

**TITLE: BRIEFING REPORT EXTERNAL INQUIRY**

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**POSITION: ASSISTANT DIRECTOR OF HEALTH STANDARDS**

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**PURPOSE:**

To report to the Board on the findings and outcomes of an External Inquiry.

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**BUSINESS OBJECTIVE:**

To ensure Better Standards of Health.

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**IMPACT ON PARTNERS:**

None.

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**RESOURCE IMPLICATIONS:**

Use of time for nominated officers of the PCT.

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**CONSULTATION:**

**Is it considered that this issue may need consideration by the Overview and Scrutiny Committee** No.

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**RECOMMENDATION:**

1. It is recommended that the Board notes the report.
2. It is recommended that the Board monitors the actions identified for 5 Boroughs Partnership and requests confirmation that they are completed.

## **Introduction**

The Department of Health expects that when a patient that is in receipt of mental health services (or has recently received them) commits a serious crime an external inquiry is conducted to establish the root causes and identify action to prevent a re-occurrence. The recommendations of the report must be made public.

There is a standing agreement in place across Cheshire and Merseyside that the Strategic Health Authority will commission external inquiries when necessary on behalf of Primary Care Trusts. A small amount of revenue is taken from all PCT budgets to accommodate this at the beginning of each financial year. The SHA view is that the report should be published in total.

## **Background**

In 2002 a young male patient of 5 Boroughs Partnership burgled a house of an elderly gentleman. In the process the patient attacked the home owner who subsequently died of his injuries. The patient was convicted of homicide in 2003 and sent to prison for life. At that point Cheshire and Merseyside Strategic Health Authority (SHA) commissioned ECRI to conduct an external inquiry. ECRI is an independent organisation that has many years experience in root cause analysis and incident investigation.

The inquiry actually started mid-2004. The delay was a result of the fact that this region of the NHS had not commissioned any external inquiries of this type previously and had to work with other organisations to agree processes and obtain consent from stakeholders.

The report has now been written and all the appropriate checks have been made to ensure it is accurate, robust and complies with confidentiality and data protection act requirements.

## **Inquiry Report**

The report and its recommendations must be presented to the PCT Board. The PCT is expected to have made reasonable attempts to contact the stakeholders before the report is made public. Concerted efforts have been made to contact the relatives of the patient and the relatives of the victim, this has proved difficult both due to the sensitivity of the case and the fact that relatives have moved house or have not wished to engage in the process. The Director of Health Standards will report verbally on the progress of these discussions. The report itself is attached in Appendix 1.

## **Key Findings**

The report found that there had been a series of system failures that resulted in the patients care being difficult to access and being fragmented. The bulk of the recommendations are to 5 Boroughs Partnership, however there are also recommendations for Warrington Borough Council as the patient was a client of the Youth Offending Team and had prior involvement with Social Services.

The action for the PCT is to ensure that the action plan for 5 Boroughs is completed and that the quality of service is monitored. This should be the responsibility of commissioners.

### **Recommendations**

3. It is recommended that the Board notes the report.
4. It is recommended that the Board monitors the actions identified for 5 Boroughs Partnership and requests confirmation that they are completed.

# External Independent Review into the care and treatment of DC

Commissioned by  
Cheshire and Merseyside Strategic Health Authority

**Reference: ECRI/MHRA/DC/013**

Report Dated:

February 2006



A NONPROFIT AGENCY

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# Acknowledgements

ECRI wishes to extend its deepest sympathy to all those affected by the tragic event that led to this investigation.

It would like to acknowledge Christine Hedley, who acted as the Inquiry Co-ordinator at 5 Boroughs Partnership NHS Trust, for her assistance and contribution during the process.

Finally, ECRI would also like to take the opportunity to thank all those who participated in and contributed to this independent investigation. Their input is much valued and appreciated.

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## 1.0 Executive Summary

The Root Cause Analysis Team was appointed by the Cheshire & Merseyside Strategic Health Authority on 18<sup>th</sup> December 2003 to investigate the healthcare and treatment of DC and to prepare a report and make recommendations.

