 2019) reports that the "number of incidents reported at West Lane Hospital has decreased" (referring to 1,069 incidents). Similarly, the report for the following quarter (1 April 2019 to 30 June 2019) reports the "number of incidents reported at West Lane Hospital has decreased" (referring to 991 incidents).

- This does not concur with the incidents reported on Datix. Our analysis shows that there were 1,348 incidents reported on Datix between January and March 2019 and 1,415 incidents between April and June 2019.

- Additionally, there were 12 incidents directly relating to specific items of bathroom hardware at WLH within a 20-day period, and this sudden escalation was not seemingly reported to the EMT.

Table 4: Incidents reported in West Lane Hospital, January to June 2019

	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Evergreen	202	192	180	136	109	118
Newberry	94	69	126	65	37	158
Westwood	190	170	125	271	264	257
Total	486	431	431	472	410	533

Total quarter 1 incidents =	1,348	Total quarter 2 incidents =	1,415

- Incident management information was insufficiently scrutinised and challenged. Oversight of incidents at QuAC was primarily via the PSG Assurance Report, which contained detailed information on the number of incidents across the Trust. We found numerous references to "incidents of physical intervention" in T4 services within these reports between 2017 and 2019 with little evidence of challenge or further information being sought.

- This report would also summarise the assurance received at the PSG from the Positive and Safe Working Group. QuAC, in March 2018, for example, was informed that "T4 CAMH services continue to have a high number of incidents which was felt to be linked to the increase in patients who are being supported with NG feeding". The report goes on to highlight that the Trust was "recently cited in a publication by the CQC regarding the positive work the Trust is doing regarding reducing the use of restraint".

- There was a tolerance of high numbers of incidents at WLH coupled with poor benchmarking and insufficient professional curiosity regarding incident levels. Several interviewees spoke of a pervasive attitude that high restraint incidents were to be expected for a service like T4 CAMHS. We found evidence of the PSG seeking further assurance in relation to the underlying causal factors for the increasing level of self-harm incidents at WLH; the response to this

challenge as noted in the minutes is defensive: "the nature of Tier 4 CYPS means there will be high levels of self-harm and control and restraint incidents on an ongoing basis […] it is not helpful to keep seeing the Patient Safety Quality Reports with graphs always showing Tier 4 Wards with high numbers of incidents".

- The threshold for reporting an SI was too high, which impacted the view those charged with governance had of the number and severity of incidents at WLH. There were only five SIs reported to the StEIS between 2017 and 2019. The failure to align the Trust's policy with the SIF resulted in false assurances being provided about the number and severity of incidents at WLH, and the Trust's policy differed from the (then) NHSE Serious Incident Framework[41] (SIF) in the definition of an SI:

SI definition per Trust policy	SI definition per NHSE SIF
Incidents involving an unexpected death or severe harm or permanent or long-term harm that are StEIS reportable.	Serious incidents in the NHS include: ■ Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in: unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past. ■ Unexpected or avoidable injury to one or more people that has resulted in serious harm. ■ Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent: the death of the service user; or serious harm."

5.69   There was a significant quantity of information on Datix (the Trust incident reporting system) which is routinely used to inform the PSG and the Trust QuAC on trends and patterns of harm as described above. However, this was either incorrectly reported or not effectively triangulated and analysed to facilitate learning from incidents and to assist in the management of environmental risks. We have, for example, identified that self-ligature was a common and increasing risk in WLH.

5.70   Our analysis shows there was an average of 62 ligature incidents reported on Datix each month between November 2018 and August 2019, rising from 37 incidents in November 2018 to 175 reported in July 2019 and reducing to 33 in August 2019. However, this rapidly increased from two reported incidents in March (when it reopened to admissions) to 76 ligature incidents reported in April. We have not seen evidence that this rising risk was reported to QuAC.

Table 5: Ligature incidents reported in West Lane Hospital, November 2018 to August 2019

	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Evergreen	1	0	2	0	0	2	0	0	26	22
Newberry	34	4	25	13	32	30	12	42	22	0

[41] serious-incidnt-framwrk.pdf (england.nhs.uk)

Westwood	2	15	16	3	2	76	60	45	127	11
Total	37	19	43	16	34	108	72	87	175	33

5.71 There was effort to provide further analysis in relation to T4 incidents to the Board and QuAC. In July 2018, QuAC received a presentation titled "Restraint and Physical Interventions in CAMHS Tier 4 Services". The minutes note that it would be of benefit for the Board to receive a similar presentation at a workshop. However, this does not take place until March 2019, some eight months after the action was first identified and four months after the November 2018 restraint incident. The presentation covered topics such as NG feeding and associated risks, and the pressure repeated restraint places on staff and patients. Given that both elements were features of the November 2018 restraint incident, the delay in scheduling the Board workshop is a missed opportunity to elevate the risks in the service to the highest level of the Trust.

5.72 We found isolated examples of the PSG being alerted to specific areas of operational risk in relation to incidents. It was noted that Newberry often saw a peak in incidents between 9pm and 11pm, and minutes record that "staff have offered to spend more time with young people during this time". We could not evidence PSG monitoring the efficacy of this action in subsequent meetings. Similarly, the PSG is informed that a post-incident debrief process was implemented across WLH in June 2019; however, it is not clear what the impact of this is.

5.73 Neither the peak in incidents or the debrief process is communicated at higher levels of the Trust's governance structure. We also found that the PSG frequently recorded apologies from leaders at service, locality and corporate level; this is concerning given that the PSG is a 'gateway' forum for patient safety incidents being calibrated and escalated upwards through the Trust.

Complaints and concerns

5.74 The Trust's oversight of complaints is similar to that of incidents: there was a tendency for complaints and PALs data to be reported, little analysis of complaint themes and a subsequent failure to identify where a remedial response was required.

5.75 QuAG meetings emphasised complaints management rather than complaints analysis and learning. Minutes show a tendency for discussion to focus on whether a complaint has been responded to and closed, rather than considering the wider implications that a complaint may indicate or the efficacy of action taken. For example, QuAG was informed in March 2019 that a complaint had been received from a service user in relation to staffing levels; however, there is no detail or discussion regarding the validity of the complaint.

5.76 The PEG, which reports to QuAC, is a Trust-wide forum tasked with the oversight of patient feedback. We found numerous examples of positive work undertaken by PEG, such as deep dives into complaints' data about feeling safe, analysis of quality visits undertaken by directors and quarterly reviews of patient experience data. Despite this, we found a lack of triangulation with other sources of information; for example, T4 CAMHS is identified as a potential outlier in relation to complaints and PALs numbers via SPC charts in April 2019, the first time such analysis is presented to PEG. This is simply stated in the minutes with no

evidence of the potential relevance of this to the health of the service. Given this is in the months following the 2018 inappropriate restraint incidents, we find this to be another missed opportunity to triangulate warning signs that the service was under significant strain.

5.77   The PEG agenda sometimes indicated that more detailed reports would be provided to QuAC. For example, the May 2019 PEG agenda includes an item QuAC received, a report titled "Feeling safe" deep dive for June QuAC. The report included some analysis in relation to WLH, noting that "participation groups have been held on Evergreen and Westwood wards" and that OT and outreach support, as well as additional activities, had been identified by participants as areas for improvement. We found no evidence that this report was provided to QuAC, which represents another missed opportunity to raise the profile of the service at the Board's committee charged with quality and safety.

5.78   QuAC reviewed complaints primarily through the QuAC Assurance Report, which summarised in only a few lines the intelligence on complaints reported to it from PEG. This report was mostly narrative in content, with no tabular or graphical depiction of data described; it did not include any analysis of complaints on a locality-by-locality basis, nor include triangulation with other reportable issues.

5.79   Private board meetings received a standing report – "Reportable Issues Log". This contained a section titled "Complaints of a serious nature", which would be used to brief BMs on contentious, vexatious, or potentially reputation-damaging complaints. We found no evidence that this report was used to analyse the trends associated with complaints, nor did it triangulate serious complaints with other forms of quality governance assurance. It is also notable that we found no evidence that the complaint outlined in case study 1 (below) was discussed in this forum, despite direct communication with the CEO.

5.80   We found evidence of significant mismanagement of complaints relating to care and treatment at WLH, coupled with failures to follow the Trust's complaints policy[42]. This is demonstrated in the following case study (1):

- On 31 July 2018, the grandmother of Christie made a complaint to the CQC regarding an incident of restraint in which Christie's clothes were alleged to have been cut off in front of a male member of staff. The complaint centred on staff having no compassion for children in their care and failing to notify parents when an incident occurred.

- CQC contacted the LADO in relation to the allegations made by the complainant. The LADO raised the complaint to the attention of the Associate Director (AD) of Nursing, who was also the Head of Safeguarding for TEWV. They responded on 22 August 2018 by stating that the Trust was undertaking an investigation into the complaint.

- On 28 August 2018, the complainant contacted the CEO directly regarding the nature of the complaint. At the same time, Christie's mother also lodged a complaint with the Trust about the same matter. On 31 August 2018, a meeting was held between the Ward Manager and the AD of nursing/safeguarding during which it is reported that the complaints were deemed not to be a safeguarding issue. There was also a discussion about the

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[42] CORP-0019-v10.1 Ratified date: 10 April 2019 Complaints Policy. Last amended: 14 April 2020.

need to obtain consent to liaise with Christie's grandmother as she was not Christie's legal guardian. Because Christie's grandmother was not her next of kin, the Trust needed Christie's consent to pursue the complaint. This is in line with their policy and good practice.

- On the same day, Christie's clinical record is updated to reflect a discussion with Christie regarding the complaint during which Christie "*consented for her grandmother to speak for her*". It is not clear why the issue of consent was not clarified by the Ward Manager to ensure that all parties were communicated with satisfactorily and to ensure that the complaint was treated as such. We were told that the Trust wrote to Christie to ask for consent; no reply was received so the complaint was not investigated. We have no evidence of the letter. The Trust's policy states that "*if the Complaints Manager is of the opinion that a representative does or did not have sufficient interest in the person's welfare or is not acting in their best interests, we will notify that person in writing stating the reasons*". We have not seen any evidence that Christie's grandmother received such a letter.

