NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD

Serious Case Review

Executive Summary prepared for the

Nottinghamshire Safeguarding Adults Board

Concerning

Adult F13

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1. Introduction

1.1. In the summer of 2013, F13 died after having tied a ligature to her neck. At the time of her death she was resident at a secure unit regulated by the Care Quality Commission for activities of assessment or medical treatment for persons detained under the Mental Health Act 1983.

1.2. The decision to hold a serious case review was made following a referral to the Nottinghamshire Safeguarding Adults Board (NSAB).

1.3. The review was recommended on the grounds that:

- a vulnerable adult died and abuse or neglect is known or suspected to be a factor in their death; and
- the case gives rise to concerns about the way in which professionals and services worked together to safeguard the vulnerable adult.

1.4. A decision was made to appoint an Independent Author for the review. Hayley Frame, Independent Safeguarding Consultant, was subsequently commissioned. Chris Hooper, Nottinghamshire Fire and Rescue Service, was appointed as Chair of the Review given that Nottinghamshire Fire and Rescue Service has had no involvement in the case.

1.5. The purpose of having a serious case review is neither to reinvestigate nor to apportion blame. The purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard vulnerable adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local inter-agency practice;
- To improve practice by acting on learning (developing best practice);
- To prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies, in order to make recommendations for future action.

2. Contributors to the Review

- The parents of Adult F13
- Children's Social Care, Nottinghamshire County Council (NCC)
- Children, Families and Cultural Services, NCC
- Adult Social Care, Health and Public Protection, NCC
- Nottinghamshire Police
- Care Quality Commission (CQC)
- Nottingham University Hospitals Trust
- Sherwood Forest Hospitals Trust
- East Midlands Ambulance Service (EMAS)
- Nottinghamshire Healthcare Trust
- Partnerships in Care
- Continuing Healthcare – Newark and Sherwood Clinical Commissioning Group
- NHS England
- NHS Direct
- Alpha Hospitals

3. **Case Summary**

3.1. F13 was known to Children's Social Care from the age of twelve years due to concern regarding self-harming behaviours and unhappiness at home. F13 disclosed her unhappiness at school but was excluded on two occasions due to her self harming behaviours. She had periods of being a Looked After Child, and was made subject to a Secure Order following increasing concerns regarding self-harm and absconding.

3.2. Concerns regarding F13's mental health increased during her time at the secure children's home. This led to her being sectioned under the Mental Health Act 1983 and being placed within mental health settings. Although F13 was seen to make progress within subsequent placements, attempts at rehabilitation were unsuccessful with escalating concern regarding suicide when in the community. As a result F13 was detained in mental health settings for much of her adolescent years.

3.3. F13 transferred from Children's Mental Health Services to Adult Mental Health Services, moving to a low-secure unit the day after her eighteenth birthday.

3.4. During this period a number of concerns were being raised in respect of the safety of patients within the hospital. Two safeguarding referrals were investigated by Adult Safeguarding and concerns were known to the CQC and NHS England.

3.5. F13's self-harming behaviour fluctuated over a period of time and escalated towards the end of her life. F13 died as a result of a ligature tied whilst subject to five minute observations.

4. **Findings**

4.1. There are a number of themes that emerge from this SCR. The themes identified are:

- Lack of Assessment
- Recognition and response to early indicators of abuse
- Appropriateness of placements and how these are commissioned
- The impact of transition planning
- The impact and interaction of the legislative frameworks
- Voice of the child / young adult
- Safeguarding in institutional settings

4.2. A key concern that has arisen within this SCR is the voice of F13. From a young age she was telling professionals that life at home was a very unhappy experience for her. Some of these disclosures were made to school staff who were trying to manage her self harming behaviours and the impact upon peers. However, the school sought to exclude her as a result of her behaviour and were unwilling to re-enrol her at a later stage.

