

Title of report	Report of the Inquiry into the Death of Child A chaired by Frances Patterson QC
Summary	Summary of the recommendations in the Inquiry Report and proposed action in response to the recommendations
Actions requested	To accept the Inquiry's Executive Summary and Recommendations; to offer the Board's sincere condolences to the family and to approve the proposed actions to reduce the risks of such a tragedy happening again.

SHA Strategic Aim supported by this paper:	Optimise the delivery of quality healthcare in the most appropriate setting
SHA Strategic Objectives supported by this paper:	Enable delivery of safe, effective health and healthcare services which provide patients and the public with the best possible experience
Equality and Diversity Assessment outcome:	Not applicable
Risks Attached to this project/initiative:	There are some potential legal and financial issues
Public and/or patient involvement:	The relevant individuals have been involved throughout the process
Resource implications:	None
Communication strategy:	A communication strategy has been prepared in conjunction with other stakeholders

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Strategic Aim: Improve the health and wellbeing for all of the North West population	
Strategic Objectives	<ul style="list-style-type: none"> 1 - Ensure people live longer and reduce inequalities in life expectancy 2 - Reduce the impact of illness on people's quality of life 3 - Reduce lifestyle-related illness 4 - Identify region-wide health needs
Strategic Aim: Optimise the delivery of quality healthcare in the most appropriate setting	
Strategic Objectives	<ul style="list-style-type: none"> 5 - Enable delivery of safe, effective health and healthcare services which provide patients and the public with the best possible experience 6 - Enable effective resource prioritisation in the North West system 7 - Improve the efficiency of the health service and value for money
Strategic Aim: Be recognised as a world-leading health system	
Strategic Objectives	<ul style="list-style-type: none"> 8 - Build capability and capacity of commissioners through e.g. World Class Commissioning, Transforming Community Services, system management 9 - Build capability and capacity of providers through e.g. Transforming Community Services, Foundation Trust Programme, system management 10 - Work closely with partners to ensure delivery of the Vision 11 - Build capability in the SHA and ensure it is an exemplar organisation across all of its internal functions 12 - Lead and manage the system during economic instability and maximise the NHS contribution to wider North West economic stability 13 - Develop expertise and become a high quality regional system manager providing leadership across the system 14 - Engage and communicate effectively with public and SHA staff 15 - Develop a leadership culture that fosters innovation and best practice across a range of activities

REPORT OF THE INQUIRY INTO THE DEATH OF CHILD A CHAired BY FRANCES PATTERSON QC

Background

1. This paper needs to be read in conjunction with the Executive Summary and Recommendations of the Inquiry into the Death of Child A.
2. The full independent report was formally submitted to the NHS North West Strategic Health Authority (SHA) Board in private session and a decision taken to accept legal advice that the full independent report should not be made public. This is to accord with requirements placed upon the SHA to comply with the relevant legislation protecting individuals, as explained below.
3. This paper focuses upon the NHS aspects of the case, noting that a Part 8 review was held as required by legislation governing safeguarding of children. The Part 8 report was issued in December 2003 and recommendations were addressed by all the agencies concerned.

Introduction

4. Frances Patterson, QC, and Chair of the Inquiry, presented her full report to NHS North West on December 7th 2009 in a private session and the attached executive summary is submitted to the SHA board today. The full report describes the tragic circumstances that led to child A's death on the 27th June 2003 when she was stabbed more than 50 times by her mother Ms B. She was five years old.
5. Ms B suffered from paranoid schizophrenia which had a relapsing and remitting course. Numerous agencies had been involved in her care for some time but there had never been any indication that any harm would come to child A. In response to the above incident, an inquiry panel was established by the former Greater Manchester SHA to investigate the circumstances, identify the lessons to be learned and make recommendations
6. Improving patient safety is a core principle of the SHA. When such incidents occur the SHA is required to act in the public interest to ensure that there is a thorough investigation, that families and patients receive the answers they need and that changes are made in services and practice to reduce the risk of such a tragedy happening again. The Part 8 report identified issues for the NHS and it was felt appropriate to hold an independent investigation to review the underpinning care and treatment provided to Ms B as required by Circular HSG (94) 27. Inevitably, this involved the other agencies contributing to either the care of Ms B, or responses to the above, or other, domestic incidents.
7. This paper provides the SHA Board with assurance that appropriate action has been taken by the NHS in response to the investigation into the care and treatment of Ms B.
8. Frances Patterson starts the report with a tribute to Child A and it is right that we should start by expressing our sincere condolences to the family and give

them our assurance that we have and will continue to take all the action necessary to reduce the risk of similar occurrences.

The Management of the Inquiry and Publication of the Report

9. The inquiry was commissioned in 2005 by the former Greater Manchester SHA and Trafford Primary Care Trust. The Chair, Frances Patterson QC, was supported by fellow panel members Dr VY Allison-Bolger, Consultant Psychiatrist, member of the Mental Health Review Tribunal and Ms Alyson Leslie MA (Oxon) Social Worker. In addition a range of expert witnesses provided evidence including psychiatrists, social workers, a GP and those representing the stakeholders.
10. The investigation has been thorough. The initial stages of evidence gathering were completed by November 2006 and sections of the draft report were issued in November and December 2007 for factual accuracy checks and further representation was allowed. All the comments have been carefully considered by the independent panel and changes have been incorporated into the final report. .
11. The final draft report was made available to the SHA in mid 2008 and the SHA then followed a process of due diligence checks. This has been a time consuming process as it has been a complex case, has involved a number of agencies and it has been important to take into account the family's concerns and wishes.
12. The SHA has established that due process in conducting the inquiry has been followed and that it fulfils its terms of reference. However, whilst consent had been given to access confidential clinical records, consent had not been provided by Ms B to publish extracts from those clinical records.
13. In addition during the course of the inquiry, the National Patient Safety Agency guidance for the management of mental health investigations has been published, our understanding of patient safety has broadened significantly and the mental health services have undergone widespread development through the implementation of the National Service Framework. All of which have had an impact on the SHA's decisions surrounding publication.
14. As a general principle the SHA has determined that all independent investigation reports will be published in full but anonymised. Poor practice and unacceptable standards of care will always be addressed but it is important to ensure that health care staff feel able to raise concerns about patient safety and give detailed accounts of serious incidents. Set in context and being able to see how their contribution to care fits with others' responsibilities, hearing about the experience of service users and their families, makes a significant impact on health care staff. It emphasises the importance of the recommendations, encourages learning which in turn delivers improvements in services.
15. The full independent Inquiry report has been anonymised and has taken account of the NPSA guidance but because it contains extensive personal information, drawn from confidential clinical records, about Ms B's life and the

SHA has not been given consent to publish this detail, the SHA has accepted the legal advice that it is not appropriate to publish the full report.

16. Instead it has been agreed with Ms B's legal representatives that the full independent Inquiry report will be shared with the family, the organisations and professionals involved in the case and under strict restriction. This will ensure that Mr A (child A's father) and his family receive a full explanation and that each agency can take all necessary action to reduce the risk of this happening again. The professional staff involved in the case will be able to understand the full background to the Inquiry team's findings and consider this in the context of changed practice.
17. It has been agreed with Ms B's legal representatives that the executive summary which details the main findings and recommendations of the panel, should be published. However, there is a wider public duty placed upon the SHA to ensure that others learn from these events and as the full report is not to be published a summary of the key events and lessons is outlined below. This will be placed on the SHA's web site together with the Executive Summary of the Inquiry.

The Care and Treatment of Ms B

18. The full independent report provides a chronology of events including Ms B's early life. The impact of the trauma she experienced as a child was never fully explored or resolved. At the age of 16 she met Mr A. She was welcomed by the extended family and achieved a period of stability.
19. Child A was born when Ms B was 17 years old. Ms B was young and vulnerable but is described as a good and caring mother when she was well. Unfortunately, over the next five years she developed an enduring psychotic illness requiring hospital admissions and continued support from the community mental health team. She also received help from the specialist team IMPACT with the early warning of relapse and the development of a prevention plan.
20. Her symptoms were complex. She had psychotic episodes and delusions that her partner, Mr A, would hurt child A of whom she was fiercely protective. She had physically attacked Mr A. On other occasions she would become mute and unresponsive which resulted in different diagnoses of paranoid schizophrenia, depression and dissociative stupor with behavioural elements.
21. She had a history of not taking her medication because of the side effects and the IMPACT team had identified that her condition was unstable and could deteriorate very rapidly.
22. Mr A gave up his job to look after Ms B and child A. During her relapses, this was very difficult. He understood her symptoms and knew when she was unwell. He recognised that child A could be at risk as a result of her mother's inability to care for her properly. There was never any indication that Ms B would harm her child.
23. In the days preceding child A's death, a series of circumstances came together which had an unforeseen and tragic outcome.

- Ms B was discharged from hospital on June 3rd 2003. Her discharge summary had a diagnosis of 'dissociative stupor with behavioural elements' referring to her mute and unresponsive behaviour during her admission. Her previous diagnosis of schizophrenia remained but this dual diagnosis was not fully explained to Ms B. She was referred back to the community mental health team but the arrangements for a medical review appointment fell through.
- Ms B believed she was not mentally ill and as on earlier occasions stopped taking her medication which had side effects.
- Ms B's symptoms had never completely disappeared and became worse. She became obsessed with child A's welfare and attacked her partner, Mr A on the evening of 25th June. The police were called and took her first to the police station where she became mute and unresponsive. She was referred to Manchester Royal Infirmary from where she was discharged home.
- The police and the hospital staff had only a partial understanding of recent events. They knew she had mental health problems and there had been a domestic incident but had no details of her medical case history. The hospital staff had only her calm assurances that she was well enough to go home.
- On the 26th June, her concerns about child A's welfare continued but Mr A managed to get child A to school. The head mistress and class teacher recognised that Ms B was unwell and between them they managed to separate mother and child and take child A to her class room. Mr A called an ambulance to the school but Ms B would not go with the ambulance. The headmistress recognised that Mr A was becoming increasingly distressed.
- The community mental health team care coordinator with two team colleagues, the team manager, and a community psychiatric nurse visited Ms B and the family at the grandmother's home later that day. They recognised that she required care but concluded that she had not reached the 'threshold for admission'.
- Ms B refused a number of community based options but agreed to an assessment the following day and to accept a prescription for diazepam which she could take if agitated. They were unaware of the full details of the previous evening's events when she had become violent towards Mr A and the subsequent impact it had had on Mr A. They assumed that Mr A would be staying with Ms B.
- Mr A, Ms B and child A then went home. Later, Mr A's mother took the prescription to Mr A and Ms B's home. Mr A was very distressed and told his mother that he could no longer cope. She suggested that he should go to his sister's house which he did.
- Mr A's mother contacted the police twice. First by phone to express her concerns and secondly in person having discovered that child A was not with her father (as she had expected). When the police went to the

house, Ms B appeared calm and spoke to them through the window. At 3.55am on the 27th June, a neighbour called the police who found that Ms B had killed her daughter.