- After multiple attempts to secure an adequate response from the Trust, the LADO was informed on 11 December 2018 that Christie's "*dignity was preserved*" and "*safety was maintained*". The role of the LADO is explored in Section 5.98.

- There were significant delays in responding to both complainants, and the Trust did not adhere to its own policy of responding to a complaint within 60 days. Trust representatives met with Christie's family in December 2019, during which the delayed complaint was discussed. It was agreed that there would be an investigation into the complaint and the delay. After a further meeting was postponed by the Trust, a further meeting took place in January 2020. It was agreed a formal response to the family's concerns would be sent; this was done on 28 February 2020, 18 months after the original complaint was received, and eight months after Christie's death.

5.81 We found the Trust's approach to learning from complaints and concerns to be lacking. The complaint in relation to Christie outlined above resulted in the production of an undated SBARD[43] briefing document. This was circulated to staff to ensure that they use de-escalation techniques and anti-tear clothing; however, we found no reference to this in key service meetings, such as QuAG nor in PEG, a forum in which learning from complaints could ostensibly be shared across the Trust.

5.82 The SBARD also referred to numerous significant issues which we have found were key to the dysfunction at WLH, such as lack of adherence to Trust policy on observations; use of restrictive practice; identification of risk and escalation; evidence of decision-making; and staff training. This points to an organisational awareness of these issues coupled with a failure to escalate and act.

5.83 We have analysed the complaints received in relation to WLH between 2017 and its closure (fig. 2). Key points to highlights are:

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[43] SBARD briefing = Situation Background Assessment Recommendations Decision – a way of sharing important information in a shortened and easily accessible form that relays the salient points

- 15 complaints in relation to the "environment" were received and all related to understaffing concerns;

- The Trust was made aware throughout December 2018 and January 2019 by many staff in both emails and in verbal communication that there were significant concerns about the risks to patient safety and quality of care.

- Patient and family complaints about West Lane had increased from three a month in August, September and October 2018 to eight in January 2019 (increasing to 11 in April 2019). Many of these complaints were about care and treatment, staffing levels and patient safety.

- The first complaints relating to care at West Lane Hospital, date as far back as 2017.

Fig 2: Complaints in totality across WLH locations from 2017 until closure
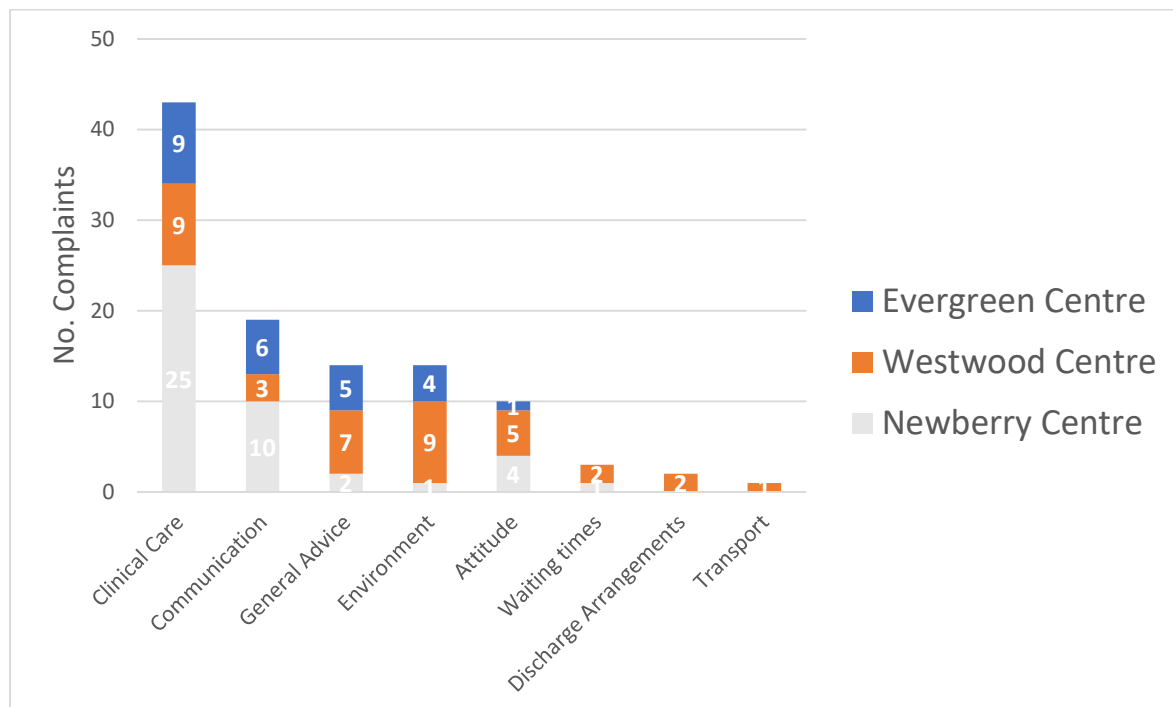
Safeguarding

5.84   The Trust has an Executive Lead for Safeguarding who is the Executive Director of Nursing. The Trust also has an Associate Director of Nursing for Safeguarding who is accountable for ensuring compliance with statutory safeguarding guidance and is directly accountable to the Executive Lead for Safeguarding, in accordance with the NHS England Safeguarding Accountability and Assurance Framework 2019.[44]

5.85   The Trust has a quarterly safeguarding meeting; its membership includes the Executive Lead for Safeguarding, the Associate Director of Nursing

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[44] NHS England » Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework

(Safeguarding) the Medical Director and Heads of Service. This meeting reports directly to QuAC.

5.86   WLH is within the Middlesbrough Council footprint, and therefore Middlesbrough Council were responsible for managing any safeguarding referrals relating to T4 CAMHS. It did this via the Middlesbrough Local Safeguarding Children Board (now the South Tees Safeguarding Children Partnership); statutory members of the partnership were Middlesbrough Council, South Tees CCG (as was) and Cleveland Police. TEWV was a relevant agency to the partnership and, as such, its Head of Safeguarding for TEWV sat on the Partnership Board and its sub-groups.

5.87   Since the closure of WLH, Middlesbrough Safeguarding Partnership has become South Tees Safeguarding Children Partnership (STSCP), which is a multi-agency partnership between Middlesbrough Council, Redcar and Cleveland Borough Council, Tees Valley CCG and Cleveland Police.

5.88   Working Together[45] guidance stipulates that "there is a shared responsibility between organisations and agencies to safeguard and promote the welfare of all children in a local area". However, there is no evidence that there was a collaborative effort by the Trust or its partners (namely the CCGs, NHSE, NHSE Specialised Commissioning and the local authorities) to ensure that there was a robust safeguarding framework in place to protect children and young people at WLH. The lack of clarity regarding commissioning responsibility and quality oversight in relation to T4 CAMHS extended to safeguarding; the impact of this was that there was little scrutiny of safeguarding processes or risks at WLH by commissioners.

5.89   There was a missed opportunity to use the local Safeguarding Investigating Complex (organised or multiple) Abuse protocols, which would have provided transparency and external support. Investigations into the incidents for each child were not transparent for any of the children or parents involved.

5.90   The CCG was told that NHSE Specialised Commissioning commissioned T4 CAMHS and was therefore responsible for quality monitoring and safeguarding assurance. The NHSE Safeguarding Lead for the region shared the view that the responsibility for quality assurance and safeguarding sat within NHSE Specialised Commissioning. NHSE Specialised Commissioning, however, do not and have not historically had a safeguarding lead, which resulted in a fundamental gap in the independent scrutiny of safeguarding at WLH and a failure on the part of commissioners to clarify safeguarding responsibilities.

5.91   The Associate DoN at TEWV (safeguarding) met regularly with CCG designated nurses. However, there was no evidence of any formal reporting of safeguarding concerns from the Trust to the designated nurses in relation to WLH. During interviews, we were informed that concerns regarding WLH were discussed with designated professionals; however, this was via the safeguarding partnership following the concerns raised via the CQC. There was no evidence that these concerns were formally shared with the CCG via any formal quality assurance processes. We were also told that when the CCG became aware of Christie's 2019 incident, the Trust informed them that it was not required to be reported on STEIS.

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[45] Working Together to Safeguard Children 2018 (publishing.service.gov.uk)

5.92 TEWV is a member of all the safeguarding partnerships that are represented within its geographical footprint. The Trust has a central safeguarding service led by the Associate Director of Nursing (safeguarding), and the team consists of named nurses for adult and children safeguarding. The Associate Director of Nursing (safeguarding) sits on all safeguarding partnership boards and ensures appropriate representation at relevant sub-groups of the partnership.

5.93 The Trust has a quarterly Safeguarding and Public Protection sub-committee which is chaired by the DoN and reports to the QuAC. Membership is comprised of HoS and nursing leads from across the Trust, as well as named safeguarding professionals. The sub-committee is not well attended by heads of nursing/heads of service. This was identified and escalated by the DoN in October 2017 with no significant improvement during 2018/19. It is a particular failure that there continued to be a lack of service-level engagement after the 2018 inappropriate restraint incidents and the deaths of Christie and Nadia; this presents a further missed opportunity to identify the safeguarding risks on the unit.

5.94 Minutes reveal the primary focus of the sub-committee to be on safeguarding training across the organisation, along with other safeguarding performance measures, supervision referrals and safeguarding reviews. There was a distinct lack of attention afforded by the sub-committee to safeguarding associated with care and treatment. There is no evidence within the minutes of any points of escalation from the sub-committee to the QuAC.

