AN INDEPENDENT INQUIRY

TO EXAMINE THE CIRCUMSTANCES SURROUNDING

THE CARE AND TREATMENT OF Q

COMMISSIONED UNDER THE DOH GUIDANCE HSG (94)27

SUBMISSION TO SURREY & SUSSEX STRATEGIC HEALTH AUTHORITY JULY 2003

1. FOREWORD

The infliction of suffering by one human being upon another induces many human responses. This Inquiry is one. It arose because a girl, who had been considerably abused as a child, killed as a young woman. Its aim is to recommend improvements in service delivery that may lessen the likelihood of similar events happening again. The Inquiry report is focussed by its Terms of Reference, which concentrate on the role of statutory agencies and their collaboration during the relevant period of Q's life. This is a mental health homicide Inquiry report. When one is addressing the development of childrens' mental health, the child's family, education and home environment all have to be taken into account and it has therefore been necessary to examine Q's upbringing as a child.

There is always a danger that the behaviour of people in the past is judged against the knowledge and practice of today. Every attempt has been made to judge practice in the context of its particular time, although certain judgments are nonetheless made, such as emphasizing that physical and emotional abuse of children is always wrong and that the protection of children from such abuse must take priority over providing facilities for them after they have been abused.

During the Inquiry no evidence was adduced to suggest that the performance of agencies was the only factor in determining responsibility for the tragedy of Q's history. It was the unanimous view of the panel that home environment and parental involvement, both of which appeared to have been underestimated by certain of the involved professionals, had considerable effect on the course of events.

It is accepted that since the index offence in 2000, many changes in working practices have been made at both local and national level. This is helpful, but there is still a long way to go and the Recommendations of this Inquiry panel state clearly what is still needed. The publication in January 2003 of the Report of the Victoria Climbié Inquiry covers some of the same issues and makes many cogent points with which this Inquiry panel agree, but the Climbié inquiry was concerned with the care and safeguarding of children, whereas this Inquiry is of mental health origin, following Department of Health guidelines.

During her childhood and beyond there were people who didn't listen to Q or, if they did, didn't fully understand early enough the significance of what

she said. This Report therefore concentrates on the recognition of child abuse in all its forms and its effect on the lifetime mental functioning of such a person. The Panel believe that if the report's recommendations are effectively implemented it will reduce any future risk being faced by children on a daily basis.

As the focus of this report is on improvements in service provision in the future, the names of those involved have been anonymised to afford some protection and minimise the impact of disclosing personal information about Q and her family.

2. TERMS OF REFERENCE

General remit	Beginning with the Internal Report to examine the relevant circumstances surrounding the treatment and care of Ms Q by the mental health services and from the criminal justice and social services viewpoint. To consider other matters as the public interest may require, which might arise during the course of the inquiry.
Treatment and care	The appropriateness of her treatment, care and supervision in respect of: • her actual and assessed health and social and support needs; • her actual and assessed risk of potential harm to herself and others; • her history of prescribed medication and compliance with it; • her previous psychiatric history and treatment; • her previous forensic history; • the documentation recorded relating to the above.
Compliance	The extent to which Ms Q's care corresponded to statutory obligations, particularly the Mental Health Act 1983 and relevant other guidance from the Home Office and Department of Health (Care Programme Approach (HC (9()) 23/LASSL (90) 11) Supervision Registers (HSG (94)5); Discharge Guidance (HSG (94) 27; and local operational policies.
Care plans	The extent to which care plans were effectively drawn up with Ms Q, and how these plans were delivered and complied with.
Joint working	To examine the process and style of the collaboration within and between all of the agencies, including the police and Home Office, involved in the care of Ms Q and the provision of services to her and her family.
Risk	To examine any issues of in-service training that arise

Management in relation to those caring or providing services to Ms Q and to consider the adequacy of the risk management and training of all staff involved in Ms Q's care and supervision.

Report To prepare a report and to make recommendations to the East Sussex, Brighton and Hove Health Authority and other relevant agencies.

3. INTRODUCTION

In 2000 Q was arrested and subsequently charged with the murder of S. She was convicted of manslaughter on the grounds of diminished responsibility and sentenced to life imprisonment. She was made the subject of Section 45a of the Mental Health Act 1983.

Q had a long history of contact with a variety of statutory agencies prior to this incident. Two internal reports were prepared subsequently by Eastbourne and County Healthcare NHS Trust (EACH) and East Sussex Social Services Department. Following this action a joint report was compiled by independent management consultants using the information contained in these internal reviews. This covered, inter alia, the appropriateness of the care and support given to Q; identified any shortfalls in the care and support; and made recommendations for immediate and long-term actions to improve service provision in cases of this nature. This report was completed in December 2000 and an action plan agreed between the Trust, Social Services, Probation Service and the Health Authority on ways of taking the recommendations forward.

At the same time the Probation Service prepared a report for the Home Office, as is required in all such circumstances, outlining what actions had been taken during the supervision of Q by the service.

The Inquiry report is focussed by its Terms of Reference, which concentrate on the role of statutory agencies and their collaboration during Q's life. The Inquiry has been conducted under the auspices of the Department of Health Guidance HSG(94)27 - which recommends that in cases of a homicide committed by individuals in receipt of mental health services, an independent mental health inquiry should be set up. The East Sussex, Brighton & Hove Health Authority commissioned this present Inquiry. The guidance states (paragraph 34) "In cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved. The only exception is where the victim is a child and it is considered that the report by the Area Child Protection Committee fully covers the remit of an independent inquiry".

So, while this is a mental health Inquiry report carried out under the auspices of the relevant guidance, it is important to note that in addressing

the development of children's mental health, many other factors have to be taken into account and they have been here. Further, although the circumstances in this case would not trigger a Chapter 8 Inquiry by the relevant Area Child Protection Committee, and the Panel was not charged with a specific brief to review children's services, much consideration, nonetheless, has properly been about Q's engagement with children and young peoples' services, and the recommendations include issues relevant to the ACPC and practice in relation to children looked after by the local authority.

During the drafting of this report the Victoria Climbie' Inquiry chaired by Lord Laming reported in January 2003. The concerns expressed in the Panel's findings, about which have been framed recommendations to the local authority and ACPC, refer to events of 10 and more years ago. The tenor of particular recommendations is to ensure that practice is in line with procedures, that front line staff have training, support and supervision firmly in place and that it is adhered to. The practice and managerial failures described in the Victoria Climbie' Inquiry Report vividly reinforce the need to review practice and effective sharing and use of information locally between agencies.

This Inquiry panel was set up under the chairmanship of John Wells-Thorpe, OBE (formerly a chairman of a Mental and Community Health NHS Trust, and a magistrate) comprising Ian Cockling (retired Senior Probation Officer); Nick Georgiou (a Director of Social Services); Greg Richardson (currently a Consultant in Child and Adolescent Psychiatry); and Philippa Slinger (currently Chief Executive of a Mental Health NHS Trust). Lynda Winchcombe of GW Management Consultants Ltd was appointed Inquiry Manager.

The panel has reviewed records spanning several years that were made available in file or document form from a wide variety of agencies and institutions numbering over 13,500 pages. It has not considered records relating specifically to third parties and any references to other members of Q's family have been taken from information contained in Q's files.

The Panel conducted 30 interviews with individuals involved with Q's care and treatment over the years. Visits have also been made to key sites and establishments involved with Q's long history, which included two meetings with her, when on both occasions she was accompanied by her solicitor and when the panel also had the opportunity of speaking to clinical staff currently involved in her care.

The primary objectives of this Inquiry are to identify any difficulties within any individual agency's practice and procedures, between agencies and organisations, and any resource implications, in order to make recommendations so as to decrease the likelihood of offences such as Q's happening again.

Upon completion of the Panel's main remit, it will reconvene six months after publication of the Inquiry report and again after twelve months so that, in the public interest, progress made in implementing its recommendations can be clearly demonstrated.

4. EXECUTIVE SUMMARY

4.1 INTRODUCTION

In 2000 Q was arrested and subsequently charged with the murder of S. She was convicted of manslaughter, on the grounds of diminished responsibility, and sentenced to life imprisonment. She was made the subject of Section 45a of the Mental Health Act 1983.

Q had a long history of contact with a variety of statutory agencies prior to this incident.

The Inquiry report concentrates on the role of statutory agencies and their collaboration during Q's life. The Inquiry has been conducted under the auspices of the Department of Health Guidance HSG(94)27 - which recommends that in cases of a homicide committed by individuals in receipt of mental health services, an independent mental health inquiry should be set up.

Much of the Inquiry's consideration has properly been about Q's engagement with children and young people's services, and the recommendations also include issues relevant to the Area Child Protection Committee and practice in relation to children Looked After by the Local Authority.

4.2. CHRONOLOGY

For ease of reading the chronology of significant events in Q's life is divided into relevant time periods, starting before Q was born.

Period 1 1977 – March 1981 prior to Q's birth

Q's mother had had a troubled childhood and exhibited very demanding patterns of behaviour, which resulted in her being taken into the care of the local authority at the age of 12.

Period 2 March 1981 – May 1990 Q aged 0 to 9

Throughout the 1980's there is a catalogue of injury and incidents experienced by Q and her siblings, that appears not to have been brought together, investigated or acted upon coherently. In retrospect, all of this information presented a situation demanding intervention, notwithstanding the attitude and avoidance of engagement by the parents.

Period 3 May 1990 – December 1991 Q aged 9 to 10

Q refused to go home after school in May 1990 when she was 9 years old. For a child to take such a step and to maintain it for several months takes an enormous effort and reflects the great anxiety and fear she felt for herself and her younger sister, D4.

While in care away from the family home Q spoke to professionals, acted with disturbed behaviour in the foster homes and broadly maintained her account of abuse and threats, the substance of which accorded with the known history of events in the household.

During Q's period in the care of the local authority new children's legislation, namely the Children Act 1989, was introduced into practice from October 1991.

In the weeks before she went home for a trial period in September 1990 there was considerable disagreement and discussion in the agencies about the best course of action for Q. The Guardian Ad Litem, possibly in line with his reading of the new legislation, took the view that Q should return home, recommending to the Court that the Care Order be revoked.

The Court's decision was to revoke the Care Order. This was probably the most damaging decision taken during her history of engagement with statutory authorities. In Q's view, and probably that of her sisters, it is likely that this failure to listen to and safeguard them determined their view of their parents' power and invulnerability, and, especially for Q, of the inadequacy of the authority figures to listen to what she was saying and to act in her best interests.

Period 4 December 1991 to July 1994 Q aged 10 to 13

On 3 June 1992 the Supervision Order lapsed and in July 1992, the case conference noted that the social worker found it hard to arrange times to meet with the family and when she visited, after the supervision order had ended, she was refused access to Q. The decision of the meeting was to remove Q's name from the Child Protection Register.

It should be noted that even before the Supervision Order had expired in June 1992, the parents had ceased their co-operation with social services. The decision in July 1992 to remove Q from the Child Protection Register was surprising, given her attendance at the Accident and Emergency department the previous week and the extreme difficulty faced in working with this family.

Throughout these years there are reports for both children that show a continuing pattern of abuse within the household that the authorities were unable to penetrate and from which they were therefore unable to protect these girls.

Period 5 July 1994 to January 1995 Q aged 13

This period marks the beginning of Q's demanding behaviour and management activities that continued in various forms over the next few years.

Statutory procedures were followed and appropriate assessments sought, placements with foster carers assessed, and preparation made to cope with Q's behaviour, which was all thought to be in Q's best interests. However, in November 1994 it could be argued that a residential therapeutic setting should have been more actively pursued in line with the assessments of need and the clear breakdown in the foster placements.

Period 6 January 1995 to March 1996 Q aged 14

Q was now offending on a regular basis. She had become dangerous and violent. She could be very threatening and could seriously frighten staff, which increased the anxiety in, and risk for, those responsible for her care. This was compounded by the serious risk of self-harm that Q posed.

The emphasis remained on finding stabilising and tolerant therapeutic accommodation that would enable her to develop self-esteem in a safe setting. However by this time it was too late as she was too old for most therapeutic settings to accommodate her.

Period 7 March 1996 to March 1997 Q aged 15

During this year Q's behaviour became more demanding and there was a feeling that the agencies had run out of options. There does not appear to have been a coherent, continuing, shared interagency care plan, but rather a series of reactions to crises or to legal requirements, such as Q leaving secure accommodation.

There was considerable assessment activity with insufficient indication of effective follow-through, even granted the serious difficulties presented in this case.

The placement of Q at home after she went home for Christmas in December 1996 appears to have been a pragmatic move as no other care could be provided for her, reflecting the paucity of suitable settings nationally. This view is reinforced by her subsequent placement in supported lodging and then bed & breakfast accommodation before her 16th birthday.

Period 8 March 1997 to March 1998 Q aged 16

During this year Q was in a succession of supported accommodation and B&B settings. She worked occasionally as a chambermaid. She engaged in drug and solvent use, had overdosed and her offending behaviour was increasing.

This level of unsupported accommodation for a girl known to be self-harming and potentially dangerous to others was ill-advised, even given the immense placement and management difficulties presented to the social and health care agencies.

She was not mentally ill, and therefore could not be "treated" by mental health services. She was the wrong age for some of the communities, and she undermined some of the placements that were available to her in spectacular ways.

Period 9 March 1998 to March 1999 Q aged 17

In June, Q stabbed an adult male, S, in the arm. She appeared before magistrates and was then remanded to Holloway Prison, charged with Grievous Bodily Harm, (GBH) and possession of an offensive weapon.

This year was marked by Q's increasingly dangerous behaviour, both to herself and to others. She underwent further assessments in connection with the offence of GBH and remanded to prison, with a potential care path identified through a possible placement at the Cassell Hospital, a NHS mental health hospital. However the Cassell was not prepared to accept her immediately, following their assessment. There was no clear alternative care plan for her.

The Pre-Sentence Report had linked the offence to alcohol and substance misuse, referring only to "turbulent family relationships" and not to the substantial abuse the Inquiry panel consider she had experienced in her family.

Within two months of the order being made, Q attacked her sister and threatened to poison her mother. Social Services referred her to an adult psychiatrist, who began to work with her and, on learning of Q's thoughts about causing harm to children, considered that she needed forensic psychiatric intervention.

East Sussex, along with other areas, did not have in place a Dangerous Persons Panel or similar interagency forum in 1998 to which Q could have been referred, and which would have enabled an agreed risk assessment to have been prepared. Such interagency forums are now in place, (since 2001), which would now automatically consider cases such as Q's. The absence of such a forum, or its equivalent, made tracking Q's activities harder

Period 10 March 1999 to March 2000 Q aged 18

At the beginning of May Q assaulted a woman neighbour and was subsequently charged with Actual Bodily Harm. She was remanded in custody in mid-May for breaching bail conditions and in early June she was sentenced to 9 months imprisonment at Bullwood Hall, a Young Offenders Institution.

Q was released from prison under Licence at the beginning of October and although a National Children's Home worker became aware during October that Q was again seeing S, this was not passed on to the probation officer or social services.

This year saw a repeat of Q's previous behaviour pattern. However the differences are that the risk posed was escalating as her propensity to violence increased and, notwithstanding the number of professionals and agencies involved, the level of monitoring and contact decreased.

To some degree she was 'lost' to the local services while in Bullwood Hall, especially as she was expected to go to London on her release.

It is as if, at each phase the agencies knew the background but there was no significant progress in how they would work with Q, the strategies they would use, the objectives of their engagement with her or the main resources they would seek to obtain to contain her behaviour.

The difficulties that she and her family presented were not underestimated and there is no doubt that this was a very challenging case, and also that professionals involved with her showed commendable tenacity and tolerance in their work. However at each phase it felt as if the professionals were chasing the game which was played at Q's pace.

Similarly, her transition out of care to adulthood and the transfer of responsibility from Social Services to the Probation Service was not managed well. Notwithstanding the efforts of the individual workers, this process lacked coherence and strategic intent.

4.3 RECOMMENDATIONS

This report has considered issues, circumstances and evidence spanning over 20 years. Therefore some of the areas of concern have already been inevitability addressed by changes in legislation and practice, and others through the implementation of recommendations made from the Internal Review.

Recommendation 1

The East Sussex Area Child Protection Committee (ACPC), and the Social Services Children and Families Division are recommended to review their working practice, training, support and supervision for staff in respect of the following areas of concern:

a) Inclusion of parents/carers in child protection and statutory care planning meetings.

The presumption of partnership and inclusion of parents in such meetings is properly at the heart of childcare practice in line with the spirit and guidance in the 1989 Children Act. However, when there are circumstances that cause professionals to question the benefits and non-benefits of parental involvement for the child whose welfare is the primary focus, it can be difficult and contrary to normal good practice to enforce an exclusion of the parent(s), it may, nonetheless, be the right action to take.