Learning from the Inquiry

24. The inquiry concludes that:

- Child A's death could not have been predicted and therefore prevented.
- The actions of individuals were 'not directly causative of the tragedy' and there is no evidence to suggest that had they acted differently the outcome would have been different.
- However, the panel are clear that on a number of occasions the care provided was sadly lacking, the family were left isolated and felt let down.

25. It is for each agency to implement the recommendations and consider the actions of its staff and services. The SHA's concern is to improve patient safety in all organisations and ensure that recommended action has been taken. The report provides an invaluable insight into the challenges experienced by people with enduring mental health conditions, their families and the agencies involved in providing care.

26. Incidents happen when a series of events come together and an understanding of those events, people's actions and decisions can help to reduce the risk of it happening again. The lessons emerging from this Inquiry are consistent with those identified within the SHA's review of the other mental health legacy incidents 'Promoting Patient Safety' (2009): safeguarding vulnerable children, the involvement of carer's, compliance with medication, interagency collaboration and rigorous care planning and risk assessment processes.

27. Ms B came into contact with several professionals and agencies in the days preceding child A's death. They were all committed professionals working to provide Ms B with the care she required but as the investigation shows :

- They were making decisions and assumptions on the information they had available to them at the time. Individual professionals and most importantly the family had additional vital information which was not shared and it is with hindsight that the full picture becomes visible.
- They were managing busy case loads and incidents and had numerous demands on their time. The community mental health team had, at different times, to provide cover for sickness, maternity leave and the recruitment of new staff. On the 26th June 2009 the care co-ordinator was on call and responding to other emergency situations; the police were managing incidents following a pop concert.
- There was uncertainty about procedures and referral protocols.

28. Managing competing demands and taking decisions in crisis situations are the requirements of clinical practice and involve risk. To ensure that these risks are managed appropriately requires the following effective multi professional team and interagency working and clear processes and protocols that are understood by all those operating them.

- **Team Working and Multi Professional Collaboration**

The integrated community mental health team was described as 'ahead of its time' and included social work, medical and nursing input but it was stretched and at an early stage of its development. The systems and relationships in place need to enable team members to share the information that is available to them, challenge their assumptions and develop their expertise through supervision.

Strong teams have effective accountability, management, record and supervisory systems in place. Co-location and providing team members with assistance is the first step. The report highlights the importance of integrating the different professional perspectives to support a holistic approach and ensure that professionals make their expert contribution and involve other team members or professional colleagues appropriately.

- **Risk Assessment and CPA**

A rigorous Care Programme Approach is fundamental to effectively managing risks and providing holistic care. A CPA process was in place and the care coordinator and team were focusing primarily on Ms B, responding to her immediate practical needs and the management of her symptoms.

A rigorous analytical approach supported by good record keeping and regular review ensures that all concerns/risks were taken into account when making decisions and planning care.

Ms B had complex varying symptoms and different diagnoses. The detailed assessments and relapse prevention plan developed by the IMPACT team contained vital information.

In addition Ms B had a history of non compliance with medication. Ms B found coping with the side effects difficult and at the time of her last discharge from hospital, she believed that she was not mentally ill.

- **The Family and Carer's involvement**

A recurrent theme in many inquiries is the importance of listening to and involving carers. Mr A and his family knew Ms B well and they knew when she was ill. Mr A was Ms B's main carer, and a carer's assessment is critical for identifying risks when planning how best to provide services to Ms B.

- **Safeguarding Vulnerable Children**

Assessing any potential risks to the children of service users recognises the impact of mental illness on the family. Child A was the focus of Ms B's delusions. Ms B had not addressed the issues concerning her own childhood and when she was unwell she was not able to care for child A properly. However, at no time was there any indication that Ms B would harm child A; in fact she was very protective of child A.

- **Interagency Collaboration**

Referrals were made to other agencies and the agencies responded but at times, there was uncertainty as to who should be contacted, vital information was not passed on and there was no 'out of hours' service. The Inquiry's executive summary and recommendations identify the improvements to processes which need to be implemented.

However, it is difficult to design systems to meet all eventualities and the actions of the headmistress epitomise an important patient safety lesson: that when you have concerns it is important to take action and follow through.

She recognised that Mr A was having difficulty coping, that Ms B was not well and she was concerned for child A. She made repeated attempts to alert other authorities of her concerns and only stopped when she was assured that the community mental health team had arrived and were assessing the situation.

Changes Implemented by the Greater Manchester West Mental Health Foundation Trust

29. As the full report sadly demonstrates not all risks can be predicted and whilst it is not possible to guarantee that such tragedies will not happen again, there are measures which can reduce the risks. The Greater Manchester West Mental Health NHS Foundation Trust and Trafford Metropolitan Council have responded and their services are very different from those in place in 2003.
30. They have ensured that all the action points have been implemented from the two earlier investigations:
 - Bolton, Salford and Trafford Mental Health NHS Trust Internal Incident Review (November 2003).
 - Trafford Metropolitan Borough Part 8 Review under Child Protection Regulations (December 2003).
31. Both organisations co-operated fully with the independent inquiry into the care and treatment of Ms B. When the individual chapters were shared with the stakeholders, the trust and council jointly commissioned an independent review to establish their position in relation to the recommendations and to provide assurance that the trust and Trafford MBC arrangements were robust.

32. The draft report was received by the Trust in July 2009 and all recommendations from the Inquiry have been addressed. A summary of the action taken is attached (appendix 2). It indicates that:
- Multi-disciplinary working within the integrated mental health teams has been improved, and the weaknesses in the functioning of the Community Health Care Teams identified in the report have been addressed. The Care Programme Approach is now well established.
 - 24 hour access to crisis teams for individual families 7 days per week.
 - Greater Manchester West Mental Health NHS Foundation Trust works closely with all Local Authorities in relation to Child Protection and meets all statutory requirements of Safeguarding Children legislation and best practice.

NHS North West's Response to the Report

33. The introduction of national standards for CPA and the new community treatment orders will address some of the issues raised in the full Inquiry report. The SHA has reviewed the trust's response along with the trust's original legacy review submission and can confirm that these recurrent themes have been addressed. Outstanding actions from both the legacy review and this inquiry will be followed up by the PCT commissioners.
34. In terms of wider learning, the SHA has further assurance following the legacy review that other mental health trusts across the region have also taken steps to ensure that child safeguarding and carer's assessments are included in their risk assessments.
35. As with previous SHA independent reports the clinical quality team will be facilitating workshops for the clinical networks. Clinical leaders are keen to understand what happened and apply the lessons to their own services.
36. The North West Mental Health Improvement Programme will be undertaking development work with trusts to strengthen risk assessments in mental health with particular emphasis on the involvement of service users and carers.
37. In summary the SHA will be taking the following action in response to the report
- Offer a meeting with the family to ensure that their questions have been answered.
 - Circulate the full report to the key stakeholders.
 - Publish the executive summary on the NHS North West website and forward a copy to the NPSA, together with a copy of this report to set the Inquiry's executive summary in context.
 - The Clinical Quality Team will facilitate workshops with clinical networks to review the lessons learned.

- Mental Health Improvement Team will work with mental health trusts to improve risk assessment and to ensure that the service responds to the needs of users and carers.
- The Clinical Quality and Performance Management Teams will work with the PCT commissioners to ensure that the recommendations are fully implemented.

Recommendations

1. To accept the Inquiry's Executive Summary and Recommendations.
2. To offer the SHA Board's sincere condolences to the family.
3. To approve the proposed actions to reduce the risks of such a tragedy happening again.

Mike Farrar
Chief Executive

Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Interface of Mental Health and Children’s Services

Recommendation Number	Response
<p>A.1</p> <p>It is recommended that a practice development group be set up for all practitioners working at the mental health/child protection/child care interface using action learning principles to identify common blocks to practise and implement successful strategies to support parents.</p>	<p>This recommendation has been superceded by Local Safeguarding Childrens Board arrangements. The Trust is represented on all of the Local Authority Safeguarding Children’s Boards across Bolton, Salford and Trafford by a senior officer.</p> <p>Within the Trust, a joint safeguarding children’s group with safeguarding leads for each clinical service, and local authority safeguarding leads meets on monthly basis to share learning and best practice, any lessons from Serious Case Review and national and local policy in relation to child protection. The group also considers and problem solves any local practice difficulty, identifying solutions and action planning. It has developed standards around clinical supervision and policy for publication which sets standards for content of supervision and case discussions and introduced a rolling programme of audit planning which is reviewed annually.</p> <p>In response to the recent Care Quality Commission’s review of ‘Safeguarding Children’ nationally, the Board of Directors of the Trust has also reviewed arrangements against CQC requirements and is satisfied that it meets CQC requirements. These include:</p> <ul style="list-style-type: none"> • Meeting employment Criminal Records Bureau checks • All safeguarding policies and systems in place • Level 1 training mandatory for all staff • Named professionals are clear about their role and have appropriate support to carry out their role • Designated Board level Executive Director lead for safeguarding • Annual Report on child safeguarding activities to Board of Directors with agreed work-plan and rolling programme of audit. <p><u>This recommendation has been met.</u></p>

Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Interface of Mental Health and Children’s Services

Recommendation	Response
<p>A.2 It is further recommended that an audit process of the implementation of such steps arising from the practice development group’s recommendations be established and be the subject of regular review.</p>	<p>The Child Welfare and Adult Mental Health Practice Development Group is accountable to the Safeguarding Children’s Board in Trafford with the social care lead from the Trust as its Chair and representation from the Council’s safeguarding lead. It has a particular remit to:</p> <ul style="list-style-type: none"> • Maximise opportunities for the two services to work in partnership to improve outcomes for people with mental health problems and their families. • Audit and make recommendations about the professional development and training requirements of operational staff in both Adult Mental Health and Children’s Services. • Conduct audits to ensure service standards and delivery comply with the Joint Protocol and National Policy Guidance. <p>The development groups work is reported to the Local Safeguarding Board who will scrutinise all the practice group’s recommendations.</p> <p>The Annual Audit of Safeguarding Arrangements demonstrates that the named doctor takes a particular leadership role in this area using junior doctors to undertake meaningful audits. <u>This recommendation is ongoing</u></p>

Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Interface of Mental Health and Children's Services

Recommendation	Response
<p>A.3 It is recommended that a process for auditing the accessibility of CAT/CDAT and of the dedicated child protection line be devised and carried out monthly with reports going to senior manager and the LSCB.</p>	<p>Multi Agency Referral and Assessment Team (MARAT) has now replaced CAT/CDAT, and there is a fully operational child protection line, which is widely published through training and policy and procedures.</p> <p>Senior officers from the Trust sit on the Local Safeguarding Boards and ensure that the Trust has in place policies and procedures and working arrangements which support Local Safeguarding Boards. The Trust has an identified lead for safeguarding services for children and vulnerable adults in each of its district services. A named doctor leads the process of auditing the Trusts' compliance with the requirements of the Local Safeguarding Board.</p> <p><u>The Trust and Local Authority have met this recommendation.</u></p>

Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Medication

B.1	It is recommended that social workers do not advise anyone to change/stop medication, or request particular medication without that person first seeing a medical practitioner.	<p>While Social Workers are members of the community mental health teams, professional roles are very clearly defined and Trust Drug Policy and Procedures specifically comment on roles and responsibilities – Social Workers do not have professional responsibility for medication.</p> <p><u>This recommendation has been met.</u></p>
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**Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Referrals to Medical Practitioners**

Recommendation	Response
<p>C.1 It is recommended that when a referral is received by CMHT from a medical practitioner, a report should be made within 28 days of the initial contact with the patient. The report should outline the CMHT assessment plan, any actions required by the GP/medical practitioner and indicate arrangements for liaison and patient contact.</p>	<p>Any referral received by the CMHT is screened against the Serious Mental Illness Criteria. If referrals meet the criteria then:-</p> <ul style="list-style-type: none"> • Urgent referrals are seen the same day. • Non urgent referrals are seen within one week or less in most instances but a maximum wait of 2 weeks. <p>If referrals do not meet the criteria then the GP/Referrer are signposted to the most appropriate service which may be the Primary Care Mental Health Team.</p> <p>If referrals are accepted an assessment is carried out by the CMHT and if accepted for ongoing treatment, CPA documentations is sent to the referrer or a letter explaining why the client was not felt appropriate for ongoing treatment.</p> <p>This process has been independently audited and were found to be of good quality and of a standard format.</p> <p><u>This recommendation has been met and exceeded.</u></p>
<p>C.2 It is recommended that, where specific medical advice is sought the report back to the referrer must be checked by the Consultant Psychiatrist or by another medical practitioner to whom they delegate the task.</p>	<p>All medical changes are authorised by either the Consultant Psychiatrist or his/her delegated deputy. Each CMHT has a linked Consultant Psychiatrist and Junior Doctor. The addition of Staff Grade doctors for each locality has improved the availability of medical staff to undertake joint home visits, as part of standard practise/case management. This is preferable to joint visits only taking place when a request for a Domiciliary Visit has been made to undertake a Mental Health Assessment to ascertain if compulsory admission to hospital is indicated.</p> <p><u>This recommendation has been met.</u></p>

Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Contact Arrangements

Recommendation	Response
<p>D.1 It is recommended that information about working hours/availability of care co-ordinators should be made available to patients and carers and should include contact arrangements both in and out of working hours.</p>	<p>Each service user has the contact details of their care co-ordinator within their CPA Care Plan. Additionally, the Crisis Resolution Home Treatment Team is now available 24/7 for residents of Trafford. The Integrated Clinical Information System (ICIS) enables all practitioners to access the care record on a 24/7 basis to support continuity of care.</p> <p><u>This recommendation has been met.</u></p>

**Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Practice Guidance**

Recommendation	Response
<p>E.1</p>	<p>It is recommended that practice guidance be developed and made available to first line social managers on how to use supervisions effectively to assess and enhance the quality of practise, explore and manage risk or support or develop workers.</p> <p>The Trusts revised multi-professional supervision policy was ratified in July 2009 (Clinical and Social Care Governance Committee). This policy was developed by the Trusts Professional Advisory Group/Social Care, Nursing, Medical Staffing and AHP Leads.</p> <p>The Policy makes clear the roles and responsibilities of practitioners and supervisors in relation to supervision as an opportunity for critical reflection in practice and practice development.</p> <p><u>This recommendation has been met.</u></p>
<p>E.2</p>	<p>It is recommended that practice guidance be developed and implemented in relation to care planning to ensure that care planning is evidenced by all social care interventions which should be linked to the plan objectives and that case records demonstrate how the plan is being implemented and what it is achieving.</p> <p>The CPA Policy and ICIS IT systems are integrated health and social care policies and systems, which ensure that social work interventions are recorded in the CPA care plan. Should the social worker have care co-ordinator responsibilities for the patient/client, the production of the care plan will be their responsibility. A progress report is also included in the CPA/ICIS documents and this provides a running record of all contacts with a particular client/patient and identifies the author and the profession of the worker, ie Registered Social Worker, Support Worker.</p> <p>The national requirement is for care plans to be reviewed every 12 months. However, the Trust has set itself a local standard which is more challenging of care plan review every 6 months.</p> <p>The Trust was awarded the “Highly Commended” Care Programme Approach Association Award in Policy and Procedures to support the revised CPA Policy in January 2008. The documentation is included on Department of Health website as example of good practice.</p> <p><u>This recommendation has been met.</u></p>

**Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Protocols**

Recommendation	Response
<p>F.1 It is recommended that protocols are put in place to:</p> <ul style="list-style-type: none"> a) Clarify when medical personnel must be contacted or medical reviews requested by social workers for CMHT patients for whom they are key workers/care co-ordinators. b) Emphasise the rights of nearest relatives to request MHA assessments. c) Ensure that there are no artificial barriers to MHA assessments being undertaken. d) Ensure social workers in CMHTs are able to request directly of consultant medical staff that they undertake domiciliary visits. 	<ul style="list-style-type: none"> a) There are clear procedures in place for medical involvement at reviews. That is, there are weekly MDT meetings where all cases have the opportunity of being discussed with the Consultant Psychiatrist, Specialist Registrar and SHO. Care co-ordinators also attend ward rounds and outpatient appointments. Should a more urgent medical response be required the care co-ordinator will contact the specific Doctor, and if an urgent domiciliary visit is indicated, this will be undertaken by either the Consultant or Registrar. This meets the requirements of section (d) of this recommendation. b) The right of the nearest relatives to request Mental Health assessments is included in the revised CPA and Standard Care Procedures document (5.10.3.). This states it is particularly important that all Nearest Relatives are informed of their rights under Section 13(4) of the Mental Health Act 1983 to request an assessment if they believe admission is required where the service user is refusing to go into hospital. c) A protocol for staff based on the new Code of Practice and Reference Guide has been implemented to ensure that there are no artificial barriers to MHA assessments. <p><u>This recommendation has been met</u></p>

Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Care Programme Approach (CPA) Reviews

Recommendation	Response
<p>G.1 It is recommended that consideration should be given to enhanced CPA reviews being chaired independently (as many child protection cases are).</p>	<p>New CPA was introduced nationally since the Inquiry recommendation was first drafted. Nationally the requirement for a care plan review is every 12 months. The Trust is working to a minimum standard for CPA review of 6 monthly review with an emphasis on service user and carer partnership with the professionals involved in the planning and delivery of care.</p> <p>The emphasis on partnership and multi professional contribution to CPA reviews provide assurance that care planning is robust and inclusive.</p> <p><u>This recommendation has been met.</u></p>
<p>G.2 It is recommended that the Trust establish minimum information requirements for CMHT CPA reviews including the requirement for attendance by a medical practitioner and the requirement that professionals who cannot attend reviews are issued with a standard letter requesting reports/information in advance of the review.</p>	<p>The CPA Policy states that CPA reviews have to be multi-disciplinary. CPA reviews take place in a variety of settings, ie out-patient clinics, patients/clients own homes. There is a requirement to indicate who attends the review, who was invited, and for those absent, if any additional information has been obtained ie from mother, GP etc contacted by phone. All CPA Care Plans include advice to GPs on how they should respond if additional help is needed and the patient's GP receives a copy of the CPA review .</p> <p><u>This recommendation has been met and exceeded.</u></p>
<p>G.3 It is recommended that each CPA review consider whether the current care co-ordinator/care manager is best placed to service the client and whether any additional professionals need to be brought in.</p>	<p>Current systems for case allocation include a discussion about presenting needs and which professional has the most appropriate skills set to meet those needs.</p> <p>Where identified other professional skills will be sought to contribute to the overarching care plan in partnership with the service user.</p> <p><u>This recommendation has been met.</u></p>

**Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Case Management Arrangements**

Recommendation	Response
<p>H.1 It is recommended that, where required, job share arrangements shared responsibility for cases, rather than part-time arrangements, are used for employment of workers managing people on enhanced CPA.</p>	<p>Part-time workers are employed in the CMHTs to meet flexible working requirements and family friendly policies. Locality Managers would only allocate to part-time workers those cases with less frequency and intensity of need. In addition should there be an urgent need for a response, when the Care Co-ordinator is unavailable for whatever reason (leave, sickness, holidays), an appropriate response will be provided by the Duty Officer (who will often undertake house visits with a member of the Crisis Team). Should there be an extended period of absence by the Care Co-ordinator, the particular cases will be discussed by the MDT who would re-allocate the patient.</p> <p><u>This recommendation has been met.</u></p>
<p>H.2 It is recommended that where cases are closed or contact is suspended for a period of time, the referrer is made aware of the changes and that the patients' GP and other professionals involved are also advised.</p>	<p>In cases which are assessed as being 'stable', and no longer requiring the long term input of the CMHT certain conditions have to be met, for the case to be closed to the CMHT, and stepped down to the GP. These are: client has been stable for six months, (this includes no hospital admissions); client is managing their illness well; the GP is agreeable to CMHT support being withdrawn, and the client has an excellent community support network in place. If the client is stepped down to the GP, and the GP re-refers, the client is seen on the same day.</p> <p><u>This recommendation has been met.</u></p>
<p>H.3 It is recommended that artificial distinctions between referral and non-referral is reviewed across all social services.</p>	<p>A new system is now in place. The old team has been replaced by a multi-agency referral and assessment team that includes a full time duty social worker who can receive calls, a police officer, health visitor, and several social workers who can act on any referral. Unannounced OFSTED inspection found this to be good practice.</p> <p><u>This recommendation has been met</u></p>

**Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Recording Practice**

Recommendation	Response
<p>I.1 It is recommended that minimum standards be devised for social work case records and that these be subject to audit within the case file system.</p>	<p>The ICIS system includes all mental health social work case records as part of the integrated system, and they are subject to the same standards and audit as all CPA case notes. The standards are incorporated into the Ten Golden Rules of Clinical Record Keeping on ICIS. This places particular emphasis on the need for timely and accurate records, the use of non-technical language, and workers to record what is observed rather than assumption.</p> <p>The case notes seen on ICIS fulfil all the above recommendations. In addition audits of case records are carried out annually, by selecting a random number of case files, and by the audit being undertaken by a senior manager who is not the manager of that particular team. The format of the audit is comprehensive.</p> <p><u>This recommendation has been met.</u></p>
<p>I.2 It is recommended that file entries in supervision records should contain as a minimum: date of meeting, details of those present, follow up matters arising from previous session, a list of cases considered, particular concerns, questions of risks, actions to be taken by the supervisor and person supervised, date by which the actions are to be followed up and checked.</p>	<p>The revised Supervision Policy includes a proforma fulfilling all of these recommendation requirements, which is used for clinical audit purposes too.</p> <p><u>This recommendation has been met.</u></p>
<p>I.3 It is also recommended that in supervision files there should be a note in the record of any specific advice or instructions given, CPA and other reviews due and outstanding, any concerns the supervisor has expressed to the worker</p>	<p>Response as above. In addition, Commissioning for Quality and Innovation (CQUIN) Key Performance Indicators include an accurate figure, which identifies individual practitioners of CPA review dates and whether these are completed or not through ICIS.</p> <p><u>This recommendation has been met.</u></p>

