5 Boroughs Partnership NHS
NHS Trust

Report to the Trust Board
4 May 2006

Independent Inquiry into the Treatment and Care of DC

PURPOSE OF REPORT

DC is a young man who was the perpetrator of a homicide in 2002. At the time he had been accessing the Child and Adolescent Mental Health Services in Warrington. DC is currently serving a custodial sentence for murder. Following the incident the Strategic Health Authority, on behalf of Warrington PCT, commissioned an independent inquiry in line with Department of Health requirements.

The report on the independent inquiry is attached. In addition a report prepared for Warrington PCT on the Trust's progress with the implementation of the recommendations from the internal review as well as the inquiry itself is also attached.

It must be noted that this incident took place July 2002.

This incident and the implementation of recommendations has previously been reported to part 2 of Trust Board meetings prior to the public disclosure of the independent inquiry report in April 2006.

RECOMMENDATIONS

That the Board notes the content of the report and approves the progress with the implementation of the recommendations.

IMPLICATIONS FOR TRUST

As with all incidents there are usually lessons to be learnt and improvements to systems and processes to be made. In this case there were very few and the practitioners involved in DCs care were acting within their expected level of practice. The key issue however, was in relation to inter agency working. To this end the Warrington PCT Board have asked that the Warrington Safeguarding Children Board consider the report.

The Trust is committed to learning lessons from serious untoward incidents. The recent Clinical Negligence Scheme for Trusts (CNST) assessment gave a 100% compliance with the management of Serious Untoward Incidents and the implementation improvements if indicated.

INVOLVEMENT OF STAKEHOLDERS

As already stated the Trust is working with Warrington PCT and the Local Authority to consider the recommendations in the report, which relate to inter agency working and communication.

LINK TO CORPORATE OBJECTIVES

Objective 1

To influence and respond to opportunities to raise the profile of mental health promotion, to champion social inclusion and the mainstreaming of mental health services at both a national and local level.

Objective 5

To manage risk and provide high-level assurance to internal and external stakeholders on the governance and performance of the organisation.

PRESENTING DIRECTOR TO THE BOARD
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26 April 2006.

REPORT TO WARRINGTON PRIMARY CARE TRUST
Publication of External Inquiry – DC
8th February 2006

1. Purpose of the Report

To inform Warrington Primary Care Trust of the actions taken by the 5 Boroughs Partnership NHS Trust following the external inquiry recommendations made by ECRI in relation to a client known as DC.

2. Background

ECRI were commissioned by Cheshire & Mersey SHA on behalf of Warrington PCT to undertake an external inquiry using a root cause analysis approach. ECRI, a non-profit organisation, used the following terms of reference:

a. To independently examine all circumstances surrounding the care and treatment of DC.

b. To establish the facts regarding the mental health care of DC up to the date of the offence.

c. To consider and comment on the appropriateness, or otherwise, of the care and treatment and supervision of DC including:

- His assessed health and social care needs
- His assessed risk of potential harm to himself or others
- Any previous psychiatric history (including drug/alcohol abuse)
- The number and nature of any previous contacts with the criminal justice system.

d. To consider any specific issues which the families of DC, and/or the family of the deceased, may wish to raise with due regard to confidentiality.

e. Determine the extent to which the services corresponded to statutory obligations and local policies.

f. To examine the quality of the risk assessment undertaken.

g. Establish what action has already been taken.

h. Draw conclusions and make recommendations for any further action.

The RCA Team reviewed evidence from a number of individuals and agencies involved, including the Trust's Internal Inquiry Report. It published its first draft report in early 2005, stating that although lessons could be learned *"there was no evidence of error on the part of any individual member of the clinical teams involved with the care of DC, nor were there any intentional or non-intentional violations of Trust protocols apparent."*

The RCA Team further stated that following review of the Internal Inquiry report and action plan, the 5 Boroughs Partnership NHS Trust had identified primary issues related to the incident and responded appropriately.

ECRI made four further recommendations to improve safety as follows:

Recommendation 1

The Trust should consider the delivery of a more responsive CAMH Service to patients such as DC. The RCA Team recommends a review is conducted by the Trust of the demands and resources within CAMHS to ensure they are meeting the requirements of service users and other clinicians. In particular, the review should consider how and on what basis referrals are prioritised. A care pathway should be identified as appropriate to facilitate a young person's entry into contact with specialist services such as CAMHS. The findings of the review should be reported to the Trust Board, together with a plan to address any issues identified as requiring action. The findings should also be fed into the clinical audit process to ensure regular monitoring occurs.

