

**Prisons &  
Probation**

**Ombudsman**

Independent Investigations

# Independent investigation into the death of 'Child T' while living at Aycliffe Secure Centre on 18 February 2017

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Child T died on 18 February 2017 after being found in her room with a ligature tied around her neck at Aycliffe Secure Centre. She was 17 years old. I offer my condolences to her family, friends and staff at Aycliffe.

Child T was the first person to take her life in a secure children's home (SCH) in over 20 years. A second, completely unrelated death occurred at another SCH shortly after Child T's and, although that was not a self-inflicted death, there are some similarities to our findings in the two cases.

Keeping Child T safe required a sophisticated approach because she was sometimes at very high risk of suicide or self-harm and this was the reason she had been placed at Aycliffe. Aycliffe told us that Child T was "at the edge" of what they felt able to look after because at times, she demonstrated a serious intent to end her life or self-harm. In the seven months she was at Aycliffe, Child T tried to self-harm or take her own life on more than 100 occasions.

It is clear that Aycliffe have a caring and motivated staff team. However, we identified a number of significant concerns about the way Child T's risk was managed and about the effectiveness of well-being checks.

We found the suicide and self-harm measures lacked a detailed risk assessment process and were not sufficiently responsive to changes in Child T's risk. The rationale behind Child T's risk management plans was sometimes difficult to understand. The mental health care from the Kolvin Service lacked a clear diagnosis for Child T and the clinical reviewer judged the risk assessment and care planning processes to be inadequate. I agree.

The well-being checking regime, although well-intentioned, was also clearly inadequate. This view, bolstered by our other SCH investigation, requires significant attention, co-ordinated at a national level to ensure lessons are learned.

Unfortunately, I think Child T's death could have been foreseen and, possibly, prevented.

Aycliffe need to introduce a more comprehensive, multi-disciplinary suicide and self-harm assessment and management system for those young people judged to be at risk to themselves. The whole staff team - medical, residential and educational - should work together to assess risk, agree a care plan and decide the measures necessary to keep someone safe. Accurate recording of suicide or self-harm attempts should inform risk and treatment decisions.

Worcestershire Local Authority made the decision to place Child T at Aycliffe and to continue her placement there. The Worcestershire Safeguarding Children Board commissioned a Serious Case Review under section 5 (2) b of the Local Safeguarding Children Board Regulations 2006. This review considers the decisions made by the Local Authority in placing and keeping Child T at Aycliffe.

This version of my report, published on my website, has been amended to remove the names of staff and young people involved in the investigation. We have also redacted certain details to protect the privacy of young people mentioned in the report.

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**April 2018**

## **Contents**

Summary .....	1
Findings .....	11



# Summary

## Events

1. Throughout this report, we refer to the young person who died as 'Child T'.
2. Child T had been in the care system since the age of 14. She had a history of self-harming by cutting and tying ligatures and in June 2016 took an overdose of paracetamol after researching how many tablets it would take to end her life. Soon afterwards, Child T absconded from her residential placement and was found on train tracks. She said she wanted to die and was waiting for a train to come. Worcestershire Local Authority felt Child T needed to be in secure accommodation for her own safety and applied to the court for a section 25 order. On 6 July 2016, one was granted and Child T moved to Aycliffe Secure Centre in County Durham. Child T lived in Auckland House.

## 2016

3. Staff completed a Comprehensive Health Assessment Tool (CHAT) assessing Child T's physical and mental health needs. They continued her prescription for an anti-depressant and sleeping aid. Child T was aware of being diagnosed with attachment disorder and emerging borderline personality disorder (by a psychiatrist who assessed Child T in June 2016) but did not know what these disorders meant. The Kolvin Service (a specialist multi-disciplinary service that provides assessment and treatment for young people living in the two secure children's homes in the north east of England) at Aycliffe said they would provide information about these diagnoses, but did not do so.
4. Over the next few months, Child T had periods of both settled and self-harming behaviour. Residential staff decided a set of measures designed to keep Child T safe by restricting access to things she might hurt herself with and high-risk areas of Auckland such as the kitchen. These practical measures were written into a risk management plan (usually reviewed every two weeks). Staff observed Child T every five minutes and she was not allowed to spend time in her bedroom during the day unless a member of staff sat at her door.
5. Child T worked with a community psychiatric nurse from the Kolvin Service in order to assess her mental state and for help regulating her moods. The Kolvin Service felt Child T's self-harm was best addressed through a behavioural management approach. They advised staff not to show their emotions when dealing with Child T's self-harm and said staff should not spend time with her in response to self-harm.
6. On 20 September, the Kolvin Service answered questions from Worcestershire Local Authority and said Child T met the criteria for post-traumatic stress disorder. The Kolvin Service said Child T's self-harm had reduced since her admission to Aycliffe and recommended a six month secure order be sought at the next court hearing on 4 October to enable further work to be done (one was subsequently granted).
7. On 12 October, Child T spoke to her siblings for the first time (on the telephone) and later said she felt happy, sad and overwhelmed.

8. A risk assessment completed by the Kolvin Service on 24 October listed some of Child T's previous self-harm but did not refer to the overdose or being found on train tracks in June. The assessment referred to a diagnosis of emerging borderline personality disorder but said it was not known whether Child T was aware of this.
9. A Team Around the Child (TAC) meeting at the end of October reviewed Child T's risk management plan and discussed other areas of her life such as education and exercise. Child T was preparing for a police interview after making a statement that she had been sexually abused by a close relative. Auckland residential staff commented that Child T's downturn of mood and self-harm since the last TAC meeting two weeks ago was partly due to the admission of a new young person into the house. (Staff subsequently said that in time, the relationship between Child T and this young person settled and they became friendly.)
10. An extraordinary TAC meeting on 3 November discussed additional support which could be offered to Child T during the lead up to her police interview on 8 November. The member of staff Child T was most able to talk to would sit in the interview with her, and other steps were agreed. During that week Child T self-harmed by cutting her arms, banging her head and tying ligatures. She was very upset during the police interview and the police decided to return the following week to complete it.
11. On 14 November, Child T smashed a microwave plate and hid some of the glass. That evening Child T tied many ligatures and cut herself. She said she wanted to kill herself. Staff had to restrain her at times and the house manager called the police and paramedics. Staff stayed with Child T until she fell asleep around 2.00am. The next morning was the day of Child T's second police interview. Following assessment by two Community Psychiatric Nurses, who agreed she was well enough to do so, Child T decided to go ahead with it (after handing a piece of glass to staff in the morning). Her case manager said that afterwards, it was as though a great weight had been lifted off Child T's shoulders.
12. Over the next two months, Child T's self-harming behaviour continued to fluctuate between periods of calm and periods of self-injury. The weeks leading up to Christmas were more settled and staff felt things were beginning to improve. Formulation meetings took place (designed to help both staff and Child T understand more about the causes of her self-harm and to identify steps that could be taken to help reduce it). Phone calls with her siblings did not always take place as planned because the social worker was not always with the siblings at the times of pre-arranged calls. Child T found the cancellation or postponement of calls difficult.
13. On 27 December, Child T broke a glass shelf in the fridge and hid some of the glass. She gave some to other young people. The next night Child T self-harmed by punching herself in her face and making scratches to her arms. On 30 December, Child T was very unsettled in the evening, banging her head and tying a ligature. Staff restrained her to stop her hurting herself further. Later that evening Child T put another ligature around her neck and was short of breath and limp when the staff took it off. The next day, New Year's Eve, Child T told

one of the residential staff that she planned to run away on any future hospital trips and wanted to harm her father and his partner. In the evening, Child T tied ligatures and banged her head on the wall. Staff found two suicide notes. Staff had to restrain her at times to stop her hurting herself. Child T eventually fell asleep at 3.00am.