The ACPC Procedures identify this issue; they should ensure that this is incorporated, and reviewed in the interagency training programme. Similarly, the Social Services Department should ensure such training for staff working with children in the care of the local authority, where the occasional exclusion of the child's parent will require sensitive handling.

b) Working with difficult and noncompliant parents/carers.

The ACPC and Children and Families division must ensure that front line staff have training specifically geared to work with such people and deal with the implications of this in their decision-making. The Report of Newham ACPC into the death of Ainlee Labonte/Walker (December 2002) sets out detailed recommendations for working with dangerous families, which the local ACPC is urged to consider in formulating its training and in reviewing interagency procedures.

c) Working with carers where induced/fabricated illness of children is suspected.

The ACPC Procedures provide information and guidance reinforcing the requirement for strong interagency understanding, information gathering and planning. Effective training and the availability of expert advice is necessary to enable front line practitioners across the agencies to work

effectively in this complex area. The Social Services Department has to ensure that the expertise and guidance contained in the ACPC procedures is properly applied in cases where they are reviewing work with children in their care, both those who are Accommodated and Looked After.

d) Ensuring comprehensive and accurate record-keeping within A & E departments.

To ensure that as part of the assessment of children presenting with unexplained medical symptoms, unexplained child deaths or injuries, there is effective cross referencing of those names with other children on the Child Protection Register to ascertain whether there are siblings in the household who may also be victims of suspected abuse.

e) That where a child is presented in A&E the names of all siblings and other children who live in the household are recorded.

f) If a child is discovered injured in any inpatient hospital setting or residential placement it must be treated as an Untoward Incident and fully investigated by people not directly involved in the child's care.

g) Reference is made to the local Multi-agency Public Protection Scheme under their local arrangements.

Since June 1998 these procedures should have been effectively embedded in local services with greater clarity about the criteria for consideration and smoother process for accessing this forum. However, the ACPC and Sussex Public Protection Steering Group should review their working protocol to ensure there is effective understanding and implementation of referral mechanisms and any follow up actions.

Recommendation 2

The local authority should be more proactive in developing specific services under the umbrella of the Lansdowne Unit (or any equivalent centre,) working with its partners in the health and education services to disperse the costs associated with such provision. Such a development might also link with more specialist fostering resources where foster carers are prepared and supported to care for abused children and young people.

Recommendation 3

Young people should not be placed by Statutory Authorities to live in independent settings before the age of 16 and even when over 16 (up to the age of 18) only with an individually tailored care package.

Recommendation 4

That the Social Services Department ensures that all court reports are up to date and that a record of the judgement of the Court is maintained within the case files as a matter of course.

Recommendation 5

That the Children and Family Court Advisory Support Service (CAFCASS) is encouraged and enabled to: -

a) arrest the decline in the number of Children's Guardians;

b) encourage suitably experienced people to continue in and take on this work;

c) ensure that adequate funding is authorised for particularly complex cases;

d) achieve effective monitoring, support and audit arrangements with independent contractors to ensure that these Guardians are supported and that their work is monitored and of good quality;

e) resolve the classification of the status of independent contractors with the Inland Revenue in order that their work is better supported and monitored.

Recommendation 6

The panel recommends that all those involved in the Statutory provision of Child and Adolescent Mental Health (CAMH) services consider whether section 31 of the Health Act 1999 would help improve the services they offer, or whether some other form of

formalised integration would be beneficial. Such integration should include Education as a core component of a CAMH service.

Recommendation 7

This recommendation covers a number of single points within the management and administration of mental health services that require change. To ensure effective implementation all the Statutory Agencies will need to work together, however in circumstances such as these, the lead is clearly with the NHS Trust.

a) The details of all people detained within a Police Station under Section 136 of the 1983 Mental Health Act, who are seen in the Police Station and are assessed as not subject to further detention or voluntary admission must be communicated to the Mental Health Services to ensure that if they are or have been patients of such services, the event is duly recorded within their notes and the information is available to those who do, or may, provide care to them.

b) There must be a protocol developed that clearly demonstrates how a child within the CAMH services makes the transition from being in receipt of care to full discharge or to Adult Services. This protocol should be multi-agency and show at each stage which service is responsible.

c) All professionals working with people with mental health problems should be fully trained in Risk Assessment techniques and receive regular updates.

d) Organisations must undertake random audits to ensure that Risk Assessment protocols and procedures are being adhered to.

e) All individuals admitted to a general hospital following an attempt to take their own life must have a Psychiatric assessment.

f) There should be clear minimum qualifications for Locum Psychiatrists established through the Trust's Clinical Governance Procedures.

g) Locum Consultant Psychiatrists must receive a comprehensive induction to ensure that they fully understand all the operational protocols required to enable them to assess and treat patients. This should include details of how referrals to other services should be made.

h) There must be a clear understanding across organisations of what constitutes an Untoward Incident and what the response is to such an Incident. The organisations involved must hold multi-agency reviews of all internal and external inquiry reports within 6 weeks of the publication of the report. The review must include a systematic appraisal of all of the recommendations and identify a timescale for completion and a lead agency responsible for ensuring delivery. This must be recorded and continue to be monitored by the Commissioners of the services involved at twice yearly reviews until such time as all of the recommendations have been implemented.

Recommendation 8

When any defendant, having been identified by Multi-agency Public Protection Panels (MAPPP) as potentially dangerous, appears before the courts on any charge, then a system should be in place which ensures: -

a) that the Court Assessment and Diversion Scheme is alerted to ensure an initial assessment is made with the assumption that a full forensic psychiatric report will be prepared in most cases.

b) that the Court Assessment and Diversion Scheme liaise with probation report writers, and where appropriate Courts, to seek full forensic psychiatric reports.

c) that the report writer has access to all the information held by MAPPP on the defendant and refers to this in the report.

d) that there should be liaison through the local MAPPP, with the Prison Service, to ensure that all information held by the MAPPP is available to inform any rehabilitation/treatment programme and the release plans made to manage the offender in the community.

Recommendation 9

There is outstanding work from the Internal Review and the panel considers that the organisations involved in the internal review should complete the implementation of the following: ***(numbering corresponds to numbering within Internal Review Report dated December 2000.)***

a) 9.2. It is imperative that all Information Sharing Protocols include the processes to be followed when sharing information about a child. Information Protocols should be "age seamless".

b) 9.3. and 9.13. The Care Programme Approach (CPA) Policy should clearly identify the CPA responsibilities and arrangements for all 16 – 18 year olds regardless of whether they are under the care of CAMH or Adult services. It should also determine the mechanism and procedures to be followed when transferring the care responsibilities from CAMH to Adult services.

c) 9.4 and 9.5. The Forensic Access criteria that have been established should be reviewed to include the following: -

- ***Response times for acknowledgement of referral, referral to assessment, assessment to feedback to referrer.***
- ***The criteria that will determine when an individual is ready for transfer to Adult services.***
- ***Written protocols for how joint work between Forensic and Adult services will be co-ordinated.***

d) 9.6. The National Service Framework for Working Age Adults clearly identifies the introduction of electronic CPA as a target that should have been achieved in 2002. It should be multi-agency and easily accessible. It is imperative that this is progressed within all services and that the format includes a system of "flagging" high risk individuals to all agencies.

e) 9.7. Probation Services should be involved in the Forensic/Adult Mental Health Liaison Forums.

f) 9.8. Multi- agency training should continue on a regular basis.

g) ***9.9. It would be helpful if the Forensic Access Criteria document included "role outlines" of all staff involved within the service as an aid to referrers.***

h) ***9.14. Joint training for CPA including Risk Assessment and Management must be introduced.***

The Inquiry Panel commends these recommendations to the Commissioning Agency and trusts that the necessary actions will be taken forward and acted upon.

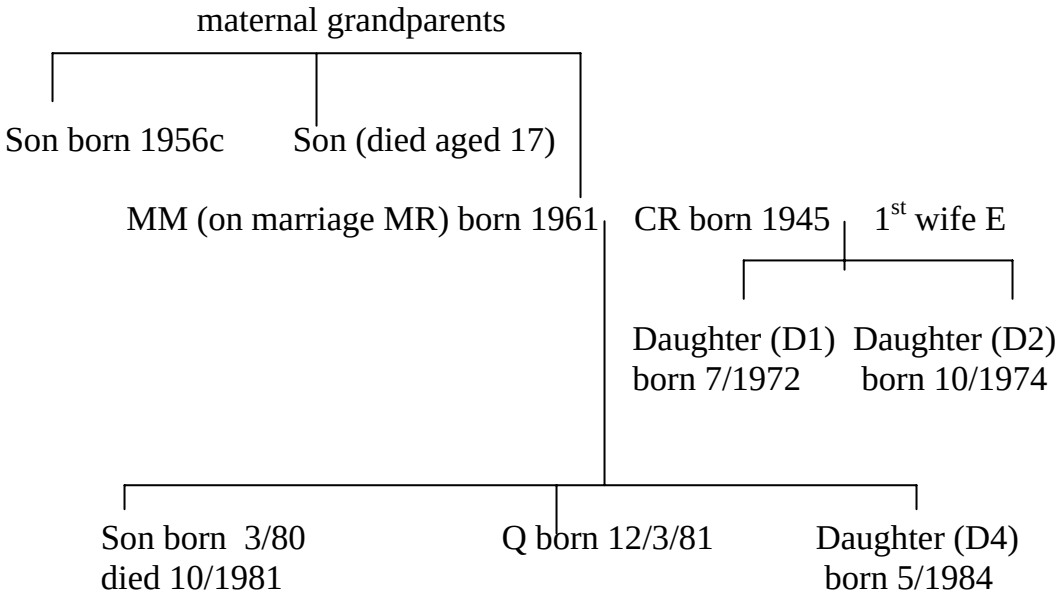
5. CHRONOLOGY AND COMMENTARY

5.1 Introduction

The chronology of significant events in Q's life is divided into relevant time periods. Each period is followed by a commentary setting out the main considerations and issues raised in relation to this period in her life and the actions of the agencies involved in her care at that time.

A child develops in its family setting. The family's behaviour, attitudes and dynamics are fundamental to the development of their personality, self-esteem and engagement within society. To provide a context to Q's early years, the panel is of the view that the chronology has to commence prior to her birth and therefore the initial period starts in 1977, when her biological mother moved in with her biological father.

Set out below is the family tree of the immediate family group:



5.2 Chronology Period 1 1977 – March 1981

1. *After spending her adolescent years in the care of the local authority from the age of 12, MM moved in with CR and his then wife E in 1977 when she was 17. CR's wife moved out of the household in March 1977, with her daughters D1 and D2 remaining in their father's care.*

2. *The following year, in 1978, she and CR were married; at that time CR was 33 with two young daughters D1 aged 5 and D2 aged 3.*

3. *In 1978 D1 experienced a convulsion and was admitted to hospital for tests. No previous health concerns had been recorded. D1 had an abnormal EEG and was started on anti convulsants.*

4. *In 1979 D2 is reported to have had a seizure and was admitted to hospital for tests. No previous health concerns had been recorded.*

5. *During 1978, 1979 and 1980 there are various reports in the case file of bruising to both girls and anxiety about their emotional well-being. The NSPCC visited the house on at least two occasions. Both D1 and D2 were placed on the Non-Accidental Injury Register by the social services department in December 1979.*

6. *CR and MR's first child, a son, was born prematurely in March 1980.*

7. *From March 1980 through to July 1982 there was specific concern about the treatment and care of D2 with references to her neglect and injuries; various professional staff involved at this time described her as "anxious", "miserable", "terrified". She was removed from the NAI Register in July 1982.*

8. *In August 1980 the son was admitted to hospital and described as pale and cyanosed.*

9. *CR and MR's second child, Q, was born on 12 March 1981, 4 weeks prematurely. There were some concerns resulting in her remaining in hospital for 11 days after her birth.*

5.2.1 Commentary

MR had had a troubled childhood; she exhibited very demanding patterns of behaviour, so that her mother was unable to care for her and enlisted the help of Social Services. MR was taken into the care of the local authority at the age of 12. At one stage she was placed in an in-patient adolescent psychiatric unit. She met her future husband when he was virtually twice her age and assumed a caring role as step-mother as a 17 year old while still herself in the care of the local authority.

Prior to MR moving into the R family group, there is no evidence that either of CR's daughters had suffered childhood convulsions or unexplained injuries.

A pattern of injury, harshness and vulnerability to apnoeic episodes within the family group is apparent from this retrospective examination of available information. Although the agencies had their concerns, formally recognised by placing the girls on the Non Accidental Injury (NAI) Register, it is not evident that the children's paediatric and social histories were coordinated and taken into consideration. Monitoring rather than any remedial intervention appears to have been undertaken.

5.3 Chronology Period 2 March 1981 – May 1990 Q aged 0 to 9

1. *On 18 May Q was admitted to hospital for the first time with an episode of "pallor and cyanosis", she was discharged a few days later, subsequently readmitted later in May and discharged again at the beginning of June.*

2. *The son, after a previous admission to hospital in October 1981 when (as reported in Q's medical notes) he was limp and cyanosed, was again admitted to hospital on 20 October 1981 in cardiac and respiratory arrest. Q's medical notes state that he died on the 21 October aged 19 months.*

3. *In November 1981 Q was admitted to hospital for investigation of apnoeic episodes. While in hospital she suffered an unexplained fracture to her right arm, brought to the attention of ward staff by MR, but this fracture was never explained.*

4. *A case conference was held in December 1981 focusing on the circumstances and cause of Q's several cyanotic episodes. The conclusion of this discussion appears to have been that child abuse was not suspected. It also appears that there was concern from the social services that they were not kept adequately informed by other agencies about those agencies' involvement with the family.*

5. *In November 1981 and throughout 1982, Q had several hospital admissions, because of her apnoeic episodes, which were intensively physically investigated, but no cause was found. The consultant paediatrician stated that in his view "we do not fully understand the nature of children with this problem, but certainly there is nothing we have found to suggest any form of child abuse". At one point a middle ear infection was identified and ENT opinion sought in regard to the apnoea but no ENT cause was identified.*

6. *In February 1982 D2 presented at school with a cut to her head, said to have been caused, (in Q's notes), when she tripped and cut her head on the banisters at home, requiring six stitches.*

7. *In July 1982 D2 was removed from NAI Register.*

8. *In September 1982 Q had an unexplained fracture of her right humerus, (upper elbow), while at home, said to have been caused when she fell out of her cot.*

9. *In March 1983 Q was admitted to hospital with a burn to her hand, said to be the result of touching a hot oven. Also that month an anonymous call was made to social services alleging that Q had been hit on the head, although the record is unspecific on who might have hit her.*

10. *In April 1983 Q had two hospital admissions for an apnoeic episode and febrile convulsions; no other admissions were recorded during 1983.*

11. *In March 1984 Q was discharged from the paediatrician's care as the apnoeic episodes had ceased.*

12. 5 May 1984 D4 born.

13. In October 1984 concerns were expressed to social services by extended family about ill treatment of the children and punishment administered by both parents.

14. In November 1984, according to Q's notes, there was specific concern about D4 and her failure to thrive. The family were not accepting home visits so she was seen at clinic, there was concern about injury to D4's arm, although no fracture was found on x-ray. The hospital opinion was that it may have been wrenched.

15. November/December 1984, when a social worker visits the home, CR confirms that he has a scale of physical punishment he administers to children.

16. From 1985 to 1988 there was no direct social services involvement as family were unprepared to accept social work involvement.

17. In March 1987 reports received from school concerning D2 and alleged abuse by MR that she was too frightened to report for fear of reprisal. Attempts to engage family by Education Welfare Officer and clinical psychologist previously involved in 1980 fail.

18. In July 1987 D4 presented at hospital with injuries to face and neck, reported (in Q's notes) to be caused by falling off her bike.

19. In February 1988 D1 received into care aged 15 after leaving home because of the treatment she experienced there. She spent time with foster carers before being returned home again.

20. In March 1988, Q was admitted to hospital with an injured right leg; a couple of days later there was anonymous contact with social services expressing concern for these children.

21. In April 1988 MR contacted social services about an injury to D4, because she said that the hospital would do so in any case, with an apparently inconsistent explanation of how the injury had occurred.

22. In January 1989 a case discussion was held at the request of school nurse, but no action taken as a result.

23. *In August 1989 Q and D4 appeared at local police station having run away together for the fourth time in previous few weeks. Reported that they had been punched, suffocated and otherwise injured. A few days later there was a referral from GP concerning injury to Q's stomach caused by a punch. Social services were reported as monitoring the family.*

24. *In November 1989, D2 leaves family home to live with her maternal grandmother and expresses concern to school about possible risk to D4 and Q.*

5.3.1 Commentary

Throughout the 1980s there is a catalogue of injury and incident that appears not to have been brought together, investigated or acted upon coherently. In retrospect, all this information presented a situation demanding intervention notwithstanding the attitude and avoidance of engagement by the parents. This information was available at the time.