5.95 We were told that there was a robust process to safeguard any under 18 patients who were admitted to adult wards. However, it was found during the review that this process was not consistently followed, and therefore, under 18s were admitted to adult wards without the knowledge or oversight of the Trust's safeguarding team. We would expect corporate safeguarding teams to maintain oversight of any under 18 that is admitted to any adult ward to ensure that the young person is being adequately safeguarded and the Trust remains compliant with national guidance.[46]

5.96 Interview feedback suggested that there was a reluctance on the part of WLH staff to engage with the Trust's safeguarding team, a feature which was attributed to the "closed culture" of the unit. We were told that there was an awareness amongst locality leadership that WLH was an area of concern for the safeguarding team from 2018 onwards. However, attempts to work with the service were met with resistance. This issue was not, however, effectively acted upon or consistently escalated. Emily's care was an example of a failure to make appropriate safeguarding referrals; Emily alleged that staff would be abusive to her during periods of self-harm, and Ferndene staff raised concerns that items used to self-harm had been found in her self-soothe box on transfer from Newberry. A safeguarding referral to the LADO should have been made, to enable the LA to triangulate information and maintain oversight of the care and treatment of young people at WLH.

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[46]https://go.gale.com/ps/i.do?id=GALE%7CA200251762&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=1 4658720&p=AONE&sw=w&userGroupName=anon%7Ef3842360.

5.97 Staff were trained at Level 3 Safeguarding Children training in accordance with the Safeguarding Children Intercollegiate Document 2019.[47] However, they failed to recognise abuse within the context of the care setting.

LADO

5.98 The LADO is a local authority-based mechanism to safeguard children and young people from potential harm caused by staff responsible for their care[48] and is governed by a multi-agency policy.[49] We found several points of failure in the LADO process linked to WLH, including:

5.99 A lack of understanding of the role of the LADO – when to refer, which agencies to involve and how other organisations (namely the Trust) are to engage with the LADO:

- LADO referrals not being dealt with within appropriate timeframes.

- Social workers (and children's services more broadly) not being notified of LADO referrals or invited to LADO meetings.

- Strategy meetings not being held for individual children.

- Multiple children and staff being identified on referrals, whereas LADO procedure is to complete one referral per child.

5.100 There was a lack of effective coordination of LADO referrals from the Trust. There was no formally documented procedure to guide staff when managing allegations against healthcare professionals. We would expect such a procedure to articulate how a Trust's safeguarding team would work with a HR team to ensure that referrals are appropriately and promptly made to the LADO.

5.101 The role of Trust HR staff in liaising with the LADO and responding to requests for information was not clear and there was also a perceived reluctance from them to work collaboratively. Specific findings include:

5.102 Locality HR managers regularly attended meetings with the LADO and would monitor LADO referrals; however, they did not see it as their responsibility to identify any potential service risks arising from LADO referrals, and this was not done by any other member of staff.

5.103 There was a lack of engagement and oversight from locality and corporate HR staff of the LADO process:

- LADO referrals were not consistently brought to the attention of the Trust's safeguarding team; this was demonstrated in the investigation into Emily. The inadequate link between the LADO process and Trust safeguarding

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[47] ROAN information sheet 36: Intercollegiate document on safeguarding guidance, 2019 revision. https://www.england.nhs.uk/medical-revalidation/ro/info-docs/roan-information-sheets/intercollegiate-document-on-safeguarding-guidance/ This is an update to safeguarding training guidance, published in 2014.
[48] The LADO works within children's services and should be alerted to all cases in which it is alleged that a person who works with children has: behaved in a way that has harmed, or may have harmed, a child, and/or possibly committed a criminal offence against children, or related to a child.
[49] https://www.teescpp.org.uk/procedures-for-the-safeguarding-process/18-managing-allegations-against-those-who-work-or-volunteers-with-children

procedures undermined the extent to which the Trust could safeguard young people and promote their welfare.

- We found the Trust to function too passively at times. The complaint regarding Nadia's care was an example of this: we believe that the Trust should have reported the incident directly to the LADO.

5.104 There were "quite fundamental disagreements" about the respective roles and responsibilities of the LADO and the Trust in the investigation of allegations and the requirement to share information. After a review of the communication between the Trust and the LADO in response to the August 2018 referral in relation to Christie's care, following her grandmother's complaint, we found significant deficiencies in the Trust's response, as well as a lack of assertiveness from the LADO given the severity of the allegations. Between August and December 2018, the LADO requested the outcome of the Trust's investigation on several occasions. When a response was finally received, it was wholly inadequate in its robustness and transparency: "The outcome was that this had happened on a unit where there were escalating concerns about many of the young people. Her dignity was preserved throughout, and her safety was maintained. An SBARD was developed and circulated to staff to ensure that they use de-escalation techniques and anti-tear clothing." It is not clear why such a response took five months to be provided.

5.105 There were multiple LADO postholders between 2017 and 2021. Interview feedback suggests that there were differing approaches in relation to information requests, the robustness of LADO investigations and the tenacity with which information requests were monitored.

5.106 Cases did not consistently follow LADO policy, which resulted in partners not being adequately sighted on the level of risk and potential intervention required. There was a lack of communication with and involvement from social workers in LADO meetings and we noted that some strategy meetings did not take place. For example, the minutes of a LADO meeting held on 23 November 2018 in relation to Nadia and an allegation of inappropriate restraint, for example, note that "[Nadia] has a social worker but unfortunately it has not been possible to contact her". As a result, Nadia's social worker was not informed of the allegation and associated safeguarding referral. There is no evidence that attempts were made to contact alternative staff at children's services.

5.107 The referral made in relation to the 2018 inappropriate restraint incidents did not trigger the LADO to consider whether complex abuse was taking place, despite the scale of the allegations. This was further compounded by the lack of communication about the referral by the Trust or the LADO with other agencies. From an LA perspective, the multiple referrals received by the LADO should have prompted action to review the case under the Multi Agency Complex Abuse Procedures. This would have allowed greater oversight and coordination of the response and actions to ensure that children and young people in WLH were adequately safeguarded.

5.108 Due to a failure to effectively communicate with key agencies, neither the CCG nor NHS Specialised Commissioning were represented at any of the LADO meetings, and it was suggested that this could have been due to the perceived position that this was not a service commissioned by the CCG and therefore not

their role. We would typically expect a CCG representative to attend such meetings and for there to be a mechanism by which NHSE keeps the CCG informed. (Recommendation 9)

Management information, reporting and escalation

5.109 There was a lack of clear and sufficiently granular safety performance information at the Trust relating to T4 CAMHS in the years prior to the 2018 inappropriate restraint incidents, at the time of the girls' deaths, and afterwards. Information sat across various reports with insufficient triangulation, data was subject to inadequate analysis and there was no accepted 'version of the truth' used to inform the actions of ward teams and management.

5.110 The quality of management information was, at best, inconsistent and there was a tendency to overly-simplify assurance as it ascended the Trust's governance structure, resulting in key risks being missed or 'watered-down'. For example:

- November 2017: the Board receives the QuAC Assurance Report, which is prefaced by a cover sheet stating that there is concern around waiting times in CAMHs. Only on reading the main body of the QuAC Assurance Report does it becomes clear that the key issues in T4 CAMHS relate to rising acuity, bed pressures and integrating newly employed inexperienced staff. Westwood is also highlighted in the 'Hard Truths' nurse staffing report to the same meeting due to "one complaint … about the lack of staff to supervise a relative [as well as] a high fill rate and a level 3 self-harm incident". There is no evidence to suggest that the two reports were linked during the Board's discussion.

- December 2017's QuAC meeting is alerted to the fact that Newberry and Evergreen are outliers in relation to restraints, with Westwood showing increasing levels of restraint. This is not highlighted in the preface to the PSG report to QuAC and is only apparent on reading the detailed appendices to this report.

- In June 2018, T4 CAMHS is not mentioned in the executive summary of the Tees Locality Assurance Report to QuAC; however, the main body of the report notes concerns associated with the high use of agency staff, high numbers of restraint and "very low scores in relation to feeling safe".

5.111 The frequent use of verbal summaries in situations that would be best suited to more robust written assurance also contributed to this issue. We noted that it was common for LMGBs to receive a verbal summary of locality issues from the HoSs, which placed undue reliance on the verbal presenting skills of each HoS, as well as limiting the effectiveness of the meeting in ensuring that each locality was afforded equal and sufficient attention.

5.112 Reporting was disjointed between each level of the Trust's governance structure, a feature exacerbated by a tendency towards multiple new reports and dashboards to be introduced without being properly tested before embedded. We also found that management information was often presented at an aggregate Trust level which provided insufficient 'line of sight' to emerging risks in T4 CAMHS. We found multiple 'red flags' that WLH was a service in distress embedded within reports; however, the disparate nature of reporting coupled with insufficient risk escalation meant that these 'red flags' were not connected and calibrated. The lack of correlation in reporting at each tier of governance was a

fundamental weakness in the Trust's oversight of emerging risk at WLH and exacerbated further by poor escalation methods.

5.113 Examples of this include:

- A Tees Locality Scorecard which contained data on quality performance was received by T4 QuAG; however, this was not disaggregated by service and therefore provided little insight into any service-specific issues.

- A separate quality scorecard was produced quarterly for QuAG, although minutes show that by October 2017, this had not been received for "a long time" and it appears that the service was passive about this, not following it up until the Quality Data Performance team came to observe the meeting on a separate matter. Minutes also indicate that there was a low level of awareness that this was accessible in the Trust's Integrated Information Centre.

- A Positive and Safe dashboard was introduced in February 2019 and was received by the Positive and Safe Group. This was widely regarded to be a positive step towards more robust incident reporting. It included analysis of incident types per ward, a quarterly comparison of numbers and types of incidents, and the number of PBS plans in place. One interviewee noted that, "I felt it would have been better having access to that, months if not years before." This was not provided to T4 QuAG until August 2019, which was a missed opportunity to ensure there was consistent and well understood safety reporting at a service-level.

- We also found a reference to an Inpatient Resource Intensity Tool (IRIT) being trialled at Westwood in June 2018 and reported to T4 QuAG. The tool was developed as a means of communicating the current care needs of individuals and groups of young people in an inpatient setting and seeks to indicate whether the ward is being "overloaded", independent of the number of current patients. There were very few references to the tool after this point. However, it was not clear how long it was being used for or why it did not become a standing report for T4 QuAG.

- A Quality Strategy Scorecard was presented at QuAC. This provided data on seven indicators, including 'physical interventions'. Performance was only reported at locality and divisional level, with service-level performance only being reported verbally on an ad hoc basis by the relevant locality DoO.