	<p>(for example about frequency of contact with a patient), concerns the team member has expressed about anything which affects their capacity to do their work (eg work load).</p>	
<p>1.4</p>	<p>It is recommended that standards for case work recording are established and require as a minimum that social work records:</p> <ul style="list-style-type: none"> • Are legible • Are accurate • Are dated in terms of event and recording • Are signed • Are sequential and continuous • Are analytical and interpretative not simply descriptive • Provide quarterly summaries of progress on care plan goals and outcomes • Details needs not met. <p>State for each contact/intervention: the initiator, person involved, date of contact, type of contact, purpose of contact, action taken.</p>	<p>The ICIS system of case recording meets all the requirements including the need to state each contact/intervention, the person involved, date, type, purpose of contact, and action taken. This information is included in the on-going case records (ICIS Progress Notes).</p> <p><u>This recommendation has been exceeded.</u></p>

Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Continuity of Care

Recommendation	Response
<p>J.1 It is recommended that archiving of records of vulnerable young people no longer in receipt of services should be managed in a way which makes them readily accessible to staff who subsequently undertake assessments of their needs or management of their care.</p>	<p>All information on past Child Protection Conferences is stored separately in the Child Protection Unit. Other information is archived but is readily accessible to all workers. Paper files are also supplemented by a software system, and specific information officers are now employed to support accessibility by staff.</p> <p><u>This recommendation has been met.</u></p>

**Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Staff Development and Training**

Recommendation	Response
<p>K.1</p>	<p>It is recommended that training in implementing the CPA effectively, care planning and care co-ordination be made available to every CMHT member at least every 2 years.</p>
<p>K.2</p>	<p>It is recommended that basic and enhanced training in undertaking social histories should be made available on a rolling programme basis, to social work staff working with vulnerable adults.</p>
<p>Rolling Programme of CPA training will commence in November 2009 to ensure that the responsibilities associated with the role of CPA Care Co-ordinator in the context of national and local Mental Health Policy and emerging best practice is understood. All directorate care co-ordinator will be targeted and the training will also offer a joint learning exercise with inpatient and specialist staff to improve joint working arrangements. The Trust will also run training for non care co-ordinators and staff in third and voluntary sectors which will include service users and carers.</p> <p>Service user and carer involvement is built into the CPA training programme.</p> <p><u>This recommendation has been implemented.</u></p>	<p>The training programme has been planned and tendered by Trafford Council Employee Development Team to fulfil recommendation by May 2010.</p> <p><u>This recommendation will be met in May 2010.</u></p>

Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Carers

Recommendation		Response
L.1	It is recommended that training should be made available to all CMHT staff every 2 years on building effective partnerships with carers. Such training should emphasise that family carers are the backbone of support systems for people with mental illness and address interviewing carers and responding to the needs and concerns of carers.	<p>The training by Trafford Council Employee Development Team in collaboration with Trafford Carers Centre is incorporated within the CPA Training Schedule and delivered by the Carers Centre.</p> <p><u>This recommendation has been met</u></p>
L.2	It is recommended that all main carers of people on enhanced CPA should be seen on their own at least once a year for an assessment of their needs to be undertaken or updated. This assessment should include plans for meeting needs and details of unmet needs.	<p>Main carers of people on enhanced CPA are seen on their own each six months rather than a year for an assessment of their needs. Compliance with this target is monitored quarterly by the Board of Directors.</p> <p><u>This recommendation has been met and exceeded.</u></p>
L.3	It is recommended that carers assessments be audited and analysed at least every 12 months and a report prepared for the Trust on how far carers needs are being met, what is working, where gaps and problems are and how economies of scale can be achieved in addressing unmet need.	<p>The Trust has introduced a performance monitoring/audit system that provides all district services with a Performance Report on key CPA practice standards. This includes the standard of how many carers have been assessed or offered assessment in any given period of time. Reviewed quarterly at the Board of Directors.</p> <p>Following some innovative work involving carers in Bolton, the Trust has become a Department of Health pilot site for good practice and has received national investment to roll this out across the Trust.</p> <p><u>This recommendation is met.</u></p>

**Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Action Plan and Audit**

Recommendation	Response
<p>M.1 It is recommended that a sub-group of the LSCB in conjunction with BST develop an action plan for the implementation of these recommendations within four months of the report being received and that the implementation and outcomes be reviewed after one year.</p>	<p><u>This recommendation will be agreed and acted upon by LSCB and GMWMHT within the timescales suggested upon receipt of the final Inquiry Report.</u></p>

**Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Psychiatric Services**

Recommendation	Response
<p>N.1</p>	<p>At every admission to hospital as an inpatient a doctor must record in writing a full maudesley model history and mental state examination as soon as possible and present to the responsible medical officer.</p> <p>A good sound comprehensive history is now taken across the Trust by suitably qualified people for all admissions to inpatient services. A more robust and modern mental health practice is now provided which uses the full range of information gathering tools and initiatives on record keeping. Evidence is reviewed within the Board Performance Report, monitored monthly on gate keeping admissions. STAR Risk Assessment on Integrated Care Information System now includes safeguarding for children and vulnerable adults.</p> <p>In addition audits of admission checking of all new admissions on The Moorside Unit in Trafford have been carried out. The results demonstrated that over 90% of admissions had a full medical history taken within 48 hours of admission - the remaining patient's clinical condition preventing a history being taken within the timescale. Instead these were taken as soon as clinically appropriate.</p> <p>Formal supervision arrangements are in place and Ten Golden Rules of Good Clinical Record Keeping have been developed.</p> <p><u>This recommendation has been met.</u></p>
<p>N.2</p>	<p>A patient on a s2 admission should be considered for leave outside the hospital as soon as it is risk assess that it is safe to do so. If no leave is granted the reason for that must be recorded.</p> <p>Services have developed significantly and are different to those at the time of the Inquiry. The Trust has an amended form to complete (Section 176 Form) with conditions for leave. An annual audit is conducted by the Mental Health Act Commissioners with regular and transparent reviews by the Commissioner of Mental Health Act Compliance.</p> <p>In addition audits of admission checking of all new admissions on The Moorside Unit in Trafford have recently been carried out. Over 90% of admissions having full medical history taken within the first few days of admission.</p> <p><u>This recommendation has been met.</u></p>

N.3	On every instance of overnight leave risk assessments should be done before and after it takes place and recorded.	<p>Risk assessments before and after leave are recorded on ICIS as standard practice across the Trust. The need for risk assessment and recording is included in clinical risk and management training.</p> <p><u>This recommendation has been met.</u></p>
N.4	All patients who are discharged from hospital should be given an outpatients appointment before they leave the ward.	<p>Trust compliant with 7 day follow up target and monitored monthly at Board of Directors to ensure continued compliance.</p> <p><u>This recommendation is now obsolete.</u></p>
N.5	After each appointment matters to be addressed should be set out and recorded for which a date should be set.	<p>Recommendation now superceded by modern mental health practices and included within Care Programme Approach process of Annual Review. The Trust is compliant with national target and has set it self a more exacting target monitored monthly by Board.</p> <p><u>This recommendation has been superceded</u></p>
N.6	All discharge summaries must be reviewed and signed off by the Consultant Psychiatrist.	<p>This recommendation would be difficult to operationalise. All trainees receive weekly supervision by Consultant Psychiatrists which is build into job planning of the consultants and in SHO job plans agreed with the Deanery and School of Psychiatry. Weekly supervision includes a review of record keeping and is covered also specifically in induction programmes on record keeping and clinical correspondence.</p> <p>The signing of discharge summaries by Consultant Psychiatrists would introduce delays into the discharge process. The Trust has adopted an approach whereby this is a multi-disciplinary team agreed diagnosis prior to discharge.</p> <p><u>This recommendation has been met in the context of delivering modernised mental health services.</u></p>
N.7	Psychiatrists and mental health nurses should as part of continuing professional development, do training on the core concepts in mental health of “illness” “personality” and behaviour”.	<p>Trust has a supervision framework for all professionals covering continuing professional development. The Trust’s Medical Director as the lead responsible officer ensures compliance with the revalidation process for doctors requiring re-certification and covers all aspects of mental health.</p> <p><u>This recommendation has been met.</u></p>

**Inquiry into the Death of Child A
Trust Response to Inquiry Recommendations
Psychiatric Services**

Recommendation	Response
<p>N.8</p>	<p>Training in mental health for medical practitioners should include training on note taking as part of an appropriate standard</p>
<p>All trainees receive weekly supervision by Consultant Psychiatrists which is built into job planning of consultant medical staff and in SHO job plans agreed with the Deanery and School of Psychiatry. Weekly supervision includes review of record keeping covered also specifically in induction programmes on record keeping and clinical correspondence.</p> <p><u>This recommendation has been met.</u></p>	
<p>N.9</p>	<p>Patients on enhanced CPA should see their RMO at least once a year.</p>
<p><u>This Recommendation has been superceded</u></p> <p>The Trusts strict target of every 6 months rather than the required 12 months for CPA Review.</p>	
<p>N.10</p>	<p>There should be a registered medical practitioner present at the weekly community health team meetings.</p>
<p>Weekly meeting attendance at community mental health team recorded from multi-disciplinary team. Clinicians requirement to attend included within job planning and performance management framework to address lapses in attendance.</p> <p><u>This recommendation has been met.</u></p>	

REPORT OF THE

INQUIRY

INTO THE DEATH OF CHILD A

FRANCES PATTERSON Q.C.

DRAFT

JANUARY 2010

EXECUTIVE SUMMARY
AND RECOMMENDATIONS

CHAPTER 1

EXECUTIVE SUMMARY

- 1.1 Child A was born in December 1997. She was killed by her mother in June 2003 when she was stabbed more than 50 times. Her mother, Ms B, pleaded guilty to murder in 2004.
- 1.2 After submission of the main report from the Inquiry, Ms B had her appeal against conviction allowed by the Court of Appeal in 2008. A conviction of manslaughter on the grounds of diminished responsibility was substituted for the earlier conviction of murder. Ms B was sentenced to a Hospital Order with a Restriction Order unrestricted in time.
- 1.3 In giving the judgement of the Court of Appeal, Lord Justice Toulson recorded that Ms B suffered from paranoid schizophrenia which had a relapsing and remitting course. In bad times she suffers from psychotic episodes when she suffers from delusions and her mood becomes severely disordered. In the days leading up to the tragedy he recorded that a number of people who knew her had expressed concerns about her state of mind. He observed that the case had been *“not only tragic but (an) exceedingly difficult case over a number of years.”* (sic)
- 1.4 Those words sum up the position which faced the Inquiry Panel in carrying out its task.
- 1.5 With Ms B’s prolonged history of mental illness a range of agencies were involved with her care and had been for some time. None predicted or expected any harm to any child of Ms B. The task of the Inquiry Panel was to investigate into the circumstances leading up to the death of Child A, examine whether there were any lessons to be learnt and to make recommendations for the future.
- 1.6 We carried out that process through oral hearings, examination of the mass of background documents and expert reports into the overall circumstances and in relation to each agency.