There appears to have been little connection between the series of hospital admissions of each of the R children. Aggregated, this is a worrying picture of medical problems within a family. Articles in the medical press at this time were calling attention to the possibility of such problems being induced within a family that might merit further investigation[1], although there were also concerns that abuse was being over diagnosed[2].

Information relating to MR's background in care was available and does not appear to have featured in the analysis of what was happening within the family.

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[1] Meadow, R. (1977) Munchausen by proxy. *Lancet,* 2, 343.
Verity, C. M., Winckworth, C., Burman, D., Stevens, D. & White, R. J. (1979) Polle syndrome: children of Munchausen. *British Medial Journal,* 18 August 1979**,** 422-423.
Roberts, J., Lynch, M. A. & Golding, J. (1980) Postnatal mortality in children from abusing families. *British Medical Journal,* 12 July 1980, 102-104.
Minford, A. M. B. (1981) Child Abuse presenting as apparent "near-miss" sudden infant death syndrome. *British Medical Journal,* 282, 521.
[2] Editorial (1981) Child abuse: the swing of the pendulum. *British Medical Journal,* 283**,** 170.

Case conference information was available dating from 1978 and 1979 about bruising to the older girls. Both were placed on the NAI Register in 1979. Similar concerns were recorded in 1980, 1981 and 1984 in relation to D2 and D1.

There does not appear to have been a thorough investigation into how Q's humerus was fractured while she was in hospital, nor again when she sustained a fracture of her right humerus at home in September 1982.

There were no active outcomes from the engagement with this family as a result of the worrying history of illnesses of the children and physical abuse reported.

There is ample indication in Q's files that both her mother and her father physically abused both her and the other children and this was considered by the relevant agencies at the time. Additionally there is information available that suggests that in part at least, Q's illnesses may have been induced which led to her being extensively and unnecessarily investigated and treated.

Although there was engagement by social services as D1 and D2 left home, investigations appear not to have been pursued despite expressed concerns, the history and the known vulnerability of the two youngest girls still living with the parents.

The absence of planned and sustained intervention during the 1980s by the authorities stands out as a stark omission.

5.4 Chronology Period 3 May 1990 – December 1991 Q aged 9 to 10

1. *In May 1990 Q refuses to go home after school and stays at a friend's home. Child protection procedures were instigated with a Place of Safety Order made, social worker allocated, interim care order made, and Guardian Ad Litem appointed. Both Q and D4 were placed on the Child Protection Register under the categories of physical and emotional abuse.*

2. *In June 1990, Q was placed with foster carers, an assessment process of Q and family begun by clinical psychologist, and a referral made to*

Maywood Family Centre. Case review conference monitoring access visits with MR described as "cold" towards Q, with CR largely absent during access. For Q the main stated reason for access, which she did not enjoy, was to remain close to D4 because of her concern for her safety in the home.

3. *In September 1990, Q remained with foster carers through the summer, but some tensions arose with Q and children in the family and because of theft from the family. She was moved to a new foster family at the end of September.*

    * *A Maywood Family Centre referral was not taken up by Mr and Mrs R.*

    * *A Case review conference at the end of September decided that it was in Q's interests to exclude MR from the meeting, where it was decided to seek continuation of the Care Order at the forthcoming Court Hearing, continue with supervised access and re-referral to Maywood.*

    * *Court decided to grant a Full Care Order to the local authority in line with the reports of the social worker, Guardian Ad Litem and clinical psychologist.*

4. *In October 1990, Access (Contact from October 91[3]) continued, which was reportedly upsetting for Q and difficult to supervise, including an allegation that CR shook her by the neck on one visit. Q started at a new school; Maywood referral progressed with Mr and Mrs R.*

5. *The social worker commissions engagement of an independent therapist to work 1:1 with Q for six sessions from October to January 1991.*

6. *During November 1990 to January 1991, Access (Contact from October 91) continued with difficulties and some disruption.*

[3] With the introduction of the Children Act 1989 and the Children Act Guidance from October 1991 the concept of Access, enabling parental access to a child, changed to Contact which promoted the right of the child to have contact with their parent. This represented an important shift towards promoting through this legislation the child's rights.

7. *Meanwhile during 1990 S (later killed by Q in March 2000) married and had the first of his two children. He separated from his wife in 1992.*

8. *In February 1991, Mr and Mrs R give notice that they would apply to the court for revocation of the Care Order on Q. The Court Hearing in June was adjourned with the full hearing (subsequently scheduled for September) eventually taking place in December 1991.*

9. *From February to September 1991, assessments continued at Maywood and with clinical psychologist; Q moved to a new foster placement in March; unsupervised access initiated in late April. Abundant correspondence was exchanged between the social worker, Mr and Mrs R and their solicitor concerning expectations in respect of Q's contact and their working relationship with involved professionals.*

10. *A Case review in July noted changes in the recent period and progress made towards a home trial.*

11. *In September 1991, Q returned home on a trial basis with an agreed undertaking for CR and MR to continue working with the Maywood Family Centre and, as appropriate, to involve Q and D4 in this work. It was also arranged for Q to continue to see the psychologist or other suitable person involved in assessment work.*

12. *From October 1991 the new 1989 Children Act was being applied in social services departments. A major feature of the act being interpreted and introduced at this time was for local authorities to be less interventionist with the onus on children remaining with, or returning to, their birth families. Also introduced with this new legislation was the concept of Contact as a right of the child.*

13. *In October 1991, a Case Conference acknowledged that Q's return home appeared to be working out. Although there was "cautious optimism" the decision of the meeting was to maintain Q and D4 on the Child Protection Register.*

14. *At the Court Hearing in December 1991 the court revoked the Care Order and substituted in its place a Supervision Order of 6 months duration. The main reports considered by the court were a social enquiry report by the social worker, a report from the Maywood Family*

Centre, the social service's commissioned assessment by the clinical psychologist, and that of the Guardian Ad Litem.

* *Of these, the reports and evidence presented in the Inquiry suggests that, with the exception of the Guardian Ad Litem, they were equivocal or opposed to the court lifting the Care Order. The clinical psychologist was clear and unequivocal in her warning of the danger Q faced if the Care Order were to be revoked.*

* *The social worker's Social Enquiry Report, Family Centre and clinical psychologist's reports are all dated as for a court hearing prior to December. Only the Guardian Ad Litem's report was written immediately prior to the actual court hearing date in early December 1991*

* *The court revoked the Full Care Order and substituted in its place a 6-month supervision order with no conditions attached.*

5.4.1 Commentary

At the time Q refused to go home after school in May 1990 she was 9 years old. For a child to take such a step and to maintain it for several months takes an enormous effort and reflects the great anxiety and fear she felt for herself and her younger sister, D4.

The professional staff involved were aware of the family history, and recorded the difficulty they had in engaging both mother and father, who were regarded as unlikely to change their style of parenting or become more co-operative. Indeed CR made it clear that his style of discipline and punishment, which appears to have been applied within what he regarded as a rational framework, relating his scale of punishments as to what he regarded as bad behaviour, was not going to change.

While in care away from the family home Q spoke to professionals, acted out with disturbed behaviour in the foster homes and broadly maintained her story of abuse and threats, the substance of which accorded with the known history of events in the household.

It is worth noting that in September 1990 the Chair of the Case Review Conference decided to exclude the mother from the meeting presumably to

promote fuller discussion among professionals. At this time such exclusions were common, and often might have been detrimental to the case discussion gaining a full view and promoting partnership working. Later, in line with the spirit of the Children Act into the 1990s and in contemporary practice the norm was to include parents (and children) as will be evident later in this chronicle of work with Q. While there are usually good reasons for inclusion, there will always be justified exceptions; it is probable that not applying such exceptions later during Q's involvement in the care system proved unhelpful.

During Q's period in the care of the local authority, new children's legislation, with the advent of the Children Act 1989, was introduced into practice from October 1991. This laid considerable emphasis on partnership with parents and although the welfare of the child was crucial to the actions to be taken in children's work there was, nationally, a period when childcare specialists and the courts were less certain about the best course of action to maintain the welfare and safety of the child while at the same time promoting closer work with the child's birth family. Implementing this new legislation may have led professionals then to prioritise such partnership over the welfare of the child, although the welfare of the child is at the core of the Children Act.

It is understood from evidence given to this Inquiry that, in the weeks before she went home for a trial period in September, there was considerable disagreement and discussion behind the scenes about the best course of action for Q. The Guardian Ad Litem (GAL), possibly in line with his reading of the new legislation took the view that Q should return home and that the care order be revoked. This position was not agreed with initially and it would appear from comments made to the Panel that there was eventual acquiescence to the view of the Guardian Ad Litem by the social services department, notwithstanding that this is not reflected in the written reports prepared for court some time in advance of the hearing.

The recorded view of the social worker is measured, expressing concern about the degree of effective protection that could be offered Q, and who she might feel it safe to turn to if events went wrong if the care order were to be revoked returning her to the care of her parents with a Supervision Order only in its place.

Similarly, the clinical psychologist's report to the court dated September 1991 was definite about the risks to Q in revoking the Care Order. Her considered view was that further work with the family was a prerequisite to

her returning to the care of her parents, that Q would find it hard to tell anyone of any distress she might experience in the future, and that because of the dangerousness Q would face, revocation was not an option in this case.

The Guardian Ad Litem notes the disagreement between his view and that of the clinical psychologist on the family and its strengths and weaknesses. It is the view of the Panel that the Guardian Ad Litem's view of the parents and his appreciation of the family's previous history was overly optimistic, although it has to be recognised that these matters may be clearer with hindsight. Properly, the GAL in making a report to the court conveyed his recommendation, it was for the Court to reach a decision. We are referring to a time when the working of the then new Children Act 1989 was in its infancy and the intention and application of the Act was being developed. Notwithstanding this additional complexity, in the view of the Panel this report had little evidence base, poor structure with limited narrative and little apparent understanding of Q and her family.

The Court's decision was to revoke the Care Order. This was probably the most damaging decision taken during her history of engagement with statutory authorities. In Q's view, and probably that of her sisters, it is likely that this failure to listen to and safeguard them determined their view of their parents' power and invulnerability and, specifically for Q, of the inadequacy of the social services, legal system and other authority figures to listen to what she was saying and to act in her best interests. In the view of the Panel, Q as a 10 year old and her sisters were failed by this decision.

5.5 Chronology Period 4 December 1991 to July 1994 Q aged 10 to 13

1. *In January 1992, the social worker involved with Q since May 1990 left the department and a new social worker had been allocated who attended the Child Protection Case Conference in January 1992. It was reported that both appointments at Maywood scheduled since the court decision in December had been missed, and also that there had been no contact with the family since that date. The decision of the meeting was to remove D4's name from the Child Protection Register (CPR) and to maintain Q on the CPR. The next review was scheduled for July 1992*

six months later and some six weeks after the expiry of the Supervision Order.

2. *By February 1992 Family Centre therapeutic sessions petered out as the R family had attended one only since November 1991.*

3. *A&E attendances by Q recorded in March with a finger injury reportedly sustained playing basketball, and in July 1992, with a painful back, reportedly as a result of something falling on her.*

4. *3 June 1992, the Supervision Order lapsed.*

5. *In July 1992, the case conference noted that the social worker had seen Q three times since December, had found it hard to arrange times with MR and CR, also that on 2 June she had been unable to meet them and when she visited, after the supervision order had ended, was refused access.*

    * *the decision of the meeting was to remove Q's name from the Child Protection Register and monitor through the school.*

    * *Effectively this was the end of contact with the case formally closed in September 1992.*

6. *In November 1993 there was an injury to Q's right hand middle finger, reportedly sustained in a PE lesson.*

7. *In January 1993 D4 approached her school teacher to talk about past abuse in the family home.*

8. *In March 1993, D4 was admitted to hospital with various pains to back, neck, side and tummy, but there is no record of cause. During this time she again talks of abuse in the past.*

9. *In March 1993, at a Child Protection Strategy Meeting in regard to D4, it was decided that D4 could return home and that her parents had agreed to work with the CAMHS Child and Adolescent Psychiatrist.*

10. *In June 1993, the family refuses to see social worker to discuss D4.*

11. *In July, August and October 1993 Child Protection Strategy sessions were held in relation to D4.*

12. *In September 1993 MR informed social services that D4 had injured her ankle.*

13. *In November 1993, Q reported to her school that she had been pushed downstairs, and reported to be terrified of her mother. She then withdrew this allegation and was willing to go home. She did so with no further action taken.*

14. *By December 1993, there were similar concerns reported to school by Q. There was a report by her mother that Q was stealing money, also she reported that father had hit Q.*

    * *Q apparently ran away from home to be returned that same night.*

    * *Commencement of shoplifting by Q, who was cautioned.*

15. *In January 1994, various incidents occurred involving Q taking money from home, minor truanting, fire setting. These led to Q being Accommodated briefly by social services with foster carers before being returned home.*

16. *In February 1994, father acknowledged caning Q.*

17. *In July 1994, Q was accommodated at the Lansdowne Open Unit after further allegations against parents, when bruising was visible. Also Q's offending behaviour had been escalating involving shoplifting, taking money from home, and offences against previous foster carers.*

    * *Parents questioned on charges of Actual Bodily Harm, father's punishment book seen; mother denies kicking or slapping Q. Matters not taken forward to prosecution.*

    * *Child Protection Case Conference held with both mother and father present, Q declined to attend, the reason for not attending given was fear of her parents. Both Q and D4 are placed on the Child Protection Register; it was decided to seek an alternative placement for Q other than the children's residential unit.*

5.5.1 Commentary

Even before the Supervision Order had expired in June 1992, the parents had ceased their co-operation with social services. As there were no conditions attached, there was little the department could do short of returning to court, a course of action that would have been difficult to justify and unlikely to succeed at that time in the light of previous reports and recommendations.

The decision in July 1992 to remove Q from the Child Protection Register was surprising given her attendance at A&E the previous week and the difficulty faced in working with this family. Being on the Register did give some (minimal) leverage into the household, which was then lost. Monitoring by the school was a feasible option given the decision, and it is the case that social services departments were, and still are, working to an expectation that the CPR should be an active register where children do not stay on it in a dormant manner.

Throughout these years there are reports for both children that show a continuing pattern of abuse within the household that the authorities were unable to penetrate and therefore were unable to safeguard these girls. Such a situation will have had its effect on the girls developing maturity and their sense of their parents' power. Although the Panel has not seen the file in regard to D4, the references in Q's files indicate that there would have been concern in regard to the treatment D4 received at the hands of her parents.

Emotional abuse produces emotional immaturity as the child is not exposed to the experiences that allow them to make emotional sense of their world. For example, how does a child learn where to go for reassurance if seeking reassurance results in violence or being ignored? The child's inability to obtain reassurance from adult professionals may then be viewed as emotional immaturity. Equally, if a child has no experience of a parent taking responsibility for their own actions and always blaming others for untoward events, they are unlikely to see themselves as responsible for their own actions.

This may explain Q's lack of self blame and her propensity to blame others for her own behaviour and her own absence of remorse. It may also account for her "victim pathology" whereby she saw herself as a victim of the action of others, taking no responsibility for her own actions e.g. by

justifying attacks on others because of their behaviour. In Q's victim world there were many perpetrators but few, if any, saviours.

In the months preceding Q's admission into care in July, there is a pattern of increasing offending behaviour and recklessness. Throughout her life to this point, she had been the recipient of physical and emotional abuse. As a little girl she had told people what was happening both to her and her sisters. The reality of being returned home without external supervision or support probably demonstrated all too vividly that no one was listening and that for her, actions would have to speak louder than words in the future.

5.6 Chronology Period 5 (i) July 1994 to December 1994 Q aged 13

From July to December 1994 there were several key actions:

* *In July the parents were arrested for Actual Bodily Harm to Q, but no changes pursued in regard to this.*

* *Q was placed on an Interim Care Order in September.*

* *A referral for CAMHS psychiatric assessment, which was carried out by the CAMHS consultant psychiatrist.*

* *She was placed with foster carers considered able to cope with Q's demanding behaviour and to offer her a stable placement; in this new setting Q enrolled at a new school, but was quickly suspended after setting fire to a litter bin.*

* *The Guardian Ad Litem commissioned an assessment by a clinical psychologist, (both the same people who had been involved in December 1991), who recommended a therapeutic residential setting.*

* *The CAMHS psychiatrist was also of the view that Q needed a long-term stable setting in a residential therapeutic setting.*

* *In November Q took money from her foster carers, was arrested by police and charged.*

* *A case conference decided to maintain both Q and D4 on CPR, seeking to maintain the current foster placement despite difficulties and known assessment recommendations to seek a residential therapeutic setting. The mother was involved in case discussions; there were also concerns about little progress being made in assessing D4's needs while she remained at home.*

* *The Social Services Team Manager approached the local Health Commissioner seeking funding agreement for referral to Ticehurst Hospital for an independent psychiatric assessment. The aim was to obtain therapeutic input for Q either in a local residential setting or foster placement. There is no record of the outcome of this request.*

* *In late November and December, the foster placement breaks down after a family car was stolen and crashed. Escalation of offending behaviour follows with Q instigating criminal activity with others. Interim care order extended and first use of a Secure Accommodation Order with Q admitted to the secure unit at Lansdowne, an Intensive Treatment Facility (ITF).*

5.6.1 Commentary on period July 1994 to December 1994

This period marks the beginning of behaviour and various management activities that continued in various forms over the next few years.