- LMGB received updates on each service in the locality; however, we found that there was a preference towards reports being overly narrative in style as well as verbal summaries from each HoS being used to relay information.

5.114 The analysis and interpretation of safety reporting contributed to the organisational narrative that level of incidents in T4 CAMHS would always be high. It was clear throughout many interviews that the service was considered by many to carry an inherent tendency towards high numbers of restraint incidents, although it is not clear how this view was formed, robustly challenged and regularly reviewed.

5.115 Challenging this view was also inhibited by the lack of benchmarking data used in relation to restraint. We were frequently told that the nature and configuration of services provided by WLH made benchmarking performance data, including incidents, highly challenging. For example, in July 2018 there was a discussion at

QuAC regarding the high levels of restraint incidents at WLH, although it was determined that there were no appropriate national comparators to benchmark the use of force. Similarly, the Executive Time Out session in January 2019 receives benchmarking data applied to T4 CAMHs, but the notes of the session capture this being dismissed as "T4 comparisons are of limited value". The Board is also told in July 2019 that "the new national definition of restrictive interventions should support benchmarking in the future, but it was not practicable at present".

5.116 We found, however, evidence of a discussion at QuAG in December 2017 about incident levels and reference to benchmarking in relation to the Westwood Centre which had been straightforward by utilising clinical networks. In March 2019, QuAC also tasked the PSG "to undertake some benchmarking with other Trusts who provide nasogastric feeding and other range of interventions and bring a report back to QuAC". This action has initially been identified in December 2018, then it was agreed in February to review in six months. It is not clear from the minutes why such a long timeframe was agreed. There remains a clear lack of agreement and/or understanding about whether a meaningful benchmark group exists for T4 CAMHS.

5.117 The metrics monitored in relation to T4 CAMHS was overly narrow and did not provide meaningful intelligence on the most challenging and inherently risky aspects of care. For example, we found no evidence that the Trust consistently and clearly monitored the number of children in AMHS beds, nor the number of NG tube insertions.

(Recommendation 10)

HR reporting

5.118 The Board was appraised of ward-by-ward staffing levels via the Nurse Staffing Report. WLH would sometimes be highlighted as an area of concern on this report, although we found no evidence that this resulted in remedial action or closer scrutiny of the unit. For example, in May 2017 Newberry is 'red' in relation to planned fill rate (between planned and actual Registered Mental Health Nursing Staff (RMHN) of 75.8%, one of the lowest across all wards. This includes a 'severity score' which combines risk factors such as bank usage, fill rate and missed breaks – Newberry is the second highest scored ward in the Trust. Minutes show that the Board was advised that the ward-by-ward severity score approach was only six months old and "that a longer period of time was needed to enable meaningful trends to be identified". Minutes also state that "the severity scores had not highlighted any new issues". This points to the challenges associated with staffing at WLH being normalised 18 months prior to the 2018 inappropriate restraint incidents.

5.119 The same report is presented to the Board in January 2019 and shows that Westwood has one of the highest overtime usages across the Trust. Evergreen also flags in the report as 'red' for RMHN fill rate. Despite this being reported shortly after the 2018 inappropriate restraint incidents, there was no discussion about risks to the safety and quality of services at WLH posed by staffing pressures.

5.120 Whilst the Board has also been supported by a resources committee for a number of years, a review of papers and minutes from this forum shows that safe staffing rarely featured in its oversight. In recognition of the need to elevate the profile and scrutiny of the people and culture agenda, a People and Culture Committee was introduced in 2020. We welcome this addition, as prior to this point, there was a material gap in the Board's assurance in relation to staffing, workforce strategy, culture and engagement.

5.121 A review of QuAG papers showed that HR was afforded a dedicated section on the agenda; however, minutes indicate that there was rarely an in-depth discussion about HR or staffing at this forum. Several interviewees shared the view that, prior to November 2018, the structure and content of HR reporting did not indicate that WLH was an area of concern. One interviewee stated that: "I believe that some of the workforce indicators didn't help us in the way we wanted them to, and they certainly made me reflect on how much value would I assign to things like mandatory training compliance, staff survey results by the ward."

5.122 We found that assurance in relation to staffing at WLH lacked clarity which, in turn, diluted the readers' appreciation of the level of risk at the unit. The Board, for example, received a report by the Head of Professional Nursing and Education in January 2019 regarding staffing at WLH. It noted that there "appeared to be adequate staff to carry out duties as required; however, coordination of the requirements of the individual wards and the wider West Lane site was not always evident which may result in a perceived lack of staff".

5.123 The report also noted the overarching concerns of staff being their fragility, feeling burnt out and being "paralysed by fear". The report concluded that, although there were other issues needing action and further development (skills and leadership, debrief following incidents, clear purpose of admission, robust clinical supervision, and risk management and engagement) "a review of the health roster would

indicate in terms of numbers that the levels of staff are adequate to meet the needs of the patients". At that time there was no commentary about the skills and capability of the nursing staff required to work with young people.

HR and organisational development function

5.124 The form and function of the HR directorate did not enable the Trust to calibrate and respond to risks at WLH and prevented the identification of the service as being under significant pressure. Key functions within the department operated in siloes with the most resources being allocated to transactional HR (such as the management of grievances, disciplinaries and staff absence) rather than OD and staff engagement. There were several HR-related warning signs about WLH, covering such as sickness level, staff turnover, grievances and staff morale; a more integrated directorate with strong communication channels may have been better placed to identify and respond effectively.

Directorate structure and function

5.125 Each locality at the Trust was support by a HR locality manager who reported to the Head of Service for HR Operations, illustrated by fig. 1 below.

Fig. 1 HR Directorate
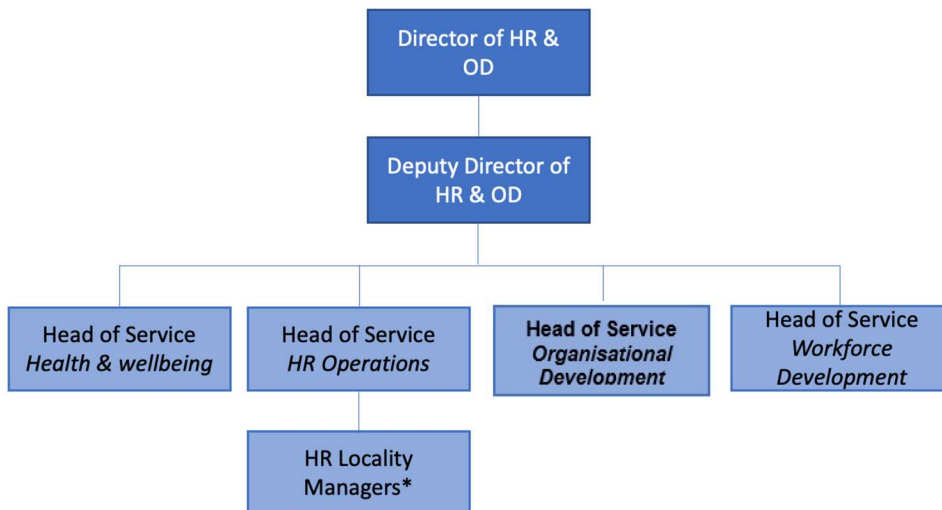
5.126 The remit of the HR manager per their job description was to provide "advice and guidance to a directorate(s) or geographical area on all aspects of employment law, terms and conditions of service and best practice [including] advice on all employee relations issues including disciplinary and grievance cases, sickness absence management and organisational change". There was broad consensus that the scope of the *HR locality manager role was too heavily skewed towards transactional HR. Post holders were not expected to monitor signs that a particular directorate or service was showing signs of distress or make referrals to other teams within the broader directorate, such as OD and health and wellbeing. Some interviewees spoke with regret that the HR manager role did not have a broader remit and act as the main conduit for all matters pertaining to HR and OD between the locality and the corporate centre. This has been recognised more recently by the Trust and we understand that steps have recently been taken to restructure the role.

5.127 We also found a lack of clarity in relation to how the HR department engaged with the LADO. Whilst we know that the HR Locality Manager or a member of their team attended LADO meetings, we were also told that it was the Locality HoN who was the Trust representative at these meetings, with the HR Locality Manager present to provide "HR updates". Further findings in relation to the LADO process are outlined in Section 5.98; however, we would expect there to be absolute clarity on who is responsible for LADO liaison and how this process feeds into the HR directorate.

5.128 The management of service-level staffing establishment also appears to have fallen into a 'grey area' between different roles and teams. We were told unequivocally that establishment reviews "would not be an HR-led process"; instead, the expectation was for services to identify the need for an establishment review and to work with commissioners in relation to funding.

HR governance structure

5.129 We found the governance structure for HR-related issues to lack clarity and definition, resulting in variation and likely omission in the way in which HR matters were reported, discussed, and escalated. We were told that the escalation route for significant HR issues was often dictated by the Human Resource Director (HRD), rather than by a clearly articulated governance framework. Whether an issue warranted escalated to the EMT or the Board was felt by some interviewees to be a subjective decision and a clearer definition would have been welcomed. We found that:

- The T4 QuAG agenda had a standing item titled "HR matters"; however, the minutes typically note that there was "nothing to report". Elsewhere in this meeting, there would frequently be references to staffing challenges at WLH, but these were generally raised by service-level staff. Despite the structure of the QuAG agenda, we were told by staff in the HR directorate that the main route for HR issues to be escalated upwards was via the LMGB meeting, not T4 QuAG. This is a concern given that matters such as supervision compliance and staffing levels were key features of T4 QuAG discussions.

- As outlined earlier, we found the profile of T4 CAMHS at LMGB meetings to be low due to the density of the agenda. There is little evidence to suggest that this was the forum in which oversight of HR matters in the service was enacted.

- We were told that HR utilised a Band 7 meeting which was a weekly forum for HR locality managers to meet "discuss and share key Locality issues, including feedback from attendance at Locality meetings" (ToR, January 2017). We were told that this forum was a possible opportunity for the concerns associated with staff morale and culture in WLH to be surfaced, although we did not find any evidence to suggest that WLH was identified as an area of concern via this meeting.