## January 2017

14. The next day, 1 January 2017, Child T's behaviour continued to be erratic and unsettled and a member of the Child and Adolescent Mental Health team visited and spoke to Child T. He did not feel she needed to be in a mental health hospital. Child T tied more ligatures on 2 January and was seen by the Kolvin Service psychiatrist the next day. Child T told him her troubles were mainly about relationships with other residents in the house.
15. Over the next few days Child T's self-harm reduced. Staff managed her apart from other young people in the house. Child T's risk management plan was reviewed on 7 January but no significant changes were made. At the TAC meeting a few days later, Child T told staff she had planned to smash the glass shelf in the fridge for weeks before actually doing it.
16. Child T continued to be managed separately from one other young person on the house (as staff were concerned she had a negative influence on Child T and encouraged self-harm). Child T began to have more stable days. On 20 January, Child T met her lead nurse from the Kolvin Service to begin work on emotional regulation (eight sessions were planned). Child T did not self-harm during this period but staff were concerned about her mood, describing it as "morose".
17. A secure review held on 24 January decided to continue Child T's placement at Aycliffe. On 28 January, Child T met a solicitor and they spoke about the possibility that Child T might be required to give evidence at a court hearing. Child T told the solicitor she had "lost everything". The solicitor was concerned about Child T and wrote to Worcestershire Local Authority (we do not know what action the local authority took in response to this letter). The solicitor did not share these concerns with staff at Aycliffe.

## February 2017

18. During the first ten days of February, Child T's behaviour was reasonably settled and she did not self-harm. However, a new girl (who had a number of issues) arrived in Auckland House about a week before Child T's death. This young person needed a lot of staff time and attention. Child T found this very difficult and struggled with the attention staff were giving her. Child T became increasingly abusive towards staff, especially towards the member of staff she liked the most. She made violent threats.
19. Child T's risk management plan was reviewed on 14 February. The only change was to allow her to have an MP3 player (dependent on her mood). The next day Child T was verbally abusive towards staff and made derogatory comments about the new girl in the house.
20. On 16 February, Child T went to education saying she "hated everyone" and continued being verbally abusive. The house manager met Kolvin Service staff

to discuss the difficult dynamics on Auckland House at that time. The Kolvin Service recommended that staff continue to implement the behaviour management plan for Child T.

21. In the afternoon, Child T refused to engage in the mood regulation session which was unusual, as she normally got along well with the lead nurse. In the evening, Child T's education tutor spent some time talking and listening to her on Auckland House. Child T said no one liked her anymore and only the education staff cared about her. Her tutor thought she was struggling with the needs of the other young people in the house. Child T's mood lifted after their conversation but the next day Child T was rude and argumentative towards the residential staff again. Child T was restrained on two occasions but was calmer by tea time and ate her food alongside the rest of the house.

### 18 February

22. On Saturday 18 February, Child T seemed to wake up in a good mood. She asked a member of staff if they could go to the art room to get some black paper (Child T complained that the light coming in around the window blind kept her from sleeping.) Child T stuck the black paper on her window, making her room darker.
23. At lunchtime Child T said she was tired and asked to go to her room to sleep during the afternoon (this was unusual behaviour for Child T). She was locked in her bedroom at 12.33pm and staff began to make five minute checks (using a fob to demist the privacy glass in the door). Child T appeared asleep. At 3.00pm staff noticed Child T had used the bathroom (there is a sensor in the bathroom that activates a small light in the corridor – it stays on for ten minutes after the en suite area has been used). Five minute checks continued. Nearly all the staff checks were brief (just a few seconds long) and staff did not specifically check that they could see Child T breathing. Child T lay on her back with the blanket pulled up to her chin.
24. At 4.26pm the member of staff doing the check thought the room had become too dark to carry out the check. He spoke to another member of staff and they decided to wake Child T as it was nearly teatime. He went back to her room, opened the door and called her name, but did not get any response. He went up to Child T and saw a ligature around her neck. He ran out of the room and alerted other staff who collected the anti-ligature knife and cut the ligature (black elastic) off. A general alarm was transmitted. There was uncertainty about whether Child T had a pulse or was breathing.
25. When the duty manager arrived about a minute later he said Child T was lying on her own in the bedroom (two members of staff were there, but not next to Child T). The duty manager tried to get a response, but there was none. He began chest compressions. Another member of staff rang 999 and paramedics, police and an air ambulance were sent to Aycliffe. Child T was taken to hospital by air ambulance, arriving at 5.33pm. Efforts to resuscitate her stopped at 6.00pm.
26. Child T left three letters in her room – one to her siblings, one to the staff and one to her favoured member of residential staff. Child T thanked the staff for everything they had done but said she had felt very low for the past few days and

had had enough. Child T said she would be at peace now. To her siblings she said she loved them all and would miss them but was going to a happy place.

## Summary findings

### Child T's placement at Aycliffe

27. Child T was not considered by psychiatrists to be detainable under the provisions of the Mental Health Act. The professionals who decided her placement felt however that it was unsafe for Child T to live anywhere other than a secure unit because of her suicide risk.
28. Aycliffe told us that while there were periods of time when Child T was stable, engaging in education, taking part in some therapeutic work with the Kolvin Service and living a relatively normal life (within the confines of a secure setting), she remained at the outside edge of what Aycliffe could manage because of her determination, at times, to end her life. We also note that at the time of Child T's death, Auckland House held a particularly complex mix of young women.
29. Questions about the appropriateness of placing Child T at Aycliffe, the expectation that they should be able to manage very complex young people like Child T and the level of resources given to Aycliffe to equip them to do so, are beyond the remit of our investigation. The Serious Case Review will consider the appropriateness of Child T's placement (and the decisions taken to continue that placement) by Worcestershire Local Authority. It is for Durham Local Authority to determine whether Aycliffe is appropriately resourced to offer the level of care required by the young people it is asked to look after.

### Assessing and managing those at risk of suicide and self-harm

30. We found that the two processes of risk assessment and risk management were largely independent of each other at Aycliffe. The Kolvin Service completed Child T's risk assessments and Aycliffe staff wrote her risk management plans. There was insufficient joint working between Aycliffe staff and the Kolvin Service.
31. The mental health clinical reviewer did not consider the 'plan' section of the Kolvin Service risk assessment constituted an integrated risk management plan as recommended in the NICE guidance, "Self-harm in the over 8's: long term management, 2011". There was no clearly identifiable part of the care plan relating to risk management and no evidence it was multi-disciplinary. There were no details about any coping strategies Child T was willing to try and no crisis plan. The mental health clinical reviewer felt there was no coherent rationale for the Kolvin Service reviews of Child T's risk assessment and said they were not updated regularly. The assessments were not therefore able to guide or inform the risk management plans that Aycliffe developed and implemented as the day to day way of keeping Child T safe. Overall, the mental health clinical reviewer felt, and we agree, that the Kolvin risk assessment process was inadequate.
32. We do not consider that the reviews of Child T's risk management plan considered her fluctuating risk factors and therefore the range of possible measures that might keep her safe. Reviews appear routine and a continuation

of previous measures rather than relating to a current assessment of risk. Measures which had been previously relaxed should have been tightened when Child T's risk level was thought to have increased.

33. We consider Child T was often at high risk of suicide or self-harm while in Aycliffe. Short periods of time during which Child T did not self-harm were not, in themselves, indications of a long-term reduction in risk. Staff believed Child T had been making progress in a number of areas – she won 'Student of the Term' award; had built up a positive relationship with some staff; and at times, acknowledged her issues and spoke positively of her future.
34. We accept that Child T did not self-harm after 15 January, but her mood deteriorated significantly when a new person arrived in the house a week before she ended her life and Child T's behaviour became very confrontational and difficult. This, coupled with the knowledge that Child T had struggled to cope with a new admission before (in October) and when relationships with her peers were difficult (over the New Year), alongside the fact that she found it hard when she did not get the attention she wanted from a particular member of staff that she favoured (who was trying to help the new girl settle in the house), should have led staff to review Child T's risk, increase their support and revise the risk management plan. Aycliffe's risk assessment processes were not sufficiently attuned to all of Child T's risk factors to identify the crisis period she was entering in the last week of her life.
35. We are also concerned about the monthly figures Aycliffe captured about Child T's self-harm. We do not consider they could be used to accurately measure changes in the level or degree of self-harm and that the key reason to capture self-harm information should be to generate this picture and inform treatment decisions and measure progress (or lack of) over time. The monthly figures should be shared with the Kolvin Service, key workers, the placing authority and discussed at multi-disciplinary meetings that assess risk.