Community Mental Health Team (CMHT)

- 1.7 The CMHT was involved with the care of Ms B from June 1998 when she was referred to them by her GP. The establishment of an integrated mental health service

in Trafford for planning and delivery was advanced and pre-empted Department of Health Guidance by some years.

- 1.8 The problem was that, despite its objective of integration, the service did not function in a truly integrated way. It operated in a strongly medicalised and individualised approach where those perspectives dominated rather than being a broad and equal mix of perspectives including a psycho social one.
- 1.9 As a result the team did not function as it should. The psycho social element that effective social workers can bring to the team was, as a result, sadly lacking throughout the time of the Inquiry investigation.
- 1.10 Ms I was the Approved Social Worker (ASW) looking after Ms B throughout the period in question. She completed her training as such in March 1998 and was added to the list of ASWs in October of that year. She was relatively inexperienced when she took on the case of Ms B in June 1998.
- 1.11 The social worker, Ms I, was well intentioned and cared for her clients but she was hampered by too heavy a case load, inadequate supervision and insufficient resource support. She was time poor. She began by adopting too narrow an approach to the care of Ms B which she was then unable to correct herself and was not encouraged to do so by others. She did not think across a sufficiently broad perspective and was not encouraged to think in a psycho social way. She failed to adopt a longitudinal view when dealing with Ms B.
- 1.12 Despite Ms B being on enhanced Care Programme Approach (CPA) her CPA reviews were lacking. That meant that there was a missed opportunity for management overview and involvement in her case. The social worker's involvement with Ms B coincided with a time when there was insufficient team management and leadership for most of the time within the Trafford North team.
- 1.13 Mr A was the partner, carer and constant presence for Ms B. He was central to the family unit and critical in supporting Ms B and providing child care for their children. Yet his needs were never assessed by the CMHT.
- 1.14 That omission was indicative of the failure on the part of the CMHT to consider the family as a unit, to think in a holistic fashion and provide a longitudinal perspective to their work with the family. The broader family needs and requirements were consistently ignored. As a consequence, and in spite of the occasional positive

experience, the family have found their involvement with social services to be a bruising and disenchanting encounter.

- 1.15 The social work assessment in the afternoon of 26th June 2003 was seriously flawed. Although the resulting plan was sufficient on the information that the team drew out on the afternoon, they did not elicit vital pieces of information relating to the incident of the previous evening or the events at the school during the day which may have affected the decision-making process. Further, the plan was built around the assumption that Mr A would stay the night with Ms B and Child A but no party asked him whether that was to be the case.
- 1.16 At the time under investigation by the Inquiry, the CMHT was under performing and not delivering the breadth of care with the ethos of clarity, care and consistency which are the hallmarks of the CPA process and which should characterise all of its processes and practices. It was a service which at the time had endemic weaknesses and serious failings.
- 1.17 There was however, nothing which gave anyone within the CMHT who was involved with the family any indication of the possibility that Ms B might be violent to her child in such a fatal way in the early hours of 27th June 2003. Ms B had not perpetrated violence towards child A on any previous occasion and was, if anything, over protective towards her.
- 1.18 The many failings on the part of the CMHT are thus not directly causative of the tragedy here.

Psychiatric Services and Care

- 1.19 Ms B was involved with psychiatric services from 1999. She had three admissions to Moorside Hospital. Between those periods of in patient treatment there were occasions of relapse that were treated in the community and with periods of respite care at Chapel Road. There was a constant ebb and flow of psychiatric problems during the period of the Panel investigation.
- 1.20 Of the inpatient stays at Moorside there were three. They were of varying length. First, from 29th June 1999 to 22nd June 2000, a substantial length of time some six months after giving birth to Child A. On that occasion she was diagnosed with schizophrenia. Second, from 14th May 2001 until 12th July 2001 various diagnoses were considered and depression without psychosis recorded. Third, from 15th May

2003 until 3rd June 2003. The discharge summary on that occasion recorded a diagnosis of “dissociative stupor relating to behavioural element.”

- 1.21 There was no acknowledgement of the longitudinal diagnosis in the discharge summary from the third admission which made no mention of the underlying state of Ms B. The discharge summary was below the standard to be expected at the time. Ms B, herself, clearly understood her diagnosis as at June 2003 to be of a different condition than she had had previously. She concluded that she was not ill but that her problems were behavioural.
- 1.22 Despite assertions by Dr A, the consultant psychiatrist at the time of the third admission, that the dual diagnosis was explained to Ms B, there were no records to support that contention. The independent expert evidence found Ms B’s belief in her condition unsurprising as was the fact that she stopped taking her medication. The Panel found that Dr A was insufficiently clear and rigorous in her approach to communication and record keeping in the case of Ms B. Her failure to impart a clear understanding of Ms B’s condition to Ms B contributed to her condition after discharge.
- 1.23 Ms B was clearly a complex case diagnostically. She began to relapse shortly after her discharge on the third occasion. Her partner, Mr A was of the view that she was only partially treated. Ms B stopped taking her medication shortly after discharge. There was no outpatient appointment to follow up with Ms B. The system for making outpatient appointments was imperfect.
- 1.24 That is not to say that Dr A’s failures were causative of the events of 26th/27th June. No one could have foreseen the tragic events of that day and evening. What is clear is that the overall performance of Dr A was lacking.

The General Practitioner

- 1.25 Dr B was the GP for Ms B throughout the period of 1998-2003. He was a competent but busy inner city GP. He saw Ms B at regular intervals and mostly he had a good relationship with her.
- 1.26 Dr B recognised at the outset that he required help in the management of Ms B. He referred her to the CMHT. They took just short of a year to respond to that referral which was not satisfactory.

- 1.27 He was confused by the discharge diagnosis from the third admission that Ms B was at Moorside. He responded to the request from the social worker, Ms I, on the afternoon of 26th June to issue a prescription for diazepam for Ms B. He believed then that there had been an assessment of Ms B's condition involving a psychiatrist.
- 1.28 Through his regular contact with Ms B, the GP was potentially an important resource who could have been better used by the CMHT operating in a more holistic way.

The Greater Manchester Police (GMP)

- 1.29 The GMP became involved in the early hours of 26th June 2003 when they were called to deal with the domestic incident when Ms B was being violent to her partner, Mr A, the night before the killing.
- 1.30 There was confusion amongst the police as to the extent of their powers of arrest initially. They arrested Ms B and took her to Stretford Police Station where the Sergeant referred her on to the Manchester Royal Infirmary. That was an appropriate act.
- 1.31 The dealings of the police with Mr A in the early hours of the morning were lacking, in that they failed to involve him in their decision making process as to future charges against Ms B.
- 1.32 After the events of the night, the GMP sent a fax describing the events to Social Services. The description was inadequate in that, amongst other factors, it failed to describe the presence of children at the premises. There is now a revised Information Sharing Protocol and Assessment Procedure which should avoid the deficiencies that were thrown up as a result of the occasion of investigation.
- 1.33 The police became involved again in the early evening of 26th June. The partner's (Mr A) family had become increasingly concerned about the condition of Ms B and were frustrated by the failure on the part of the CMHT to section her. They telephoned Stretford Police Station to express their concerns in the hope that the police could act. The police were restricted in their actions as a result of the action on the part of the CMHT that afternoon. Despite that, police constables were sent round to the family home to check on the conditions. That was an appropriate course of action. All seemed to be well when they attended. They spoke to Ms B who communicated through an upstairs window. There was no basis upon which they could have forced entry.

- 1.34 At about 10 pm, Mr A's mother and brother (Mrs E and Mr F) attended in person at Stretford Police Station. They had learnt during the course of the evening that Ms B was now alone in the house with Child A. With remarkable intuition and prescience they pleaded with the police that they do something as Child A was alone with her mother and needed help. The police were restricted in what they could do given the intervention earlier that day on the part of the CMHT. Sgt A could have ensured that the family had the emergency contact number of the Social Services or he could have referred the case on to the emergency team. He failed to do either.
- 1.35 That is not to say that the Emergency Duty Team would necessarily have acted in a way, or within a time, that would have avoided the tragedy but at least the family would not have felt bereft and without help as they understandably did after the events of the evening.
- 1.36 With the exception of the incident set out, the GMP, although confused in their actions at times, conducted themselves appropriately in the circumstances and did not contribute to the events in question. Although there were occasions when their conduct was lacking it was not of direct relevance to the matters of the Inquiry investigation.

Exemplary Conduct

- 1.37 There were examples of exemplary conduct that the Panel uncovered in their investigations. Two services stood out amongst the rest. They were the education service and IMPACT.

Education Services

- 1.38 The head teacher and Child A's form teacher at Victoria Park Infants School were extremely impressive, both as witnesses and in their conduct during the critical events before the evening of 26th June.
- 1.39 Faced with an awkward and potentially distressing episode for the whole school on the morning of 26th June (the day of the school photograph), when Ms B arrived late at school clinging on to Child A and then refused to let Child A go, both acted with sensitivity, insight and care.
- 1.40 The head teacher, Mrs S, tried to contact Social Services because of her concern for the family, the evident state of Mr A in particular, and to explain what she had witnessed after Ms B had brought Child A to school.

- 1.41 The head teacher, Mrs S, did not rest until she had made, after repeated attempts, contact with the Social Services and assured herself that the CMHT was at the family's house assessing Ms B. She thought that Ms B would be sectioned under the Mental Health Act.
- 1.42 Miss T, the form teacher, was able to take Child A into the classroom, away from her mother and ensure that Child A was not disturbed by what she had seen and experienced.

IMPACT

- 1.43 The IMPACT Team were involved over a period from March 2000 to March 2002 with cognitive therapy work with Ms B. They worked on both an individual and family basis.
- 1.44 Mr M, Mr N and Dr C, in particular, thought and acted in a holistic manner and brought a degree of rigour of process that was lacking in many of the other agencies. Through their intervention they devised an early warning signs relapse prevention plan and worked with the family as a whole.
- 1.45 The team had a process of anticipating problems rather than reacting to them. Their action was goal orientated, focused and well documented. They were instrumental in initiating the CPA Review in 2002. Ms B engaged well with their efforts. Whilst never fully in control of her thoughts she learnt to challenge them to some extent as a result of the intervention on the part of IMPACT.
- 1.46 The IMPACT Team were an example of good practice.