5.130 There was a quarterly Workforce Development Group which was chaired by the HRD. This sought assurance on the implementation of the workforce strategy, which included matters such as retention and recruitment, training, and culture. The level of reporting to this group, however, was rarely sufficiently granular to clearly identify T4 CAMHS as a service warranting further scrutiny:

- The Board was supported by a Resources Committee; however, this did not cover the full remit of the HR and OD agenda. We understand that a People and Culture Committee was established in late 2021 as part of a broader review of the HR governance structure.

- The Right Staffing Programme Board with four workstreams including: establishment; recruitment and retention; role redesign; workforce development and training was also unable to surface issues.

Organisational development

5.131 There was not a clearly articulated nor understood process for services to access OD support. Most interviewees (including those at a senior level) stated that they did not know how a service would be referred to OD or cited the networking skills of one specific individual (the Head of Service for OD) as the principle method of identifying a service in need of OD support. Given the size and complexity of the Trust, this was not a robust, reliable, and objective approach. It was not considered the remit of the HR manager, for example, to liaise with OD colleagues in relation to a service in possible distress. We would also expect there to be numerous ways in which a service is identified as needing OD intervention.

5.132 The Trust had a Raising Concerns Group, but most interviewees acknowledged that the impact of this group was limited. The group focused its attention on FSU reports, as well as national staff survey results. We understand that the FSU Guardian had not been alerted to any significant concerns about WLH, nor did WLH present as an outlier in national staff survey results. It was also not clear to several interviewees where the Raising Concerns Group reported to nor what the reporting expectations were.

5.133 The OD team was sporadically involved in WLH at various points in the investigative chronology; however, there was broad agreement amongst interviewees that the OD team was not utilised to its fullest extent. Rising service user acuity, the high use of restraint, and staff attrition were also consistently referred to by interviewees as key challenges for the unit, although these also did not trigger the OD team being asked to support staff at WLH. One interview stated that "people thought they had it in hand … I don't think people thought it was as much of an issue as it turned out to be."

5.134 We have been told that, in 2017, OD supported a mediation exercise regarding a new member of staff being alienated by more long-standing staff. The mediation exercise was deemed to be successful, and no further work was commissioned in T4 CAMHS by the OD team. After this point, OD were commissioned to provide four one-off workshops to various groups of staff (outlined in Table 6 below), three of which occurred in the first four months of 2019 in direct response to the 2018 inappropriate restraint incidents.

5.135 In September 2018, the Head of Service for OD was also informally briefed on the issue of staff attrition at WLH, which was partially attributed to the high use of restraint on the unit and the subsequent impact of this on staff. This concern was also referred to during a Raising Concerns meeting but there is no evidence of further action being taken or any further work being commissioned by the OD team.

Table 6: Summary of OD intervention

Date	Description of OD intervention
June 2018	Workshop for Band 6 staff focusing on the components of effective leadership.
January 2019	Workshop for Band 6 staff exploring resilience, Trust values and what to do if staff raise a concern.
April 2019	Workshop for Band 6 staff exploring resilience, Trust values and what to do if staff raise a concern. The presentation for this session was the same as the January 2019 session outlined above.
April 2019	Workshop for Band 3 staff exploring resilience, boundaries and whistleblowing procedures.
October – November 2019	An independent practitioner (one of whom is a Trust member of staff who worked in the OD department but also operates an external consultancy - WCA) is commissioned to interview staff who "worked at or were seconded to WLH at the time of its closure".

5.136 Given the scale and seriousness of the 2018 inappropriate restraint incidents, we expected to see significantly more OD involvement at WLH in the subsequent months. Aside from some one-off workshops with Band 3 and Band 6 staff, OD were not commissioned to undertake work in the unit, despite the unit undergoing a series of strategic shocks in the form of mass suspensions, staff returning to work, the amalgamation of AMHS and CAMHS staff, significant management churn and an increasing level of public scrutiny exerted by social media, the press and parents.

5.137 Several interviewees noted that an external OD consultant was commissioned to undertake work with the unit in autumn 2019. We have reviewed the output of this work, undertaken by WCA and Quintessent Ltd, which was commenced 11 months after the original restraint incident and after the closure of WLH. The themes arising from the WCA review are broadly consistent with our own findings and included poor/absent leadership:

- Leaders lacking experience in CAMHS.

- Unclear lines of accountability and roles.

- Staff not feeling involved in decision-making.

- Staff not feeling psychologically safe.

- Poor communication, particularly following significant events.

- Concerns associated with patient safety not being listened to and acted on.

5.138 We found a number of aspects of the WCA review concerning, namely: the review did not take place until 12 months after the 2018 inappropriate restraint incidents, and the findings of the review were not published for a further four months. This delay represents a further missed opportunity to identify some of the dysfunctional elements of the service and enact change. We also note that the review was

repeatedly described as "independent" to us, yet we understand that one of the reviewers was employed by the Trust's OD department.

Staff development

5.139 New staff are required to attend a corporate induction[50]; this does not apply to "temporary staff appointed as per the Engagement and Use of Temporary Agency and Self-Employed Workers Procedure". Interviewees were generally complimentary about the Trust's corporate induction but were more critical of the local induction. We were told that the quality and provision of a local induction was variable and heavily dependent on the function of the unit at any given time.

5.140 We found the oversight of clinical supervision to be inadequate. We found intermittent references to supervision compliance in T4 QuAG meetings; however, this was typically in the context of CQUIN performance. In late 2017, it was reported to T4 QuAG that the service was not meeting the CQUIN target and that there had been a reduction in clinical supervision on Newberry and Evergreen due to "an increased number of complex cases"; we found no evidence of any action being taken to address this issue, or a wider discussion about the impact of reduced supervision on the safety and quality of the service.

5.141 Supervision was identified by numerous interviewees as an area of weakness at WLH. Supervision was described as "ad-hoc" and several interviewees stated that staffing pressures and patient acuity resulted in supervision being rushed or cancelled. NICE guidance for the recognition and management of BPD[51] stresses the importance of "good supervision arrangements, especially for less experienced team members"; however, we found little evidence to suggest that this was in place. Senior staff brought into the unit after the 2018 inappropriate restraint incidents recalled their shock at the lack of individual and group supervision in place, as well as appraisal. Clinical supervision is essential for all clinical staff as this provides an opportunity for staff to change or modify their practice where needed and to identify training and continuing development needs.

5.142 The oversight of service-level training needs was low and poorly defined. We received varying descriptions from interviewees about how the HR directorate were sighted on training gaps. This prevented the identification of training needs, which had a direct impact on the care and treatment at WLH. Specifically, we found that there was a lack of training and skills in autism-informed approaches which, for example, meant that patients did not receive care in an environment that recognised sensory sensitivity/overload, and staff did not use precise language but gave vague or abstract answers, rather than concrete responses, which could raise distress. Additionally:

- There was a lack of training and skills in caring for patients with personality disorders, as well as in trauma informed CAMHS approaches.

- There was a failure to implement CAMHS-specific training linked to the National Suicide Prevention Strategy.

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[50] Induction Procedure HR-0009-v9.0

[51] Borderline personality disorder: recognition and management. https://www.nice.org.uk/guidance/cg78

- The service used a high number of temporary staff, and there were insufficient controls to monitor whether there were sufficient numbers trained to deal with violence and aggression.

External elements

Commissioning responsibility

5.143 The quality of care provided to children and young people at WLH was undermined by a complex and frequently disparate commissioning landscape. Interviewees frequently raised the issue of a lack of role clarity between NHSE as the specialised commissioner (often referred to as "Specialised Commissioning") and the local CCGs. It was also clear from interviews that different partners held different and sometimes conflicting opinions about commissioning roles and responsibilities.

5.144 Table 7 summarises the timeline and role of the main commissioning bodies involved in T4 CAMHs services at WLH (up to 2020):

Table 7: Commissioning involvement

Date	Commissioning event
April 2013	T4 CAMHS becomes a specialised service commissioned by NHSE or Specialised Commissioning. The intention of this was to "*implement standards consistently across the country*" for all elements of CAMHS inpatient services.[52] Prior to 2013, services were largely commissioned by primary care trusts (PCTs). Specialised Commissioning case managers are appointed to oversee each patient's pathway and care. They would be responsible "*for tailoring services to the individual requirements of mental health patients/clients. They work with professionals in provider organisations, sharing information to ensure that patients receive the best possible care in the most appropriate setting for their needs.*"[53]
	Under the Health and Social Care Act 2013, PCTs were formally abolished on 31 March 2013 and CCGs became operational on 1 April 2013. CCGs retained responsibility for commissioning T2 and T3 services, including the provision of early intervention services which could prevent service users' conditions and problems escalating to the point at which a hospital admission is required.
2015	2015 – CCGs receive Children and Young People's Transformation funding from the government. This is used as the basis for a CCG-led plan to provide MH support to the local population.

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[52] 'Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report'; NHS England, July 2014.
[53] NHS England » Specialised commissioning

1 April 2020	South Tees CCG (becoming NHS Tees Valley CCG) is created, replacing the three separate authorities of NHS South Tees CCG, NHS Hartlepool and Stockton on Tees CCG, and Darlington CCG.
July 2020	South Tees CCG publishes its long-term plan (LTP). Prior to this, each of the three CCGs had their own separate Children and Young People's Mental Health and Emotional Well-Being Local Transformation plans.

5.145 A lack of clarity about the statutory functions of commissioning bodies involved in WLH directly resulted in a failure to ensure the safety and quality of services provided. Commissioner responsibilities were not well understood and remain so by the relevant organisations. This ultimately resulted in gaps in the oversight of and response to known issues at WLH. For example:

Commissioning case study 1: Safeguarding	
What should have happened:	What actually happened:
• Local CCGs retain a statutory responsibility for safeguarding under the Working Together guidance[54].	• The CCG believed NHSE Specialised Commissioning was responsible for quality monitoring and safeguarding assurance.