The Root Cause Analysis investigation was established under the terms of the Health Service Guidance HSG (94) 27 – Guidance on the discharge of mentally disordered offenders, Department of Health. The investigative Root Cause Analysis process was progressed in accordance with national and international best practice guidelines in this area.

The Root Cause Analysis terms of reference were as follows:

### **Terms of Reference**

1. To independently examine all the circumstances surrounding the care and treatment of DC
2. To establish the facts regarding the mental health care of DC up to the date of the offence
3. 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 any drug and alcohol abuse)
  - The number and nature of any previous contacts with the criminal justice system

4. 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
5. Determine the extent to which the services corresponded to statutory obligations and local policies
6. To examine the quality of the risk assessment undertaken
7. Establish what action has already been taken
8. Draw conclusions and make recommendations for any further action

## **DC – DOB 22/02/1987**

On 29<sup>th</sup> May 2002, DC killed a 75 year old man during a burglary by inflicting fatal head injuries to him. At his criminal trial in April 2003, DC was convicted for murder. DC is currently resident at a Young Offenders Institution.

At the time of the offence (aged 15) DC had a history of contact with Child and Adolescent Mental Health Services (CAMHS) and had a previous history of behavioural disturbance since the age of 7. He was being cared for by his mother and stepfather until September 2000 when he was parented by his mother alone.

DC was receiving home visits from the CAMHS prior to the offence.

The Root Cause Analysis Team have reviewed evidence from a number of individuals, read substantial documentation from the relevant agencies involved including the report of the internal inquiry into the care and treatment of DC by 5 Boroughs Partnership NHS Trust.



All of those interviewed who provided information have had the opportunity to amend and approve the information they have provided. All agencies involved have replied in a punctual and efficient manner in regards to requests made of them for such records and documentation.

In practice with Root Cause Analysis (RCA) procedures, and in order to encourage an uninhibited contribution by those involved, individuals are not identified by name.

Clinical and service delivery issues identified included:

- DC had a range of symptoms and signs consistent with the diagnosis of conduct disorder which may have been caused by his history of abuse.
- Although there were a number of agencies involved in DC's care there was no evidence of a thorough multidisciplinary needs assessment. This may have been beneficial in terms of elucidating and managing some of the environmental stressors in DC's life.
- The RCA Team found that communication between the various agencies involved in DC's care was of variable quality and intermittent. This may have hindered the management of DC's overall care.
- The 'opt in' system of referrals, whilst recognised as being recognised practice in mental health, may not be wholly appropriate to vulnerable young service users and their families who may not understand the consequences of failing to follow the administrative processes outlined in such referral practices.

- the need for stronger relationships and information sharing with the police when circumstances warrant this.
- The investigative team reviewed both local and national service policies and frameworks. There was no indication that either were not followed during the care of DC.

The investigative team have reviewed the Trusts Action Plan generated in response to this incident and the actions proposed appear to demonstrate that much has been learned from this incident. In addition, it is noted that the internal review carried out by the Trust appears to have identified the primary issues related to this incident. The investigative team recommend that the action Plan be reviewed by the 5 Boroughs Partnership NHS Trust Board to ensure the actions identified have been implemented.

## 2.0 Investigative Methodology

1.1 Root Cause Analysis is a retrospective systematic process of analysis of an incident conducted according to guidelines published at both national and international levels. Its purpose is to identify what, how, and why a particular event occurred. The output from such an analysis is then used to identify areas that require change and provide recommendations and sustainable solutions, in order to minimise the chance of re-occurrence of the incident.

1.2 The process consists of six main activities:

- o data gathering
- o information mapping
- o identifying issues
- o analysing issues for contributory factors
- o agreeing the root causes
- o recommendations and reporting

1.3 The government Chief Medical Officer's report '*An Organisation with a Memory*' (2000) presents the results of findings by an expert group reviewing adverse incident management and the options for learning from such events.

A number of subsequent publications from both the Department of Health and the National Patient Safety Agency identify the key requirements for NHS organisations to manage, learn and administer adverse incidents.

