Bradford Safeguarding Children Board

Serious Case Review

Executive Summary

Regarding a Child who was born on 17/4/2000 and died on 18/2/2010

August 2010

1.0 Introduction

1.1 The requirement for Bradford Safeguarding Children Board to conduct a Serious Case Review is detailed in Chapter 8 of *Working Together to Safeguard Children: a Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children* (HM Government 2010) and in the Local Safeguarding Children Boards Regulations 2006.

1.2 The purpose of a Serious Case Review as identified in *Working Together* is to:

Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result; and
Improve intra-and inter-agency working and better safeguard and promote the welfare of children.

1.3 The Serious Case Review (SCR) Overview Panel was also mindful that it should focus, as far as possible, on how this child experienced his life and family relationships, his wellbeing and his wishes and feelings. That is, it should seek to understand how the world looked and felt to this child from information that became available during the SCR process.

2.0 Reasons for the Serious Case Review

2.1 On 18/2/2010 the child, then aged nearly ten years, was attacked with a knife by his older brother. At the time the child had gone to visit his sister and her baby who lived nearby and his brother had followed him there. He was taken to Hospital where he was found to be dead on arrival. The cause of the child's death was identified as multiple stab wounds.

2.2 Prior to the child's death, his brother had been detained between May and August 2009 as an inpatient at a Psychiatric Hospital for an assessment of mental illness. He was later diagnosed as suffering from paranoid schizophrenia and following his discharge from Hospital, the Early Intervention in Psychosis Team from Bradford and Airedale Community Health Services was responsible for his care and treatment. During late 2009 the child's brother attended two out-patients appointments with a Consultant Psychiatrist who thought his care and treatment should continue while he remained living with his family. The child's family became concerned about his brother's deteriorating behaviour and contacted the Early Intervention in Psychosis Team in February 2010. A Community Psychiatric Nurse visited the family on 18/2/2010 but did not assess the child's brother as presenting such a risk that he should be removed to hospital on that day. On the same day the GP saw the child's brother and his mother and did not identify any significant cause for concern. The attack on the child occurred later that day.

2.3 The child's family received services from several health and social care agencies from 1995 until 2010. These agencies were largely concerned with responding to the child's brother's disturbed and challenging behaviour at home and school, and to his later offending behaviour and mental health problems. Some services, notably Education Support and the Youth Offending Team were also involved with the child's older sisters. It was also known

from at least 1995 that the child's mother experienced violence from her partner, that the children frequently witnessed these incidents and that, as a consequence, the children were likely to suffer emotional harm.

2.4 On 19/2/10 the child's brother was charged with the murder of this child and with wounding his sister and was later placed in a secure Psychiatric Hospital. The Overview Panel with responsibility for conducting the SCR was aware that in providing the above explanation for the SCR, it was doing so prior to a criminal trial and any possible finding of guilt in respect of the child's brother. However, information which became available to the Overview Panel led to the conclusion that it would be reasonable to refer to the child's brother's responsibility for causing the fatal injuries.

3.0 The Serious Case Review process

3.1 Following the decision by the Chair of Bradford Safeguarding Children Board that a SCR should be completed, an Overview Panel was established to conduct the SCR. Members of this Panel represented agencies which had provided services to the child's family but they had not had any involvement with the case and could thus take an independent view of the family's history and service provision. Bradford Safeguarding Children Board appointed an independent Chair of the Overview Panel and an independent author to write the overview report, neither of whom had any involvement with the family, Bradford's Safeguarding Board or agencies which provided services to the family.

3.2 The Chair of Bradford Safeguarding Children Board is Professor Nick Frost. Ruby Parry, Director of Consultancy for Reconstruct Children's Services was the Chair of the Overview Panel and Dr Carole Smith, Honorary Senior Lecturer in the School of Nursing Midwifery and Social Work at the University of Manchester was the independent author of the overview report.

3.3 Members of the Overview Panel were:

Ruby Parry - Independent Chair
Interim Manager - Bradford Safeguarding Children Board
Designated Nurse for Safeguarding - NHS Bradford & Airedale
Head of Specialist Services - NHS Bradford & Airedale Community Health Services
Adult Mental Health Consultant Psychiatrist - Bradford District Care Trust
Group Services Manager - Department of Services to Children and Young People (Social Care)
Strategy Manager - Education Bradford
Youth Offending Team Manager - Youth Offending Team
Service Manager - Adult and Community Services
Area Manager - West Yorkshire Probation
Chief Inspector - West Yorkshire Police
Administrator - Bradford Safeguarding Children Board
Administrator - Child Death Overview Panel

In attendance: Dr Carole Smith – independent author

3.4 The Overview Panel decided that Individual Management Reviews should enquire into the involvement of local agencies/organisations and professional actions to examine:

- Whether appropriate single and inter-agency safeguarding procedures and processes were followed in respect of the child, his siblings and family according to legal and practice standards at the time. Particularly, whether the assessment of the levels of risk and thresholds at referrals and during assessment processes were identified and acted upon.
- The impact of levels of multi-disciplinary work and communication between different health services and functions, with a view to the management of risk for the child and his family, with particular reference to the problems and mental illness experienced by his older brother.
- Communication between all agencies, including the level and type of information shared and to what degree the needs of the children were highlighted and specifically, the interface between children and adult services and the understanding of relative responsibilities.
- Responses of agencies/professionals to the level and nature of violence within the household with particular reference to safeguarding concerns, for example mental health issues and substance abuse.
- The daily life experiences of the child and his siblings in the context of household violence and of his brother's mental health issues. This will include consideration of issues of culture and identity and their impact on any assessments and services in relation to the family.
- Factors that may have impeded the delivery of services, for example, house moves and transfer of records and information, their impact on the response of agencies/professionals and any associated consequences for the children.
- Whether specialist Mental Health Services were available and whether there was an appropriate response at the times when the child's family was in crisis and in the build up to the child's death.
- Whether appropriate assessments and exit strategies and plans were in place for each of the siblings after they had completed their Youth Offending Team Orders and involvement, and to what extent agencies were supportive of the identified plans/actions.
- The role and impact of Education Support Services particularly in relation to the child and his older brother including multi-agency SEN provision and Education Support Services to all children within the family.

3.5 The SCR examined the provision of services and events in the child's life from 1995 when health and social care professionals first recognised the family's need for services, to the child's death on 18/2/10. The Overview Panel also recognised that enquiries concerning the child would be substantially incomplete without including an examination of the circumstances and experiences of his siblings. This was particularly the case because the child's older brother was directly responsible for his death and the family's difficulties had an impact on all the children in terms of their development and wellbeing.

4.0 Parallel processes and investigations

4.1 Serious untoward incidents/adverse events

4.1.1 Guidance provided in *Independent Investigation and Adverse Events in Mental Health Services* (Department of Health, 15 June 2005) specifies arrangements for conducting a review of professional practice, policy, procedures and the working environment following a

serious untoward incident (SUI)/adverse event, including homicide perpetrated by a user of mental health services. The NHS Trust providing mental health services is required to undertake an internal review and the Strategic Health Authority (SHA) must commission an independent investigation of relevant issues. Since the inception of Primary Care Trusts (PCT) as service commissioners in 2006, they have assumed some investigatory functions from the SHAs.

4.1.2 The NHS Mental Health Trust internal review relating to the provision of mental health services for the child's brother will be managed by the PCT. In the circumstances of this case (a homicide where the perpetrator was subject to intervention from mental health services *and* associated child safeguarding issues) the PCT is responsible for conducting an investigation and submitting its report to the SHA. The SHA then assumes responsibility for performance management in response to the PCT's findings/recommendations. Individual Management Reviews submitted for the Serious Case Review will contribute to the PCT's enquiries.

4.2 The independent mental health homicide review

4.2.1 In this case the Yorkshire and Humber SHA has established an Independent Investigation Committee in response to the SUI concerning a homicide in respect of a child. The purpose of an independent investigation when a homicide has been committed by a person who is, or has been under the care of specialist mental health services in the six months prior to the event, is to examine all the circumstances surrounding the provision of care and treatment, to identify any errors or shortfalls in the quality of service and to make recommendations for necessary improvements. There is no statutory timescale for completion of this process. Information and findings from this Serious Case Review, including Individual Management Reviews from Bradford and Airedale Community Health Services, NHS Bradford and Airedale, the Combined Health Provider and Commissioning Individual Management Review and the Serious Case Review overview report will provide evidence for the Committee's enquiries. Under these circumstances Yorkshire and Humber Strategic Health Authority has suspended its investigations until the conclusion of this Serious Case Review.

4.3 Bradford and Airedale Community Health Services independent review

4.3.1 NHS Bradford and Airedale Community Health Services has commissioned an external and independent review of work undertaken by the Early Intervention in Psychosis team (EIP) following the identification of issues and concerns in other investigations of serious untoward incidents/adverse events. The EIP team provided services to the child's brother and his family between April 2009 and February 2010. The Review will focus on EIP's service-delivery model and philosophy in comparison to national guidance, implementation and monitoring of quality assurance systems, the quality of clinical practice and supervision and organisational arrangements. Work on this Review will be completed by the end of September 2010.

4.4 It is currently uncertain whether and when the child's brother will stand trial and the timing of criminal proceedings and a Coroner's inquest is therefore unknown. The child's brother has entered a plea of manslaughter in respect of the child's death. The Overview Panel has clear information about the attack on the child and his sister and the circumstances under which this occurred. It was therefore considered unnecessary to delay completion of

the Serious Case Review by awaiting the outcome of criminal proceedings or a Coroner's inquest.

5.0 Involvement of the child's family in the Serious Case Review

5.1 It is important to involve family members in the Serious Case Review process so that they can understand its purpose and comment on the Overview Panel's work. The family's views on professional intervention and service provision during the period covered by the Serious Case Review form an important part of the Overview Panel's enquiries. In this case the Chair of the Overview Panel and the independent author met the child's mother and maternal grandparents at the family home and the child's two sisters who were also present contributed to the discussion. The family had been through an extremely difficult time and following this meeting felt they did not wish to be further involved with the Serious Case Review, although the Panel Chair offered to see them again if they thought this would be helpful. At the point of completing this Serious Case Review the child's brother had not responded to an invitation to participate, although the Overview Panel remained willing to arrange a meeting at a later date.

6.0 The benefits of hindsight

6.1 It is important to assume some degree of caution and intelligent thinking in respect of this Serious Case Review. The benefits of hindsight have enabled the Overview Panel to identify elements of poor professional practice, including a lack of attention to family history and relationships, inadequate assessment/risk analysis and the association between these factors and the outcome in this case. However, it should be appreciated that the prediction of events is not a straightforward matter. It has been noted from national evaluations of Serious Case Reviews that the way in which complex risk factors interact in *individual* cases and under *specific* circumstances is difficult to predict. The use of hindsight can also convey an impression of clarity and order with regard to retrospective description and analysis, which was not of course available to professionals at the time. The Executive Summary should be read bearing in mind this cautionary note.

7.0 History of agency involvement with the child's family

7.1 This part of the Executive Summary records the sequence of events that attracted professional intervention and service provision to this family over the period covered by the SCR. It is a necessarily highly summarised account of what happened and how agencies/services responded to the family's difficulties. The Overview Panel and the independent author were very aware that this section should respect the sensitivity of information relating to this family while at the same time it should meet the requirements of an Executive Summary and support public confidence in the SCR process.

7.2 At the beginning of the period covered by this Serious Case Review (1995) the family consisted of the child's mother and father, his older brother (then aged five years) and his two sisters (aged nearly four and nearly two years). The child who is the subject of this Serious Case Review was not born until 2000. The Serious Case Review starts in 1995 because at this time the family was receiving services from Children's Social Care and Children's Mental Health Services in response to the child's brother's very disturbed behaviour. Because the child's brother's difficulties were so central to professional concern about this family, the brother attracted significant attention during the Overview Panel's enquiries. It is therefore

important to remember that this Serious Case Review was about the subject child, rather than his brother, and about learning from the history of professional involvement and decision making during the years leading up to his death.

7.3 The child was described by his school teacher as 'a likeable character with a good sense of humour. He could be described as street-wise but was never malicious. Although he had occasional bouts of fighting he was not generally aggressive but followed the street code of sticking up for him-self'. The child's mother said that her older son had loved his younger brother and they had spent time and laughed together.

7.4 During 1995 and 1996 the Children's Social Care Family Centre initially worked with the family and the child's brother continued to receive help from Child and Adolescent Mental Health Services. Children's Social Care closed the case in August 1995 after completing an assessment but concluding that the child's parents did not want social work help. Professionals were aware the family had a history of domestic violence and the child's mother had sometimes left the family home with the children because of this. Although the children experienced frequent parental separations, these were followed by their parents' reconciliations. This did mean, however, that the children lived at numerous different addresses and this was compounded by additional family house moves. The child's brother's behaviour remained very disturbed at home and school, but the Child Psychiatrist who was working with him thought his family experiences were significantly contributing to his social and emotional difficulties.

7.5 In January 1997 the child's brother's school called a multi-agency meeting because of concern about the brother's behaviour. Although invited, Children's Social Care did not attend this meeting. Later this year the child's brother's Head Teacher referred the brother to Children's Social Care because of his serious behavioural problems. Children's Social Care did not re-open the case as the family was receiving services from other agencies. While the family was living in another area the Consultant Psychiatrist who was at that time working with the child's brother diagnosed the brother as suffering from Attention Deficit Hyperactivity Disorder (ADHD) and prescribed medication. Early in 1998 a statement of special education needs was completed in respect of the child's brother because of his emotional and behavioural difficulties. The child's brother and the family were still receiving help from Child and Adolescent Mental Health Services.

7.6 During 1999 the child's brother's behaviour was still causing concern and although his medication for ADHD appeared to help, his parents sometimes withdrew this because of their concerns about its side effects (poor sleeping patterns and suppression of appetite). The child's brother and his family continued to receive help from Child and Adolescent Mental Health Services.

7.7 The child who is the subject of this Serious Case Review was born in April 2000 and initially his older brother was very gentle and protective towards him. The Health Visitor noted that the child made good developmental progress during this year. Later in the year, however, the child's mother reported to the Child and Adolescent Mental Health Services that the child was being 'tormented' by his older brother who was also demonstrating disturbed behaviour more generally. There were frequent arguments between the child's brother and his two sisters. One of the child's sisters also needed speech therapy to help with her language development.

7.8 In June 2001 the Child and Adolescent Mental Health Services referred the family to Children's Social Care because of increasing concern about the child's brother's behaviour. Children's Social Care completed an initial assessment and offered the family respite care for the child's brother and attendance at a Parent and Adolescent Support Group. The parents felt that neither of these services would meet their needs and the case was closed in January 2002. The Children's Social Care Individual Management Review notes that this assessment concentrated on the child's brother and paid insufficient attention to the needs of other children in this family. Until about June 2001 the child had been making good progress, but his inadequate weight gain at around this time prompted professional concern and an intention to check his weight more frequently. This was not followed up.

7.9 In early 2002 the child's brother and mother missed an appointment with the Child and Adolescent Mental Health Services and did not respond to a letter inviting them to attend. This service therefore closed the case in June 2002. The child's brother was moved from his school to a Pupil Referral Unit (a specialist educational setting for children who are unable to learn in mainstream schools) early this year because his emotional and behavioural difficulties could not be managed in his local school. He began to engage in minor offending behaviour as did one of his sisters (sister 'A'), and by September 2002 it was noted he was using cannabis. The Youth Offending Team began to work with the child's brother this year to try and divert him from further offending.

7.10 The Youth Offending Team supported the child's brother during 2003 and provided help with anger management, but he continued to demonstrate aggressive and disruptive behaviour at the Pupil Referral Unit. All the children from this family had problems attending school on a regular basis and the Education Social Work Service became involved to help them improve their school attendance. Sister 'A' was also presenting behaviour problems in school. In October 2003, Children's Social Care again completed an initial assessment in response to a referral that the child had been caught up in domestic violence between his parents. Children's Social Care visited the family and found that the child was well. His parents did not want support or services from Children's Social Care and the case was therefore closed in December 2003.

7.11 During 2004 the child's sister 'A' continued to be disruptive and rebellious at school, his brother engaged in further offending and often failed to attend the Pupil Referral Unit, and his other sister ('B') also began to commit minor offences. The child witnessed a heated argument between his parents to which the Police were called. Health visitors began to express concern about the child's behaviour and development.

7.12 During 2005 the child's brother had his final Special Educational Needs review prior to leaving the Pupil Referral Unit where it was noted his attendance had been very poor and he had not achieved any of the objectives in his Statement. The child's brother continued to receive a service from the Youth Offending Team and his sister 'A' continued with irregular school attendance and disciplinary problems when she was at school. Sister 'B' was also attending school irregularly and the school requested extra support services to help with her learning. From early in 2005 the subject child was generating concern because of his poor school attendance and lack of educational progress.

7.13 In 2006 the child's sister 'A' continued her poor attendance at school and when she was there attracted disciplinary measures for her disruptive and sometimes aggressive behaviour. She was referred to the Youth Offending Team after committing a criminal offence. The

child's sister 'B' also received a service from the Youth Offending Team in relation to her offending behaviour. She also failed to attend school on a regular basis. The child's brother remained involved with the Youth Offending Team because he had committed further offences and was subsequently transferred to the Probation Service for a period when this service was responsible for providing Court reports. Police were called to the family home on two occasions to deal with heated family arguments, first between the child's brother and a sister and second, between the brother and his mother. The school was concerned about the child because of his poor attendance and his inability to concentrate and make progress with learning objectives.

7.14 During 2007 the Youth Offending team continued to work with the child's brother whose breach of Court Orders, further offending and cannabis and alcohol use were causing significant concern. The Police Offender Management Unit allocated a police officer to the child's brother, who visited him and the family frequently, supported the brother at Court appearances and other appointments and worked closely with other agencies to try and divert him from further offending. Although the child's sister 'A' became more settled at school, his sister 'B' was moved from mainstream school to the Pupil Referral Unit because of her persistently challenging behaviour. Children's Social Care completed another initial assessment following an incident when the child's brother punched his sister ('B') around the head, but subsequently closed the case as the parents did not want their help and the Youth Offending Team remained involved with the child's brother and sister 'B'. Police attended the family home on another three occasions because of heated arguments between family members. The child who is subject to this Serious Case Review witnessed at least two of these incidents and Police intervention. He continued to cause concern at school because of poor attendance, disruptive behaviour in class and his lack of educational progress.

7.15 The child's brother continued to breach his Court Orders and to misuse alcohol and cannabis during 2008. His allocated Police Officer from The Police Offender Management Unit became increasingly worried that this brother was breaching Court Orders because he did not understand the conditions which they imposed on him. The Police Officer also observed behaviour that suggested the child's brother was suffering from mental health problems and he therefore worked with the brother's solicitor and the Probation Service to persuade the Court that a psychological assessment was necessary. A psychological assessment was finally completed in November 2008. It identified problems with the child's brother's organisational and thinking capacity and recommended urgent medical investigations. Although this psychological assessment was not a diagnosis regarding the child's brother's difficulties, it was consistent with the later diagnosis of paranoid schizophrenia. Following his mother and grandmother's increasing concern about his deteriorating mental health, the child's brother attended three appointments late in this year and early in 2009 with a Doctor from the Community Mental Health Team. During 2008, the child's sister 'B' continued to break the law, to use cannabis and to stay away from the Pupil Referral Unit. The Child's sister 'A' gave birth to her baby and moved out of the family home to live in her own house nearby.

7.16 In April 2009, the child's brother was referred to the Early Intervention in Psychosis Team for assessment and help with his mental health problems. However, soon afterwards he physically assaulted his mother and sister 'B' on several occasions. Following the last assault on his sister 'B' he was detained in a Psychiatric Hospital under the Mental Health Act 1983 where he stayed for four months until his discharge to the family home in August 2009. Mental health practitioners used the Care Programme Approach to helping the child's brother

and his family. This approach is an established part of Government policy to assist in assessing, treating and supporting seriously mentally ill people and their families and requires the mental health team to hold regular planning meetings, to ensure that multi-agency risk assessments are completed and to involve service users in making and implementing care plans.

7.17 The child's brother was discharged from Hospital with a diagnosis of paranoid schizophrenia after successful preparatory periods of home leave. The Early Intervention in Psychosis Team was responsible for his care in the community and made home visits, helped the child's brother to try and find supported accommodation and employment and encouraged him to take his medication at a level he could tolerate. This brother continued to use cannabis and alcohol despite the known association between cannabis use and psychotic/violent episodes in mentally ill people. Following the child's brother's Hospital discharge, he saw a Consultant Psychiatrist on two occasions during 2009. The Psychiatrist balanced the risk of harm that the brother posed to family members against the negative effects of re-admitting him to Hospital and decided that he should continue to receive mental health services in the community. The child's sister 'B' continued to commit offences and to use cannabis. She left full-time education in the summer of 2009.

7.18 During 2009 the child who is the subject of this Serious Case Review attracted professional concern because of a significant deterioration in his wellbeing. The school reported that he was dishevelled, lethargic, disruptive in class and aggressive towards other pupils. He also told his teacher about difficult family relationships and circumstances at home. This child had witnessed violent family arguments, some of his brother's assaults on his mother and sister and had lived with the unpredictability and anxiety which was generated by his brother's mental illness.

7.19 Children's Social Care carried out another initial assessment in 2009 when the child's brother was hospitalised following his assault on his sister 'B'. This assessment focussed on the risks that might be posed to the child and his sister 'B' during contact with the child's brother and following his discharge home from Hospital. As a result of this assessment Children's Social Care informed mental health practitioners that there should be no unsupervised contact between the child, his sister 'B' and the child's brother and indicated that another assessment would be necessary prior to the child's brother's discharge from Hospital. Children's Social Care then closed the case while the child's brother was detained in Hospital.

7.20 The Serious Case Review found evidence that the social worker from Children's Social Care and mental health professionals, including those from the Early Intervention in Psychosis Team, were not initially able to establish a good working relationship. This was related to different professional priorities and perspectives where Children's Social Care was concerned about the safety of the child and his sister 'B' while mental health professionals were concentrating on the child's brother's care and enabling his discharge from Hospital. Additionally, Children's Social Care did not share full information with the Care Programme Approach Team until July 2009 about the family's early history, including the child's brother's disturbed behaviour as a young child. Thereafter, significant miscommunication occurred between Children's Social Care and mental health practitioners, when the Care Co-ordinator from the Early Intervention in Psychosis Team requested Children's Social Care to re-open the case and to provide an assessment so the child's brother could have unescorted home leave from Hospital which would facilitate his eventual discharge. Children's Social

Care did not re-open the case and indicated to mental health practitioners that they would no longer be involved. The child's brother was thus discharged from Hospital to the family home without Children's Social Care conducting a further assessment. Children's Social Care thought they would be informed prior to the brother's discharge and that mental health practitioners would complete an assessment of any risk of harm that the brother might pose to family members. In the event, neither Children's Social Care nor mental health practitioners completed a risk assessment prior to the child's brother's discharge home.

7.21 During the period of four months in 2009 when the child's brother physically assaulted his mother and sister 'B', the Police referred the mother for a Multi-Agency Risk Assessment Conference (MARAC). A MARAC is designed to ensure that all agencies with protection/safeguarding functions collaborate to share information and to prepare plans to reduce and manage the risk of harm to the individuals concerned. Although the child's mother was referred for a MARAC, the Conference quickly became aware of the risk of harm to the child and his sister 'B' and considered this during its meetings. Although Children's Social Care reported to the MARAC that it had a safeguarding plan in place regarding possible harm from the child's brother to the child and his sister 'B', the MARAC Lead Officer was not confident this was the case and requested written confirmation following the last MARAC meeting. The Lead Officer did not receive this confirmation and the matter was dropped.

7.22 Contrary to Bradford's Care Programme Approach Policy and Government guidance, mental health practitioners did not hold a Care Programme Approach meeting either immediately before the child's brother's discharge from Hospital or following his discharge. This meant that mental health practitioners did not have an opportunity to collate and assess risk factors associated with the child's brother's discharge from Hospital to the family home or to agree a plan to reduce or manage the risk of harm that he might pose to family members. Risks at that time included the child's brother's lack of compliance with his medication regime, his continuing use of cannabis/Skunk, the family's anxiety about his behaviour and return to the family home, the child's and his sister's residence at home and indications from research that individuals with a diagnosis of psychotic mental illness do not function well in families with a high level of argument and emotional expression.

7.23 On his discharge from Hospital the Early Intervention in Psychosis Team did not assess the risk of harm from the child's brother as high and this meant that supervision and support for the child's brother and his family was not as intensive as it could have been. The Individual Management Review and the Overview Panel considered that, given identifiable risk factors, the risk assessment in respect of the child's brother should have been located at a high level. Furthermore, the Early Intervention in Psychosis Team did not review the risk assessment until four months after the child's brother had been discharged from Hospital.

7.24 In early 2010 a member of the Early Intervention in Psychosis Team visited the family home and found the child's brother 'heavy-eyed', barely communicating, confused and apparently responding to unseen stimuli. The maternal grandfather subsequently telephoned the child's brother's Community Psychiatric Nurse because the family was concerned that his mental health was deteriorating. Although the child's brother's allocated Community Psychiatric Nurse was on annual leave, another Community Psychiatric Nurse visited the family immediately upon receiving the message. This Community Psychiatric Nurse assessed the situation, thought the child's brother did not require hospitalisation and arranged to visit again in three days. The child's brother visited his GP for a 'sick note' on the same day and

the GP reported that he was calm and his behaviour did not suggest any significant cause for concern. Later on the same day (18/2/10) the child's brother followed his younger brother to his sister's home where he fatally stabbed him.

8.0 Key themes and learning from this Serious Case Review

8.1 This section of the Executive Summary identifies major issues arising from professional practice and decision making in relation to this case and, in hindsight, lessons that should be learned about more effective assessment, multi-agency collaboration and planning to safeguard children from harm.

8.2 Multi-agency assessment and planning

8.2.1 The Overview Panel identified an absence of any multi-agency meetings, except for a strategy meeting in February 1995 and a meeting at the child's brother's school in 1997 which was not attended by Children's Social Care. Care Programme Approach meetings and MARACs are not designed to enable a professional focus on children's needs, appropriate intervention and planning in children's best interests. At no point over fifteen years did Children's Social Care initiate child protection enquiries, a Child Protection Conference, or a core assessment in accordance with the *Framework for Assessment of Children in Need and their Families* published by the Department of Health in 2000, which would have included multi-agency meetings. Despite evidence that all the children were subject to poor school attendance, had behavioural difficulties and were unlikely to achieve good social, educational and employment outcomes, their schools/Pupil Referral Unit failed to arrange a Common Assessment Framework assessment and the relevant Individual Management Reviews report that, even now, this early assessment for children with additional needs is not fully embedded in practice and does not command the confidence of schools.

8.2.2 This, of course, means that for most of the period covered by this Serious Case Review there was no multi-agency forum in which information about his family could be shared and could contribute to an understanding of how the *children's* family life was influencing their wellbeing and cognitive, social and emotional development. A partial explanation for this failure seems to be that each agency assessed and worked with individual children from this family according to its own assessment procedures and did not link the children's difficulties together or understand them in the context of family and environmental factors. For example, the Youth Offending Team Individual Management Review points to its assessment protocol as concentrating professional attention on *each* child without encouraging an awareness of their inter-relationship or family context. Similarly, the Schools/Pupil Referral Unit and education support services did their best but did not identify, understand or explore the children's difficulties in a family or broader inter-agency context. Some Individual Management Review authors and professional practitioners explained to the Overview Panel and the independent author that they were inhibited from initiating multi-agency meetings unless these were procedurally required. It is unfortunate that professionals felt unable to use their discretion to arrange multi-agency meetings if they thought this would contribute to the children's wellbeing and to more effective inter-agency collaboration.

8.2.3 Despite legislation (s.11, Children Act 2004) to improve collaboration between agencies working with children and their families, this clearly did not happen for the child subject to this Serious Case Review and his siblings. Learning from this Serious Case Review indicates that when agencies become aware that children from the same family are

experiencing difficulties they *must* initiate inter-agency communication and, when appropriate, take steps to arrange a multi-agency meeting.

8.2.4 Learning in relation to multi-agency assessment and planning identifies the necessity for improvement in the following areas:

- All professionals should be aware of the importance of arranging multi-agency meetings whether this occurs within the framework of child protection procedures, a core assessment and provision of s. 17 (Children Act 1989) services or a Common Assessment Framework assessment. If a professional becomes concerned about numerous problems in a family over time, they should take the initiative in arranging a multi-agency meeting even if this does not fall within the provisions of statutory/procedural frameworks.
- Professionals from health and education services should be more proactive in implementing a Common Assessment Framework assessment where they identify that one or more children from a family have additional needs.
- Professionals in Education and Education Support Services should remain alert to the role that other agencies may be playing in supporting children and ensure that they are invited to relevant meetings, for example Special Educational Needs review meetings.
- Overall, when children's disturbed behaviour, poor school attendance and lack of consistent support from parents raises concerns about the quality of parenting and family life, professionals must make further enquiries to identify the possible involvement of other agencies.
- Some national assessment tools/protocols, particularly those used by the Youth Offending Team and the Probation Service tend to focus professionals' attention on *individual* children/young people in a family and do not encourage professionals to identify links/relationships between children or to assess their needs in the context of family relationships. These tools/protocols should be reviewed and professionals should be encouraged through supervision and management oversight to think about children's/young people's needs in relation to broader family issues and relationships.

8.2.5 It should be noted that local policy and practice has already responded to some of these issues. For example, in Education developments in the delivery of Pupil Referral Unit services in Bradford have culminated in the establishment of a core team including a full-time police officer, education social worker and case managers. Integrated multi-agency service delivery is now coordinated through a Common Assessment Framework management process, frequent Child and Adolescent Mental Health Services and Youth Offending Team case discussion forums and Special Educational Needs review procedures. Similarly, the Youth Offending Team has introduced tighter quality assurance measures to ensure the standards expected from assessments. These should also encourage practitioners to recognise and respond to service users' needs in a family context and to consider the implications arising from sibling referrals.

8.2.6 Recommendation 9.1.8 from the Overview Panel addresses the importance of assessing and responding to children's difficulties in the context of family relationships, considering the possible involvement of other agencies and recognising the need, where appropriate, to initiate multi-agency meetings/collaboration. Youth Offending Team recommendations identify measures to ensure that practitioners record and respond to a child's/young person's offending behaviour in the context of sibling referrals and family relationships. Recommendations from Services to Children and Young People: Learning Services address

the implications for schools of recognising and responding to the needs of 'whole' families in the context of thresholds for intervention. Further recommendations from Education Bradford concentrate on recognising when several siblings are presenting educational and school attendance problems, clear recording of multi-agency involvement and greater use of Common Assessment Framework assessments.

8.3 Inter-agency communication and professional challenge

8.3.1 The effectiveness of inter-agency communication is related to points made at 7.2.1. Had inter-agency communication been more effective, this might have led to closer multi-agency collaboration. Despite the Child and Adolescent Mental Health Services chronology identifying in June 1996 that the practitioner from this service would refer the child's brother to Children's Social Care because of significant concerns about his behaviour, there is no evidence that this referral was ever made. It took until January 1997 for the Child and Adolescent Mental Health Services to communicate with Children's Social Care about its concerns. In March 1997 the child's brother's Head Teacher also contacted Children's Social Care about significant problems relating to his behaviour in school. The Bradford District Care Trust's Individual Management Review comments that the Child and Adolescent Mental Health Services should have challenged Children's Social Care's response that there was nothing they could do under the circumstances. The same could be said about the child's brother's Head Teacher's referral to Children's Social Care when this service said they would not intervene because he was already receiving a service from the Child and Adolescent Mental Health Services.

8.3.2 The Youth Offending Team and the Probation service did not communicate with Children's Social Care, largely because they were treading their own paths and the Youth Offending Team assessment protocol was not designed to elicit information about family circumstances and the risk of harm to other family members. Individual Management Reviews also identify poor communication between the Youth Offending Team and the Probation service. There were difficulties in communication between Children's Social Care and mental health practitioners deriving from problematic professional relationships and a difference in professional perspectives between the child's brother's need for rehabilitation and the family's safeguarding needs. The Police reported incidents of domestic violence to Children's Social Care, appropriately referred the child's mother for MARAC attention in April 2009 and in February 2007 had sent Children's Social Care a record of all domestic incidents in this family recorded by the Police.

8.3.3 There is evidence of major miscommunication between Children's Social Care and mental health services with regard to the child's brother's unescorted leave from Hospital and his eventual discharge home. Children's Social Care first completed an initial assessment and advised mental health services that the child's brother should not be allowed unescorted home leave because of the risk he posed to children in the family. Children's Social Care then closed the case on 29/6/09 noting that the child's brother was detained in hospital and anticipating completion of a mental health risk assessment before his discharge home. The Care Co-ordinator from the Early Intervention in Psychosis Team appropriately re-referred the case to Children's Social Care when unescorted leave was considered for the child's brother. Children's Social Care responded that it understood the children's father would supervise the brother's home leave and there was no further role for this agency. Although there is evidence that Children's Social Care expected further contact from mental health services prior to the child's brother's discharge so it could consider a further assessment, a

letter from Children's Social Care on 29/7/09 made it clear that this agency had closed the case. It is unsurprising, therefore, that mental health practitioners failed to notify Children's Social Care of the child's brother's discharge from hospital. This episode is mired in confusion. The Individual Management Reviews suggest at various points that Children's Social Care wanted to re-assess safeguarding issues prior to the child's brother's home leave and Hospital discharge, while at the same time Children's Social Care anticipated that mental health practitioners would take responsibility for conducting a risk assessment and they thus refused to re-open the case.

8.3.4 While there is evidence from the Individual Management Reviews of good *intra-agency* communication, for example within Education services, the Youth Offending Team and Early Intervention in Psychosis/mental health services, this was not the case for communication *between* agencies. Frequently, poor inter-agency communication related to a failure to comprehend the extent of this family's difficulties, a professional concentration on individual children without reference to their family relationships and a lack of lateral thinking about the possible involvement of other agencies.

8.3.5 The importance of inter-disciplinary challenge has been identified in national evaluations of Serious Case Reviews as a way of clarifying professional understanding, encouraging professionals to 'think again' and ensuring thorough consideration of a case. However, it must be acknowledged that this kind of challenge rests on professional confidence and a willingness and ability to pursue matters when there are reasons for dissatisfaction. Sometimes this requires sound advice and support as was provided to the Early Intervention in Psychosis Team staff when they consulted the Bradford District Care Trust Named Safeguarding Nurse in May and June 2009.

8.3.6 The Overview Panel was concerned in the context of inter-agency communication about arrangements for West Yorkshire Police to send notifications, rather than referrals, to Children's Social Care regarding domestic violence incidents. Where West Yorkshire Police made referrals to Children's Social Care in this case these are recorded in the Children's Social Care Individual Management Review chronology. The West Yorkshire Police Individual Management Review indicates that *notifications* to Children's Social Care about domestic violence incidents were given a risk assessment according to categories of high, medium or standard risk but these assessments were not based on the risk of harm to children in the family. This process left Children's Social Care with the responsibility of differentiating between the importance and urgency that should be attributed to each notification in relation to safeguarding issues. The Overview Panel considered that this arrangement was inadequate and should be replaced by multi-agency screening arrangements to identify the severity of risk posed to children by recorded incidents (notifications) of domestic violence.

8.3.7 Learning in this context points to the need for improvements in the following areas:

- Professionals need to *think* about whether children with whom they are working are likely to have attracted the attention of other agencies and to be proactive in identifying whether this is the case. They should ensure that appropriate referrals are made to Children's Social Care when a child/family presents difficulties that indicate child protection/safeguarding concerns.
- Professionals should be clear in their written and verbal communication and think about how their communication will be understood by the recipient.

- Where professionals from children's and adult services are working together, they should first, understand that they may have different perceptions about their roles and priorities and second, ensure that they have clarified any issues in this context so working relationships are based on mutual understanding, respect and co-operation.
- Professionals should be encouraged though their qualifying programmes, joint training opportunities and supervision to be challenging if necessary in inter-disciplinary relationships so that other professionals are required to think again about their decision making, to consider an alternative perspective and/or to re-examine their response to a case.
- Further consideration should be given to multi-agency arrangements for assessing the priority that should be accorded to Police notifications about incidents of domestic violence. This is necessary to avoid the current situation where Children's Social Care must sift through and assess child protection/safeguarding issues from numerous Police notifications which do not provide an assessment of the risk of harm to children.

8.3.8 Recommendation 9.1.1 from the Overview Panel seeks to address professional relationship and communication difficulties between Children's Social Care and adult mental health services in relation to their roles and priorities when there are child protection/ safeguarding concerns. A further Overview Panel recommendation (9.1.4) responds to current difficulties associated with Children's Social Care's responsibility for prioritising between numerous Police notifications about domestic violence incidents when children are present. Individual Management Reviews include recommendations that are designed to improve inter-agency communication and collaboration.

8.4 Management oversight and professional supervision

8.4.1 There is evidence from the Children's Social Care Individual Management Review of a lack of management oversight and effective supervision particularly from April 2009 when an agency manager was recruited to replace a manager who was on sick leave. Additionally, the Youth Offending Team and Probation Individual Management Reviews identify poor practice when practitioners failed to up-date assessment records and then conducted new assessments on the basis of 'old' information. Although it is clear from the Early Intervention in Psychosis Team chronology that this service had regular team meetings, the Overview Panel was concerned about inadequate evidence of effective management oversight and individual supervision.

8.4.2 A lack of effective management oversight in Children's Social Care meant that referrals were not accorded an appropriate response and, despite evidence that historical records were accessed, there is no indication that the family's case history informed subsequent decisions. In OFSTED's national evaluations of Serious Case Reviews it noted that the role of managers should be to 'stand back and see the bigger picture' but this did not always happen in this case. Without attention to the 'bigger picture' practice tends to be reactive and incident-driven. This approach, particularly in the absence of a comprehensive/core assessment, results in fragmented and short-term planning. Children's Social Care repeatedly opened and closed this case and completed five initial assessments, without any attempt to understand the 'bigger picture' or to engage in longer-term planning.

8.4.3 The Individual Management Reviews do not generally refer in detail to professional supervision arrangements, although the Children's Social Care Individual Management

Review notes that the social worker's supervision was poor and irregular during May 2009 and thereafter. However, this Serious Case Review has identified questions about the effectiveness of clinical supervision/consultation arrangements for professionals working in mental health services in relation to child protection/safeguarding. The Overview Panel further noted that there should be a professional imperative to consult appropriate experts with regard to children's safeguarding in addition to ongoing supervision/consultation. Lord Laming's review of child protection arrangements published in 2009 identifies 'regular, high quality, organised supervision' as vital for good practice. This should apply to all professionals working in areas that have implications for Children's and Adults' Social Care. Supervision should, in a supportive environment, act to challenge decision making and to encourage the development of professionals' thinking and analytical skills.

8.4.4 In terms of learning, this Serious Case Review suggests that:

- Agencies should ensure the provision of effective management oversight with regard to decisions about case allocation and case management and should identify the importance of understanding and responding to case histories. A Manager's ability to stand back and to see the 'bigger picture' should ensure that case histories inform decision making and avoid reactive and incident driven professional responses.
- Intelligent, challenging and supportive supervision is vital to enhancing professionals' thinking skills and analytical capacity. This must be established and quality assured by agencies. The quality of professional qualifying programmes for health and social care practitioners and opportunities for ongoing professional development are also relevant here.

8.4.5 Overview Panel Recommendations 9.1.3 and 9.1.5 intend to ensure improvements in the provision of effective management oversight and clinical supervision/consultation arrangements.

8.4.6 Recommendations from Children's Social Care and Bradford and Airedale Community Health Services (Community Nursing Services) respond to the need for more robust management oversight and professional supervision in these agencies/services.

8.5 Safeguarding arrangements

8.5.1 The Overview Panel identified several occasions when Children's Social Care should have initiated child protection enquiries in response to referrals about the child's brother's behaviour and evidence of domestic violence/abuse in the family. Children's Social Care chose not to do so and instead conducted sequential initial assessments, which by their very nature, could not provide an in depth understanding of safeguarding issues or the children's needs. When the child's brother was hospitalised in May 2009 and there were concerns about his younger brother's and sister's safety during his home leave periods and following discharge, Children's Social Care failed to initiate child protection enquiries and depended on two social work home visits to ensure their safety. In the final event Children's Social Care relied on an anticipated risk assessment by mental health services, although there is no evidence that this was completed, and on an arrangement for the children's father to supervise the brother when he was on home leave. Children's Social Care assured the MARAC that a safeguarding plan was in place, when there is no evidence that this was the case. Most research concentrates on the risk of harm to children which is associated with

abusive *parenting* and it may be that professionals find it difficult to transfer safeguarding *thinking* to risks posed by siblings.

8.5.2 Children's Social Care's emphasis on the child's and his sister's safety pending their brother's discharge from hospital caused tensions between social work and mental health practitioners. Practitioners from the Early Intervention in Psychosis team did not observe and record or evaluate the child's brother's contact with his brother and sister when he was on home leave. Neither did Early Intervention in Psychosis team practitioners arrange a proposed meeting between the child's brother and his siblings to assess their interaction. Mental health professionals may not fully understand or prioritise safeguarding issues with regard to children, not only in the narrow sense of child protection but also in relation to broader aspects of children's development and wellbeing. Although the Child and Adolescent Mental Health Service and the children's schools were concerned about safeguarding issues and made appropriate referrals to Children's Social Care, they did not pursue these or challenge Children's Social Care's refusal to intervene.

8.5.3 In this context the Serious Case Review's findings indicate that learning should focus on:

- Ensuring all professionals and particularly those working in Children's Social Care, are equipped to identify and report signs of child abuse and to anticipate and properly assess safeguarding issues.
- Enabling professionals to understand that safeguarding refers as much to harmful long-term effects on children's cognitive, social and emotional wellbeing as to the immediate risk of injury or death and to ensure appropriate intervention in these circumstances.
- The necessity for Children's Social Care to consider the circumstances in which a comprehensive/core assessment should be completed following referrals from other agencies and the prior completion of several initial assessments.
- The importance of extending professionals' thinking/awareness of harm that may be perpetrated by parents to the likelihood of harm for which siblings may be responsible.

8.5.4 Recommendations 9.1.1 and 9.1.11 from the Overview Panel respond to learning about the necessity to improve awareness and responsiveness to child protection/safeguarding issues in adult mental health services and arrangements for joint working between Children's Social Care and mental health professionals in this context.

8.5.5. Further recommendations arising from Individual Management Reviews intend to improve professional awareness of child protection/safeguarding issues, particularly in relation to domestic violence/abuse, and to ensure that professionals seek specialist safeguarding advice where appropriate.

8.6 Professional judgement and decision making

8.6.1 The Bradford District Care Trust Individual Management Review suggests, in hindsight, that Psychiatric out-patient assessments of the child's brother, especially during late 2008 and 2009, were insufficiently rigorous in recognising and responding to the risk of harm that he posed to others and particularly to his siblings who were living in the family home. As noted earlier in this summary, contrary to the procedural requirements of

Bradford's Care Programme Approach Policy (2009) there was no pre-discharge Care Programme Approach meeting that might have collated known risk factors and developed a multi-agency risk management plan. There was similarly no post-discharge Care Programme Approach meeting that should have assessed the child's brother's continuing problems and evaluated the significance of 'relapse indicators' identified when the Community Psychiatric Nurse reviewed the risk assessment in December 2009. The Early Intervention in Psychosis team did not identify the child's brother as being in a high risk category on his discharge from Hospital and home visits from this team's practitioners were not, therefore, as frequent and therapeutically intensive as they could have been. The Early Intervention in Psychosis team did not review the risk assessment for the child's brother until four months after his hospital discharge. This clearly represents poor and unacceptable professional practice.

8.6.2 One of the possible dangers here is that over time mental health professionals had become used to the child's brother's behaviour and did not give sufficient attention to the family's reports of his deteriorating condition. Alternatively, mental health professionals and others may have adopted a 'fresh start' attitude following the child's brother's release from Hospital and been unwilling and/or unable to incorporate new information into assessments which challenged their existing beliefs. The child's brother's young age, slight physical stature and dependence on his family for care may also have generated sympathy and lowered professionals' perception of risk. National evaluations of Serious Case Reviews have identified these factors as clouding professional judgement. At the same time, however, it should be recognised that professional judgements involve the collation and analysis of complex information in situations where decisions are often finely balanced and accurate prediction of outcomes is difficult to achieve. Prediction and hindsight are clearly very different concepts.

8.6.3 In hindsight it is *relatively* easy to identify and collate risk factors associated with the child's brother's violence, mental illness and continuing cannabis (Skunk) use in the context of his family history and the ongoing nature of his family life and relationships. However, although this information became available to different health and social care professionals over time and was thus fragmentary in nature, this Serious Case Review has identified evidence that professionals did not always use available avenues (for example, comprehensive/core assessments, risk assessments and Care Programme Approach meetings) to effectively inform and support professional judgement and decision making.

8.6.4 It is also relatively easy to appreciate, in hindsight, changes and trajectories in the children's lives that were not readily apparent at the time. However, professional attention to case histories, effective inter-agency communication, comprehensive/core assessments and long-term planning should enable a more acute awareness of changes and their implications for intervention.

8.6.5 Learning from these aspects of the Serious Case Review should prioritise:

- Ensuring procedural requirements, particularly with regard to Care Programme Approach meetings and risk assessments, are clear and that mental health professionals comply with them.
- Ensuring that all mental health professionals, including Consultant Psychiatrists and associated medical practitioners are aware of child protection/safeguarding issues and seek specialist safeguarding advice where necessary.

- Through supervision and management oversight, ensuring that mental health practitioners are able to retain an acute sense of risk where this is necessary to protect others, and particularly children, from harm.
- Encouraging mental health practitioners to listen carefully and to accord appropriate weight to family members' concerns about a mentally ill person.
- Ensuring mental health practitioners understand the relationship between cannabis and particularly Skunk use and a mentally ill person's psychotic episodes and that they take a robust approach to minimising and managing the consequences of continued cannabis use.

8.6.6 Recommendations arising from relevant Individual Management Reviews address the necessity for improvements in mental health professionals' procedural compliance, arrangements for implementing Care Programme Approach risk assessment and planning and professionals' recognition and responsiveness to risk factors when mentally ill individuals receive care in the community.

8.7 Invisible fathers

8.7.1 National evaluations of Serious Case Reviews note a dearth of information about men, a frequent failure to involve men/fathers in assessments and rigid professional thinking about father figures as 'all good or all bad'. Relevant literature and research shows how professionals tend to exclude men/fathers from safeguarding work with families on the presumption that they are likely to constitute a risk and that women/mothers should be responsible for protecting their children. There is evidence that this was the case when professionals intervened to help this family. The children's father was not involved in assessments and professionals did not challenge him about his responsibility for domestic violence and its impact on the children's wellbeing. Although the children's father was fully involved in the Care Programme Approach to his son's mental illness, professionals had neglected his role in the family prior to this.

8.7.2 Although the children's father was not living with his family for some periods and at times was working away from home, these factors do not explain why professionals made little effort to include him when they were working with the family. Professionals may have been anxious and wary about the father's history of domestic violence but there is no evidence from the Individual Management Reviews that this was considered in working arrangements.

8.7.3 Achieving learning requires the following actions:

- Ensuring professionals are aware of the significance of men/fathers in family life and safeguarding assessments/plans and that professionals involve them, as far as possible, in whatever intervention might occur in the family.
- Taking a measured professional approach to the contribution that men/fathers might make to improving family circumstances and the children's wellbeing, while at the same time ensuring that working arrangements protect practitioners from threats of violence/intimidation.

8.7.4 The Overview Panel's recommendation (9.1.9) addresses this issue.

8.8 Parental resistance to professional intervention

8.8.1 The Individual Management Reviews note that for most of the period covered by this Serious Case Review, the parents' rejection of help from agencies impeded service provision. However, the children's mother did appreciate her early involvement with the Family Centre and engaged at that time with her health visitor. She and her partner also accepted help from the Child and Adolescent Mental Health Service with regard to the child's brother's earlier difficulties. The child's parents and maternal grandparents worked closely with mental health services in the Care Programme Approach to the child's brother's mental illness. Critical comments in this summary about some agencies' failure to initiate a Common Assessment Framework assessment should acknowledge the consensual requirement for this approach and the child's parents may well have resisted this form of intervention.

8.8.2 National evaluations of Serious Case Reviews have noted a frequent resistance to professional intervention from families. These evaluations comment that professionals can provoke co-operation or hostility by their behaviour and there are numerous reasons for parental non co-operation including 'negative experience of services, being in denial about their problems, fearing children will be removed if problems are admitted, getting no support for non-acute problems or an overwhelming amount of support when problems become so bad that they meet service thresholds'. However, these evaluations suggest that parental hostility to professional intervention can be modified by 'positive engagement skills' and should not be viewed as an 'inherent and unchangeable attribute'.

8.8.3 The Overview Panel was concerned in this context about broader impediments to professionals' willingness and ability to exercise their authority in response to parental resistance/non-co-operation. A *perceived* policy and legislative emphasis on working in partnership with parents under the Children Act 1989, subsequent Government guidance and the Human Rights Act 1998, has arguably led to a culture where professionals eschew the application of authority, inappropriately accept parental resistance to intervention and service delivery and tend to focus their attention on children as being in need of support rather than in need of protection from harm. This perception has been compounded by the absence of any focus on risk in the Integrated Children System templates imposed on Children's Social Care by the previous government.

8.8.4 Professionals, and particularly Children's Social Care, could therefore have been more skilled and persistent in trying to engage with this family. However, in the absence of parental co-operation and with evidence of safeguarding concerns, professionals should have considered a more authoritative approach to intervention.

8.8.5 Learning in this context indicates the following actions:

- Ensuring that professionals, through appropriate training and supervision, are able to enhance their 'engagement skills' to encourage parental co-operation and to develop effective working relationships with parents/carers.
- Empowering professionals, particularly in Children's Social Care, through effective supervision and management oversight, to employ their authority in helping parents to accept professional intervention in the best interests of their children. Where this is ineffective agencies should consider a more interventionist approach to safeguarding children's wellbeing.

8.8.6 Recommendation 9.1.10 from the Overview Panel is intended to improve professional practice in this regard.

8.9 A focus on children's needs, wishes and feelings

8.9.1 The Overview Panel was concerned that the subject child's experiences, needs, wishes and feelings were overlooked by professionals whose primary focus was on his older brother's difficulties. Children's Social Care too readily accepted the parents' resistance to intervention and because this agency depended on sequential initial assessments, social workers were never able to develop a trusting relationship with the children or to explore their wishes and feelings.

8.9.2 The subject child's brother's difficulties largely dominated professional attention, with the exception of his older sister's ('B') educational problems and offending behaviour, during the period covered by this Serious Case Review. This meant that professionals paid insufficient attention to the needs of other children in this family who had experienced the same quality of parenting and adverse family circumstances.

8.9.3 Learning in response to these issues must ensure that:

- Professionals, particularly from, Children's Social Care, health visiting, community nursing services and Education services, appreciate the importance of communicating directly with children and observing indicators of their wellbeing.
- All professionals should remain alert to the individual experiences and needs of *all* the children in a family rather than focussing their attention on a child or children who, because of their behaviour, are attracting particular professional concern.

8.9.4 Recommendation 9.1.2 from the Overview Panel seeks to ensure improved professional practice in response to learning from this Serious Case Review.

8.10 The importance of human (professional) intelligence

8.10.1 The Overview Panel was concerned about the role and effects of electronic recording systems, protocols and pro-forma requirements that direct professionals' attention to the characteristics of individual service users and indicate algorithmic relationships between prior conditions and specific interventions. These instruments frequently depend on if...then logic and may constrain lateral thinking and initiative.

8.10.2 While such instruments can aid professional recording and decision making, it is important that they should not erode the role of human intelligence in making connections between historical events and *thinking* about the possibility of other agencies' involvement with a family, risk factors and safeguarding concerns. National evaluations of Serious Case Reviews lead to the conclusion that practitioners should be encouraged to be 'curious and to think critically and systematically' in order to better understand the risk of harm to children.

8.10.3 Learning here requires that:

- National and local agencies should review their assessment and recording systems/ protocols to ensure that they encourage rather than obstruct the application of professional thinking skills and discretion.

- Government should consider the ways in which current guidance and legislation act to inhibit the exercise of professional authority in response to families which are resistant to professional involvement.
- Professor Eileen Munro's review of social work practice should explore and respond to this issue and her conclusions should be considered in relation to professional practice in other agencies.

8.10.4 The Overview Panel's recommendation (9.1.8) is relevant to learning in this context.

8.11 The role of GP Practices in collating information and recognising safeguarding concerns

8.11.1 GPs were the recipients of information about the parents and children, which came from individual patient consultations, letters from the Child and Adolescent Mental Health Service about its earlier involvement with the child's brother and records from mental health professionals about their later work with the family. Despite difficulties about written communication reaching appropriate GP Practices when families frequently change their address, there were only four GP Practices involved with this family over the period covered by this Serious Case Review. GP Practices were therefore in a prime position to collate information about this family, to identify safeguarding issues and to make appropriate referrals to other agencies. There appears to be no system in place for GP Practices to ensure that this happens.

8.11.2 Learning from this case points to the importance of:

- Ensuring that GP Practices are aware of their role in protecting/safeguarding children and make arrangements to enable the effective collation of relevant information and the identification of child protection/safeguarding concerns.

8.11.3 Recommendation 9.1.7 from the Overview Panel seeks to address this issue and a recommendation arising from the NHS Bradford and Airedale Individual Management Review emphasises the importance of information sharing/liaison between GP Practices and attached professionals from Bradford and Airedale Community Health Services.

8.12 Cultural/professional attitudes to drugs misuse among young people

8.12.1 Information from the Youth Offending Team indicates that the child's brother and his sister ('B') frequently used cannabis and preferably Skunk from a relatively young age. Despite referring them for group and individual support, the child's brother and sister did not engage with these opportunities to control their drug use. Individual Management Reviews also describe the child's brother's use of cannabis/Skunk during his hospitalisation and following his discharge to the family home. The Early Intervention in Psychosis Individual Management Review suggests that mental health professionals should have taken a more robust approach to educating the child's brother and his family about the risks associated with cannabis/Skunk use and identified their approach to managing this issue in the care plan. The Overview Panel was concerned about indications from some Individual Management Reviews that professionals accepted the widespread use of illicit substances by service users and that their interventions were relatively ineffective in modifying this behaviour.

8.12.2 The Overview Panel's recommendation 9.1.6 identifies the need for attention to this issue.

8.13 Could the subject child's death have been predicted?

8.13.1 In hindsight it is possible to identify and collate risk factors associated with the child's brother's mental illness and his presence in the family home. There seems to be little doubt that known risk factors on his discharge from hospital should have alerted professionals to the probability that his psychotic illness and lifestyle would present a significant risk of harm to members of his family. This Serious Case Review has identified failures in professional practice that might have better identified these risks and more effectively instituted arrangements to ameliorate/manage them. However, previous evidence of the child's brother's propensity to violence could not have led mental health professionals to anticipate the nature of his attack on his younger brother. The Overview Panel agreed that this attack could not have been anticipated with a high degree of probability by professionals involved with this case.

8.14 Evidence of good practice

8.14.1 Serious Case Reviews, by their very nature conduct in depth enquiries into professional practice, procedural compliance, management and supervision arrangements and the roles played by individual agencies and multi-agency collaboration. It would be surprising if during this process the Serious Case Review did not identify matters that required attention and improvement. However, this does not mean that good practice cannot be identified. Good practice was particularly evident in the following areas:

- The children's schools worked hard internally and in collaboration with Education Support Services to improve their school attendance and to support their learning. There is evidence that schools and the Pupil Referral Unit tried to engage the parents in supporting their children's educational opportunities.
- During 1995 the family's health visitor identified indicators of emotional abuse and referred the family first to the Family Centre and then to the Child and Family Unit. She was able to engage the children's mother in talking about a history of domestic violence and its impact on the children's wellbeing.
- The Youth Offending Team and its Community Nurses worked hard to monitor and improve the effects of lifestyle factors on the child's brother's and his sister's health and wellbeing and to limit the extent of their offending behaviour.
- The Police Offender Management Unit provided intensive support to the child's brother and his sister 'B' and demonstrated determination and commitment in their efforts to divert them from offending behaviour. The child's brother's allocated police officer did everything within his power to draw professional attention to the brother's mental health problems and to ensure that he and his family received appropriate help.
- Mental health professionals at the Hospital where the child's brother was detained ensured good internal communication about the brother's symptoms and treatment and responded appropriately to his differential needs for monitoring, control and therapeutic intervention.

9.0 Recommendations for Bradford Children Safeguarding Board (BSCB) from the Overview Panel

9.1 The following recommendations, which require action from Bradford Safeguarding Children Board, have been constructed by the Overview Panel in response to issues identified during this Serious Case Review. The associated action plan is appended to this report.

9.1.1 BSCB to request Children's Social Care, Bradford and Airedale Community Health Services and Bradford District Care Trust to jointly review and report to BSCB their assessment, intervention and planning processes to enable a co-ordinated approach to meeting children's safeguarding needs when adults in a family are also receiving mental health services.

9.1.2 BSCB to ensure, with member agencies, that all professionals understand their responsibility, during assessment and service delivery, of paying attention to the needs of every *individual* child in a family, observing indicators of their wellbeing and seeking to understand their wishes and feelings.

9.1.3 BSCB to ensure with member agencies that all first line managers across Children's Services are skilled, child-focussed and understand their responsibility to provide effective and challenging leadership both to their own staff and in working relationships with other agencies.

9.1.4 BSCB should consider, with the Domestic Abuse Partnership, the development and implementation of an agreed multi-agency screening and intervention process for according priority and responding to all situations where children are identified as living with domestic violence.

9.1.5 BSCB should evaluate with member agencies supervision/consultation arrangements to ensure that these facilitate and deliver effective decision making, professional reflection and collaborative working relationships in a single and multi-agency context.

9.1.6 BSCB to consider and agree a position statement/advice to respond to children and young people who routinely rely on using drugs/alcohol such that this significantly impairs their emotional and physical wellbeing.

9.1.7 BSCB to request NHS Bradford and Airedale to consider ways of encouraging and enabling GP Practices to more effectively collate information which they hold about service users so they are better equipped to identify safeguarding concerns about children and to make appropriate referrals to other agencies.

9.1.8 BSCB recommends that Government agencies should review national assessment and service delivery tools/protocols to ensure that they encourage a professional focus on family relationships and family context and thus direct attention to the possible involvement of other agencies and the need for multi-agency meetings/collaboration. Such a review should ensure that tools/protocols are designed to encourage professional curiosity, judgement and reflection rather than to constrain the application of these elements of good practice.

9.1.9 BSCB member agencies to ensure through supervision, management oversight and training programmes that professionals understand and respond to the role that men/fathers play in family life and the children's wellbeing during their work with family's on assessment and service delivery.

9.1.10 BSCB to consider with member agencies the implementation of measures that will support effective professional intervention with families where parents/carers reject help/services and there are vulnerable children and to incorporate these as appropriate into supervision, guidance, procedural frameworks and multi-agency training.

9.1.11 BCSB to examine relevant findings following completion of the outstanding enquiries/parallel processes by the Strategic Health Authority, the Primary Care Trust, NHS Bradford and Airedale Community Health Services and possible criminal proceedings with respect to the child's brother, with a view to evaluating the effectiveness of Children's safeguarding arrangements in adult mental health services.

10.0 Recommendations arising from Individual Management Reviews

10.1 Serious Case Review enquiries and Individual Management Reviews are likely to identify areas for improvement in individual agencies/services. The following recommendations have arisen from Individual Management Reviews. Corresponding action plans are appended to this report. Where health-related Individual Management Review recommendations are also included or developed in the Combined Health Provider and Commissioning Overview IMR prepared by NHS Bradford and Airedale Primary Care Trust, this is identified below.

10.2 Bradford Teaching Hospitals NHS Foundation Trust

10.2.1 Storage and retrieval of old Accident and Emergency notes to be addressed either by a systematic re-file of paper records or electronic scanning of old notes and electronic availability at time of attendance.

10.3 Education Bradford

10.3.1 Improve the recording of casework to better reflect the work done on an intra- and inter-agency basis.

10.3.2 Improve the robustness of current processes for scrutinising the annual reviews of pupils with a statement.

10.3.3 Improve the robustness of sibling checks. Improve the level of detail in record keeping and better identify which agency is taking a lead on agree actions. Further improve advice to schools.

10.3.4 Educational Psychologists to consider how to improve the robustness of their monitoring of the most vulnerable pupils.

10.4 NHS North Yorkshire and York

10.4.1 The Lead Director for Safeguarding Children in Tees Esk and Wear Valley (TEWV) will send a reminder to all CAMHS clinical staff regarding the importance of fully documenting all contacts and consultations, including documenting family composition and relationships. This will be completed by 1st December 2010.

10.4.2 The Lead Directors for Safeguarding Children in TEWV and Scarborough and North East Yorkshire Hospital Trust (SNEY) will alert all clinical staff to the importance of actively seeking information from patients/parents or carers of children about possible domestic abuse where there are issues raised about relationship difficulties. Where there are issues of domestic abuse revealed by a parent, this must then be discussed with a member of the organisation's Safeguarding Children Team to ascertain whether a referral needs to be made to the Local Authority Children's Social Care Department. This will be completed by 1st December 2010.

10.4.3 The Lead Director for Safeguarding Children in TEWV will issue a reminder to all CAMHS staff regarding the criteria for making a Child in Need/Section 17 referral to Children's Social Care. This will be completed by 1st December 2010.

10.4.4 The Lead Directors for Safeguarding Children in TEWV and SNEY will review all 'in-house' Safeguarding Children and Safeguarding Adults training to ensure that it addresses the importance of clinicians looking beyond the presenting problem to the impact that such a problem and its background may have on the parenting/caring abilities of their patient or the siblings of a child patient, addressing social, emotional, developmental, parenting and environmental issues. This will be completed by 1st December 2010.

10.4.5 The Lead Director for Safeguarding Children in TEWV will ensure that wherever a child has previously been seen by another CAMHS department, information is sought from that department about the care and treatment received by the child and any other relevant information. This directive will be in place by 1st September 2010.

10.4.6 The Lead Director for Safeguarding Children in TEWV will ensure that all staff working with children and young people are clear about their responsibilities to offer appropriate advice to the parents or carers of those children when the worker identifies a possible physical or mental health need in that parent/carer. This directive will be in place by 1st September 2010.

10.4.7 The Lead Director for Safeguarding Children in TEWV will ensure that systems are in place to ensure that clinicians are clearly aware when children miss appointments and that parents/carers are asked why this occurred in order to work together to minimise missed appointments and facilitate appropriate care and monitoring of the child's needs. This will be in place by 1st December 2010.

10.4.8 The Lead Director for Safeguarding Children in TEWV will ensure that systems are in place to ensure that CAMHS clinicians always record their observations of attachment between the children that are their patients and their parents or carers. This will be in place by December 2010.

10.4.9 The above recommendations are also included in the Combined Health Provider and Commissioning Overview Individual Management Review.

10.5 Probation Service

10.5.1 Practice expectation in respect of the need to ensure assessments are based on all the available information, do not rely on past assessments, and are always updated when new, relevant information is obtained, to be reinforced through the bulletin to all staff and team

briefings by August 2010. This should incorporate reference to circumstances where there may be greater vulnerability to error.

10.5.2 Practice expectation regarding the need to follow up on information received regarding recent Children's Services involvement to be communicated via staff bulletin and team briefings, and current policy on Children's Safeguarding checked to ensure this is addressed, by August 2010.

10.5.3 Policy and practice guidance in respect of adult safeguarding to be developed and disseminated to practitioners by march 2011.

10.5.4 Practice instruction regarding the importance of ensuring effective liaison and information exchange with all relevant agencies or multi-agency forums involved in a case to be issue via staff bulletin and team briefings by August 2010.

10.5.5 Training plan for 2010/11 to address mental health, learning difficulty and offenders, supplemented by practitioner guidance and resource material through the intranet, by March 2011.

10.5.6 Learning from this case to be shared with local Offender Health Boards in West Yorkshire by December 2010.

10.6 Youth Offending Team

10.6.1 A full list of the immediate family members is recorded (Case details) under the family and personal relationships section. This practice will be added to the Youth Offending Team's Quality Assurance monitoring template tool.

10.6.2 If the Youth Offending Team becomes involved with a second young person from the same family, the internal Risk Management process is triggered with both cases discussed together at a Risk Management meeting.

10.6.3 When10.6.2 above occurs both (or more) assessments will reflect the significance of this by indicating it as a high risk of re-offending factor. This point will be added to the Youth Offending Team's quality assurance monitoring template.

10.6.4 Through annual appraisals all case managers' depth of knowledge and experience in the effects of domestic violence on children will be reviewed. Additional training will be provided where supported by the team manager.

10.7 Early Intervention in Psychosis Team (EIP)

10.7.1 Review the utilisation of the care planning process within the Early Intervention in Psychosis service. This review of process should include focussing on the discharge process for inpatients and the procedures that ensure a community care plan is in place. Regular audits of the Care Programme Approach process should also be in place. Initially a review of current caseload care and management plans to ensure that standards within policy are met should be completed.

10.7.2 A review of the risk assessment process and documentation should be initiated within EIP services. All risk assessments should accommodate any change of circumstances (i.e. inpatient to community, change of accommodation, circumstances within the family/environment). Competencies of individual staff members regarding risk assessment should be included within Joint Development Reviews utilising the knowledge and skills framework.

10.7.3 Review treatment package within the care plan, of all clients on EIP caseload currently with a Dual Diagnosis. Review current education packages delivered to the EIP team on dual diagnosis.

10.7.4 The assertive outreach approach and model delivered within the EIP services should be reviewed against national guidance.

10.7.5 Address gaps within interagency working between teams providing care to the same individual (e.g. substance misuse, EIP, in patient, children's services) – particularly focusing on communication and information sharing. Review information sharing protocols, internally between the hub and the spoke and externally between agencies.

10.7.6 Procedures for cover and hand over during care coordinator periods of absence should be reviewed. This is to include practice regarding use of mobile phone contact throughout staff leave (i.e. diverting calls).

10.7.7 Review communication methods, in particular the use of texting/ mobile phones and how this is recorded in clinical records.

10.7.8 The Combined Health Provider and Commissioning Overview Individual Management Review develops the above recommendations and makes additional recommendations for the Early Intervention in Psychosis Service as follows:

10.7.8 1 Review the use of the Care Programme Approach within EIP.

- All Care Plans to be reviewed on discharge from in-patient care to ensure they reflect community care. This is completed and part of EIP Service practice.

- Audit caseload to ensure all those who are on the EIP risk list have robust care plans with clear risk indicators, management plans and relapse signatures. This has been completed and will be regularly audited within EIP current systems. Partnership working with BDCT must include a review of the CPA policy, especially regarding interagency working.

- Review discharge planning.

- Review individual and team consistency in carrying out risk assessment.

- Ensure clear competencies for staff that carry out Risk Assessment are included within Joint Development Reviews, utilising knowledge and skills framework.

10.7.8.2 Review of the risk assessment process in EIP. In particular risk assessment documentation to a include risk management plan.

- Ensure all Risk Assessments accommodate change of circumstances (i.e. in-patient to community, change of accommodation, change of presentation).

- Review the EIP high risk list strategy which can influence approach to those not on the list and ensure that those placed on high risk are identified within the team. This has already been reviewed and action taken accordingly.

- Review current education packages delivered to the EIP Team on dual diagnosis and assess further requirements.

- Review treatment package of all clients on EIP caseload currently with a Dual Diagnosis.

10.7.8.3 Review the assertive outreach approach in EIP.

- Benchmark the assertive outreach approach with assertive Outreach Teams and agree a definition in line with MHA.

- Document visiting frequency required for high risk clients within the care plan. This has now been implemented by the service.

10.7.8.4 Address interagency working between teams providing care to the same individual (e.g. substance misuse, EIP, in patient, children's services)

- Particularly focusing on communication and information sharing.

- Review information sharing protocols, internally between the hub and the spoke and externally between agencies.

10.8 Multi-Agency Risk Assessment Conference (MARAC)

10.8.1 The Bradford Domestic Abuse Partnership to ensure that the new risk assessment is used by all agencies referring to MARAC.

10.8.2 The Bradford Domestic Abuse Partnership and the individual Chairs of the two MARACs ensure that agencies attending the Bradford MARACs understand the confidentiality statement relating to MARACs and that all agencies are continually made aware of their responsibilities in relation to carrying out actions and giving feedback of those actions to the MARAC Lead Officer.

10.8.3 The Bradford Domestic Abuse Partnership to ensure that the number of cases referred to each MARAC does not exceed the recommended number of cases by screening.

10.8.4 Individual agencies to ensure that the representatives attending MARACs are at a level of seniority appropriate enough to be able to make decisions and ensure actions are carried out.

10.8.5 The MARAC Lead Officer to implement systems across both MARACs consistently and ensure that spelling of names is cross checked prior to paperwork being distributed to representatives.

10.8.6 The Bradford Domestic Abuse Partnership and the chairs of the MARACs to ensure that all agencies attending MARACs have the same spelling of names, dates of births and addresses of all concerned. Also, this will include information relating to disabilities, including mental health issues.

10.8.7 The Bradford Domestic Abuse Partnership and West Yorkshire Police to ensure the consistency of the MARAC Chairs for both MARACs.

10.9 Bradford and Airedale Community Health Services (BACHS)

10.9.1 The development of a domestic violence referral pathway for BACHS staff.

10.9.2 School nursing teams must discuss any school-age children who have been subject to a MARAC with the Named Teacher with safeguarding responsibility with in the appropriate school.

10.9.3 Review of current BACHS Safeguarding Supervision Policy.

10.9.4 Review of electronic systems used by BACHS staff with a view to greater clarity about which services are being provided to a family, and improving information sharing.

10.9.5 The link between domestic violence and harm to children to be included as part of mandatory safeguarding children training for Level 2 and 3 staff.

10.9.6 Revision of Safeguarding Supervision to include all children identified through the MARAC process.

10.9.7 Review of the Health Service provided to the Youth Offending Team with particular reference to Safeguarding Practice.

10.9.8 The above recommendations are also included in the Combined Health Provider and Commissioning Overview IMR.

10.10 Bradford District Care Trust

10.10.1 Child Visiting: work with the electronic recording system (RiO) development Group to ensure that the assessment form focusing on key principles of the Child Visiting Policy is available electronically on the RiO system for staff to complete on each occasion a Child Visit occurs to an in-patient area.

10.10.2 Community Mental Health Teams Duty Workers and Duty System: ensure that the current re-configuration work underway within the Community Mental Health Teams includes a review of the Duty Workers role and the Duty System ensuring that the lessons learnt from this case with regards to safeguarding children practice are implemented and sustained.

10.10.3 Domestic Abuse: Develop a trust wide domestic abuse strategy endorsed by the Trust Board to ensure that Bradford District Care Trust is committed to and engages with the Multi Agency Risk Assessment Conferences (MARAC) process for the District and complies with the requirements of the Violence against Women and Children's Strategy.

10.10.4 Joint working between Bradford District Care Trust and Children's Social Care: Agree a working protocol with Children's Social Care colleagues regarding consistent and sustainable joint working of cases common to both agencies.

10.10.5 CPA Planning**:** The Trust will work to develop its RiO information system to ensure that prompts are included for staff regarding the need to invite other agencies/professionals to Care Programme Approach meetings.

10.10.6 Section 17 Leave/Discharge Planning: The Trust will work to develop its RiO information system to ensure that staff have actively considered the issues of care / need at home pertaining safeguarding (adults and children) where section 17 leave / discharge is being planned.

10.10.7 The above recommendations are also included in the Combined Health Provider and Commissioning Overview IMR.

10.11 Services to Children and Young People: Learning Services

10.11.1 Schools to be advised to review their systems of record keeping to ensure that numbers of incidents and contacts are clear to include; records of telephone conversations with/between agencies that need to be recorded on a consistent, standard pro-forma, which includes date/time/précis of conversations/key persons/agency contacts/actions/future actions/review.

10.11.2 Schools to be involved in the Consultation launch and training, review and audit of the new Threshold of Need Document.

10.11.3 BSCB/Children's Trust Executive to clarify how the Threshold of Need Document can be applied to the families' needs as a whole.

10.12 Children's Social Care (CSC)

10.12.1 CSC to ensure that managers in Children's Assessment Teams have active oversight of all referrals coming through for initial assessment. This includes making sure historic information and chronologies are actively used to challenge analysis and reference is made to previous assessments. Service standards and performance need to be implemented consistently in all teams.

10.12.2 Service Managers need to have in place clear arrangements that support assessment team managers in making decisions as well as ensuring regular scrutiny of front line decision making.

10.12.3 The initial assessment must look at the needs of all the children in a family and not just the referred child.

10.12.4 Ensure that there is active supervision of staff within assessment teams. Staff need regular supervision which is reflective and challenging even when their overall caseload is short term and duty work.

10.12.5 Children's Social Care to ensure that they are fully engaged with MARAC at both a strategic and operational level ensuring that appropriate levels of seniority are represented and that information is accurately presented and recorded on the file.

10.13 Director of Neighbourhoods, East and West City In-communities

10.13.1. Practice should be reviewed so as to ensure that when action is taken to obtain an Anti Social Behaviour Order against an individual not residing in one of the IC properties, a comprehensive assessment is completed so the organisation is assured that the enforcement action is balanced with that of the individual's vulnerability

10.14 West Yorkshire Police

10.14.1 The West Yorkshire Police will ensure that all domestic abuse incidents involving children are initially reviewed by the Child and Public Protection Unit to determine if any further investigative action is required and the CPPU should reallocate the VIVID report to the Police Safeguarding Unit. This will ensure that the Safeguarding Unit are made aware of domestic history (involving both children and adults) in their risk management of each case.

10.14.2 The West Yorkshire Police will ensure that the Force complies with the Police and Criminal evidence act 1984, Code C Codes of Practice in relation to facilitating the timely attendance of appropriate adults at the police station for juveniles and mentally vulnerable persons.

10.15 Additional recommendations from the Combined Health Provider and Commissioning Overview IMR

10.15.1 NHS Bradford and Airedale Primary Care Services

- All GP Practices in NHS Bradford and Airedale should appoint a Safeguarding Lead
- The named GP's will keep a register of these Safeguarding Leads.
- Safeguarding leads will ensure that all staff employed within the practice have had basic safeguarding training, and keep up to date as necessary.

10.15.2 NHS Bradford and Airedale Recommendations, as Commissioners of Services

10.15.2.1 NHS Bradford and Airedale will commission an Independent and external review of the Early Intervention in Psychosis Service and will ensure the implementation of any recommendations through the Clinical Governance Sub-Committee of the Primary Care Trust Board.

10.15.2.2 NHS Bradford and Airedale will review and monitor the individual action plans to ensure compliance through the Serious Case Review Sub-group of the BSCB and through the Clinical Governance Sub-committee of the Primary Care Trust Board.

10.15.2.3 Bradford and Airedale Community Health Services (BACHS) and the Local Medical Committee for Primary Care to discuss and agree a process for appropriate information sharing and liaison between GP practices and their attached BACHS staff.

10.15.2.4 Bradford District Care Trust (BDCT) and BACHS to discuss and agree a process for appropriate information sharing and liaison between Child and Adolescent Mental Health Services (CAMHS) practitioners and BACHS Community Nursing staff. BDCT and BACHS and NHS Bradford and Airedale to discuss and agree a process for appropriate information sharing and liaison between adult mental health practitioners, general practitioners and primary care staff.

10.15.2.5 BDCT to review the access to Adult Mental Health Services of all previous records including CAMHS records for clients without the need to make specific requests.

10.15.2.6 BDCT, BACHS and NHS Bradford and Airedale to agree the pathway for working together to provide clarity regarding the current working practice of the EIP Service with regard to provision of safeguarding advice, training needs, audit and reporting requirements and performance management.