4.3. Research indicates that there are strong links between sexual abuse, emotional abuse, bullying and low self-esteem, self-harm, suicidal ideation and suicide. Limited protective and resilience factors also increase the risk of suicide. F13's profile included a number of these risk factors from a young age. The SCR found that services focused upon risk yet failed to recognise and respond to the underlying cause of the presenting behaviours. There was a lack of a comprehensive multi-agency assessment of F13's social, emotional, physical and health needs. This therefore led to care plans being reactive rather than based upon analytical assessment and planned accordingly. Even

at the conclusion of this SCR, the underlying cause that was driving F13's behaviour is not clear although it was likely to be as a result of a combination of factors; abuse and neglect; complex family dynamics, and dysfunctional attachment compounded by an inability to cope in non-secure settings.

4.4. A focus upon process and whether F13 met relevant eligibility criteria for services is evident within the agency records; for example whether F13 met criteria for mental health services, and whether she met the criteria for significant harm as per child protection procedures. Given the legal and procedural constraints, there appeared to be a tendency to focus upon process and criteria rather than need.

4.5. F13's status under the Mental Health Act had a significant impact upon her status under the Children Act 1989, as the Mental Health Act had primacy. The fact that F13 was the responsibility of either Health or Children's Social Care dependent upon her legal status added to the complexity of determining long term plans for F13.

4.6. The transition from Children's Mental Health Services to Adult Mental Health Services was a complex process. It is evident that there was a range of professional opinions regarding the transition to Adult Services regarding whether F13 should return to her mother's care or be moved to a low-secure hospital. These were resolved yet understandably caused great concern to F13 and her mother. The overall view of professionals was that F13 would relapse if returned to her mother's care.

4.7. The briefing completed on behalf of the Bradley Commission entitled 'Young adults (18–24) in transition, mental health and criminal justice' raises some important issues in respect of transition planning. The briefing recommends that there should be eight core components of effective engagement with young adults in the transitions process. These are:

- A primary focus on emotional wellbeing and communication difficulties (focusing upon early identification of emerging mental health difficulties in adolescence and early adulthood).
- Consistent and continuous relationships (recognising that attachment underpins effective engagement especially for those with a history of poor attachments relationships and childhood trauma – a clear factor for F13).
- Prioritising the journey (in the knowledge that short or intermittent interventions are not appropriate).
- Service user led (services led by someone who has been there before are better placed to engage with young adults).
- Addressing multiplicity (a holistic approach to addressing a young person's needs)
- Operationalising complexity (see below).
- Accessibility (flexibility in approach to service provision).
- Client led engagement and decision making.

4.8. Operational complexity is highly relevant in the case of F13. The briefing recommends that '*Establishing strategic level interagency and collective working arrangements to bridge gaps is vital. Ideally, commissioning arrangements will support continuous service provision for those with long-term complex needs across key transition points. This requires a degree of boundary blurring or spanning (Kislov, 2013) within multi-professional implementation teams, for example, to create overlaps (but not mistaken overlaps) between services for 16 to 25 year olds'.*

4.9. Boundary blurring or spanning in the case of F13 could have led to a more creative way to meet her transitional needs. However it must be recognised that currently the procedural and legislative constraints act as an inhibitor.

4.10. Safeguarding concerns arose in respect of the low-secure unit where F13 was placed as an adult and were reported to the CQC and in turn NHS England. Adult Safeguarding within Nottinghamshire County Council also completed two safeguarding investigations, both of which concerned F13. What is significant is that firstly the two safeguarding investigations were not tied together and were seen as separate incidents, and secondly the concerns known to all three agencies were not shared in a coordinated manner. The recurring themes of patient safety and lack of staffing were known to all three agencies but not brought together into a cohesive plan of investigation prior to F13's death.