Statutory procedures were followed with appropriate assessments sought; placement with foster carers who were assessed and prepared to cope with Q's behaviour at that time were thought to be in Q's best interests. However, in November it can be argued that a therapeutic setting should have been more actively pursued in line with the assessments of need and the breakdown in the foster placement.

The tone of the Case Conference notes imply that MR had been fully accepted into a role where she contributed fully to consideration of her daughter's treatment and placement options in a way that appears to disregard the history of manipulation and physical and emotional abuse recorded over the years, and Q's stated fearfulness at attending previous conferences because of her mother's presence.

The spirit of the Children Act to try to work in partnership with natural parents may well have been achieved at the expense of the child in this case, as Q is seen as the problem and commits ever more self (and other) damaging actions. Physical and psychological injuries inflicted on a child are a result of the behaviours of adults responsible for them. They are not symptoms inherent in the child implying the need for long term "treatment". It appears that Q gained benefit from the care and support she received episodically in the secure facility at Lansdowne over the next few years.

5.7 Chronology Period 5 (ii) January 1995 to March 1996 Q 14

1. <u>January to April 1995</u>

* *The year opened with Q appearing in court charged with burglary and taking and driving away a car. She was given a 2 year Supervision Order by the Youth Court.*

* *Interim Care Order extended.*

* *Additional Interim Secure Order put in place.*

* *Q referred for assessment by educational psychologist.*

* *Social worker and psychiatrist working closely to find an appropriate therapeutic setting. Several places approached without success because they did not feel that Q was suitable for their organisation or there were no vacancies.*

* *A Full Care Order was granted in April fully supported by the Guardian Ad Litem. This hearing also made a 12 month Supervision Order on D4 with the direction that she attend appointments with the CAMHS psychiatrist.*

* *Q attended A&E after aerosol inhalation.*

* *Eventually, after a period in Lansdowne Open unit, Q was offered a place at Sedgemoor College in Somerset. Q had responded*

well on an initial visit and she was placed at Sedgemoor. This was not considered an ideal placement, but offered skills and attributes considered likely to benefit Q in the absence of a therapeutic community option.

* *One week after taking up the Sedgemoor College place Q was readmitted to Lansdowne Secure Unit after absconding. She returned to Sedgemoor two days later, at the end of April.*

2. *May to July 1995*

* *During May there was a persistent sequence of absconding from Sedgemoor and criminal behaviour, shoplifting and assault.*

* *Q received an 18 months conditional discharge for common assault.*

* *Both Q and D4 were deregistered from the CPR as the factor causing registration in relation to Q, ie, at home, was no longer in place, and for D4, no worrying issues had emerged.*

* *During May and June there were several episodes of Q absconding, readmission to ITF and returning to Sedgemoor. This period also saw considerate shoplifting activity.*

* *The CAMHS Psychiatrist observed that he "Felt she was perhaps pathologically identifying with her mother and felt trapped in the sense that history was repeating itself in a way that was beyond her control".*

* *Q overdosed in July on paracetamol and was admitted to hospital in Somerset. Following this the psychiatrist who saw her recommended a forensic psychiatric assessment from the Adolescent Forensic Service at the Gardener Unit in Manchester. This was initiated by the CAMHS psychiatrist in Eastbourne.*

* *The Sedgemoor placement was terminated and in mid July Q was readmitted to the Lansdowne ITF with a 3 month Secure Order made permitting her to remain in a secure setting.*

3. <u>September to December 1995</u>

* *The Gardener Unit assessment was made by a consultant adolescent forensic psychiatrist and a specialist occupational therapist. The assessment summary was "that Q presents with a range of offending behaviours and deliberate self harm, unconstrained by self control, insight into her own offending or empathy with others. Unless or until she responds to therapeutic input she remains a risk to self and others".*

  The recommendations included therapeutic work to increase self-esteem and self-image, work on developing empathy and appreciation of the feelings of others and anger management. It was recognised however that Q's motivation was likely to be poor. In considering placement options it was felt that a secure setting with associated open accommodation might offer possibilities, although overall it was felt that Q's prognosis was poor and that "it is highly likely that Q is moving towards a diagnosis as an adult of borderline personality disorder"

  The assessment also noted that "Sedgemoor College is normally as well able as anyone to cope with young people like Q in open conditions, and I would be surprised if there were any other residential school facility which could do better".

* *During October a further Interim Secure Order was obtained pending placement at Old Roar House, Hastings at the end of October. Her time at Old Roar, until early January, was marked by deteriorating behaviour, regular absconding, offending, abusing solvents, threats to staff, and threatening and actual self-harm.*

* *In late November she had various weapons found in her possession and removed from her. She also cut herself and overdosed on one occasion.*

4. <u>January to March 1996</u>

* *Q collapsed and was admitted to hospital as an emergency after sniffing deodorant. From hospital she was returned to Lansdowne ITF.*

* *Three Interim Secure Orders were made in January and February to maintain her in the ITF.*

* *In late February she began a process of introduction to the Cumberlow Community which was terminated in late March because of the disruption Q caused to the resident group.*

5.7.1 Commentary to Q's birthday in March 1996

Q was now offending on a regular basis. She had become dangerous and violent. She could be very threatening and could seriously frighten staff, which increased the anxiety in, and risk for, those responsible for her care. This was compounded by the serious risk of self harm that Q posed.

The emphasis remained on finding stabilising and tolerant therapeutic accommodation that would enable her to develop self-esteem in a safe setting. However, by this time it was too late as she was too old for most therapeutic settings to accommodate her. The opportunity to offer her an appropriate setting had been lost when, as a 10 year old, she was returned to the care of her parents.

This early failing was compounded as her parents, especially her mother, continued to attend planning meetings seeking to determine Q's future options. This would undoubtedly have negatively affected Q's behaviour and her contributions to those meetings and may well have served to undermine attempts at building her self confidence, as the parents were very interested in holding onto a psychiatric diagnosis.

There was extensive use of the Intensive Treatment Facility (ITF) during this year, appropriately recorded and actioned in line with the Children Act. In retrospect, it becomes clear that the ITF offered a setting that gave Q a positive experience and was the best of the options available to date. Lansdowne was an excellent facility for Q, providing care of a very high standard. The drain on staff must have been immense. Such a facility ran by a multidisciplinary team, including psychiatric input, would improve the range of inputs and treatment/management options as well as help the sophistication and support of staff themselves.

The placement at Sedgemoor in 1995 seemed worth supporting by all professionals and Q was initially keen.

In 1995 there appears to be have been good interagency co-operation in assessing and planning to meet Q's needs between social services and CAMHS. The CAMHS consultant psychiatrist was closely involved and, following the Somerset assessment, sought assistance from a national centre of excellence to guide planning. The social services department was comprehensive in considering the options to safeguard Q and the community. Notwithstanding this, it is probable that there was a certain frustration that there was not a "psychiatric" answer to the problems Q presented. The review recommendation of August that the psychiatrist was "to see Q as often as possible" probably reflects professional anxieties about Q and unrealistic expectations of psychiatric input, rather than a realistic appraisal of her needs.

The Gardener Unit report called attention to serious markers that Q's parents were abusive, physically, emotionally and possibly through producing factitious illness in the children. It was recorded that Q had shoplifted tools with the intention of killing her mother and she had written to her mother saying she would do so. At this time there are other references in the files to Q having knives and saying that she would cause harm to others. Q also talked of jumping off Beachy Head as a relative was said to have done. However the context in which these threats were made was considered and Q's known potential dangerousness should have been taken very seriously.

It is unfortunate that no way was found to ensure Q was detained in secure accommodation in October 1995 after the Gardener Unit's stated opinion about her dangerousness. It may be considered that Q and the community were put at risk when the legal criteria for staying in secure accommodation were not met, especially as, while in secure accommodation, Q appeared to "sabotage", consciously or unconsciously, movement to less secure accommodation, when this was the appropriate reward for previous positive behaviour. It is probable that Q herself considered the ITF as her preferred placement, and acted in such a way as to try and remain there as long as she could.

Following the Gardener Unit's assessment, a possible placement at Aycliffe Young People's Centre was considered, but funding for this was refused by the director of social services who instructed that she

should continue to use the department's own secure provision at Lansdowne.

At this time there is evidence that the different parts of the social services and CAMHS worked well together in tackling the immense management and placement problems Q presented. We have learned through the Inquiry just how tight resources were in the CAMHS and that they were operating within an NHS Health Trust where their services were not given priority.

5.8 Chronology Period 5 (iii) March 1996 to March 1997 Q aged 15

1. *March 1996 to July 1996*

* *The original introduction to the Cumberlow Community placement was terminated in late March because of the disruption Q caused to the resident group.*

* *A further Secure Order, her second, (to this date there had also been 6 Interim Secure Orders) was made enabling Q to remain in the ITF until mid-July.*

* *In May there was a paper assessment by an consultant psychiatrist based in a specialist adolescent unit who was unequivocal in his view: "The danger is that Q will attempt to deal with her own terrifying experiences of having her life threatened, by identifying with the aggressor, and herself becoming extremely violent towards others. She is in my opinion therefore, potentially a very dangerous girl. I think that she does need assessment in a secure unit for some time, such as Aycliffe."*

* *The Aycliffe option was not pursued and, in part at least, this decision was made on the grounds of funding, but also because the authority had its own secure unit at Lansdown.*

* *In June, Q made a Court appearance on a charge of affray and common assault against a member of staff at Old Roar.*

* *As the Interim Secure Order expired in July, Q was transferred to the Lansdowne Open Unit. The psychiatrist requested funding for 1:1 psychotherapy, but no response from the Health Authority is evident in the files.*

* *In July, at the child care review, social work responsibility was transferred to a new social worker in the Youth Support Team as she had turned 15. The previous worker had been working with Q since December 1991.*

* *At this time Q was refusing to see a psychiatrist.*

* *Engagement of CAMHS now ceased, without a definite discharge process.*

* *This review meeting decided to move towards Q going into independent living when 16, in the following March, accommodated in supported lodgings.*

2. *<u>August to December 1996</u>*

* *During this half of the year there were hospital admissions for self inflicted injuries, lacerations to the wrist, inhaled antiperspirant and medication. She also attended the Drug and Alcohol service, and was described as using solvent abuse and self harm as a way to resolve her anger.*

* *In December Q returned to the family home for Christmas.*

3. *<u>January to March 1997</u>*

* *The year began with Q remaining at home after Christmas with the support of parents. This arrangement broke down in late February 1997.*

* *In February, Q was placed in supported lodgings. This placement offered the opportunity to develop practical skills such as shopping, cooking and budgeting as well as low-level counselling. This placement broke down after a week or so following the theft by Q of property and jewellery to the value of about £1000 from the lodgings. Q was then arrested.*

* *In February Q telephoned her former social worker at her private home phone and was abusive.*

* *At the beginning of March while still under 16 years of age Q was placed in Bed and Breakfast accommodation, for want of an alternative. This lasted for 3 days and ended following a threatening anonymous telephone call to the landlady. Subsequently, through March and early April, Q was in other B&B accommodation with active social work support.*

5.8.1 Commentary

During this year Q's behaviour became even more demanding and there was the impression that the agencies had run out of options. There does not appear to have been a coherent, continuing, shared interagency care plan, but rather a series of reactions to crises or to legal requirements, such as Q leaving secure accommodation. The result was a continuing search for a placement that "would meet all her needs", which was unrealistic and interfered with the idea of a practical care plan.

There was considerable assessment activity with insufficient indication of effective follow through, even acknowledging the serious difficulties presented in this case. Recurrent assessment does not constitute 'management' and indeed militates against cohesive multi-agency, multidisciplinary management. It reflected only the involved professionals' anxiety and individual feelings of impotence.

Treatment and therapy depend on the establishment of a therapeutic alliance between patient and therapist. It is unreasonable to expect a young person, especially one who has been abused within her family and perceived by other adults to be unresponsive, to establish such an alliance. In its absence, such young people require containment and care with the ever-present opportunity to develop a relationship with a staff member that may lead to the development of a therapeutic alliance.

No therapy for young people is a substitute for protecting them from abuse. The concept of "treatment" or "therapy" for abused children implies they can somehow be repaired; they cannot. If well managed by

all agencies involved, they may be able to live more satisfying lives than if badly managed because of prevarication while "therapy" is awaited.

Considerable energy was expended looking for a "therapeutic" placement for Q when the local facility was excellent and provided more adequate care and containment than any other placement was willing or able to provide.

The evidence produced that a therapeutic community would have been helpful to Q was limited and appears to have been based upon the beliefs of involved professionals and the Guardian Ad Litem. A secure therapeutic community may have been helpful, but there is not a lot of evidence for this. The secure environment and high quality staff at Lansdowne secure unit provided the major therapeutic setting at the time, although the therapeutic value of this placement was probably not recognised.

The placement of Q at home after she returned for Christmas in December 1996 appears to have been a move of desperation, as no other care could be provided for her. This view is reinforced by her subsequent placement in supported lodgings and later bed & breakfast accommodation before her 16th birthday.

CAMHS involvement appears to have decreased after receiving very strong opinions in 1995 from independent psychiatrists about her dangerousness and the potential risks she posed. Although there were no mental health solutions to managing Q, a mental health professional's input would have been very helpful to the staff caring for Q, particularly in supporting direct care staff at the ITF.

The reason and timing of the cessation of CAMHS involvement is unclear, as Q's needs and behaviour had not diminished and her mental health problems were manifested in difficult and dangerous behaviour. It is hard to justify the withdrawal in these circumstances, especially as it appeared to be by default rather than part of a planned withdrawal. Coinciding with the loss of contact with CAMHS, Q's dependable and consistent social worker came off the case. There was therefore a double loss of continuity of people that was regrettable and should not have happened.

The Mental Health Act 1983 was not used as Q was not mentally ill and there was not a treatment option to which it was thought she would

respond. There appears to have been unrealistic expectations of psychiatric services by other agencies, which appear to have led to a confusion of therapeutic and placement needs in the context of very limited options available. The needs and concerns for limiting agencies' expenditures may have taken priority over needs. There is some evidence of this with the decision to not pursue Aycliffe in 1995, and similarly a refusal to fund a placement at Cumberlow Lodge at that time, with the social worker asked to look for a fostering placement instead, when it was already apparent that such a placement had little chance of either being secured or of working effectively for Q.

5.9 Chronology Period 5 (iv) March 1997 to March 1998 Q aged 16

1. *<u>March to August</u>*

* *At her Care Plan Review meeting in March it was determined to progress Q's move into independent living with the local National Children's Homes scheme.*

* *Q was moved into supported lodgings in Eastbourne under the preparation for independence scheme in early April.*

* *In April Q attended the hospital Ear, Nose and Throat department about her hearing impairment.*

* *Also in April, Q's lifelong friend died in a fire; Q was very distressed, and attended the funeral.*

* *At the August Care Plan Review it was noted that Q was reluctant to engage in preparation work, but that the placement was holding.*

* *In May, an A&E attendance for sprained shoulder after falling downstairs is recorded.*

* *In June, Q appeared in court and was ordered to pay compensation for common assault.*

2. <u>September to December 1997</u>

* *In September, the supported lodgings placement breaks down. Q tried to sell a TV set she had taken that belonged in the placement.*

* *Further B&B placement was arranged but Q rarely stayed there and was uncooperative with her social worker and the NCH.*

* *Q attended A&E with injury to her jaw sustained in a fight.*

* *Social worker remained as key worker, but the case transferred to Youth Justice and Support Team.*

* *Q attending further education college on a part time basis.*

* *In December, the day before Christmas Eve, the B&B placement broke down and Q indicated her wish to return to the family home. Contact with parents was re-established and Q went home over the Christmas period.*

* *During 1997 Q met S.*

3. <u>January to March 1998</u>

* *Q remained with her family over Christmas and in early January 1998 she was formally placed with them while remaining in the care of the local authority. An agreement was drawn up about behaviour and conduct within the family home by the social worker.*

* *At the end of January the Care Plan Review agreed to continue the preparation for independence and to support the placement within the family home.*

* *3 days after her 16th birthday Q was hospitalised following an overdose on her mother's prescribed medication and alcohol. She discharged herself from hospital stating that she wanted to die. There is no record of psychiatric involvement at this point.*

* *Q was reporting difficulties at home at this time, an accommodation search was undertaken but she remained at home.*

5.9.1 Commentary

During this year Q was in a succession of supported accommodation and B&B settings. She worked occasionally as a chambermaid. She engaged in drug and solvent use, had overdosed and her offending behaviour was increasing. Her best friend, with whom she had carried out some of this offending behaviour, died in a fire. Q was very distressed by her friend's death. As in the previous year, she ended the calendar year staying in the family home.