Recommendation 2

A system of clear and effective care co-ordination should be introduced similar to that found with the adult CPA process, whereby there is effective communication and care management via a key worker between the various agencies involved in a young person's care. This process should facilitate the young person's progress through the care pathway, enhance risk assessment and improve the effectiveness of risk reduction measures.

Recommendation 3

A system of clear and standardised risk assessment should be included in a young person's care plan. Risk assessment should then be carried out at regular intervals at locations that are appropriate, and the process documented as such, in order to achieve maximum risk mitigation.

The components associated with a risk assessment are:

- Identification of the hazards
- Decide who might be harmed and how
- Evaluation of the risk and develop an action plan
- Document the findings
- Review and monitor the assessment over time.

Recommendation 4

The RCA Team recommends that the Trust conducts a review of its referral process to assess whether the 'opt in' system is the most appropriate arrangement for both new and existing service user populations. It should consider whether non-attendance is an appropriate indicator for 'case closure', or whether a more proactive contact is required before it is agreed that this should occur.

3.0 Progress to Date

During the two years following the incident and whilst the external inquiry was underway, significant developments occurred nationally and locally for CAMHS, following the publication of the 'NSF for Children' in 2004 and its predecessor, 'Emerging Findings' in 2003. The latter identified a need for more comprehensive CAMHS nationally in anticipation of the NSF, and supported this with Department of Health targets to increase CAMHS resources by at least 10% year on year from 2003 to 2005.

Despite Warrington CAMHS only receiving approximately 30% of the NSF recommended baseline funding, it achieved the 10% year on year increase over consecutive years.

Recommendation 1

In line with the performance targets described, the Trust reviewed the demands and resources within Warrington CAMHS via the CAMHS Partnership Group. Through this multi agency forum, the entry criteria to CAMHS was increased and for those with less complex mental health problems, an agreement was achieved that they would receive

services from partner agencies. Additional funding was also secured via the PCT and Local Authority to appoint the following:

WTE	POST
0.55	Consultant Psychiatrist
1.00	Cognitive Behavioural Therapist
0.80	Clinical Psychologist
0.80	Nurse Specialist (CAMHS and Learning Disabilities)
1.00	Nurse Specialist (CAMHS and Substance Misuse)
0.55	Medical Secretary

The final part of recommendation 1 identifies the development of a care pathway to facilitate access to CAMHS. Local developments have been superseded by the national development of the Common Assessment Framework (CAF) and Information Sharing Assessment (ISA) pilot which commenced in 2004. The CAF will be launched in Spring 2006 across all statutory and non-statutory children's services and will become the standardised multi-agency assessment and referral tool for all specialist children's services including CAMHS.

Recommendation 2

The development of an Effective Care Co-Ordination (ECC) approach was identified by the Internal Inquiry Panel in 2002. This was developed jointly by all Trust CAMH Services in 2003, piloted in Warrington and Wigan in Spring 2004 and went live in October 2004, following successful evaluation.

The process has clear similarities to the Adult ECC model ensuring a named key worker, planned reviews, standardised risk assessment and effective communication.

Recommendation 3

ECRI identified the need for standardised risk assessment to achieve maximum risk mitigation. This has been achieved in the development of an ECC process, as described in Recommendation 2 and meets the full criteria of the recommendation.

Recommendation 4

Whilst the 'Opt In' system remains in place for new referrals, a new system was introduced following the internal inquiry to ensure any individuals re-referred to the team are subject to a professionals meeting (including external agencies) to consider potential complex need and risk.

The 'Opt In' system will be subject to review as a result of the implementation of the Common Assessment Framework, which should reduce the number of inappropriate referrals to specialist services. The review will take place following the launch of the CAF in April 2006.

4. Conclusion

The findings of the ECRI external inquiry were consistent with the findings of the internal inquiry undertaken by the 5 Boroughs Partnership NHS Trust in 2002.

The Trust responded immediately to the recommendations of the internal inquiry and the majority of required actions were in place or had commenced prior to the start of the external inquiry.

The 5 Boroughs Partnership NHS Trust can confirm that all recommendations as a result of the ECRI Inquiry have been fully acted upon and are currently operational.

Michelle Maguire
Head of Corporate Support
8th February 2006