Conclusions

- 1.47 Despite two examples of good practice those examples were isolated and stand out.
- 1.48 There was nothing to give rise to any suspicion that Ms B would harm her daughter but the events leading up to the horrific incident in which Ms B killed Child A revealed various practices on the part of the agencies involved with Ms B that were sadly lacking.
- 1.49 As a consequence the family was neglected. They were not treated as a whole unit with inter-related needs. Rather, there was a narrow focus on the medical and practical needs of Ms B.

- 1.50 In many instances the stakeholder agencies have recognised their practices were lacking. They have taken steps to sort out their own systems. We hope our recommendations will assist in that on going process also.
- 1.51 One is left, however, with an over-riding feeling of sympathy for Child A's family. Their intuition was not listened to. Yet they knew Ms B the best. As a result they are bound to feel let down by a system that failed to act in relation to a situation that they rightly thought was bound to end in danger to Child A.

CHAPTER 2

RECOMMENDATIONS

2.1 The recommendations of the review panel are set out below.

A. Interface of mental health and children's services

A.1 It is recommended that a practice development group be set up for all practitioners working at the mental health/child protection/child care interface using action learning principles, to identify common blocks in practice, and promote and implement successful strategies to support parents with mental illness and protect and support their children.

A.2 It is further recommended that an audit process of the implementation of such steps arising from the practice development group's recommendations be established and be the subject of regular review.

A.3 It is recommended that a process for auditing the accessibility of the Community Advice Team/Children's Duty & Assessment Team (CAT/CDAT) and of a dedicated child protection line be devised and carried out three monthly with reports going to the senior manager and the Local Safeguarding Children's Board (LSCB).

A.4 It is recommended that the functionality of the CDAT/dedicated child protection lines is tested each day.

A.5 It is recommended that a review of the telephone lines into the CDAT team be carried out with particular reference to a provision of a dedicated line with a queuing system which other employees of Trafford Metropolitan Borough Council can use.

B Medication

B.1 It is recommended that all social workers in CMHT or social services teams must be reminded that:

- They must not advise anyone to change or stop taking medication
- They must not request a particular medication for a patient without that patient being seen by a registered medical practitioner.

C Referrals from Medical Practitioners

- C.1 It is recommended that when a referral is received by CMHT from a medical practitioner, a report should be made to them within 28 days of the initial contact with the patient. The report should outline the CMHT assessment plan, any actions required by the GP/medical practitioner and indicate arrangements for liaison and patient contact.
- C.2 It is recommended that, where specific medical advice is sought, the report back to the referrer must be checked by the Consultant Psychiatrist or by another medical practitioner to whom they delegate the task.

D Contact Arrangements

- D.1 It is recommended that information about working hours/availability of care coordinators should be made available to patients and carers and include contact arrangements both in, and out of, working hours in the event of the co-ordinator being unavailable.

E Practice Guidance

- E.1 It is recommended that practice guidance be developed and made available to first line social managers on how to use supervision effectively to assess and enhance the quality of practice, explore and manage risk or support or develop workers.
- E.2 It is recommended that practice guidance be developed and implemented in relation to care planning to ensure that care planning is evidenced by all social work interventions which should be linked to the plan objectives, and that case records demonstrate how the plan is being implemented and what it is achieving.

F Protocols

- F.1 It is recommended that protocols are put in place to:
- i. Clarify when medical personnel must be contacted or medical reviews requested by social workers for CMHT patients for whom they are key worker/care co-ordinator.
 - ii. Emphasise the rights of nearest relatives to request Mental Health Act (MHA) assessments

- iii. Ensure that there are no artificial barriers to MHA assessments being undertaken;
- iv. Ensure social workers in CMHTs are able to request directly of colleague consultant medical staff that they undertake domiciliary visits.

G Care Programme Approach (CPA) Reviews

- G.1 It is recommended that consideration should be given to enhanced CPA reviews being chaired independently (as many child protection case conferences are).
- G.2 It is recommended that the Trust establish minimum information requirements for CMHT CPA reviews, including the requirement for attendance by a medical practitioner and the requirement that professionals who cannot attend reviews are issued with a standard letter requesting reports/information in advance of the review.
- G.3 It is recommended that each CPA review consider whether the current care coordinator/care manager is still best placed to service the client and whether any additional professionals need to be brought in.

H Case Management Arrangements

- H.1 It is recommended that, where required, job share arrangements with shared responsibility for cases, rather than part time arrangements, are used for employment of workers managing people on enhanced CPA.
- H.2 It is recommended that, where cases are closed, or contact is suspended for a period of time, the referrer is made aware of the change and that the patient's GP and other professionals involved are also advised.
- H.3 It is recommended that artificial distinctions between "referral" and "non-referral" are reviewed across all social services.

I Recording Practice

- I.1 It is recommended that minimum standards be devised for social work case records and that these are subject to audit within the existing case file system.
- I.2 It is recommended that file entries in supervision records should contain as a minimum:
- The date of the meeting

- Details of who was present
- Follow up to matters arising from the previous session
- A list of cases considered – and whether this is routine or requested consideration and if the latter, the reasons detailing for each case
- Particular concerns
- Questions of risks
- Actions to be taken by the supervisor and person supervised, and
- The date by which the actions are to be followed up/checked.

I.3 It is also recommended that in supervision files there should be:

- A note in the record of any specific advice or instructions given
- CPA and other reviews due and outstanding
- Any concerns the supervisor has expressed to the worker (for example about frequency of contact with a patient); and
- Concerns the team member has expressed about anything which affects their capacity to do their work (e.g. workload)

I.4 It is recommended that standards for casework recording are established and require as a minimum that social work case records:

- Are legible
- Are accurate
- Are dated, in terms of event and of recording
- Are signed
- Are sequential and continuous
- Clearly distinguish opinion and fact
- Are analytical and interpretative not simply descriptive
- Provide quarterly summaries of progress on care plan goals and outcomes
- Detail needs not met
- State for each contact/intervention: the initiator, persons involved, date of contact, type of contact, purpose of contact, action taken.

J Continuity of Care

J.1 It is recommended that the archiving of records of vulnerable young people, no longer in receipt of services, should be managed in a way which makes them readily

accessible to staff who subsequently undertake assessments of their needs or management of their care.

K Staff Development and Training

- K.1 It is recommended that training in implementing the CPA effectively, care planning and care co-ordination be made available to every CMHT member at least every two years.
- K.2 It is recommended that basic and enhanced training in undertaking social histories should be made available on a rolling programme basis, to social work staff working with vulnerable adults.

L Carers

- L.1 It is recommended that training should be made available to all CMHT staff every two years, on building effective partnerships with carers. Such training should emphasise that family carers are the backbone of support systems for people with mental illness and address interviewing carers and responding to the needs and concerns of carers.
- L.2 It is recommended that all main carers of people on enhanced CPA should be seen on their own at least once a year for an assessment of their needs to be undertaken or updated. This assessment should include plans for meeting needs and details of unmet need. Such a system should be flexible and responsive to the carer's needs and an assessment may be triggered by a significant event during the year.
- L.3 It is recommended that carers' assessments be audited and analysed at least every 12 months and a report prepared for the Trust on how far carers' needs are being met, what is working, where gaps and problems are and how economies of scale can be achieved in addressing unmet need.

M Action Plan and Audit

- M.1 It is recommended that a sub group of the Local Safeguarding Children's Board in conjunction with the Primary Care Trust develop an action plan for the implementation of these recommendations within four months of the report being received and that the implementation and outcomes be reviewed one year after.

N Psychiatric Services

- N.1 It is recommended that at every admission to hospital as an inpatient, a doctor must record in writing a full Maudsley model history and mental state examination as soon as possible and present it to the responsible medical officer (RMO) .
- N.2 It is recommended that a patient on a Mental Health Act Section 2 admission should be considered for leave outside the hospital as soon as it is risk assessed that it is safe to do so. If no leave is granted the reason for that must be recorded on the file.
- N.3. It is recommended that on every instance of overnight leave, risk assessments should be done before and after it takes place and recorded.
- N.4 It is recommended that all patients who are discharged from hospital should be given an outpatients appointment before they leave the ward.
- N.5 It is recommended that after each outpatient appointment, matters to be addressed should be set out and recorded for the next appointment for which a date should be set.
- N.6 It is recommended that all discharge summaries must be reviewed and signed off by the Consultant Psychiatrist.
- N.7 It is recommended that psychiatrists and mental health nurses should, as part of continuing professional development, do training on the core concepts in mental health of “illness” “personality” and “behaviour.”
- N.8 It is recommended that training in mental health for medical practitioners should include training on note taking to ensure that all material considerations are recorded and that the note taking is of an appropriate standard.
- N.9 It is recommended that patients on enhanced CPA should see their RMO at least once a year.
- N.10 It is recommended that there should be a registered medical practitioner present at the weekly Community Health Team meetings.

N.11 As a matter of good practice the carer should be involved in all significant decisions, such as discharge from hospital or rescission of a section 2 detention, wherever possible and practicable to do so, relating to the service user.

O Greater Manchester Police

O.1 It is recommended that all police officers receive some basic training in mental health issues both as part of their induction training and as part of their continuing professional development

O.2 It is recommended that all persons in custody transferred to hospital be accompanied by a written report from the police (Detained Persons Medical Form), which is to be handed over to the receiving hospital with a receipted copy handed to the police

O.3 It is recommended that all Custody Officers transferring a person in custody to hospital, carry out, and record, a Risk Assessment for the continued detention, so that the accompanying officers know what is expected of them in all circumstances of the continued detention of the detained person in custody. At all material times, instructions should be given that at least one officer should accompany the detained person until his/her release

O.4 It is recommended that should there be a visit to the family of the detained person, that the officers should exercise due sensitivity and thoroughness in their dealings with the family, such that the family views are elicited and recorded as to the potential return home of the detained person and any potential views on laying of criminal charges or the institution of a caution against the detained person;

O.5 It is recommended that a template fax be devised for use after domestic violence incidents adapted from the Domestic Abuse Information Sharing Form (or similar) to ensure that key information is not omitted from any onward transfer such as the time of the incident, whether children were present in the home and whether they witnessed any part of the incident;

O.6 It is recommended that all Station Sergeants have, readily accessible, the telephone number of the Emergency Duty Team from Social Services for them to give out in appropriate circumstances to members of the public.

- O.7 It is recommended that the policy of recording information on FWINS is reviewed to ensure that
- there is a proper policy for the grading of incoming calls;
 - there are proper quality control and assurance procedures in the use of FWINS with an objective of minimising inaccuracies within them.
- O.8 A policy be devised and adopted of communicating with the family and/or carer of the detained person, wherever possible to do so, where the detained person's presentation and/or detention may relate to mental health issues to elicit as much information as possible about the detainee before the GMP decide what course to follow.