She was placed in Bed and Breakfast accommodation before she was 16 years old. Previous assessments and direct experience had pointed to the risks Q posed. This level of unsupported accommodation for a girl known to be self-harming and potentially dangerous to others was ill-advised, even given the immense placement and management difficulties presented to the social and health-care agencies.

The ideal placement was not available. She was not mentally ill, and therefore could not be "treated" by mental health services. She was the wrong age for some of the communities, and she undermined some of the placements that were available to her in spectacular ways.

What Q now needed was to be placed in a long term environment, where she could be safely contained and given the opportunity of having caring adults around her to provide the good adult role modelling which she had missed. This may have enabled her to address and deal with the previous hurt in her life and learn to deal with it in such a way that she could return safely to the community. Her settled periods and progress whilst in the secure unit support this view.

There is no record of a psychiatric assessment while in hospital as a consequence of her overdose, or after she had discharged herself in March 1998.

5.10 Chronology Period 6 March 1998 to March 1999 Q aged 17

1. *<u>March to June 1998</u>*

* *A week after her 16th birthday Q requested the termination of her care order, but this was not actioned after Q decided not to proceed following discussion with her mother.*

* *During April Q reported to the Youth Justice and Support Team on a regular basis, often under the influence of alcohol and solvents, and expressed suicidal thoughts during these sessions.*

* *At end of April Q was detained in Police custody for theft, on the same day that the family placement broke down. Emergency supported lodgings were arranged, but Q did not stay in them.*

* *On 1st May, Q was placed locally with D1 and her brother-in- law, with a social services support package provided. Q expressed suicidal thoughts at this time.*

* *On 4th May Q was admitted to hospital following overdose of tablets, aerosols and alcohol. On discharge she returned to D1 and her brother-in-law.*

* *On 7th May, the Social Service Emergency Duty Team was contacted by Q stating that she couldn't stay because of disturbance with other people living in the house, but in the event the placement held until 19th May*

* *A subsequent B&B placement lasted for almost a month before it broke down, due to her alleged burglary at this address.*

* *In mid June Q was detained at Police Station after she had tried to cash a stolen cheque for £800.*

* *She was bailed the next day, 19th June, on condition she stayed at a specified B&B setting and adhered to a curfew.*

* *On 20th June, Q stabbed an adult male, S, in the arm. She appeared before magistrates and was then remanded to Holloway Prison,*

charged with Grievous Bodily Harm and possession of an offensive weapon.

2. *June to November 1998*

* *On 22nd June, Q was assessed by the psychiatrist from the East Sussex Court Assessment and Diversion Scheme while on remand in police cells, whose view was that there was "no evidence of psychiatric symptoms or any other signs of serious mental illness….she may benefit from long-term therapeutic environment and support". "A further risk assessment was recommended to be carried out whilst she was in prison, and the psychiatrist wrote that he would arrange this. This does not appear to have happened nor to have been followed up. This may not have occurred due to the defence lawyers engaging a psychologist, to prepare a report.*

* *While on remand at Holloway there were episodes of self-harm.*

* *She was assessed by a clinical psychologist engaged by her solicitor, who recommended a period of inpatient treatment at the Cassell Hospital for residential psychotherapy. Subsequently the Cassell began its assessment of Q's suitability for their year- long therapeutic programme.*

* *At the court hearing in early November the judge noted that she had spent four months in custody and she was sentenced to a two year Probation Order in line with the recommendation intended to facilitate the placement at the Cassell.*

3. *November to March 1999*

* *From November to December Q spent time staying at the family home and at an address in London with a friend she had met while on remand in Holloway.*

* *On 27th January Q disclosed to her social worker that she had thought about killing her mother and that she had assaulted her sister D4 causing significant bruising to D4's neck. Q is reported to have said that she might have ended up killing D4 had she not been restrained.*

* *An urgent referral was made for Q to be seen by the local adult psychiatrist who saw her on the 28th January. It is unclear from the notes and information given to the Inquiry who actually made this referral or the background information available to the psychiatrist at that time, who incidentally was in her first week or so in a locum consultant post.*

* *The psychiatrist observed that Q was abusing alcohol and solvents and that "Q is not suffering from a formal mental illness or mental impairment. Given her history of repeated maladaptive patterns of behaviour including self-harm and her forensic history, I think the most probable diagnosis in this case is one of personality disorder with borderline and dissocial traits".*

* *On 29th January a multi agency meeting with health, probation and social services agreed for: -*

    i. *liaison arrangements between agencies*
    ii. *the psychiatrist to offer outpatient appointments, arranged for 12/2, 19/2 and 21/4*
    iii. *the Out of Hours Community Mental Health Team to be alerted to respond to potential out of hours emergencies*
    iv. *social services to continue to monitor and offer support at home*
    v. *relevant medical reports and assessments to be forwarded to psychiatrist*
    vi. *alternative accommodation to be sought, however nothing was found*

* *A discussion was held between the probation officer and manager at which consideration was given to instituting Breach Proceedings, but it was decided that this action was not appropriate.*

* *In early February MR informed social services that Q had left home to go and live with her friend in London, so supervision from the Inner London Probation Service was arranged. No health service referral was made as it was thought that this visit would only be transitory.*

* *On 11th February Q attended an assessment session at the Cassell. Later in February the Cassell completed its assessment and decided to defer a decision for two to three months.*

* *Q attended an out-patient appointment with the psychiatrist on 19th February, where she disclosed thoughts of doing something harmful to children.*

* *The psychiatrist was concerned by this disclosure and from what she knew of Q's history informed social services and referred her to the local forensic psychiatric service on the 24th February.*

* *During February Q informed workers involved in her care that she was spending time between the London address and sister D2 in Eastbourne.*

* *At the beginning of March the probation service referred Q to the forensic psychiatric service in support of an earlier referral.*

* *On 12th March, Q had her 18th birthday and the Care Order ended.*

5.10.1Commentary

This year was marked by Q's increasingly dangerous behaviour, both to herself and to others. She underwent further assessments in connection with the offence of GBH and remanded to prison, with a potential care path identified through the Cassell initiative. However, this was never more than a possibility and arguably lost any prospect of successful implementation when the Cassell Unit refused to accept her immediately following their own assessment. There was no clear alternative care plan for her. The condition of residence within the probation order had been to ensure that she remained as a resident in the Cassell Unit should she be accepted. Once the Cassell had refused her, given the history of difficulty in finding her suitable accommodation, then such a condition was difficult to enforce. The problem was further compounded, when there was no agreed view on what the most appropriate placement for her was, by the difficulty in finding places and of Q's repeated behaviour of non-compliance with placement requirements.

The Pre-Sentence Report had linked the offence to alcohol and substance misuse, referring only to turbulent family relationships and not to the substantial abuse the Panel consider she had experienced in her family. The probation officer who had been in regular contact with

social services, did not use the full history and there are no records on this history in the probation file.

More information on her abuse as a child and subsequent history could have assisted the court in its sentencing and produced a much stronger package of therapy and support on her release from prison. This could have generated a more coherent care plan rather than what happened as the Cassell unit would not accept her and therefore no treatment began. Clearly this went against the expectations of the courts.

Within two months of the order being made Q attacked her sister and threatened to poison her mother. Social Services referred her to an adult psychiatrist who began to work with her and, on learning of Q's thoughts about causing harm to children, considered that she needed forensic psychiatric intervention.

There was not in place a Dangerous Persons Panel or similar interagency forum in 1998 to which Q could have been referred, and which would have facilitated an agreed risk assessment. Interagency forums have been in place since 2001, which would now automatically consider cases such as Q's. The absence of such a forum in 1998 made tracking Q's activities harder. Mental health is disturbed by many factors from bereavement to major mental illness such as schizophrenia. The management of differing mental health needs therefore requires individually tailored approaches and mental health professionals should be involved in these to varying degrees even when there is not an induction for a 'psychiatric' intervention.

Q stabbed S in June 1998, whilst she was being supervised under a Probation Order. There was contact between the individual workers in Probation and Social Services during the time Q was remanded in custody.

A case conference was held on 29 January 1999, following an attack by Q upon her sister, and Q stating that she had thought about killing her mother.

5.11 Chronology Period 7 March 1999 to March 2000 Q aged 18

1. <u>March to June 1999</u>

* *During April Q was seen twice by the clinical psychologist with the forensic service. The outpatient appointment with the adult psychiatrist was a tense session in which the psychiatrist felt threatened by Q. This was caused by Q feeling that the psychiatrist had broken her confidence by passing information to social services about her baby-sitting for D2 and disclosure at the previous meeting. This ended the involvement of the psychiatrist as she felt that the therapeutic relationship was broken. She informed Q's GP who subsequently re-referred her, and an appointment was made for mid June but this did not take place.*

* *In mid April Q was admitted to A&E following an overdose of drugs and alcohol. She was detained under Section 136 of the Mental Health Act 1983, and subsequently discharged home.*

* *A social worker visited sister D2 about concerns for her children. D2 did not accept that Q would harm or abuse her children and felt them to be safe in her charge.*

* *Social Services remained involved for three months beyond March with the intention of then transferring her to adult services.*

* *At the end of April a professionals meeting agreed that a clinical forensic psychologist's involvement would be the only therapy offered to Q. At this meeting the psychologist "expressed concern that Q was acting out in a variety of ways and was freely admitting that she wanted her mother dead. She considered her risk of offending to be very high and was not of the view that she was ready, given the instability of her accommodation situation, to make use of psychological therapy". Both social services and the probation service agreed to continue seeking appropriate accommodation.*

* *At the beginning of May, Q assaulted a woman neighbour and was subsequently charged with Actual Bodily Harm.*

* *Q was remanded in custody in mid May for breaching bail conditions.*

* *A professionals meeting concluded that responsibility for Q was now with the criminal justice system with probation taking the lead agency role. Social Services notified the meeting that they had decided to close the case.*

* *In early June she was sentenced to 9 months imprisonment at Bullwood Hall Young Offenders Institution. The probation officer agreed to contact forensic services in September when Q would be due for release if this was considered appropriate. However Q formed a relationship with another inmate, and informed the Prison Service that she was going to live with this friend, in London, on her release. Her case was therefore transferred to the Inner London Probation Service.*

2. <u>June to December 1999</u>

* *Q was released from prison under Licence at the beginning of October.*

* *Thereafter she went to London on release but shortly after returned to Eastbourne.*

* *Supported accommodation through the NCH support scheme was arranged during October with sessional support from social services to help Q develop independent living skills.*

* *An NCH worker became aware during October that Q was again seeing S, but this was not passed on to the probation officer or social services.*

* *During October and November Q was reported to be still drinking, abusing drugs and self-harming. She was subject to a number of Section 136 orders (one of which related to a threat to her sister D1) and was seen during this period by both the Section 12 Approved Medical Officer and an Approved Social Worker.*

* *In November it was confirmed that there were no specific issues that warranted social work allocation, and the probation service reduced the requirement on Q to report to them from once a week to every two weeks, in line with national reporting standards set out by the Home Office.*

* *A new probation officer was allocated to the case in December.*

3. <u>January to March 2000</u>

* *Q went to the social services office in late January and was subsequently visited at home in February, when the possibility of the After-care/Leaving-care team becoming involved was discussed. Q said that she had stopped attending counselling for alcohol abuse as she no longer felt she needed it. She mentioned that she had a new partner and that she intended to marry him in early March 2000. Q also said that she had met his parents.*

* *in late February Q killed S. Shortly before midnight police found Q at Beachy Head having been alerted that she was there. She was briefly detained under Section 136 and assessed by the Approved doctor and Approved Social Worker before the police returned her home at about 1.40 am. S's time of death was assessed as 2am. Q called the police back to her flat, they arrived at 2.27am and found S's body. Q was subsequently charged with murder.*

* *Q was interviewed at the police station by a forensic psychiatrist, remanded initially to Holloway and subsequently transferred to a Special Hospital in April under Section 48/49 of the Mental Health Act 1983.*

5.11.1Commentary

This year sees a repeat of Q's previous behaviour pattern. However the differences are that the risk posed was escalating as her propensity to violence increased and, notwithstanding the number of professionals and agencies involved, the level of monitoring and contact decreased.

As with her previous GBH charge, the Pre-Sentence Report states ' she is a very damaged individual whose current circumstances are unstable, and she requires significant and long term intervention if she is to be considered less of a danger to herself and others. To some degree she was 'lost' to services while in Bullwood Hall. She was expected to go to London on her release and the probation input was transferred to the London Service who visited once. However in line with previous patterns of behaviour she returned to Eastbourne and contact with the local Probation Service had to be re-established.

Reaching the end of this long history of engagement it is possible, in retrospect, to see a consistent pattern of behaviour. However, it is not possible to see that the agencies, separately or together, built on the mountain of assessment information amassed to develop their engagement effectively. At each phase, while the background was known, there was no significant progress in how they would work with Q, the strategies they would use, the objectives of their engagement with her or the main resource they would seek to obtain to contain her behaviour.

Finding places for people like Q who are inconsistently prepared to engage with services or with even basic domestic arrangements is extremely difficult. The Panel has considerable sympathy with those trying to solve the conundrum, and do not consider that the provision of more places in any one setting would have solved the problem. A complex range of settings was needed that could respond to, and be tailored, to meet individual needs. Matching very difficult people to a domestic setting is extremely difficult without imposition, a circumstance that cannot be applied lightly.

The difficulties she and her family presented are not underestimated and there is no doubt that this was a very challenging case, and also that professionals involved with her showed commendable tenacity and tolerance in their work. Nonetheless it is hard to see how the work with her really developed. At each phase it seems as if the professionals were chasing the game, which was played at Q's pace. This can happen with particularly demanding, but there is an indication that, as the pattern became more entrenched and the risks increased, the engagement of the agencies diminished. That the CAMHS stepped out at the time they did, for example, is a comment on process rather than reflecting Q's needs or those of the workers who remained engaged without this service. Similarly, her transition out of care to adulthood and the transfer of responsibility from social services to the probation service was not managed well. Notwithstanding the efforts of the individual workers, this process lacked coherence and strategic intent.

6. CRITICAL POINTS

It may be helpful to consider Q's development in terms of critical points at which alternatives may have led to different outcomes. These points, which arise from the chronology and commentary, commence before Q's birth.

6.1 Chronology Period 1 1977 – March 1981

1. 1978
CR, aged 33, married MM, aged 17, who had come to live at the house the year before, with CR in a parental position. An investigation into MM's welfare having once been a child in care, may have been the first critical point, but it is accepted that no statutory agency could have intervened at this stage.

2. 1978 – 1979
CR's two existing daughters, aged six and four, remained living with their father and his new wife. They suffered no medical problems until MM, now MR, entered the family. Then in the year of CR and MM's marriage, daughter D1 is reported to have had a convulsion as did daughter D2 the following year. Some questioning of why two previously healthy children were both reported to be having convulsions may have led to closer scrutiny. Daughter D1 was put on anticonvulsant medication.

3. August 1980
CR and MR's son required admission to hospital, when five months old, with an obscure apnoeic attack. Involved health and social service professionals did not connect this with critical points 1 and 2, which would have raised concerns about this family.

6.2 Chronology Period 2 March 1981 – May 1990 Q aged 0 to 9

1. May 1981
Before she was two months of age, Q had been admitted to hospital with an apnoeic attack. Four children in this family had now been presented to hospital with unclear symptomatology. The children were now put on the Non-Accidental Injury Register.

2. October - November 1981
CR and MR's son died.

Within a month Q was admitted to hospital with an apnoeic attack. During the course of this hospital admission she suffered a fractured humerus that was never explained. A full investigation at that time may have represented another critical point, and could have been expected to clarify how the injury was caused. In view of the previous history, it may be considered that Q was at serious risk, but she remained in the care of her family nonetheless.