## 3.0 Sources of information

- 3.1 5 Boroughs Partnership NHS Trust Serious Incident Fast Track Record, dated 5<sup>th</sup> July 2002.
- 3.2 5 Boroughs Partnership NHS Trust Serious Incident Internal Inquiry, 15<sup>th</sup> October 2002.
- 3.3 5 Boroughs Partnership NHS Trust Serious Incident Internal Inquiry Terms of Reference, dated June 2002.
- 3.4 5 Boroughs Partnership NHS Trust Clinical Case Notes.
- 3.5 Interviews were held on 1<sup>st</sup> September 2004 at 5 Boroughs Partnership NHS Trust with:
  - Child and Adolescent Mental Health Services Manager (CAMHS 1)
  - Clinical Psychologist (CP1)
  - Youth Offending Team Worker (YOT2)
- 3.6 5 Boroughs Partnership NHS Trust, Child and Adolescent Mental Health Services, 'Reasons for Referral', undated
- 3.7 5 Boroughs Partnership NHS Trust, 'Service Specification'
- 3.8 5 Boroughs Partnership NHS Trust, 'Referral Process'
- 3.9 5 Boroughs Partnership NHS Trust, 'Allocation Process'
- 3.10 Department of Health, Organising and Delivering Psychological Therapies, dated July 2004

- 3.11 Department of Health, Treatment Choice in Psychological Therapies and Counselling. Evidence based practice guideline, dated 2001
  
- 3.12 Department of Health, National Service Framework for Mental Health. Modern Standards and Service Models, dated September 1999
  
- 3.13 Detailed, tabulated cross referenced chronology prepared by ECRI

## 4.0 Contact List and Anonymisation Key

<b>Department or Affiliation</b>	<b>Designation</b>	<b>Key</b>
Index Family	Index patient	DC
Child & Adolescent Mental Health Service (Warrington Hospital)	Clinical Psychologist	CP1
Child & Adolescent Mental Health Service (Warrington Hospital)	CAMHS lead Warrington	CAMHS 1
Child & Adolescent Mental Health Service (Warrington Hospital)	CAMHS	CP5
Warrington Child Mental Health Team (Warrington Hospital)	Clinical Nurse Specialist	CNS1
Newchurch County Primary School (Warrington)	Head Teacher	HT1
Culcheth County High School (Warrington)	Head of Year 10	HT2
Culcheth County High School (Warrington)	Head Teacher	HT3
School Services (Woolston Clinic, Holes Lane, Woolston, Warrington)	School Medical Officer	SMO1
School Services (Winwick Hospital, Winwick, Warrington)	School Medical Officer	SMO2
School Services (Garven Place Clinic, Sankey Street, Warrington)	Senior Clinical Medical Officer	SCMO1
Family & Child Advisory Service (Warrington Hospital)	Consultant Child and Adolescent Psychiatrist	CP2
Family & Child Advisory Service (Warrington Hospital)	Family Therapist	FT1
Primary Care (Thompson Avenue Surgery, Culcheth Warrington)	GP	GP1
Primary Care (Thompson Avenue Surgery, Culcheth Warrington)	GP	GP2
Primary Care (Thompson Avenue Surgery, Culcheth Warrington)	GP	GP3
Primary Care (Eric Moore Health Centre, Warrington)	GP	GP4

Youth Offending Team (Warrington)	Manager	YOT1
Youth Offending Team (Warrington)	Worker	YOT2
Youth Offending Team (Warrington)	Worker	YOT3
Youth Offending Team (Warrington)	Worker	YOT4
Warrington Police Services	CID	CID1
Warrington Police Services	CID	CID2
Social Services	Social worker	SW1
Outpatient Services (Warrington Hospital NHS Trust, Lovely Lane, Warrington)	Consultant Paediatrician	CP3
Outpatient Services (Warrington Hospital NHS Trust, Lovely Lane, Warrington)	Consultant Radiologist	CR1
ENT Services (Warrington Hospital NHS Trust, Lovely Lane, Warrington)	Consultant ENT Surgeon	CES1
ENT Services (Warrington Hospital NHS Trust, Lovely Lane, Warrington)	Specialist ENT Registrar	SPR1
ENT Services (Warrington Hospital NHS Trust, Lovely Lane, Warrington)	Specialist ENT Registrar	SPR1
Child & Adolescent Services (Warrington Hospital NHS Trust, Lovely Lane, Warrington)	Consultant Paediatrician	CP4
Child & Adolescent Services (Garven Place Clinic, Warrington)	Senior Speech & Language Therapist	SLT1