4.11. It is evident that F13 was clear in her intention to kill herself. Staff at the low-secure unit did not fully realise the risk of suicide or understand that this was escalating in the days before her death. F13 was subject to five minute observations; however this was insufficient as she was able to self-harm and tie ligatures within these intervals, ultimately culminating in her death. F13 also managed to tie a ligature when in the presence of staff; such was her determination to harm herself.

4.12. It has been acknowledged that the risk assessment and care plan to manage her self-harm was not robust and was not reviewed appropriately given the increase in suicide ideation. This was compounded by the staff team on the ward not functioning effectively and internal poor communication.

5. IMR Recommendations and Changes in Practice

5.1. IMR recommendations are taken from each agency's IMR, and individual action plans will be produced and monitored by respective agency commissioners.

5.2. A number of changes in practice within agencies have been identified during the course of this SCR although not all have arisen as a result of the case. These are identified below. A significant national development is that the National Institute for Health and Care Excellence (NICE) has been asked by the Department of Health and Department for Education to develop a guideline of transition from Children's to Adult Services that covers both Health and Social Care. This is in recognition of the consequences of poor transitions upon the outcomes for young people. It is anticipated that the guideline will address organisational frameworks required for effective transition as well interventions required to support transition. It will address barriers to good practice in transition planning and promote joint working between Children's and Adult Services (Health and Social Care). Notably, the guidance will address the age at which young people move from Children's to Adult Services, and rather than a focus upon transition being a description of one move that occurs at the age of eighteen years, it will be seen as a process for young people in transition up to the age of twenty-five years.

5.3. Children's Social Care, Nottinghamshire County Council (NCC)

IMR Recommendations:

- The Children's Social Care Service Director should, within six months of the approval of this report, consider developing a Risk Management Framework which effectively meets the needs and manages the risk of children and young people who self-harm and / or express suicidal ideation.
- The Children's Social Care Service Director should be assured within two months of the approval of this report that the Emergency Duty Service responds in an

effective and timely manner to incidents of adolescent self-harming and suicide attempts.

- The Children's Social Care Service Director should ensure that within three months of the approval of this report there is good practice guidance available to practitioners and managers regarding children and young people who are subject to the Mental Health Act:1983 which (a) establishes their legal status in relation to the Children Act:1989, (b) ensures that each child has either a Child in Need (CIN) or Looked After Child (LAC) plan (depending on legal status) informed by a single assessment which is updated as appropriate, and (c) that the Child Care plan is reviewed as per statutory guidance and if needs be integrated with the Care Programme Approach (CPA) process.
- The Children's Social Care Service Director should ensure within three months of the approval of this report that the current (January 2014) Terms of Reference - Specialist Integrated Resource Panel (SIRP) Guidance document provides for regular (it is suggested six monthly) review regarding quality of placement and continuity of funding.

Changes in Practice:

- Since 2010 Children's Social Care has increased its front line capacity by fifty-six Social Worker posts and an additional nineteen Advanced Social Work Practitioners to support front line Social Workers.
- The new operating model in Children's Social Care implemented in 2012 has resulted in Looked After Children having a dedicated Social Work Service.
- There is no unallocated work in Children's Social Care.
- All qualified Social Workers and Team Managers have received training in undertaking assessments.
- Team Managers have received training in supervision and reflective supervision.
- A Central Placements Team has been established within Children's Social Care to ensure that children are placed only in appropriate placements and that placements are regularly reviewed.
- All Looked After Children have access to an independent advocate.
- Looked After Children are seen regularly, and are regularly seen alone, by their social workers.

5.4. **Children, Families and Cultural Services, NCC**

IMR recommendations:

- The Local Authority produced guidance ("Self-Harm – Notes of Guidance", Nottinghamshire County Council, Educational Psychology Service, March 2011) on self-harm in 2011 but, as the conclusions section indicates, further work will be needed to ensure that all schools are familiar with the advice and have the opportunity to consider how to implement it in their school.
- The Local Authority has developed new protocols regarding the admission of pupils to schools. They should take this opportunity to review their effectiveness.