Commissioning case study 2: Incident management	
What should have happened:	What actually happened:
• As the service commissioner, **NHSE** had a responsibility to *"assure themselves of the quality of services they have commissioned and should hold providers to account for their responses to serious incidents"*.[55] • The local CCGs should have also played a monitoring role in relation to incident management at the Trust. Under the SI framework, local CCGs retain a responsibility to *"determine how best to manage oversight of Sis … particularly where multiple commissioners commission*	• NHSE predominantly focused on incident reporting provided via StEIS, rather than seeking more thorough incident analysis and assurance. This remained to be the case after concerns about the quality and safety of services at WLH were widely known. This approach undermined the extent to which NHSE could assess the effectiveness of the Trust's approach to incident management, including its ability to learn from incidents. • The Trust's main CCG was clear that they did not have any responsibility in relation to oversight of incidents at WLH because they did not commission the service. Whilst we recognise that T4 CAMHS is a specialised service

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[54] HM Government (July 2018). Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

[55] NHS England (March 2015). Serious Incident Framework. serious-incidnt-framwrk.pdf (england.nhs.uk)

services from the same provider".	commissioned by NHSE, the CCG maintains a statutory responsibility to play a monitoring role in relation to incident management for the Trust as a whole. Had there been a more collaborative approach between local CCGs and Specialised Commissioning prior to the 2018 inappropriate restraint incidents, the weaknesses in the Trust's approach to incident management may have been identified and rectified at an earlier stage.

5.146 Even if commissioning responsibility regarding incident oversight had been clear and robust, we found multiple failures in the definition, collation, analysis, and escalation of incidents as outlined in Section 5.5.

5.147 The role of NHSE was to seek assurance that all inpatient care for young people with a diagnosis of ASD is provided in line with the NICE guidance on ASD in under 19s.

5.148 The response of commissioners was undermined by the lack of effective, proactive and transparent communication from the Trust. For example, Nadia was in seclusion for at least three days in July 2019; this was not communicated to NHSE Specialised Commissioning. We also found evidence of a lack of responsivity to signs of escalating risk at WLH. We were repeatedly told by interviewees that they escalated concerns, particularly in relation to staffing levels, to NHSE Specialised Commissioning; however, we found little evidence that this triggered closer scrutiny or specific action to be taken.

5.149 Once the service was placed in Business Continuity, action plans were developed and provided to NHS England Specialised Commissioning and the CQC. However, although Business Continuity focused further significant management attention on WLH, the Trust did not invoke the Emergency Business Continuity Plan until 11 July 2019, after Christie's death.

New Care Models

5.150 NCM derived from NHSE's Five Year Forward View,[56] a five-year strategy for the NHS which was published in October 2014. A major part of this strategy was a three-year-long national programme to develop NCM to coordinate care across primary care, community services and hospitals that could be replicated across the country. These models were intended to contribute towards achieving the triple aim of improved patient care, reduced cost and better population health.

5.151 The Trust was awarded NCM 'wave 1' pilot status for T4 CAMHS in 2017 and was also included as a 'wave 2' pilot site in partnership with NTW (now CNTW). The purpose of the pilot was to reduce the number of children and young people being admitted to out-of-area inpatient beds and to redivert funding to prevention strategies in community CAMHS.

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[56] Five Year Forward View (england.nhs.uk)

5.152 Staff interviewees voiced their support for the conceptual aims of NCM, although several felt that the operational implementation of NCM at WLH lacked strategic clarity, and many shared the view that the pilot increased several risks at WLH. Many interviewees perceived that patient acuity increased significantly because of NCM. Whilst we acknowledge the challenge in evidencing a direct causal relationship between NCM and patient acuity, many staff held the view that the drive to keep patients close to home, coupled with a national shortage of specialist beds, led to a more complex patient mix at WLH. Staff interviewees explained:

> "[we] became aware through the new care model work of the increasing acuity on the wards, and the increase in the level of staff required so, through the new care model, it was highlighted that the actual staffing levels were much higher than the established staffing levels to meet the needs of the young people, so we knew the acuity was increasing."
>
> "Up to NCM we would carefully select … we tried to mix diagnoses and presenting behaviours so … we could manage the risk of the unit. When NCM came in … the priority became that we would take any admission from the local area. There were times when the HoS overruled the Clinical team and we were told we would be taking that young person."

5.153 It appears that the Board was aware of the impact of NCM on patient acuity at WLH. The November 2017 Board minutes record that "the need for additional investment in the services had been anticipated". The nature and outcome of the additional funding is not clear from Board papers or minutes, nor was this risk formally recorded at either service, locality, or corporate level.

5.154 The specific requirements for the T4 CAMHS NCM pilot were outlined in the NHS Standard Contract for Mental Health Specialised Services. As per the 2019/20 contract, the Trust was required to complete a quarterly report which included the following information:

- evidence of lessons learned from incidents at a service-level;

- a standalone section on restraint incidents exceeding 10 minutes;

- admissions periods greater than three months;

- all episodes of restraint;

- quarterly safeguarding alerts; and

- DoC.

5.155 We found evidence of such a report first being produced for Quarter Four 2017/18 (1 January 2018 – 31 March 2018). This was titled "Quality Report: Activity in areas Commissioned by Specialised Commissioners". The report contained information for all specialised services and, much like other reports produced by the Trust, showed a bias towards reporting numbers rather than analysis. For example, the number of SIs per month and which ward they related to are included in the report, but there is little information on the nature of the incident, triangulation with other data, or evidence of lessons learned being identified and implemented.

5.156 The quality report produced by TEWV did not consistently include data relating to DoC or safeguarding. As outlined earlier in the report, we also found significant weaknesses in the Trust's compliance with DoC for both Christie and Nadia, coupled with a general weakness in the oversight of DoC and safeguarding. Safeguarding data was introduced into the report from Q1 2019-20. This showed the number of safeguarding concerns raised per month per ward; however, the report lacked thematic analysis and any detail on the consequence of a safeguarding concern being raised. Moreover, we found that the report itself failed to triangulate safeguarding issues: the Q3 2019–20 report details a complaint relating to WLH that includes safeguarding concerns; however, the safeguarding section of the report makes no mention of this.

5.157 We found some improvements in the analysis provided within the report towards the end of the relevant timeframe; for example, the report covering Quarter 2 2019/20, during which WLH was closed, included analysis of complaint outcomes as well as the number of agency shifts per ward which breached the agency cap.[57]

5.158 The contract also stipulates the need to report "episodes of restraint … relating to:

- reporting month;

- number of restraints for each patient;

- position (e.g. prone, supine, sitting);

- duration of restraint; and

- was IM medication administered in the same episode?"

5.159 Review of the Quality Report shows that this information clearly shows that the number of restraint incidents per patient per WLH ward was provided in tabular form.

5.160 The Quality Report was produced for the NCM Quality Governance Group (QGG), which first met in August 2018. We have been unable to ascertain why there was not an equivalent meeting from the inception of the NCM pilot in T4 CAMHS at WLH. We were told that being part of 'wave 2' of the NCM pilot with NTW triggered the creation of the QGG, which was chaired by an Executive Director from NTW. The membership of the QGG included multiple senior managers from TEWV, such as the HoS for CAMHS, the DoQG, and the Head of Corporate Reporting, as well as representatives from NHSE.

5.161 Minutes of the NCM QGG show little triangulation of the data relating to T4 CAMHS in the Quality Report. A short discussion about the service took place during February 2019 following the presentation of a 'position paper' which summarised the inappropriate restraint incidents in October/November 2018. However, no further assurance about the quality of care and treatment on the unit, nor the link to the NCM pilot, appears to have been sought by those present. We also note that the CAMHs HoS gave apologies at this meeting and was not deputised, which possibly limited the depth and breadth of the discussion about the state of the service.

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[57] NHS England » Reducing expenditure on NHS agency staff: rules and price caps

5.162 As concerns about WLH grew, minutes show representatives from NHSE present at the QGG requesting further intelligence about the T4 CAMHS service. May 2019 minutes, for example, state "complaints section – there is not enough detail" and crucially, "in relation to CAMHS incidents, there are a high number, but NHS England are still not getting any reports through". There are signs that scrutiny of staffing is increasing too: "[X] asked if there was something that should be included within this report in relation to cancelled leave". These valid actions appear not to have been effectively carried forward in the meeting's action log and it is not clear whether they were implemented or followed up on.

5.163 The oversight applied to NCM by the Trust evolved over the course of the pilot. Initially, we found that the oversight of NCM generally displayed a bias towards financial performance and lacked meaningful scrutiny of the quality impact of the participation in the pilot. We found:

- References to the T4 QuAG NCM pilot at QuAG and LMGB meetings were exclusively in the context of funding and capacity, rather than outcomes and quality.

- Assurance pertaining to NCM was provided to the Resources Committee, which in turn reported to the Board. The fact that QuAC did not take a leading role in assessing the pilot is illustrative of the performance-focused attitude to NCM at the Trust.

- Little evidence of regular scrutiny at Board-level of the qualitative and quantitative impact of NCMs across the Trust. We note that discussions about T4 CAMHS and the pressures it faced, such as the Board seminar held in March 2019, failed to triangulate the potential benefits or risks of the NCM pilot on the service.

5.164 We were also told that an unforeseen consequence of NCM was lower engagement between staff at WLH and NHSE Specialised Commissioning, which diluted opportunities for external scrutiny of the service. The shift towards managing patients closer to home wherever possible led to more local management of cases, which was typically led by the HoS rather than NHSE Specialised Commissioning case managers: "I feel that our contact with NHSE case managers reduced once the New Models of Care came in".