## 5.0 Narrative Chronology of Key Events

- 5.1 **April 1997** DC's first contact with Child & Adolescence Mental Health Services. DC had a prior history over the previous six years of behavioural difficulties, unexplained hearing loss, and a general lack of concentration. DC was the subject of entry to the child protection register in 1992. During the course of 1996 DC attended family therapy sessions in order to help manage DC's behavioural problems.
- 5.2 **January 1997** DC continued to have difficulties at school where he was involved in a number of minor incidents. During April 1997 DC's teacher contacted family therapy services and indicated he was not improving at school and appeared to pick on other children and was very disruptive. Later that month he was expelled from school.
- 5.3 **November 1997** DC's behaviour is reported to improve since he was expelled and had now started at another school. He self reported his behaviour being attributed to the school being a much more positive experience.
- 5.4 **February 1998** DC attends the A&E Department at Warrington Hospital with a series of physical illnesses. No diagnosis was identifiable and he was discharged under the care of his GP.
- 5.5 **June 1998** DC attends the A&E Department at Warrington Hospital with injuries to his left wrist. DC was discharged to the care of his GP.
- 5.6 **March 1999** DC is reported to have been suspended from school for assaulting another pupil.



- 5.7 **July 2000** DC is reported to be suspended from school for assaulting a female pupil. He is also regularly reported to be absent from school and classes and is often excluded from these due to disruptive behaviour. The behavioural characteristics apparent are reported to reflect threatening and violent behaviour.
- 5.8 **September 2000** DC attends the A&E department at Warrington Hospital for a contusion and abrasion to his knee and foot in addition to head injury. DC's injuries were treated and he was discharged to the care of his GP.
- 5.9 **September 2000** DC's general practitioner requests an appointment for him with the Child and Adolescence Mental Health Services (CAMHS). His social worker also refers to CAMHS. His behavioural problems continue and include violent and aggressive acts mainly at home.
- 5.10 **October 2000** DC is seen by a clinical nurse specialist at CAMHS. It is reported that there were no mental health issues apparent with DC and it is felt that he was been managed by the appropriate agency namely social services and no appointment was needed for him.
- 5.11 **December 2000** DC attends the A&E Department at Warrington Hospital with an injury to his left hand. This was a sprain/ligament injury which was treated and he was discharged to the care of his GP.
- 5.12 **February 2001** DC was suspended from school for assaulting female pupils.

- 5.13 **March 2001** DC was suspended from school for assaulting female pupils.
- 5.14 **May 2001** DC's general practitioner requests an appointment with a consultant psychiatrist within CAMHS for DC to be assessed. DC has a history of disruptive behaviour, poor concentration, low motivation, low self esteem and considerably disrespectful to his immediate family.
- 5.15 **June 2001** Warrington CAMHS, in a letter to DC's mother, indicates that DC has been referred to the service which, at the current time, there is a six month waiting and a further appointment will be sent nearer the time. Later that month DC is suspended again from school for unacceptable language to a member of staff for assaulting a male pupil.
- 5.16 **August 2001** Letter to DC's mother from CAMHS confirms that she will receive an appointment for attendance in 8 to 10 weeks time. Later that month, on 20<sup>th</sup> August, DC's mother receives a further letter from CAMHS indicating that they had not received a reply and requested confirmation that the appointment was still needed.
- 5.17 **September 2001** DC is arrested for stealing from School. The Youth Offending Team assessed DC and no mental health problems were identified. The YOT were not aware that CAMHS were involved.
- 5.18 **September 2001** DC's mother receives another letter from CAMHS asking about the appointment. The letter confirms if no response is received the file will be closed. Later that month DC is suspended from school for assaulting a male pupil.