3. December 1981 & January 1982
Despite two further hospital admissions, one with apnoea and one with acute diarrhoea, the Non-Accidental Injury investigation went no further. NAI investigations may have been hampered by the referral to a paediatrician specialising in apnoeic attacks for investigation of Q's apnoeic attacks, i.e. a physical explanation for her symptoms was being considered. This view may have been confirmed by Q's paediatrician's statement that "We do not fully understand the nature of children with this problem, but certainly there is nothing we have found to suggest any form of child abuse", which would have seriously undermined any child abuse investigation.

4. 1982 & 1983
During 1982 Q had eight hospital admissions, one of them with a broken arm. The child protection response to this by all agencies appears to have been lax and another critical opportunity missed for considering whether Q should be removed from an environment in which she appeared to suffer harm. Q was commenced on anti-epileptic medication. There were two further apnoeic episodes in 1983.

5. May 1990
Q ran away and was placed on the Child Protection Register and on a Place of Safety Order. At this critical point, Q's family background was

extremely worrying as detailed in the social enquiry report of the social worker, dated 19.9.1990.

6.3 Chronology Period 3 May 1990 – December 1991 Q aged 9 to 10

1. September - December 1991
Despite informed professional opinion, Q was returned home after Contact arrangements were introduced in September. This and the subsequent court decision to end the Care Order and leave Q with her parents may be considered the most critical point in her life.

The Guardian Ad Litem's report of 2nd December 1991 report contained little discussion of the risks to Q and contained a view of progress made by the parents notably different from those of other professionals. There is no consideration of the welfare checklist, although the Children Act 1989 was being implemented at this time.

In the Panel's view it very probably led Q to believe that no-one was going to protect her from her parents or care for her. Her subsequent behaviour might well be explained in the light of this. The decision of the court was not in Q's best interests and probably prompted her view that she could not trust agencies to protect her from her parents. This lack of trust may then have characterised all her dealings with statutory agencies. She may have thought that those involved with her care had failed to detect the seriousness, in spite of a number of indicators over a sustained period of years, of the dangers to which she and her siblings were exposed in the family. Q would perceive that her parents had successfully fooled the system and professionals had not acted on the evidence, so Q and her sisters felt "no-one ever listened". It seems Q retreated into herself and refused to engage constructively with outside agencies from that time on. Perhaps if Q had been protected effectively at this time, she would have cooperated, and as she grew older, had more faith in the agencies working with her. She was only contained in the future by legal frameworks for detention.

6.4 Chronology Period 4 December 1991 to July 1994 Q aged 10 to 13

1. July 1992
Q's name was removed from the Child Protection Register despite two attendances at A&E with minor injuries and avoidance of involvement and contact with social services prior to the ending of the supervision order in June. This was probably the last critical point when Q could have been protected from her parents.

2. 1993 - 1994
Q made allegations against her mother but then withdrew them. Her withdrawals may have been related to her perception that statutory agencies were powerless against her parents, and the risk her parents posed to her if she maintained her allegations. By the time Q was received into care, her behaviour was becoming out of control, so future change was unlikely as she had already been so badly damaged.

6.5 Chronology Period 5 July 1994 to March 1998 Q aged 13 to 16

1. September 1995
The adolescent forensic psychiatrist, whose organisation's opinion had been specifically sought, considered that Q, at the age of 14 years, 6 months, was a risk to herself and to others. If such specialist opinions are to be sought, they must be actively considered and incorporated into care plans by all involved professionals from all agencies. There does not appear to have been any particular treatment or care plan developed to incorporate this specialist opinion.

2. *1994 - 1996*
By this time it was becoming increasingly clear that Q could only survive in a secure environment, but the legal basis for providing this made it impossible. This may be an indication for legislative change. There was not and is not a legal process for containing her and reducing her dangerousness**.**

3. 1996 – 1998
As Q had disengaged from CAMHS input, CAMHS had ceased to be involved, which meant that there was not a managed transition from CAMHS to adult mental health services. Similarly, the hand-over from youth to adult services in social services was poor, given her assessed dangerousness. Better transitional services could have led to a more comprehensive care plan.

6.6 Chronology Period 6 March 1998 to March 1999 Q aged 17

1. June 1998
Q assaulted and stabbed S. While on remand she was psychiatrically assessed and consideration was given to placing her for long term residential psychotherapy at the Cassell Hospital. Unfortunately, wishful thinking about this placement led to an ineffective court judgment and yet again a critical point when Q's future could have been realistically planned was lost as mental health support and service involvement in care planning was not arranged in the community.

2. November 1998
Q was sentenced to Probation with a condition to live where directed by the probation service in order to facilitate her placement at the Cassell Hospital. More usefully, the case should have been adjourned until the placement at the Cassell Hospital had been confirmed or rejected. Sentencing would then have been based upon facts, not hopes.

3. January 1999
Q was seen urgently by an adult psychiatrist, who provided an assessment. The psychiatrist had only just been appointed as a locum consultant psychiatrist, possessed no higher specialist training in psychiatry and was unfamiliar in working with social services. The psychiatrist was therefore faced with a young person, about whom she knew very little and with no knowledge of whom she might turn to for support and advice. Similarly the psychiatrist considered she had no knowledge of local agencies and had not met personnel working in them. It is unlikely that these factors would have substantially changed the outcome for Q and her victim, but it would have ensured that the psychiatrist could have had readier access to information about Q's background, initiated a multi-agency approach to Q more easily

and would have known how to best use the forensic services. Closer liaison with forensic mental health services initially may have led to a more focussed approach to her needs and her dangerousness.

4. January 1999
In the Probation Service a number of officers new to the area were faced with this very difficult, complex, high risk offender without full knowledge of the local agencies and professionals involved with Q. There were multi agency meetings where information was shared but there appears to have been a disconnection between all involved agencies, none of them fully understanding the remit of the other, or working together.

6.7 Chronology Period 7 March 1999 to March 2000 Q aged 18

1. May 1999
Q's assault on a female neighbour was probably the last critical point at which matters might have turned out differently, as she had again violently attacked someone. The Probation Officer was not informed that Q was back in contact with the man she had previously stabbed and, it later transpired, would subsequently kill.

7. PRINCIPAL ISSUES IDENTIFIED

7.1 Listening To Children

Three young women, as children in the family of CR and MR, Q especially, did not feel that they were listened to by professionals and agencies with responsibility for their welfare. There are numerous examples from the records in the 1980s and early 1990s when they told adults in positions of authority what was happening to them individually, and to each other, at home.

The records indicate that they were believed, but this would not have been evident to them as children, given that they would have seen little sign of intervention or protection. Indeed for Q, as her career in the care system progressed, she may well have felt the powerlessness of her situation as her mother appeared to have participated very conspicuously in case decisions about her and been listened to.

7.2 Using Information And Information Sharing Between Agencies

Particularly during Q's first 13 years, until she was put on the Care Order that continued until she was 18, there are numerous examples of abusive behaviour to all four girls in the family over several years. Although child protection processes were instituted in line with arrangements in existence at the time, it is not clear that previous knowledge was adequately considered to build a picture of continuing abuse that required stronger intervention during the 1980s and early 1990s.

Later, in the pattern of care planning, support and placement options pursued for Q, there was not a strong illustration of using the knowledge gained over the years in developing care and holding strategies. There were several assessments of need and options proposed, but it is not clear how these were incorporated in Q's care plan.

Specialist reports from independent consultants in adolescent psychiatry called attention to Q's dangerousness to herself and others, but this did not lead to her dangerousness being clearly considered in planning arrangements. There was no ideal placement for Q at this stage, but all

aspects of her functioning needed to be taken into account when she was being placed. In this context, using bed and breakfast accommodation before she was 16 was in conflict with specialist assessment and advice, putting both Q and the public at risk.

7.3 Planning And Action

Throughout Q's career in the care of the local authority the requirement to hold a variety of child protection, strategy and review meetings was adhered to, and in general these meetings appeared to be attended by the relevant professionals. However, her needs were not considered in a proactive manner considering such topics as where she would live and, conspicuous by its marginalisation, what her educational needs were once she had left the formal school system. There was an over-emphasis on her psychological needs and the "therapy" necessary to meet them. When she was in the ITF there was input from Lansdowne's Head of Education on her learning needs and achievements in the ITF. However, it may be that a broader LEA educational perspective would have ensured that the learning, achieving and social aspects of her education were considered at every turn and education authorities would have been more positively involved when specialist education was being designed and paid for.

Although key people were involved, somehow the opportunities for proactive decision making and planning did not happen. The difficulties in managing Q and her family were not underestimated, but rarely was there evidence in the case records that the work with her was forward-looking.

There was some contention that a therapeutic community was the right setting for Q, although all agreed that she needed a setting that would offer her stability and the opportunity to develop. As has been said in this report already, the major opportunity to achieve security and emotional development for Q through being in a therapeutic setting had been lost when she was returned home as a 10 year old, and by the time she returned into the care system she was too old for most therapeutic community settings to consider accepting, and was arguably too scarred by the abuse she had suffered to cope with such a placement.

It is possible that the contention between professionals about finding a setting, and also the Court direction to pursue a therapeutic community, got in the way of seeing what seemed to work best and to build on that. Had that been progressed then the good work undertaken in Lansdowne ITF,

which Q appeared to respond to least disruptively, could have been the basis for developing a placement that might have better met both her needs and stated requirements.

The placement and management difficulties Q presented were such that the usual range of options were not adequate and although it was possible to see this at the time, the case discussions do not reflect thinking about more progressive options. In the course of this Inquiry, in discussion with involved professionals, the prospect of developing some form of outreach connected to and supported by Lansdowne was identified as an option that might have worked for Q, and which, if she presented today, might be more positively pursued. There is reference in the notes of planning and review meetings that a specific support for Q under the Lansdowne umbrella was considered but not pursued. It is not clear why such an option was not formally considered. Had such a support been developed it would undoubtedly have been an expensive resource and, as such, would have merited some cost dispersal with involved agencies expected to make a contribution. This should have been pushed for at the time taking account, in its planning, of the potential constraints of finance and the limitations of legislation in regard to the secure order requirements.

When Q approached 18 there is some evidence that preparation for independence was being put in place. However, Q's movement between home, London, short-lived supported accommodation and bed and breakfast over the years aged 16 and 17 made this very difficult to achieve. There was uncertainty about what sort of setting and support would best suit Q in terms of setting boundaries, giving direction and gaining her compliance. The difficulty inherent in this is not underestimated, but through these years it is evident that the professionals were unable to set the direction and determine where Q's (and society's) interests might be best provided for. During this time she was not compliant, in the main, with those working with her. It can be argued that involved professionals were constrained over what they could do to secure Q's cooperation and compliance by their inability to use more secure settings more extensively.

In view of the extreme nature of Q's behaviour, it was assumed to be indicative of mental illness, rather than being acknowledged as the psychological damage resulting from a very abusive childhood. At times of high professional anxiety there was a tendency to only use child mental health professionals to try and label Q with a mental illness and hence gain access to mental health resources. However, at less fraught times there was a recognition that a child and adolescent mental health perspective was

considerably wider than the diagnosis of disease. Q's development was seen in the context of her family background and social circumstances, so that her psychological needs could be addressed by a developmentally and interactionally informed perspective. The involvement of the child and adolescent psychiatrist in planning meetings for Q is to be commended, both on the part of social services who invited mental health professionals to planning meetings, usually accepting there was no specific treatment for Q's problems, and on the part of the psychiatrist who made considerable effort, in a very busy work schedule, to attend the meetings.

The CAMHS disengagement is difficult to understand and may reflect a retreat to more treatment-based thinking about psychiatric interventions. It was not well timed, being at a critical point when independent professional opinion was describing her potential dangerousness. This will have contributed to some indecision about responsibilities and consideration of management strategies for Q.

Unfortunately, the need for mental health expertise in planning was not recognised in the transitional period from childhood to adulthood. There should have been a clearly agreed plan between the child and adolescent, and adult mental health services, of responsibility for involvement in Q's care, so that mental health expertise informed the care plans when Q was drifting in and out of the legal system with no consistent multi-agency care plan and follow-up.

The transfer of lead responsibility from social services to probation was occasioned when Q was Remanded in May 1999. Prior to that, there had been active consideration of transferring her case to adult services. In the event Social Services closed the case on Q's 18th birthday and there was no transfer to the adult mental health team.

7.4 Decision Making

The decision of the court in December 1991 to revoke the Care Order was not in Q's interest. In retrospect this cannot be justified, and it is the understanding of the Inquiry Panel that at the time there was indeed contention between professionals. The record of reports presented to the court shows that the social services report was written some months prior to the actual hearing and had been prepared for an earlier hearing at Eastbourne Juvenile Court in May 1991.

It may be that undue weight was given to the drive of the (then) new Children's Act being introduced at that time to maintain children in the care of their families. Certainly at a national level there was some tendency to over-react to what was expected through new legislation. It is very likely that the GAL, at least, was unduly influenced in a way that contributed to the presentation of his argument, which, from evidence seen by the Panel, indicates that the social services department concurred with his view, as did the court in revoking the care order. Unstructured narrative reports of the type submitted to the Court by the GAL were common in the early 1990s. It did not demonstrate systematic consideration of the best interests of the child in keeping with the Welfare Checklist being introduced currently.

The report of the clinical psychologist with its accurate and considered analysis, did not command the support of the Court for reasons that are not evident or reported in any recorded judgement of the Court available to the Inquiry Panel.

During the period after the revocation of the Care Order in 1991 when she returned to the care of her parents, there was minimal intervention and the non compliance of the family with social work supervision and engagement at the Maywood Family Centre proved an effective means of dropping out of view. Although the Supervision Order had no conditions attached, there was significant history, a concurrent pattern of avoidance of contact with social services, and hospital A&E attendance, to make the decision in July 1992 to remove Q from the CPR remarkable. Subsequently, in September, the case was closed. There was concern about D4 within 4 months but little appears to have happened, although the concerns reported by the children would have echoed similar patterns stretching back over 10 years.

Q's increasingly difficult and risky behaviour continually raised anxiety, and this led to repeated requests for assessment from Child and Adolescent Psychiatrists, and Forensic Adolescent Mental Health Services. As the placement options recommended were not realistically obtainable, further assessments were requested rather than the agencies who knew Q agreeing together and deciding on what was the best possible option in the circumstances and developing it. Almost by default the placement at Lansdowne was the least worst option and, if this had been recognised, it might have been supported more effectively by a mental health and educational support plan.

7.5 Risk Management

It is not just in retrospect that the increasing pattern of dangerousness Q presented became evident. There was a steady escalation from the time she came into care as a 13 year old throughout the next five years. Progressively, Q presented a risk to others as the frequency of threatening and actual harm to others increased. Similarly, she gradually increased the levels of self-harm and the range of actions, cutting herself, inhalation of chemicals (glue, aerosols, perfume), drug taking, alcohol abuse, and overdosing both intensified and increased in effect. Added to this, she was increasingly engaged in criminal behaviours, primarily shop-lifting.

The record indicates that she targeted people who she knew and who were close to her, as indeed was her eventual victim, S. As well as the direct information that professionals possessed from Q's presentation, they also had specialist views presented by the Gardener Unit after assessment and by an independent specialist psychiatrist's paper assessment that she was "potentially a very dangerous girl". Such assessment information should have been held in probation records as they would have informed the writer of the recommendation presented to the courts in pre sentence reports.

7.6 Difficult And Noncompliant Parents/Carers

Abusive parents are by their nature intimidating, powerful, deceptive and threatening, primarily to those they abuse, and those characteristics may also be apparent to professionals involved with the family.

Professionals working in both mental health and in child protection services often have to face potentially difficult people, sometimes the service-user themselves and sometimes their families or associates. In this case, when Q was very young, and similarly with her older sisters, the record shows that her parents would have presented themselves as resistant to engagement by workers, and on occasion might have appeared threatening. It is probable that, specifically at the time when the Care Order was revoked in 1991 and in the following six months of the supervision order, their stance and resistance to engagement was not tackled. Such behaviour should have indicated the need for greater vigilance and the need for engagement, but instead, (and given the revocation of the Care Order this course of inaction is more understandable in retrospect, and would have been harder to pursue at the time) the family were enabled to drop from sight, other than occasional reports from school.

From the time Q returned to the care system as a 13 year old her mother appears to have played an active part in case discussions. On one level this is entirely in line with the spirit of the Children Act 1989 and good practice. However, such engagement in these circumstances and with such a long and documented history, does merit comment. It is possible that MR's continued engagement in these meetings reinforced to Q both her mother's power and the inability of those charged with her care to promote her interests over those of her family. It is surprising that this situation and the possible exclusion of the mother was not more formally considered alongside a stronger promotion of Q's engagement in such planning meetings concerned with her care and future options.

7.7 Constraints

The work with Q as an adolescent was constrained by three major issues not specific to her but to the legislative and professional framework within which professionals were working. These were: -

- The question of diagnosis and the age at which a child might be described as having a mental illness.