Regulatory response to WLH

Care Quality Commission

5.165 WLH closed in September 2019 following receipt of a closure notice from the CQC in August 2019. However, the quality regulator was aware of risks to the care and treatment of children and young people over 12 months earlier:

Table 8: CQC involvement

Date	Nature of CQC involvement	Issue identified relating to WLH
June/July 2018	Full inspection of the Trust.[58]	Whilst no material concerns were identified during the inspection, some 'should do'

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[58] Provider section - RX3 Tees, Esk and Wear Valleys NHS Foundation Trust (12/06/2018) INS2-3179697385 (cqc.org.uk)

		actions relating to T4 CAMHS were identified, including:
		• *The Trust should ensure that effective systems and processes are in place to monitor the compliance and quality of clinical supervision.* • *The Trust should ensure that there are sufficient staff available to coordinate activities scheduled for children and young people.*
August 2018	Complaint about an inappropriate restraint is made directly to the CQC.	The complaint: staff having no compassion for children in their care and failing to notify parents when an incident occurred. The CQC's management of the complaint made by Christie's grandmother lacked rigour. The complaint was referred to the LADO and we found little evidence to suggest that the CQC sought a robust response in relation to the allegations; the LADO tried multiple times to obtain an adequate response to its requests for information. It is not clear whether the CQC was alerted to these challenges and the failure of the Trust to provide a meaningful response.
November 2018	CQC is alerted to the inappropriate restraint incidents and subsequent suspensions.	The CQC were alerted to the CCTV footage and associated complaint. Following this, we were told that the CQC liaised *"sometimes daily, but certainly at least weekly… getting updates, taking them back to management review meetings … we regularly reviewed what was happening at West Lane"*.
May 2019	Complaint made in relation to Emily's care on Newberry.	The CQC undertaking a management review which concluded that no further action was required because *"there has been no other intelligence about this ward in recent months to suggest that there are concerns for other patients' safety"* and *"we receive monthly staffing and incident data"*.

5.166 The management review into the May 2019 complaint refers to the 2018 inappropriate restraint incidents and notes that "staff involved are no longer at this hospital and current staff have received additional training and supervision on restraint". Whilst there is evidence that staffing establishment numbers were considered, it is not evident from the minutes of the Management Review Meeting that the CQC sought additional detail on how the staff on the ward were being

managed or supervised, what the residual impact on the service culture was, nor what the leadership structure was.

5.167 We found evidence that suggests the CQC's request for information about safety at WLH lacked rigour. As outlined earlier, the CQC sought information on StEIS-reportable incidents, and the focus on only StEIS incidents gave a false and incorrectly positive view of safety at the unit and was overly reliant on self-reporting. Had a more robust approach been taken to seeking detailed data on incidents reported via Datix, it is possible that the CQC would have been alerted to the concerning pattern of restraint incidents, coupled with the evident lack of analysis and learning on the part of the Trust.

5.168 The CQC inspected WLH between 17 to 20 June 2019, which resulted in the Trust being served with a s31 notice under the Health and Social Care Act 2008 on the basis that "we believe a person will or may be exposed to the risk of harm if we do not do so". The CQC raised concerns in relation to:

- Observation records were not being maintained in line with the Trust's policy.

- Patients on enhanced observations did not have observations recorded in their patient record.

- Ligature risks were identified which were not recorded in the suicide prevention environmental survey and risk assessment.

- The mitigation for ligature risks identified by WLH was "individual intervention plans", including enhanced observations which were not evidenced.

- The inspection team witnessed serious medication errors which were considered to be borne out of insufficient staffing levels.

- Prior to the last day of the inspection, the CQC raised concerns that staffing was insufficient, and we have been told that assurances were provided to the CQC prior to the inspection team leaving site that additional staff would be provided immediately. Christie ligatured on the day before the CQC concluded their visit, which led the CQC to conclude that "care and treatment was not provided in a safe way and that staff on the ward at the time were unable to respond to the risks posed by patients".

5.169 The Trust created an action plan to address the concerns raised by the CQC in June 2019. Whilst we have been provided with a version dated 8 July 2019, we found no evidence that this action plan was subject to Board-level scrutiny at this time. This is particularly surprising given that Christie died only seven days after the CQC inspection ended; we would have expected WLH to dominate the Board's agenda at this time.

5.170 The CQC undertook a further unannounced inspection at WLH on 19 and 20 August 2019, shortly after the death of Nadia on 5 August 2019. This was triggered not only by the death of Nadia, but also a staff member from WLH alleging that there continued to be non-compliance with the Trust's observation policy. The closure notice was issued on 23 August 2019. Over the next month, the Trust made arrangements for inpatients to be transferred elsewhere or discharged, where appropriate, and the unit closed on 16 September 2019.

NHS England/Improvement

5.171 We have outlined our findings in relation to NHSE in its role as the commissioner of a specialised service at the Trust in section 5.90. As outlined earlier in this report, we found no evidence of robust safeguarding oversight from either NHSE Specialised Commissioning or NHSE/I.

5.172 Following the 2018 inappropriate restraint incidents, NHSE implemented "enhanced surveillance".[59] This involves the local Quality Surveillance Group (QSG) applying closer scrutiny to information about a provider's services at meetings, holding "focused discussions" (otherwise referred to as "single-item QSGs") with the provider, and considering whether further action is required due to concerns not being resolved. NHSE Specialised Commissioning also increased the presence of senior staff at WLH in the aftermath of the November 2018 incidents and particularly during June, July and August the following summer. They also brought in new case managers to the unit in spring/summer 2019. These were individuals with CAMHS-experience.

5.173 Despite the nature of the 2018 inappropriate restraint incident, we are not aware the local QSG requested additional information in relation to incidents that did not meet the StEIS threshold. The meeting held in March 2019, during which it was confirmed that Westwood could reopen to admissions, recorded remaining concerns about "incident reporting, including … identifying StEIS reportable incidents".

5.174 NHSE has taken no action in relation to the Trust's licence due to the closure of WLH and cessation of T4 CAMHS services.

Inter-agency liaison

5.175 Recipients of T4 CAMHs services often present complex health and social care needs, yet we found there to be inadequate communication, coordination, and collaboration between the key partners to ensure that children and young people receive the help and support they need.

5.176 Interviewees across all agencies involved in this review acknowledged that an individual's care rarely has a distinct separation between health and social care needs. However, this complexity is not reflected in the way in which key agencies are established and operate. In July 2014, NHSE published a national review of T4 CAMHS[60] which was "designed to map current service provision, to consider issues that had arisen since April 2013 and to identify specific improvements that are required as an immediate and urgent priority through national commissioning."

5.177 This report notes that "given the multi-agency nature of services, and complex commissioning arrangements, there is also potential for a lack of integration between agencies, particularly at a time of shrinking resources. This can result in children and young people falling through the net, or alternatively escalating up the care pathway and experiencing greater distress and potentially requiring more expensive services." Despite this being a nationally recognised risk over five years prior to the closure of WLH, we found the acknowledgement and management of this by all agencies involved to be lacking.

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[59] quality-surveillance-groups-guidance-july-2017.pdf (england.nhs.uk)
[60] NHS England Report Template 7 - no photo (sensitive subject matter)

Table 9 below highlights some examples of missed opportunities for key agencies to communicate and proactively engage with one another; had this taken place, risks contributing to poor care and treatment at WLH may have been identified earlier and managed more successfully:

Table 9: Key agency communications

Agency	What happened?	What should have happened?
NHSE CQC CCGs Ofsted	Ofsted[61] identified several areas of concern with Middlesbrough Council's children's services, notably in relation to safeguarding, in August 2018. Insufficient improvement was made, and Ofsted awarded a rating of "Inadequate" in December 2019. There is no evidence that there was communication of this between the CQC, NHSE or local CCGs. There was no multi-agency consideration of the implications of this on care and treatment at WLH.	NHSE should consider the impact and risks on Tier 4 CAMHS if a local safeguarding board is found to be weak or inadequate, or a local provider is found to have a major staffing issue.
Cleveland Police	A decision was taken by Trust Board members not to undertake an internal investigation into the death of Nadia due to a police investigation being underway. We have been informed that the police did not require any internal investigation to be paused or deferred and at no point had this been instructed.	Clarity on police investigations and internal investigations under the PSIRF is required nationally.
LADO	There were significant delays in sharing information relating to the 2018 inappropriate restraint incidents with the LADO.	There should have been a transparent and prompt flow of information, or assertive escalation of any failure to do so.
NHSE Specialised Commissioning CCGs	Multiple interviews across a variety of organisations expressed a long-standing lack of clarity about who held responsibility for oversight of key	A more proactive, patient-centred clarification discussion should have taken place to resolve this long-standing issue.

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[61] Ofsted is the Office for Standards in Education, Children's Services and Skills. Ofsted inspects services providing education and skills for learners of all ages, and also inspects and regulates services that care for children and young people.

		aspects of safety, such as incidents, although some interviewees from NHS Specialised Commissioning were confident that this was clear.	
TEWV LA		Transitions were not always well managed, resulting in inappropriate placements once young people turned 18.	The Trust is responsible for a safe discharge and the LA is responsible for the provision of support to young people following their inpatient spell. We found a tendency for neither party to proactively identify, prepare and respond to inadequate transition plans, nor was there sufficient collaboration on the topic of transitions.
		Safeguarding responsibility was not clearly understood by relevant parties. We found LA staff did not challenge clinical practices and care planning when there were safeguarding issues, believing it to be the responsibility of healthcare staff. LA staff failed to exercise their duties concerning the welfare and safety of children whilst they were under the care of health services.	Staff from both agencies should have better understood safeguarding responsibilities. Both agencies should have displayed a more risk-aware and patient-centred approach to problem-solving.

5.178 Effective engagement between a T4 CAMHS service and the relevant LA is an important part of quality care delivery for children and young people. Examples of LA responsibility for a child or young person admitted to a unit like WLH include: ensuring regular visits from social workers, health assessments, personal education plans (PEPs) and accommodation provision upon discharge, as well as more strategic functions such as safeguarding and LADO oversight of a service.

5.179 Most local authorities commission accommodation placements from private providers. For young people aged 16 and under, these placements have to be regulated by Ofsted and are subject to regular inspections, with very specific criteria in respect of how the provider looks after young people. For young people aged 16 and 17, it is possible to place them in 'unregulated accommodation', which does not have to be registered with Ofsted. Unregulated accommodation is currently under review by the government as concerns have been expressed about this type of arrangement for young people.