### **Physical health care**

36. The physical health clinical reviewer, judged that Child T's general healthcare needs were met and was of a standard equal to that which Child T would have received in the community.

### **Mental health care**

37. The mental health clinical reviewer considered that, overall, there was no coherent framework for Child T's mental health care. It was unclear whether a psychological or psychiatric approach was central. No clear diagnosis was established, shared or followed by the mental health staff team. The reviewer commented that the psychological approach used in formulation meetings (with staff and Child T) and the DBT skills sessions in the New Year lacked integration with the overall risk assessment and risk management processes.

### **Staff checks and observations of young people**

38. We found that many of the staff checks and observations of Child T were superficial and not the well-being checks they should have been. In particular, many of the staff checks during the afternoon of 18 February lasted just a few

seconds. We do not think this is long enough for a check to be effective – they were merely a glance in Child T’s room. The checks would ascertain that Child T was inside, apparently in bed, but were not well-being checks and did not provide any assurance she was alive.

39. While we do not know when Child T tied the ligature around her neck, we are not satisfied that it can be said with any certainty that it was after the check at 4.22pm and before a member of staff became concerned when he could not see inside her room properly at 4.26pm.
40. The eventual aim of the interventions provided by the Kolvin Service and reinforced by residential staff is to reduce a young person’s desire to want to end their life, but while this work is being done, some uncomfortable steps might need to be taken. There is no exact formula for deciding how often young people should be checked by staff. We think Aycliffe should determine the frequency of checks based on their assessment of a young person’s suicide and self-harm risk. We can see there is a careful line to take, balancing the desire to be respectful and not overly intrusive in the care of young people living at Aycliffe, while at the same time, keeping them safe, at times, from themselves. The critical point, of course, has to be that the checks have to be meaningful. In extreme cases, we think keeping someone safe can involve a level of searching and observing that makes both staff and the young person feel uncomfortable.
41. The level of search required of Child T’s room, its contents and her clothing was not clearly identified in the risk management plans. Room searches were not recorded as they should have been on the Safety and Security Check Sheet. There is no evidence of any searches of Child T’s bedroom in February 2017. Staff told us that bedrooms were normally searched each weekday. This might well be true, but it is not acceptable practice for staff to fail to complete the relevant log with the details of each search. Because Child T’s clothing was not always checked each day for damage, she was able to remove the elastic from some black leggings, unnoticed by staff, at some time in the week(s) before her death.
42. Our investigation into the other SCH death that happened shortly after Child T’s found concerns with the welfare checks at that home.

### **Emergency response**

43. The emergency response was initially flawed. The alarm was not raised in the correct way and this meant responding staff were unaware of the nature of the emergency (and consequently some emergency equipment was not taken directly to Child T’s bedroom).
44. The actions of the two staff who tried to resuscitate Child T were calm, professional and appropriate. We do not feel as comfortable about the actions of those staff who were the very first to react when Child T was found with the ligature and the Centre Manager will wish to consider whether a disciplinary investigation is appropriate.
45. While we understand that finding Child T in that way was a very shocking situation, we are disappointed that the staff did not make more thorough checks

of Child T for signs of life. It was not appropriate to place her in the recovery position (we are not certain they did) and those staff should have remained next to her, continuing to make checks and reassure themselves she had a pulse and was breathing. We do not think Child T was breathing as other staff described her as cold, grey and that her lips were blue. Resuscitation, in the form of chest compressions, should have been started straightaway.

46. We also note that the first paramedic to arrive was unsure where the entrance to the Secure Unit was and road signs within the site directing people to the main entrance should be considered to eliminate any uncertainty.

### **Child T's contact with her siblings**

47. Although our remit does not extend to consideration of the actions of Worcestershire Local Authority in the management of Child T, we wish to draw the issue of Child T's contact with her siblings to the attention of the Serious Case Review.

## **Recommendations**

- The Centre Manager, Kolvin Service lead and Physical Health Care lead should carry out an immediate review of the suicide and self-harm risk assessment and risk management systems. Focus should be on:
  - Developing a multi-agency approach to suicide and self-harm risk assessment.
  - Ensuring information from a range of sources is incorporated into a comprehensive risk assessment.
  - Regular reviews of risk assessments whenever new risk factors are identified or when there is a change in the frequency or type of self-harming behaviour.
  - Encouraging the involvement of the young person in risk assessment meetings.
  - Accurate and meaningful recording of risk assessment meetings detailing those present, how the young person's level of risk has been assessed at that time and actions to be taken.
  - Ensuring that, following an assessment of risk, there is consideration by the multi-agency team of measures to support the young person and measures to reduce the ability of the young person to harm themselves, and reflect these in a risk management plan.
  - Formulation and recording of risk management plans in a format that aids readability and understanding of the measures to be applied to keep a young person safe.
  - Sharing of the risk management plan with relevant staff.
  - Effective compliance with and no informal relaxation of the measures detailed in the risk management plan

- The Centre Manager should review how self-harm information is captured and recorded. Information about the number of self-harm attempts and the severity of each attempt should be recorded and a picture built up over time. This information should be used to assist treatment decisions and in the assessment of suicide and self-harm risk.
- The Department for Education and the Welsh Government should review current practice and introduce a clear framework for delivering welfare checks on young people to include:
  - clear instruction about the nature and purpose of checks;
  - details of how to accurately record checks;
  - details of who decides what checks are necessary and how these are communicated to staff;
  - consideration of the frequency of checks required on young people including whether it is necessary to check all young people throughout the night regardless of their risk;
  - consideration of the number of staff needed to undertake checks;
  - instruction as to when staff should go into a young person's room;
  - management oversight of checks.
- The Centre Manager should ensure risk management plans address:
  - the frequency of bedroom searches;
  - the nature of search required, including whether clothing and paperwork are to be searched;
  - alterations to the fabric of bedrooms; and
  - staff accountability for searches through the completion and signing of the Safety and Security Check Sheet.
- The Centre Manager should:
  - Consider whether a formal disciplinary investigation is warranted into the actions of some of the staff involved in Child T's emergency response.
  - Ensure all staff are aware of their responsibilities if they are the first on scene in a life threatening emergency.
  - Consider whether further training is required.
  - Liaise with the North East Ambulance Service and complete a joint review of emergency procedures at Aycliffe.
  - Ensure there are appropriate signs along the road network within the site directing arriving vehicles to the main entrance.

- Review the policy about issuing anti-ligature knives to staff. Staff should be able to access these knives quickly in emergency situations.

## Findings

48. By way of introduction to these detailed findings, it is important to acknowledge the very challenging circumstances in which staff were operating and trying to keep Child T safe.
49. Child T had previously been admitted to hospital for care under the Mental Health Act. However, while living at Aycliffe, neither the Kolvin Service psychiatrist nor the member of staff from the Child and Adolescent Mental Health Service felt Child T needed to be in a mental health hospital. Worcestershire Local Authority applied to the courts for a secure order (and to continue the order) because they felt it was unsafe for Child T to live anywhere other than a secure unit due to her suicide risk.
50. Aycliffe felt that while there were periods of time when Child T was stable, engaging in education, taking part in some therapeutic work with the Kolvin Service and living a relatively normal life (within the confines of a secure setting), she remained at the outside edge of what Aycliffe could manage.
51. At times, Child T seemed determined to end her life. At other times, Child T seemed to look forward and talked about getting out of Aycliffe and her hopes for a career. Child T was capable of planning her suicide attempts or self-harm for some weeks and of concealing these intentions from staff.