- 5.19 **October 2001** DC's school implements an individual behaviour plan in order to help DC improve his relationships with staff and pupils and his concentration. Also a plan is developed to help DC avoid conflict and inappropriate behaviour. DC is to have counselling on behaviour with both the teachers and YOT. Later that month (2<sup>nd</sup> October 2001) DC's mother receives a further letter from CAMHS indicating that DC's file has been closed as there has been no response to previous letters.
- 5.20 **September 2001** DC is suspended from school for assaulting a male pupil.
- 5.21 **October 2001** DC's mother receives a further letter (dated 2<sup>nd</sup> October 2001) alerting that as they have received no response to previous letters. As such CAMHS have closed the case file. A telephone message, dated 5<sup>th</sup> October 2001, is subsequently received by CAMHS from DC's mother indicating that she had not received any of the previous letters and does not want the file closed. Later that month an appointment for DC and his mother were confirmed for 8<sup>th</sup> November 2001.
- 5.22 **November 2001** DC attends the A&E Department at Warrington Hospital with head injury and swelling to the nose from a alleged assault. Later that month DC's mother makes contact with CAMHS and cancels the appointment that was scheduled as she had a physical injury. She requested a further appointment. This was confirmed for DC and his mother and scheduled for 11<sup>th</sup> December 2001. Later that month DC attended Warrington Hospital for a manipulation of fractured nasal bones under a general anaesthetic.

- 5.23 **December 2001** DC receives a final warning from the police regarding a burglary. The youth offending team is involved.
- 5.24 **January 2002** An appointment was confirmed for DC and his mother in relation to a home visit by a consultant psychologist at their home on 5<sup>th</sup> February 2002.
- 5.25 **February 2002** DC's mother calls and indicates she is not able to make the appointment and requests a further appointment for the 11<sup>th</sup> March 2002. This was confirmed.
- 5.26 **March 2002** DC's mother contacts CAMHS and indicates that DC has walked out of school and she wants him to talk to the clinical psychologist.
- 5.27 **April 2002** In a letter to DC's mother from CAMHS an appointment is confirmed for DC at their home for a visit by the clinical psychologist on 29<sup>th</sup> April. Further appointments were offered at DC's home during May and June 2002.

5.28 **June 2002** DC is involved in a burglary from a garden shed and is given a referral order for six months with the youth offending team. Later that month a telephone message is received from DC's mother to the clinical psychology team asking them to make contact with the head of year at his school. Two such calls are received. The clinical psychologist subsequently visited DC at home although only his mother was present. He arrived some time later and apologised for being late. DC had difficulty responding to questions in relation to his behaviour and exclusion from school. It was agreed that the family would benefit from family therapy and it was felt beneficial for DC to be seen on this own by the clinical psychologist. A further appointment was made for a visit at home on 16<sup>th</sup> July. Later that month, DC was seen by the Youth Offending Team and it was agreed that he should be seen every two weeks for anger management, victim awareness and in development with family relationships.

5.29 **July 2002** DC is arrested on suspicion of murder and is suspected with involvement in a burglary where a man is killed. DC is subsequently charged with murder and remanded to a young offenders institution.

## 6.0 Clinical and Service Delivery Issues

### Context

At the time of the offence (aged 15) DC had a history of contact with Child and Adolescent Mental Health Services (CAMHS) and had a previous history of behavioural disturbance since the age of 7. He was being cared for by his mother and stepfather until September 2000 when he was parented by his mother alone.

DC was receiving home visits from the CAMHS prior to the offence.

### Psychiatric Diagnosis:

In hindsight, DC appeared to be suffering from Conduct Disorder<sup>1</sup> despite this diagnosis not appearing in the documented notes received.

It is considered important that the diagnosis should have been well documented because of the implications for treatment, risk assessment and prognosis. However, due to difficulties in establishing service contact no formal outpatient based assessment consultation appears to have taken place.

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<sup>1</sup> *The ICD-10 Classification of Mental and Behavioural Disorders – Clinical descriptions and diagnostic guidelines* World Health Organisation 1992 p 266.

## **Risk Assessment/Multi-Agency Child & Adolescent Protection Procedures**

There was evidence of intermittent risk assessment of DC in September 2001 and June 2002 by the Youth offending Team. CAMHS are not subject to the Care Programme Approach (CPA) and further risk assessment appears to have been carried out using non standardised procedures. The regular use of a standardised risk assessment tool may have been helpful in determining the level of risk posed by DC, in particular within the context of his previous behavioural problems.

There was no documented multi-agency risk assessment or documented MAPP meeting following DC's history of offending. There was no documented formal liaison with the police to share information on risk and co-ordinate management with a view to public protection. This would have had the benefit of: informing the police of the difficulties of the health care system in protecting the public from a young person with a diagnosis of Conduct Disorder; finding out the problems experienced by the police in protecting the public from DC; sharing information to provide for a collective risk assessment profile for DC; and developing a co-ordinated management plan to maximise public protection.

It is possible that a multi-agency risk assessment meeting may have enabled all agencies to form a collective view of the problems being experienced by DC and hence be able to generate and coordinate an action plan to help resolve the issues concerned.

## **Multidisciplinary Needs Assessment**

Although there were a number of agencies involved in DC's care there was no evidence of a thorough multidisciplinary needs assessment. This may have been beneficial in terms of elucidating and managing some of the environmental stressors in DC's life.

## **Communication**

The RCA Team found that communication between the various agencies involved in DC's care was variable and intermittent and may have hindered the management of DC's overall care. As previously discussed, it is the investigative teams view that a multiagency meeting would have assisted the care of DC and led to a greater understanding of the clinical workload pressures prevalent at the time.

## **Service Provision - 1**

The RCA Team noted that DC was referred to the CAMH Service on four separate occasions over a six year period. CAMHS operated an 'opt in' approach where the family needed to formally respond to a letter requesting whether they still wanted an appointment. On two occasions the family did not respond and the case was closed.

It was also documented that CAMHS had a waiting list of at least six months following referral from his GP in May 2001. There was no evidence available of a managed approach of psychological referral waiting lists at the time of the incident.



The 'opt in' system of referrals, whilst recognised as being accepted practice in mental health, may not be wholly appropriate to vulnerable service users and their families who may not understand the consequences of failing to follow the administrative processes outlined in such referral letters.

When contact was achieved, of note is the fact that it was not possible to assess DC in a setting away from the home environment. Whilst this may not have altered any of the outcome of the care provided clinical staff have commented it was difficult to engage and assess DC whilst in the home environment. It is the investigative teams view that an assessment in an outpatient setting would have been beneficial.

## **Service Provision -2**

The National Service Framework for Mental Health<sup>2</sup> outlines the need for the availability of programmes for individuals at risk. This particularly applies to children with behavioural problems at school. It identifies the availability of such programmes negating the development of difficulties in later life.

There is documented evidence within the chronology of contact between DC's school and other agencies including his GP. The RCA team found no evidence of a documented proactive multiagency response that addressed the requirements of DC within the school setting. It is felt that this would have been beneficial and could have potentially led to the development of an appropriate care plan

*(<sup>2</sup> Department of Health, National Service Framework for Mental Health, September 1999, page 16).*

## **7.0 Human Factors Error and Violations**

Upon review by the RCA team, 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.

## **8.0 Contributory Factors Error and Root Causes**

*These are determined using brainstorming, barrier analysis, five whys and cause and effect charts. Whilst not a predictable event in itself, the following findings, both individually and combined, are considered to be possible root causes of a disruption to the clinical care provided to DC in the months leading up to the homicide and are all issues concerning quality of care.*

- 8.1 Although DC had a history of fire setting, burglary, threats to others and assaultative behaviour. The RCA team considers that this would have been consistent with a conduct disorder. The RCA process found that on the basis of the evidence available to clinical staff prior to the homicide, and despite such behavioural characteristics, it would not have been easily determined that such an event was going to occur. He was being regularly seen by the Warrington Child Mental Health Team prior to the homicide and there were no immediate documented concerns regarding threats to himself or others. With the benefit of the development of the chronology of care for DC there are documented instances of violence. In hindsight, these were cause for concern and, as previously stated, a multi-agency meeting may have been beneficial in helping to develop an appropriate care plan to help manage such.