- The use of secure accommodation in a therapeutic setting over a sustained period of time.

- Treatment and placement options available for children with such complex and demanding needs.

7.8 Diagnosis

The question of diagnosis of mental illness in children and young people is a vexed one. Adult mental disorders such as schizophrenia or bipolar affective disorder occurring in adolescents are clearly psychiatric disorders which affect the sufferer's behaviour and are treatable conditions. Children with Pervasive Developmental Disorders such as Autism and Asperger's syndrome are often managed by mental health services, although the specialist input for them is primarily educational. Children who have suffered considerable emotional damage present with behaviours of an antisocial nature and/or self harm. These are seldom responsive to

treatment, for if they have not benefited by good emotional experience they are emotionally disabled.

Such children acquire the diagnoses of conduct disorder and later in life, borderline personality disorder. These disorders respond poorly to mental health interventions in adolescence and the lack of treatment for these conditions often leads to considerable frustration in the carers and other professionals involved in looking after them. This can lead to dysfunctional interagency working. Generally, this did not happen when Q was a teenager, but at times when she engendered a lot of professional anxiety there is occasional evidence of services' frustration with each other. The services are to be complemented that this did not interfere with their long term relationships. However some of the placements recommended did appear to be based on wishful thinking rather than on evidence that they would be helpful to someone like Q.

7.9 Secure Accommodation

The use of secure accommodation is quite properly tightly controlled. Social Services followed the procedures in gaining two Secure Accommodation Orders (SAO) and 6 Interim Secure Accommodation Orders, and the panel of Independent Persons was appropriately constituted and involved.

There was a prevailing view at the time and certainly evident to the Inquiry Panel that Q's most stable periods were when she was in the Lansdowne ITF. However, this was not built on, in part because for Q to remain in such a setting she would have needed a sustained SAO and the legislation would not permit that. In the absence of a treatable mental illness it would not have been legal to detain Q under the Mental Health Act 1983 and the involved professionals behaved quite properly in this respect.

7.10 Treatment and Placement Options

Children and young people presenting as Q did are difficult to place in settings that will meet all their needs. Such resources are expensive and selective regarding whom they will accept. While this is understandable for the agencies providing the resource, as they want to select children they believe they can offer a positive opportunity to, and do not want to take excessive risk in taking placements which may prove disruptive of their

regime and the other children and young people that they are caring for, it does place an immense burden on responsible professionals, the child and their family, in securing a setting. Often, social workers are faced with finding such resources in situations of extreme concern or pressure and it is not surprising that placements of marginal benefit are sometimes made, and occasionally decisions that are wrong in absolute terms, such as Q's placement in bed and breakfast accommodation before her 16th birthday.

This is a problem without an easy solution: nationally, children's services have suffered years of under-funding and both the focus of responsibility and culture in the provision of services have changed over the past decade or so.

It is not merely with hindsight that the strength of Lansdowne ITF in managing Q – and in providing a local setting that generated a sense of security for her – was apparent. This was recognised in various meeting notes throughout her teenage years in the care of the local authority, and at times a specific development was suggested recognising that this would meet significant, but not all, of her needs. Unfortunately, this was not formally progressed and one has to question why, faced with the continuing placement failures and need to balance security with moving towards independence constructively, development of a specific scheme under Lansdowne's umbrella was not more seriously presented up the social services management line. Such a scheme might have built on the known positives of Lansdowne's relationship with Q, that it was local, and on the reputation of a well managed children's setting.

The local CAMHS was poorly resourced and appeared to have had little priority in health planning within their NHS Trust. Despite this, the consultant psychiatrist put considerable time into assisting in the management of Q. This must have affected his ability to deal with many other pressures on the service. There was good working here between CAMHS and Social Services in this case. However, specific input to management and care staff working at Lansdowne at the time, in helping to manage the manifestation of disturbed adolescent behaviour associated with mental health problems, would have been helpful in general and in managing Q in particular.

Unfortunately, because of the many other difficulties presented, Q's education appears not to have been a priority and was not considered in significant detail at the planning meetings.

8. RECOMMENDATIONS

This report has considered issues, circumstances and evidence spanning over twenty years. If these events were to be considered in isolation, the Inquiry Panel's recommendations' would have been numerous. However, since the events of Q's childhood there have been many changes in legislation, improved partnership working and protocols between the various agencies, which have been implemented prior to and during the Inquiry process. Since the index offence in March 2000 the following has taken place: -

a) Spontaneous post-incident action immediately after the event;

b) Consideration of the Internal Review and its recommendations by the agencies (December 2000);

c) Government or department instructions, protocols or guidance at national level being promulgated in any event from March 2000 – present day;

d) Organisational or geographical reconfiguration of agencies taking place in any case;

Furthermore, as liaison with social services formed a significant part of Q's history, the recent publication of the Victoria Climbie' inquiry report (January 2003) contains many recommendations that will action changes within the service, some of which have a bearing on Q's circumstances.

This report's recommendations are therefore confined to relevant issues not previously enunciated, together with renewed emphasis on residual recommendations from the Internal Review of December 2000.

8.1. Looked After Children and Child Protection Procedures

Major concerns have been expressed in this Inquiry report about childcare practice during the 1980s and early 1990s. The major improvements to childcare and child protection procedures since that time deal with several of these concerns, and indeed examination of contemporary guidance and procedures set out in the East Sussex Area Child Protection Committee (ACPC) Procedures describe guidance, practice and procedural

responsibilities that promote more purposeful and effective intervention to safeguard children than was the case for Q and her siblings. Therefore several of the concerns identified have already been addressed through improved procedures and professional practice since Q's childhood. But as is clear from the Victoria Climbie Inquiry report (January 2003), which describes practice and management failures, it is necessary to ensure that current arrangements to safeguard children effectively are followed in everyday practice.

In order to ensure that practitioners are confident in their dealings with families and in the effective implementation of ACPC and local authority care procedures, the Inquiry Panel recommends that the following issues in work with children and their families are reviewed.

Recommendation 1

The East Sussex ACPC, and the Social Services Children and Families Division are recommended to review their working practice, training, support and supervision for staff in respect of the following areas of concern:

a) Inclusion of parents/carers in child protection and statutory care planning meetings.

The presumption of partnership and inclusion of parents in such meetings is properly at the heart of childcare practice in line with the spirit and guidance in the 1989 Children Act. However, when there are circumstances that cause professionals to question the benefits and non-benefits of parental involvement for the child whose welfare is the primary focus, it can be difficult and contrary to normal good practice to enforce an exclusion of the parent(s). It may, nonetheless, be the right action to take.

The ACPC Procedures identify this issue; they should ensure that this is incorporated, and reviewed in the interagency training programme. Similarly, the Social Services Department should ensure such training for staff working with children in the care of the local authority, where the occasional exclusion of the child's parent will require sensitive handling.

b) Working with difficult and noncompliant parents/carers.

The ACPC and Children and Families division must ensure that front line staff have training specifically geared to work with such people and deal with the implications of this in their decision-making. The Report of Newham ACPC into the death of Ainlee Labonte/Walker (December 2002) sets out detailed recommendations for working with dangerous families, which the local ACPC is urged to consider in formulating its training and in reviewing interagency procedures.

c) Working with carers where induced/fabricated illness of children is suspected.

The ACPC Procedures provide information and guidance reinforcing the requirement for strong interagency understanding, information gathering and planning. Effective training and the availability of expert advice is necessary to enable front line practitioners across the agencies to work effectively in this complex area. The Social Services Department has to ensure that the expertise and guidance contained in the ACPC procedures is properly applied in cases where they are reviewing work with children in their care, both those who are Accommodated and Looked After.

d) Ensuring comprehensive and accurate record-keeping within A & E departments.

To ensure that as part of the assessment of children presenting with unexplained medical symptoms, unexplained child deaths or injuries, there is effective cross referencing of those names with other children on the Child Protection Register to ascertain whether there are siblings in the household who may also be victims of suspected abuse.

e) That where a child is presented in A&E the names of all siblings and other children who live in the household are recorded.

f) If a child is discovered injured in any inpatient hospital setting or residential placement it must be treated as an Untoward Incident and fully investigated by people not directly involved in the child's care.

g) Reference is made to the Multi Agency Public Protection Scheme under their local arrangements.

Since June 1998 these procedures should have been effectively embedded in local services with greater clarity about the criteria for consideration and smoother process for accessing this forum. However, the ACPC and Sussex Public Protection Steering Group should review their working protocol to ensure there is effective understanding and implementation of referral mechanisms and any follow up actions.

8.2. Placement Options

The current range of settings available for children and young people with needs such as Q's are insufficient in quantity, often unable to meet specific needs and can be many miles from the child's known area increasing the risk of social isolation from peers and friends. This is a national issue that cannot be easily resolved. In the view of the Inquiry panel the causes lie with a combination of factors:

Finance	Social service departments across the country spend above their children's PSS FSS, effectively being subsidised from budgets for other social services and local authority services;
Specialist placement options	These will be geared to take only the placement of children and young people who meet their particular entrance criterion;
Legislation	Constraints exist on using Secure Accommodation as a long term setting;

Foster placements which may have offered a viable alternative to Q's own family when she initially came to the notice of the social services, proved unable to offer a satisfactory alternative as she got older and more set in her behaviour.

Given the reality of the paucity of settings available nationally, and the importance of developing provision suitable to the individual child we recommend:

Recommendation 2

The local authority should be more proactive in developing specific services under the umbrella of the Lansdowne Unit (or any equivalent centre), working with its partners in the health and education services to disperse the costs associated with such provision. Such a development might also link with more specialist fostering resources where foster carers are prepared and supported to care for abused children and young people.

Recommendation 3

Young people should not be placed by Statutory Authorities to live in independent settings before the age of 16 and even when over 16 (up to the age of 18) only with an individually tailored care package.

8.3. Care Proceedings

Since the court decision in December 1991 to revoke the Care Order and return Q to the care of her parents, practice in interpreting and decision-making under the aegis of the 1989 Children Act has advanced. The 1989 Children Act is well regarded legislation that promotes both the spirit and practice of partnership working, involving the best interests of the child. However, there are lessons to be learnt about how the early days of the implementation of new legislation or guidance can adversely affect decision-making. We cannot say with certainty that the December 1991 decision was taken with a simplistic appreciation of the need to promote children being with their families that swayed the preparation of the GAL's report, the social service's acquiescence and the court's decision, but in the Inquiry panel's view this is probably what happened.

The Panel urges professionals, organisations and Courts to be vigilant in guarding against simplistic appreciation and application of what is new where an appreciation of the spirit and requirements may be incongruent with previous practice. Guarding against pendulum swings in professional approach and application of legislation or guidance requires effective training, scrutiny and supervision.

When preparing reports for courts where decisions about children's future welfare are to be made, professionals must be assiduous in their

investigation and understanding of the circumstances which have led to the child being in their present predicament. Such investigation requires a consideration of social, educational and mental health issues affecting the child in their earlier life. Only by such careful consideration are recommendations likely to benefit the child. A chronology will be the basic foundation for the understanding of the child's history, upon which will be built the accumulative impact of events on the child's development. It is only with the benefit of detailed understanding that realistic recommendations for the future can be made.

The management arrangements for Guardians (now called Children's Guardians not Guardian Ad Litem) have changed significantly with the introduction of Children and Family Court Advisory Support Service, (CAFCASS), in April 2001. The difficult evolution of this agency is a matter of public record; the implication of this difficulty, in the context of concerns raised in this Inquiry, is that some Guardian work is less well monitored with independent contractor Children's Guardians inadequately supported than previously through local authority GALRO Panels.

There has been a lively exchange between CAFCASS and the Guardian's professional association over the past two years or so, some of which is considered relevant to the work of this Inquiry, given our comments on the contribution of the GAL in this case. In particular, we are concerned that the quality of support and scrutiny Guardians experience and their reports to courts receive, may be diminished since the introduction of CAFCASS; that the level of experience (three years instead of five) required of a Guardian may diminish the quality of their work; that there are significant shortages of Children's Guardians in parts of the country that will, in effect, reduce the quality of work carried out to safeguard children in public law proceedings.

Overall the quality and order of Social Services files over the many years of engagement with the R family and with Q specifically were in good order. However the absence of a specific Social Work report to the Court in December 1991 with a report prepared in May 1991, more than 6 months earlier, used with no evidence that it had been updated, was not good enough. Although just the specific concerns relate to 1991 as noted elsewhere, we make the following recommendations:

Recommendation 4

That the Social Services Department ensures that all court reports are up to date and that a record of the judgement of the Court is maintained within the case files as a matter of course.

Recommendation 5

That CAFCASS is encouraged and enabled to:-

a) arrest the decline in the number of Children's Guardians;

b) encourage suitably experienced people to continue in and take on this work;

c) ensure that adequate funding is authorised for particularly complex cases;

d) achieve effective monitoring, support and audit arrangements with independent contractors to ensure that these Guardians are supported and that their work is monitored and of good quality;

e) resolve the classification of the status of independent contractors with the Inland Revenue in order that their work is better supported and monitored.

8.4 Child and Adolescent Mental Health Services

In many services the professionals working for separate Statutory Organisations have different policies and conflicting priorities. This is counter productive. There are now mechanisms available to enable Agencies to work together within a single, clearly understood framework. Section 31 partnership arrangements in the Health Act 1999 offer one solution. This Act offers the NHS and local government the opportunity to formally combine services and resources in three possible ways; integrated commissioning, integrated provision and pooled budgets, known as the three 'flexibilities'. The advantages of this approach offer an opportunity for all services to work to the same priorities, with one method for clinical governance and supervision issues and one set of policies. It facilitates the development of practical issues such as a single

set of notes as all involved work for the same service. It also helps all those professionals work as one team, pooling their knowledge, skill and expertise to deliver high quality care to those they serve and ensure robust support for each other.

In the Panel's view during the mid to late 1990's, CAMHS was not given priority in the NHS Trust service. The Children's National Service Framework gives added impetus affording CAMHs priority in interagency community working.

Recommendation 6

The panel recommends that all those involved in the Statutory provision of CAMH services consider whether section 31 of the Health Act 1999 would help improve the services they offer, or whether some other form of formalised integration would be beneficial. Such integration should include Education as a core component of a CAMH service.

8.5 Systems, Procedures and Organisations

Throughout the Inquiry the panel found a number of circumstances where systems and procedures should have been better integrated. Whilst there was some educational input, this was to meet Q's right to a minimum education rather than to ensure that a developmental/educational approach was incorporated into the care plan. There are examples where professionals did not have access to all the relevant information at the time they made an assessment; a single set of case notes would help ensure this did not occur. Across agencies the Integrated Children's System is now being piloted to ensure that the involvement of any one agency is known to another. There were times when referral to another professional may not have been the best solution and what was required was the ability to share expertise to support the care plan, rather than have another agency take over responsibility.

Recommendation 7

This recommendation covers a number of single points within the management and administration of mental health services that require change. To ensure effective implementation all the Statutory Agencies

will need to work together, however in circumstances such as these, the lead is clearly with the NHS Trust.

a) The details of all people detained within a Police Station under Section 136 of the 1983 Mental Health Act, who are seen in the Police Station and are assessed as not subject to further detention or voluntary admission must be communicated to the Mental Health Services to ensure that if they are or have been patients of such services, the event is duly recorded within their notes and the information is available to those who do, or may, provide care to them.

b) There must be a protocol developed that clearly demonstrates how a child within the CAMH services makes the transition from being in receipt of care to full discharge or to Adult Services. This protocol should be multi-agency and show at each stage which service is responsible.

c) All professionals working with people with mental health problems should be fully trained in Risk Assessment techniques and receive regular updates.

d) Organisations must undertake random audits to ensure that Risk Assessment protocols and procedures are being adhered to.

e) All individuals admitted to a general hospital following an attempt to take their own life must have a Psychiatric assessment.

f) There should be clear minimum qualifications established for Locum Psychiatrists established through the Trust's Clinical Governance Procedures.

g) Locum Consultant Psychiatrists must receive a comprehensive Induction to ensure that they fully understand all the operational protocols required to enable them to assess and treat patients. This should include details of how referrals to other services should be made.

h) There must be a clear understanding across organisations of what constitutes an Untoward Incident and what the response is to such an Incident. The organisations involved must hold multi-agency reviews of all internal and external enquiry reports within 6 weeks of

the publication of the report. The review must include a systematic appraisal of all of the recommendations and identify a timescale for completion and a lead agency responsible for ensuring delivery. This must be recorded and continue to be monitored by the Commissioners of the services involved at twice yearly reviews until such time as all of the recommendations have been implemented.