Changes in Practice

- Guidance in respect of self-harm was issued in 2011 although it is recognised that further work is needed to ensure that all schools are familiar with the advice and how to implement it within their school.

5.5. **Adult Social Care, Health and Public Protection, NCC**

IMR Recommendations:

- Nottinghamshire County Council should develop operational guidance procedures for MASH. These should include clear guidance on information sharing with other agencies. This should be reviewed on an annual basis with contribution from partner agencies.
- All Adult Social Care, Health and Public Protection (ASCHPP) staff acting in the role of safeguarding officer or safeguarding manager should have attained the level of competence as required in the National Safeguarding Capability Framework.
- ASCHPP should establish a method of reporting which identifies safeguarding incidents by provider units and organisations.

Changes in Practice

- The Nottinghamshire Safeguarding Adults Multi-Agency Procedures have been revised and are being reissued in line with the national 'Making Safeguarding Personal' agenda. This has provided a greater emphasis on outcome focused assessment and planning.
- The revised Nottinghamshire Procedures make specific reference to ensuring the separation of role between safeguarding manager and safeguarding assessment investigation officer.
- The MASH guidance in relation to adults' service referrals is in the process of being redrafted.

5.6. **Nottinghamshire Police**

IMR Recommendations:

- To ensure that all missing persons are recorded correctly, there is a requirement for regular auditing of all incidents created as high risk missing person or concerns for safety.
- In response to National best practice it has been proposed that Nottinghamshire Police have Missing From Home Co-ordinators. This is currently the subject of discussion by the Chief Officer Team and when these posts are agreed they will be the most appropriate person to complete the auditing. This has now been ratified and five Missing From Home coordinators are in the process of being recruited and will commence in post April 2014.
- Officer to receive training in how to recognise vulnerability and when to make a referral via a C51 in relation to both children and adults. In August 2013, Nottinghamshire Police commenced a new one day training delivery to all frontline police officers and police staff (Response and Neighbourhood Policing Teams). The subject matter will be 'Vulnerability' and aimed to support a holistic frontline approach to safeguarding and vulnerability, taking full consideration of mental health, substance misuse and domestic violence in both adults and children. This training has commenced and is ongoing.

Changes in Practice:

- There is now a dedicated Public Protection Detective Inspector on call each day to address matters of a serious and urgent nature.

- There is now a dedicated Adults at Risk Team in operation.
- Computerised systems have been developed to improve the recording of missing episodes within COMPACT and therefore trigger referrals to Social Care.
- Training has been established that focuses upon vulnerability of both adults and children.

5.7. **East Midlands Ambulance Service (EMAS)**

IMR Recommendations:

- The author would recommend that Essential Education during 2014-15 on safeguarding is delivered in a think family approach with particular emphasis on neglect by individuals within a care setting, both adults' and children's. This is to support the crews to recognise and acknowledge not just the issue of the patient they are attending may have but also the individuals that they are leaving behind within that unit. This should be evidenced through education attendance figures of 2014-2015 and assured the following year through the safeguarding audit process 2015-2016.
- The author recommends that Essential Education for EMAS during 2014-2015 highlights the need to safeguard all children who have ingested alcohol, illicit substances and self-harm. This would help to ensure that information is shared and access is provided to meet the child / young persons and family needs to receive the support that is required. This education should be delivered alongside information around holistic assessment and the need to record patients' wishes. Both adults' and children's wishes should be recorded even if they conflict with the referral that is being made. This should be evidenced through education attendance figures of 2014-2015 and assured the following year through the safeguarding audit process 2015-2016.

Changes in Practice:

- The National Ambulance Mental Health Group is working on developing a clinical performance indicator to ensure that in instances of suicide and self-harm the Suicide and Depression (SAD) person scale is used to support risk assessment and decision making.