- 8.2 There appeared to be difficulty in DC accessing care due to the lack of a responsive care pathway. DC had not been able to gain access to specialist mental health services for young persons on a number of occasions due to the 'opt in' appointments system in use and an apparent lack of resources resulting in a long waiting time for an appointment with CAMHS. The consequence of this was that DC was out of contact with appropriate CAMHS service provision for a period of time. However, it is not possible to conclusively indicate that such contact would have prevented the homicide.
- 8.3 There was evidence of risk assessment of DC by the Youth Offending Team in September 2001 and June 2002. However, there was no evidence of the regular use of formalised risk assessment documentation following this. In the opinion of the RCA team, a subsequent lack of the regular use of risk assessment tools could have hindered the objective assessment of risk posed by DC. To this extent, it is considered that the risk mitigation measures in use were not as robust as they could have been. However, again it is not possible to conclusively indicate that had this been achieved this would have led to prevention of the homicide. Risk assessment measures are part of an overall process of care of a mental health service user and such techniques are not panacea solutions for the prevention of homicide.

- 8.4 The RCA Team noted that DC was cared for by a number of agencies who were not always aware of each other's activities. The Youth Offending Team and CAMHS only became aware of each other's involvement with DC during June 2002 just prior to the homicide. Communication was often limited between the different agencies involved especially between those allied to the criminal justice system and CAMHS.

There appeared to be no multi-disciplinary needs assessment to help co-ordinate services in particular during his behavioural difficulties during attendance at school. Two weekly meetings between the school, CAMHS and Social Services would have enabled the development of a shared care programme for DC. These meetings could then have been reduced to a lesser frequency when the care programme started to achieve a measurable effect, such as reductions in violent episodes, etc.

## **9.0 Recommendations for improving safety**

- 9.1 The Trust should consider the delivery of a more responsive CAMH Service to patient's such as DC. The RCA team recommends that 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.
- 9.2 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 keyworker 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.

9.3 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

9.4 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.

## SERIOUS INCIDENT REVIEW ACTION PLAN

**TRUST IDENTIFICATION NUMBER:**  
**PATIENT INITIALS:** DC

**BOROUGH:** WARRINGTON  
**DATE OF INCIDENT:** July 2002

NUMBER	ACTION	LEAD DIRECTOR/ OFFICER	TIMESCALE	PROGRESS TO DATE
1	A case management process needs to be operationalised in CAMHS, which clearly identifies the key worker and participants of the care plan to improve communication, ensure reviews and effective joint working. A risk assessment procedure also needs to be developed to inform the plan. At present, no agreed protocols are in operation in the CAMHS services across the 5 Boroughs Partnership NHS Trust.	CAMHS Lead & Consultant Clinical Psychologist	April 2003	During 2003, CAMHS lead clinicians and Operational Managers developed an Effective Care Co-ordination process incorporating standardised risk assessment across the 5 boroughs, based on the adult model. Warrington opted to undertake the pilot during March-July 2004. The system is currently in operation with a view to roll out Trustwide in 2005.
2	Comprehensive recording of internal CAMHS communications and referrals to other agencies.	CAMHS Lead	December 2002	Actioned December 2002.
3	Audit of re-referrals to CAMHS and protocols developed to ensure early detection.	Consultant Clinical Psychologist	February 2003	Five-year audit of re-referrals undertaken in May 2003. All referrals are now screened daily and re-referrals are subject to professionals meeting as necessary.
4	Review of staff safety and home visiting policies.	CAMHS Lead & Consultant Clinical Psychologist	March 2003	All CAMHS staff have now undertaken C & R Breakaway and De-escalation techniques. A buddy system also operates to ensure staff reporting safe.
5	Review of role of CAMHS worker within Youth Offending Team	Consultant Child & Adolescent Psychiatrist	December 2002	Actioned 2003 by Consultant Psychiatrist



6	Review of supervision policy and processes within CAMHS.	CAMHS Lead & Consultant Clinical Psychologist	April 2003	Supervision arrangements reviewed in CAMHS. System monitored in terms of adherence, quality, accountability and appropriateness by Clinic Lead.
7	Review CAMHS focus and priorities, and develop system to provide appropriate response to referrals within agreed timescales.	CAMHS Lead & Consultant Clinical Psychologist	April 2003	Operational Policy describing service criteria, priorities, response and referral procedures produced and ratified by Multi Agency CAMHS Partnership Board in August 2003.