### 1. Assessing and managing those at risk of suicide and self-harm

#### Risk assessment and risk management

52. **We found the two processes of risk assessment and risk management to be largely independent of each other. The Kolvin Service completed Child T's risk assessments and Aycliffe staff wrote her risk management plans. The Kolvin Service completed risk assessments for Child T in July and October. Aycliffe staff decided the day to day measures intended to keep Child T safe, detailing them in the risk management plan.**
53. **Risk management plans were usually reviewed every two weeks, but often by one member of staff rather than a team review and discussion. There are no minutes of these reviews and no identifiable part that would constitute an assessment of Child T's risk and whether it had increased or reduced since the last review.**
54. **The TAC meetings included an element of assessing risk of suicide and self-harm and reviewing risk management plans, but there were inconsistencies between notes of TAC meetings and the risk management plans and we are concerned that TAC meetings were too general, discussing many issues about a young person and not focusing on assessing the risk of suicide and self-harm.**
55. **Overall, we do not think there was a clear relationship between the two key processes of assessing Child T's risk and managing that risk and insufficient joint working between Aycliffe staff and the Kolvin Service.**

56. The aims of Aycliffe's Suicide and Self-harm Policy are:
- to help staff identify those at risk of self-harm and suicide;
  - to assist in providing a cohesive and consistent approach to responding to incidents of self-harm;
  - to provide information and guidance for staff to assist in managing such behaviours; and
  - to give staff an awareness of services available in which they can seek support and guidance.
57. The policy states that regular reviews of risk will take place in Team Around the Child (TAC) meetings and that individual and environmental factors will be considered. Young people will be monitored according to the observations policy. The case manager and house manager are responsible for the risk management plan, identifying the level of risk and preventative measures. Staff are asked to be alert to any changes in a young person's mood and behaviour which may signify an increased risk. Residential staff are asked to update the risk assessment following an incident of self-harm or threat to self-harm (staff told us they make entries directly onto the digital risk assessment file). Staff are also asked to change the risk management plan where additional actions are required.

#### **Assessing the risk of suicide and self-harm**

58. **At the multiagency meeting on 21 February 2017 Aycliffe staff spoke of the "usual pattern of indicators" that meant Child T was likely to self-harm. They said Child T's mood would drop, she would start to look for conflict with a member of staff, become confrontational and call them names in an attempt to upset them and would start searching rooms for items she might use to harm herself.**
59. **This appears to more or less summarise Child T's behaviour from 14 to 17 February. She was low in mood (both on the house and in education), rude and abusive to several staff and her behaviour led to restraint and red cards. Child T refused to speak to a community psychiatric nurse with the Kolvin Service, with whom she normally had a good relationship. Child T was clearly struggling with the arrival of a new resident and the staff time and attention that she felt was being given to her, particularly by her favoured residential worker. Child T shared these feelings with her education tutor a few days before she died.**
60. **We are surprised that more concern was not felt about Child T at this time. Aycliffe (both Kolvin Service and Auckland House staff) should have been aware that a known risk factor for Child T was conflict with her peers and new admissions into the house. They should have considered whether Child T was at an increased risk of suicide and self-harm, carried out a risk assessment review and revised her risk management plan. Neither the Kolvin Service nor Aycliffe staff undertook such reviews despite there being dialogue between the them about the complex dynamics in Auckland House and how best to manage the young people living there two days before Child T's death.**

61. **The mental health clinical reviewer listed a number of Child T’s risk factors which should have been identified by Kolvin and Aycliffe staff and incorporated into a comprehensive risk assessment. The list includes:**
- **self-harm as a means to punish herself in relation to feelings of guilt;**
  - **poor interpersonal problem-solving skills as a precipitant to self-harm (finding peer relationships stressful);**
  - **the negative impact of new residents coming to the house who had complex difficulties and needed a lot of time, precipitating feelings of insecurity and rejection;**
  - **struggling to manage changes in relationships such as staffing changes and irregular contact; and**
  - **evidence of a prior planned and hidden suicide attempt.**
62. **The mental health clinical reviewer did not feel the ‘plan’ section of the Kolvin Service risk assessment constituted an integrated risk management plan as recommended in the NICE guidance. There was no clearly identifiable part of the care plan relating to risk management and no evidence that the care plan was multi-disciplinary. There were no details about any coping strategies Child T was willing to try and no crisis plan.**
63. **The mental health clinical reviewer felt there was no coherent rationale for the Kolvin Service reviews of Child T’s risk assessment and assessments were not updated regularly. They were not therefore able to guide or inform the risk management plans that Aycliffe developed and implemented as the day to day way of keeping Child T safe.**
64. **Overall, we and the mental health clinical reviewer consider that the Kolvin Service risk assessment process was inadequate. We also found Aycliffe’s risk assessment process (via discussion in TAC meetings) to be insufficiently attuned to all of Child T’s risk factors.**
65. **The National Institute of Clinical Excellence (NICE) guidance, “Self-harm in the over 8’s: long term management, 2011”, states that “A risk assessment is a detailed clinical assessment that includes evaluation of a wide range of biological, social and psychological factors that are relevant to the individual and, in the judgement of the healthcare professional conducting the assessment, relevant to future risks including suicide and self-harm”. The guidance states that when assessing risk, the young person should be involved in identifying and agreeing the specific risks taking into account:**
- **methods and frequency of current and past self-harm;**
  - **current and past suicidal intent;**
  - **depressive symptoms and their relationship to self-harm;**
  - **any psychiatric illness and its relationship to self-harm;**

- the personal and social context and any other specific factors preceding self-harm such as emotions and changes in relationships;
  - specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm;
  - coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm; and
  - significant relationships that may either be supportive or represent a threat and may lead to changes in the level of risk.
66. Child T's recent previous suicide attempts when she arrived at Aycliffe (an overdose of paracetamol in June 2016 and being found on train tracks waiting for a train) were described in the risk assessments by the Kolvin Service on 8 July and 27 July. Additional information about Child T's paracetamol overdose was contained in a letter sent to the Kolvin Service on 12 August, describing how Child T had researched the toxic quantity of paracetamol, intended to end her life and planned the suicide attempt over a period of weeks. Staff at Brook Farm, a residential children's home in Redditch, said that immediately prior to the suicide attempt on 5 June 2016, Child T appeared to be doing well.
67. The risk assessment by a community psychiatric nurse (CPN) on 24 October, however, did not include reference to the overdose in June, the additional information or Child T running away and being found on train tracks. The CPN told us she was unaware of the paracetamol overdose, although it is referred to in the initial CHAT documentation, the risk assessments in July and other documentation.
68. In the October risk assessment, the CPN's analysis of the methods Child T used to injure herself by did not include concerns about the potential lethality of tying tight ligatures despite this being something Child T had done several times since being in Aycliffe. The risk assessment did not refer to the significant risk of accidental death, despite both current and historical information about Child T's use of potentially lethal attempts to end her life. The risk assessment did not include analysis of the frequency of self-harm nor an assessment of whether self-harm rates were increasing, decreasing or staying the same. She told us her main way of monitoring rates of self-harm was through Child T's self-report or comments made by residential staff. This is unreliable and she herself said, "Some things I'd be completely unaware of to be honest."
69. The risk assessment in October said Child T had a diagnosis of emerging borderline personality disorder but did not explore the relationship between this and her risk of self-harm. One of the key features of borderline personality disorder is emotional instability and this can lead to frequent fluctuations in a person's risk level. The mental health clinical reviewer said some staff were not clear that this was Child T's diagnosis and talked about post traumatic stress disorder.