THIS EXECUTIVE SUMMARY IS PUBLISHED BY THE NW NHS,
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JANUARY 2010 FINAL

NHS North West

Report into the inquiry into the Death of Child A

Questions & Answers

A. GENERAL QUESTIONS

1. What are the background facts to the case?

Child A was born in 1997. She was killed by her mother in 2003 who pleaded guilty to murder in 2004. Ms B had her appeal against conviction allowed by the Court of appeal in 2008. A conviction of manslaughter on the grounds of diminished responsibility was substituted for the earlier conviction of murder. Ms B had been sentenced to a hospital order with a restriction order unrestricted in time.

Ms B had been receiving care from North West mental health services due to her developing a psychotic illness at times requiring hospital admission and at others, needing continued support from the community mental health team.

2. What are the roles of the agencies involved?

The following agencies are involved in this case:

- **NHS North West Strategic Health Authority** – responsible for commissioning independent investigations into serious untoward incidents; for accepting reports produced and determining publication; we are responsible for making sure that lessons identified in independent reports are shared across clinical services;
- **Greater Manchester West Mental Health Services NHS Foundation Trust** – responsible for providing services to people with mental illness and in this case, for providing both inpatient and outpatient (community) services to support Ms B.
- **Trafford Metropolitan Borough Council** – responsible for providing social services to support individuals – in this case doing so via the integrated community mental health team.
- **Manchester Royal Infirmary** –in this case, responsible for providing emergency care and treatment when Ms B presented to their services
- **Greater Manchester Police** – responsible for responding to emergency. Contacted by family members as domestic incidents arose
- **Trafford Primary Care Trust** – responsible for commissioning local health services for Trafford residents including mental health and primary care services

B. QUESTIONS RELATING TO THE INQUIRY ITSELF

1. Who commissioned this report / review?

The inquiry was commissioned by the former Greater Manchester SHA via Trafford Primary Care Trust.

2. When was the inquiry commissioned?

The inquiry was commissioned in 2005.

3. Who were the panel members?

The chair Frances Patterson QC was supported by fellow panel members Dr VY Allison-Bolger, Consultant Psychiatrist, member of the Mental Health Review Tribunal and Ms Alyson Leslie MA (Oxon) Social Worker.

In addition, the Inquiry heard from a number of expert witnesses during the course of the Inquiry; in some cases, selected by the professionals and organisations involved.

4. Who selected the panel members to review this case?

Trafford PCT appointed the Chair and panel members. The chair needed to be a senior barrister and a selection panel, chaired by the PCT Chair chose Ms Frances Patterson QC as the preferred candidate. This reflected her considerable experience in public law and experience as a Queen's counsel and part-time Recorder in the Criminal Courts. Ms Patterson was involved in selection of the other panel members.

Dr Allison-Bolger is an experienced consultant psychiatrist who has sat as a part-time medical member of the mental Health Review Tribunal. Ms Alyson Leslie was appointed after the original social work panel member died. Ms Leslie was selected on the basis of her experience at a senior level in social work; her experience as an Associate Member of the GMC and having chaired other similar inquiries.

5. What were the criteria used to do this?

The criteria are described above.

6. What were the Inquiry's Term of Reference & objectives?

The terms of reference for the Inquiry were:

- 1) To examine all the circumstances surrounding the treatment and care of Ms B by the agencies involved with her;
- 2) To examine the adequacy of co-ordination, collaboration, communication and organisational understanding between the various parties involved in the care of Ms B or in the provision of services to her, in particular, whether all relevant information was effectively passed between the parties involved and other relevant agencies and whether such information was acted upon adequately;

- 3) To examine the adequacy of the communication and collaboration between the statutory agencies and the family of Ms B and to consider the adequacy of support, information and liaison with her family;
- 4) To review and comment on the adequacy of all records in respect of the care and treatment of Ms B; and
- 5) To prepare an independent report of the Inquiry's findings and make recommendations as appropriate to the Trafford North Primary Care Trust/Greater Manchester Strategic Health Authority.

In summary, the task of the Inquiry Panel was to investigate into the circumstances leading up to the death of Child A, examine whether there were any lessons to be learnt and to make recommendations for the future. The terms of reference were agreed with the stakeholders involved in the case

7. Which organisations & individuals did the Inquiry take evidence from?

The Inquiry panel heard evidence from a range of expert witnesses including psychiatrists, social workers, a GP and those representing the stakeholders including Trafford PCT, Greater Manchester West Mental Health NHS Foundation Trust, Trafford Metropolitan Borough Council and Greater Manchester Police. The panel received evidence from family members and from Ms B herself.

C. QUESTIONS RELATING TO PUBLICATION OF THE INQUIRY REPORT

1. How will the Inquiry report be published?

The full Inquiry report will not be published widely; it will be published under restriction to the stakeholders; the family; Ms B and the professionals involved in the case.

The Inquiry's Executive Summary and Recommendations will be published on the SHA's website, www.northwest.nhs.uk, after it has been received by the NHS North West Board on Wednesday 13 January 2010.

2. Why is the SHA not placing the full Inquiry report into the public domain

The SHA has a responsibility to make sure that, in publishing any independent report, it takes account of legal advice relating to consent to publish; data protection; and human rights legislation. This is balanced against publication in the wider public interest. In this case, there is a need to protect the interests of a minor (a sibling) and the mother of child A has not given consent to confidential clinical information being shared. The SHA's legal advice is that it can fulfil its duties by:

- Sharing the full report under restriction to the organisations and professionals involved – this means they are able to use it to improve practices and systems where that is necessary; this will enable agencies to take any necessary action to reduce the risk of similar incidents happening again;
- Sharing the Executive summary and recommendations by placing it into the public domain, together with an SHA Board report that draws out the lessons identified by the Inquiry panel;

- Sharing the full report under restriction with the family so that they have a full understanding and explanation for the circumstances leading to this tragic incident.

3. Why is the report and Executive summary anonymised?

As a general principle, the SHA has determined that all investigation reports will be anonymised. This approach is to encourage health care staff to raise concerns about patient safety and give detailed accounts of serious incidents openly to such investigations.

4. Did the other stakeholders concerned have the opportunity to comment on the inquiry report?

All stakeholders have had the opportunity to comment on the draft report, for factual accuracy. All the comments have been considered by the independent panel; some have been accepted as valid and included in the final Inquiry report which was presented to NHS North West at a private meeting in December 2009, to comply with the legal position regarding publication.

5. How long has it taken to publish this review?

The Inquiry panel were appointed in 2005. The initial stages of evidence gathering were completed by November 2006 and sections of the draft report were issued in November and December 2007 to individuals and/or organisations for factual accuracy checks and further representation was allowed. All the comments have been carefully considered by the independent panel; some have been accepted as valid and included in the final report.

6. Why has the process leading to publication taken so long?

It is also important that the SHA acts in a consistent way and applies the principles of patient safety and public interest described in this report regardless of when the investigations were commissioned. This means that a series of due diligence checks have to be undertaken and professional and legal advice sought to assure the SHA that due process had been followed.

A key part of the process is to enable factual accuracy checks on the report and compliance with the terms of reference. It has taken time to work through these issues, distinguishing between factual accuracy based on evidence, the opinion of the reviewers and the perception and experience of those involved.

D. QUESTIONS RELATING TO THE OUTCOME OF THE INQUIRY/REPORT ITSELF

1. What were the Inquiry's findings?

The Executive Summary and Recommendations provide an outline of the Inquiry's findings. This can be accessed on the SHA's web site www.northwest.nhs.uk after it has been received by the NHS North West Board on Wednesday 13 January 2010.

The key message is that this tragic incident could not have been predicted. There are a series of findings that will help improve mental health services and establish improved processes such as inter-agency communication.

2. What patient/public safety lessons have been learned?

The Inquiry has made recommendations for all the agencies involved in this sad case. The SHA's Board report sets out the key lessons for mental health services and this can be accessed on the SHA's web site www.northwest.nhs.uk.

Key highlighted by the Inquiry relate to the importance of risk assessments, carer's assessments and inter-agency communication.

3. What implications does the report have on health service organisations and other agencies involved?

NHS North West's concern is to improve patient safety and the report provides an invaluable insight into the challenges experienced by people with enduring mental health conditions, their families and the agencies involved in providing care to such individuals.

The other agencies will receive a copy of the full Inquiry report (under restriction), together with the Executive Summary and Recommendations and it is their responsibility to consider the actions of their staff and the performance of their services and put in place action to address any potential shortcomings. It is important to note that as several years have passed since this tragic incident, all significant changes have already been made to services across all agencies.

4. Was the incident predictable?

As the Inquiry panel have clearly identified in their conclusion the death of Child A could not have been predicted.

5. How have policies and practices been changed in order that such an incident can be dealt with in future?

Nationally and locally mental health services have been significantly improved with the implementation of the National Service Framework and New Safeguarding procedures are in place for the protection of vulnerable children. New community treatment orders have been introduced which will facilitate the management of patients in the community who are not taking their medication.

The Greater Manchester West Mental Health Foundation Trust and Trafford Metropolitan Borough Council have worked together to implement the recommendations arising from the incident, serious case review and inquiry reports and the details have been published on the website www.northwest.nhs.uk. The major changes are as follows:

- Multi-disciplinary working within the integrated mental health teams has been improved, and the weaknesses in the functioning of the CMHTs identified in the report have been addressed. The Care Programme Approach is well embodied in practice and the service is seen as performing well.

- 24 hour access to crisis teams for individual families 7 days per week.
- Greater Manchester West Mental Health NHS Foundation Trust works closely with all Local Authorities in relation to Child Protection and meets all statutory requirements of Safeguarding Children legislation and best practice.

6. Following the publication of this report, are there any other steps that the SHA and other agencies will be taking?

The SHA will be taking the following action in response to the report

- Offering a meeting with the family to ensure that their questions have been answered.
- Circulate the full report to the organisations and professionals involved, as well as to the family.
- Publish the executive summary on the NHS North West website and forward a copy to the NPSA.
- The SHA's Clinical Quality Team will facilitate workshops with clinical networks to review the lessons learned.
- The SHA's Mental Health Commission Improvement Team will work with trusts to improve risk assessment.
- The SHA's Clinical Quality and Performance Management Teams will work with the PCT commissioners to ensure that the recommendations are fully implemented.

7. How are the recommendations of the report being implemented in each of the different agencies?

As the report sadly demonstrates not all risks can be predicted and whilst it is not possible to guarantee that such tragedies will not happen again, there are measures which can reduce the risks. The Greater Manchester West Foundation Trust and Trafford Metropolitan Council have responded and their services are very different from those in place in 2003.

They have ensured that all the action points have been implemented from the two earlier investigations:

- Bolton, Salford and Trafford Mental Health NHS Trust Internal Incident Review (November 2003).
- Trafford Metropolitan Borough Part 8 Review under Child Protection Regulations (December 2003).