8.6 Probation Services

When Q entered the criminal justice system there was no interagency forum in place which could have assessed her risk and developed an interagency strategy for managing this. Since 2001 the interagency Risk Assessment Meetings, (RAM) and Multi-Agency Public Protection Panels (MAPP) have been established and these would now automatically consider such cases as Q's.

Since the period covered by this report there have been many changes in the Probation Service and its working patterns with partner agencies where an individual is identified as a known potential risk to the public. As Multi-Agency Protection Panels are now well established nationally as well as in Sussex, it has not been necessary for the panel to make a specific recommendation about such forums.

Recommendation 8

When any defendant, having been identified by MAPPP as potentially dangerous, appears before the courts on any charge, then a system should be in place which ensures: -

a) that the Court Assessment and Diversion Scheme is alerted to ensure an initial assessment is made with the assumption that a full forensic psychiatric report will be prepared in most cases.

b) that the Court Assessment and Diversion scheme liaise with probation report writers, and where appropriate, Courts, to seek full forensic psychiatric reports.

c) that the report writer has access to all the information held by MAPPP on the defendant and refers to this in the report.

d) there should be liaison through the local MAPPP, with the Prison Service, to ensure that all information held by the MAPPP is available to inform any rehabilitation/treatment programme and the release plans made to manage the offender in the community.

8.7 Progress on Actions to be taken following the Report of the Internal Review into the Care and Treatment of Ms QR

In December 2000 a Joint Internal Report between East Sussex Social Services Department and Eastbourne and County Healthcare NHS Trust was published. The report reviewed the care and treatment of Ms Q and made a number of recommendations for changes to systems and practices. Progress on implementation has been reviewed using documentary evidence only by the panel and the following recommendations remain outstanding. (A full set of the recommendations can be found at Appendix Five)

Recommendation 9

There is outstanding work from the internal review and the panel considers that the organisations involved should complete the implementation of the following: (numbering corresponds to numbering within Internal Review Report dated December 2000.)

a) 9.2. It is imperative that all Information Sharing Protocols include the processes to be followed when sharing information about a child. Information Protocols should be "age seamless".

b) 9.3. and 9.13. The CPA Policy should clearly identify the CPA responsibilities and arrangements for all 16 – 18 year olds regardless of whether they are under the care of CAMH or Adult services. It should also determine the mechanism and procedures to be followed when transferring the care responsibilities from CAMH to Adult services.

c) 9.4 and 9.5. The Forensic Access criteria that have been established should be reviewed to include the following: -

- ***Response times for acknowledgement of referral, referral to assessment, assessment to feedback to referrer.***

- ***The criteria that will determine when an individual is ready for transfer to Adult services.***

- ***Written protocols for how joint work between Forensic and Adult services will be co-ordinated.***

d) 9.6.The National Service Framework for Working Age Adults clearly identifies the introduction of electronic CPA as a target that should have been achieved in 2002. It should be multi-agency and easily accessible. It is imperative that this is progressed within all services and that the format includes a system of "flagging" high risk individuals to all agencies.

e) 9.7. Probation Services should be involved in the Forensic/Adult Mental Health Liaison Forums.

f) 9.8. Multi- agency training should continue on a regular basis.

g) 9.9. It would be helpful if the Forensic Access Criteria document included "role outlines" of all staff involved within the service as an aid to referrers.

h) 9.14. Joint training for CPA including Risk Assessment and Management must be introduced.

The Inquiry Panel commends these recommendations to the Commissioning Authority and trusts that the necessary actions will be taken to implement them in full.

Appendix One

Records of Visits and Meetings

A number of relevant sites were visited in the locality.

Presentations were received from: -

- East Sussex, Brighton and Hove Health Authority (Surrey and Sussex Strategic Health Authority from April 2002)
- Eastbourne County Healthcare NHS Trust (East Sussex County Healthcare NHS Trust from April 2002)
- East Sussex Social Services
- Sussex Probation Area, National Probation Service

Witness interviews took place on: -

- 7th and 8th March 2002
- 13th and 17th May 2002
- 30th and 31st May 2002
- 13th and 14th June 2002

Panel meetings took place on: -

- 17th September 2001
- 2nd and 20th November 2001
- 14th December 2001
- 5th April 2002
- 18th July 2002
- 21st August 2002
- 24th September 2002
- 11th November 2002
- 3rd and 17th December 2002
- 14th January 2003
- 14th February 2003
- 9th May 2003

Appendix Two

Glossary

Adenoidectomy	*Removal of the Adenoid gland situated at the back of the nose*
Anticonvulsants	*Drugs used to prevent epileptic seizures*
Apgar	*Score used to assess the health and well being of babies as soon as they are born*
Area Child Protection Committee (ACPC)	*A statutory body composed of representatives of local agencies, essentially social services, education, police, health, probation, required to ensure working together within a framework of local procedures consistent with national guidance.*
Bipolar affective disorder	*A disorder characterised by two or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting, on some occasions, of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy (depression).*
Borderline Personality Disorder	*A chronic difficulty in maintaining relationships characterised by demanding and dependent behaviour. Such disorders are usually caused by disrupted emotional experiences in childhood.*
CAMHS	*Child and Adolescent Mental Health Services*
Care Order	*Care and supervision orders are granted by the court on the application of the local authority (usually):* *(a) placing the child in the care of the local authority, or (b) putting them under the supervision of the local authority or probation officer*
Children Accommodated	*The local authority may provide accommodation for any child in need as a result of "the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care" providing that there is no objection from their parent or person with parental responsibility.*
Children Act 1989	*New legislative framework for children's services that was introduced from 1991onwards. A main feature of this legislation was for local authorities to be less interventionist with the onus on children remaining with, or returning to, their birth families.*
CAFCASS	*Children and Family Court Advisory Support Services introduced in April 2001*

Children Looked After	*Children in the care of the local authority.*
Child Protection Conference	*Part of the ACPC procedures with a prescribed format and process to promote consideration of the child's circumstances, needs and specific actions by designated professional staff of the involved agencies. Will involve parent(s) and child unless specifically excluded.*
Child Protection Register	*A register managed by the social services department under the auspices of the ACPC of children where there is concern for their safety.*
Cholresteatoma	*A growth appearing in the middle ear as a result of chronic infection*
Condyle	*A rounded prominence at the end of a bone*
Convulsion	*Rapidly alternating contractions and relaxations of muscles causing irregular movement of limbs or other parts of the body, often accompanied by unconsciousness. Also known as an epileptic fit or seizure*
Court Assessment and Diversion Scheme	*Schemes which aim to identify defendants who have mental health issues and make assessments of them to assist the courts to deal with them appropriately*
CPN	*Community Psychiatric Nurse*
Cyanosed	*A blue appearance caused by lack of oxygen in the blood*
Dangerous Person's Panel	A multi-agency group who manage dangerous people in the community, led by the Probation service
Eczema	*A skin condition causing redness and itching*
EEG	*Electro Encephalograph, a device for monitoring and recording brain waves*
Fabricated or Induced Illness	*Illnesses in children that are made up by their carers, or the children are injured so as to make them appear to be suffering from a condition which the injury mimics. Further harm accrues to the child by medical investigation*
Febrile	*Having a temperature higher than normal*
Flupenthixol Decanoate	*A long acting major tranquillising drug administered by injection*
GBH	*Grievous Bodily Harm*

Guardian Ad Litem (GAL)	*An officer of the court representing the views and interests of the child*
Guardians Ad Litem and Reporting Officers Panel *(GALRO)*	*Panel of GALs established by the local authority to carry out the responsibilities of the GAL*
Humerus	*The bone in the upper arm*
Hyperextension	*Being bent back further than normal*
Interim Secure Order *(ISO)*	*A court order permitting use of secure accommodation*
MAPPS	*Multi-Agency Public Protection Panels*
Munchausen Syndrome by Proxy	*See Fabricated or Induced Illness*
NAI	*Non Accidenial Injury*
Nitrazepam	*A hypnotic drug administered to help sleep*
National Service Framework	*National Service Framework developed by the Department of Health*
National Standards	*Standards for areas of probation work, set by the Home Office, and measured by them through inspection*
Occipital Region	*The back part of the head*
OGRS	*Offender Group Reconviction Scale. A software programme which calculates an individual's risk of re-offending*
Otitis Media	*An infection of the middle ear*
Parietal	*A part of the brain or skull lying to each side of the skull*
Police Protection	*Action taken by the police to remove the child to suitable accommodation where there is "reasonable cause to believe that a child would otherwise be liable to suffer significant harm"*
Pre-Sentence Report. (PSR)	*Report prepared by the Probation Officer on the defendant, following a conviction – to assist the court on sentencing*
Public Protection Team	*A team within the Probation Service which supervises offenders who have committed violent offences, or who are assessed as dangerous or having a mental illness, and those who have been sentenced to 4 years or over imprisonment. Now includes all*

	offenders who are sentenced to imprisonment for 12 months or over
RAM	*Risk Assessment Meetings*
Risk Assessment in the PSR	*Should address two areas a) risk of re-offending b) risk of harm to the public*
Section 24 of the Children Act 1989	*To prepare a young person for independence "where a child is looked after by a local authority, it shall be the duty of the authority to advise, assist and befriend him with a view to promoting his welfare when he ceases to be looked after"*
Section 25 of the Children Act 1989	*Conditions and provisions permitting the use of secure accommodation for restricting liberty*
Section 136	*Powers for the police to detain those acting in a disorderly manner in the public and thought to be suffering from a mental illness in order for a Mental Health Act assessment to be undertaken.*
Secure Order	*A court order granted under specific conditions in specified settings, to restrict the liberty of a child Looked After by the local authority. Other than for very specific circumstances considered individually by the court, the maximum period authorised is three months*
Seizure	*See convulsions*
Thioridazine	*A major tranquillising drug*
Threadworm	*A parasitic infection of the bowel*
Trifluoperazine	*A major tranquillising drug*
Tympanoplasty	*An operation on the middle ear*

Appendix Three

List of Interviewees

Name	Occupation	Organisation
	Locum Consultant Psychiatrist	Department of Psychiatry, Eastbourne
	Consultant Psychiatrist	Specialist Secure Services, Ashen Hill
	Consultant Psychiatrist	Child and Adolescent Mental Health Services
	Consultant Paediatrician	Eastbourne Hospitals NHS Trust
	Clinical Psychologist	Independent contractor
	Group Manager	East Sussex Social Services, Children & Families
	Social Worker	East Sussex Social Services, Children & Families
	Team Manager	East Sussex Social Services
	Consultant Child and Adolescent Psychiatrist	Sedgemoor College
	Consultant Adolescent Forensic Psychiatrist	Gardener Unit Manchester
	Social Worker	Broadmoor Hospital
	Consultant Forensic Psychiatrist	Broadmoor Hospital
	Manager	East Sussex Social Services, Lansdowne
Sisters		

	Children's Guardian	Guardian Ad Litem
	Detective Sergeant	East Sussex Police
	Social Worker	East Sussex Social Services, Children & Families
	Mental Health Strategy Manager	East Sussex, Brighton & Hove Health Authority
Grandmother		
	Assistant Chief Officer	Sussex Probation Area, Hove
	Chief Executive	East Sussex County Healthcare
	Service Director	East Sussex County Healthcare NHS Trust
Mother		
	Assistant Director for Children & Family Services	East Sussex Social Services, Children & Families
	Unit Manager	East Sussex Social Services,
	Probation Officer	Probation Service
	Probation Officer	Probation Service
	Team Leader	Sussex County Healthcare NHS Trust
	Primary Nurse	Broadmoor Hospital

Appendix Four

Inquiry procedure

1. All sittings of the inquiry will be held in private. The press and other media will not be invited to attend.

2. Witnesses will receive a letter in advance of appearing to give evidence informing them:

    - of the terms of reference and the procedure adopted by the Inquiry;
    - of the areas and matters to be covered with them;
    - whether they are required to provide written statements to form the basis of their evidence to the inquiry;
    - that when they give oral evidence they may raise any matter they wish which they feel might be relevant to the inquiry;
    - that they may bring a lawyer, a member of a defence organisation, a friend, relative, colleague or member of a trade union, provided no such person is also a witness to the inquiry;
    - that it is the witness who will be asked questions and who will be expected to answer;
    - that their evidence will be recorded and a copy sent to them.

3. Witness will be asked to affirm that their evidence is true.

4. Any points of potential criticism concerning a witness will be put to that witness, either orally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

5. Representations will be invited from relevant professional bodies, agencies and individuals to present arrangements for persons in similar circumstances to Miss R and as to any recommendations they may have for the future.

6. Those profession bodies, agencies or individuals may be asked to give oral evidence about their views and recommendations.

7. The findings of the Inquiry and any recommendations will be made public.

8. The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, save as disclosed within the body of the Inquiry's final report.

9. Findings will be made on the basis of the evidence received by the Inquiry. Comments that appear within the narrative of the report and any recommendations will be based on these findings.

Appendix Five

Internal Review Recommendations and Actions

- There is a clear need for a major expansion of specialist services for young people with serious mental health problems and involvement with the criminal justice system, (possibly linked to Youth Offender Teams and to Social Services provision such as at Lansdowne).

- New service audit performance indicators are to be agreed between the relevant agencies

- The Eastbourne & County Healthcare NHS Trust with East Sussex Social Services Department should ensure that Modernising the CPA is fully implemented and should include services for young people aged 16-18 and those with Social Services and Probation involvement. As part of this process, it is important to ensure that important information, including the outcome of court hearings, is shared with all concerned.

- It is important to understand and appreciate that responsibility for the management of that individual remains with the referring agency until such time as a formal handover of responsibility has occurred. The full implementation of the CPA should ensure that this takes place.

- Access criteria to the community forensic services requires clarification and formalising prior to being adopted following consultation by all parties. This would clearly identify those cases that the specialist forensic services are able to work with and prevent de-skilling of general adult psychiatrists in their role of assessing and managing difficult but not unmanageable individuals. The criteria would need to differentiate between referrals for assessment and advice from those for treatment and management. Timescales for response to referrals should be agreed.

- In addition to formalising access criteria to specialist forensic services there is a need to identify exit criteria and establish at what stage in the treatment process that individuals can be managed either wholly or in part by adult mental health services.

- The health authority and local trusts need to agree a process of identification and sharing information, both inter and intra agency on individuals that are a high risk of serious offending so that if they move from one service to another the assessment of high risk would naturally

transfer with them and those organisations would already be aware of them. There may be an IT solution to this process or as part of the integrated assessment documentation. Use of modern technology in communicating and arranging meetings will inevitably speed up some delays.

This should apply equally for the sharing of information and the referral of individuals moving out of the area to the relevant receiving services irrespective of how long it is envisaged they might stay in the area.

- There are liaison forums being set up across the county between adult mental health services and specialist forensic mental health services. Consideration should be given to the inclusion of probation representatives at those meetings to allow discussion of either individuals for whom there is a shared inter-agency interest or to enable better joint working, for example on issues around the sharing of information. Care will need to be taken on issues of confidentiality and the appropriate sharing of information.

- There is a need to provide ongoing training for all agencies involved in the treatment and care of what can loosely be termed "mentally disordered offenders". This training forum would allow the opportunity to review cases of a complex nature requiring multi-agency input and encourage closer working relationships and formulation of joint polices and protocols surrounding the provision of care, the CPA risk assessment and risk management.

- The implication of the multiple accountability of forensic psychiatrists in relation to people held in custody by the police should be reviewed and clarified to avoid potential conflicts with other agencies. In particular, the review should consider the situation when the psychiatrist is requested to make an assessment by the person's solicitor, and clarify the implications for information sharing with other agencies, and for the psychiatrists NHS responsibilities and role.

- All referrals to the specialist secure team should be officially acknowledged within an agreed time standard, possibly three days, so that the referring agent at least is aware that the referral has been received. The Specialist Secure Service should inform the referrer when the patient will be assessed and when the requested advice, assessment or treatment will be made available.

- It should be made clear by the specialist services, e.g. forensic specialist services, what level of service is being provided from the range of; -

    - Sharing information
    - Giving advice
    - Assessing and advising
    - Assessing and treating

- The level of maintained involvement from adult mental health services in these circumstances can be discussed and agreed at a CPA review.

- When transferring a child to another service clearly identified dates and handover plans and time schedules should be in place prior to the transfer date. Ideally, in the case of a child being transferred to adult services this should be on his/her 18th birthday.

- Another area that requires closer consideration is the area of joint training with the aim of providing seamless services to individuals with very complex needs, ensuring that all services work within the whole system and promoting a cohesiveness within the context of the wider team approach. This training should also facilitate a framework for the co-ordination of CPA and risk assessment and risk management.

- There has been a considerable amount of local work on provision of specialist services for women, particularly those who may require secure care and those whose needs are not well met by current service provision. A detailed report and recommendations has been produced including those for intensive input to women with complex needs within a community setting. Such a service may have been very relevant in this case.