70. Child T spoke to the CPN on 14 October about her self-harm and said the dynamics in the house were difficult (Child T's emotions were also affected by her first phone call with her siblings). At the TAC meeting on 31 October the residential staff commented that Child T's recent self-harm and downturn in mood had been since the admission of a new young person into the house. When Child T spoke to the consultant psychiatrist and the CPN on 3 January 2017 about her intense period of self-harm and suicide attempts over the New Year period she attributed 90% of her troubles to difficult relationships with her peers in the house.
71. Some staff told us that Child T was "much better" and "very settled" in January and February and that her death was unexpected. However, several staff also spoke about the highly complex mix of girls living in Auckland House at the time of Child T's death. Many of the young people had serious self-harm issues while others were managed apart because of their risk of harming others. On one corridor there were two girls being managed away from others. One of these girls was thought to be a negative influence on other young people, including Child T, and staff were concerned that she encouraged others to self-harm. The other young people living in Auckland lived on the same corridor as Child T. The arrival of a new resident, about a week before Child T died, seemed to change the dynamic in the house. Child T in particular, struggled with some of the new arrival's difficult behaviours.
72. Aycliffe's centre manager said the new arrival was very unsettled when she arrived and needed a lot of attention from staff. He added that she had been at Aycliffe twice before and their experience was that she had settled reasonably quickly. He felt it would not have been reasonable for them to decline to take her. Much more should, though, have been put in place to support Child T through this unsettling period. Staff told us Child T could not bear to hear the shouting and screaming from the new arrival (who was put in the bedroom next door to Child T) and felt she was getting all the time and attention of staff. The Auckland House manager sought advice from the Kolvin Service on 16 February and the consultant psychiatrist made specific recommendations about four of the girls. For Child T, he did not recommend any changes to the plan already in place.
73. The CPN said risk assessments are reviewed every six months but can also be reviewed if there is a change in the type of self-harm. The mental health clinical reviewer commented that this approach does not take into account other factors that influence risk such as other young people in the house, relationships with staff, contact with Child T's siblings and court hearings. Child T's risk assessment was not reviewed or updated after:
- the formulation sessions in December;
  - the intense period of serious suicide attempts and self-harm over the New Year and after Child T told the consultant psychiatrist on 3 January that the trigger had primarily been difficult dynamics on the house with other young people;
  - the Dialectical Behaviour Therapy (DBT) informed skills based sessions in January and February; or

- the downturn in Child T's mood and behaviour after the new arrival in Auckland House. In February.

### Managing the risk of suicide and self-harm

74. **We do not consider that the reviews of Child T's risk management plan took into account all her risk factors and possible measures to keep her safe. They appear routine and a continuation of previous measures rather than related to an assessment of her risk at the time of the review. Measures which had been relaxed should have been tightened when Child T's risk level was thought to have increased.**
75. **We think Child T was often at high risk of suicide or self-harm while in Aycliffe. Short periods of time during which Child T did not self-harm were not, in themselves, indications of a long-term reduction in risk. While we accept that Child T did not self-harm after 15 January, her mood deteriorated significantly when a new person arrived a week before she ended her life and Child T's behaviour became very confrontational and difficult. This, coupled with the knowledge that Child T had struggled to cope with a new admission before (in October) and when relationships with her peers were difficult (over the New Year), alongside the fact that she found it hard when she did not get the attention she wanted from a residential worker (Child T's favoured member of staff, but who was trying to help the new girl settle in the house), should have led staff to review Child T's risk, increase their support and revise the risk management plan.**
76. The risk management plan was Aycliffe's day to day way of managing Child T's suicide and self-harm risk. The plans should be routinely reviewed every two weeks (and discussed at TAC meetings), but there should be reviews whenever a young person's presentation changes, such as an increase in self-harm.
77. We think risk management plans would be easier for staff to read and adhere to if the measures put in place were grouped under appropriate headings such as observation level, searching requirements, access to areas (both on and off house), access to items, managing incidents, etc. Having a long list of 26 measures (as Child T's risk management plan did) cannot have made it easy for staff to remember or refer to with ease.
78. We are unclear about the relationship between TAC meetings and risk management plan reviews. We were told that risk management reviews were done during TAC meetings. However, the dates of TAC meetings and risk management reviews do not always correspond. Aycliffe told us this is because some reviews were carried out immediately, without waiting for the TAC to convene. There also appear to be inconsistencies between what the TAC meeting thought Child T's observations were and what the risk management plan had set them at. The TAC on 14 November indicated in the actions summary that Child T was allowed supervised access to the kitchen. However, the risk management plan review the next day said Child T would have no access to the kitchen.
79. Some of the measures put in place via risk management plans seem surprising given Child T's behaviour around the time of the reviews. For example, on 7

November, Child T's management plan was revised to give her access to the playcourt area. However, three days earlier Child T had been on the playcourt, become abusive and tried to damage things and was restrained. On 28 December, Child T's risk management review said she was allowed to spend time in her room alone. However, the day before, Child T had smashed a glass shelf in the fridge and secreted pieces of glass to harm herself with.

80. We were also told that Child T's management plan was informally relaxed by staff at various times, often in response to a period when Child T seemed to be doing well. We are concerned that this may have led to confusion among the staff team about which measures were to be applied and which were not. There should not have been informal relaxation of measures.
81. The mental health clinical reviewer was concerned that one of the measures on the management plan stated staff were "not to show emotion throughout" during an incident of self-harm. She thought the rationale for this recommendation was unclear and could be misinterpreted as recommending a dispassionate, cold approach which would be counter to the 'respect and understanding' recommended by the NICE guidelines "Self-harm in the over 8's: short term management and prevention of recurrence 2004".
82. In general, the risk management plans seem to have been more reactive to changes in Child T's mood, behaviour and self-harm level in the first period of her time at Aycliffe. In November for example, around the time of Child T's police interviews, there were frequent reviews of her risk management plan and an emergency TAC was held.
83. Child T's risk management plan until the end of December 2016 included measures that did not allow her to spend time alone in her room during the day unless a member of staff sat at her door. At the review of the risk management plan on 28 December this measure was relaxed and Child T was allowed to spend time alone in her room (unless staff had concerns about her low mood or intent to self-harm). Between 28 December and 3 January, Child T self-harmed many times, putting numerous ligatures around her neck and some staff thought Child T seemed determined to end her life. Child T's risk assessment should have been carefully reviewed via an emergency TAC meeting and a revised management plan developed. It is difficult to understand why the earlier, more restrictive measure on spending time alone in her room was not reintroduced.
84. When the crisis CAMHS team saw Child T on 1 January they recommended constant observations. Although constant observations were done for a short period of time we are unsure when they ended from the documents. Aycliffe told us they continued until Child T was assessed by the consultant psychiatrist from the Kolvin Service on 3 January. Child T's risk management plan was not updated to reflect constant observations, nor were the other measures in that plan reviewed as part of a risk assessment process. The Auckland House case manager telephoned Child T's social worker on 5 January to discuss the difficult period Child T had been going through. She spoke of the CAMHS team and Kolvin Service assessments of Child T and said a very stringent risk management plan had been implemented again (Aycliffe told us she was referring here to the fact that Child T and another young person were being

managed apart from 30 December because of the smashed fridge shelf). Child T's risk management plan was not reviewed until 7 January however and at this review, existing measures were continued rather than new 'stringent' ones introduced (managing Child T away from another young person was not listed as a measure in the risk management plan, although they continued to be managed separately).