Both organisations co-operated fully with the independent inquiry into the care and treatment of Ms B. When the individual chapters were shared with the stakeholders, the trust and council jointly commissioned an independent review to establish their position in relation to the recommendations provide assurance that the trust and Trafford MBC arrangements were robust.

The report was received by the Trust Board in May 2009 and all recommendations from Inquiry already now implemented. It indicates that:

- Social workers are now fully integrated into the community mental health teams with health and social care acting as one agency and with one shared care record that everyone has access to quickly.
- 24 hour access to crisis teams for individual families 7 days per week.
- Greater Manchester West Mental Health Foundation Trust works closely with all Local Authorities in relation to Child Protection and meets all statutory requirements of Safeguarding Children legislation and best practice.

Full details of the actions taken by Greater Manchester West Mental Health NHS Foundation Trust and Trafford Metropolitan Borough Council can be found in the NHS North West's Board paper which can be found at the following link under Agenda Item 5:
<http://www.northwest.nhs.uk/whoweare/boardpapers/january%202010.html>

8. Was the report accepted without reservation by all agencies?

Responsibility for accepting the report rests with the SHA. The other agencies involved in the case have copies of the Inquiry's conclusions and recommendations and will be responsible for taking any action they feel relevant to address the recommendations. Trafford Council, Greater Manchester West Mental Health NHS Foundation Trust and Trafford PCT have accepted in full the recommendations in the Report and have ensured that they have been addressed across the service.

9. If the report had come out earlier would it have helped to prevent subsequent child deaths elsewhere?

When a child death occurs in these circumstances, there is an immediate requirement for a safeguarding investigation across agencies leading to a Part 8 report and recommendations. This happened following this tragic incident and agencies concerned did take immediate steps to address any system or process issues, improving services. However, the findings of the Inquiry were that the death could not have been foreseen.

10. Were there any child protection failings identified and have they been addressed by all Agencies involved?

The original Part 8 review's purpose was to address any potential child protection issues. The Inquiry was about reviewing the circumstances leading to the tragedy and particularly, focusing on the provision of services and agency responses to the family. The Part 8 Review did not identify child protection failings which contributed to A's death, but it did recommend better

communication between mental health and children's social work services, a point also picked up in the later Inquiry.

E. QUESTIONS RELATING TO MS B

Factual Position

Ms B was sentenced to a hospital order with a restriction order unrestricted in time. Ms B successfully appealed in 2008 against her original conviction of murder. A conviction of manslaughter on the grounds of diminished responsibility was substituted by the Court of Appeal.

1. Where is Ms B now?

Ms B was sentenced to a hospital order and is in the care of in-patient mental health services.

2. What will happen if Ms B is discharged?

Ms B is currently still a patient in mental health services and she is engaging fully with the clinical team and her therapist in recovery and rehabilitation tackling the difficult and painful issues brought about by the publication of the Inquiry's recommendations. Any decisions relating to discharge will be based upon clinical recommendations and linked to ongoing care planning.

3. Is there a planned / anticipated date for her discharge?

Discharge would be a clinically recommended decision and it is not appropriate for the SHA to comment on an individual case.

ENDS

Media Statement

12 January 2010

This statement is embargoed until Wednesday 13 January 2010 at 12pm

Independent Report Into The Death Of Child A

NHS North West today (13/01/10) published the Executive Summary and Recommendations of the independent Inquiry commissioned into the death of Child A. The report's recommendations have been welcomed by Greater Manchester West Mental Health NHS Foundation Trust and Trafford Council.

Child A was killed by her mother in 2003. She was five years old. Her mother, Ms B, pleaded guilty to murder, although this conviction was later substituted for one of manslaughter on the grounds of diminished responsibility following a Court of Appeal ruling.

The Inquiry was commissioned in 2005 and was tasked to investigate the circumstances leading up to the death of Child A, examine whether there were any lessons to be learnt and to make recommendations for the future.

The Inquiry carried out their role through a process of oral hearings, examination of all background documents and expert reports into the overall circumstances and in relation to each agency. These agencies are Trafford Primary Care Trust, Greater Manchester West Mental Health NHS Foundation Trust (formally Bolton, Salford & Trafford Mental Health NHS Trust), Trafford Council and Greater Manchester Police (GMP).

Mike Farrar CBE, Chief Executive at NHS North West, said: "Everyone involved in this case has been shocked and moved by the tragic death of this child. This has been a long and sensitive Inquiry that has helped to highlight how unpredictable

...more...

mental illness can be and the dreadful impact it can have on families. We fully accept the findings of this report and, whilst a substantial number of the changes it

recommends to ways of working have already been implemented, it must be said that nothing we implement can change the tragic outcome of this case.

“However, we will continue to work with all our partner organisations to ensure that our agreed action plan is fully implemented and that improvements to care continue to be delivered.

“This report shows that there were shortcomings in the care and treatment of the child’s mother, who was a vulnerable person. This is always a serious cause for concern, no more so than in this case. We are deeply sorry that, as a patient, she was let down and we give our sincere apologies to the family.”

The report states that Ms B displayed complex mental health symptoms, which included periods of stability. It also explains that the extraordinary nature of the incident means Child A’s death could not have been predicted and therefore prevented.

However, it does highlight some shortcomings in the care and treatment of Ms B prior to the death of Child A and makes a number of recommendations, not just for the individual trust concerned but also for the wider mental health service and partner organisations.

Amongst the recommendations the report states that, in particular, responsibility for managing and treating similar patients should only be given to professionals who have sufficient experience and training to do so. It is also recommended that there needs to be a greater sharing of information and improved communication across all agencies and particularly with carers / families involved.

Immediately following Child A’s death, the predecessor Trust (Bolton, Salford and Trafford Mental Health NHS Trust) and Trafford Council worked together to undertake a full review of the circumstances and events leading up to the incident.

...more...

The recommendations of this External Inquiry have reinforced those of Bolton, Salford and Trafford Mental Health NHS Trust and Trafford Council reviews of 2003 that, whilst some elements of service to the family could have been improved, the tragic incident itself could not have been prevented.

Greater Manchester West Mental Health NHS Foundation Trust and Trafford Council have already implemented all the report's recommendations. Multi-disciplinary working within the integrated mental health teams has been improved and the weaknesses in the functioning of the Community Mental Health Teams (CMHTs), identified in the report, have been addressed. The Care Programme Approach is well embedded in practice and the service is seen as performing well. Greater Manchester West Mental Health NHS Foundation Trust works closely with all Local Authorities in relation to Child Protection and meets all statutory requirements of Safeguarding Children legislation and best practice.

Bev Humphrey, Chief Executive of Greater Manchester West Mental Health Foundation Trust, said: "It is clear that mental health services, in terms of professional practice, leadership and management and services delivery, have improved significantly since 2003. Whilst these improvements have reduced the likelihood of harm to service users, carers and the public, risk cannot be removed entirely and the Inquiry report confirms that the incident was impossible to have foreseen.

"Our thoughts are with the family at this time and we hope that publication of the Inquiry recommendations will provide them with some element of closure and help them to rebuild their lives."

Janet Callender, Chief Executive, Trafford Council, said: "The protection of children remains our priority as a Council, and we have worked with our colleagues in the mental health services to ensure that together we offer appropriate support to families. We hope that the completion of this Inquiry helps the family and all those affected by this tragic event as they look to the future."

ENDS

Further information

- The Inquiry was commissioned in 2005 and Frances Patterson QC was appointed as Inquiry Panel Chair.
- Frances Patterson QC is Head of Kings Chambers in Manchester and Leeds and also Head of the Public Law Department within chambers. In 2008 she was appointed Deputy High Court Judge of the Queen's Bench Division, authorised to sit in the Administrative

Court. In December 2009 she was appointed as a Law Commissioner. Miss Patterson is a leading practitioner in all aspects of town and country planning, environmental law, compulsory purchase and compensation, highways, education, administrative law and community care law.

- The task of the Inquiry Panel was to investigate the circumstances leading up to the death of Child A, examine whether there were any lessons to be learnt and to make recommendations for the future.

For further information please contact the following:

- NHS North West Communications Team on **07824 463 578**

Notes to Editors:

About NHS North West:

1. NHS North West's mission is to maintain and improve the health of the North West population and ensure the delivery of world class services for those who need care.
2. NHS North West knows from listening to patients and the public that they expect to see and feel clear benefits and improvements in their health service. That's where our 5 promises come in: our promises comprise our pledge to deliver; quality, a healthy life, personal care, involvement and value for money. We will be held to account for NHS progress against these tests. For more information on our promises and what we are doing to deliver them please visit: www.northwest.nhs.uk
3. Health Service staff in the North West outnumber the combined workforces of the regular British Army, Navy and Air Force, making the NHS a major influence in the region.

About Greater Manchester West Mental Health NHS Foundation Trust

1. Greater Manchester West Mental Health NHS Foundation Trust provides district and specialist mental health services throughout Greater Manchester and the wider North West.
2. As a provider of Mental Health and Substance Misuse Services....
 - i. We put service users & carers first - promoting recovery & responsible choices
 - ii. We deliver remarkable results - accountability for performance & quality
 - iii. We achieve more together - Partnerships, inclusion & diversity shape our vision
 - iv. We release our talents - Passion for learning to achieve the unthinkable

- v. We provide quality service - Ambitious delivery with drive & commitment
- vi. We build fantastic teams - Team-working for creativity & innovation

About Trafford Council

The Council's vision for the borough by 2021 is:

1. All Trafford's people and communities will enjoy the highest quality of life in a safe, clean, attractive healthy and sustainable environment with an excellent education system and first class services.
2. Trafford businesses will be provided with all the tools and support to be able to continually and successfully compete for skills and investment on an international basis.
3. As a destination, Trafford will consolidate and build upon the reputation of its renowned world class attractions (Manchester United, Lancashire County Cricket Club, Imperial War Museum and the Trafford Centre) providing a breathtaking mix of cultural, sporting heritage and natural attractions together with vibrant shopping and town centres.

About NHS Trafford

1. Trafford Primary Care Trust (PCT) is currently responsible for
 - commissioning health services from a range of local providers, including hospitals, to meet the health needs of our local population; and
 - providing primary and community healthcare services to the residents of Trafford
2. Our plans over the next five years are, in simple terms, about '**Helping people to live longer, healthier and better quality lives - in short adding years to life and life to years**'
3. Supporting our vision we have identified six priorities:
 - i. Protect and improve the health of Trafford citizens and reduce health inequalities
 - ii. Ensure that quality is enshrined in all our activities
 - iii. Ensure that our services are value for money
 - iv. Commission services that meet the needs of local citizens

- v. Ensure that we systematically involve staff, patients and the public in decisions about their health and healthcare
- vi. Ensure the organisation is well run and fully fit for purpose