5.180 We found there to be a failure of key agencies to proactively communicate about, respond to and adapt to the complex health and social care needs of service users. This resulted in poorly managed and sometimes inappropriate

accommodation placements and care packages being made, which had a direct adverse impact on service users' mental health. For example:

- Christie was experiencing an escalation in self-harming symptoms in early 2019. However, the relevant LA (County Durham Council) received community-based accommodation that was not risk assessed and contained hazards such as easy access to a loft space and loose screws. In late spring 2019, Christie was discharged, as an informal patient initially, to the family home and then to her own house but was not provided with any social service commissioned support.

- Nadia experienced delays of five months during summer/autumn 2019 in being placed in an appropriate setting. Whilst we recognise the real difficulties in finding community placements with the skills and resources to meet the needs of young people with complex difficulties, case records and interviewees noted that there was tension between TEWV and CYPS, with each being frustrated by a perceived lack of progress made by the other party.

5.181 Changes in a service user's environment can often trigger an escalation in symptoms. However, we found there to be an inadequate inter-agency management of points of transition. Many interviewees shared the perception that TEWV and both local authorities displayed a tendency to shun their responsibilities to a service user once they had crossed an organisational boundary and generally appeared to lack a proactive desire to ensure that packages of care were appropriate. A key example here is in relation to Christie, who only received support from the CAMHS Crisis team following discharge in May 2019. Given that Christie was in receipt of local authority-commissioned support in the previous six months, we would have expected an application for an interim care order and secure order to have been made, which would have triggered an intensive support package from the CYPS.

5.182 The NHS Tees Valley Children and Young People's Mental Health and Emotional Wellbeing Plan 2019/20 recognised that "services are not as joined up as they should be" and we fully support the plan's ambitions in relation to Whole Pathway Commissioning to improve the holistic health and wellbeing of children and young people. A September 2021 update to this plan reflects the impact of Covid-19, noting that it has further exacerbated the complexity and acuity of mental health needs in the local population. Indeed, joined up care is a national issue now being addressed through provider collaboration.

Report summary statement

This report has reviewed and reported upon an extensive amount of evidence relating to corporate functions, care delivered, procedures, national directives and inter-agency working. The culmination of events described here is due to a number of issues occurring in synergy, culminating in the distressing overall reduction in care quality on a CAMHS unit. These challenges are detailed within these pages and summarised at the outset of this report.

The review team are conscious of the challenges and complexities of managing a unit of this nature and of course of the challenges generally of managing large, geographically dispersed hospitals.
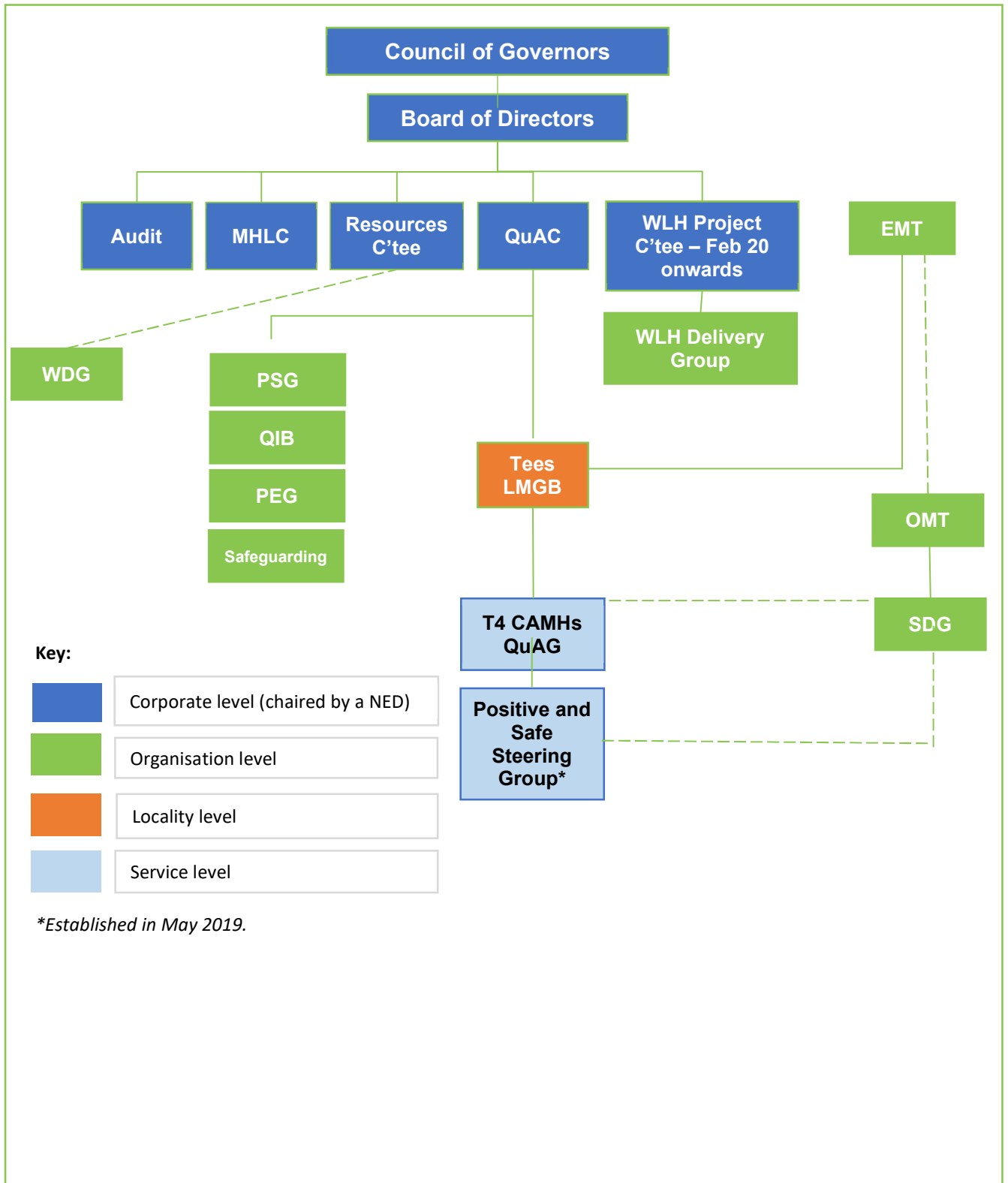
Appendices

Appendix A: Full terms of reference

Ref	Terms of reference
1	Review and comment on the Trust's handling and management of clinical concerns raised and escalated by families and patients
2	Consider if there were effective and appropriate arrangements in place for the escalation of concerns and the resolution of family concerns and complaints
3	Assess whether the actions carried out by the Trust, in response to concerns being raised were/are appropriate and correct, including foresight of the staffing crisis following concerns raised by a patient's advocate
4	Following the suspension of a number of staff, consider the impact of other, regulatory and HR processes on remaining staff Explore and comment on any perceived disconnect in clinical leadership, culture and clinical management at Ward to Board level
5	Taking into account the size and geographical spread of the Trust, review and assess the efficacy of the Trust's clinical governance arrangements and processes, the reporting of the same to the Trust Board, including whether the Board had a 'clear line of sight' of individual service areas/departments and any presenting issues.
6	Consider the skill mix and availability of appropriately trained staff for the West Lane Unit and the use of agency staff
7	Examine and consider the quality, efficacy and safety of the service prior to the cessation of the service and transfer of patients
8	Considering the complexity of the patient group, evaluate the Trust's ability to provide safe and effective care which met the needs of the cohort of patients Consider the impact of 'least restrictive practice' principles and evaluate staff's understanding and its application in care planning and the management of patients
9	Analyse the impact of the Trust being a New Care Model and how the Trust managed their responsibility to provide assurances to NHS England that patients in their services were in receipt of safe and high-quality care and assess the efficacy of NHSE assurance arrangements and processes with regard to this.
10	Determine and test the robustness of overall governance, review and assurance processes of the Trust, NHS England Specialised Commissioning and the Commissioner (CCG)

Appendix B: Glossary of terms used

AD	Associate Director
AMHS	Adult mental health services
ASD	Autistic spectrum disorder
BAF	Board Assurance Framework
BLS	Basic life support
BPD	Borderline personality disorder
CAMHS	Child and adolescent mental health services
CD	Clinical Director
CoG	Council of Governors
CRR	Corporate Risk Register
DH	Department of Health
DoL	Deprivation of liberty
DoO	Directors of operations
DoQG	Director of Quality Governance
EFA	Estates and Facilities Alert
EMT	Executive Management team
FSU	Freedom to Speak Up
HSIB	Healthcare Safety Investigation Branch
IRIT	Inpatient Resource Intensity Tool
ITU	Intensive therapy unit
LA	Local authority
LADO	Local authority designated officer
LTP	Long-term plan
MHL	Mental Health Legislation
NCM	New care models
NMC	Nursing and Midwifery Council
NRLS	National reporting and learning system
OD	Organisational development
OT	Occupational therapy
PAT	Positive Approaches team
PBS	Positive behavioural support
PCT	Primary care trusts
PEG	Patient Experience Group
PEP	Personal education plans
PICU	Psychiatric intensive care unit
PMVA	Prevention and management of violence and aggression
PSG	Patient Safety Group
PSR	Professional standards review
PTSD	Post-traumatic stress disorder
QGG	Quality Governance Group
QI	Quality Improvement
QSG	Quality Surveillance Group
QuAG	Quality Assurance Group
RR	Risk register
RRP	Reducing Restrictive Practice
STSCP	South Tees Safeguarding Children Partnership
TCS	Transforming Community Services
TNA	Training needs analysis
WLH	West Lane Hospital

Appendix C: Overview of governance structure

Council of Governors

Board of Directors

Audit

MHLC

Resources C'tee

QuAC

WLH Project C'tee – Feb 20 onwards

EMT

WLH Delivery Group

WDG

PSG

QIB

PEG

Safeguarding

Tees LMGB

OMT

T4 CAMHs QuAG

SDG

Positive and Safe Steering Group*

Key:

	Corporate level (chaired by a NED)
	Organisation level
	Locality level
	Service level

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