85. At the review on 7 January, Child T remained on five minute checks and the management plan remained exactly as the plan on 28 December. We struggle to understand the rationale behind this, given the intent and severity of Child T's self-harm between these reviews. The TAC meeting on 9 January recorded her observations as enhanced, but the risk management plan did not reflect this. Triggers for Child T's self-harm at that meeting were listed as "being managed away" and "not being given her own way" and it is unclear whether residential staff spoke to Child T about what the triggers were. Child T told the Kolvin Service her self-harm and suicide attempts were primarily linked to issues with peers in the house.
86. Child T's risk management plan was reviewed on 14 February. There should have been a further review of her plan on 16 or 17 February after her behaviour deteriorated. She was abusive towards staff, sullen in mood, refused to see the CPN for one to one work, received several red cards, was restrained and concerns were voiced by teachers.
87. The clinical psychiatrist told us about "core groups" – care planning meetings similar to Team Around the Child meetings but which involve a cross disciplinary group of staff from Aycliffe and the Kolvin Service. Led by the Kolvin Service, they assess each young person on their caseload in a more in-depth way, consider their care plan, effectiveness of interventions, their progress and treatment pathways. Young people may be referred to the core group if they have particularly complex needs or where there are significant concerns about them. At the time of Child T's death they were not standard practice and Aycliffe staff told us they had no mechanism to refer a young person to such a meeting. Since her death such meetings have been convened more often.
88. We think a new system for assessing, supporting and monitoring needs to be brought in for those who are most at risk of suicide and self-harm at Aycliffe (we were told this is usually two or three young people at a time). There should be multi-disciplinary case reviews to assess risk and decide a risk management plan and we recommend:

**The Centre Manager, Kolvin Service lead and Physical Health Care lead should carry out an immediate review of the suicide and self-harm risk assessment and risk management systems. Focus should be on:**

- **Developing a multi-agency approach to suicide and self-harm risk assessment.**
- **Ensuring information from a range of sources is incorporated into a comprehensive risk assessment.**

- **Regular reviews of risk assessments whenever new risk factors are identified or when there is a change in the frequency or type of self-harming behaviour.**
- **Encouraging the involvement of the young person in risk assessment meetings.**
- **Accurate and meaningful recording of risk assessment meetings detailing those present, how the young person's level of risk has been assessed at that time and actions to be taken.**
- **Ensuring that, following an assessment of risk, there is consideration by the multi-agency team of measures to support the young person and measures to reduce the ability of the young person to harm themselves and reflect these in a risk management plan.**
- **Formulation and recording of risk management plans in a format that aids readability and understanding of the measures to be applied to keep a young person safe.**
- **Sharing of the risk management plan with relevant staff.**
- **Effective compliance with and no informal relaxation of the measures detailed in the risk management plan.**

#### **Information about suicide attempts and self-harm**

89. **The Aycliffe monthly figures cannot be used to accurately measure changes in the level or degree of self-harm. We think the key reason to capture self-harm information should be to generate this picture and inform treatment decisions and measure progress (or lack of) over time. The monthly figures should be shared with the Kolvin Service, key workers, the placing authority and discussed at multi-disciplinary meetings that assess risk.**
90. Aycliffe collate monthly figures for those young people who regularly self-harm. These figures are shared with the management team but not the Kolvin Service. The self-harm figures we were given for Child T from July 2016 to January 2017 are useful, but we are concerned that they do not always give an accurate or full picture:
- Sometimes the number of self-harm incident packs referred to in the monthly breakdown does not add up to the total shown on the first page. For example, October 2016 states there were 10 self-harm incidents, but there are 12 dates listed in October when self-harm was said to have taken place.
  - Totalling the number of self-harm incident packs may lead the reader to think this is the total number of self-harm attempts. For example, in January, the self-harm figure states there were 5 incidents of self-harm. There is one incident pack for 1 January but we know Child T self-harmed many times that day, punching herself in the face, tying several ligatures and needing to be restrained at times to stop her hurting herself further.

- The severity of the self-harm or level of intent is not reflected in the figures.
  - Between 11 and 15 January 2017, Child T made diary entries indicating she ate very little. The entries by staff in Child T's daily log during this period do not state whether she refused her meals (the log records her eating some meals but these are the ones Child T said she made herself sick after). Refusing meals or making yourself sick is a form of self-harm and should be recorded as such by residential staff.
91. Only long-term therapeutic work and a long-term reduction in Child T's suicide attempts and self-harm over a period of months could be regarded as an indicator of progress. The social work team manager at Worcestershire, said in an e-mail to the Auckland House case manager on 6 September, "I always feel anxious when Child T's self-harm reduces as it has meant so far, that she is planning something else." There was an over reliance by the Kolvin Service on self-reporting, both by Child T and from Aycliffe residential staff.
92. We recommend:
- The Centre Manager should review how self-harm information is captured and recorded. Information about the number of self-harm attempts and the severity of each attempt should be recorded and a picture built up over time. This information should be used to assist treatment decisions and in the assessment of suicide and self-harm risk.**

## 2. Clinical care

93. The clinical review is a detailed and comprehensive review of Child T's mental and physical health care at Aycliffe. It should be read in full in conjunction with this report. The key points from the review are summarised here.

### Physical health care

94. **The physical health clinical reviewer judged that Child T's general healthcare needs were met. In line with good practice and the requirements of the Looked After Children's Health Assessments, Child T was offered age appropriate checks and screening. The physical healthcare provision was of a standard equal to that which Child T would have received in the community.**
95. Nursing records show staff at Aycliffe made attempts to contact previous health care providers (twice in July 2016 and again in December) and Child T's social worker (twice in July) for information about her past medical history, medication compliance and immunisation status. It is unfortunate that attempts to contact other healthcare professionals about Child T were not met with efficient responses. The physical health clinical reviewer recommended a review of communications practices in order to improve the continuity of healthcare for young people arriving at Aycliffe.
96. We agree with the physical health clinical reviewer's recommendation that a single electronic patient record system should be introduced to improve information sharing between healthcare staff who work at Aycliffe.

97. The physical health clinical reviewer felt there was confusion among the nursing team about the advice given by the Kolvin Service about Child T's management. Some nurses seemed to know about taking a low emotional response after Child T's self-harm, while others were not aware of any particular advice. Nurses review all self-harm incidents at Aycliffe. The nurses said they did not have any input into Child T's risk management plans although they did usually attend TAC meetings (which were meant to be a time when her risk of suicide and self-harm were reviewed). They would have had an opportunity for input and to raise concerns at this meeting.
98. With the exception of two administering errors (by Auckland House staff), Child T's medicines were given appropriately. Refresher training was provided for residential staff after these errors. The physical health clinical reviewer considered the medicine management processes at Aycliffe were satisfactory.
99. The physical health clinical reviewer made several other recommendations which the Centre Manager will need to take forward with the physical healthcare team.

### Mental health care

100. **The mental health clinical reviewer felt that overall, there was no coherent framework for Child T's mental health care. It was unclear whether a psychological or psychiatric approach was central. No clear diagnosis was established, shared or followed by the mental health staff team. They felt the psychological approach used in formulation meetings (with staff and Child T) and the DBT skills sessions in the New Year lacked integration with the overall risk assessment and risk management processes.**
101. Child T had been given a diagnosis of emerging borderline personality disorder before going to Aycliffe. She had asked for an explanation of this disorder from the Kolvin Service, but not received one despite staff giving several commitments to do this. The diagnosis of borderline personality disorder was documented in some risk assessments and care plans but was not known to all the Kolvin staff. The consultant psychiatrist said he did not see it as a helpful diagnosis.
102. The mental health clinical reviewer said the formulation document did not take sufficient account of Child T's primary presenting problem, which was her risk to herself. Risk of suicide was not identified as a presenting problem, nor was accidental death. The mental health clinical reviewer thought the joint working between Kolvin and Aycliffe staff on formulation was an area of good practice, but felt it was unclear how the formulation plan related to other plans such as the mental health care plan and Aycliffe's risk management plan. It was unclear who was responsible for taking work forward and at a review meeting on 21 December, a number of recommendations had not been implemented.
103. Work to help Child T regulate her emotions was identified in the letter to the social work team manager at Worcestershire on 20 September, but the eight sessions did not start until 20 January 2017. We were told that Child T was not ready to do this work until January as it took time to build up a relationship with the CPN. The mental health clinical reviewer felt the DBT skills based approach used was not sufficiently considered and a key aspect of the standard DBT model was not incorporated into the treatment plan offered to Child T (the Kolvin

Service told us they were not resourced to provide a full DBT service). The purpose of individual DBT sessions is to monitor, evaluate and review risk in relation to the skills being learnt. This was not incorporated into Child T's care plan. In the last session on 16 February, Child T was described as presenting with "difficult and oppositional behaviour" over the previous two days because of a new admission into the house, she was angry in the session and it could not continue as planned.