5.8. **Nottinghamshire Healthcare Trust:**

IMR Recommendations:

- The School Nursing Service, within Health Partnerships, should consider how they might:
    - Develop effective information pathways with partners in education which are able to identify children who are not on a school roll.
    - Influence the Public Health led review of the school nursing service to develop a school nursing service which is able to work effectively with children and young people who are not on a school roll.
    - Take forward developments in practice which will enable School Nurses to have the skills, tools and knowledge base to effectively support children and young people who present with self-harming behaviour in the school / community setting.
- All Nottinghamshire Healthcare NHS Trust services considered in the scope of this IMR should review how they ensure that record keeping includes:

    - Analysis
    - Action planning
    - Roles and responsibilities within the action plan
    - The voice of the child
    - A Recovery focus
- Child and Adolescent Mental Health Services (CAMHS) services to consider how they might provide safeguarding supervision for CAMHS professionals which enables the recognition and respond to presentations of abuse, challenge and escalate safeguarding concerns through means such as:
    - 1:1 safeguarding supervision with a safeguarding specialist
    - Group safeguarding supervision facilitated by a safeguarding specialist
- CAMHS services to give consideration as to how they might be facilitated to access to the 'System one' electronic record keeping systems utilised by Children's Community Health Services (Health Partnerships) to promote effective information sharing, partnership working and communication pathways across Children's Health Services.
- CAMHS services to positively engage and effectively influence the CAMHS Public Health led pathway reviews to provide equitable self-harm services to include the:
    - The provision of out of hours self-harm assessments across Nottingham City and County
    - Access to expert nurse consultant services across the City and the County.

Changes in Practice:

Children in Care Health Services:

It is noted that since 2008 significant improvements with regard to communication pathways between the Children in Care Health Teams, CAMHS Looked After Children teams and Social Care have been made. Pathways to enable the regular review of children in the care of the Local Authority have been established; invitations to Looked After Reviews are received and are operational. Recommendations from the Serious Case Review Child E, OFSTED inspection 2010 and service developments ensure that:

- Named caseloads for the Clinical Nurse Specialists for children in care ensure regular and robust follow up of children in care.
- Placement notifications, demographic changes and information sharing between Health and Social Care occur routinely.
- Notification pathways for children in care who go missing are in place between Health and Social care.
- Self-Harm Pathway established.
- Established notification processes with Nottinghamshire County Local Authority following episodes of missing for children in care.
- The use of the Strengths and Difficulties questionnaire to assess the emotional health and well-being of children in care is established.

School nursing:

- Record keeping is now established utilising electronic record keeping systems 'System one' which ensures that children in care are identified on caseloads under Category 4 of the Pathway to Provision.
- Children in care remain open on school nursing caseloads to the age of eighteen years.
- Information sharing between the School Nurse and the Children in Care Health Team is robust.

- School Nurses now receive safeguarding supervision from the Specialist Safeguarding Nurses, Health Partnerships (Guidance *for Practitioners on Accessing Advice and Supervision to Safeguard Children, May 2010).*

Child and Adolescent Mental Health Services (CAMHS) - Self-harm Team:

- Discharge planning meetings for young people admitted through the self-harm pathway are identified by the Safeguarding Team at Nottingham University Hospitals (NUH) and are led by Social Care. This ensures that all children / young people discharged from NUH following an episode of self-harming, where there are safeguarding concerns identified, have a clear and communicated multi-agency discharge plan.
- Safeguarding supervision for CAMHS professionals is now included in management supervision.
- The Self-Harm Team now routinely notifies the School Nursing Service of discharge plans for all children / young people who have been assessed through the self-harm pathway.
- There is currently a review of support services for young people self-harming in Nottingham City which aims to provide a more developed follow up of services for young people self-harming. The Self-Harm Team is linking in with the services to be provided at a Tier 2 level – 'Kooth' / on-line services.
- Although there is no distinct Self-Harm Team working in the north of the county young people who present with self-harming behaviours at Kings Mill Hospitals will be seen and assessed following the same criteria used by the Self-Harm Team and following the same pathway. The availability of the Specialist Nurse Consultant Services, is however, not countywide.
- The use of Bed Managers by commissioners through the East Midlands Commissioning Service now ensures that all providers of CAMHS in patient services are monitored, challenged and reviewed by this team. This now ensures that professionals when seeking a Tier 4 CAMHS placement can be assured that there is a level of scrutiny regarding placements made.
- Professionals attending CPA meetings for children and young people placed outside of Nottingham in CAMHS Tier 4 provision are enabled to challenge decision making by the external provider to ensure the best outcomes for Nottingham children and young people.
- Acute bed management meetings are now held monthly between CAMHS Senior Professionals and CAMHS Commissioners (Bed Management) at which all placements outside Nottingham are discussed and reviewed.
- A weekly bed placement proforma is completed by Senior Mangers detailing admissions and discharges of Tier 4 placements and shared with NHS England.

Child and Adolescent Mental Health Services - Out Patients:

- Safeguarding supervision is now included in management supervision.
- Directory of Services is now available which clearly outlines the range of CAMHS services available and how they work together and should ensure greater clarity across agencies with regard to the range of services provided by CAMHS.

Paediatric Liaison Health Visiting Service:

- The Paediatric Liaison Health Visiting Service (PLHVS) has access to the electronic record keeping systems 'System one' which ensures that there is the immediate sharing of information about young people who access ED at NUH as well as follow up with paper copies of ED attendances.

- The PLHVS routinely scrutinises all ED attendances for the over five year olds / under eighteen year olds against a set of vulnerability criteria.

Child and Adolescent Mental Health Services Children Looked After team:

- There have been significant improvements in communication pathways between the Children In Care Health Team and CAMHS Looked After Children; to include direct referral pathways, joint meetings, access to consultation meetings, sharing of consultation letters.

5.9. **Partnerships in Care**

IMR Recommendations:

- That where patients are moving between Adolescent and Adult Services, that robust transitional arrangements are put in place by both the discharging and the receiving unit.
- That the Senior Management Team takes into account a range of factors such as specialised patient need, acuity of patient group and the geographical spread of units when deciding upon the case load for senior clinicians. That senior professionals should have time in their working week to devote to clinical and leadership roles.

Changes in Practice:

- The 09:00 handover meeting has been re-structured. These meetings are mandatory and Multi-Disciplinary Team (MDT) staff are required to attend. The meetings focus on and discuss clinical incidents, risk, safeguarding issues, complaints, and staffing. Senior Clinical staff and the Registered Manager attend these meetings. The meetings also discuss referrals, admissions and discharges. Discussion at these meetings is minuted. Actions are decided upon at these meetings, and there are allocated responsibility for these. The Responsible Clinician will follow up incidents on their ward.
- The unit has a dedicated MDT, i.e. the service has a dedicated Consultant Psychiatrist, the Registered Manager has no other regional responsibilities, and the Unit has a dedicated team that includes a Clinical Nurse Manager, an Occupational Therapist, a Social Worker and a dedicated Psychologist. These changes have made significant differences to the quality of MDT working and communication.
- The nursing structure has been reviewed. There is an experienced Charge Nurse covering the two wards, and there is a Deputy Charge Nurse on each ward.
- The structure of ward rounds has been reviewed and there is now greater structure to these meetings and individual care reviews.
- Local Service Development meetings and Clinical Governance meetings occur at monthly intervals.
- All patient risk assessments have been reviewed and are kept under regular review.
- Training has been provided to the team on bullying awareness, therapeutic boundary setting, and care planning training has been delivered to staff nurses.
- Communication and briefing meetings occur at regular intervals, and all staff have been issued with resource packs.
- Robust systems are now in place to ensure that supervision is provided to all members of the nursing department.

5.10. **NHS England**

IMR Recommendations:

- The Specialised Commissioning Team will ensure that the findings and outcome of the national review of CAMHS service availability is embedded into local commissioning arrangements.
- Specialised Commissioning Team to ensure that appropriate scrutiny and challenge is given to assessments and care planning carried out by provider organisations.
- Monitoring of record keeping standards should be undertaken to ensure that Case Managers and other relevant staff adhere to the required standards for record keeping.

Changes in Practice:

- Routine service visits have been undertaken and continue to be planned for all specialised services in the East Midlands.
- The Mental Health Team has introduced a provider surveillance log following the routine visits which is utilised on a fortnightly basis in team meetings to monitor quality and patient experience in services. The provider information is populated by the case managers responsible for the service and information from other agencies.
- The Quality and Nursing Directorate of Leicestershire and Lincolnshire Area Team has joined the Mental Health Team to undertake routine and reactive service visits to explore quality and safety in services.
- Safeguarding training has been undertaken by all members of the Mental Health Team as a refresher and mandatory training. The training is more rigorous than previously in that the module must be passed.
- A provider regional Safety and Quality Group has been established to share good practice and learning from serious untoward incidents. This is chaired by LLAT and learning shared both locally and nationally.
- A national database has been established which standardises clinical record keeping for all case managers nationally. Information governance is part of new mandatory training.
- The Mental Health Team has appointed to the vacant posts in the team at the time of this incident.
- Meeting with safeguarding teams to establish contacts and sharing of information has been undertaken to develop closer working relationships. Meetings and liaison with CQC continue.
- A national review is being undertaken of Children's Services (CAMHS) which will help to shape better services and commissioning for the needs of children.

5.11. **Continuing Healthcare (Newark and Sherwood CCG)**

IMR Recommendations:

- CSU to provide assurances to Newark and Sherwood CCG that the electronic database is accurately maintained.

5.12. **Care Quality Commission**

IMR Recommendations:

- CQC staff must prioritise and act more promptly in undertaking an inspection when the weight of evidence signals serious care failings. This is particularly relevant when the concerns about the quality and safeguarding come directly from the people in the service. There should be a minimum delay and inspections carried out promptly to corroborate or refute the evidence that has been made available.
- CQC staff must ensure that where there are discrepancies with commissioners and other external stakeholders about the levels of risk and harm to patients that the issues are discussed and handled through the Safeguarding Adults Team and an agreed action plan is signed off.
- CQC staff should continue to inspect services with the commissioners and Local Authority when relevant and appropriate to do so and in particular when there are major concerns about the welfare and safety of the people in the service.

5.13. **Nottingham University Hospitals NHS Trust**

IMR Recommendations:

- Minutes from child protection multi-agency strategy discussions should be filed in Nottingham University Hospital (NUH) notes. The NUH Safeguarding Team has worked over recent months to establish robust systems with Social Care (who typically convene and minute Strategy Meetings) to ensure notes of Strategy Meetings are made available to key NUH professionals.
- NUH should explore with CAMHS development of a joint discharge proforma which supports shared responsibility and joint communication around discharge and follow plans in young people who self-harm.
- NUH should discuss at a senior level with Nottinghamshire Healthcare Trust the way forward, if visible, co-location with CAMHS self-harm and acute services on an identified ward environment where the nursing staff and medical staff could develop joint expertise and foster a “therapeutic environment” providing specialist mental and physical healthcare which is age - and developmentally - appropriate for young people.
- There should be better support for doctors caring for children with mental health issues, perhaps a forum where CAMHS and NUH staff could discuss cases to allow each team to understand the importance of communication and information recording, and develop a stronger working relationship.
- There should be a better method of assigning a medical lead to a young person with complex health needs child such as this and make this obvious on our hospital system on admission. This should continue to take place until a child is sixteen years of age or transfers to Adult Services by eighteen years of age.
- The access policy should be implemented across the Trust: this gives children up to their eighteenth birthday access to the Nottingham Children’s Hospital while providing those in late adolescence (sixteen to eighteen years) with a choice as to whether they are seen in Paediatric or Adult Services. It was not recorded whether F13 was offered this choice.

6. Conclusion

6.1. This is an unusual and highly complex case. A high number of agencies were involved with F13 and whilst agencies were aware of her family history, there was no real sense of a full understanding of the underlying reasons for her emotional distress.

6.2. There is evidence of agencies working hard to keep F13 safe and to prevent her from ending her life by suicide including evidence of some very effective multi-agency partnership working. Agencies were however predominately reactive to crises, although this is understandable given F13's behaviour, and this impacted upon professionals' ability to undertake a considered assessment of the situation. The further impact of this upon the ability to reflect upon F13's case, and make informed decisions about her future based on her assessed need was no doubt compromised. There is a sense of agencies anticipating that if F13 were to commit suicide it would be in the community; hence her being placed in secure settings for lengthy periods of time. Agencies were concerned that F13 was becoming institutionalised, and indeed there was evidence of her not coping with life in the community. What this meant for F13 was that the 'normality' of teenage life was not a reality for her.

6.3. A significant factor in the case is the impact of procedural and legislative frameworks upon the care planning for F13. Her status under the Children Act 1989 and the Mental Health Act 1983 governed who took responsibility for her; however the planning processes were inextricably linked. Boundary blurring or spanning in the case of F13 could have led to a more creative way to meet her needs, not only in the later transitions process but also earlier when she was a child. A co-working approach between Mental Health and Social Care Services would have been appropriate for F13 as the actions and planning of one impacted directly upon the actions and planning of the other. This would also have mitigated against divergence in opinion as was evident in this case. For F13 in the middle, this was likely to be a confusing experience for her and her voice was lost amongst the intricacies of procedural and legislative constraints. Despite these inbuilt challenges there were some examples of good multi-agency working and planning.

6.4. The safeguarding concerns at the low-secure unit were not responded to in a timely or cohesive manner by the investigative, commissioning and regulatory bodies. There are indications that the safety of patients including F13 was compromised by the care received.

6.5. It is not evident whether the reality of suicide for F13 was explored with her within therapeutic interventions. What is evident is that F13 made clear and repeated assertions that she did not want to live. In the last days before her death, consideration was not given to 1:1 supervision of F13. Although this may well have prevented her death in the short term, the likelihood is that future suicide attempts would have been made. The knowledge of this, throughout the course of agency engagement with F13, influenced the need for her ongoing containment and as such positive outcomes for F13 were significantly compromised.

7. Overview Recommendations

7.1. The overview recommendations are multi-agency and a multi-agency action plan will be developed.

7.2. It is evident that there are likely to be significant national developments with regard to transition planning which will impact upon local service planning and delivery. The local multi-agency transitions policy and pathways will need to be updated to be inclusive of mental health and make reference to the NICE guidance once published and the Care Act. This should include the pathway where the young person is detained under the Mental Health Act and a clear process of transition from CAMHS services to Adult Mental Health services including transfers of relevant responsibilities to both Social Care and Health. The policy and pathways will need to consider the expectations of service users and family members regarding transition.

7.3. A process to profile the most high risk young people should be developed, and a multi-agency creative solutions panel take responsibility for identifying appropriate resources for these young people in order to promote a more integrated approach to planning.

7.4. A review of processes which allow for information sharing in order to identify any concerns regarding providers of independent health and care services. Relevant agencies that would need to be involved in the process include Nottinghamshire County Council, NHS England, CCGs and the CQC.

7.5. Adult safeguarding enquires need to consider the totality of information; including that held by commissioning and regulatory bodies and subsequent interventions need to be timely, proportionate and coordinated. This is particularly relevant for healthcare providers.