104. The mental health clinical reviewer said the advice, training and support offered to Auckland house staff over the duration of Child T's stay in Aycliffe was unclear, reflecting both psychiatric and psychological approaches, without either being central to a multi-agency approach to her care. They felt the Kolvin Service over-emphasised a behavioural approach to Child T's difficulties and under-emphasised emotional states such as shame and guilt and the complex relationships between Child T and the staff team and Child T and other young people on the house.
105. Child T feared abandonment and rejection (typical to people with histories of insecure attachments and relationship problems). The mental health clinical reviewer felt too little attention was given to the potential impact of missed or changed appointments by staff (some appointments the CPN had made were changed and some secondary appointments the consultant psychiatrist had agreed to were not followed through).
106. The mental health clinical reviewer made several recommendations, which the centre manager will need to take forward with the Kolvin Service.

### 3. Observations, checks and searching at Aycliffe

#### Frequency of staff checks

107. **There is no exact formula for deciding how often young people should be checked by staff. We consider that Aycliffe should determine the frequency of checks based on their assessment of a young person's suicide and self-harm risk.**
108. There is no national requirement for young people in secure accommodation to be observed at least every 15 minutes, although the centre manager thought that, in practice, most secure children's homes did observe those in their care at this interval (or more frequently). He said that when he became the centre manager two years earlier he felt it was a good standard to have and was reassured that all children were checked at least every 15 minutes. Since Child T's death, there have been discussions about whether that frequency of check takes staff focus away from the young people most likely to self-harm or try end their life. He commented however that other young people might come into a secure setting who have not been suicidal or self-harmed before, but develop those thoughts for various reasons (perhaps the strange environment or influence of other young people). He did not want any young people to go unchecked for long periods of time.
109. We agree that this is a difficult issue to get right. It relies ultimately on the risk assessments made by staff to decide who is at risk of suicide or self-harm and to

judge when someone is in a crisis period. Just as staff might increase the checks of someone with a history of self-harm from every five minutes to enhanced because of increasing concerns, they could increase the observations of someone with no history of self-harm because they start to behave differently in the house. We do, however, note the central purpose of any well-being check is to confirm the child's well-being. This consideration underpins the following findings.

### Quality of checks

110. **We found that many of the staff checks and observations of Child T during the afternoon of 18 February were superficial and not the well-being checks they should have been. Most checks lasted just a few seconds. We do not think this is long enough for a check to be effective – they were just a glance into Child T's room. The checks would ascertain that Child T was inside, apparently in bed, but did not provide any assurance she was alive.**
111. **The residential worker who later found Child T with the ligature did a longer visual check at 3.50pm but even after this ten second check, said he could not be certain that Child T was alive because he did not see her breathing under the blanket. All of the checks after this time were under two seconds. While we do not know when Child T tied the ligature around her neck, we are not satisfied that it can be said with any certainty that it was after the last check by another residential worker at 4.22pm and before the residential worker who found her with the ligature became concerned when he could not see properly at 4.26pm.**
112. Aycliffe's policy Observations of Young People (2015) is silent as to the exact nature of a check. Some other custodial settings stipulate that the member of staff making a check must assure themselves that the person being observed is alive and well. This might be through eye contact, a verbal response, seeing movement, seeing breathing or the context of the check (for example observing the person writing a letter or watching television).
113. Several Auckland staff told us they would look for movement or breathing when checking a young person who seemed asleep and would remain at the door until they felt reassured. The deputy centre manager commented that observations of young people should always be to check they are safe and well. She acknowledged the difficulties of a check when the young person is under their blanket, seemingly asleep, but felt staff should wait until they are clear they have seen movement or breathing.
114. A week after Child T's death a police constable with Durham Constabulary, visited Aycliffe and looked through Child T's glass door panel at 4.30pm. Her room had been kept the same with four sheets of black art paper at the window. He said the room was very dark and it took him a few seconds for his eyes to focus and see the things inside the room. He said in his opinion, it would be difficult to see if Child T was breathing at the staff checks if she was covered with a blanket (as staff said she was). He said he had to cup his hands around the side of his face in order to help his eyes focus. With the corridor lights on, it was more difficult to see clearly inside the room.

115. The average number of breaths per minute for a young person Child T's age is 15 to 20, that is a breath approximately every three seconds. A two or three second look into a darkened room (when it is turning dark outside) at someone under a blanket would not be nearly long enough to check they were breathing. We acknowledge the practical difficulties of well-being checks when someone is under bedding and the room dark. We discuss this further in the next section.
116. The elective separation log is used to record checks when a young person is in their room and not in direct sight of a member of staff. The person carrying out the check is the person who should complete the log. In practice, this is not always the case. Staff told us the person who does the check tells the person writing the log what they saw and the log is filled in. Staff should time and record their own checks and Aycliffe need to revisit how this can best be done.
117. After Child T's death, the centre manager introduced the concept of "Linger Longer", meaning that staff should observe young people until they are sure they have seen movement or gained a response of some sort. This might be a very brief check if the young person is sitting on their bed watching television, but a longer check is the person is under their covers and apparently asleep. Managers review a sample of CCTV to assure themselves that young people are being checked properly. The night light is left on for all young people who are on enhanced checks. We think these are positive moves by the centre manager.

### Design and fabric of the bedrooms at Aycliffe

118. **The ultimate aim of the interventions provided by the Kolvin Service and reinforced by residential staff is to reduce a young person's desire to want to end their life, but while this work is being done, some uncomfortable steps might need to be taken. Child T was placed in secure accommodation because of her risk of suicide and self-harm. There is a careful line to take, balancing the desire to be respectful and not overly intrusive in the care of young people living at Aycliffe, while at the same time keeping them safe, at times, from themselves.**
119. **In extreme cases, we think keeping someone safe can involve a level of searching and observing that makes both staff and the young person feel uncomfortable. Keeping someone safe may well mean watching them all the time, restricting access to areas of the house, checking their clothing when they get changed, keeping a light on throughout the night, asking for a verbal response while using the bathroom, in order to keep them from ending their life.**
120. Senior managers told us Aycliffe is not resourced or built to accommodate young people who need to be constantly supervised. Constant observations are difficult because the bedroom door needs to be kept open and two staff have to sit at the entrance. The management team felt young people with such acute needs should be in a secure mental health setting. If a young person's presentation changed so that they required constant supervision for a short-term crisis, then staff could watch them continuously. A senior manager said the decision to put someone on constant watch is taken by senior managers after seeking advice from the Kolvin Service, talking to the case manager and residential staff.

121. Our findings in both this investigation and the other death in a secure children's home have highlighted concerns about the ability of staff to ensure a young person's well-being when they seem to be asleep and we recommend:

The Department for Education and the Welsh Government should review current practice and introduce a clear framework for delivering welfare checks on young people to include:

- clear instruction about the nature and purpose of checks;
- details of how to accurately record checks;
- details of who decides what checks are necessary and how these are communicated to staff;
- consideration of the frequency of checks required on young people including whether it is necessary to check all young people throughout the night regardless of their risk;
- consideration of the number of staff needed to undertake checks;
- instruction as to when staff should go into a young person's room;
- management oversight of checks.

### Searching bedrooms

122. **We do not know when the last signed for search of Auckland's bedrooms was as the extract from the Safety and Security Check Sheet we were given (9 January 2017 onwards) does not evidence any searches of Child T's bedroom (or any other bedrooms). Despite staff assurances that searches took place, the paperwork we were given does not provide evidence of this. Senior managers we spoke to said they were not happy with the practice of staff searching a room but failing to record that search - and neither are we.**
123. Child T's risk management plan on 14 February 2017 said her room must be searched before she went to bed and this requirement had been in place for several months. Residential staff told us bedrooms were searched Monday to Friday while the young people were at school. A senior residential worker thought Child T's room was searched in the evening as well to make sure there was nothing she could harm herself with. We were told the reason searches did not happen at the weekend was because it would often lead to confrontation between the member of staff and the young person.
124. We asked whether young people are allowed to put paper or pictures on their window in order to try to block out the light that comes in around the edges of the blind. The decision to allow a young person to put paper or a poster on their window appears to be taken on an ad-hoc basis. A residential worker took Child T to the art room on the morning she died in order to get some black paper. The Auckland House manager also agreed to her having the paper. Other staff told us they would not have allowed Child T to put anything on her window because of her suicide and self-harm risk. This is something that should be considered on a case by case basis when a young person's risk management plan is reviewed.

For someone on 15 minute checks with no self-harm history, it would not seem unreasonable for them to put things on their window. For someone like Child T however, anything that limited staff's ability to observe her and check she was safe and well, should not have been allowed.

### Searching clothing

125. **Child T's clothing was not always searched or checked for damage. She was able to remove the elastic from some black leggings, unnoticed by staff, at some point in the weeks before her death.**
126. There was no specific requirement in Child T's risk management plan that her clothes should be searched when she handed them to staff at bedtime in exchange for nightwear. (There were requirements to check Child T had handed out her bras and that her trainers had their laces, but no general checking of clothing for damage.) A senior residential worker said staff should have been checking Child T's clothing when it was exchanged to see if there was any damage. A residential worker said staff were strict with Child T's clothing, only allowing her one set at a time and checking for damage at the end of the day.

### Searching paperwork

127. Child T's risk management plan did not give staff any guidance about whether things she had written should be read by staff during room searches. We know some things Child T wrote were read by staff, because that is how they found out about her plan to abscond during an escort to court on 22 August 2016. (Aycliffe staff said the plan had been left in plain view during a room search, with the title 'Plan to run away'.)
128. The centre manager told us he believed staff may read papers, notes and poems, but not legal mail. A senior manager had a similar view and said that because of Child T's risk, he would look through things she had written or drawn (except for legal mail). An acting senior residential worker said he would have a brief look through paperwork in a bedroom during a room search, but added that there was an ethos at Aycliffe that notes and letters were personal and confidential and he thought staff would not routinely read things. Some other staff told us they were not permitted to read things a young person had left in their room.
129. There is a balance to be found between privacy and safety. In order to keep someone safe, Aycliffe might feel it necessary to scan read things a young person has written. The suicide and self-harm risk assessment process should inform this decision and be reflected in the risk management plan.

#### **The Centre Manager should ensure risk management plans address:**

- **the frequency of bedroom searches;**
- **the nature of search required, including whether clothing and paperwork are to be searched;**
- **alterations to the fabric of bedrooms; and**  
**staff accountability for searches through the completion and signing of the Safety and Security Check Sheet.**

#### 4. Emergency response

130. **The initial emergency response was flawed. The actions of the duty manager and a residential worker, when they tried to resuscitate Child T were calm, professional and appropriate. We do not feel as comfortable about the actions of the residential staff who found Child T with a ligature.**
131. **While we understand that finding Child T with a ligature was very shocking, we are disappointed that they did not make more thorough checks of Child T for signs of life. It was not appropriate to place her in the recovery position (we are not certain they did anyway) and the first on scene staff should have remained next to her, continuing to make checks and reassure themselves she had a pulse and was breathing. We do not think Child T was breathing when found by staff as other staff described her as cold, grey and that her lips were blue. Resuscitation, in the form of chest compressions, should have been started straightaway.**
132. **The Centre Manager will want to consider whether the actions of some staff fell below what could be reasonably expected and whether a disciplinary investigation should be conducted.**
133. Day staff at Aycliffe do not carry anti-ligature (fish) knives, but night staff do. We were told the rationale behind this was the risk of the fish knife ending up in the hands of a young person who might refuse to hand it back and subsequently try to get access to the sharp blade held within. During the day, fish knives are stored on a shadow board in the office on each house. This results in a short delay in being able to cut a ligature off a young person while staff collect the knife. When the residential worker found Child T with the ligature on 18 February it took another 40 seconds for staff to be in a position to cut it off. He had to leave the room, bang on the door to get the attention of others, a colleague ran to the bedroom, back to the office to get the fish knife and then back to Child T's room with it. In a life threatening situation, every second can make a difference to the chance of someone surviving.
134. Aycliffe's policy at the time of Child T's death was that the person coming across a life threatening emergency situation should make a speech call, using the term "code red". This alerts the duty manager and others responding to the situation that it is potentially life threatening. The staff in the communications room (known as the hub) know to call 999 and ask for an ambulance. Staff told us that code red is used very infrequently and they are unfamiliar with the system.
135. The residential worker who found Child T with the ligature did not make any radio message. After giving the ligature knife to him, another residential worker pressed her Bosch alarm. She did not make a code red message. When the Bosch alarm button is pressed everyone with a Bosch gets a message to tell them where the location of the alarm is. However, the ability to communicate directly with the hub is disabled until the 'alarm' is stood down by a member of staff ringing the hub to let them know the situation has been resolved.

136. We understand why the residential worker pressed her Bosch alarm and that this was an instinctive reaction, but it led to several problems – it disabled communication, the hub did not know to call 999 and staff responding to the alarm did not know it was a life threatening emergency. Staff told us they assumed it was a restraint and did not react with the same speed they would have done had they known the nature of what had happened. They had no moment to prepare themselves for what they might be faced with managing. No one knew to take the defibrillator or grab bag (both outside the safeguarding office where the duty manager was when the alarm went off). It was fortunate that a colleague took it upon himself to call 999 and stay on the phone to the ambulance control room while the paramedics travelled to Aycliffe.
137. The centre manager told us he has carried out some scenario based training exercises since Child T's death, but there were problems with staff hearing the code red message because of the general noise levels in the houses. Some further work will therefore need to be done to identify the best way of alerting staff to an emergency situation.
138. The first paramedic to arrive at Aycliffe initially went to another building before being directed to the main entrance by a member of staff. Aycliffe Secure Centre is on a large site with several other buildings and it could be easy to make the wrong turn.
139. We recommend:

**The Centre Manager should:**

- **Consider whether a formal disciplinary investigation is warranted into the actions of some of the staff involved in Child T's emergency response.**
- **Ensure all staff are aware of their responsibilities if they are the first on scene in a life threatening emergency.**
- **Consider whether further training is required.**
- **Liaise with the North East Ambulance Service and complete a joint review of emergency procedures at Aycliffe.**
- **Ensure there are appropriate signs along the road network within the site directing arriving vehicles to the main entrance.**
- **Review the policy about issuing anti-ligature knives to staff. Staff should be able to access these knives quickly in emergency situations.**

## **5. Contact between Child T and her siblings**

140. Aycliffe should have known when calls did or did not take place and should have recorded this information in Child T's daily log. However, they were unable to provide us with accurate records and said this was because it was the social worker for the siblings who was responsible for being with the siblings at the pre-arranged times.

141. Child T did not have any contact with her younger siblings from her admission to Aycliffe on 6 July 2016 to 12 October. An outcome of the Secure Review on 2 August was that Worcestershire Social Services were to approach Child T's step-mother to seek her agreement for Child T to have contact with her younger siblings using a video link. On 12 October, a telephone call between Child T and her siblings took place and plans were for fortnightly calls thereafter. It is unclear why it took over three months from the date of the Secure Review to the first phone call. There was also agreement for the calls to be made via Skype, so that Child T could see her siblings as well as talk to them. The calls did not always take place fortnightly and none of them were Skype or video calls.
142. Aycliffe told us they were frustrated about the contact between Child T and her siblings and that calls (or their cancellation) had a significant impact on Child T's mood and risk of harming herself. A solicitor felt Child T was unable to have a proper ongoing relationship with her siblings (because of their young age) without them being able to see one another.
143. We asked Worcestershire Local Authority to provide us with dates and times when calls went ahead and reasons why scheduled calls did not happen. We only received a partial answer and no explanation as to why some calls did not take place. There should have been better communication between Aycliffe and Worcestershire Social Services so that prearranged calls were not cancelled without good reason.
144. **While our remit does not extend to consideration of the actions of Worcestershire Local Authority in the management of Child T, we wish to draw the issue of Child T's contact with her siblings to the attention of the Serious Case Review.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations