

# **Independent Multi-agency Review Report**

**In respect of: Miss G**

**Report Produced by Professor Pat Cantrill**

**27<sup>th</sup> November 2012**

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## EXECUTIVE SUMMARY

### INTRODUCTION

On 14th February 2012 South Yorkshire Police received a call from Child A who told the call operator that she had been stabbed. Twenty minutes later a call was made to South Yorkshire Police from a member of staff at Rethink Centre stating that Miss G had arrived at the centre and informed them that she had stabbed someone. As a result, officers were sent to Rethink and arrested Miss G on suspicion of assault. Later that day, Child A died from the injuries she had sustained. Miss G was arrested and charged with murder. In July 2012 Miss G was tried and found guilty of the murder of Child A and sentenced to 22 years in prison.

### REASONS FOR CONDUCTING THE REVIEW

An Independent Multi-agency Review was commissioned by NHS Doncaster in accordance with the requirements of its Incident Management Policy (including serious incidents & never events) (2010) and the National Framework for Reporting & Learning from Serious Incidents Requiring Investigation (National Patient Safety Agency 2010).

An Incident Coordination Group was established to lead the review and an Investigation Overview Panel ensured the completion of independent individual management reviews, a mental health overview report and this Independent Multi-agency Review Report to the required standard to ensure that the lessons to be learned, recommendations and action plans related to the death of Child A are identified and organisations act upon the reports' findings and recommendations. The Independent Multi-agency Review report will be examined by both Doncaster Children Safeguarding Board and Doncaster Adult Safeguarding Partnership Board Boards.

In preparing their reports, authors of the independent individual management reviews, the mental health overview and this Independent Multi-agency Review have examined both the available records of Child A and Miss G. Child A received routine universal services only. No concerns have emerged about the services she received. Therefore, all the reports, including this report focus on the services provided to Miss G.

### Miss G

Miss G was born in July 1985. Both her mother and father had significant health problems which impacted on their ability to parent both Miss G and her brother who was two years older than her. Miss G's parents made the decision that their children should be home educated and it was not until she was ten years old that Miss G attended school. In 1993 her GP contacted Doncaster Council's Children's Social Care (CSC) to express concerns that her parents were neglecting her. Support was given to assist her parents to be able to improve the care of the children without a detailed assessment of the situation or discussing with the children their needs. There was little improvement in the neglect of the children.

During the second period of contact with CSC Miss G needed regular periods of respite care as her mother had died and her father's health deteriorated resulting in frequent hospital admissions. During this period there was no improvement in the state of the family home and the ability of her father to care for his children deteriorated. Miss G started to attend school in September 1995, at the age of ten and found herself educationally delayed, isolated and bullied. Teachers, other professionals and family members contacted CSC to raise their concern about the neglect of Miss G.

In 1998 she became a looked after child in the care of Doncaster Council and was placed in foster care. What followed was a relatively brief period of stability with reports in 1999 that Miss G's health and hygiene had improved and that she was regularly attending school. However between March 2001 and June 2001 Miss G's behaviour is said to have deteriorated. In June 2001 her foster placement was ended. Her father died in September 2001. Miss G's behaviour gradually worsened during this period. She left the care of Doncaster Council in 2001 aged 16. She was homeless and lived in a hostel. She was drinking, self harming and using cannabis. Her contact with mental health services began in 2002 when she was referred by her GP to a Community Mental Health Team after complaining of being depressed. In August 2002 she was admitted to hospital for a short period of time. She attended outpatient appointments on a regular basis and remained in contact with services until 2008.

Between 2008 and 2011 her contact with mental health services ceased. In July 2011 she attended Accident and Emergency department at Doncaster Royal Infirmary to ask for contact with mental health services again.

In September 2011 Miss G was stopped by police and as a result of officers asking her if she was carrying any prohibited articles, she stated that she had a knife. This incident was followed by her arriving in London where she went to Belgravia Police Station. She was homeless and slept in a bookshop until the owner contacted mental health services and Miss G was admitted to hospital. Although she stated she did not wish to return to Doncaster she was returned and after a brief period in hospital in Doncaster was discharged. In November 2011 she arrived at the Accident and Emergency department at Doncaster Royal Infirmary having taken an overdose with, she said, the intention of ending her life. In November 2011 Miss G became anxious about living in the flat she had lived in for ten years and requested a housing transfer.

In early January 2012 Miss G contacted mental health services requesting admission. She stated that she needed to be "locked up". Following assessment she was offered crisis accommodation. Whilst staying at the crisis accommodation she was assessed by a psychiatrist. On 15 January she was discharged to her home address and followed up by the home treatment team. On 30 January Miss G was discharged from the home treatment team but was still receiving support from the crisis accommodation outreach worker. She was awaiting an appointment with the community therapy team to whom she had previously been referred.

On 14<sup>th</sup> February Miss G purchased two kitchen knives, approached Child A, a complete stranger, and stabbed her. She then went to crisis accommodation at Rethink and told them what she had done.

## **CONCLUSION**

It is important to note that it was the actions of Miss G that led to the tragic death of Child A and that at her trial she was found guilty of murder and not manslaughter as a result of diminished responsibility.

The purpose of this review is to examine the services that were provided to Miss G to enable lessons to be learnt and services improved. The content of the Review report paints a not unusual picture of mixed performance in meeting the needs of Miss G.

A combination of factors influenced the care provided for Miss G over nineteen years. They include;

- ineffective leadership and management
- dysfunctional organisational systems,

- workforce and cultural factors and
- individual deficient practice.

The potential for poor outcomes for Miss G increased significantly because of a lack of early intervention at a stage to address early signs of concern. No single agency 'owned' her care and frequent movements between agencies resulted in a degree of fragmentation of care. The cost to her in terms of her emotional and psychological well being appears to have been considerable. Later in life some people did try to help her and she was signposted to a number of services. However, because she was not motivated, because of the lack of coordination or because services failed to drive through the required contact she did not receive the help she needed. No one person during her childhood, adolescence or adulthood established a long standing therapeutic relationship with her, coordinating her care or acting as lead professional. This is an essential principle when managing people with borderline personality disorder. Throughout her life it appears services failed to listen to her concerns. There was a lack of inter-agency and multi-agency working in many instances. She was almost invisible to some services. The impact of her not receiving the required quality of care on her ability to make choices about her life and care was not considered by most services. What is evident is that she told many agencies of her concern that she was going to harm someone. Assessments made by them did not identify a high level of risk of this occurring. It is hard to establish if this was because she was not really heard. There were missed opportunities to work with her more effectively. This could have changed the course of events in Miss G's life and well being.

## **LEARNING LESSONS, IMPROVING SERVICES**

### **Record Keeping**

- 1) Firstly what is clear is that there is a lack of consistency in the quality of and retention periods for the different records created and maintained by agencies. Management of information and sharing within and between agencies and by individual professionals is crucial to safeguarding children, young people and vulnerable adults. There remain some issues in record keeping which across services was generally poor.

### **Safeguarding Children**

- 2) It is important that there are clear lines of accountability and systems in place to support professionals to undertake their role. Lack of clarity about the functioning of services, asymmetrical changes within and across services, lack of resources and effective auditing, all added to produce an environment which made it difficult for professionals to provide high quality services. There is evidence of issues associated with ineffective management and workload pressures.
- 3) A good child protection system should be concerned with the child's journey through the system from needing to receiving help, keeping a clear focus on children's best interests throughout. This includes developing the expertise and the organisational environment that helps professionals working with children, young people and families to provide more effective help.
- 4) There are problems associated with the ability of practitioners to critically analyse data and information to identify indications and patterns of safeguarding issues. Contemporary practice calls for the ability to use assessment tools and techniques, observational skills,

objective measures and a systematic approach and constantly striving to advance practice and ensure that reflective practice is at the heart of assessment.

- 5) All professionals need a solid foundation of theoretical knowledge and a thorough understanding of the nature of professional practice, understanding the forms of knowledge used in practice and the ways in which knowledge is developed about practice from practice.
- 6) Munro and Laming<sup>1</sup> recognise the importance of early intervention. There is sometimes confusion about what is meant by intervention in safeguarding and child protection. Procedures should place the practitioner in the right place at the right time with the required skills and competence to respond on behalf of their agency.
- 7) Neglect is an issue in its own right. Practitioners need to respond to concerns about the standard or quality of care that a child is receiving. Evidence shows that neglect may inhibit the appropriate development of certain regions of the brain (Glaser, 2000<sup>2</sup>). Children who experience rejection or neglect are more likely to develop antisocial traits as they grow up and are more associated with borderline personality disorders and violent behaviour (Schore, 2003<sup>3</sup>). A thorough assessment of the specific circumstances of each family where neglect occurs is needed in order to establish the nature of the difficulties that underpin the neglect in that case. This means a move away from reacting to symptoms, towards an analysis of and work with the causes of neglect.
- 8). Reder and Duncan<sup>4</sup> identify the danger of professionals failing to share discrete pieces of information. The knowledge held by an individual agency may not, on its own, appear worrying but when collated the overall picture may indicate a more significant level of concern and risk. Effective intervention will therefore draw on a range of professional perspectives and will require a coordinated response from all professionals and services involved.
- 9). Poor co-operation, deception, and combination of plausible and disengaged presentation added to a lack of focus. Practice became task focussed. Working with a disengaged family, young people and adults is a challenge to most experienced professionals and knowledge, skills and expertise need to be developed and supported by effective supervision. In cases of chronic neglect, long-term intervention may be necessary. However, in order to avoid drift, interventions need to be purposeful, focused and underpinned by in-depth assessment, measurable objectives for change, strategies for achieving these changes, and ways of evaluating whether the required changes have taken place.
- 10). There was a consistently high threshold across agencies before concern triggered action and the attitude of the professional culture overall was too tolerant. The passive approach taken by some services is evidence that the challenges, and therefore the required systems and practice and the use of effective assessment tools, were not fully in place.

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<sup>1</sup> Stein, M. and Munro, E.R. (2008) *Young People's Transitions from Care to Adulthood: International Research and Practice*. London: Jessica Kingsley Publishers

<sup>2</sup> Child Abuse and Neglect and the Brain—A Review. Danya Glaser (2000) *Journal of Child Psychology and Psychiatry*, Volume 41.

<sup>3</sup> Schore AN. *Affect dysregulation & disorders of the self*. New York: WW Norton; 2003.

<sup>4</sup> Reder, P. and Duncan, S. (1999) *Lost innocents: a follow-up study of fatal child abuse*, London: Routledge

- 11). Children and young people who have to undertake inappropriate caring responsibilities can be affected not only during childhood, but also as they become adults. The absence of family-focused, positive and supportive interventions by professionals, combined with inadequate income, have negative effects for young people and their parents.
- 12). All professionals need to recognise the responsibility and accountability that comes with the role they undertake whether they are a social worker, GP, teacher or psychiatrist.
- 13). What is clear from the Review is that there are considerable issues associated with safeguarding young vulnerable adults and the need for improved understanding and systems in place to identify and address their needs. It is important that links are made between the planning and provision of safeguarding services for children, young people and vulnerable adults. There is not enough research and knowledge about working with teenagers.
- 14). Improving the role of the corporate parent, as part of Children's Social Care, is key to improving the outcomes for children who are looked after. It is with the corporate parent that responsibility and accountability for the wellbeing and future prospects of children in care ultimately rest. A good corporate parent must offer everything that a good parent would, including stability. It must address both the difficulties which children in care experience and the challenges of parenting within a complex system of different services. Care leavers, like Miss G, are generally more likely to have poorer educational qualifications, be younger parents, be homeless and have higher levels of offending behaviour, mental health problems and social isolation. If pathway plans are as detailed as they should be, then the young person will, at the very least, be able to identify the steps that he/she needs to take in order to achieve his/her goals. The difference to a young person between having no pathway plan or a bad pathway plan, to having a lawful, detailed plan, is enormous and the lack of support and planning can lead to tragic consequences<sup>5</sup>.
- 15). Examination of the chronology of Miss G's contact with services from 1993 to 2012 identifies that both the lack of coordinated plans and a lead professional resulted in services deciding to end contact with her or not pushing to maintain contact with her at a point when she was at her most vulnerable, for example in the case of social care.

### **Mental Health Services**

- 16). Risk management needs to be consistent and constant throughout an organisation's culture, its strategy and the implementation of that strategy. It is important to be able to assess risk effectively and to identify accumulating risk from Board to practice levels. Risk should be managed at two overlapping levels; strategic/management level and day-to-day staff and service operational level. Mental health professionals working in community-based services and teams should be trained to assess risk and need, so that treatment, therapeutic interventions and management are in accordance with National Institute for Health and Clinical Excellence (NICE) guidance.
- 17). In 1999 the National Service Framework for mental health was introduced to set out national standards for mental health services. Specialist community mental health teams were set up, offering home treatment, early intervention or intensive support for people with complex needs. A major theme throughout all mental health policy documents at the

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<sup>5</sup> Stein, M. and Munro, E.R. (2008) *Young People's Transitions from Care to Adulthood: International Research and Practice*. London: Jessica Kingsley Publishers

time was that mental health services needed to give a high priority to issues relating to clinical risk assessment and risk management. The Care Programme Approach (CPA) was introduced in 1999 to ensure the effective coordination and delivery of mental health care. Risk assessment and risk management were introduced as being central to effective mental health practice within the CPA process. Another important policy and subsequent guidance relevant to this case is the national policy and NICE guidance on the management of people with personality disorder. These documents advise on the type of service provision and therapeutic interventions for people with this diagnosis.

- 18). Mental health professionals including clinicians working with people with a borderline personality disorder should have routine access to supervision and staff support. Supervision provides staff with a confidential, safe and supportive environment, to critically reflect on professional practice, to improve the quality of patient services by improving mental health practice, by encouraging reflection on attitudes towards people with mental health problems and disorders, their family members and carers.

### **Recommendations**

1. Doncaster Safeguarding Childrens Board will review the retention and transfer of records policies and practice across agencies to establish consistency in line with legislative requirements and best practice.
2. Doncaster Safeguarding Childrens and Adult Safeguarding Boards will review the systems in place and training that is provided to support leadership throughout partnership organisations.
3. Doncaster Safeguarding Childrens and Adult Safeguarding Boards will review their current policies, practices and training strategies to reflect the need to better address issues associated with:
  - Assessment and critical analysis skills using assessment tools
  - Working with teenagers
  - Working with disengaged or hostile individuals and/or families.
  - Effectively monitoring the progress of families in safeguarding situations including managing risk, identifying patterns and predictive modelling.
  - Formulating and sharing information and opinions, managing networks
  - Challenging colleagues and making yourself heard in the network.
  - The management of information within and between agencies and by individual professionals.
4. Commissioners will review the contract used to commission services to meet the needs of people with borderline personality disorder in order to adhere to the NICE guideline on the treatment and management of borderline personality disorder 2009.

### **Doncaster Safeguarding Children's Board**

5. Doncaster Safeguarding Childrens Board will carry out a quality assurance process to ensure that the Neglect Policy and Framework is understood and being implemented across agencies.
6. Doncaster Safeguarding Children's Board will ensure that the safeguarding and education of children and young people being home educated is effectively monitored.

7. Doncaster Safeguarding Childrens Board will ensure through a quality assurance process, that the welfare and care needs of looked after children are given the highest priority, and that improvements in the outcomes for looked after children are met and sustained.

### **Doncaster Children's Services**

8. Doncaster Council will review the powers it has to assess the suitability of education provision for children educated at home and should use these wherever possible.

### **Rethink**

9. Rethink Mental Illness will review local operating procedures, to address outreach caseloads and create new/revised procedures on communication, referral and risk management. Rethink will work in partnership with Rotherham, Doncaster and South Humber NHS Foundation Trust to ensure where appropriate learning is shared.
10. As a result of the organisational learning from this review, Rethink Mental Illness will establish a Clinical Governance and Risk group to support and share practice across the charity's high support services.

### **Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)**

11. RDaSH will review the quality of record keeping in adult community mental health services and establish an improved system of routinely monitoring the quality of records. Adult mental health in-patient services will move to an electronic patient record that is routinely shared with community mental health services.
12. RDaSH will review clinical supervision within community mental health services to strengthen the focus on excellence in clinical practice including the need to ensure effective and appropriate risk management and continuity of care between services for patients.
13. RDaSH will review the function and capacity of the access team to address care delivery and include the team managers' oversight of the patients in most need. Referral and clustering processes from the access team/home treatment team to treatment teams within the adult mental health services will be included within this review.
14. RDaSH will review the Access Teams Operational Policy and Standard Operating Procedures and Care Programme Approach and Disengagement Policies to support a more effective process for the admission of patients to and discharge from services. An effective audit process will be established to assure implementation.
15. RDaSH will review the care pathways between substance misuse and adult community services.
16. RDaSH will implement training and awareness for staff in relation to services for people with complex needs whose primary diagnosis is not mental illness.

### **Yorkshire Ambulance Service**

17. YAS will review within 6 months all safeguarding training resources to update and emphasise the impact of mental health issues and the risks associated with non-conveyance to hospitals.

18. YAS Head of Safeguarding will within 3 months ensure that individual action plans for Emergency Operations Centre staff associated with this case will have been delivered and all actions completed.

### **Housing Options**

19. Housing options staff will be provided with additional guidance to ensure that information provided by other agencies informs decisions about a case and in turn what information should be provided to the referring or other agencies.

### **M25**

20. A review of assessment guidance will be undertaken to increase the emphasis on initial action plans especially when clients are not admitted to the M25 service.

21. Guidance and training will be provided for support workers to ensure that when they are involved in complex cases there is:

- appropriate sharing of client information with other agencies
- timely responses for clients and referring agencies when a client is not admitted to the service.
- effective management of cases of intermittent contact.
- assessment of risk assessment and management.

### **Doncaster and Bassetlaw Hospitals NHS Foundation NHS Trust**

No recommendations identified.

### **St Leger Homes**

No recommendations identified.

### **South Yorkshire Police**

No recommendations identified.

## **SECTION ONE: INTRODUCTION AND BACKGROUND**

### **1.1. Introduction**

On 14th February 2012 South Yorkshire Police received a call from Child A who told the call operator that she had been stabbed. Police officers and ambulance staff arrived quickly at the park where the assault had taken place and administered first aid. Twenty minutes later a call was made to South Yorkshire Police from a member of staff at Rethink Centre stating that Miss G had arrived at the centre and informed them that she had stabbed someone. As a result, officers were sent to Rethink and arrested Miss G on suspicion of assault. Later that day, Child A died from the injuries she had sustained. Miss G was arrested and charged with murder. In July 2012 Miss G was tried and found guilty of the murder of Child A and sentenced to 22 years in prison.

### **1.2. Reasons for Conducting the Review**

An Independent Multi-agency Review was commissioned by NHS Doncaster in accordance with the requirements of its Incident Management Policy (including serious incidents & never events) (2010) and the National Framework for Reporting & Learning from Serious Incidents Requiring Investigation (National Patient Safety Agency 2010).

A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm

It was decided by the Doncaster Children's Safeguarding Board and Doncaster Adult Safeguarding Partnership Board that they would not commission a Serious Case Review with respect to this case. The Chair of the Children's and Adult Safeguarding Boards is a member of the Incident Coordination Group (ICG). The Independent Multi-agency Review report will be examined by both Boards.

### **1.3. Terms of Reference**

The Terms of Reference address both the scope of the investigation and the issues to be considered.

On 17<sup>th</sup> February 2012 the Incident Co-ordination Group agreed that all agencies should examine their records and all information they had on Child A and Miss G. It was proposed for agencies to undertake a Root Cause Analysis. The following timeframe, scope and terms of reference for the completion were agreed:

- All agency summary involvement for Child A is to commence from 07/07/1998 to the 13/02/2012.
- All agency reviews and chronologies for Miss G are to commence from 30/07/1985 to the 14/02/2012 (upon arrest).
- All chronologies should include detailed information about when Miss G was seen, spoken to or observed.
- Reviews of all records and materials should be considered including:
  - Electronic records
  - Paper records and files
  - Patient held records

The Root Cause Analysis should be quality assured and signed off by the most senior officer of the reviewing agency.

In addition to analysing individual and organisational practice, identifying lessons learned and making recommendations to improve future practice, this review should address the following:

- Did staff in each agency follow relevant inter-agency and single agency policies and procedures which were in place at the relevant time? Did these policies and procedures reflect National Guidance?
- Did the organisation appropriately recognise Miss G as a child in need / vulnerable adult, and the need of a protection plan?
- What were the contributory factors of the incident?
- What other lessons could be learnt from this incident?
- Were there any training needs identified?
- Make SMART recommendations, which indicate the person responsible for implementation, timescales and required outcomes.

#### **1.4. Process of the Review**

##### **1.4.1. Incident Coordination Group**

An Incident Coordination Group was established to lead the review. The group first met on 17<sup>th</sup> February 2012. Membership consisted of:

<b>REPRESENTATIVE FOR:</b>	<b>NAME</b>	<b>POST</b>
NHS Doncaster	Margaret Kitching Chair	Nurse Director
Doncaster Metropolitan Borough Council	Joan Beck	Director of Adult Services
Doncaster Metropolitan Borough Council	Chris Pratt	Director of Children's Services
Doncaster Metropolitan Borough Council	Roger Thompson	Chair of Children & Adults Safeguarding Board
NHS Doncaster	Mary Shepherd	Associate Director for Quality and Patient Safety
NHS Doncaster	Ian Carpenter	Head of Communications
NHS Doncaster	Karen Price	Assistant Director for Quality
Rotherham Doncaster and South Humber NHS Foundation Trust	Helen Dabbs	Deputy Chief Executive
Rotherham Doncaster and South Humber NHS Foundation Trust	Sarah Mainprize	Communications
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Hilary Bond	Director of Nursing
NHS Yorkshire and the Humber Strategic Health Authority	Wendy Ambler	Integrated Governance Manager
South Yorkshire Police	Peter Norman	Superintendent
South Yorkshire Police	Natalie Shaw	Detective Chief Inspector
Rethink Mental Illness	Dave Shaw	Regional Manager
CQC	Jenny Wilkes	Compliance Manager
Verita	Mrs Brougham	Independent Mental Health Adviser
Pat Cantrill Workforce Development Ltd	Professor Cantrill	Independent Review Author

The Incident Coordination Group considered that although Miss G, the suspected perpetrator, had been arrested and charged, because of the potential delay in learning lessons from the review, it should be commissioned and not delayed by pending legal action. Agencies and interested parties were notified of the requirement to secure any records pertaining to the homicide to inform the subsequent Serious Incident Report. The Crown Prosecution Service was informed that a Serious Incident review had been commissioned.

#### 1.4.2. Investigation Overview Panel

An Investigation Overview Panel was established. Membership consists of:

<b>REPRESENTATIVE FOR:</b>	<b>NAME</b>	<b>POST</b>
NHS Doncaster	Mary Shepherd Chair	Associate Director for Quality and Patient Safety
Doncaster Metropolitan Borough Council	Vicki Lawson	Assistant Director for Children and Families
Doncaster Metropolitan Borough Council	Karen Johnson	Assistant Director for Communities
Rotherham Doncaster and South Humber NHS Foundation Trust	Sharon Schofield	Deputy Director of Nursing
South Yorkshire Police	Peter Horner	Manager and Lead for Public Protection
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Hilary Bond	Director of Nursing
NHS Doncaster	Andrew Russell	Head of Quality Vulnerable Adults
Rethink Mental Illness	Mike Hartley	Associate Director Service Improvement
NHS Yorkshire and Humber Strategic Health Authority	Wendy Ambler	Integrated Governance Manager
St Leger Homes	Judith Jones	Director of Housing Services
Yorkshire Ambulance Service	David Blain	Head of Safeguarding
Professor Cantrill Workforce Development Ltd	Professor Cantrill	Independent Overview Author
Verita	Mrs Brougham	Independent Mental Health Advisor

The purpose of the Investigation Overview Panel was to ensure the completion of independent individual management reviews, mental health overview report and the Serious Incident Overview Report to the required standard to ensure that the lessons to be learned, recommendations and action plans related to the death of Child A are identified and organisations address the issues.

### **1.4.3. Investigation Overview Review**

The Investigation Overview panel at the first meeting on 24<sup>th</sup> February 2012 requested that the following agencies/bodies secured their records and identified and commissioned an independent author of sufficient experience and seniority to undertake an Individual Agency Root Cause Analysis:

- Rotherham Doncaster and South Humber NHS Foundation Trust
- NHS Doncaster – General Practice
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- South Yorkshire Police
- Doncaster Metropolitan Borough Council - Children's Social Care including education.
- Doncaster Metropolitan Borough Council - All other services.
- Rethink Mental Illness.
- St Leger Homes
- M25
- Yorkshire Ambulance Service

Subsequently it was established that the Barnardo's and the Foyer elements of the investigation would be included with the Doncaster Council Investigation Report.

The authors of the Individual Investigation Reports were independent in accordance with guidance.

The Chair and author of the Review is Professor Cantrill, who is a Registered Nurse and Health Visitor and was a senior civil servant at the Department of Health. Professor Cantrill has led a number of high profile serious incident reviews particularly in relation to safeguarding vulnerable adults, domestic violence, homicide and children. She has also had considerable education experience, is a qualified teacher and has been a senior university lecturer, senior tutor/education manager and Governor at Sheffield College. Professor Cantrill is a Visiting Professor at Sheffield Hallam University and the University of Lethbridge in Canada.

Additionally as a result of the crucial nature of Miss G's mental health and use of mental health services additional expertise was commissioned from Mrs Brougham.

Mrs Brougham is one of Verita's most experienced investigators and has conducted some of its most high-profile mental health reviews. In the course of her career she has held senior positions at regional and local level within the NHS, including Director of Mental Health. Dr Douglas Gee, Medical Director in a NHS Foundation Trust as well as practising as a General Adult Consultant Psychiatrist has also been commissioned to provide professional psychiatric advice. Dr Gee has provided independent expert advice and opinion into a number of independent investigations.

#### **1.4.4 Development of Individual Management Reports**

The objective of the Individual Management Reports (IMRs) which form the basis for the Review is to give as accurate as possible an account of what originally transpired in an agency's response to Child A and Miss G to evaluate it fairly, and to identify any improvements for future practice. IMRs also propose specific solutions which are likely to provide a more effective response to a similar situation in the future. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals receiving services.

This report is based on IMRs commissioned from professionals who are independent from any involvement with the victim, or the alleged perpetrator. The IMRs have been signed off by a responsible officer in each organisation and have been quality assured by the Incident Coordination Group.

<b>Organisation</b>	<b>Author name</b>	<b>Author title</b>
South Yorkshire Police	Helen Smith	Sergeant, Public Protection Unit
Doncaster and Bassetlaw Hospital Foundation Trust	Gill Genders	Named Nurse for Safeguarding Children and Team Leader for Safeguarding
RDASH Doncaster Community Integrated Services and Mental Health Services	Sharon Schofield	Deputy Director of Nursing
DMBC All other Services	Tracey Harwood	Head of Service - Housing Options
Children's Social Care including Education	Antony Philbin	Business manager for a North West Local Safeguarding Children's Board.
St Leger Homes	Dave Abbott	Head of Service Tenancy and Estate Management

Rethink Mental Illness	Mike Hartley	Associate Director of Quality and Improvement
NHS Doncaster – Primary Care	Alistair Graves	Medical Director
Yorkshire Ambulance Service NHS Trust	Dave Blain	Head of Safeguarding

The report’s conclusions represent the collective view of the Investigation Overview Panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

In addition a comprehensive integrated chronology of agency involvement and significant events has been compiled and analysed by the Investigation Overview Review Panel.

In reporting the views of individuals who received services, the Investigation Overview Panel is not endorsing those views as accurate or as a fair assessment of the services they were given. They are the subjective views of the service user and should be considered with respect, in that they may offer lessons for the services involved.

Miss G was informed that IMR authors would access her records of relevance to the review. The IMR author and mental health reviewer met with Miss G in prison to discuss her perceptions of the services she received during her childhood and adult years.

### **Dissemination**

Following acceptance of this report by the ICG, a ‘briefing note’ encapsulating key messages for each organisation and agreed recommendations will be circulated to relevant managers in each of the agencies that contributed to this review.

The review report will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned.

The content of the Report and Executive Summary is anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998. The Report will be produced in a form suitable for publication without redaction before publication. Child A's family will be briefed about the report and have confidential access before publication.

## 1.5 Family and Household Composition

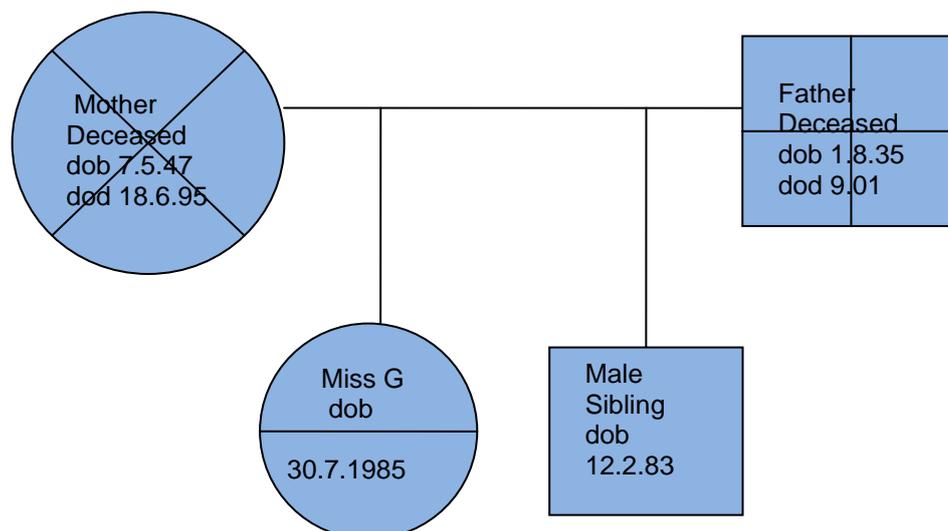
### Victim (Child A)

The victim (Child A) was a 13-old school girl.

### Perpetrator:

#### Miss G

The perpetrator (Miss G) is a 27-year old unemployed woman whose parents died when she was a child. She has an older brother with whom she appears to have little contact. Miss G lived alone and does not appear to have been in a recent relationship.



### Involvement of the Family

In homicides, members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's and perpetrator's experiences. The Review Panel considered carefully the potential benefits gained by including individuals from both the victim's and perpetrator's networks in the review process. Contact was influenced by the criminal proceedings which were on going at the start of the review. The report author met with Child A's father and family. Contact was also made with Child A's mother and family.

Miss G was contacted after her trial to establish if she wanted to meet with the report author and mental health specialist and agreed to meet with them.

## **SECTION TWO: INCIDENT INVESTIGATION REVIEW PANEL REPORT**

### **2.1. INTRODUCTION**

In developing this report authors of the individual management reviews and mental health overview report have examined both the available records of Child A and Miss G. What is clear from analysis of information available is that Child A received routine universal services only and that contact has no relevance to the terms of reference of the Review. Therefore the rest of the report will focus on Miss G's contact with services.

This review report is an anthology of information and facts from ten agencies, all of which were potential support agencies for Miss G. This report examines agency responses to and support given to Miss G.

Ten agencies had records of contact with Miss G. They are:

- Rotherham Doncaster and South Humber NHS Foundation Trust
- NHS Doncaster - General Practice
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- South Yorkshire Police
- Doncaster Metropolitan Borough Council - Children's Social Care including education.
- Doncaster Metropolitan Borough Council - All other services.
- Rethink Mental Illness.
- St Leger Homes
- M25
- Yorkshire Ambulance Service

Additionally a Mental Health Overview which has evaluated services across mental health providers has been completed and incorporated fully into this report.

### **2.2 SUMMARY OF THE CASE**

#### **Child A**

Child A was born on 7<sup>th</sup> July 1998 and lived with her family in a village in Doncaster. Like most 13 year olds she was happy, active, enjoyed listening to music on her mobile phone, messaging her many friends and emailing to keep in touch. On 14<sup>th</sup> February 2012 she left home at lunchtime to catch a bus close to her home and intended to walk across the park to get to her friends house where she was going to stay overnight. She had with her an overnight bag and the phone she used to text her friend the details of her imminent arrival. As she walked through the park she was approached by Miss G

a complete stranger who stabbed her. Child A collapsed on the path as Miss G carried on walking. Child A managed to call 999 on her mobile phone to get help but died eight hours later in hospital. The trial heard it was a motiveless, random attack by Miss G.

## **Miss G**

Miss G was born in July 1985. Both her mother and father had significant health problems which impacted on their ability to parent both Miss G and her brother who was two years older than her. Miss G's parents were Mormons and made the decision that their children should be home educated and it was not until she was ten years old that Miss G attended school. In 1993 her GP contacted Children's Social Care (CSC) to express concerns that her parents were neglecting her. Support was given to assist her parents to be able to improve the care of the children without a detailed assessment of the situation or discussing with the children their needs. There was little improvement in the neglect of the children.

During the second period of contact with CSC Miss G needed regular periods of respite care as her mother had died and her father's health deteriorated resulting in frequent hospital admissions. During this period there was no improvement in the state of the family home and the ability of her father to care for them deteriorated. Miss G started to attend school in September 1995, at the age of ten and found herself educationally delayed, isolated and bullied. Teachers, other professionals and family members contacted CSC to raise their concern about the neglect of Miss G.

In 1998 she became a Looked After Child in the care of Doncaster Council and was placed in foster care. What followed was a relatively brief period of stability with reports in 1999 that Miss G's health and hygiene had improved and that she was regularly attending school. However during March 2001 and June 2001 Miss G's behaviour is said to have deteriorated. She missed school and some of her examinations and she went missing from her foster home. She also made a complaint about her carers being abusive. In June 2001 her foster placement was ended. In September 2001 she went missing and services lost contact with her. Her father died in September 2001 after a period in a nursing home. Miss G's behaviour gradually worsened during this period. She left the care of Doncaster Council in 2001. She was homeless and lived in a hostel. She was drinking, self harming and using cannabis. Her contact with mental health services began in 2002 (when she was 16 years old) when she was referred by her GP to a Community Mental Health Team after complaining of being depressed. In August 2002 she was admitted to hospital for a short period of time. She attended outpatient appointments on a regular basis and remained in contact with services until 2008. Between 2008 and 2011 her contact with mental health services ceased until in July 2011 she attended the Accident and Emergency department to ask for contact with mental health services again.

In September 2011 Miss G was stopped by police and as a result of officers asking her if she was carrying any prohibited articles, she stated that she had a knife. This incident was followed by her arriving in London where she went to Belgravia Police Station. She was homeless and slept in a bookshop until the owner contacted mental health services and Miss G was admitted to hospital. Although she stated she did not wish to return to Doncaster she was returned and after a brief period in hospital in Doncaster was discharged. In October 2011 a friend of Miss G attended the police station to state that she believed Miss G had been burgled but Miss G denied this. In November 2011 she arrived at A and E having taken an overdose, she said with the intention of ending her life. In November 2011 Miss G became anxious about living in the flat she had lived in for ten years and requested a housing transfer.

In early January 2012 Miss G contacted mental health services requesting admission. She stated that she needed to be “*locked up*”. Following assessment she was offered crisis accommodation. Whilst staying at the crisis accommodation she was assessed by a psychiatrist. On 15<sup>th</sup> January she was discharged to her home address and followed up by the home treatment team. On 30<sup>th</sup> January Miss G was discharged from the home treatment team but was still receiving support from the crisis accommodation outreach worker. She was awaiting an appointment with the community therapy team to whom she had previously been referred.

On 14<sup>th</sup> February Miss G purchased two kitchen knives and approached Child A, a complete stranger and stabbed her with a kitchen knife. She then went to crisis accommodation at Rethink and told them what she had done. They contacted the police and she was arrested. At her trial Miss G was found guilty of murder and was given a prison sentence of a minimum of 22 years.

## **2.3 THE CONTEXT OF SERVICE INVOLVEMENT**

The purpose of this section is to provide an overview of the context in which the homicide of Child A happened and identify changes that have occurred in the provision of services during the timescales of this review. It will enable assessment of the provision of services to take place with an understanding of the environment in which practitioners worked: the policy frameworks, organisational structures and professional practice from 30<sup>th</sup> July 1985 to 14<sup>th</sup> February 2012.

### **2.3.1 Children’s Policy and Practice**

A significant time period is covered by the review from 30<sup>th</sup> July 1985 to 14<sup>th</sup> February 2012. To assess the provision of services to Miss G it is useful to examine the legislative and policy frameworks, which informed organisational structures and

professional practice during the review period. The legislation, guidance, policy and procedures that informed practice from 1985 to 2002 included:

- The Children and Young Persons Act 1969
- Report into the Inquiry into Child Abuse in Cleveland (HMSO 1988)
- Working Together – A Guide to Arrangements for Inter Agency Cooperation for the Protection of Children from Abuse (DoH 1988)
- Protecting Children – A Guide for Social Workers Undertaking a Comprehensive Assessment (HMSO 1988) (The Orange Book)
- Children Act 1989
- The Local Authority Social Services Act 1970
- Children (Leaving Care) Act 2000
- Doncaster Child Protection Procedures. (Revised during the time period).

The context for the management of the case of Miss G will have been influenced by the above documents, policies, and procedures and by the national inquiries into child abuse and neglect. Throughout the 1970/80's there were approximately 40 official national inquiries into child abuse, the inquiries included children who lived within their nuclear family and children who were in the care of local authorities. There were also a number of inquiries, which focussed attention on the failure of Social Services Directorates in the way that child abuse investigations were conducted. The inquiries provided a window into the issues affecting the delivery of safeguarding services for children and young people and therefore the climate for the provision for Miss G.

The inquiries highlighted a number of issues concerning individual poor practice, lack of inter-agency communication, and failure of organisations in the way they conducted investigations. A general theme to emerge from the inquiries was that agencies / individual workers did not act quickly enough to the danger signals which were present in abuse, whereas in terms of sexual abuse, with specific reference to Cleveland, the criticism was that social services acted too quickly and did too much, too soon.

The assessment guidance for social workers during a significant segment of the review period was the document; Protecting Children: A Guide to Social Workers Undertaking a Comprehensive Assessment DoH 1988 (Orange Book).

The Orange Book primarily addressed undertaking a comprehensive assessment as part of the long term planning, as opposed to assessment at the initial investigation stage and early decision-making. The Orange Book Assessment reinforced the importance of inter-agency cooperation, it emphasised that the social worker had ultimate responsibility for carrying out the assessment and deciding on the best option that should be followed. It also identified some of the differences in practice between professional groups and introduced the notion of inter-agency and professional dangerousness.

Until the introduction of the National Assessment Framework for Children and Young People (2000) social workers were using fairly arbitrary and ad hoc assessment tools on which to base their decisions during early involvement with a case or at the outset of an investigation. The Orange Book only offered guidance for comprehensive assessments once problems were identified and children were deemed to be at risk, generally following the names being placed on the Child Protection Register, as opposed to offering an early assessment tool.

Child Protection Procedures from 1988 were based on the document; Working Together 1988<sup>6</sup>. Working Together 1988 was published following the Cleveland report. A key message of the publication was identification of the stages in managing individual cases including;

- Referral and recognition
- Immediate protection and planning the investigation
- Investigation and initial assessment
- Child Protection Conference and decision making
- Comprehensive assessment and planning
- Implementation and review – and where appropriate de-registration.

It raised issues concerning the importance of investigating new incidents, even where local authorities knew a family, and the importance of facilitating reports from members of the public.

In relation to social work practice during the first episode of involvement with Miss G; the Orange Book guide to assessment, the 1988 Working Together guidance should have influenced policy, practice and procedures. The reality was that various agencies were still working as they always had done, which was within their own terms of reference. They were continuing to contribute individually rather than working together. This would apply to different agencies and social service departments across the country. Information therefore was seen in isolation as opposed to being analysed as factors in combination.

The Children Act 1989 was implemented in July 1991 and brought with it a philosophy that children are best brought up by their family. The emphasis on prevention contained in the act and highlighted in the guidance, is that if there is an improvement in the family situation the potential for abuse is diminished. This was the model of working with Miss G and her family.

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<sup>6</sup>Working together to safeguard children : a guide to arrangements for inter-agency co-operation for the protection of children from abuse Department of Health and Social Security and the Welsh Office 1988

Prevention was of central importance in the work of all agencies involved with children, and provision of family support to help parents to bring up children and seek to prevent admission to care were the key principals of the legislation. The basis of the guidance documents produced for professionals stressed where possible to promote and protect welfare of children in their own family. This philosophy was emphasised throughout Part III of the Act. Children in Need were defined under Section 17 and the requirement to provide family support was clearly stated.

There was a requirement to look at the impact of abuse on children as defined within the significant harm criteria. This included the psychological consequences of abuse and introduced the notion of the likelihood of harm. There was a complete overhaul of the legislation to protect children under Part V of the Act and the Family Court was established to deal with both the public and private elements of the Act.

The Children Act emphasised local authorities' duty to safeguard and promote the welfare of children, and as mentioned above, the concept of a child in need was introduced under Part III, including the range of family support services local authorities were encouraged to provide, in order to assist parents in bringing up their children.

Social Work Services sought to encourage a balance between protecting children from significant harm and working in partnership with parents, and ensuring families receive the help and support they need. Whether this balance had been satisfactorily achieved was questioned by researchers who investigated the operation of the child protection system (DoH 1995). Their findings led the Department of Health to launch what was to become known as the "refocusing debate" one of the outcomes being the publication of the Common Assessment Framework 2000.

### **Present Safeguarding System**

It is useful to examine the present safeguarding children and young people system and how it now differs from that in place during most of the service input to Miss G. There is now a clear definition of safeguarding:

*'The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.'*

Safeguarding and promoting the welfare of children remains the responsibility of local authorities working in partnership with other public agencies, the voluntary sector and children, parents and the wider community. A key objective for local authorities is to ensure children are protected from harm. The Children Act 2004 firmly places duties

on local authorities, to safeguard and promote the welfare of children and young people. A challenge for local authorities is to ensure that their partner organisations providing universal services prioritise safeguarding when they are faced with competing targets.

The present framework for safeguarding children in Doncaster has changed significantly during the period of involvement with Miss G as a result of:

- The appointment of a Director of Children's Services (DCS) and designated Lead Member for Children's Services.
- Doncaster Safeguarding Children Board has an independent Chair. This facilitates greater independence in chairing and reporting and a focus on a wider safeguarding role in addition to child protection and providing leadership.
- The establishment of Strategic partnerships for delivering services to safeguard and promote the welfare of children. Agencies are working together better to safeguard children.
- DCS has led the development of a strategic Children and Young People's Plan (CYPP). The plan reflects the core requirement of local authority services for children and young people with the involvement of local partners across the whole range of services for children and young people providing a plan for coherent and comprehensive planning and service delivery.
- The Common Assessment Framework has been developed to support an integrated approach to meeting the needs of children<sup>7</sup> who fall below the statutory threshold of Section 17<sup>8</sup>. Its use is gradually being embedding in practice by social care and universal services, to address problems before they become serious, therefore improving outcomes for children. The Framework for the Assessment of Children in Need and their Families is being used to establish an inter-agency model of assessment and service provision.

### **2.3.2 Doncaster Children's Trust**

Doncaster has a resident population of approximately 72,000 children and young people aged 0 to 18, representing 24.7% of the total population of the area. In 2010, 10.7% of the school population was classified as belonging to an ethnic group other than White British compared to 22.5% in England overall and 0.75% of pupils are of Roma or Traveller background. Some 6.3% of pupils speak English as an additional

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<sup>7</sup> Every Child Matters: Stay safe, be healthy, enjoy and achieve, make a positive contribution and economic well being.

<sup>8</sup> Children Act 1989. Section 17. Statutory threshold "Child in Need".

language. Polish and Urdu are the most recorded commonly spoken community languages in the area.

The Doncaster Children's Trust was not established until January 2010. The Trust includes representatives from the Doncaster Youth Council, NHS Doncaster, South Yorkshire Police, South Yorkshire Fire & Rescue, Chamber of Commerce, Voluntary & Community Sector, Jobcentre Plus and representatives of the Council, local schools and colleges. The Doncaster Safeguarding Childrens Board (LSCB) became independently chaired in 2009, bringing together the main organisations working with children, young people and families in the area that provide safeguarding services.

Social care services for children have 164 foster carers, eight children's homes and 102 externally commissioned foster carers and 40 residential placements. Community-based children's services are provided by four teams in the Children's Assessment Service, three teams in Targeted Family Support and four teams in the Children and Young People in Care Service. They are supported by teams for children with a disability, youth offending, adoption and fostering. There is an emergency out of hours service providing cover for the Borough. Other family support services are delivered through 21 children's centres and extended services in schools. Some services are provided or coordinated through children and young people's services such as youth services, the teenage pregnancy service and Connexions

At the end of 2011 there were 460 looked after children. They comprise 120 children less than five years of age, 293 children of school age (5–16) and 47 post-16 young people. A further 186 young people aged 18 to 25 years are currently supported by the 16 plus service. At the time of the last inspection there were 400 children who were the subject of a child protection plan. This is an increase over the previous two years. The categories of abuse leading to child protection plans are; neglect at 46% (185); emotional abuse at 29% (116); sexual abuse at 14% (57) and physical abuse at 11% (42).

### **Doncaster Metropolitan Borough Council - Children's Services**

As identified earlier the purpose of this section is to provide a Children's Services context for the review of services provided for Miss G during the period 1993 to 2002 and to assess the impact of change on services since that time.

The review of the services provided to Miss G during her childhood and adolescence identifies three key areas of practice during this period:

- children in need
- home education
- looked after children

It is useful to examine external inspections that are available during this period and it can be established that the Doncaster Children's services have had major issues in achieving the required standards for services during this period. It has only been possible to trace independent reports back to 1999 to 2012. The reports have been analysed and there are fairly consistent issues. The Ofsted and Joint Area Review inspectors examined all aspects of work with children against the five key national priorities and found arrangements for keeping children safe in Doncaster between performing poorly and adequate. The appointment of the current senior management group has provided increased stability after several years of debilitating turbulence. (The issues for improvement are identified at Appendix 1).

The annual performance assessment of children's services in 2008 describes services for children and the council's capacity for improvement to be inadequate. The number of looked-after children with an allocated social worker had declined significantly. The proportion of initial and core assessments completed within target timescales was low and significantly worse than in similar authorities.

The Department for Children Schools and Families diagnostic review, which was published in April 2009, echoed a number of these criticisms. It found it was still unclear whether child protection cases were allocated and the local safeguarding children board was not working effectively. In 2009 and 2010 there continued to be concerns about the quality of children's services and the consistency of front-line child protection services and Doncaster Council was judged to be performing poorly. Re-organisation of council services in 2010 was heavily criticised and is recognised as being a very significant factor in the failure of children's services. In April 2011, following a full inspection of safeguarding and services for looked after children, both areas were judged to have made improvements and to be adequate recognising improvements made. Doncaster Children's Services are making progress but have to deal with the legacy of cases that in the past have not been effectively handled.

The 2012 position identifies improvement in all areas for safeguarding and looked after care of children including;

- *Practice is supported by easily accessible and comprehensive child protection policies and procedures. Work is underway to further strengthen information about thresholds for referral to children's social care.*
- *Management oversight of contacts and referrals is mostly timely and effective. Staff and managers respond promptly to child protection concerns about children.*
- *Child protection enquires are always carried out by qualified social workers and are of a good standard. Detailed multi-agency risk assessments enable effective*

*safeguarding inquiries. Joint investigations with the police are conducted where this is identified by the strategy meeting as appropriate.*

- *Partner agencies appropriately understand the thresholds for children's social care services and provide increasingly good quality information in referrals which enhances further decision making.*
- *Early intervention through the common assessment framework (CAF) is satisfactory and numbers of plans are increasing. Regular monitoring and evaluation of CAF activity undertaken by the local authority confirms that children and families value the support services they have received and that outcomes have improved.*
- *Most initial and core assessments demonstrate good analysis of information gathered including risk and protective factors.*
- *Children, young people and their parents/carers are routinely consulted during assessments and this is appropriately recorded on children's case files. Good attention is paid to children's individual needs including their age, gender ethnicity and disabilities, and this effectively influences the provision of services to them.*
- *Most children's case files are up to date with appropriate evidence of management oversight and decision making which contributes to effective safeguarding of children.*
- *Transfer arrangements of cases between teams are clear and timely, and well monitored by senior managers. This ensures that social workers are able to respond swiftly to new referrals and children who require ongoing support are promptly allocated to other teams.*
- *The Emergency Social Services Team provides an adequate service and there are generally timely links and transfer of information to the day service.*
- *All managers robustly implement a detailed performance management framework including regular case file auditing, ensuring a shared understanding of the strengths and weaknesses of social work practice.*
- *Effective feedback of findings to staff results in improved provision of services to children and staff report this contributes to significantly improving their practice.*
- *Front line managers effectively support staff and provide considered oversight of social workers' and social work assistants' casework. Staff have regular supervision which includes personal and professional development issues as well as critically reflective casework discussion. This has a positive impact on the quality of case assessment and planning.*
- *Staff, including agency staff, are suitably qualified and experienced in safeguarding. They have good access to targeted training which ensures they are able to respond to the range of children's needs. Staff have manageable caseloads and confirmed to inspectors that they have sufficient time to undertake direct work with children.*
- *Core assessments are not always initiated when child protection enquiries commence, resulting in the potential for historical information to be overlooked when evaluating risk and protective factors.*

- *Although social work capacity has been improved, there continues to be a high reliance on agency social work staff. The council is aware of this and has plans to reduce the need for agency staff but this has yet to have the full planned impact. This was an area for development at the previous inspection.*
- *Service delivery is not yet influenced by the experiences of service users. This is understood by the council and plans are being developed to address this*

### **Elective Home Education**

Local authorities have the legal responsibility to satisfy themselves that all children educated at home are having a legally adequate and suitable education. In order to carry out responsibilities, the Consultant for Elective Home Education contacts parents seeking to make an initial visit to discuss their plans and strategies, to explain their legal rights and responsibilities, to give advice and make recommendations

The responsibilities of the parent in situations of home education are clearly set out in Section 7 of the Education Act 1996<sup>9</sup> which states:

*The parent of every child of compulsory school age shall cause him or her to receive efficient full time education suitable:*

- *to his age, ability and aptitude*
- *to any special educational needs he or she may have either by regular attendance at school or otherwise.*

There is no rule about what suitable education might be but it should prepare a child for life in a modern society and allow the child to reach his or her full potential. It should open opportunities. It should offer:

- A broad and balanced curriculum.
- English, mathematics, science and information and communications technology (ICT).
- Opportunities for physical, social, spiritual and cultural development.

Parents who educate their children at home do not have to follow the full National Curriculum. The phrase "full time" is usually understood to mean similar in hours to school hours, but can be interpreted differently, since a child's education at home is often on an individual basis. If the education being provided does not meet the legal requirements, the local authority should instruct the parents to register the child at a school. Should they not do that, a School Attendance Order can be sought from the courts. After a number of attempts have been made, should it prove impossible to meet the parents it will be presumed that a legally suitable education is not being provided. Given the level of neglect of Miss G and the health of both parents it seems likely that she was not receiving the required level of education.

<sup>9</sup> [www.hmsso.gov.uk/acts/acts1996/1996056.htm](http://www.hmsso.gov.uk/acts/acts1996/1996056.htm)

Children who are electively home educated in Doncaster are identified by Doncaster Council. Doncaster has relatively high numbers of children and young people who are taught at home. A protocol has been developed with health services to cross reference the list of known children with births in the area and identify those children who are due to start school, so that children can be followed up. A new Elective Home Education policy and procedure has been developed by Doncaster Council, defining minimum expected standards and clarifying safeguarding requirements. Staff who visit children have been trained in safeguarding procedures and the use of the CAF but are respectful of the parent's right to educate their children at home.

## **Looked After Children**

The Children (Leaving Care) Act 2000 made a number of amendments to the Children Act 1989 in order to:

*"improve the life chances of young people living in and leaving local authority care. Its main aims are: To delay young people's discharge from care until they are prepared and ready to leave; to improve the assessment, preparation and planning for leaving care; to provide better personal support for young people after leaving care; and to provide the financial arrangements for care leavers."* (Paragraph 1 Children (Leaving Care) Act 2000 Guidance).

There will come a time in the life of all young people in the care of a local authority when they are ready to move on to independence, or reach an age at which they have no choice but to leave the care of the local authority. A local authority has a continuing obligation to support any child over the age of 16 who is, or has been, a "looked after child", until they are 21 (or 24 if they are pursuing a programme of education or training). The young person must be provided with support comparable to that which a parent would normally provide to their child. This must be set out in a document called a pathway plan

As in the case of Miss G, every 16 or 17 year old who has been looked after by a local authority for a period of 13 weeks or more since the age of 14, at least one day of which is after his 16th birthday, becomes entitled to leaving care provision. This means that the social services department of the responsible local authority owes a duty to the young person to provide them with a social worker and a personal advisor. A social worker must carry out an assessment of the young person's needs in order to determine what advice, assistance and support the young person requires, both whilst they are being looked after, and once they cease to be looked after. The local authority must also prepare a detailed plan called a "pathway plan" as soon as possible after the assessment.

Regulation 8(2) of the Children (Leaving Care) (England) Regulations 2001 provides:

*"The pathway plan must, in relation to each of the matters referred to in the Schedule, set out –*

- (a) The manner in which the responsible authority proposes to meet the needs of the child; and*
- (b) The date by which, and by whom, any action required to implement any aspect of the plan will be carried out."*

The Schedule identifies matters to be dealt with in the pathway plan and review as being:

- The nature and level of contact and personal support to be provided, and by whom, to the child or young person.
- Details of the accommodation the young person will occupy.
- A detailed plan for the education or training of the young person.

None of this happened in the case of Miss G. Neither would it appear was she provided with a personal advisor. This is a role which is essentially to act as a "go between" between the young person and the local authority. Regulation 12 of the Children (Leaving Care) (England) Regulations 2001 sets out the functions of personal advisors. Perhaps most importantly, their role is to provide advice (including practical advice) and support, but personal advisors should also participate in the young person's assessment, preparation of and reviews of the pathway plan.

Ofsted reviews of the Looked After Children services in Doncaster identify that the care provided by Doncaster in the past has not met the quality and standards required. There has been an improvement in services since 2002 with recognition in recent inspections and in 2011<sup>10</sup> that:

*The overall effectiveness of services for looked after children is adequate. The council and its partners have clear and articulated plans to fundamentally improve and remodel looked after children services. Statutory requirements are now met and improved outcomes have been evidenced in a range of requirements such as the timeliness and effectiveness of statutory reviews and all looked after children are now allocated to a qualified social worker as a result of successful recruitment. Social workers in the current teams have manageable caseloads, regular formal supervision and easy access to informal advice and case discussions with senior practitioners and team managers. (See appendix 1)*

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<sup>10</sup> Doncaster Inspection of safeguarding and looked after children Ofsted /CHC 2011

## **Training**

Doncaster provides three day partnership training which brings together all the learning from serious case reviews and learning lessons reviews and raises the awareness and understanding of individual practitioners about the 'risks' for children and young people if the correct procedures are not followed and appropriate interventions offered. Managers are required to attend the training and must ensure that their staff attend. An annual delivery plan is available for all partner agencies through the Doncaster Safeguarding Children's Board web site. To assist staff after they have completed training a practitioners CAF and Threshold Handbook is available to act as a prompt and ensure clarity.

Each agency also has in place its own programme of training in relation to children, young people and adult safeguarding.

### **2.3.3. Doncaster Council Adult - All Other Services**

Doncaster Metropolitan Borough Council (DMBC) provides a range of services to the population of Doncaster. These services include directly delivered services and commissioned services. Of particular relevance to this Review is that the Council delivers services to customers like Miss G who are in receipt of Housing and Council tax benefits through Revenues and Benefits service and Housing Options \ Advice service. The Housing Options Service's main aim is to work in partnership with customers and other organisations to develop the service to ensure positive housing outcomes for the public and to prevent homelessness. Adult Social Care services are also provided directly by the Council for some vulnerable client groups. St Leger Homes manages the stock of housing on behalf of Doncaster Council. Mental health services are provided as an integrated service with Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).

### **2.3.4. National Health Service Context**

#### **Organisational Changes**

Like many other public services, the NHS since 1985 has been through a considerable amount of change with Government initiatives influencing legislation, policy and structural changes. A major issue for partnership development and inter-agency planning, working and service delivery is the frequent reorganisation and mergers of organisations and in some instances resultant changes in functions and responsibilities and key personnel.

The present Government is reorganising the NHS again. The new structure is outlined below to provide an overview of how the changes that are taking place will impact on

services in the future and therefore on the implementation of the recommendations made by this Review.

The NHS Commissioning Board (NHSCB) is a statutory NHS body and will work under its mandate from the Department of Health to commission high quality and effective health services and improve population health within a defined budget. Some of its key responsibilities will include:

- The development and assurance of Clinical Commissioning Groups
- The direct commissioning of Primary Care and Specialist Health Services
- Driving quality improvement in health services through clinically led outcome based commissioning

The NHSCB will hold the statutory responsibilities for safeguarding children as detailed in the Children Act 2004. The Chief Nursing Officer will be responsible for Safeguarding at a national level, which includes taking responsibility for nationally commissioned services. The NHSCB has already indicated that it will have a single operating model and will work through 4 geographically based sectors and 77 local field forces.

The result of the changes in Doncaster has been:

### **Hospital and Community Services**

- NHS Doncaster presently commissions health services for the population of 308,000. In 2010/11 they had a resource allocation of £575 million. NHS Doncaster is responsible for planning and delivering health services and ensuring that local hospital services and specialist treatment are available for local patients who need them. NHS Doncaster also commissions a number of services from GP practices, opticians, pharmacists, hospital trusts, and mental health care services, independent and voluntary providers. As the Government reforms expect PCTs to contract in size before they eventually disappear in 2013, a new structure has been established called NHS South Yorkshire and Bassetlaw.
- NHS South Yorkshire and Bassetlaw oversee and account for the delivery of services on behalf of the five primary care trusts – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. This is to ensure that each individual PCT continues to meet its legal, financial and performance responsibilities and obligations until the Clinical Commissioning Groups assume full responsibility for budgets in April 2013. Under section 11 of the Child Protection Act 2004, NHS bodies have a statutory duty to make arrangements to safeguard and promote the welfare of children. These bodies are also statutory members of Local

Safeguarding Children Boards (LSCBs) under section 13 of the Act. LSCBs are the key statutory mechanism for ensuring the effectiveness of local work to safeguard and promote the welfare of children. They are also responsible for performance managing the commissioning of mental health services across the five areas.

- SHAs currently have a significant role in overall system assurance of PCTs and NHS Trusts. They have the statutory responsibility for PCT performance management and ensuring the delivery of CQC recommendations and action plans. They often also have a role in supporting professional leadership and in the commissioning of education and training for designated and named professionals. Post March 2013, PCTs and SHAs will be abolished, replaced by the NHS Commissioning Board and Clinical Commissioning Groups (led by GPs and other clinicians), Public Health England will be created and local public health functions transferred to local authorities and the provider landscape will be much more pluralist with all NHS Trusts on a pathway to Foundation Trust Status.
- The Doncaster Clinical Commissioning Group (DCCG) is a formal sub-committee of the NHS South Yorkshire and Bassetlaw board. The DCCG is a clinically led committee, which is working alongside NHS Doncaster to effectively and efficiently commission health services for the people of Doncaster. DCCG does not have a legal standing but has been given delegated responsibility for budgets, by NHS South Yorkshire and Bassetlaw. The DCCG will be solely responsible for allocating over £550 million each year from April 2013. Like the NHS Commissioning Board, Clinical Commissioning Groups are also statutory NHS bodies and so will have statutory obligations under the Children Act. As primarily clinical commissioning organisations, CCGs will be responsible for 70-80% of commissioning services, including mental health services and will need to ensure that they are commissioning a safe pathway for children in line with national guidance and within the pluralist provider landscape. In addition, CCGs will also have a key local NHS leadership role, through their statutory membership of Local Safeguarding Children Boards and Health and Wellbeing Boards. They will also have a key role (which will grow over time) for improving and assuring the quality of local primary care services, which are vital components of the safeguarding system.
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust provides acute and maternity services and is a first-wave foundation Trust. The Trust has achieved Three Stars each year since the introduction of the Government's "star ratings" system and have featured consistently in the list of the Top 40 Hospitals. In 2011 following new ratings by the Care Quality Commission (CQC), the Trust was classified as excellent for quality of services and good for use of resources. The Trust is represented on the Doncaster Safer Partnership Board and on Doncaster

Children Safeguarding Board and Doncaster Adult Safeguarding Partnership Board. The Trust Board is provided with assurance with respect to safeguarding policies and procedures via an Annual Safeguarding Adults and Safeguarding Children and Young People Reports.

- Transforming Community Services was a change programme established by the previous Labour Government to change the delivery of community health care services to help meet new requirements in commissioning health care. Central to its focus was the separation of Primary Care Trusts' (PCTs) commissioning and provider functions. On 1<sup>st</sup> April 2011 Doncaster Community Healthcare (DCH), would move to RDaSH, and the DCH's long-term conditions and children and family services would be delivered via a partnership between RDaSH and Doncaster Council. This has provided an opportunity to integrate services across acute, mental health and community care proving coherent care pathways
- Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) operates services in 260 locations across Rotherham, Doncaster, North Lincolnshire, North-East Lincolnshire and Manchester. The Trust employs over 4,300 staff and has over 200 volunteers. Approximately 111,426 people access their services. RDaSH operates a business division model structured around eight clinical business divisions led jointly by an Assistant Director and a Clinical Director. The business divisions are:
  - Mental health services for adults
  - Mental health services for older people
  - Children and young people's mental health services
  - Learning disability services
  - Forensic services
  - Substance misuse services
  - Psychological therapy services
  - Doncaster community integrated services

RDaSH in 2008 was awarded 'Excellent' for Quality of Services, having achieved 'fully met' in both the Government's core standards and existing national targets and again scored 'Excellent' in the new national targets in the Care Quality Commission's performance ratings for NHS Trusts in England. The CQC took over from the three health and social care regulators (the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission) on 1<sup>st</sup> April 2009. In April 2009, the Trust received unconditional registration under the Health and Social Care Act.

## **General Practitioner Services**

General practitioners are not directly employed by the NHS. Rather, they provide services to their local NHS commissioning organisation, under the terms of a national contract. There is very limited discretion to vary the terms of this contract. General practitioners employ their own staff e.g. practice nurses, receptionists etc. As a result Primary Care Trusts and their predecessor organisations have limited powers in relation to the management of performance of GPs and their practice staff as they are independent providers of services and not employees of the PCT. Involvement in safeguarding and domestic violence protection does not form part of the contract with GPs and therefore does not attract the same incentives as the provision of other areas of care.

General Practice is the main point of contact for all primary healthcare services. It can be expected that General Practitioners will have a holistic overview of their patients and their needs. However, General Practice has changed significantly in the last decade. The traditional practice where one or two practitioners know all their patients, and their extended families, is disappearing. Moves towards larger practices with part-time and/or salaried clinicians, and a range of service providers (e.g. GP Out of Hours Services, Walk-in Centres, and GP-led Health Centres), have tended to fragment the knowledge base and continuity of care. It is therefore critical that communication and record-keeping is robust and meticulous.

### **2.3.5. Rethink Mental Illness**

Rethink Mental Illness is a service provision, membership and campaigning charity. Now in its 40<sup>th</sup> year, it supports 60,000 people every year across England to enable them to get through crises, live independently and realise they are not alone. The charity gives information and advice to 500,000 more and campaigns for attitude and policy change for millions.

The service is based in the Yorkshire, North East and North West Regions of Rethink Mental Illness. The Imperial Crescent crisis service accommodation has been in operation for approximately three years. The crisis accommodation service is commissioned by and funded by NHS Doncaster. The service is commissioned to provide flexible crisis accommodation integrated with the local Rotherham, Doncaster and South Humber NHS Trust Crisis and Home Treatment team (Access team from 2011).

The service model offers crisis bed access 24 hours, seven days a week for a period of up to seven days. The service also manages two step-down beds at Milton Court, which is a local authority sheltered scheme. The crisis accommodation service

receives referrals from the Access Team any time across the 24 hour period from an Access Team professional and verbal core information recorded. The Access Team member will usually accompany the service user to the service. All referrals are informal and attend voluntary. The Access Team referrer will complete the Rethink Mental Illness referral form and indicate risks and key goals for the stay at the service.

All service users accessing the service are screened and assessed by the Rotherham, Doncaster and South Humber Access Team. All service users therefore are referred to the Imperial Crescent Crisis accommodation exclusively by the Access Team. The service has been registered with the CQC since October 2010. The outreach service is not registered with CQC and is not required to be; as such it was not subject to inspection in November 2011.

The service has to be compliant with the CQC Essential Standards of Quality and Safety and has recently been inspected by the CQC in November 2011 and found to be compliant with the outcomes inspected on that visit with no recommendations.

### **2.3.6. Conclusions About Services in Doncaster**

The context for Miss G's care between 1993 and 2009/10 is characterised by a poorly performing children's services which had been assessed by external inspections as not meeting the requirements to safeguard children and young people and was placed into Government intervention in April 2009. Significant analysis arising from a number of Serious Case Reviews alongside other analysis resulted in the establishment of an improvement plan with clear actions and timescales.

This Improvement Plan has continued to be refined and updated and is subject of external oversight by an Independent chairperson who reports on progress to the Government.

Inspections since 2009 have demonstrated some improvement across all service areas. There has been the appointment of an experienced Director of Children's Services and a new leadership team. Whilst there has been some progress there is more to do as much of the improvement is in its early stages and requires embedding and a permanent and skilled workforce is critical to this. There is a requirement for children's services to keep their vision clear and to maintain the determination to achieve the key cultural changes required as described in the Children and Young People's Plan. The impact of financial constraints, reconfiguration of services and changes to Working Together could influence the implementation of the required changes and it is important that the Children and Young People's Plan is supported by all partnership organisations to ensure that the level and quality of child protection and safeguarding is met.

## **2.4 ANALYSES OF INDIVIDUAL MANAGEMENT REVIEWS**

The focus for this section of the report will be an analysis of the response of services involved with Miss G, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available with the benefit of hindsight and the application of foresight.

It is important that the findings of the review are set in the context of the internal and external factors that were impacting on delivery of services and professional practice during the period 30<sup>th</sup> July 1985 to 14<sup>th</sup> February 2012. This context is described in section 2.3.

The IMR authors, the mental health and review authors have attempted to provide a valid analysis and to cross reference information to complete gaps. Where possible, triangulation of sources of evidence has been used to increase confidence in the findings. All of the agencies involved in this review have provided frank accounts of their involvement in order to learn lessons.

The report describes the involvement of each agency to enable greater clarity of involvement and identification of issues. The accounts of involvement of services with Miss G cover different periods of time. Some of the accounts have more significance than others. All ten agencies responded with information indicating some level of involvement with Miss G.

The majority of the contact of services in the early stages of Miss G's life was with universal services

### **Information from Family and Colleagues**

Whilst an offer was made for the Review author to meet with Child A's parents a meeting only took place with Child A's father, partner and grandmother. However the Chief Executive and Chief Nurse from NHS South Yorkshire and Bassetlaw met with both families. As a result of the meetings a list was developed of the questions that they wanted to have answered by the review. Whilst most of these will have been answered during the trial there remain questions regarding the standard of service provision to Miss G and this review has sought to answer them.

The key questions they want to have answered are:

- When was the last NHS / Service contact with Miss G? Who with and why?
- How long had she been known to which services, particularly mental health services?
- Who was her main contact and when did she last see them?
- Was there a care plan?
- Was she receiving treatment?
- Were there other issues/needs?
- Does she have a carer (family or from the services)?
- Has she ever been subject to formal action e.g. section?
- Who supervised the services she used?
- What was her connection to Rethink?
- Any recorded history of violence or threats of violence?

### **Meeting with Miss G**

The Mental Health Overview author and Report author met with Miss G after her trial to discuss her views about the services that have been provided for her since 1993. The information provided is Miss G's perception and experiences. There were areas that she was not able to recall as she found the experience of talking about her childhood difficult.

Miss G recalled the difficulties created by being part of a family that was influenced by the impact of religious views particularly as she was a female. She feels that she did not have a voice then and that continued throughout her life. She talked about the verbal and sexual abuse that she experienced and the difficult relationship she had with her brother. She feels that she was always blamed for anything that went wrong in the house and that mind games were played. She cannot remember ever being able to talk to a social worker about her situation and resents the fact that she was left in the home environment she had to live in and the impact that had on her at school. She remembers feeling that she was different from all the other children and how she felt isolated. She did not feel any one cared about her or that she could discuss her situation with anyone as she grew up. She was very distressed about the fact that when she left care and went to the Foyer (Salvation Army) her brother was also living there and that caused her to self harm.

As she got older and needed support from the mental health services she found again that people did not listen. She was afraid that if she told friends they would not understand. She self medicated using cannabis which she feels helped her and was the reason why she did not have any contact with services from 2008 to 2011.

She gradually began to get more afraid that someone was going to hurt her and this got worse during 2011. She asked for help but felt people did not listen or take her seriously. She asked to be locked up as she was afraid that she might hurt someone. She feels that professionals egos got in the way of providing the help she needed and she was always sent home.

#### **2.4.1 DONCASTER COUNCIL CHILDREN'S SOCIAL CARE (CSC)**

##### **Involvement of Doncaster Children's Social Care from 2/11/1993 to 28/05/2002**

As identified in section 2.3 Doncaster Children's Social Care involvement with Miss G spans significant changes in legislation and statutory guidance both national and local. Any assessment of practice needs to reflect the changes in policy, procedure and expected practice.

The first issue is that there has been difficulty accessing all the records for the time period identified. Those records obtained are of generally poor quality, with significant gaps and are largely descriptive of incidents and actions, containing very little assessment, analysis or rationale. A number of the records reviewed are also logs of telephone calls, the notes of which were hand written and typed by an administrator on a monthly basis and therefore are not contemporaneous.

The review is divided into two periods 1993 to 1998 and 1998 to 2002

##### **1993 to 1998**

The major issues identified during the period 1993 to 1998 are associated with:

- Child neglect
- Home Education
- Looked after care

During this period Doncaster Children's Social Care received referrals from two professionals, the Grandmother of the children and an anonymous caller expressing concern about the neglect of Miss G.

As identified in the GP section, on 2<sup>nd</sup> November 1993 a referral was made by Miss G's GP (Miss G aged 8 years) to Children's Social Care. The family had been registered with the practice since 1988 and there had been significant contact with the family including 'many home visits'. The letter details:

- a marked deterioration in home conditions and describes an 'alternative lifestyle' which included home educating the children.
- the house as being in a disgusting state,
- the parent's significant health problems and both children being asthmatic.
- The violent and aggressive behaviour of the children and that psychological counselling had been recommended but that the family would not engage with the service.

In response to the letter received from the GP the social worker allocated the case for assessment. The identified action required related to enquiries about the children with the Education Department and home visits to assess the situation. Contact was made by the Social Worker (SW) with the Education Department two weeks later on 19<sup>th</sup> November 1993. The Education Advisor informed the SW that she had not seen the children since August 1993 as the family had a variety of illnesses that prevented her visiting. She confirmed that she also had concerns about the state of the house.

The first intervention organised by the SW was on 30<sup>th</sup> November 1993 when an occupational therapist visited the family. The parent's medical condition was detailed in the records and the children's attention seeking behaviour and 'cluttered' nature of the home conditions described. The focus of the visit was supplying housing adaptations for the parents, stair lift repairs and assessment for kitchen adaptations. An occupational therapist is not trained or professionally competent to make an assessment of a child in relation to their child protection and safeguarding needs. This should have been completed by a qualified social worker.

The next visit was made in December 1993. It is not recorded which professional made this visit. The house was described as 'a mess, full of all sorts'. The parents explained that they were unwell and that the tidiness of the house was way down on their list of priorities. Miss G was described as looking overweight, bright, energetic and very sociable. The parents reported that they felt the children did not miss out by not going to school as they had a large social network of friends. The parents stated that they welcomed checks from the education department whenever the department wanted to carry them out. During 1994 two letters were sent by SW to the parents arranging home visits however there is no indication in the files that any were made.

On 22<sup>nd</sup> August 1995 the children's grandmother contacted Children's Social Care to express concern that Miss G's family's home was full of rubbish and the children were unkempt. An anonymous referral from a family friend was also received on the same day containing the same information. The social worker recorded that Miss G's mother had died in June 1995 and that community liaison had been involved. On 24<sup>th</sup> August 1995 social workers received a further referral from a professional. The designation of the individual was not recorded. The referral detailed that Miss G's mother had died 6

weeks previously and that her father had 'a stroke in the past and that he was diabetic, had poor eye sight, bulimia, had a short fuse and was a compulsive liar'. The father was said to have no insight into the needs of the children. The children were home educated. It was recorded that the children were neglected. They were eating out all the time, black refuse sacks full of rotting food were in the house. Some of the rooms were 'full of dead cats and excreta'. The children did not have clean clothes. Two of the rooms in the house were described as 'off limits'. It was recorded that the father took the children into town and left them there. No observations or decisions made by the social worker are recorded on the referral form however the social worker arranged a joint home visit with the housing department. The issue that the children were being neglected seems to have been lost.

At the joint visit they found Miss G appropriately dressed and clean. She talked about how she missed her mum and it was a struggle to come to terms with this. The poor home conditions were discussed with her father and he assured the social worker that he would address this. It was agreed to carry out a follow up visit one week later and that the case would be discussed with the Senior Domiciliary Care Organiser to look at the possibility of using home care services. A further visit occurred on 11<sup>th</sup> September 1998. Miss G's father had been working on cleaning the house. There were improvements recorded with the back room clear of cat excrement. It was recorded that Miss G's father recognised the reason for CSC concern for '*the health and safety of him and the children.*' The SW suggested that the family may benefit from access to a councillor. He expressed concerns about CSC and housing actions and was assured that CSC would be honest and keep him informed and that they would work in partnership with other agencies. It was recorded that he was happy for liaison with school and health services and for CSC involvement at this time.

The social worker was aware that the family were being visited by a health visitor who had become involved with the family following Miss G's mother's death. The health visitor was working with Miss G and her father to support Miss G to lose weight.

It has not been possible to access Miss G's education records although extensive efforts have been made to trace them. What information is available is that indicated in the CSC chronology and records. It was not until September 1995 aged 10 years that Miss G attended school. Prior to this she was educated at home. The home education status of Miss G was known to the Education Department, reported by referrers and an assessment was requested by the Director of Education. There is no evidence of an assessment of home education status in the CSC record nor any assessment or analysis of the impact that this could have had on Miss G's health and development.

During this period a number of contacts were made with CSC by the school nurse, head teacher, education welfare officer and Director of Education expressing concerns about Miss G and the impact of her home environment on her health and well being. Miss G's performance at school was influenced by:

- Lack of contact with children of her own age in an educational environment until the age of 10 years.
- Many years of neglect.
- Home Education potentially not meeting educational need resulting in educational delay e.g. mathematical ability assessed as being four years behind that expected.
- Her personal hygiene is said to have alienated her from other children some of which bullied her. The head teacher indicates that she was a loner.
- She had difficulty coming to terms with the death of her mother and her father's serious illness for many years.
- Her relationship with her brother was difficult.
- She experienced lack of consistency at home as she was moved between Looked After Care and that of her father.
- She was frequently returned to the care of her father which she preferred but the state of the home worsened her health and her father's worsening health made it difficult for him to parent her effectively.

Miss G's mother died in July 1995 and during this period her father's health deteriorated and he required frequent periods of hospitalisation. The outcome for Miss G was that she required respite care short-term/emergency Looked After placements provision by Doncaster Council. Miss G's father did not want family members to care for her. This period of intervention should have provided opportunity for more in-depth assessment of Miss G's needs and longer term care planning because of the implementation of the Looked After Child process. The CSC chronology identifies that key LAC documentation was completed consisting of Essential Information Parts 1 and 2 and Care Plan for each of the four periods of care and one LAC review which occurred on 23<sup>rd</sup> April 1997. Miss G had six different respite placements in five years.

## **1998 to 2002**

This period represented some coordination and planning of a series of interventions by the department much of which was task focussed. During this timeframe there was a significant improvement in the quality of record keeping and this provided the opportunity for CSC to carry out a period of assessment and monitoring of Miss G's health and welfare. On 18<sup>th</sup> November 1998 Miss G was accommodated by Doncaster Council under Section 20 of The Children Act 1989 because her father had been taken into hospital due to a serious illness. Miss G and her sibling were cared for in separate

placements. It is not recorded why separate placements were arranged for the siblings. Current practice would now make every attempt to place sibling groups together and only in exceptional circumstances would sibling placements be with different carers e.g. a separate placement would be arranged if one sibling presented a risk to others or the sibling group was too large. It is however clear that the siblings did not 'get on' and the social worker may have been aware of this.

The placement was expected to last until her father recovered and was able to resume care of them. However the LAC care plan (completed on 11<sup>th</sup> December 1998) identifies that it would be in her long term interest to remain looked after to ensure her current care needs were met. The correct placement paperwork was completed by CSC. Although this was a planned short term respite placement the department had formed the view that long term placement was in Miss G's best interest. The rationale for this change in thinking is not evident in the CSC record. Her behaviour is recorded as being difficult at this time which was attributed to her father's hospitalisation.

The assessment and action record completed by the SW gave an opportunity to establish what had happened to Miss G in the last year. It was designed to enquire if she was getting the care, guidance and opportunities she required to assist her transition to adult life and finally identify what else needed to be undertaken to meet her needs. The document was developed with input from Miss G. However it was not fully completed as key sections were omitted. The overall view formulated in the assessment record does not correlate with what the department already knew about Miss G, her behaviour and the impact of past events in her life for example the death of her mother, the impact of past separations from her father. It presents an optimistic picture of her life and does not plan for her entry into adulthood. This was a missed opportunity to undertake an effective assessment influenced by Miss G's views to provide an informed analysis and future planning by using the LAC process.

A further Looked After Children review on 16<sup>th</sup> April 1999 occurred within prescribed time scales. The record of events makes an effective assessment with required future interventions identified. The LAC review acknowledges Miss G's difficulties in the initial period of placement but recognises improvements in her behaviour and provides a picture of a more settled period of her life. The review identifies work and interventions that remained outstanding and needed completion. This review met required practice standards within the LAC process. It was decided that:

- Miss G's placement was to continue until long term residency was identified,
- Form E was to be prepared<sup>11</sup> and
- Her case developed for Foster Panel,

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<sup>11</sup> This has been replaced by Childs Permanence Report but it was the form that contained all the child's details .

- LAC medical to be arranged,
- Life story work to commence and an early 2<sup>nd</sup> review was to take place on 21<sup>st</sup> May 1999.

Following an alleged abuse concerning Miss G's Foster Carer and another child in the same placement a Strategy Meeting was scheduled in May 1999 (Area Child Protection Committee policy & procedures). The plan formulated was that Miss G's SW was to be informed about the situation 'in support of Miss G and that an investigation was to be carried out and further meeting re-convened'. There was no further record of this process contained in Miss G's CSC record therefore the outcome cannot be established but she was not removed from the placement. Current practice regarding allegations is governed by statutory guidance contained in Working Together to Safeguard Children (2010) and the Local Authority Designated Officer (LADO) framework and process. The LADO process provides independent overview of allegations management and the framework for ensuring planned interventions are implemented and challenge provided. It is the author's opinion that if this situation was to occur again the framework exists to prevent delay and to ensure tasks are completed within process. At inspection in 2011 the opinion was that arrangements for managing allegations against people who work with children in Doncaster were good. Doncaster Council had effective and widely understood policies and procedures. Allegations were received by the Local Authority Designated Officer (LADO) from a wide range of agencies, including the voluntary sector, and were managed within timescales. Effective arrangements ensured that when allegations were substantiated, appropriate action was taken and the relevant professional bodies and employers were informed. The LADO attended the regional network group where good practice was shared to support improvements and compare statistics. Information about allegations had been analysed and was used to inform safeguarding practice. A report to the LSCB was presented, as required, and formed part of the suite of quality assurance reports used by the board to oversee and evaluate practice.

The Looked After Children review of arrangements in May 1999 reports an improvement in Miss G's overall engagement in the care process and records a general improvement in her health and wellbeing. The review describes Miss G as being much more settled and appeared much more relaxed. It is recorded that she was more assertive and growing in confidence and able to talk about her mother without becoming upset. It was recorded that all work was being completed for the Foster Panel in July 1999 when it was expected that a long term placement would need to be found. It was generally felt that her placement at that time would meet her needs.

This represented a change in overall opinion about what would be in Miss G's best interest during this care episode and the transition to leaving care. Possible explanations for this change could be:

- The current stability and overall improvement generally of Miss G which might be put at risk by changing placement arrangements
- Miss G's age (14) and her stated desire to leave care at 16 and return to live with her father.

The decision and planned work were appropriate and the next review was planned to occur within statutory timescales in November 1999. Form E<sup>12</sup> was completed by the SW in June 1999 and should have contained:

- All the relevant information on the child, their family and circumstances past and present to inform the matching process for permanent placement.
- Key information gathered from the multi-agency partnership.
- The placement plan for the child and record of any legal advice sought and given.

The form however is of poor standard and incomplete in key sections including missing carers report, photographs, medical reports, child's written statement and key additional material. It was completed by a student social worker with no evidence of management supervision and oversight. Part 2 of the form provides family history for the adults and children concerned but omits an analysis of the impact of neglect on Miss G. The section enquiring if legal advice had been sought wrongly attributes this to be the responsibility of Miss G's father to seek and clarify. Again this represents a missed opportunity for the department to undertake an effective assessment and review of information regarding Miss G's life and the impact of previous events to aid care planning, therapeutic intervention and inform the decision regarding a long term placement plan. The fostering panel in July 1999 recommended that a permanent placement was sought for Miss G as it would be in her best interests.

The Looked After Children review of arrangements in November 1999 occurred within prescribed timescales, however a reduced amount of contact is recorded with Miss G and her family and carers (2 occasions in 6 months). The placement is described as very settled and that Miss G had made 'positive developments'. It was recorded that the placement was to now be recognised as her long term placement and that she was in agreement with the planned arrangements. The next review was planned for May 2000. There was no rationale recorded for the decision to make this a long term placement, however, it could have been as a result of stability and improvement in Miss G's circumstances and may have been viewed as in her best interests. However without any record of analysis and planning it is not possible to comment on the

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<sup>12</sup> This has been replaced by Childs Permanence Report but it was the form that contained all the child's details .

decision making during this assessment period. There are no records of the department's involvement with her during the year 2000.

The CSC records in terms of quantity and quality deteriorates further in 2001 making it difficult to complete an analysis of involvement. A recorded entry in January 2001 of the decision from the foster panel that she should no longer be considered for a permanent placement does not contain any rationale or demonstrate any decision making process.

## **2001 to 2002**

The Looked After Children review of arrangements in March 2001 records that the current placement of Miss G would be her final placement until a planned move to independence could be facilitated. The review document is of poor quality as there is no record of the discussion or how decisions were made. The date of the next review is not included. The record however does make reference to a gradual disengagement of the service with Miss G, her carers and her family. They had only been seen once since the last review.

The record of CSC involvement with her between March and June 2001 is extremely poor. Her father's health had deteriorated and he was admitted to a nursing home in March 2001. It is also recorded that Miss G's behaviour had deteriorated but no investigation, assessment and subsequent plans to address this is recorded. It is unclear from the case record who held case responsibility.

In June 2001 it is recorded that Miss G's placement was closed. Her father died in September 2001. Records of Miss G continue to identify deterioration in her behaviour but no investigation, assessment or subsequent plan is recorded to address this. It is still unclear from the case record who held case responsibility. The arrangements for the provision of Leaving Care Services in Doncaster in 2002 were commissioned from Barnardo's. CSC has attempted to secure the records for this time frame but these have been unsuccessful therefore it has not been possible to give an analysis of contact/intervention.

## **Analysis of CSC Involvement**

Following on from the analysis of service involvement the following themes are apparent:

- a. Response to neglect
- b. Assessment and evaluation
- c. Assessment of home education provision

- d. Respite care: planning, provision and permanency
- e. Leaving care arrangements
- f. Leadership, management and supervision
- g. Poor record keeping and storage

### **Response to Neglect**

The initial contact and action taken by CSC in 1993 following a referral made by Miss G's GP set the pattern for all future involvement by CSC with her. CSC recognised the extremely poor home conditions Miss G lived in from the start of their contact with the family and that became the focus for intervention. The IMR author identifies that CSC's response to the referral was to offer help and support to the parents to assist them to develop the skills and environment required to care for their children. However it is unclear what action was planned by CSC to achieve this outcome. No assessment or analysis of the children, parental capability or home conditions can be found in the CSC record. There is no evidence to suggest that the children who were the reason for the referral were effectively assessed and seen separately from their parents.

The decision to support the family by provision of services to enable them to care for the children set the tone for future interventions. The conclusion to work with the family at this level of need meant that multi-agency assessments and coordinated planning did not occur although other agencies held key information that would have enabled more holistic assessment, care planning and service delivery to have been made. CSC simply became responsive to deteriorating home conditions which, with the parents' failing health became more pronounced and were unlikely to improve.

There is evidence to suggest that the case was initially considered at a Child Protection level<sup>13</sup> however a decision seemed to be made to offer support at Child in Need level<sup>14</sup>. A home visit was made by an occupational therapist and the focus appears to have been on providing equipment for Miss G's mother and father to support them to provide better care for their children. This view is supported by evidence in the records that liaison with other services did occur leading to home visits by services. The CSC referral form completed by the department is said to identify that

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<sup>13</sup> The decision to make a child the subject of a Child Protection plan is made at a Child Protection Case Conference. The purpose of the multi-agency plan is to: ensure the child is safe and is prevented from experiencing further harm ;promote the health, development and welfare of the child and support the family to safeguard and promote the welfare of the child. The plan is formally overseen by a named social worker for the child and monitors the progress of the requirements set out by the Conference via the Core Group meetings.

<sup>14</sup> The Child in Need Plan ,Section 17 of the Children Act 1989, provides for children who are assessed to be 'in need' of services to improve their life chances. These plans may be overseen by a social worker or other professional to ensure that there is ongoing improvement to the situation over a sustained period of time.

as support was planned and put in place no further action was required and the case was closed. Munro and Laming<sup>15</sup> recognise the importance of early intervention but that intervention has to be focused on identified need which did not occur in Miss G. There is sometimes confusion about what is meant by intervention in safeguarding and child protection. Procedures should place the practitioner in the right place at the right time to respond on behalf of their agency.

The referral received from the children's grandmother and anonymous caller in August 1995 resulted in the same departmental response. There was evidence documented of deterioration in home circumstances. Miss G's mother had died six weeks previously and her father was recorded as having no insight into children's needs and was described as having "a short fuse" and being "a compulsive liar". Again this should have led to the department undertaking a full assessment of need and subsequent planned interventions but it did not. Despite the recognition of the dangers of child neglect, practitioners it appears were applying alarmingly high thresholds for intervention. (see Glossary for definition, Appendix 2)

In the report leading from the death of Victoria Climbié Lord Laming<sup>16</sup> raised the issue of professionals being overly optimistic about the ability of parents to have the skills to meet the needs of their children not just physically but emotionally. There is evidence to suggest that CSC were overly optimistic about the ability of Miss G's parents to meet her needs.

Child neglect is the failure to provide a child's basic needs, physical health care, supervision, nutrition, emotional nurturing, education or safe housing. These are necessary behaviors a caregiver must provide a child in order for the child to develop (physically, socially, and emotionally). Neuroscience has shown how persistent neglect and trauma impacts significantly on brain development and functioning, leading to greater anxiety, impulsivity, poor affect regulation, hyperactivity as well as reduced ability in problem solving, empathy and sexual exploitation. The long term impact is seen in adult life with increased risk of depression, heart disease and substance misuse associated with adverse childhood experiences<sup>17</sup>.

Whilst it is recognised that awareness of child neglect has changed considerably over the last 19 years and information is now widely available regarding the devastating impact of neglect on child health and development, it was possible, even in 1993, to place children on the Child Protection Register as a result of neglect. With the

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<sup>15</sup> Stein, M. and Munro, E.R. (2008) *Young People's Transitions from Care to Adulthood: International Research and Practice*. London: Jessica Kingsley Publishers

<sup>16</sup>The Victoria Climbié Inquiry report of an inquiry by Lord Laming 2003 DoH

<sup>17</sup> Gilbert, R., Spatz Widom C., Browne K., Fergusson, D, Webb, E., & Janson, S. (2009) 'Burden and consequences of child maltreatment in high-income countries', *Lancet*, 373:68-81.

evidence available in this case it is clear that an investigation should have been undertaken at a Child Protection level. This would have enabled a controlled period of key agency involvement, assessment and planning therefore with the possibility of a different outcome for Miss G.

Doncaster LSCB now provides policies, procedures and training on recognition and response when children are at risk of or experiencing neglect and emotional abuse. Tools are available to assist professionals in establishing levels of need, e.g. the Common Assessment Framework and multi-agency Child Protection Procedures, and a policy framework exists with assessment tools, based on the Graded Care Profile developed by Dr Srivastava, for the management of neglect (see Glossary). The use of this tool and multi-agency implementation of the neglect policy framework should provide better outcomes for the children concerned and lead to a more coordinated response which does not rely on the actions of individual workers. Therefore in 2012 a different response to the referrals of neglect of Miss G would be expected.

As previously stated, policies did exist in 1993 which should have guided the response to the referrals made about Miss G. However the department quickly established their position that Miss G was a child in need of services via supporting her parents rather than a child in need of protection. This set the tone for interventions from first contact and throughout CSC's involvement with her and her family.

There was a consistently high threshold before concern triggered action and the attitude of the professional culture overall was too tolerant in its expectations of the parents. The passive approach taken by CSC is evidence that the challenges, and therefore the required systems and practice and the use of effective assessment tools, were not fully in place. One of the factors that frequently challenges professionals working with families is how to work with parents/families who chose not to engage and this was a challenge in this case.

How agencies work individually and collectively to meet children's and their family's needs has changed considerably in the last 15 years. Several land mark cases have resulted in major legislative changes and associated statutory guidance. Consequently the approach agencies use to assess and plan their interventions in such cases is markedly different and should ensure that in 2012 young people in a similar situation to that of Miss G receive a more coordinated level of service intervention, assessment and planning.

In other IMRs and at her court appearance Miss G talked about the physical and sexual abuse she experienced as a child. There is no evidence in any of the available documentation that this was disclosed by her as a child and she has confirmed this. Neither is there any evidence that this was considered as a cause of her behaviour.

Miss G confirmed that she did not disclose to anyone during her childhood that she was being abused.

## **Assessment and Evaluation**

There is no evidence to suggest that any formal assessment of parenting capacity and capability, a risk assessment and outcome were completed.

*“Assessments should be based on a set of theoretical constructs that guide the type of information needed and the sense that can be made of it. The theoretical framework should be the central reference point for selecting the observations to be made, formulating appropriate questions and giving meaning to the response. Otherwise the assessment is directionless and generates a mass of discrete pieces of information that cannot be organised or understood. (Reder & Duncan<sup>18</sup> 1999 pg. 98-100).*

Assessments of Miss G reflect the final statement in this quote in that it did not lead to an effective plan of care the result was that care was directionless; there was a lack of leadership, coordination and stasis and the recognition of her real level of vulnerability.

Risk assessments should have been completed and they should have identified the core features of the vulnerability of the child including:

- Accurate identification of the risk the child is exposed to and why
- The likely impact or consequences of the risks to the child
- Whether the risks are externally posed or are endemic to the child and their circumstances
- Whether the risks are acceptable.

The lack of a coordinated plan of care based from effective assessment also resulted in episodic care not based on required outcomes for Miss G and that was not evaluated. A systematic process would have enabled agencies to identify that there had been no improvement in the neglect of Miss G from 1993 the point of the initial referral to 1999 when she was placed in long term fostering. During this period there were 12 family and professional referrals to CSC which do not appear to have been effectively assessed. There were attempts by the school to communicate professional concerns that were not properly heard by Children’s Social Care. There are also a number of occasions when the case was closed without effective assessment of the current situation by CSC only to be quickly opened again because of the worsening situation for Miss G. There appeared to be an eagerness to close CSC involvement

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<sup>18</sup> Reder, P. and Duncan, S. (1999) Lost innocents: a follow-up study of fatal child abuse, London: Routledge

with Miss G even when her self harming behaviour, loss of her father, homelessness and drug use should have resulted in increased contact.

There have been a number of significant changes in the way that Doncaster Children's Services assess referrals and work with complex families. Children's Assessment Service (CAS) has been transformed and now provides a strong 'front-door' safeguarding service. The CAS has been developed into the Children Multi-Agency Referral and Assessment Service (CMARAS), which has physically located together the Police Public Protection Unit and the social work teams, with the involvement of health safeguarding professionals. The CAS/CMARAS has been the subject of three external Ofsted inspections<sup>19</sup> since this date, which have all evidenced continuous improvement. The inspection in January 2012 concluded that "staff have manageable caseloads".

The establishment from April 2011 of the Integrated Family Support Service (IFSS) within the Children and Young People's Service (CYPS) has brought together seven separate services that previously worked in isolation into four integrated locality teams. The prime responsibility of this new service is to work proactively with families where children and young people are most at risk. The Council has also established a strong partnership with the local health service (particularly RDaSH, one of the main health provider trusts) to develop a locality based integrated multi-agency service bringing together health, social care, education, early years and family work professionals. A pathfinder is currently being run in the North West of the Borough. Expanding the use of the Common Assessment Framework (CAF) and Team Around the Child (TAC) meetings across all agencies has allowed for the early identification of families requiring help and intervention in respect of issues such as anti-social behaviour. This has facilitated professionals and agencies working better together to tackle key issues such as anti-social behaviour rather than in isolation. This has been supported by developing a better understanding amongst staff from all agencies in the use of the thresholds (for intervention).

To assist in situations where professionals are questioning the actions or inaction of other services a Dispute Resolution process is in place and its use is included in all safeguarding training and awareness sessions. The Dispute Resolution process is used when a practitioner (or group of practitioners) believe the criteria for a referral into children's social care has been met, and they have made the referral through the correct channels, but it has been refused for social work intervention. This enables practitioners to escalate any professional differences they have through the management structure including, if necessary, to the Assistant Director or Director. If

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<sup>19</sup> Annual unannounced inspection of contact, referral and assessment (January 2010 and January 2012); Inspection of Safeguarding and Looked After Children Services (March 2011)

practitioners have used their individual management structure to raise concerns and they still believe a case is 'high risk' and meets the threshold criteria, they can refer to the independence of the DSCB Serious Cases Sub Group. Since its introduction the amount of cases taken through the process has begun to reduce as there is now a better understanding by practitioners about thresholds.

The training strategy for the Doncaster Safeguarding Children's Board includes CAF/lead professional training, which is compulsory for all practitioners. The Neighbourhood Teams have agreed a policy for their service that ensures that they have a designated person within their teams to offer advice on a day to day basis about the need to use the CAF and TAC, including accessing professionals to relevant training.

### **Assessment of Home Education Provision**

There have been concerns expressed by some local authorities regarding the ability to be able to intervene when children are not being provided with the quality of education required as a result of home education. Home education legislation (S7 Education Act 1996) and guidance (DCSF Elective Home Education Guidelines for Local Authorities 2007) enables adults to effectively remove children from state education and the effective oversight of professionals, empowering adults and enabling them to isolate the children, whilst also limiting the range of opportunities open to professionals to intervene.

The lack of any prescribed opportunities for children to express their views, or to undertake active participation in this process, has to represent a significant legislative failure. Following the death of Khyra Ishaq and the subsequent Serious Case Review the Government have made no additional legislative powers available to local authorities regarding home educated children which results in a significant barrier to effective intervention. Statutory guidance states that a local authority can make informal enquiries of parents who are educating their children at home to establish that a suitable education is being provided however they have no right of entry. Doncaster Council did have the legislative power if limited to intervene and it is anticipated that in 2012 the Council could have acted differently in respect of the home education of Miss G.

The Review could not find an assessment of home education status and quality in the CSC records nor any assessment or analysis of the impact that this could have had on Miss G's health and development. A parent can, however, be asked to prove that the education provided at home is suitable and if it appears to the local authority that a child is not receiving a suitable education then it is possible for the local authority to serve a school attendance order. Therefore if Doncaster Council had undertaken to

investigate the quality of home education provision for Miss G and had reason to think this was not suitable her parents may have been ordered to send Miss G to school. This may have prevented Miss G's entry into the special educational needs (SEN) system when she finally attended school and may have diminished the isolation she experienced while home educated and accompanying her only partially effective integration into a school environment. It is to the school's credit that Miss G progressed well at school and was expected to get all B's (GCSE) if she had been supported to complete her examinations.

### **Respite Care: Planning, Provision and Permanency**

It was evident from the first Looked After episode that a long term placement should have been sought for Miss G. The fact that CSC only ever considered these as respite placements represented a missed opportunity to plan and implement a care package that would have met her needs and support her transition from care into independent living.

The framework for management of cases such as Miss G remains the same in 2012 as it did during the latter end of the provision time period in the late 1990s. The lack of management oversight and independent challenge to these episodes perpetuated the respite nature and lack of long-term planning. An Independent Reviewing Officer (IRO) should have ensured that children Looked After by the Local Authority have regular reviews to consider the care plan and placement. It is the role of the IRO to ensure that a child's views are taken into consideration and that the Local Authority is fulfilling its duties and functions. The IRO is in a key position to influence decision making and escalate poor practice. This is one of the safeguards for children such as Miss G. Learning from previous local serious case reviews has reinforced this key oversight role however the DSCB should ensure, through quality assurance processes and the impact of SCR Action Plan reports, that the existing framework is applied and outcomes are met for young people currently in the care system.

As stated earlier it is clear from the completed documentation (Placement Plan and Care Plans) that Looked After arrangements were only ever considered to be temporary respite and the plan was always to return Miss G to her father's care. Although no medical report of her father's condition and prognosis is contained in the CSC record, it is evident from the records that social care staff discussed with hospital staff the general deterioration of her father's condition over time. With this knowledge and the increased frequency of her father's hospitalisation it is difficult to understand why the placements were seen as temporary. Enough information and evidence was available to the department at this time to indicate that a more permanent care solution should have been planned.

During this time there are frequent entries in the CSC record of Miss G's continuing to struggle with her grief of her mother's death and missing her father. Whilst a health visitor earlier in Miss G's life had provided some support there is no evidence that opportunities taken by social worker since 1995 to consider that, with the deterioration in her father's condition and loss of family life, she should be referred for specialist support around bereavement at this time.

The Looked After Review dated April 1997 is the first document in the CSC record which provides an in-depth report and review of Miss G. It is completed by a social work assistant. The quality of the record is variable and is mainly descriptive of events with no analysis contained in the social work report. All sections are completed by the social work assistant with no evidence of IRO input apart from a signature. The review contains information which should be present elsewhere in the CSC record but is not, e.g. describing Miss G's special educational needs and review. It describes the difficulty that the worker has in forming a relationship with Miss G but makes no plans to address this. Given that Miss G had nine different social workers from 1993 to 2001 it is not surprising. The record of discussion section is descriptive and brief and the decisions are all concerned with continued support until the discharge of Miss G's father from hospital. The poor quality of the review again represents a missed opportunity to gather and discuss information from a range of agencies and formulate a plan for a more permanent solution to Miss G's care needs. The care given is episodic and mainly task focussed.

What is clear from records is that from 2000 the situation for Miss G began to worsen. She was said to be improving in all areas in school in February 2000 and by March 2001 she is going missing from her foster placement, she stopped going to school and misses some of her examinations. Her father died in September 2001 and she was living in a homeless hostel. One month after the death of her father the SW closed her case. In April 2002, the social worker saw her once, she was asked to leave the Foyer and emergency accommodation was arranged and she was referred to Banardo's leaving care project. There is no evidence that SWs assessed Miss G's behaviour or the impact of transition on her. She should, under LAC requirements have been receiving support.

On 1<sup>st</sup> April 2011 the role of the Independent Reviewing Officer (IRO) in reviewing the cases of children in care was enhanced, ensuring that children and young people in care had access to their IRO between reviews. A set of standards was introduced that enabled the service to be measured against the care planning regulations 2010 including deadlines for report writing, increased participation of children in reviews and in raising formal disputes where there are significant areas for concern. The Safeguarding and Standards Service was split into two teams in December 2010: The Child Protection Advisor Team and the IRO Team; to ensure a clearer pathway to

improve the service to children in care. Young people are now encouraged to be involved in the chairing and the recording of their own review, which has led to an increase in participation to an average of 95%. A system for recording any disputes within the review has now been formalised. A specific form on which to record formal disputes has been developed in line with Chapter 6 of the IRO Handbook. These disputes are escalated to senior managers and are addressed at regular meetings with the Assistant Director and Heads of Service. The Safeguarding and Standards Service has also provided training on the role of the IRO and the legal framework around the new care planning regulations to staff across children's services.

## **Leaving Care Arrangements**

Young people during their journey to adulthood who have experienced neglect or other forms of abuse or period of being in care have to make the transitions from care, and their lives after care. It is suggested that three main groups of young people can be identified from leaving care research studies: young people "moving on", "survivors" and "victims". It is argued that promoting the resilience of young people leaving care will require more comprehensive services across their life course. This will include, first, better quality care, providing more stability, holistic preparation, a positive sense of identity and assistance with education, second, opportunities for more gradual transitions from care, less accelerated and compressed, and more akin to normative transitions; and third, the provision of better quality and more extended support.

For most young people, their journey to adulthood includes three connected and reinforcing pathways: entering further or higher education, and finding satisfying employment; being settled in accommodation; and achieving good health and a positive sense of well-being.

The local authorities' duties under the Leaving Care Act are:

- Duty to ensure pathway plan is in place by 16<sup>th</sup> birthday
- Duty to make assessment and meet needs
- Duty to provide financial support
- Duty to provide Personal Adviser
- Duty to ensure accommodation

The services for young people leaving care were at the time provided by Banardos. Due to the absence of any documentation relating to the Leaving Care Service no conclusion can be drawn about the adequacy of the provision for Miss G. Doncaster Council brought this service in-house in 2009 and the Leaving Care Service is now 'provided in house' by their CSC service. Doncaster Council had a commissioning responsibility to ensure that Banardos maintained records and achieved contractual

requirements. Doncaster Council now commissions services very differently under the leadership of a specific Director and application of a governance process to monitor performance.

Current arrangements for Looked After Children in Doncaster provide a much more robust framework around the LAC review process. Independent oversight by the IRO would have provided more of a challenge to CSC's plans and decision making and would possibly have provided a different outcome for Miss G. The Integrated Children's System now in place for recording the Looked After process, actions and interventions provides management with clear oversight of process and the ability to challenge poor decision making and failure to comply with practice guidelines

### **Leadership, Management and Supervision**

One of the issues identified as part of the review is the issue of leadership not just at the top and middle of the organisations involved but most importantly the issue of dispersed or distributed leadership. The complex nature of all public service organisations means that leadership is needed at different levels and not simply at the top. The nature of professional practice requires individuals to be able to lead and advocate for the care management of their client/patient/student caseload and to provide leadership as a group or network. There is evidence of a lack of senior level leadership but there was also a lack of group or network leadership. If there had been the required level of professional discussion taking place within and across organisations the care of Miss G is likely to have been more effective.

Agencies and professionals have to be willing and able to seize the initiative, demonstrate a desire to 'get to the bottom' of things and gain a complete understanding of situations rather than settling for the superficial face-value. Leadership is about taking responsibility as opposed to minimisation, gaze aversion or taking the line of least resistance. Effective service delivery is often as a result of extraordinary efforts by individuals and sometimes despite, not because of system structures.

There is no evidence apparent in the CSC record of management oversight, control or challenge of social work decisions or questioning assessments being completed by unqualified staff.

### **Supervision**

Supervision is the process which facilitates the identification of factors known to be associated with child abuse and neglect; signs of maltreatment, strengths and ameliorating factors in order to assess risk and intervene effectively to safeguard and protect children.

In 2012 learning from previous serious case reviews has clearly identified the need for a strong social care supervision framework which has been implemented in the service. This provides management overview and worker challenge particularly in complex cases.

The process of supervision, underpinned by appropriate training, seeks to ensure that meaningful assessments of individual cases are made; so that the families that need it most are identified, prioritised and receive the service in an anti-oppressive, anti-discriminatory manner that addresses the needs of all stakeholders. The main body of literature on supervision refers to four main functions<sup>20</sup>;

- Management; to ensure that the supervisee is clear about their role, responsibility and accountability and that the worker meets the agency's objectives and standards.
- Educative; to develop a supportive and positive climate in order to enhance the worker's professional development, and to offer support in managing the tasks relating to the work.
- Supportive; to help the worker to deal with the emotional demands of the work and
- Mediation; to promote clear communication between the organisation and the worker.

### **Consulting and Listening to Children**

Since 2001 legislation in the United Kingdom requires that children are consulted about any decisions that will affect their lives (DoH 2001). Miss G like many vulnerable children appears to have experienced low self-esteem, and self-confidence. A Child Centred Approach would have promoted her to choose, make connections and communicate. Miss G was not really seen by any agency at that time as the highly vulnerable child she was and the care provided by some agencies reflected the outcome of her vulnerability rather than addressing the cause.

Hart's<sup>21</sup> recommends a model that is *child initiated and directed* and *child initiated and shared power*, where the children hold the most power and control while adults only

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<sup>20</sup> Towle, 1963; Pettes, 1967; Kadushin, 1976; Westheimer, 1977; Payne-Scott, 1982; Richards et al 1991; Sawdon and Sawdon, 1991; Morrison, 1993; Hughes and Pengelly, 1997; Morrison, 2001.)

<sup>21</sup> Hart, R.(1992) *Child's Participation: From Tokenism to Citizenship*, UNICEF, International Child Development Centre, London

provide support or guidance when needed. Work would have been needed to develop Miss G's self-confidence, self-motivation and feeling of empowerment but it is an approach that was more likely to gain her support.

Opportunity was available in Doncaster at this time to ask the young people for their opinion through consultation booklets. As evidenced in the chronology throughout this period, home conditions did not improve and are regularly described as "poor". The consultation documentation to put forward the views and opinions of carer, parent and Miss G is partly completed and perpetuates the enduring view of the respite nature of care provision.

During the period of care CSC did not have an advocacy service for young people in care which reflects the national picture at this time. This could explain why Miss G's views are not adequately represented as evidenced by the brief and partial completion of the consultation document. The role and positive effect of the advocate is well documented. CSC now have an advocacy service the details of which are given to every child in care within their welcome pack. Even though the continuation of neglect is apparent from the record during periods when Miss G was in respite care this does not factor in to any consideration when returning her to father's care. Neither was the issue of her health although records indicate that her asthma improved whilst she was in respite care. Yet again the department continued to work with the family at an "in need of services" level rather than considering Miss G a child at risk of harm. Professionals failed to listen and consider situations from Miss G's perspective. The model of involving Miss G in her care would have been crucial because of not only her delay in learning but her lack of self esteem and disengagement with services. CSC services in the latter stage of her care did not recognise the correlation between those young women who had the most complex needs arising from their childhood experiences and those who were least willing to engage with services to help safeguard them.

### **Poor Record Keeping and Storage**

As stated earlier the review has proved difficult to complete due to the poor standard of record keeping and the gaps in records relating to Miss G. The introduction of the Integrated Children's System in Doncaster provides an electronic record of interventions is available and that alerts are in place for key events. Had this been in place at the time of Miss G receiving services, gaps in planning and provision for Miss G should have been identified at a managerial level. In addition historical information would have been accessible and therefore a longitudinal picture of continuing neglect and deterioration in her home conditions and behaviour would have been apparent. This could have resulted in more effective placement and service planning for her as well as highlighting her level of risk within her home environment.

## Conclusion

Based on available records the quality of practice at this time was inadequate. There were a number of missed opportunities to safeguard and protect Miss G against neglect including not listening to and hearing her and seeing her as an individual. Practice was adult focused and failed to ensure that the welfare and protection of Miss G remained paramount. The parent's poor co-operation, deception, and combination of plausible and disengaged behaviour added to the focus being on keeping their cooperation and losing sight of the children.

There was a lack of a multi professional approach which indicates that professionals had a different understanding of what constitutes abuse and neglect and thresholds for effective intervention. Whilst professionals made referrals to Children's Social Care they could have been more robust in challenging the actions that were taken or not taken. Practitioners need to be aware of the process in place to escalate concerns and the necessity of using this facility. Attempts made by the children's grandmother and health professionals to disclose neglect when they were young children were not sufficiently heard and not taken seriously by adults as no protective action followed. Care became episodic and focused on doing things. Professionals were overly optimistic about the parent's ability to be able to parent the children effectively.

Miss G was a vulnerable young woman whose needs were not fully assessed by any agency that had contact with her. Serious case reviews in the past have highlighted the importance of services seeing, observing and hearing the child. Few services actually saw, observed and heard Miss G as the highly vulnerable child she was and who society had a responsibility to protect. CSC were the lead agency from 1993 to 2002 and as such should have done more to protect her and meet her development needs.

Doncaster Children's Social Care Services have already put in place many initiatives that should reduce the risk of this happening again however the changes will require determination and commitment not only from policy makers and leaders but also from every practitioner if they are going to be successful.

The record of CSC involvement with Miss G finishes in 2002, 10 years prior to the tragic events which prompted this review. The impact of CSC service provision would have some bearing on how Miss G developed as an adult however it would not have been possible at that time to predict or prevent the incident based on the analysis of the service interventions and involvement with Miss G as a child.

## **PERIOD TWO - 2002 to 2012**

### **HOUSING SERVICES**

Following Miss G leaving care in 2001 she went to stay at a Women's Centre before going missing and then being found at Salvation Army Foyer accommodation provided for young single homeless people aged 16-25, care leavers and young people at risk. She became homeless again at the age of 16 years after being asked to leave Foyer as a result of using cannabis and evidence of self harming. She then went to stay at M25 and was finally accommodated in 2002 by an arm's length agency that managed property for Doncaster Council.

#### **2.4.2 DONCASTER COUNCIL - ALL OTHER SERVICES**

As an adult Doncaster had limited contact with Miss G. Most of the contact outlined was routine associated with housing and council tax benefits. In February 2012, Miss G visited to purchase a heating ticket.

#### **Analysis of Involvement**

Service involvement was in line with organisational expectation. Revenue and benefits agency's involvement was for routine matters concerning council tax and also housing and council tax benefits. It is identified that staff are fully trained in the organisation's policies and procedures as well as customer service provision. They are able to identify issues of concern, and have knowledge of how to raise these concerns with the appropriate departments. During the contact with Miss G there were no concerns identified. Most contact was routine and within a legislative framework (e.g. housing benefit and council tax visits and letters). There were no incidents that required any assessment or action to be taken. At the time Miss G was only eligible for advice and assistance due to her housing situation through Housing Options services and she was referred to St Leger Homes.

Miss G's contact with St Leger Homes is described in more detail in the next section of the report. She was seen within a week of making the initial approach and was provided with advice and assistance as she was not making a homeless application. Housing Options did not contact RDaSH having received a supporting letter from the Access Team in terms of her mental health. This may have added further context to her application or may have supported the interview process. Staff supervision is said to have been adequate but hindsight shows more relevance should have been placed on the letter from RDaSH within the Housing Options service. Senior managers were involved at the appropriate points.

## **Conclusions**

Housing Options was the service that had face to face dealings with Miss G and from analysis, the service dealt with Miss G in a timely and appropriate manner.

Miss G was provided with appropriate information and sign posting to services and benefits to assist her. The decision making process could have been improved by consideration being given to the letter from RDaSH and contact having been made with them to establish more information which may have resulted in a quicker response to Miss G's housing needs. However, it is felt further information would not have changed the advice and assistance given and process followed.

### **2.4.3 ST LEGER HOMES**

St Leger Homes was established by Doncaster Council in 2005 as an Arm's Length Management Organisation to administer the day-to-day running of 21,000 council homes and to deliver a major programme of Government investment to bring council homes up to the Decent Homes Standard.

#### **Summary of Involvement**

Miss G left Looked After Care in May 2002 when she was 16 years old. There is little evidence in records of Children's Social Care's involvement in her accessing housing however as stated earlier it has not been possible to find the records to confirm this. Between February 2002 and December 2003 her occupation of a flat was managed by Stonham Housing Association. This arrangement ended and Miss G automatically became a secure tenant of the Council. St Leger took over the management of the Doncaster Council housing stock in 2005. She was 17 years old and became the secure tenant one year later. There is no reason provided on record why she became the secure tenant or details about her support needs at that time.

During the period 2003 to 2010, the only contact apart from appropriate repair calls to Doncaster Council, St Leger Homes had with Miss G was in respect of her rent account in 2006 and 2007. On these occasions she received appropriate assistance in applying for and receiving housing benefit payments.

St Leger Homes had limited contact with Miss G until November 2011 when she made her request for re-housing. Records indicate no concerns with her as a tenant and that she looked after her home. Whenever she spoke to the staff in the office or on the phone she was always polite. She did not indicate any problems with her neighbour.

It was not until November 2011 that St Leger Homes property allocations team (Homechoice) received an online application from Miss G to join the Mutual Exchange

Register. This was the first time Miss G had expressed an interest in moving away from the estate since commencing her tenancy in December 2002. She followed up this application by visiting the Housing Office to ask for assistance in finding alternative accommodation either in Doncaster or London. She provided a letter of support from the RDaSH Access Team.

Housing Options suggested that she asked for assistance from St Leger Homes and she visited their office on the same day. During the interview Miss G explained that she was not having any issues with individuals but she did not like the area and felt that moving away would help with her mental health. She produced a discharge letter from RDaSH Access Team which stated that she had been admitted to hospital at the end of November 2011 following a suicide attempt. It also detailed that she had taken 4 overdoses in the previous year, and had been seen by mental health services in the past. The letter also included that 'there are some ongoing housing issues, and the Crisis Team have written a letter to support her housing application. The letter stated that they were happy there was no acute mental illness, and have referred her for community therapies, and advised her about further sources of support. She was referred to M25 Tenancy Support but did not want to be referred to the Mental Health Team stating that she had been supported by them before and it did not help her. She later changed her mind about this and she was referred to the team. St Leger Housing team leader agreed to refer her transfer request to the Housing Assessment Panel and obtain the details of housing authorities in London. Miss G was asked if she had anyone to stay with and she confirmed that she had the support of friends but that they did not know how she felt. Following the interview Miss G's case was placed on the safeguarding spreadsheet due to the potential risk she posed to herself. This provided an internal alert for staff having contact with Miss G.

The Estates officer then kept in touch with Miss G to keep her informed of the progress being made and informed her that a referral to the Housing Assessment Panel would be made to try and obtain a priority move given the circumstances. She also asked for details of some social housing providers in the London/Sussex area. The Estates Officer obtained this information from the internet and sent it in the post. At the end of December 2011 Miss G completed an application to be considered for medical priority for re-housing. The Estates officer contacted her on a weekly basis to keep her informed.

At the panel meeting in January 2012 the Housing Partnership Manager phoned the team leader at the local office to ask further questions about the case, but there was nothing to add to the information contained in the report. The panel agreed to defer their decision pending outcome of assessments completed by M25 Tenancy Support and the Mental Health Team to establish:

- Clarification of the reasons for not being able to remain at her present address.
- What support plans are or will be in place.
- If Miss G is engaging with services
- Which areas of Doncaster would Miss G consider for transfer

St Leger Homes made courtesy calls to Miss G on the 1<sup>st</sup> and 8<sup>th</sup> February. Miss G told them she was doing fine and that she had been contacted by M25 Tenancy Support and the Mental Health Team who would be providing her with support. M25 Tenancy Support was visiting her that afternoon to discuss and assess what support she required.

St Leger Homes records indicate that Miss G placed bids on three properties the last of which was on 13<sup>th</sup> February 2012.

### **Analysis of Involvement**

The team leader was concerned about Miss G because of the information contained in the discharge letter and her general fragile state. Her conversation focussed on obtaining support and assisting her with a move. Her actions followed the training and procedures on safeguarding adults and children which focus on four elements:-

- Prevention
- Recognition
- Reporting
- Monitoring

The team leader had agreed a way forward with Miss G and provided a coordinated approach which included referrals to support agencies (M25 and later the Mental Health Team) and help with a transfer (Housing Assessment Panel) or mutual exchange (providing a list of Local Authorities in London & Sussex). She also placed the case on the safeguarding spreadsheet.

The team leader opened up a line of communication with Miss G and arranged for an Estate Officer to keep in touch and provide Miss G with information and support. The referral to the Housing Assessment Panel was appropriate given the circumstances of the case. The team leader was well aware of the large number of applicants on the housing register; therefore without priority from the Assessment Panel Miss G's chances of a quick house exchange would have been reduced as she would have been classed as a low priority transfer.

The difficulty with Miss G's case was that the request went to the first meeting of the Housing Assessment Panel with limited information regarding why she wanted to

move, no support plans in place and there was no indication that she was engaging with services because the support from M25 and Mental Health had not started. The only support they were aware of was St Leger Homes. Miss G did not indicate where she wanted to go which was important because single person's accommodation for young people is limited to certain areas.

The panel's terms of reference includes a section on function which states that the panel is responsible for the assessment of housing applicants whose priority requires assessing due to 'mitigating circumstances'. There is no clarification regarding what might define mitigating circumstances. The panel were aware of all the information on file but the only medical information was that provided by Miss G in the discharge letter and the letter of support from RDaSH. The Panel agreed to defer their decision pending the outcome of assessments by M25 and the Mental Health Team. It was hoped that this would help progress the case. This was a sensible approach given the circumstances.

There was a delay between the St Leger Homes referral to the two support services and their assessments, this information if received would have greatly assisted the panel in their decision. Furthermore the support worker could have attended the panel meeting to discuss the case.

The team leader's actions on the 16<sup>th</sup> December 2011 were appropriate given the situation she was faced with. She had no reason to think that Miss G needed immediate re-housing or medical attention. The plan of action consisted of ways to provide support and help with re-housing. This is in line with St Leger Homes training and procedures.

The referral to the Housing Assessment Panel was the correct action because Miss G's transfer request needed to be considered for additional priority because of her problems with depression and history of suicide attempts. The Housing Assessment Panel's request for additional information was reasonable. They needed to be sure that moving Miss G was going to be beneficial and part of a wider support plan.

There was no evidence to suggest that Miss G would take the action she did on the 14<sup>th</sup> February 2012. She had not displayed any signs that she would or could be violent, if anything she was said to be quite the opposite. The principle concern was that she might self harm by taking another overdose.

## **Conclusion**

In the process of undertaking this review the issue of Miss G's concern about housing has become evident. St Leger homes provided a supportive service to Miss G and

attempted to coordinate a response to her care needs across agencies. The team leader recognised Miss G as a vulnerable woman and placed her name on their safeguarding list due to the perceived potential risk she posed to herself. The Estates Officer assisted Miss G and kept her informed of progress and monitored Miss G's responses. They were not aware of Miss G expressing violence towards anyone else. There does not appear to have been any follow up regarding the referrals that had been made to M25 and the mental health team although this did delay the ability of the Housing Assessment Panel to make an informed decision about Miss G's priority.

#### **2.4.4 M25 - HOMELESSNESS HOUSING & SUPPORT GROUP**

The M25 Housing & Support Group is a homelessness charity that has worked in Doncaster since 1994. The purpose of M25 is:

*To prevent homelessness and relieve, support, and assist homeless persons in the Doncaster District and surrounding area by providing accommodation either directly or by any other charitable means as shall from time to time be deemed necessary.*

The charity has two hostels for single homeless people, peripatetic support services with the aim of resettlement following a period of homeless or working with a client to prevent homelessness and a housing advice centre.

#### **M25 had four periods of contact with Miss G:**

April 2002 to December 2002

The file in relation to the charity's involvement with Miss G during this period has been destroyed but the IMR author has interviewed key workers to establish the involvement of M25 with Miss G at this time. Miss G was resident at accommodation which was a 17 unit 'homeless hostel' accommodating 12 male clients and 5 female clients. The referral would have been made by Doncaster Council Homeless Persons Unit. The accommodation provided relatively short term accommodation averaging 3-6 months whilst working with a client to move them to greater independence. Miss G is said to have made friends during this period and engaged. It was also indicated during an interview that a M25 worker had been informed by another client that Miss G had told her that she had been abused by a member of her family. As there are no records it is not possible to determine if this was followed up or referred to another agency. She then moved into supported accommodation managed by Stonham Housing Association.

September 2003- October 2003

Miss G attended a class called the *Skilled Project* which helped participants to develop

numeracy and literacy skills. Miss G attended four sessions in the period. Again Miss G is said to have engaged well with the training. She was said to be intelligent, articulate and achieved qualifications.

June 2004 to July 2006

During this period there were nine contacts with Miss G. The contact within this period is said to have been ad hoc and intermittent in nature. There was no formal involvement at this time that led to records being taken as Miss G needed only support from the M25 workers that she knew when other agencies were not available. It was noted that Miss G was not felt to need an advocate. There were no issues identified of a crisis nature that would have required greater or more prolonged intervention. There were no expressions of aggression or violence that workers witnessed and there were no extremes in her mental health that would have initiated a referral.

December 2011 to February 2012

On 19<sup>th</sup> December 2011 a referral was received from the St Leger Homes Housing Management Service. The referral stated that Miss G felt depressed, suicidal and that this related to the area in which she lived. Miss G stated that she wished to be moved from the property and had recently applied for re-housing. Miss G was said to be in contact with her GP and that the referrer was going to make a referral to the single point of access for mental health and psychological therapy. The referrer was also examining a referral to the Housing Assessment Panel. The referral stated that Miss G required emotional support as she felt depressed and isolated. The referral was passed to a M25 worker on 9<sup>th</sup> January 2012. The worker stated that two or three attempts were made to contact Miss G by phone. These proved unsuccessful. The worker wrote to Miss G on 20<sup>th</sup> January 2012 offering an appointment. The worker received no contact from Miss G before the visit but despite this on 27<sup>th</sup> January two workers visited Miss G at her home to undertake an assessment. The workers undertaking the assessment have stated that Miss G was calm, quiet and appeared intelligent. The property was sparsely furnished but clean. During the assessment Miss G was very 'matter of fact', there were no extremes in her behaviour.

The assessment elicited the following information:

- Miss G stated she had lived in the property for approximately 10 years and had no rent arrears on the property and no other issues that would lead to eviction. She had no other debts.
- She stated she had been homeless following leaving care and had lived with foster parents from 9 years -15 years of age following her mother's death and that it had not been possible for her to live with her father. Miss G stated she had been

- neglected by her father and sexually abused by a family member.
- She informed them that she had been cautioned by the Police two months prior to the assessment for carrying a bladed weapon.
  - Miss G also stated that she had previously physically attacked friends and family as 'she has a short fuse and anger issues'. Miss G stated that although she hadn't attacked anyone recently, she was likely to do it again at some point.
  - Miss G stated she was registered with a GP. Also that she had received, what was described, as Disability Living Allowance in relation to her psychosis for approximately nine years. She stated that her last involvement with the Mental Health team was two weeks prior to assessment when she asked them to 'lock her up'. Miss G informed the workers that she is a danger to other human beings and one day 'will blow up'. She had been sectioned four times and last hospitalised in December 2011.
  - Miss G stated she had attempted suicide 10 times (hanging, overdoses, bag on head, stepping out in front of cars) and often thinks of hurting herself- slashing. In terms of substance misuse she was a regular cannabis user and sometimes also used amphetamines.
  - In relation to education and training she did not want to consider this due to her mental health.
  - Miss G stated she has no family, partner or children and has some friends she sees occasionally. Miss G only leaves the property if absolutely necessary and does not want to be involved in the community.
  - In conclusion, the assessment stated that Miss G has clear mental health issues that need addressing via her GP. Miss G desperately wants to move away from the area and would need assistance with exchange.

Following the assessment the two workers met with management to discuss Miss G. They recommended that dual visits should take place if her case was accepted. However it was decided that Miss G was not eligible for M25 service. This decision was based on the fact that she was not at risk of homelessness, she had been in the tenancy for 10 years there were no rent arrears, the appropriate benefits were in place 'housing related' and there was no risk to her tenancy. The conclusion was that her needs were not 'housing related' but health related.

On discussing the case and considering the risk information it was determined that there were no direct threats made by Miss G to either immediately harm herself or another person.

## **Analysis of Involvement**

Reviewing Miss G's time at her first accommodation the aim of the service was to work with Miss G as she was homeless at the point of presentation and through key-working assist her to move to a point where she could move to more independent accommodation. As stated earlier there are indications of a disclosure being made by another client about Miss G being abused by a member of her family. It is not possible to determine if any action was taken as a result of this. M25 now have in place procedures to ensure that disclosures of abuse are handled effectively and referred to required agencies. Miss G moved on positively from M25 accommodation to accommodation with support provided by Housing Association appropriate to her needs. The fact that the information regarding this period is based on worker interview means that the detail of the work undertaken with Miss G is not available.

During the period 2004 to 2006 M25's involvement with Miss G was intermittent and ad hoc in nature. She was at the time also being supported by St. Leger Homes. As Miss G was known to M25 workers they continued to maintain contact and have interest in Miss G's progress after she had left M25 accommodation. The worker involved at the time stated they stepped in when other support agencies were not available, and that nothing in the period 'triggered' the need to increase the involvement with Miss G. These intermittent short term contacts are said to create difficulties as knowledge of clients' risks and needs are limited and records of contact are not usually completed.

The next period relates to the significant contact that the service had with Miss G on 27<sup>th</sup> January 2012 when an assessment for service involvement took place after a referral from St Leger Homes. The initial referral occurred on 19<sup>th</sup> December 2011 and it took five weeks before Miss G was assessed for the service. The length of time taken from receiving the referral to allocation was longer than the organisation's recommended time scales.

More information could have been elicited from the referring agency to see if at referral stage Miss G was going to be eligible for M25 service as it would appear to have been outside the remit of the tenancy support service. A management decision was made to allocate the case for assessment for service. The workers made a number of attempts to contact Miss G and to visit her home. Even though no contact had been made with the client prior to the visit two Tenancy Support workers attended to undertake the assessment which is usual practice when the assessment is occurring in a client's home and there is no up to date risk assessment. The assessment was carried out using the correct needs and risk assessment paperwork. Miss G gave consent and signed the assessment. The assessment

elicited information from Miss G regarding her situation. This assessment identified information that was concerning both to the safety of Miss G and others.

On the day of the assessment, the workers discussed the case and a management decision was made that Miss G was not eligible for M25 services. In relation to the eligibility criteria for the service this is a justifiable decision in that she was not at risk of homelessness. They also discussed the risk issues raised in the assessment. It was determined that there were no direct threats made by Miss G to either immediately harm herself or another person that would necessitate disclosure of the information to another agency. It is difficult to determine on what basis this assessment was made and if the risk assessment that was completed is fit for purpose. The results of M25s contact with Miss G should have been shared with the services that had ongoing professional care of her where a more effective risk assessment based from more detailed knowledge of her case would have been possible.

The statements made by Miss G were not specific or time bound, however mental health issues and problems of aggression were identified in the assessment. Even though as an organisation M25 determined that Miss G did not meet the criteria for their services, discussions should have taken place with other services that were providing services for Miss G. M25 were aware that Miss G had contact with Mental Health Services. This information should also have been provided to St Leger Homes.

M25 had not notified either Miss G or St Leger Homes of their decision not to accept her as a client prior to the incident on the 14<sup>th</sup> February 2012 which was outside the organisation's agreed time scales. M25 are reviewing their guidance on initial action planning from assessment emphasising the action required when a case does not meet the criteria for M25 services. M25 should additionally review the risk assessment tools and process that is in place to ensure its fitness for purpose.

## **Conclusions**

The service provided in relation to the first period of contact with Miss G is said to have been effective and appropriate. In relation to the intermittent contact (2003-2006) M25 had with Miss G there were no records kept. M25 need to develop a policy and process for dealing with intermittent contact with clients to ensure that services provided are appropriate to the needs of clients and can be effectively evaluated.

In relation to the assessment in 2012, the workers undertook an assessment and a discussion subsequently took place during which a risk assessment was made. From that discussion a decision was made not to provide Miss G with a service and not to disclose the information on the assessment with other organisations in terms of risk

to herself or others. This could have had consequences not only for Miss G but for others who had contact with her. M25 need to be clear about what information should be disclosed and in what circumstances. It is a difficult balance to maintain client confidentiality and at the same time client and public safety but this is usually achieved more effectively in complex cases like Miss G by multi-agency risk assessment.

#### **2.4.5 NHS DONCASTER– GENERAL PRACTICE**

##### **Summary of Involvement of NHS Doncaster GP**

The IMR author notes that Miss G's parents frequently sought the advice of the GP during the early years of her life. By the age of 10 Miss G and her parents had made 80 contacts with a pattern of attending with respiratory issues and minor ailments. Of particular note are the following consultations or communication with the GP:

##### **1985 to 2002**

- Miss G was referred to a paediatrician by the GP in August 1987. Miss G was two years and six months old and her parents were concerned that she was hyperactive and had behavioural issues. Whilst initially the referral was investigated in relation to food sensitivity there were issues raised that it could be parental management. At the age of three years and three months, the paediatrician referred Miss G to Child Psychiatry with her father's approval. She was described by her parents as violent and having aggressive outbursts and a resistance to discipline. Whilst appointments to attend Child Psychiatry were offered they were declined due to Miss G's mother being away and by her father who felt it not to be the right time. The referral was kept open and closed a year later in July 1989.
- As is identified in more detail in the CSC analysis on the 28<sup>th</sup> October 1993 the GP made a child protection referral to Children's Social Care. The specifics of this are not documented within the GP records and there is not a filed copy of the referral. There is further detail about this in the section on Children's Social Care.
- In July 1995 the medical notes indicate that Miss G's mother had died 2 weeks earlier.
- In February 1996, there is a record of Miss G being referred by the health visitor for an assessment by Children's Mental Health Services.
- In March 1996, November 1997 and January 1998 there is information provided by CSC to the GP about Miss G being placed in temporary fostering and a change in legal status.
- Between February 1997 and February 2001 there are no attendances or notes in the GP record other than five letters that were sent to the practice which include

assessments within social services teams following internal referrals. This period pre dates the electronic record.

## **2002 to 2010**

- In February 2002 Miss G, aged 17, attended the GP practice because of her mood and possible depression. Although this is not documented in the GP records, this meeting appears to have generated a referral to RDaSH as there is an initial assessment letter from a Community Psychiatric Nurse (CPN) within the notes 2 weeks after this date. Throughout 2002, Miss G attended the GP on several occasions. These were all related to her mental health in part and from the GP records, it appears that her mental health issues and support needs appeared to be escalating. There was frequent communication from mental health services and also Doncaster and Bassetlaw Foundation Trust (DBFT) Accident and Emergency department when Miss G attended after self harm. Substance misuse also appears within the GP record as an issue mainly in assessments done by secondary care services.
- From 2003 onwards, Miss G had little direct contact with the GP practice according to the notes. She was referred for termination of pregnancy to British Pregnancy Advisory Service on 2 occasions in 2003 and 2004. There are however numerous letters within the notes from secondary care services both psychiatric and DBFT Accident and Emergency department attendances.
- Between 2008 and September 2011, there is less evidence within the GP records of engagement in services, there are no letters from mental health services or support organisations.

## **2011 to 2012**

- In September 2011 Miss G was seen in the GP surgery with what the GP assessed as a worsening of her mental health symptoms. She presented with thoughts of impending death and was referred to Improving Access to Psychological Therapies services; she was seen once though subsequently discharged due to lack of contact. She was provided with information to access services and this appears to have triggered her re-engagement with Mental Health Services.
- In October 2011 the GP practice was informed that Miss G was assessed in London and detained under Section 2 of the Mental Health Act and transferred back to Doncaster. Summaries of these assessments are in the GP record. Also prior to the detention, the GP provided information to the housing section in London in relation to their attempts to find her accommodation. She was said to have travelled to London as she was fearful to stay in Doncaster. The GP was informed that Miss G was transferred back to Doncaster and her admission made informal, she was discharged three days after arriving back in Doncaster to the Crisis

Resolution Team and referred to agencies for the homeless. Following this period of admission she was not seen in primary care but attended DBFT Accident and Emergency services on a number of occasions with overdoses of Paracetamol and Benzodiazepines. Both of these episodes resulted in brief admission to Doncaster Royal Infirmary (DRI).

- On 6<sup>th</sup> January 2012 Miss G had a telephone consultation with the GP and was referred and seen the same day by the Access Team following a four day period of feeling unwell and perceiving the need for antipsychotics. She was seen by the Access Team and Crisis Team and Communities Therapies Team up to 30<sup>th</sup> January 2012 when the GP was notified that she was under the care of the Communities Therapy Team and had one week respite in The Haven. She was noted not to be psychotic and made good improvement. She was referred to Rethink, and remained under the Community Therapies Team.

### **Analysis of Involvement**

The General Practitioner service is a universal service that provides primary medical care to families twenty-four hours a day both at the local practice where a family is registered and through the Out of Hours service. It provides holistic medical care (to include physical and psychological health care) for families from birth to death. The early contact the GP had with Miss G when she was a child reflects that families with young children generate increased demands for general practitioner services as they attend GP practices more frequently. The psychological state of the mother has been shown to have an impact and to be linked to the childhood consultation rate.

As with other agencies analysis of documentation regarding the GP's contact with Miss G is influenced by the standard of record keeping but there is a level of consistency across IMRs to indicate confidence in the material provided.

It is important when making comment on standards of practice the reviewer recognises the impact of hindsight and present practice on making judgements about past practice. Using the Bolam test it is likely that during the early period reviewed the local infrastructure, training and professional knowledge related to the impact of neglect of children and impact on their mental health was not as developed and that some GPs would have responded in the same way but many would not have made the referrals made by this GP. An effective assessment was made and Miss G was referred to appropriate agencies.

The general practice involvement in the care of Miss G was what would have been anticipated. The GP made a referral to CSC when there was concern about the neglect of Miss G. When she was said by her parents to have behaviour problems from a young age she was referred into appropriate services on a number of occasions.

Initially at age two, although her family did not take up the offer of assessment at age four.

There is little evidence in the GP records of team working between the health visitor and the GP which would have improved continuity of care and may have resulted in a more consistent approach to multi-agency working. The care received by Miss G from primary care is assessed to be of an acceptable standard and not different from that experienced by similar patients in these circumstances.

Miss G was involved with a significant number of mental health agencies throughout her teenage life and the general practice made referrals to agencies for help initially in 2002 and more recently in September 2011. The more significant episode of mental illness began in October 2011 and resulted in an appropriate referral to the access team and same day assessment.

The practice was aware of the appropriate pathways for referral into mental health services and applied them to Miss G. The practice considered their involvement in the care of her to be peripheral; she was principally cared for by mental health services frequently being treated for self harming behaviour. Though recorded in the records in the form of contact summaries there is no evidence that the practice acted on these reports by following up Miss G on discharge.

Whilst not unusual in such cases there was potential for the GP to influence the provision of care for Miss G because GPs are frequently the crucible for information and are able to identify patterns and causative factors from childhood. General practitioners and other primary care professionals frequently identify, treat and refer people who have severe mental health problems. Physical, emotional and psychological symptoms are intertwined. Primary care teams can play a key role in helping to prevent and limit mental health problems in children and adolescents. Health visitors, general practitioners and other members of the team are in a prime position to observe the dynamics in vulnerable households and offer interventions when coping thresholds are reached. Generalists potentially see people along their whole life cycle and so can provide continuity with the transition to adulthood.

Miss G attended health services frequently and was under the care of a variety of mental health agencies. No single agency 'owned' her care and frequent movements between agencies resulted in a degree of fragmentation of care. The GP could have played a more significant role in ensuring more coordination of her care, and establishing a single point of contact to liaise between agencies involved.

Following discharge from the ward on 10<sup>th</sup> October 2011 the practice received the summary of this episode of care. The practice considered Miss G would continue to be

under the care of mental health services and did not attempt to follow up her hospital admission. This is in line with common practice which needs to be reviewed.

The GP practice has no policy for routine follow-up of hospital discharge. This would not be unusual in primary care and commonly such follow-up is assessed on a case by case basis, by the general practitioner. The practice received and recorded contacts with other agencies though did not act further on them, this would be common practice. Primary care could have taken a more active part in the management of the care of Miss G.

#### **2.4.6 ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST**

##### **Community Health Services**

It is difficult to analyse the involvement of universal community health services at the time of Miss G's birth and the first five years of her life as the records for this period have been destroyed in line with normal practice. Whilst normally the health visiting service would have ended when Miss G reached the age of five there is evidence to suggest in Doncaster Children's Social Care records that there was Health Visitor (HV) involvement with Miss G after this age as the health visitor supported her to lose weight and also after the death of her mother. The GP IMR also identifies that the HV made referrals to Childhood Adolescent Mental Health Services (CAMHS) and had contact with CSC. As Miss G was home educated her care did not transfer to the school health service until she started school at the age of 10 years and therefore from the age of 5 to 10 she would not have had contact with the school nurse.

Analysing the CSC records has provided some insight into the involvement of community health services and areas of communication and joint working.

#### **2.4.7 DONCASTER AND BASSETLAW NHS FOUNDATION TRUST**

This part of the report contains reference to her repeated attendance at the Accident and Emergency Department and subsequent referrals to RDaSH Mental Health Services. To avoid repetition, detail of Miss G's contact with the mental health services by referral via A and E has been included in the mental health overview section.

##### **Summary of Involvement 1985- 1991**

The focus for this section as with other parts of the report is specifically on use of the service by Miss G which is significant to the review. The involvement with the family included:

- As identified in the GP section Miss G was referred by her GP to a Paediatrician at the age of two years in December 1987 with concerns about behavioural issues. The GP requested an assessment of Miss G to establish whether Miss G was hyperactive or whether her behaviours related to parental control. Miss G was seen in February 1988 in the paediatric clinic. Her parents highlighted their concern regarding her aggressive behaviour. It is recorded within the health record that the parents reported Miss G displayed attention seeking behaviour. The family were asked to keep a food diary in order to identify food sensitivities and a further review was arranged for four weeks in order to complete a drugs challenge kit. The Paediatrician wrote to the GP, indicating that Miss G's behaviour had been normal within the clinic and he questioned the relationship between mother and child.
- The next contact with the Paediatrician involved a letter from the Department of Social Security (DHSS) in August 1988. The letter indicated that a claim had been made in respect of Miss G and requested information regarding diagnosis, treatment, behaviour and care. In response to the request, the Paediatrician indicated that based on his single acquaintance, he did not think her behaviour was outside the normal range.
- Following the response to the DHSS enquiry Miss G's mother requested a further opportunity to discuss her behaviour and her second review occurred in October 1988. The record indicates the parents did not complete the food diary and drugs challenge kit. The parents indicated that Miss G reacted violently to the first few capsules of the drugs challenge kit. Whilst the Paediatrician indicated his impression was that her behaviours were associated with parental management, he did agree to and completed a referral to a child psychiatrist.

The Trust did not provide services to Miss G between the period 1991 and 2002.

### **Summary of Involvement from 2002 - 2010**

During 2002, Miss G accessed A and E within the Trust on eight occasions. They included:

- The first contact with the Trust related to an Accident and Emergency (A and E) attendance in March 2002 via ambulance. The records indicate Miss G was intoxicated, that she had been drinking vodka at a friend's house and that she had experienced recent trouble with her boyfriend. At this time, she was aged 16 years and 8 months. She informed staff that both her parents were dead and that she lived in sheltered housing. Her brother was present. She was vomiting but it is recorded that she was alert and aware; therefore she was encouraged to take

fluids. Her boyfriend arrived at A and E and indicated he was willing to observe her overnight and she was discharged home to his care.

- Miss G next attended A and E three weeks later and again in May and July 2002. All of these incidents were associated with requesting or needing a psychiatric review as a result of self harming or threatening to self harm.
- In July 2002 Miss G attended A and E with a history of abdominal pain and vomiting blood, with one episode of melaena (blood in stools). The records indicate this attendance led to an admission overnight for medical investigations, intravenous fluids and treatment. She remained stable overnight and was discharged home the following day. The medical history includes reference to her history of depression, self harm and her social circumstances.
- Two weeks after this Miss G presented to A and E requesting a psychiatric review.
- Miss G then attended A and E in October 2002 and December 2002 with a history of overdose and poisoning and it is recorded that she was very distressed
- There were four contacts with the Trust during 2003. The first contact was an A and E attendance in January 2003. Miss G attended by Ambulance and informed triage she had a history of depression. However, she left the department without being seen.
- In June 2003 Miss G attended A and E via private transport having experienced vomiting and lower abdominal pain for four days. She informed staff she was possibly nine weeks pregnant. Additionally, the record states she was very emotional and frightened, she was unhappy about the pregnancy. She said the father was not supportive or interested and she had arranged a termination. The record references self harm marks to her arms, her previous history of self harm and the fact she was taking anti depressant and anti psychotic medications. She was referred to a Gynaecologist. The review determined she could be discharged home. However, on the following day Miss G returned to A and E via ambulance. She indicated her abdominal pain had increased and she was unable to keep her food down. A and E staff discussed Miss G with Gynaecology who advised an anti-emetic should be prescribed to reduce vomiting. A and E records also indicated that the Gynaecologist stated if Miss G did not improve she should be admitted for care. Her records indicate she did return later that day and was admitted to the gynaecology ward because she was dehydrated and she was vomiting. The records highlight that Miss G stayed in hospital for three days. Her symptoms were managed conservatively and improved. However, whilst in hospital her distress regarding the termination of pregnancy planned for June 2003, her feelings about this and the fact she had stopped taking her medication were established. It is recorded that Miss G stated she was hearing voices telling her she was horrible and because of this she felt like self-harming. She informed ward staff she felt safer in hospital and was concerned about coping at home and also that she had stopped taking medication as she had run out and she did not believe it was helping. As a result, there was a further psychiatric referral and

review. The review indicated she did not have suicidal intentions or delusions, her medication was reviewed and there was also a plan for a Community Psychiatric Nurse to make contact with her following her discharge home. However, the day after her discharge a further gynaecology review occurred and Miss G was re-admitted for observation due to severe vomiting. Miss G believed her medication had caused the vomiting. Her symptoms settled and she was discharged home later that day.

- During the period, 2004 - 2005 Miss G attended A and E twice. In January 2004 with abdominal pain and vomiting. The examining Doctor recorded that the examination findings were “highly suspect” and was of the opinion she had non specific abdominal pain. However, she was admitted to the surgical ward and records indicate vomiting persisted. The following day, whilst still in hospital Miss G requested to speak to “someone to talk about what was going on in her head”. A psychiatric referral was made and it was determined she could be discharged home. On 21<sup>st</sup> January 2004, hospital staff contacted Miss G by telephone to inform her that a pregnancy test that she had previously taken was positive. Miss G advised her GP on 9<sup>th</sup> February that she did not want to continue with the pregnancy. The GP wrote a letter to the BPAS to request an appointment for a termination of pregnancy.
- She attended A and E again in September 2005 related to a concern regarding her physical health and appropriate advice was offered.
- In July 2006 Miss G attended A and E informing staff she had felt unwell for over a week, with vomiting and pain in the central chest to the epigastric area for one day. She informed staff she had not eaten for one week as she had no money. She was found to be dehydrated with severe gastritis secondary to not eating, therefore she was admitted to the medical assessment unit. She was given medical treatment and dietary advice. She was also referred for a psychiatric review.
- Miss G attended A and E again in December 2006 she again had abdominal discomfort and vomiting and had not eaten for 3-4 days. She also indicated she lived alone. Following a medical examination medication was prescribed. Miss G requested a review from the Crisis Resolution Service and this occurred. The documentation from the Crisis Resolution Service indicates she was under the care of Consultant Psychiatrist with a diagnosis of borderline personality disorder. She had been seen during December 2006 and her next appointment was for June 2007. She denied having taken an overdose or self harming in any way and it is recorded that she had expressed no suicidal thoughts or delusional ideas. She informed the psychiatric liaison service she had no active substance misuse for 2 years and the records state there was no evidence of depressive mood. She described problems relating to her lack of budgeting skills. The plan was for a referral back to her GP to enable community mental health team input. She was advised to attend Citizen’s Advice Bureau regarding budgeting skills and

Doncaster's Women's Centre. The psychiatric liaison staff member said she could be discharged when medically fit.

The Trust did not provide input to Miss G during the period 2007-2010.

### **Summary of Involvement 2011 - 2012**

- In July 2011 Miss G attended A and E requesting help from the Mental Health Service Team and having taken an overdose. In November 2011 Miss G attended A and E twice following an overdose.
- In January 2012, Miss G attended A and E requesting to see the Crisis Team. The next day, 7<sup>th</sup> January 2012 was the final contact she had with the Trust. She informed triage staff that she was not well and that she was going to harm either herself or someone else and she stated she was "criminally insane".

### **Analysis of Involvement**

Doncaster & Bassetlaw NHS Foundation Trust (DBFT) had significant input in the care of Miss G from her childhood to adulthood relating to childhood illness, behavioural problems, pregnancy, self-harm, social and mental health related issues. It is notable from the chronology that she accessed the Trust frequently during some periods, for example during 2002 but there were periods when significant time elapsed between episodes of service provision.

The first period of involvement during 1987 was when Miss G was two years old. The paediatrician assessing her behavioural difficulties questioned parent / child attachment between Miss G and her mother and parenting techniques. As the family did not continue to engage with the Trust, and therefore contact was limited, the referral did not create any safeguarding or child protection concerns. The family were not known to Children's Social Care at this time. The records show that practice and attempts to secure engagement with the family were in line with organisational expectation at the time. From the response to the DSS request the paediatrician indicated that he did not think Miss G's behaviour was outside the normal range. There are significant developmental issues in the transition to toddlerhood which include increased mobility, growing self-awareness, and the onset of language. These three developments lead to a toddler becoming more independent. These changes can be characterised by toddlers being negative about most things and often saying 'no', having frequent mood changes and temper tantrums.

However the paediatrician made a referral to the child psychologist within CAMHS. There is clear evidence from documentation within the health record, that the Clinical

Psychologist involved at the time made efforts to secure the family's engagement with the service and of appropriate communication with the GP. At the time of this input, families were usually offered two hospital outpatients appointments, followed by discharge if they did not attend. Children's services, as a result of the findings of serious case reviews, are now far more aware of the significance of and increased risk of children not attending appointments. In 2010 the Trust developed the current Guidance for Clinical Decision Making when Children do not attend Hospital appointments - Referral to Treatment Access Policy (incorporating the Guidance for Decision Making when a Child Does Not Attend a Hospital Appointment). This guidance requires practitioners to consider whether the non attendance will impact upon the child's health needs, whether the non attendance or other issues relate to safeguarding and protecting the child and whether appropriate communication with other disciplines or agencies is required to promote engagement.

The chronology of DBFT input clearly indicates that Miss G was a very troubled young woman and adult. The incidents she presented with were progressively more serious. She disclosed to Trust staff that she had periods when she struggled to come to terms with her abusive childhood and the loss of her parents. She was 16 years old in 2002 when she first presented at A and E. The mental health worker contacted social care about her in May 2002 when Miss G made her third visit to A and E and there was concern about her mental health. Miss G left Looked After Care on the same date, 28<sup>th</sup> May 2002. She highlighted she needed assistance with housing, the records indicate that the mental health worker referred her to housing for assistance.

During 2002, Miss G was a frequent attendee at the DBFTs A and E department and acute hospital services. The eight incidents were as a result of self-harm, alcohol misuse, mental health issues and a lack of self care. Each of these episodes were treated in isolation which would have been organisational practice at that time. A and E records do not provide evidence that the pattern of contact was discussed with psychiatric services or of any discussions to establish plans to address Miss G's care needs. The IMR author indicates that during subsequent years as can be identified in Miss G's chronology, patients attend the department when they experience mental health problems as they are aware they can access mental health crisis services within the department. As a result of departmental access to psychiatric liaison services which is now situated within the department 24 hours per day there is a partnership approach which considers the issue of frequent attendance and liaison regarding individuals is more likely to take place than in 2002.

On the occasions during the review period that Miss G attended A and E with incidents of self-harm and when she indicated she was experiencing mental health problems, staff consistently made referrals to the Mental Health Team for assessment. Whilst there was no specific NICE guidance during the earlier period of this review, to

manage people that self-harmed, this was expected practice and is in line with current guidance (NICE Guideline No 16- 2004). This guidance states that “all people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment” (NICE Guideline No 16-2004-page 5). This review also identifies that staff involved with Miss G whilst she received care within Gynaecology as an inpatient in June 2003, surgery as an inpatient commencing January 2004 and the Medical Assessment ward commencing July 2006 listened to her requests for support with her mental health problems and responded accordingly and in line with organisational expectations at the time. Referrals to the mental health team were appropriate and timely.

On two occasions during 2002, following incidents of self-harm, Miss G left the A and E department without treatment and psychiatric review. At the time staff did not have specific guidance for practice when people self-harm but it is notable that in July 2002 when Miss G presented at A and E with superficial lacerations, staff appeared to have considered risk when she refused to wait for a mental health assessment, in that they established that she did have an appointment with Mental Health Services two days later. In October 2002 when Miss G left the department following an overdose and poisoning incident, staff contacted M25 in order to ask her to return to the department for physical care and when she refused they informed M25 staff of symptoms that may present and would require further emergency treatment. An adverse incident form was completed in the A and E department. This is also required practice because people who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept a psychosocial assessment or treatment (NICE Guideline No 16-2004 page 5).

In January 2003 Miss G presented at A and E with depression but she did not indicate she had self-harmed and she did not wait for treatment. As all attendances at A and E are communicated to GPs, this information would have been communicated to the GP. However, as the psychiatric liaison team are now situated with the department it would be routine for a referral to be made to them. The current NICE Guideline (2004-no 16-page 10), indicates that in an emergency situation, when a person self-harms and refuses treatment staff should now assess if the person has mental capacity and the presence of mental illness. Where a person does not have mental capacity, staff have a responsibility under common law to act in that person’s best interests and this can include detaining a person to allow assessment and treatment against their wishes. In line with practice at that time, assessment of mental capacity is not specifically documented within Miss G's record. However, it is known from the records that she self-harmed and she experienced mental health problems and depression but the records do not indicate other symptoms of mental illness, such as delusions and

hallucinations that would suggest psychosis and a more urgent need for a mental health assessment at the times when she refused treatment.

Information relating to Miss G's concern about being a risk to others was not known to the DBFT until she presented at A and E in January 2012. She informed triage staff that she was not well and that she was going to harm either herself or someone else and she stated she was criminally insane. This was the first and only time she disclosed to DBFT staff the intention to harm others although she had indicated in July 2002 that she was hearing voices telling her to kill herself and other people. This issue was appropriately referred to the mental health liaison service to enable a risk assessment. Records indicate Miss G did not have a history of violence and she had voiced no plans to harm anyone during the mental health assessment. The record indicates the plan was to admit her to crisis accommodation for increased support and further assessment.

This review demonstrates that medical assessments undertaken by the DBFT in relation to Miss G were appropriate, they related to her physical and mental wellbeing and included appropriate referrals to mental health services as required when she accessed hospital care. This occurred within the A and E department and when she accessed inpatient care within Gynaecology, the surgical ward and the Medical Assessment Unit and is in line with organisational expectations and current NICE guidelines. The health records clearly indicate the reasons for the referrals for mental health assessments throughout the review period and as previously discussed, on the occasions that Miss G left the hospital without treatment and assessment, the risk was assessed and reported appropriately and actions were taken to address potential adverse outcomes. The DBFT has policies for dealing with adverse and serious incidents (CORP/RISK 15; CORP/RISK 13), additionally the organisation contributes to the local Multi-Agency Public Protection Association and has a responsibility to share information when it is known that a person poses a risk to others.

The DBFT has a Mental Capacity Act 2005 policy and all DBFT staff are informed during single agency Safeguarding Adults training at all levels regarding the use of this policy. It is acknowledged, that the DBFT has not achieved 100% compliance with Safeguarding Adults training, this is a recognised risk and has been incorporated into the DBFTs Safeguarding work plan. This is monitored by the DBFTs Safeguarding Operational Group and progress is reported to the DBFTs Strategic Safeguarding Board. The DBFT employed a Safeguarding trainer during 2011 in order to increase the Safeguarding team's capacity to deliver training and to achieve compliance with contractual obligation regarding Safeguarding Adults training. This has led to a significant increase in the number of staff receiving training since her appointment.

It is noted, that following the incident leading to Miss G's arrest and a request for the DBFT to secure health records, it became apparent that the records were missing relating to one of Miss G's attendances at A and E in January 2012. This was treated as a risk within the DBFT and escalated appropriately within A and E and the records management team. It is known from the DBFT's computer system, that Miss G saw a GP within the department and that she requested support and was referred to Mental Health Services. However, any other details of information given to DBFT staff relating to this attendance is not available. The records were not recovered but following this incident the A and E department have implemented a Patient Record Check form, which is used at the time of filing batches of records. This process enables early identification of missing records, early searches and early reporting and increases the potential to recover records. Therefore, actions taken aim to minimise the risk and no further action will be suggested.

To analyse this period of contact with the DBFT comparison of practice has been made against three key guidelines:

- National Institute for Health and Clinical Excellence (NICE), Clinical Guideline 16, 2004 "Self-harm: The short-term physical and psychological management and second prevention of self-harm in primary and secondary care" in order to inform analysis. There are examples within the health records where this is apparent and it is clear that on three occasions Miss G informed A and E staff that she self-harmed not because she intended to end her life but to access help for social and mental health issues. The records demonstrate that her distress was acknowledged and whilst the guidance indicates that self-harm is poorly understood by many NHS staff it does appear from this review that staff within the DBFT generally responded appropriately and fulfilled treatment expectations with regard to her care whether it related to physical treatment, her requests for mental health service input or to acts of self-harm
- NICE Guideline number 78 2009 "Borderline personality disorder: Treatment and management" was consulted in order to determine an understanding of Miss G's condition and DBFT practice standards. However, it is also noted that significant DBFT input occurred before the production of these guidelines. Many of these features are apparent within the DBFT's knowledge of Miss G's life experiences.
- "Better Services for People who Self-harm Project" 2006, which indicate that service users say that being shown respect and warmth, acknowledging their distress, offering explanations and requesting consent regarding treatment choices and passing information on to other professionals involved is found helpful. With respect to DBFT input relating to Miss G across the whole time span of review period, records identify several occasions where expected practice was evident, her emotional distress was acknowledged and acted upon, staff responded to requests for mental health support and when she accessed care for

physical illness, the support she was offered included consideration of social, psychological and physical factors.

Arrangements for staff training relating to people who present with mental health problems and self-harm is provided as part of staff induction and all new staff spend time with the Mental Health Liaison team and with senior staff in the department to discuss these issues in order to build knowledge. Additionally, an action from a previous Safeguarding Children Individual Management Review during 2010 included a training plan relating to children that present to A and E following acts of self-harm and relevant NICE Guidelines.

Inexperienced staff working within A and E, that come into contact with patients experiencing mental health problems receive support from senior staff during their induction period. However, during the review period, DBFT also appointed a Lead Professional for Safeguarding Adults and adhoc supervision is available to all staff working within Adult Services when support is required relating to vulnerable adults and safeguarding issues. This has been communicated to the individual Clinical Service Units within DBFT via the Safeguarding Operational Group representatives, the Safeguarding Annual Brief 2012 and during Safeguarding Adults training.

## **Conclusions**

This review has demonstrated good inter-agency communication, information sharing and working with respect to Miss G's mental health needs. Miss G specifically requested referrals to the Mental Health Liaison Services and she consented to information sharing, which from the health records appeared to be appropriate and proportionate. This review has not identified situations that had an adverse effect upon inter-agency activity but it has identified that the integration of the mental health liaison service within A and E has improved this and enabled shorter waiting times for service users. There is an element that can be seen in the summary and analysis of involvement of services starting again with each individual contact with Miss G. Comments are made about not being clear about why she was self-harming when in earlier contacts she described her feelings and thoughts and attempts to make it clear to staff the cause of her behaviour. A new system is being established in A and E that should address this issue.

Whilst this review has demonstrated DBFT provided significant services to Miss G during the review period and held significant information regarding her social circumstances and mental health, the review has also confirmed that current practice regarding the management of patients who self-harm or access acute hospital services within DBFT is appropriate and in line with current NICE guidance. This review has demonstrated several areas of expected practice and it has not identified areas for

improvement regarding the way the service is provided, decision making or resource issues.

The positive findings of the review include the introduction and implementation of the Guidance for Decision making when Children do not attend hospital appointments, this promotes information sharing with relevant agencies and aims to ensure that children's health needs are met.

The records have clearly indicated that when accessing care during the review period, Miss G was recognised as a vulnerable adult and the practice described was patient focussed and in line with current NICE Guidelines (No 78 2004 and No 16 2009). The documentation within health records was of a good quality and did not require attention.

The prompt attention and response to Miss G's mental health needs within A and E, Gynaecology, the surgical ward and the Medical assessment unit demonstrate a patient focussed approach to care and the identification and response to risks.

The review has highlighted that the integration of the mental health liaison service within A and E improves access to the service and waiting times for service users, communication and learning opportunities for A and E staff.

Additionally, whilst the review has identified that improving staff training in Safeguarding Adults practice remains pertinent, DBFT has prioritised this, it has increased capacity for training delivery and to date has made significant progress in improving compliance.

#### **2.4.8 SOUTH YORKSHIRE POLICE**

##### **Summary of Involvement**

South Yorkshire police had limited involvement with Miss G. Contact with her related to three significant incidents which all occurred during 2011 and 2012. They include:

- On 23<sup>rd</sup> September 2011 at 02.37hrs, police received a call that a burglary was taking place at a town centre shop. As a result, officers were immediately dispatched to attend and whilst dealing with the burglary, they came across Miss G who was walking through the town centre. She was stopped and as a result of officers asking her if she was carrying any prohibited articles, she stated that she had a knife. She was therefore searched and found to be in possession of a kitchen knife. This was taken from her and she was dealt with by means of instant caution in accordance with national guidance.

- The next day on 24<sup>th</sup> September 2011 Belgravia Police rang South Yorkshire Police stating that Miss G had attended at the police station in London saying that she was 'on the run' from Doncaster. As a result, South Yorkshire staff made extensive checks on Miss G to rule out whether she was either wanted or missing or there were any other relevant significant issues. Any relevant information was passed on to Belgravia.
- On 24<sup>th</sup> October 2011 a friend of Miss G attended the police station to state that she believed Miss G had been burgled. She stated that a male had stolen her television and other items. This female felt that Miss G was too frightened to inform the police about what had occurred. She added that she believed Miss G had mental health issues and that this was also preventing her from reporting the matter to the police. As a result of this report, an officer was dispatched to attend at the home of Miss G later that same day. Miss G was adamant that she had not been burgled. She was upset with her friend for going to the police with this matter. No further police action was taken with regard to this incident.

### **Analysis of Involvement**

The police attendance at the minor incidents was at the appropriate level. Each report was dealt with in the correct manner and no supervision or management was required in any decision making process. This was appropriate due to their minor nature. All policies and procedure were correctly followed. During the limited contact that police had with Miss G, the individual contacting the police was listened to. There were no racial, cultural, linguistic or religious issues apparent in any of the reports. The liaison between South Yorkshire Police and the Metropolitan Police was positive and the appropriate information was shared. Officers that dealt with Miss G had both received Mental Capacity Act Training and were aware of the steps to take should they have had any concerns about her behaviour.

The one incident that provides evidence of Miss G carrying a knife on 23<sup>rd</sup> September 2011 was handled in line with the national police guidelines. She voluntarily disclosed to officers that she was in possession of a knife. She did not have any previous cautions or convictions, and it was therefore appropriate that she was dealt with by the administering and recording of a caution. There was absolutely no indication whatsoever that Miss G displayed any signs of behaviour that concerned the officer or would have indicated any mental health issues.

#### **2.4.9 YORKSHIRE AMBULANCE SERVICE**

Yorkshire Ambulance Service (YAS) records identify that all contacts with the subject of the review by the ambulance service resulted from 999 emergency calls.

## Summary of Involvement

The first group of incidents relate to the care of Miss G from 2002 - 2012

### Incident 1

A 999 emergency call was made to South Yorkshire Ambulance Service (SYAS) in December 2002 which stated that Miss G had taken an overdose of Citalopram and possibly other medication and that she was incoherent and mumbling. The caller also made reference to Miss G being mentally ill. During the course of the call a male caller took over the conversation as advice was given by YAS Emergency Operations Centre (EOC) staff how to best position Miss G in her current state until the ambulance arrived. YAS practitioners recall that there were two other people in the home address at the time, but their identities were never sought or recorded. YAS staff also do not recall if anyone travelled to the hospital with Miss G as an escort. She was described as quiet, distant and difficult to engage with by YAS practitioners during the incident. En route to hospital clinical observations were recorded and no further treatment was necessary by YAS practitioners apart from supportive measures and patient monitoring.

### Incident 2

A 999 emergency call was made to SYAS in June 2003. Miss G was reportedly unwell with worsening abdominal pains and had been vomiting blood, which had continued since the previous day. The male caller stated that Miss G (aged 17 years old) had attended the hospital the previous day and had been prescribed some medication prior to discharge. The caller stated that the abdominal pain was so severe that it was affecting her ability to walk and was causing her to cry. YAS EOC staff enquired if she suffered from haemophilia or was still vomiting. The caller stated that they did not think she suffered from haemophilia but was still vomiting blood and this had continued all night. YAS practitioners had very little recollection regarding this contact with Miss G despite using patient documents and information as prompts.

### Incident 3

A 999 emergency call was made to YAS in July 2006 for Miss G stating that she had not eaten for a week, was suffering from a rapid heartbeat and was advised to call 999 if a GP was not available. YAS despatched a Rapid Response Vehicle (RRV) to the incident along with a Double Person Ambulance (DPA). Miss G made a disclosure of a history of not eating or drinking for a week due to not having any money. Miss G stated that she had eaten her first meal the previous night and had begun to vomit this morning and had complained of feeling very weak. She also stated to the attending

YAS staff she had a previous history of post-traumatic stress disorder. She was said to have been very reserved, quiet and did not wish to communicate with the attending ambulance staff. YAS practitioners managed to obtain and document a name and telephone number of the next of kin for Miss G during this contact. Clinical observations were completed on Miss G and these were recorded as within normal parameters. The journey to hospital was described as routine with nothing remarkable to recall or record.

#### Incident 4

A 999 emergency call was made by Miss G to YAS in November 2011 she stated that she had taken an overdose with the intention of “taking her life”. On arrival at the incident Miss G was standing outside a phone box and disclosed to the YAS practitioners that she had taken 28 Citalopram tablets at approximately 05:00. During the ambulance journey she was described as comfortable and complained of feeling tired. Clinical observations were recorded and were within normal parameters. She disclosed a history of previous overdoses, deliberate self-harm and that she had not been taking her medication (Citalopram) before the overdose. She was said not to be very communicative and did not wish to discuss current problems or the reason behind the overdose.

#### Incident 5

A 999 emergency call was made to YAS in November 2011 for Miss G who had taken an overdose of 60 plus paracetamol as an overdose. Miss G was described as quiet, would only respond to questions when asked and was described as appearing to be under the influence of something. Clinical observations were recorded with consent. Miss G stated that she was not in pain and no further treatment was required by the attending ambulance staff. It is notable that she disclosed the use of cannabis during this incident to YAS practitioners. The IMR author could find no other mention of substance abuse or drug usage from the recordings of any of the 999 calls or when reviewing patient documents.

The final incident relates to Ms A and YAS involvement and is outside the terms of reference of the review.

### **Analysis of Involvement**

SYAS and YAS provided emergency assessment, treatment and transport to an Accident and Emergency Department for Miss G during each contact. The emphasis on dealing with 999 emergency calls is dictated by the requirement for a rapid telephone assessment, response and dispatch of appropriate resources. All calls were

triaged correctly which depended on the information supplied by the caller matched against the Advanced Medical Priority Despatch System (AMPDS). The assessment of what level of care is required, is determined at the time of the originating call. Callers do not always provide the correct, most important or truthful information to the call taker at the beginning of the call, therefore the priority of the call may change as the further information is provided.

As a provider of pre-hospital emergency care, ambulance services usually possess no historical information regarding the subjects of 999 emergency calls. Information disclosed at the time of a call is recorded, but only if the caller becomes a “frequent” caller or is threatening to the caller or attending crews, would YAS consider future planning and further risk assessments.

Often ambulance staff will have less than 10 minutes on scene to assess and transfer a patient into the ambulance, having to execute rapid decisions based on what they see and hear in a very limited time. Each incident attended for Miss G demonstrated compliant response times for categorisation of each call and conveyance to the nearest appropriate Emergency Department (ED). YAS practitioners were correct on each occasion to convey her to hospital for further assessment and treatment for the on-going mental health problems and needs.

Incidents 1 to 5 resulted in patients being dealt with by the attending practitioners only. It is apparent from documents and statements that Miss G was consistently difficult to communicate with, but this did not prompt any YAS practitioners to seek further help or support from senior managers. There is no evidence from either 999 calls or within YAS clinical documents that she was ever violent or aggressive towards YAS staff prompting escalation to senior managers via organisational reporting systems.

Assessments made by YAS staff during the five contacts with the subject of the review were dynamic, brief and reflective of service provision in pre-hospital emergency care.

During each incident Miss G was transported to hospital for further assessment and treatment for her respective conditions. YAS currently has mental health referral pathways in place for patients who call 999 and decline conveyance to hospital. However, these alternative care pathways were not available during the time period for incidents 1-4 for Miss G. It is not possible to ascertain if these pathways would have been used by YAS practitioners as an alternative to conveyance to the ED, however this should be considered within this report as the decision to convey her to hospital ensured that patient safety was maintained and other professionals were involved in the assessment and care of Miss G. YAS staff described the main influencing factor to convey Miss G to hospital on each occasion was the resistance to engage or

communicate with practitioners during the contact or provide anything other than basic information.

It is apparent from the review of the contacts with Miss G that ambulance staff were aware of the risks posed by the mental health status and the potential for deterioration unless further help was sought. The lack of background information for ambulance staff regarding individuals is a potential enhancement of risk and it is essential that information sharing systems and procedures are robust to address this within YAS and between partner agencies to safeguard vulnerable individuals, especially when not conveyed to hospital.

Contacts with Miss G resulted in clinical assessments and conveyance to hospital on each occasion. The IMR author identifies that there is no evidence to suggest that Miss G lacked capacity or withheld consent for treatment and was compliant with the option to attend the emergency department on each occasion. To have cared for Miss G at home may possibly have been detrimental to ensuring that an appropriate psychiatric assessment and/or treatment was completed by mental health professionals.

The previous and current versions of the YAS patient documents include data on ethnicity, substance misuse or any child or adult safeguarding issues. Patient documents for Miss G made numerous references to mental disabilities and vulnerabilities due to the emotional state of the patient.

YAS has numerous Information Sharing Agreements (ISA) in place across Yorkshire and surrounding borders to the Trust. Verbal information was shared during handover at the A and E department and is demonstrated via departmental signatures for hospital staff on YAS documents.

There is reference in 999 call logs that SYAS notified the police of the event during incident 1 that the ambulance service had received a call for a 17 year old who had taken an overdose. The author cannot find any reference to information being shared with other agencies during incidents 2-5 apart from the conversations completed during patient handover at the hospital.

The review emphasises the vulnerability of patients and service users who request help from the ambulance service via the 999 system.

YAS recognises the impact that mental illness may have on effective parenting and the safeguarding of vulnerable adults. YAS will benefit from a review of the contents of the organisations safeguarding training resources. This will ensure that vulnerable groups suffering from not just mental health illness, but also issues ranging from dementia,

learning disabilities and communication barriers are safeguarded. Ensuring this is sufficiently emphasised during single agency training events will assist YAS practitioners to reflect and utilise these events as a potential case study for the training.

## **Conclusions**

The service provided to Miss G was consistent with the demands placed on ambulance services and ambulance professionals in pre-hospital care settings. The lack of knowledge and background information regarding the subjects of the review dictates that information sharing systems and agreements must be robust especially when service users are not conveyed to hospital for assessment and treatment. The review highlighted that one practitioner in YAS had two contacts with Miss G, but did not recognise or realise this at the time. This was not detrimental to the treatment provided to Miss G, but is unusual in the pre-hospital setting unless the individual is a frequent user of the service.

The interface with patients during pre-hospital settings affords ambulance staff privileged access to information, households and events at unconventional and unexpected times. Other professionals and agencies should constantly challenge the ambulance service for this information.

The review of clinical documentation completed by YAS staff has not highlighted any issues for concern regarding clinical practice. The care and management of patients suffering a mental health crisis can be challenging for ambulance professionals especially if the patient is non-compliant with requests. It appears that the quality of practice during these events was consistent with expected standards.

## **2.4.10 OVERVIEW OF MENTAL HEALTH SERVICES**

**This section of the report focuses on mental health services that Miss G received from 2002 (aged 16 years) until 2012**

Services at RDaSH involved in Miss G's care were:

1. Access Team - The Access Team is staffed by Nurses, Doctors, Support Workers, Social Workers and others who work with patients to prevent hospital admission, for those who experience relapse. They also assess new patients who may be depressed and have suicidal feelings, and offer home treatment when clinically indicated.
2. Home Treatment Service - The home treatment service provided by the Access Team provides short-term help for patients who have a mental health crisis. This is as an alternative to treatment in hospital. Staff usually provide this service to patients in their own homes, but if patients wish they can ask to be seen elsewhere, perhaps at a family member's home. They may also offer a short stay in a crisis bed, which can provide 24 hour support during the early days of a crisis. If required, a doctor will usually see patients within 48 hours of the start of any home treatment episode. This is to discuss medical needs, and to assess any medication requirements. In addition, the team may offer help in dealing with feelings and support with any practical problems that are part of the crisis. Most people will be visited once a day in the early stages of treatment. As things start to improve they will be seen less often.
3. Community Therapies Team – This team provides interventions for service users with mild to moderate anxiety and depression. The team consists of Community Psychiatric Nurses, Social Workers, Approved Mental Health Professionals, Occupational Therapists, Support Time and Recovery Workers, Assessment Officers, Consultant Psychiatrist and Psychological Therapists.
4. Intensive Community Therapies Team – This team provides interventions for patients with severe depression and anxiety-related disorders, including personality disorder and obsessive-compulsive disorder. The team consists of Community Psychiatric Nurses, Social Workers, Approved Mental Health Professionals, Occupational Therapists, Support Time and Recovery Workers, Assessment Officers, Consultant Psychiatrist and Psychological Therapists.

Rethink – Rethink Mental Illness is a charity which provides short-term accommodation for people experiencing a mental health crisis. The service has 4 beds, which can be accessed for a maximum of 7 nights, during which time staff will provide emotional and practical support over a 24 hour period to assist patients using the service, to resolve their crisis. The service works in partnership with the Crisis and Home Treatment

Team. The service also delivers a 24 hour helpline which provides support and information relating to mental health issues.

### **First Episode of Care January 2002 until 2008**

Miss G was first referred by her GP to an adult Community Mental Health Team (CMHT) at Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) on 31<sup>st</sup> January 2002. She was 16 years old at the time and presented as being depressed, weepy and with thoughts of self harm. A community psychiatric nurse (CPN) assessed her with Miss G's caseworker from the hostel where she was living. It was noted that Miss G had been drinking heavily and that at times she wanted to take her life, although didn't have any plans to do it. She also said that she had started washing her hands a lot. She told the CPN that she wandered around town in the early hours of the morning and had on one or two occasions found herself walking up to a bridge but her fear of heights has stopped her from jumping off.

On 5<sup>th</sup> March Miss G attended A and E intoxicated. Her brother was present. The record states that Miss G was 16 years old and had been drinking vodka during the afternoon at a friend's house. She was examined and was alert and aware. Her boyfriend arrived and was willing to observe her overnight so she was discharged.

Later in the same month, Miss G attended A and E with depression requesting a psychiatric review. She informed staff that her parents had died and she was living in a hostel. During a psychiatric review she informed staff she had stood on the top of a multi-storey building the previous night and she had also tried to hang herself but the cord had snapped. She informed staff that her father hit her as a child and her mother died seven years ago, that she has one brother (but does not get along with him) and some close friends who are supportive. She informed staff she used to drink one bottle of vodka a day until recently and she also previously smoked cannabis. It is also recorded that she had been in care but left when she was 14 years old to stay with friends. She had previous episodes of deliberate self harm and on numerous occasions tried to hang herself from the bathroom door. She indicated on many occasions she walked onto the top of multi-storey buildings and considered jumping off. She described having no interest in things and being unmotivated but did spend a lot of time sitting around drinking alcohol with friends. She told staff she was due to be evicted from the hostel (Foyer) where she was staying in the next couple of weeks. Staff provided Miss G with information about housing. She was also offered an outpatient appointment and then discharged home.

On 6<sup>th</sup> April, Miss G was found by security staff sitting on the roof of the Frenchgate Centre in Doncaster. She was thinking of jumping off but the security staff talked her down. She had recently been evicted from the Doncaster Foyer hostel for smoking

cannabis. Miss G was admitted to the psychiatric unit at RDaSH under section 136 of the Mental Health Act<sup>22</sup> (MHA). She was assessed by a psychiatrist but discharged herself against medical advice on the same day.

A social worker from the CMHT visited Miss G at home to provide support throughout May.

On 28<sup>th</sup> May 2002 Miss G self referred to the A and E department at Doncaster Royal Infirmary. She presented with personal problems and wanting to self harm. She was assessed by a psychiatric liaison nurse who found no evidence of depression or problems with perception. She was advised to visit her GP and ask for a psychology referral, and to contact the duty social worker the following day to help with accommodation.

On 29<sup>th</sup> May 2002 Miss G was referred for Cognitive Behaviour Therapy (CBT) to help address her compulsive hand washing behaviour and morbid thinking.

A social worker from the CMHT continued to visit Miss G throughout June to provide support with her mental health and housing problems.

On 7<sup>th</sup> July 2002 Miss G attended A and E after a self inflicted laceration to her right wrist. She did not want to be seen by a psychiatrist and left.

Two days later Miss G was assessed by the CBT therapist. She was accepted for therapy and placed on a waiting list – which at that time was two years long.

Miss G went to the A and E department again on 30<sup>th</sup> July 2002. She complained of hearing voices telling her to go to high places and jump off. Occasionally the voices told her to kill people. She was prescribed haloperidol<sup>23</sup> and an urgent outpatient appointment with mental health services was arranged for her.

On 6<sup>th</sup> August 2002 Miss G's GP referred her to RDaSH because she was complaining of auditory hallucinations. She was admitted to ward 11 at Doncaster Royal Infirmary under the care of a consultant psychiatrist (1). On admission to hospital, nursing staff observed Miss G responding to hallucinations, being unable to communicate

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<sup>22</sup> If it appears to a police officer that a person in a public place is 'suffering from mental disorder' and is 'in immediate need of care or control', he or she can take that person to a 'place of safety', which is usually a hospital, but can be a police station. Section 136 lasts for a maximum of 72 hours, so that the person can be examined by a doctor and interviewed by an Approved Mental Health Practitioner and 'any necessary arrangements' made for his or her treatment or care.

<sup>23</sup> Antipsychotic medication that is prescribed for people with schizophrenia, psychotic depression, or other psychotic disorders.

effectively and agitated. The nursing assessment records identify that she told staff that she was hearing voices asking her to harm herself and others although she said she would not act on them.

She tried to leave hospital so she was placed on section 5(2) MHA<sup>24</sup>. She settled for a period so the section was rescinded. However a few days later she absconded from the ward. The missing person's procedure was implemented, the police were informed and she was subsequently found at the supported housing where she was living. She was placed on one to one observations and a further section 5(2) was applied. This was converted to a section 2 (MHA<sup>25</sup>) which Miss G subsequently appealed against. Following a mental health act tribunal she was discharged from the section on 23<sup>rd</sup> August but remained in hospital on an informal basis.

Once Miss G was an informal patient, she became settled and had periods of leave. Following a ward round she was discharged from hospital on 28<sup>th</sup> August. The discharge plan was recorded as follows:

- to go on standard care programme approach. The social worker from the homeless service within the Trust was identified as the care coordinator.
- medication
- outpatient appointment in 6/8 weeks
- attend women's centre for counselling
- awaiting CBT
- placed on Jigsaw<sup>26</sup> counselling waiting list
- an appointment to be made for Miss G to meet the young women's group.

Miss G was diagnosed with a borderline emotionally unstable personality disorder. A senior house officer (Psychiatrist 2) - who was the junior doctor to Consultant psychiatrist 1 - wrote the discharge letter to her GP:

*"It is clear that Miss G was not experiencing true hallucinations but auditory pseudo-hallucinations with derogatory content and giving her commands. No presence of third person hallucinations. No presence of any other psychotic features."*

Psychiatrist 2 concluded that the admission was triggered on the anniversary of Miss G's father's death.

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<sup>24</sup> Compulsory detention in hospital for up to 72 hours for a Mental Health Act assessment.

<sup>25</sup> Admission to hospital for assessment for up to 28 days

<sup>26</sup> A young person's advice, information and counselling centre

Following discharge from hospital, Miss G was monitored in the outpatient department as outlined in the discharge plan. The care coordinator continued to support Miss G through face to face visits or by means of a telephone conversation.

On 14<sup>th</sup> October Miss G went to A and E. Records show that she had taken an overdose of medication. It is also recorded that she had a past medical history of schizophrenia.

Miss G left A and E before seeing anyone from the psychiatric liaison service. Staff contacted M25 to see if she was there. They advised that she had gone to bed and would not go back to A and E. Staff provided advice to staff at M25 and completed an incident form.

The following day the care coordinator visited Miss G. She provided support and talked about the need for Miss G to develop alternative coping strategies. The care coordinator also encouraged Miss G to pursue the counselling referral at Jigsaw. Preparations were underway at this point for Miss G to move into her new accommodation. The care coordinator continued to visit Miss G throughout October on a regular basis providing support.

On 24<sup>th</sup> October Miss G attended an outpatient appointment with Psychiatrist 2. Two support workers from housing services came with her. It was noted that Miss G had only attended one session of counselling at the Women's Centre as she found it very difficult to talk to the therapist. She was on the waiting list for assessment at Jigsaw where she had previously seen a therapist who she felt she could engage with much better. She remained on the waiting list for cognitive behavioural therapy. Her move to independent accommodation was discussed. The psychiatrist advised Miss G to approach support workers if she experienced any difficulties once in her new accommodation. Psychiatrist 2 wrote a letter to Miss G's GP to keep him informed of progress.

In November 2002 in line with CPA, an assessment of her needs was undertaken. A care plan was developed in conjunction and agreement with Miss G. The care plan is outlined below:

- 1) *Miss G's mental health remains somewhat unpredictable, and she is likely to continue to require emotional support and monitoring of her mental health, particularly during the transition to living in her own accommodation. To be monitored by the care coordinator at present.*
- 2) *Miss G is currently waiting re-housing in a flat supported by Stonham Housing Association. They will offer practical support in settling in, managing money etc.*

- 3) *Miss G is also supported by the Young Person Project (based at M25). They will offer continuing emotional and practical support to Miss G in accessing mainstream services.*
- 4) *Miss G is currently attending counselling sessions at Jigsaw to help her address issues in connection with her childhood experiences.*
- 5) *Miss G is currently on the waiting list for Cognitive Behavioural Therapy in order to address the apparent Obsessive Compulsive symptoms.*
- 6) *Miss G is to be followed up by the psychiatrist in Out-patients clinic.*
- 7) *Miss G has been offered the opportunity to attend the Young Women's Group at the Women's Centre, but has not maintained regular contact.'*

A copy of the care plan was sent to Miss G by her care coordinator. The covering letter provided a list of people she could contact in the event of a crisis. This included her care coordinator, and the 24 hour crisis team. Miss G continued to receive support from her care coordinator, and was seen regularly by Psychiatrist 2 during November.

On 2<sup>nd</sup> December 2002, Miss G left the M25 project and moved into her new flat. The clinical notes record that Miss G is *"very pleased and positive"*.

On 27<sup>th</sup> December 2002, a female caller rang 999 advising that Miss G had taken an overdose. An ambulance took her to A and E. She informed the triage nurse she had taken an unknown quantity of medication and she wasn't sure when she took it. The records show that Miss G was markedly distressed. An echocardiogram (ECG) was carried out and she was observed. She was seen by the psychiatric liaison service. Staff thought that Miss G may have taken illicit drugs. She was admitted to ward 10 at Doncaster Royal Infirmary under the care of Consultant psychiatrist 3 for further psychiatric assessment. This was a different consultant psychiatrist to the first one she had been under the care of.

Whilst in hospital Miss G admitted taking cannabis prior to admission. A drugs screening test confirmed this. She soon settled and after a short stay in hospital she was discharged on 3<sup>rd</sup> January 2003. The discharge plan included the following:

- medication
- outpatient follow up (with a view to discharging to care of GP).

The clinical notes record that the care coordinator visited Miss G on 6<sup>th</sup> January 2003:

*"Visit to Miss G, appears to be coping reasonably well, although says she continues to hear voices, telling her to self harm, which she finds hard to ignore. Has stopped going to counselling as she found it was difficult and left her feeling drained - tried to explain that addressing difficult issues could have this effect."*

During the visit Miss G alleged that she had been raped whilst in care when she was young. Miss G did not want to discuss this in any detail saying that "*it was in the past, and that she didn't want to live in the past.*" The care coordinator contacted the child protection service who investigated the allegation, concluding that it was not substantiated.

On 23<sup>rd</sup> January a caller rang 999 to say Miss G was unwell reporting that she had abdominal pains and had been vomiting blood. This had continued since the previous day. She was taken to A and E by ambulance but left without having been seen.

On 10<sup>th</sup> February 2003, a CPA review took place. Unfortunately the care coordinator could not be present due to illness but Miss G, Psychiatrist 3 and members of staff from M25 and Stonham housing were present. It was noted that she had moved into independent housing. She told them that she was troubled by a voice that often happened when she felt low or under pressure. She advised that she had stopped taking drugs but sometimes continued to drink alcohol to excess. She had started to think about day time activities and was contemplating taking up tae-kwon-do. A further CPA review was planned for eight months time.

The care coordinator continued to provide support throughout February. In March she wrote to Psychiatrist 3 to advise him that she was leaving her job. In the letter she asked if he would take on the role of coordinator until the next CPA review in October. She advised that Miss G did not need support from the homeless team as she was receiving intensive support from Stonham housing and therefore she was closing the case.

On 24<sup>th</sup> June 2003 Miss G was admitted to Doncaster Royal Infirmary complaining of abdominal pain and sickness. She was treated conservatively. She was distressed about the hospital admission and had informed staff she had not been taking her medication. She complained of hearing voices and that she occasionally felt like harming herself with a razor blade to get some relief. A psychiatric referral was made by staff. Psychiatrist 4 (SHO to Psychiatrist 3) carried out a review of her mental state. He found no suicidal idea but did see deterioration in her mental states. He started her back on her medication and referred her to the CMHT for a CPN and a follow up appointment with the psychiatric outpatient clinic.

Although Miss G had been referred to the CMHT for a CPN to provide support, she did not engage. A letter was subsequently written to Miss G asking her to telephone the CMHT to make an appointment. The letter states:

*“If we do not hear from you within 2 weeks, we shall assume that you no longer require our help at the present time and will discharge you from our services.”*

Miss G was discharged from the CMHT but continued to be followed up in the psychiatric outpatient department.

On 31<sup>st</sup> October 2003 Miss G was seen by Consultant psychiatrist 1 again in the outpatient clinic. She was accompanied by two support workers from Stonham housing and M25. Psychiatrist 3 wrote to Miss G's GP stating:

*“She remains on an even keel, and was in good spirits. She said that her voices were occasionally troublesome, and I have increased her medication at her request.”*

On 7<sup>th</sup> January 2004 Miss G was admitted via her GP to Doncaster Royal Infirmary for abdominal pain and vomiting. The following day, whilst still in hospital, Miss G asked to speak to someone about her mental health, therefore a referral to Psychiatry was made. Four days later, on 12<sup>th</sup> January, she was discharged home and it was decided that her GP could refer her to the community psychiatric team. On 21<sup>st</sup> January 2004, hospital staff contacted Miss G by telephone to inform her that a pregnancy test that she had previously taken was positive. Miss G did not continue with the pregnancy.

In March 2004 Miss G attended a regular appointment at the psychiatric outpatient clinic. Two support workers from housing attended with her. She saw Psychiatrist 5 (an SHO). She complained of hearing voices at night time and said she was feeling down. She explained that she had seen her brother two weeks ago but he ignored her. She denied drinking but had been using cannabis. Her medication was amended and arrangements were made for her to be seen again in three weeks time.

As planned, Miss G attended an appointment at the psychiatric outpatient clinic in April. A support worker from housing attended with her. It was noted that she was feeling much better in her mood and that her sleep had drastically improved, although she still heard voices occasionally but they didn't particularly bother her. She told Psychiatrist 5 that she was still smoking cannabis.

In April 2004 a letter from Doncaster Mind befriending service to RDaSH advised that Miss G had been assessed, accepted and placed on a waiting list.

Miss G attended psychiatric outpatient appointments in June and September, seeing SHO Psychiatrists 6 and 7. She was generally feeling settled and was considering going to college. In November she told the psychiatrist that she felt the worst she had ever felt and that she had stopped taking some of her medication because she felt it made her violent. She complained that she heard her father's voice telling her to shut

up. Her medication was amended and arrangements were made to see her again in one month's time. She was referred to the community mental health team with a view to her starting an anger management course.

In December 2004 Consultant psychiatrist 1 reviewed Miss G in the psychiatric outpatient department. He noted that she was troubled by flashbacks to her father and his violent behaviour and that she continued to have outbursts of temper. Psychiatrist 1's treatment of choice for her was long term counselling and anger management. He therefore asked Miss G to make contact with the women's centre for counselling.

Later the same month the lead nurse from the community mental health team wrote to Miss G:

*"Dr A mentions that you wish to see a counsellor. To this end I would suggest that you contact Doncaster MIND. This is a service particularly geared towards depression, anxiety, anger management, and stress."*

In February 2005 Miss G attended a psychiatric outpatient appointment with her support worker from the M25 housing project where she used to live. She saw a different psychiatrist (8). She reported that she had attended the first session of an anger management course at MIND and had found it helpful and learned a lot. She reported that she still got angry thoughts and hit people. It was noted that she was not taking any medication but that she was happy with the situation. Miss G had contacted the women's centre for counselling but the waiting list had been put on hold due to increasing demand.

Miss G reported some improvement in her mental health at a psychiatric outpatient appointment in May 2005 with Psychiatrist 9. The letter written by the psychiatrist to the GP says:

*"She described feeling better after the anger management but still reacted irrationally to minor things. She reported occasionally punching the wall or take it out on a pillow but is getting less aggressive towards people."*

Miss G had a psychiatric outpatient appointment at the end of August. This time she saw Psychiatrist 10 who was the SHO to a different consultant psychiatrist. Psychiatrist 10 noted that she continued to attend anger management sessions and planned to start college in September. A further appointment was made for four months time.

In February 2006 Miss G attended a psychiatric outpatient appointment. She saw yet another psychiatrist (11, an SHO to a locum consultant psychiatrist). Miss G said although she had felt some improvement after attending anger management she could

not continue as she started feeling angry towards the therapist. She said she felt aggressive towards people but was able to keep it within her without an outward reaction. Miss G's diagnosis at this stage remained as emotionally unstable personality disorder.

In April 2006 Miss G attended a psychiatric outpatient appointment and saw an SHO psychiatrist (12). Miss G complained of feeling low and nervous and of having poor sleep. She reported staying off alcohol and cannabis. The clinical notes record that Miss G "*wants to get better and know more about her illness*". Psychiatrist 12 discussed the case with a consultant psychiatrist. Miss G was provided with literature about her diagnosis and a follow up appointment was made for 2 months time.

In July Miss G attended a psychiatric outpatient appointment and was seen by Psychiatrist 13. She reported moving to a new flat where she lived on her own. Following the clinic her case was discussed with a consultant psychiatrist and Miss G's medication was increased slightly.

In July 2006 she attended A and E informing staff she had felt unwell for over a week, with vomiting and pain in the central chest to the epigastric area for one day. She informed staff she had not eaten for one week as she had no money. She was found to be dehydrated with severe gastritis secondary to not eating, therefore she was admitted to the medical assessment unit. She was given medical treatment and dietary advice. She was also referred for a psychiatric review because she informed medical staff that she was unemployed, that both her parents died years ago and that she was taking antidepressants for post-traumatic stress. The records relating to the psychiatric review indicate that Miss G's condition was stable but she had the following problems:

- complex post-traumatic stress disorder
- moderate depression
- borderline Personality disorder
- cannabis misuse.

Appropriate communication was made with her GP and she was to receive follow-up care.

Miss G did not attend planned outpatient appointments in September or November 2006. If she had attended she would have seen Psychiatrist 13 who wrote letters to the GP advising of her non-attendance.

In December 2006 Miss G was seen by an SHO (14). She reported that "*everything is falling down around my ears*" and was pessimistic about everything. Although Miss G

was feeling low, the psychiatrist noted that she had not self harmed for two years. A further appointment was made for six months time.

Miss G attended A and E again in December 2006; she again had abdominal discomfort and vomiting and had not eaten for 3 to 4 days. She also indicated she lived alone. Following a medical examination medication was prescribed. Miss G requested a review from the Crisis Resolution Service and this occurred. The documentation from the Crisis Resolution Service indicates she was under the care of a consultant psychiatrist with a diagnosis of borderline personality disorder. She had been seen during December 2006 and her next appointment was for June 2007. She denied having taken an overdose or self harming in any way and it is recorded that she had expressed no suicidal thoughts or delusional ideas. She informed the psychiatric liaison service she had no active substance misuse for 2 years and the records state there was no evidence of depressive mood. She described problems relating to her lack of budgeting skills. The plan was for a referral back to her GP to enable community mental health team input. She was advised to attend Citizen Advice Bureau regarding budgeting skills and Doncaster's Women's Centre. The psychiatric liaison staff member said she could be discharged when medically fit.

Miss G was seen in the psychiatric outpatient clinic by a consultant psychiatrist (15) in September 2007. The following diagnosis was recorded:

1. Double depression
2. Complex post traumatic stress disorder
3. Obsessive compulsive disorder
4. Emotionally unstable personality disorder- borderline

Consultant psychiatrist 15 carried out a risk assessment and mental health examination. He noted that she was on CPA and that she had the crisis team telephone number. The management plan was as follows:

- to be educated about medication
- blood tests to be taken
- to be reviewed in the next few weeks.

Consultant psychiatrist 15 saw Miss G again on 9<sup>th</sup> October to review her medication. He planned to see Miss G again to monitor her medication on 22<sup>nd</sup> October but she did not attend the appointment. A letter was written to her informing her that another appointment had been made for 31<sup>st</sup> October. A prescription was also sent to her advising her to take it to the hospital pharmacy.

Miss G cancelled her appointment on 31<sup>st</sup> October because she was physically sick and so another one was made for 9<sup>th</sup> January 2008. Miss G did not attend her appointment in January so Consultant Psychiatrist 15 wrote to Miss G's GP expressing concern about Miss G's physical health and asking for feedback. Miss G cancelled her appointment in April for the same reason.

Miss G's GP wrote to Consultant psychiatrist 15 advising that she had episodes of vomiting that coincided with the outpatient appointments. He advised that she was being investigated for these. He said that Miss G would like to continue seeing the psychiatrist.

In July she did not attend a planned appointment for 16<sup>th</sup> July. She was therefore discharged. Consultant psychiatrist 15 wrote to the GP advising that he would be happy to see her again should the need arise in the future.

### **Analysis of Involvement**

In this section of the report, issues arising from the first episode of Miss G's care and treatment (2002 until 2008) are examined and analysed to establish whether the treatment and care was in line with national and trust policy. The following areas will be examined:

1. The care programme approach (CPA)
2. Risk assessment and risk management
3. The formulation of diagnosis
4. Treatment and management plans
5. Clinical overview of Miss G's care and treatment

### **The Care Programme Approach**

A major theme throughout all mental health policy documents during the time of Miss G's first episode of care was that mental health services needed to give a high priority to clinical risk assessment and risk management. The Care Programme Approach (CPA) (Department of Health 1999) was introduced to ensure the effective coordination and delivery of mental health care.

The main thrust of the policy was that everyone accepted for treatment or care by mental health services should have the following:

- their treatment and care needs assessed
- a package of care (care plan) to meet those needs drawn up

- a named mental health worker (key worker or care coordinator) to keep in close contact with them
- a regular review of their treatment and care needs.

The trust had a CPA policy in place and there is evidence that Miss G's needs were assessed. She was placed on standard CPA on 28<sup>th</sup> August 2002 and allocated to a female care coordinator who was a social worker from the homeless team at RDASH. She formed a good relationship with Miss G and made significant efforts to stay in touch with her and to provide support.

There is evidence that Miss G had a care plan. This was developed in conjunction and agreement with Miss G. Telephone numbers were incorporated within the care plan so that Miss G could contact someone in the event of a crisis. Records also show that between August 2002 and March 2003, CPA reviews took place, with members from the CMHT and M25 and Stonham housing. Correspondence was also sent to Miss G's GP to keep him informed of progress.

Miss G's care coordinator left the mental health service in March 2003. She wrote to Psychiatrist 3 asking him to act as care coordinator until the next CPA review in October 2003. She also advised that she was closing the case as Miss G was receiving support from housing.

There is no evidence to indicate whether a multidisciplinary meeting took place to discuss Miss G's possible discharge from the CMHT or whether psychiatrist 3 took on the role of care coordinator.

## **Conclusion**

Miss G was placed on CPA. She had a care coordinator and a care plan. These arrangements did not extend to the whole of the first period of care. If CPA had been fully in place there would have been a multidisciplinary meeting to discuss whether or not it was in Miss G's best interests to be discharged from the CMHT and whether discharge posed any risks. In addition there were no clear arrangements put in place to make sure that Miss G had an alternative care coordinator.

From March 2003 onwards there was little evidence that CPA was in action.

## **Risk Assessment and Risk Management**

At the time of Miss G's first episode of care, national policy required that risk assessment and risk management be at the heart of effective mental health practice within the CPA.

A clinical risk management tool developed by the Sainsbury centre in 2000 advised NHS Trusts that in order to assess risk accurately, information must be gathered from relevant parties to build up an accurate picture including:

- the patient
- carers, friends
- relatives
- other team members/other teams
- other statutory or voluntary sector mental health agencies
- police, probation, courts.

Miss G's first contact with mental health services was when she was aged 16. She had a long history of neglect, behavioural issues, a recent bereavement of her father and social problems. Gaining accurate knowledge and understanding about the extent of her neglect and details of significant life events that she experienced would have been important so that a longitudinal approach to risk assessment and management could take place.

There is documentary evidence that Miss G did share some of her background with health professionals. For example she told health care workers about the death of her parents and that she had been using drugs. Both of these were recorded in the health records and in risk assessments.

Throughout the first episode of care there is reference to the fact that support workers from housing regularly attended outpatient appointments with Miss G to provide support. There is no record though to demonstrate whether or not psychiatrists or other members of the multidisciplinary team gathered information from the support workers to continue to build up an accurate picture of any risks that Miss G may have posed to herself or others.

Although the mental health records refer to the neglect that Miss G experienced, there is no comprehensive chronology of her extensive history of neglect, behavioural issues and bereavement.

## **Conclusion**

Between 2002 and 2008 RDaSH had formal risk assessment procedures in place and the Sainsbury risk assessment tool was used. It is evident though that in the main, risk assessment took place on the basis of professional judgement.

Some efforts were made to get a risk history from Miss G but not from others involved in her care such as housing workers who might have had an important contribution to make.

Although risk assessments were carried out, the quality of documentation was poor so information in relation to risk could not be easily accessed or shared.

### **The Formulation of the Diagnosis of Emotionally Unstable Personality Disorder Borderline (ICD-10 code: F60.3)**

As indicated in the chronology, Miss G was admitted to the acute psychiatric inpatient unit in Doncaster on 6<sup>th</sup> August 2002 and discharged on 28<sup>th</sup> August 2002. She was referred there by her GP because she was complaining of hearing voices. Although she was admitted on an informal basis, she was later placed on a Section 5(2) and then Section 2 as she was showing evidence of psychotic symptoms, restlessness and agitation.

During her admission, she was examined by the junior doctor on the team as well as the consultant (Psychiatrist 1). There are several hand-written entries by both the junior doctor and consultant relating to medical reviews as well as MDT reviews. There is also a reasonable psychiatric history in these records. In addition, there is a detailed report by the consultant to the Mental Health Review Tribunal that covers Miss G's presentation, background history, and mental state and diagnostic formulation. The rationale for the diagnosis of borderline personality disorder is clearly set out in this letter.

### **Conclusion**

The consultant psychiatrist carried out a reasonable assessment of Miss G and the diagnosis of borderline personality disorder was based on sound clinical reasoning.

### **Treatment and Management Plans**

During Miss G's first episode of care, the national guidance 'personality disorder - no longer a diagnosis for exclusion' (National Institute for Mental Health in England 2003) set out implementation guidance for the development of services for people with personality disorders.

The guidance advises:

- the need for a therapeutic relationship
- a combination of psychological treatments reinforced by medication

- encouraging the person to remain actively involved in finding solutions to their problems
- developing a crisis plan.

Although Miss G had a diagnosis of borderline personality disorder she did present with psychotic symptoms, namely hearing voices and showing evidence of paranoid beliefs. Anti-psychotic medication was prescribed. Miss G also complained of feeling depressed on occasions and antidepressant medication was prescribed.

The guidance also outlines the key principles of effective therapy for people with personality disorder. It should:

- be well structured
- devote effort to achieving adherence
- have a clear focus
- be theoretically coherent to both therapist and patient
- be relatively long term
- be well integrated with other services available to the patient
- involve a clear treatment alliance between therapist and patient.

From Miss G's first contact with services until March 2003 her treatment plans included:

- referrals for counselling (MIND and women's centre)
- referral for anger management
- referral to CBT
- access to the crisis team
- outpatient appointments
- medication.

Miss G was referred to CBT because of her compulsive hand washing and ruminating morbid thoughts and not for her primary condition of borderline personality disorder. There is documentary evidence that she was assessed and accepted for treatment but no record to say whether she actually attended any sessions.

In December 2004 Miss G was asked to contact Doncaster MIND for counselling which was geared towards depression, anxiety, anger management, and stress. This was not Miss G's primary diagnosis.

Miss G started anger management sessions in 2005. Although she didn't complete the course she did report some improvement.

There is no record indicating whether or not Miss G was referred to an NHS psychologist. A psychologist would have assisted in the assessment of Miss G's mental health needs and provided the type of psychological therapy that may have proved more beneficial for her than counselling, anger management or CBT from other agencies. This is because a psychologist would have a good understanding of the needs of people with borderline personality disorders. S/he would be part of the multidisciplinary team and therefore contribute to the overall care planning.

## **Conclusion**

Overall, the medication and treatment plans were reasonable between January 2002 and March 2003 given Miss G's diagnosis and presentation. However, although Miss G was referred to therapies there was little evidence that staff invested much time and effort in trying to help Miss G to develop coping mechanisms or actively encouraging Miss G's adherence to the plans. During the first episode of care Miss G received no therapy apart from anger management which was carried out by a charity. This was not integrated to the mental health services that she was receiving. Intervention from an NHS psychologist may have proved more beneficial than counselling from other agencies and more likely have identified the root causes of Miss G's issues.

From 2003 onwards Miss G was seen predominantly on an outpatient basis. She received a medical approach rather than being cared for by a multidisciplinary team who could have offered more therapeutic interventions.

## **Clinical Overview of Miss G's Care and Treatment**

Miss G was under the care of five different consultant psychiatrists during the first episode of her care. Two consultants took over her care twice (2002, then 2003-2006, and a further consultant for a period in 2006 and again during the last period of episode 1 in 2007-2008). Hence, there were six changes of consultant during this time. We cannot ascertain from the records the reason why there were so many transfers of consultant care.

## **Conclusion**

The constant changing of psychiatrists during the first episode of care was not helpful. This and the fact that Miss G did not have a care coordinator for the majority of the first episode of care meant that nobody was really able to build up a long standing trusting relationship with her and get to know her.

## **Second Episode of Care September 2011 until February 2012**

### **July 2011**

In July 2011, Miss G attended A and E asking for help from the Community Mental Health Service Team. She informed medical staff she was known to mental health services but this had stopped and she had not seen her GP recently. It is recorded that she had a history of self harm and talked to herself. She informed medical staff that events in the past affected her but medical staff were unsure what these were, they also recorded that she *“kept repeating herself and going around in circles”*. Miss G informed medical staff that thoughts of self-harming were present but that she had not acted upon them. She was still using cannabis and not taking her medication. She was referred to the crisis team and subsequently seen by a mental health worker who recorded that she was clearly under the influence of cannabis and that she had admitted this. The mental health worker advised Miss G to go home and sleep it off and informed her that the crisis team would make contact later to establish whether a further assessment was required.

### **September 2011**

On 7<sup>th</sup> September 2011 Miss G took an overdose and was assessed by a psychiatrist (no 16 specialist registrar) from the Access Team. The assessment states:

*“She has been prescribed Citalopram 20mg by her GP yesterday. Plan - taken on for a period of home treatment due to current crisis. Medical review to be arranged on Thurs 8<sup>th</sup> Sept. Given access team numbers and said that she would use if needed. Signposted to Women’s Centre but said that she doesn’t trust them.”*

Miss G described problems with her flat, being convinced that people were entering it, and said that she slept with a Stanley knife under her pillow. The psychiatrist did not feel she posed a threat so the police were not informed and the psychiatrist did not ask to see the knife or remove it. A full needs assessment was carried out using CPA documentation, but the form did not indicate whether or not Miss G had been placed on CPA. The Sainsbury risk assessment was partly completed. The doctor did not feel that there was any formal thought disorder. Miss G denied any active plans or thoughts to harm others. It was noted that Miss G had a long history of cannabis abuse.

Miss G was visited on 8<sup>th</sup> September by a member of the home treatment team. The clinical records note that Miss G was difficult to engage and that she gave mostly yes/no answers. It was ascertained that Miss G had eaten the previous evening and that she had slept a little. When asked about any unusual thoughts or thoughts of self

harming Miss G answered “*I’m not thinking*”. There was some evidence of potential cannabis use, such as an unusual smell and ‘joint’ rolling paraphernalia.

On 9<sup>th</sup> September a member of the home treatment team phoned Miss G to see how she was. A home visit did not take place as two members of staff were supposed to visit because of the area that Miss X lived in and only one member was available at the time. Miss G stated that she was “*not good*” and was thinking about moving away from Doncaster to Somerset because she wanted a complete change where nobody knew her. Miss G stated that she had no thoughts of harming either herself or others. The following day Miss G was visited at home. She reported that she was “*ok*”, but didn’t want to talk.

On 12<sup>th</sup> September Miss G stated that she was feeling the same. She had some suicidal thoughts, but no plans or intent. On 13<sup>th</sup> September, a member of the team phoned Miss G who advised she was fine. Between 14<sup>th</sup> and 19<sup>th</sup> September the team attempted to contact Miss G several times but there was no response. A discharge visit was arranged for 20<sup>th</sup> September but Miss G was not at home.

On 22<sup>nd</sup> September 2011 Miss G was discharged from the Home Treatment service, without being seen, due to a lack of engagement. A discharge letter was sent to her GP advising of this, although it did not indicate whether or not Miss G had been screened under CPA. The letter advised that Miss G had been prescribed antidepressant medication and that no follow up arrangements had been made.

A housing officer from London contacted the Trust on 30<sup>th</sup> September requesting medical information to support the work they were undertaking with Miss G in relation to housing and risk assessment. Miss G gave consent for information to be shared.

A social worker in Camden, London, contacted the crisis team on 30<sup>th</sup> September informing them that Miss G was being assessed under Section 2 of the Mental Health Act (1983).

## **October 2011**

On 5<sup>th</sup> October Miss G was transferred from Camden and admitted under Section 2 of the Mental Health Act (1983) to Cusworth Ward at RDaSH. An initial risk assessment was carried out. It was recorded that Miss G had been cautioned for carrying a knife. Under the heading of ‘past history of neglect’ the ‘no’ box was ticked. The summary of assessment recorded:

*“Guarded throughout admission. Refused to answer questions relating to mental health but adamantly denied any thoughts to self harm or abscond.”*

On 6<sup>th</sup> October a care programme approach assessment was completed by an occupational therapist. The plan outlined short /medium term goals although Miss G was not placed on CPA.

Five days later a multidisciplinary team meeting took place on the ward to discuss Miss G's care. She was discharged home and given advice to contact homeless services regarding alternative accommodation. She was advised that she could access services again through the crisis team if necessary and was given contact details.

The discharge letter stated that she had been diagnosed with "*Mild depressive episode*". There was no record in the discharge letter to indicate whether or not Miss G had been screened for CPA on discharge or whether a discussion had taken place about her suitability for CPA.

### **November 2011**

On 18<sup>th</sup> November Miss G was referred to the Access Team by A and E at Doncaster Royal Infirmary, following an overdose of Citalopram (anti-depressants). She did not wish to be assessed and was discharged. The Access Team were contacted by A and E and contact numbers were given to Miss G.

On 30<sup>th</sup> November Miss G took an overdose of 60 Paracetamol and presented at A and E. The records show that she had some derangement of liver enzymes so she was admitted to hospital for treatment. She was discharged when medically fit. It was noted in the clinical records that there was no acute mental illness but she had ongoing housing problems and that a referral had been made to community therapies.

### **December 2011**

In early December Miss G was admitted to the medical assessment unit at Doncaster Royal Infirmary, following an overdose of 30g of Paracetamol staggered over 11 hours. She was assessed by the Access Team. She agreed to be referred to the community therapies team for CBT, but refused a referral to the women's centre for counselling. She was given contact numbers for the housing department and a supportive letter for re-housing. A Sainsbury risk assessment was completed.

### **January 2012**

Early in the morning of New Years Day, Miss G made a telephone call to the Access Team to say that she needed to be admitted as her head was "*all over the place*". She agreed to ring the Crisis Team later in the morning for an assessment. She later

contacted the Crisis Team and said her current difficulties were due to her unsatisfactory accommodation. The worker listened to Miss G and provided her with re-housing support contact details. Clinical records state:

*“Miss G was happy with this and is aware that she can contact the team at any time if she requires any further advice and support.”*

On 6<sup>th</sup> January 2012 Miss G presented in A and E at Doncaster Royal Infirmary with her bags packed requesting admission to hospital. She said that she was hearing German voices in her head. Notes state:

*“She stated that she was a danger to herself and others but denied any intent to harm anyone.”*

She was risk assessed and offered home treatment but declined. Miss G said she only wanted hospital admission. The Nurse said that Miss G’s community therapies treatment would be chased up on Monday as Miss G had said she would like to see a psychiatrist. The Nurse also said she would contact Miss G the following morning to see how she was.

The next day the nurse rang Miss G as planned. Miss G reported having had a better night than expected. She asked about medication and was advised to talk to her GP. In the evening, she telephoned the crisis team and said she was going to A and E. Later that evening she presented at A and E and requested hospital admission. She stated she needed to be “locked up”. She said she felt she had the potential to harm someone in the future. It was noted that she had no history of violent behaviour and no intended victim. She wanted to move to a different area. She was offered admission to a Crisis bed at Imperial Crescent via Rethink<sup>27</sup>. The referral letter to Rethink records that Miss G was cautioned in the past for carrying an offensive weapon.

In the early hours of 8<sup>th</sup> January 2012 a member of staff from the access team contacted Imperial Crescent to explain that Miss G had been assessed and had been referred there and that Miss G had a history of depression and believed she was a bad person. Staff at Rethink were told that Miss G had requested hospital admission because she felt that she would harm somebody at some point, although she had no plans to harm anybody and had no history of violence.

A member of the access team escorted Miss G to Rethink crisis accommodation. A Rethink mental illness referral form was completed by the access team member and a

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<sup>27</sup> A charity that provides short-term accommodation for people experiencing a mental health crisis

copy of the mental health clustering tool, and a Sainsbury mental health risk assessment was made available to Rethink staff.

The risk assessment noted that Miss G had been cautioned in the past for carrying a knife and recorded that she might harm someone in the future, but it stated she had no plans to harm anybody. The summary of the risk assessment recorded:

*“Appears to be struggling to cope at present (second presentation in as many days) Requesting hospital admission as she feels she needs to be locked away from society as she may harm someone at some point in the future. She has no current plans to do so and no history of such behaviour.”*

The management plan stated:

*“Offered and accepted admission to Rethink. She has agreed to keep herself and others safe and engage with staff to make the most of her stay.”*

Miss G was observed and supported throughout the night by mental health recovery workers (MHRW).

Staff at Rethink helped Miss G complete the recovery star documentation<sup>28</sup>. Miss G was not able to answer beyond the first page. She repeatedly said she did not know what had happened when she was little but that she had to stay away from people so *“they don’t get hurt psychologically”*. The MHRW advised her not to isolate herself and encouraged her to integrate with staff and other residents staying there.

On 10<sup>th</sup> January Psychiatrist 16 visited Miss G at Rethink. The psychiatrist noted her past history of abuse, her previous diagnosis of emotionally unstable personality disorder and her past treatment with anti-psychotic medication for transient hallucinations (although further assessments revealed that these could be pseudo hallucinations). Clinical records note that Miss G’s main concerns were her accommodation and debts. She reported hallucinations and paranoid ideations but was unable to elaborate on any symptoms. She stated that these experiences had been present for the last 10-12 years but was not sure why this was bothering her at the time.

The psychiatrist recorded that there was no evidence of formal thought disorder although Miss G said:

*‘...seven people were trapped in her body. She said that some of them are psychopathic, some looked down on people, some do not like children etc.’* She went

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<sup>28</sup> Tools for supporting and measuring change when working with vulnerable people.

on to say that *'she wanted to keep away from people as she was worried about hurting people not physically but psychologically'*

The psychiatrist recorded that Miss G was recently cautioned for carrying a weapon in the street but denied any intention to harm anyone. The psychiatrist agreed the following care plan with Miss G:

- 1) *Remain at Rethink crisis accommodation for increased support*
- 2) *Miss G has agreed to keep herself and others safe and engage with staff*
- 3) *Medical review (already taken place)*
- 4) *Remain medication-free until further assessments are carried out*
- 5) *Support from Imperial Crescent staff with accommodation issues and liaison with benefits office*
- 6) *Discussed support from Women's Centre to introduce some routine and structure*  
*Miss G not very keen at this time*
- 7) *Chase previous records*
- 8) *Continue assessment of mental state and risk.*

On the same day Miss G went home to collect some clothes and sort out her benefits and returned later. A MHRW spent time completing the Star recovery assessment with her, setting out her goals.

Records show that on 11<sup>th</sup> January staff at Rethink continued to observe and support Miss G. She went out to the shop, returning later. She was seen reading and appeared settled. Staff helped her cook during the evening and she was reported as *"appearing very appreciative and more talkative"*.

On 12<sup>th</sup> January Miss G received a telephone call from staff at St Leger Homes<sup>29</sup> regarding accommodation.

Records show that staff from Rethink continued to observe and support Miss G.

On 13<sup>th</sup> January, M25 Housing Association contacted Miss G regarding her referral form.

On 14<sup>th</sup> January a member of staff from Rethink telephoned the Home Treatment Team as Miss G was being discharged the next day. Miss G was nearing the completion of her seven day agreed stay in the Rethink bed and they queried whether there was a plan from the team to visit. On the same day, staff noted that Miss G was very quiet. Staff reminded Miss G that outreach support was available through Rethink.

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<sup>29</sup> A not for profit organisation that works in partnership with Doncaster Council to provide quality homes

The following day Miss G was discharged home, where she was visited by two community support workers from the Home Treatment Team. Miss G told them that she needed medication due to her psychotic thoughts.

On 16<sup>th</sup> January, Miss G was visited by a Mental Health Nurse. The clinical notes record:

*“Miss G said that she still isn’t well, that her mood is not ‘right’ that her thoughts and feelings are disturbed and that she shouldn’t be around other people due to her thoughts to want to kill other people. She said that she has bad thoughts everyday and therefore tries to stay away from people on the street. She says that she has never physically hurt anyone, but she says that she feels like she has two personalities, one that is full of anger and nasty thoughts and another that is quiet and low in mood. Miss G said that she has heard voices since being seven yrs old, but they are worse now than they have ever been. We discussed hopes, dreams, plans for the future, but Miss G says that she has none. That she has no joy, pleasure or fun in her life, that she cannot envisage this changing and has no solution to her situation. She said that she felt that antipsychotics had helped her in the past, discussed the use of antidepressants and maybe they would help lift her mood and hopefully reduce the voices she hears. Miss G said that she was willing to try anything I have advised that I will speak with Doctor and see if it is appropriate to prescribe antidepressants.”*

On 17<sup>th</sup> January, Psychiatrist 16 prescribed antidepressant medication for Miss G. The following day a member of the Home Treatment Team visited Miss G at home and prescribed seven days medication.

Three days later on 20<sup>th</sup> January Miss G was visited again by a member of staff from the Home Treatment Team. Her discharge and earlier referral to the community therapies team was discussed. The clinical notes record:

*“She stated she was not feeling much different to when she first started receiving visits from Home Treatment although stated that she did find the visits helpful.”*

On 26<sup>th</sup> January Miss G was sent an introductory letter from the Community Therapies Team. The following day a member of staff from the home treatment visited Miss G but she was out. Telephone contact was subsequently made later and a discharge visit was arranged for 30<sup>th</sup> January.

On 27<sup>th</sup> January two workers from M25 visited Miss G at home to undertake an initial assessment. The contact is described in more detail in the M25 section. The assessment made by the M25 workers provides information about Miss G's problems

with anger management, a self reported history of harm to friends and family and her potential to harm someone. This information was not reported to RDaSH staff or Miss G's GP.

On 30<sup>th</sup> January at the discharge visit, Miss G stated that she was still experiencing some thoughts of harm but could not elaborate. Miss G stated that she felt ready to be discharged and would contact the team if her mental health deteriorated. At the point she was continuing to receive support from the Rethink Crisis Accommodation Outreach Worker.

### **Analysis of Involvement**

In this section of the report, issues arising from the second episode of Miss G's care and treatment (2011 until 2012) are examined and analysed to establish whether the treatment and care was in line with national and trust policy. The issues are:

1. The care programme approach (CPA)
2. Risk assessment and risk management
3. Treatment and management plans including discharge plans
4. Management of people with borderline personality disorders

### **The Care Programme Approach**

The Trust's CPA Policy 2010 highlights the criteria to consider when deciding whether CPA is appropriate:

1. Severe mental disorder (including personality disorder) with high degree of clinical complexity
2. Current or potential risks, including:
  - Suicide, self-harm, harm to others (including history of offending)
  - Relapse history requiring urgent response
  - Current or significant history of severe distress/instability or disengagement
3. Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies
4. Currently or recently detained under the Mental Health Act or referred to Crisis/Home Treatment
5. Experiencing disadvantage or difficulty as a result of:
  - Presence of non-physical co-morbidity e.g. substance/alcohol/ prescription drugs misuse.

Miss G received a full needs assessment using CPA documentation in September 2011. She was assessed again in December. These assessments did not result in her being placed on CPA.

## **Conclusion**

Miss G met most of the criteria set out in trust policy and therefore should have been placed on CPA during episode 2 of care following the assessment on 5<sup>th</sup> December 2011. This is an important omission given Miss G's complex history and presentation.

Being on CPA would have meant that Miss G would have been allocated a Care Coordinator (Lead Professional) to oversee and coordinate her care. This leadership role has been missing throughout Miss G's care since August 2003.

A further comment about CPA is detailed in the next section.

## **Risk Assessment and Risk Management Plans**

Risk management should be an integral aspect of CPA. The outcome of risk assessment should feedback into the overall clinical management.

National best practice guidance in managing risk in mental health services (DOH 2007) sets out three risk factor categories. These are:

1. **Static factors.** These are unchangeable, e.g. a history of child abuse or suicide attempts.
2. **Dynamic factors** are those that change over time, e.g. misuse of drugs or alcohol.
3. **Acute factors or triggers.** These change rapidly and their influence on the level of risk may be short-lived.

The Trust used the Sainsbury risk assessment documentation in order to provide a consistent approach and aid clinical decision making. This tool provided structure for clinical staff carrying out risk assessments and was evidence based however it was not one of the recommended tools outlined in the national good practice guidance highlighted above. The Trust has since started using a risk assessment tool called FACE, (Functional Analysis of Care Environments). This is a recommended tool outlined in the national guidance.

In this second episode of care, there is evidence that risk assessments were undertaken by staff. However, static, dynamic and acute risk factors were not routinely considered. Where there was reference to risk, some of the information was incorrect,

for example Miss G's violent and aggressive behaviour in her early years or her aggression on admission in 2002. Where risks were identified, there was often no subsequent plan of action recorded to mitigate the risks identified.

In January two workers from M25 visited Miss G at her home to undertake an initial assessment. Following assessment they decided that Miss G was not eligible for the service. Miss G shared issues in relation to anger and aggression. Whilst no direct threats were made by Miss G to immediately harm herself or another person, Miss G did provide a self reported history of harm to friends and family. This information should have been seen as significant and shared with mental health services.

On 6<sup>th</sup> January Miss G attended A and E. The subsequent assessment identified that the risks were becoming more frequent and more severe. Although the nurse agreed to telephone Miss G the following day, consideration should also have been given as to whether a mental health act assessment (1983) needed to be undertaken.

On 10<sup>th</sup> January 2012 Miss G was assessed by Psychiatrist 16. It was at this point Miss G advised that *'seven people were trapped in her body.....and some did not like children'*. Miss G also added that she *was worried about hurting someone not physically but psychologically*. When asked about this, she would not elaborate. This was one area she identified amongst others. There were no specific threats. A detailed mental health assessment and a risk assessment using clinical judgment were carried out by the psychiatrist. As outlined in the previous section, a care plan was developed. The Psychiatrist documented the need to continue with the assessment of Miss G's mental state and risk. Miss G agreed to keep herself and others safe and engage with staff.

Whilst Miss G did not express any direct intent to physically or psychologically harm a child but to enable the risk assessment to be completed effectively Psychiatrist 16 should have considered contacting the Trusts Named Nurse or Named Doctor for child safeguarding to get advice and discuss whether there were any known risks. Miss G did not have any history of harming children or young people in the past.

## **Conclusion**

Miss G did not receive a systematic approach to risk assessment and management during her second episode of care. There is no evidence that any historic, static or acute risks that Miss G may have posed to others were routinely gathered either from Miss G or from those providing support to her. Risk information was not brought together to form a robust care plan.

Everybody knew a little about Miss G but nobody had the full picture.

CPA would have provided the platform for all agencies to share relevant information about any risks Miss G may have posed to herself or others including any issues in relation to safeguarding children so that appropriate care and risk management plans could be developed.

RDaSH have undertaken a considerable amount of safeguarding training for staff and have been evaluated regularly by the CQC to ensure that they have in place the required policies, procedures and practice in relation to safeguarding children, young people and adults. The Trust needs to ensure that safeguarding continues to be embedded into practice.

### **Treatment and Management Plans**

Miss G presented to mental health services in Doncaster after a 16 month absence following an overdose of her anti-depressant prescribed by her GP. She was assessed by Psychiatrist 16. There is evidence of a detailed assessment including a risk assessment. The record did not refer to a diagnosis of borderline personality disorder but provided a differential diagnosis of "*mental and behavioural disorder due to cannabis*" and a possible "*psychotic disorder*."

This was followed by a home visit on 8<sup>th</sup> September 2011, telephone contact on 9<sup>th</sup> September and a second home visit on 10<sup>th</sup> September. After this, there were a few unsuccessful home visits and telephone contact (about six in total) and this culminated in her discharge in her absence on 22<sup>nd</sup> September 2011. During the successful visits and the telephone call, Miss G remained symptomatic, unhappy with her life and talked about moving away.

On 3<sup>rd</sup> October 2011, there was contact from a psychiatric social worker in Camden who had been alerted by a member of the public of a person who was possibly psychotic. It was confirmed that this person was Miss G. She was then detained under Section 2 of the Mental Health Act 1983 for assessment and transferred to Cusworth ward. When assessed by the consultant psychiatrist on 10<sup>th</sup> October, she was discharged from Section 2. Records show that the reason for discharge was that there was "*no evidence of mental disorder*". The consultant's trainee doctor's discharge summary states the diagnosis as mild depressive episode and the follow up arrangements were that Miss G was "*advised to contact homeless section, Crisis Resolution Team follow up*". There was no reference in this to Miss G's lengthy and varied psychiatric history or to her previous diagnosis.

There is no evidence in the clinical record that the MDT discussed Miss G's extensive longitudinal history.

The re-grading of Miss G to informal status and the decision to discharge her was clearly a consultant decision as the trainee doctor's hand-written entry did document a range of symptoms including possible psychotic features and also referred to some of her complex past history but none of this was referred to in the discharge summary.

The quality of the consultant assessment and diagnosis and care planning of this inpatient episode fell significantly below acceptable standards of acute psychiatric inpatient care. The assessment lacked thoroughness and, as a result, the long history of disturbed behaviour and poor adjustment, which had been correctly diagnosed in the past as features of emotionally unstable personality disorder, borderline type and managed accordingly, was missed. In view of this the care plan was inadequate and not in keeping with good practice given the patient's presentation.

In early December Miss G was admitted to the Medical Assessment Unit at Doncaster Royal Infirmary, following an overdose of 30g of Paracetamol staggered over 11 hours. This was a serious overdose and therefore an assessment under the Mental Health Act (1983) should have been considered. At this point Miss G was referred to the community therapies team. This is a team that provides interventions for service users with mild to moderate anxiety and depression. Miss G should have been referred to the intensive community therapies team. This team provides interventions for service users with severe depression and anxiety-related disorders, including personality disorder and obsessive-compulsive disorder. If she had been referred to the intensive community therapies team she would have been seen at the latest by the middle of January 2012.

On 1<sup>st</sup> January 2012 Miss G reported that she needed to be in hospital as her "*head was all over the place*." A week later she requested hospital admission stating she needed to be "*locked up*". She said she felt she had the potential to harm someone in the future. At this stage there was no proper mental health assessment or a thorough risk assessment.

Nine days later Miss G told a psychiatrist that seven people were trapped in her body.

On 15<sup>th</sup> January she told a mental health nurse that she still wasn't well and that her mood was not right. She added that her thoughts and feelings were disturbed and that she shouldn't be around other people due to her thoughts of wanting to kill other people. She said that she had bad thoughts everyday and therefore tried to stay away from people on the street. She said that she has never physically hurt anyone, but she said that she felt like she had two personalities, one full of anger and another that is quiet and low in mood. Miss G said that she has heard voices since being seven years

old, but they are worse now than they have ever been. Miss G also advised that she had no solution to her situation.

Five days later, a discharge plan for Miss G was discussed. The clinical notes record that Miss G reported not feeling much different to when she first started receiving visits from the Home Treatment team. She told staff that she still heard voices and had fleeting suicidal thoughts but no plans. The discharge plan records:

*“Following receiving home treatment support by the access team, we feel your mental health has improved to such a level, we will begin to reduce the frequencies of your visits. Given that you no longer need intensive support from home treatment team you are suitable to be discharged from our services in due course.”*

On 30<sup>th</sup> January, Miss G was visited at home. It is recorded that she was quiet and gave limited responses. She reported her mood was ok but was still experiencing some thoughts of self harm. Miss G felt that she was ready to be discharged.

## **Conclusion**

There is no convincing evidence that Miss G’s mental state had improved during January to the degree that she should have been discharged from the home treatment team. There is more evidence leading to the conclusion that her mental health had deteriorated. The discharge plan does not demonstrate that Miss G had been listened to.

## **Management of People with Borderline Personality Disorders**

During this second episode of care, two national policies were in place to provide guidance on the management of people with personality disorders. Personality disorder no longer a diagnosis for exclusion (DoH) and the clinical guideline for the treatment and management of borderline personality disorders (NICE).

The table below details the key priorities set out in the NICE clinical guideline 78 for the treatment of people diagnosed with borderline personality disorders against the treatments and interventions provided by the trust.

Number	Key priorities	Treatment and interventions provided by the trust
1.	<p><b>Access to services:</b> People with borderline personality disorder should not be excluded from services because of their diagnosis or because they have self-harmed.</p>	<p>The trust did accept Miss G for services and attempted to re-engage her when she stopped attending out patient appointments.</p>
2.	<p><b>Autonomy and choice:</b> Work in partnership with people with borderline personality disorder to develop their autonomy and promote choice by:</p> <ul style="list-style-type: none"> <li>a. ensuring they remain actively involved in finding solutions to their problems, including during crises</li> <li>b. encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make</li> </ul>	<ul style="list-style-type: none"> <li>a. The clinical records show good examples of partnership working and promoting choice, such as options for counselling and providing telephone numbers for the crisis team.</li> <li>b. Autonomy was promoted but there was no intervention when Miss G was unable to progress solutions. i.e. she never received counselling but nobody seemed to register this.</li> <li>c. Miss G was given choices about her care and treatment. She was given options about medication and interventions charities.</li> </ul>
3.	<p><b>Developing an optimistic and trusting relationship.</b> When working with people with borderline personality disorder:</p> <ul style="list-style-type: none"> <li>a. explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable</li> <li>b. build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable</li> </ul>	<ul style="list-style-type: none"> <li>a. Although individual members of staff engaged with Miss G and tried to build up a relationship and explored treatment options, there was no lead professional or care coordinator who took responsibility for planning and coordinating Miss G's care and therefore nobody was able to build up a long lasting optimistic trusting relationship with her.</li> </ul>
4.	<p><b>Managing endings and transitions</b> Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people with borderline</p>	<ul style="list-style-type: none"> <li>a. There was not a comprehensive care plan or crisis plan in place for the majority of time. Miss G was provided with</li> </ul>

Number	Key priorities	Treatment and interventions provided by the trust
	<p>personality disorder. Ensure that:</p> <p>a. such changes are discussed carefully beforehand with the person (and their family or carers if appropriate) and are structured and phased</p> <p>the care plan supports effective collaboration with other care providers during endings and transitions, and includes the opportunity to access services in times of crisis</p> <p>b. When referring a person for assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them.</p>	<p>telephone numbers for the crisis team.</p> <p>b. Referrals were made to other services but clinical records show that Miss G was expected to manage this herself, for example when she was asked to contact MIND to arrange counselling.</p>
5.	<p><b>Care planning in community mental health teams.</b></p> <p>Teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user (and their family or carers, where agreed with the person).</p>	<p>There is evidence that a care plan was developed with Miss G in 2002 but little evidence of a multidisciplinary, collaborative care plan since then.</p>
6.	<p><b>The role of psychological treatment.</b></p> <p>An explicit and integrated theoretical approach to psychological therapies should be used by both the treatment team and the therapist, which is shared with the service user</p>	<p>Although Miss G was referred for counselling she never received any. She was never referred to a psychologist</p>
7.	<p><b>The role of drug treatment.</b></p> <p>Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms).</p>	<p>The drug treatment that Miss G was prescribed was appropriate.</p>
8.	<p><b>The role of specialist personality disorder services within trusts</b></p> <p>Mental health trusts should develop multidisciplinary specialist teams and/or services for people with personality disorders. These teams should have specific expertise in the diagnosis and management of borderline personality disorder</p>	<p>The Trust has only been commissioned to have one whole time equivalent who specialises in personality disorder.</p>

## **Conclusion**

Efforts were made to keep Miss G engaged with services. Some of the key priorities set out in the NICE guidelines were not in place. Miss G did not have a lead professional which meant that a trusting therapeutic relationship was harder to develop. Further, there was not always a comprehensive care plan in place and little effort was made to encourage Miss G's adherence to psychological therapies.

## SECTION THREE: CONCLUSION AND LESSONS LEARNED

### 3.1 CONCLUSION

The terms of reference listed below are answered in this section:

- **Did staff in each agency follow relevant inter-agency and single agency policies and procedures which were in place at the relevant time? Did these policies and procedures reflect National Guidance?**
- **Did the organisation appropriately recognise Miss G as a child in need / vulnerable adult, and the need of a protection plan?**
- **What were the contributory factors of the incident?**

It is important to note that it was the actions of Miss G that led to the tragic death of Child A and that at her trial she was found guilty of murder and not manslaughter as a result of diminished responsibility.

The purpose of this review is to examine the services that were provided to Miss G to enable lessons to be learnt and services improved. The content of the Review report paints a not unusual picture of mixed performance in meeting the needs of Miss G. A combination of factors, influenced the care provided for Miss G over nineteen years. They include;

- ineffective leadership and management
- dysfunctional organisational systems,
- workforce and cultural factors and
- individual deficient practice.

Local policies and procedures generally reflected National Guidance. The picture is mixed in relation to organisations applying them and working effectively with other agencies. A major issue appears to have been embedding policies into practice and leading and managing change.

The Review commences in 1993 and since that time, as identified earlier, there has been a significant change in national and local policies, knowledge, practice and subsequently in services but as the recommendations identify there remain issues for organisations to address.

There is evidence of good practice and many examples of times that individuals and organisations attempted to assist Miss G. There is no evidence that any individual set out to provide a less than satisfactory service. However there is evidence that some services, like Children's Social Care were working under considerable pressure. There

was no lack of input from agencies both statutory and voluntary with Miss G but the care provided generally did not meet her needs.

### **1993 to 2002**

During the first period of contact with Miss G and her family following a referral made by her GP to Children's Social Care in 1993 there was a series of missed opportunities:

- The referral made in 1993 was not actioned as a child protection investigation. This was a major mistake. This would have enabled the identification of a key worker, a controlled period of key agency involvement, assessment and planning and provided the possibility of a different outcome for Miss G.
- There was a missed opportunity to provide early intervention to prevent the years of neglect that Miss G experienced as a child. Nine professionals and four contacts of Miss G including her grandmother made disclosures to CSC but none of these led to the level of response required to safeguard Miss G from neglect. The quality of practice at this time was inadequate. There is no evidence of an effective assessment or analysis of her, parental capability or home conditions in the CSC records. The Review could not find an assessment of the provision and quality of the home education she received in the CSC records nor any assessment or analysis of the impact that this could have had on Miss G's health and development.
- Social work practice was adult focused and failed to ensure that the welfare and protection of the children remained paramount. The parents' poor co-operation, deception, and combination of plausible and disengaged behaviour added to the focus of services being on keeping their cooperation and losing sight of the children. Thresholds before effective intervention were too high. The impact of the health of the parents on their capacity to look after Miss G and provide home education was not assessed. The decision to support the family by provision of services to enable them to care for the children set the tone for future interventions and there is no evidence that this was reviewed even though there was a worsening situation
- Attempts made by the children's grandmother and health professionals to disclose neglect when they were young children were not sufficiently heard and not taken seriously as no protective action followed. Care became episodic and focused on doing things. Professionals were overly optimistic about the parent's ability to be able to parent the children effectively. Professionals who expressed their concern about Miss G to CSC could have been more robust in challenging the actions that were taken or not taken. Their concerns should have resulted in a multi-agency strategy meeting for professionals not only to share information and expertise but to

plan the care of Miss G and to evaluate the outcome of interventions. Practitioners need to be aware of the process in place to escalate concerns and the necessity of using this facility.

The next period of her life resulted in Miss G needing respite care as her mother had died in 1995 (she was 10 years old) and her father needed frequent periods of hospitalisation. Again there were a number of missed opportunities to assess her needs effectively and provide the required care which included:

- It was evident from the first Looked After episode that a long term placement should have been sought for Miss G. The fact that CSC only ever considered these as respite placements represented a missed opportunity to plan and implement a care package that would have met her needs and support her transition from care into independent living. There appears to have been little recognition that her behaviour, performance at school and health improved when she had periods of stability with foster carers and that she deteriorated when she returned home. Although it must be stressed that she wanted to return home. Evidence was available to CSC at this time to indicate that a more permanent care solution should have been planned. Miss G had six different foster care placements in five years and nine social workers.
- There is no evidence of effective leadership and management oversight, control or challenge of social work decisions apparent in the CSC record.
- There is little evidence of direct one to one work by CSC with Miss G using assessment and therapeutic tools and techniques, objective measures and a systematic approach to identify patterns and predict outcomes, identify escalating risk. During this time frame there are frequent entries in the CSC record of Miss G's continuing to struggle with her grief of her mother's death and missing her father. No opportunity was taken to refer her for specialist support around bereavement at this time particularly as her father's health was deteriorating.
- A lack of available records makes it difficult to identify the adequacy of the Leaving Care provision for Miss G but her deteriorating behaviour, the fact that her father died in 2001 and that she became homeless at the aged of 16 years and her behaviour was deteriorating does not indicate that a successful pathway plan was in place particularly because the record of CSC involvement with Miss G finishes in 2002 when there were many indications that she needed more support. The little consistent support she had received ended when she left care.
- Of significance is that the care of Miss G did not focus on her and her needs. There were missed opportunities to conduct a comprehensive assessment of her needs,

including a risk assessment. This resulted in a lack of a comprehensive plan of care developed with Miss G to meet her needs. Appropriate child protection or care plans, and reviewing processes were not in place. CSC continued to work with the family at an “in need of services” level rather than considering Miss G a child at risk of harm. There was a lack of inter-agency and multi-agency working in many instances She was almost invisible to some services. The impact of her not receiving the appropriate care on her ability to make choices about her life and care was not considered by most services.

- There is an obvious lack of understanding across agencies of the fact that Miss G was a teenager who had not experienced the type of family support whilst growing up that prepares an individual with the required resilience for transition to adult life and responsibilities.

## **2002 to 2012**

In the process of undertaking this review the issue of Miss G's concern about housing has become evident and it was raised at Miss G's trial. St Leger Homes provided a supportive service to Miss G and attempted to coordinate a response to her care needs across agencies. Miss G was recognised by the service as a vulnerable woman and her name placed on their safeguarding list due to the perceived potential risk she posed to herself. The Estates Officer assisted Miss G and kept her informed of progress and monitored Miss G's responses. There is no evidence that Miss G's housing issue was not treated effectively.

## **Mental Capacity**

In law, for many years there has been recognition that some people are not able to make decisions for themselves. Making a decision on behalf of someone who can't make it for themselves gives the decision-maker a lot of power over the person. The Mental Capacity Act (2005) (MCA) clarifies and defines the way decisions are made, in order to ensure that such power is not abused The MCA empowers and protects any vulnerable person aged 16 and over who is not able to make specific decisions at a particular time because of illness, injury, a disability or the effects of drugs or alcohol. The MCA makes it clear who can take decisions, in which situations and how they should do it and allows a person to lawfully provide care and treatment to someone who lacks capacity if it is in their best interest.

Whenever the term ‘a person who lacks capacity’ is used, it means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken (MCA code of practice). An important factor in considering the care of Miss G during her adult years is that there is no

indication that she lacked capacity and therefore although her behaviour made her vulnerable she was not assessed as requiring input from adult safeguarding services.

### **Mental Health Services**

Miss G was seen by 16 different psychiatrists, working in five consultant teams, and over 20 community workers over the period of time she was in touch with mental health services. Nobody was identified as a lead professional to oversee and coordinate Miss G's care and treatment. Opportunities were missed to carry out thorough risk assessments that took into account static, dynamic and acute factors. Opportunities to carry out mental health assessments under the MHA were missed. There were shortcomings in the following areas:

- no lead professional to build up a longstanding therapeutic relationship with Miss G
- no consistent coordinated approach to her treatment and care
- the application of CPA in 2011
- only part compliance with national policy and guidelines on treating people with personality disorders.

There is no convincing evidence that Miss G's mental state had improved during January 2012 to the degree that she should have been discharged from the home treatment team. There is more evidence leading to the conclusion that her mental health had deteriorated. The discharge plan does not demonstrate that Miss G had been listened to.

Since this incident RDaSH have introduced a number of good practice measures in relation to the care programme approach, risk assessment and documentation. RDaSH should also review service models for people with personality disorders to ensure that they receive high quality treatment and care.

The potential for poor outcomes for Miss G increased significantly because of a lack of early intervention at a stage to address early signs of concern. No single agency 'owned' her care and frequent movements between agencies resulted in a degree of fragmentation of care. The cost to her in terms of her emotional and psychological well being appears to have been considerable. Later in life some people did try to help her and she was signposted to a number of services. Either because she was not motivated or because of the lack of coordination or because services failed to drive through the required contact it did not happen. No one person during her childhood, adolescent or adulthood established a long standing therapeutic relationship with her, coordinating her care or acting as lead professional. This is an essential principle when managing people with borderline personality disorder. Throughout her life it appears

services failed to listen to her concerns. There was a lack of inter-agency and multi-agency working in many instances. She was almost invisible to some services. The impact of her not receiving the required quality of care on her ability to make choices about her life and care was not considered by most services. What is evident is that she told many agencies of her concern that she was going to harm someone. Assessments made by them did not identify a high level of risk of this occurring. It is hard to establish if this was because she was not really heard. There were missed opportunities to work with her more effectively. This could have changed the course of events in Miss G's life and well being.

### **3.2 LEARNING LESSONS, IMPROVING SERVICES**

#### **What Other Lessons Could be Learnt from this Incident?**

1. Firstly what is clear is that there is a lack of consistency in quality of and the retention periods for the different records created and maintained by agencies. Whilst some of the retention periods are governed by statute and now require compliance with the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 others over the years have been the result of local guidelines following best practice. Management of information and sharing within and between agencies and by individual professionals is crucial to safeguarding children, young people and vulnerable adults. There remains some issues in record keeping which across services was generally poor.
2. It is important that there are clear lines of accountability and systems in place that support professionals to undertake their role. Lack of clarity about the functioning of services, asymmetrical changes within and across services, lack of resources and effective auditing, all added to produce an environment which made it difficult for professionals to achieve quality services. There is evidence of issues associated with ineffective management and workload pressures.
3. A good child protection system should be concerned with the child's journey through the system from needing to receiving help, keeping a clear focus on children's best interests throughout. This includes developing the expertise and the organisational environment that helps professionals working with children, young people and families to provide more effective help<sup>30</sup>. There is evidence of improvements in Children's Services in Doncaster which needs to continue and consolidate during a challenging period of change and financial pressure.

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<sup>30</sup> The Child's Journey. Interim report. Munro 2011

4. There are problems associated with the ability of practitioners to critically analyse data and information to identify indications and patterns of safeguarding issues. Contemporary practice calls for the ability to use assessment tools and techniques, observational skills, objective measures and a systematic approach and constantly striving to advance practice and ensure that reflective practice is at the heart of assessment. Assessment must be one of the cornerstones of working with children and young people and adults. All assessments must be underpinned by a sound understanding of people's developmental needs. A consistent finding from many reviews is that there had been a failure to implement and ensure good practice rather than an absence of the required framework and procedures for delivering services.
  
5. All professionals need a solid foundation of theoretical knowledge and a thorough understanding of the nature of professional practice, understanding the forms of knowledge used in practice and the ways in which knowledge is developed about practice from practice. Professional expertise comes from wisdom about practice and professional artistry. There was a lack of direct one to one work with Miss G using assessment and therapeutic tools and techniques, objective measures and a systematic approach to identify patterns, predict outcomes and identify escalating risk. Work could have taken place to increase Miss G's resilience. Resilience is made up of a number of different elements including self-esteem and attachment. A useful framework splits resilience into intrinsic and extrinsic factors.

The intrinsic factors are building blocks that are necessary for resilience:

- A secure base – the child feels a sense of belonging and security.
- A sense of self-efficacy – a sense of mastery and control, along with an accurate understanding of personal strengths and limitations
- Self-esteem – an internal sense of worth and competence.

The extrinsic factors are:

- at least one secure attachment
- relationship
- access to wider supports such as:
  - extended family and friends
  - positive nursery, school and/or community experiences<sup>31</sup>

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<sup>31</sup> Daniel, B and Wassell, S (2002) *The School Years: Assessing and Promoting Resilience in Vulnerable Children*. Jessica Kingsley Publishing, London.

- 6) Munro and Laming<sup>32</sup> recognise the importance of early intervention. There is sometimes confusion about what is meant by intervention in safeguarding and child protection. Procedures should place the practitioner in the right place at the right time with the required skills and competence to respond on behalf of their agency. Practice is the authority, understanding, knowledge and skills which the practitioner needs to bring to bear on the situation. It is necessary and important to follow the agency's procedures but it is responding with the appropriate practice that is also crucial. If they are not to trap themselves into inaction, practitioners must be prepared to work only with 'reasonable inference'. Reasonable inference is when agencies follow and take full account of the facts and make a proportional response to them without prejudice to the service user.
- 7) Neglect is an issue in its own right. Practitioners need to respond to concerns about the standard or quality of care that a child is receiving. Evidence shows that neglect may inhibit the appropriate development of certain regions of the brain (Glaser, 2000<sup>33</sup>). A neglected infant or young child may not be exposed to stimuli that normally activate important regions of the brain and strengthen cognitive pathways. The connections among neurons in these inactivated regions can literally wither away, hampering the child's functioning later in life. As a result, the brain may become 'wired' to experience the world as hostile and uncaring. This negative perspective may influence the child's later interactions, prompting the child to become anxious and overly aggressive or emotionally withdrawn. Children who experience rejection or neglect are more likely to develop antisocial traits as they grow up and are more associated with borderline personality disorders and violent behaviour (Schore, 2003<sup>34</sup>). Abused and neglected adolescents are estimated to be at least 25 per cent more likely to experience problems such as delinquency, teen pregnancy, low academic achievement, drug use, and mental health problems. A thorough assessment of the specific circumstances of each family where neglect occurs is needed in order to establish the nature of the difficulties that underpin the neglect in that case. A symptomatic response (for example, one that focuses on the domestic environment alone) is unlikely to be successful if other factors (such as relationship difficulties between parent and child) have not been addressed. This means a move away from reacting to symptoms, towards an analysis of and work with the causes of neglect. The causes of chronic neglect are complex and are likely to involve a number of crosscutting or interacting factors in the intra-personal, inter-personal/family, social/community and societal domains.

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<sup>32</sup> Stein, M. and Munro, E.R. (2008) *Young People's Transitions from Care to Adulthood: International Research and Practice*. London: Jessica Kingsley Publishers

<sup>33</sup> Child Abuse and Neglect and the Brain—A Review. Danya Glaser (2000) *Journal of Child Psychology and Psychiatry*, Volume 41.

<sup>34</sup> Schore AN. *Affect dysregulation & disorders of the self*. New York: WW Norton; 2003.

Effective intervention will be directed at different levels according to the specific needs and concerns of the particular family. With the introduction of the Assessment Framework, social workers and other professionals have potentially now got a very powerful tool for promoting the holistic understanding that is needed in cases of child neglect. However, care must be taken to keep all three 'sides' of the triangle in balance – that is, assessment needs to consider strengths and concerns within each of the domains and then how they interact.

- 8) Reder and Duncan<sup>35</sup> identified the danger of professionals failing to share discrete pieces of information. The knowledge held by an individual agency may not, on its own, appear worrying but when collated the overall picture may indicate a more significant level of concern and risk. So effective intervention will draw on a range of professional perspectives and will require a coordinated response from all professionals and services involved. Clear co-ordination is also necessary to avoid overwhelming the family or individual and to prevent confusion in the professional network. Intervention strategies need to be congruent with the findings of the assessment. This requires a flexible approach and the ability to match intervention to identified needs. A wide range of formal and informal responses may be needed in any one case to increase the family's ability to offer appropriate care to vulnerable children and to support children to remain within their own family or for an individual to be able to care for themselves.
- 9). Poor co-operation, deception, and combination of plausible and disengaged presentation added to a lack of focus. Practice became task focussed. Working with a disengaged family, young people and adults is a challenge to most experienced professionals and knowledge, skills and expertise needs to be developed and supported by effective supervision. In cases of chronic neglect, long-term intervention may be necessary. However, in order to avoid drift, interventions need to be purposeful, focused and underpinned by in-depth assessment, measurable objectives for change, strategies for achieving these changes, and ways of evaluating whether the required changes have taken place. That is, practitioners need to be able to say what a successful or acceptable outcome would look like in a particular case and how they would judge whether or not it has been achieved and be prepared to remove a child if the necessary improvements cannot be made or to provide the appropriate intervention in the case of an adult neglecting themselves.

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<sup>35</sup> Reder, P. and Duncan, S. (1999) *Lost innocents: a follow-up study of fatal child abuse*, London: Routledge

- 10). There was a consistently high threshold across agencies before concern triggered action and the attitude of the professional culture overall was too tolerant. The passive approach taken by some services is evidence that the challenges, and therefore the required systems and practice and the use of effective assessment tools, were not fully in place.
- 11). Children and young people who have to undertake inappropriate caring responsibilities can be affected not only during childhood, but also as they become adults. The absence of family-focused, positive and supportive interventions by professionals, combined with inadequate income, have negative effects for young people and their parents. Parental illness or disability is usually an indirect influence. The more direct influences are the lack of appropriate, social care services, educational difficulties and poverty.
- 12). All professionals need to recognise the responsibility and accountability that comes with the role they undertake whether they are a social worker, GP, teacher or psychiatrist. They need professional maturity, the ability to respectfully challenge and an enquiring mind and the tenacity to see things through. In the case of Miss G there were fifteen professionals and at least four other people who raised their concerns about her situation.
- 13). What is clear from the Review is that there are considerable issues associated with safeguarding young vulnerable adults and the need for improved understanding and systems in place to identify and address their needs. It is important that links are made between the planning and provision of safeguarding services for children, young people and vulnerable adults. There is not enough research and knowledge about working with teenagers. At the age of 17 years Miss G was: moving out of care, self harming, homeless, using drugs, developing a chaotic lifestyle, struggling to come to terms with her parents dying, had been isolated from children of her own age and bullied at school. Adolescence is a time of rapid transition when young people begin to make choices that impact on their health and wellbeing. Children's services should consider what model of service exists in the area and whether it meets the needs of young people:
  - Has there been any needs analysis with young people in the area?
  - What evaluation of current service provision has taken place?
  - Are there services that can be enhanced or is there the need for new provision?
  - Where would available resources make the biggest impact? <sup>36</sup>

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<sup>36</sup> making health services more accessible to young people. AYPH

14). Improving the role of the corporate parent, as part of Children's Services, is key to improving the outcomes for children who are Looked After. It is with the corporate parent that responsibility and accountability for the wellbeing and future prospects of children in care ultimately rest. A good corporate parent must offer everything that a good parent would, including stability. It must address both the difficulties which children in care experience and the challenges of parenting within a complex system of different services. Young people's transition from care to adulthood is shaped by a set of complex processes related to legal and policy frameworks, and the economy which all impact upon the professional and political priority attached to this vulnerable group of young people and the type and availability of services provided to them. Care leavers, like Miss G, are generally more likely to have poorer educational qualifications, be younger parents, be homeless and have higher levels of offending behaviour, mental health problems and social isolation. Experiences before and during care affect a young person's transition; high quality and stable placements lead to more positive outcomes. Young people leaving care are negotiating the transition to adulthood at an earlier age than their peers. The majority will move to independent living before the age of 18 compared to fewer than one in ten of their peers. Simultaneously they have to cope with a number of major changes. Not only do young people leave early, the main elements of transition to adulthood tend to be compressed. Learning to manage a home, gaining a career foothold and starting a family tend to overlap in the immediate period after leaving care. Many young people will also have received inconsistent preparation for adulthood. It should not therefore be surprising to find that, while some young people have positive experiences and go on to do well, others experience considerable difficulty. Young people are unlikely to manage in adversity without a network of formal and informal support. However, research has shown a tendency for support from social workers and past carers to fall away soon after leaving care as it did with Miss G. There are three broad types of outcome visible: those successfully 'moving on' from care, those 'surviving' the transition, and those with more complex needs that are 'struggling'.<sup>37</sup>

Many young people leave care without the support to which they are entitled, unable to find suitable housing, education and employment. Most young people in and leaving care do not have the benefit of parental support to guide them. For these young people, the local authority should be fulfilling the parental role, and providing for the young person as if it were the natural parent.

If pathway plans are as detailed as they should be, then the young person will, at the very least, be able to identify the steps that he/she needs to take in order to

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<sup>37</sup> Stein, M. and Munro, E.R. (2008) *Young People's Transitions from Care to Adulthood: International Research and Practice*. London: Jessica Kingsley Publishers

achieve his/her goals. She/he will have named people to turn to, people who are able to help her/him to complete application forms, and are aware of the different support providers available and can arrange access to them. The difference to a young person between having no pathway plan or a bad pathway plan, to having a lawful, detailed plan, is enormous and, as was recently made apparent from the reported story of the death of care leaver, Andrea Adams, the lack of support and planning can lead to tragic consequences.

- 15). Examination of the chronology of Miss G's contact with services from 1993 to 2012 identifies that the lack of coordinated plans and a lead professional resulted in services deciding to end contact with her or not pushing to maintain contact with her at a point when she was at her most vulnerable for example in the case of social care.
- 16). Risk management needs to be consistent and constant throughout an organisation's culture, its strategy and the implementation of that strategy. It is important to be able to assess risk effectively and to identify accumulating risk from Board to practice levels. Risk should be managed at two overlapping levels; strategic/management level and day-to-day staff and service operational level. Risk management should include the whole spectrum of things that could and can go wrong involving staff, patients and the public, administrative errors that impact on care and incidents that have a direct effect on the outcome of care. It will also include the management of the risks associated with running a service including financial, ethical and information technology risks. Risk Management Standards should be developed within and across agencies with the development of a local coordinated approach to risk management based on the risk management approach that involves:
  - *Communicate and consult*: Who will need to know about and be involved at each stage of the risk management process?
  - *Establish the context*: How will you assess and analyse the risk? What are the criteria you will use to judge the likelihood and consequences of risk?
  - *Identify risks*: What could stop you achieving your objectives and outcomes?
  - *Analyse risks*: Are our existing risk controls working and what are the potential consequences of risks happening?
  - *Evaluate risks*: What is the balance between potential benefits and adverse outcomes of managing these risks?
  - *Treat risks*: How can we develop and implement specific cost-effective strategies to increase benefits and reduce potential costs?
  - *Monitor and review*: Are we achieving the right outcomes and how do we know?

Mental health professionals working in community-based services and teams should be trained to assess risk and need, so that treatment, therapeutic interventions and management are in accordance with NICE guidance.

- 17). In 1999 the National Service Framework for mental health was introduced to set out national standards for mental health services. Specialist community mental health teams were set up, offering home treatment, early intervention or intensive support for people with complex needs. A major theme throughout all mental health policy documents at the time was that mental health services need to give a high priority to issues relating to clinical risk assessment and risk management. The Care Programme Approach (CPA) was introduced in 1999 to ensure the effective coordination and delivery of mental health care. Risk assessment and risk management were introduced as being central to effective mental health practice within the CPA process. Another important policy and subsequent guidance relevant to this case is the national policy and NICE guidance on the management of people with personality disorder. These documents advise on the type of service provision and therapeutic interventions for people with this diagnosis.

Mental health professionals including clinicians working with people with a borderline personality disorder should have routine access to supervision and staff support. Supervision provides staff with a confidential, safe and supportive environment, to critically reflect on professional practice, to improve quality patient services by improving mental health practice, by encouraging reflection on attitudes towards people with mental health problems and disorders, their family members and carers.

## **SECTION FOUR: RECOMMENDATIONS**

The Independent Multi-agency Review panel recognises the significance of this Serious Case Review and has made recommendations suggesting changes locally as well as inter-agency changes, based on an analysis of a combined chronology and the sum of the Individual Management Review reports.

Each agency contributing to the Independent Multi-agency Review has also made recommendations for improving practice within their own agency as part of their IMR. These have been included at the end of this section.

### **Recommendations**

1. Doncaster Safeguarding Childrens Board will review the retention and transfer of records policies and practice across agencies to establish consistency in line with legislative requirements and best practice.
2. Doncaster Safeguarding Childrens and Adult Safeguarding Boards will review the systems in place and training that is provided to support leadership throughout partnership organisations.
3. Doncaster Safeguarding Childrens and Adult Safeguarding Boards will review their current policies, practices and training strategies to reflect the need to better address issues associated with:
  - Assessment and critical analysis skills using assessment tools
  - Working with teenagers
  - Working with disengaged or hostile individuals and/or families.
  - Effectively monitoring the progress of families in safeguarding situations including managing risk, identifying patterns and predictive modelling.
  - Formulating and sharing information and opinions, managing networks
  - Challenging colleagues and making yourself heard in the network.
  - The management of information within and between agencies and by individual professionals.
4. Commissioners will review the contract used to commission services to meet the needs of people with borderline personality disorder in order to adhere to the NICE guideline on the treatment and management of borderline personality disorder 2009.

## **Doncaster Safeguarding Childrens Board**

5. Doncaster Safeguarding Childrens Board will carry out a quality assurance process to ensure that the Neglect Policy and Framework is understood and being implemented across agencies.
6. Doncaster Safeguarding Childrens Board will ensure that the safeguarding and education of children and young people being home educated is effectively monitored.
7. Doncaster Safeguarding Childrens Board will ensure through a quality assurance process, that the welfare and care needs of looked after children are given the highest priority, and that improvements in the outcomes for looked after children are met and sustained.

## **Doncaster Children's Services**

8. Doncaster Council will review the powers it has to assess the suitability of education provision for children educated at home and should use these wherever possible.

## **Rethink**

9. Rethink Mental Illness will review local operating procedures, to address outreach caseloads and create new/revised procedures on communication, referral and risk management. Rethink will work in partnership with Rotherham, Doncaster and South Humber NHS Foundation Trust to ensure where appropriate learning is shared.
10. As a result of the organisational learning from this review, Rethink Mental Illness will establish a Clinical Governance and Risk group to support and share practice across the charity's high support services.

## **Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)**

11. RDaSH will review the quality of record keeping in adult community mental health services and establish an improved system of routinely monitoring the quality of records. Adult mental health in-patient services will move to an electronic patient record that is routinely shared with community mental health services.
12. RDaSH will review clinical supervision within community mental health services to strengthen the focus on excellence in clinical practice including the need to ensure effective and appropriate risk management and continuity of care between services for patients.

13. RDaSH will review the function and capacity of the access team to address care delivery and include the team managers' oversight of the patients in most need. Referral and clustering processes from the access team/home treatment team to treatment teams within the adult mental health services will be included within this review.
14. RDaSH will review the Access Teams Operational Policy and Standard Operating Procedures and Care Programme Approach and Disengagement Policies to support a more effective process for the admission of patients to and discharge from services. An effective audit process will be established to assure implementation.
15. RDaSH will review the care pathways between substance misuse and adult community services.
16. RDaSH will implement training and awareness for staff in relation to services for people with complex needs whose primary diagnosis is not mental illness.

### **Yorkshire Ambulance Service**

17. YAS will review within 6 months all safeguarding training resources to update and emphasise the impact of mental health issues and the risks associated with non-conveyance to hospitals.
18. YAS Head of Safeguarding will within 3 months ensure that individual action plans for Emergency Operations Centre staff associated with this case will have been delivered and all actions completed.

### **Housing Options**

19. Housing options staff will be provided with additional guidance to ensure that information provided by other agencies informs decisions about a case and in turn what information should be provided to the referring or other agencies.

### **M25**

20. A review of assessment guidance will be undertaken to increase the emphasis on initial action plans especially when clients are not admitted to the M25 service.
21. Guidance and training will be provided for support workers to ensure that when they are involved in complex cases there is:
  - appropriate sharing of client information with other agencies

- timely responses for clients and referring agencies when a client is not admitted to the service.
- effective management of cases of intermittent contact.
- assessment of risk assessment and management.

**Doncaster and Bassetlaw Hospitals NHS Foundation NHS Trust**

No recommendations identified.

**St Leger Homes**

No recommendations identified.

**South Yorkshire Police**

No recommendations identified

## Appendix 1 Children's Social Care

### Issues for improvement - 1999- 2010

- Safeguarding policies and procedures were not up to date or being used effectively.
- The quality of provision of safeguarding services for children and young people, including service responsiveness, assessment, case planning. This included comprehensive and timely initial and core assessments, good identification of risk and appropriate interventions that match children's needs and ensure their safety. Children in need and those for whom there are child protection concerns are not seen quickly, risks identified and addressed through strategy meetings.
- There was a lack of discussions and consultation with partner agencies.
- The lack of agreed intervention thresholds was identified as a cause for delays in providing access to services for some children.
- The quality of case recording was variable and although some case records were detailed others contain insufficient information
- The quality of assessment, planning and record keeping for individual children was inconsistent with some being very poor. Reviews and recording was assessed as adequate overall
- The level of leadership, social worker and management capacity was not adequate.
- Social workers' caseloads needed to be more manageable and the quality and availability of training for staff improved. Reducing vacancies of social workers was an issue. There was significant staff turnover, poor morale and excessive use of agency staff.
- The quality of the local authority's fostering and adoption service and the stability of placements for children in care needed to be improved.
- The engagement of children and young people in the safeguarding and child protection process needed to improve. Children were not routinely seen and seen alone during child protection enquiries, investigations and statutory visits. Their wishes and feelings were not recorded and they were not directly worked with leading to better outcomes.
- The number of children in need were higher than the statistical neighbour average. There was no discernible rise evident in the number of completed CAFs and of those completed almost half were out of time.
- Workforce development needed to be an integral element in ensuring that the safeguarding service is fit for purpose in delivering its responsibilities
- Support for young carers needed to be improved and individual support provided
- The overall effectiveness of services for looked after children was inadequate.

- Statutory requirements are now met and improved outcomes have been evidenced in a range of requirements such as the timeliness and effectiveness of statutory reviews and all looked after children are now allocated to a qualified social worker as a result of successful recruitment. Better outcomes have been achieved in education also where the progress of looked after children is now in line with comparators. Children and young people, including those from minority and vulnerable groups, have been involved well in service development and evaluation and there is evidence of their increased influence and impact.
- Fostered children did not have the required safe care plans and not all electronic case files contain full records of key decisions and actions due to the difficulties with the current electronic system. Placement stability for looked after children needed to be improved.

### **Inspection Outcome 2012- Looked After Children**

- *Leadership and management of services for looked after children are adequate. Since the current departmental senior leadership team has been in place there has been, with partners, a determined and relentless focus upon improvement, leading to the development of the multi faceted plan and, subsequently, to its implementation. Improvement in the overall quality of service has been supported by increasingly robust oversight by the Independent Reviewing Officers at statutory reviews. This has contributed significantly to curtailing drift and delay in creating and implementing care plans.*
- *Fostered children do not have the required safe care plans and not all electronic case files contain full records of key decisions and actions due to the difficulties with the current electronic system. Although placement stability for looked after children has improved in the first year, achievement of longer term stability is not yet apparent although clear plans are being implemented to address the long term and entrenched difficulties. Pathway plans are much improved, are now good and set clear courses for young people to follow. More emphasis is now placed on developing an early dialogue with 15-year old young people in care about the choices open to them and better use is made of the wide ranging provision available across schools and colleges.*
- *Health care provision for looked after children is inadequate overall and the absence of a framework for the health and wellbeing of looked after children and a designated doctor has impeded strategic development such as secure processes for health care planning. However, good CAMHS provision for children in residential care and good drug and alcohol services are impacting well with good completion rates and outcomes from treatment. Operational challenges also remain and the arrangements for ensuring that all looked after young people have*

*an initial health assessment on entering care and take with them a record of the healthcare they have received are not secure.*

- *Children and young people are increasingly encouraged to participate in their reviews and contribute to the development of their personal education plans (PEPs), reviews and pathway plans.*
- *Doncaster Council has taken appropriate action working jointly with housing services to commission additional accommodation for care leavers. Closer working with the council's housing department is enabling better matching of accommodation to need.*
- *In 2010 the proportion of looked after children continuing in employment, education or training was significantly lower than seen nationally and services had a poor record of maintaining contact with older care leavers. Over the last 12 months much has been done to remedy this weakness and good progress has been achieved.*

## Appendix 2

### Glossary

**Graded Care Profile developed by Dr Srivastava.** This tool gives an objective measure of the care of a child by their carer. The tool provides a qualitative grading for actual care delivered taking into account the commitment and effort shown by the carer. Personal attributes of the carer, social environment, and attributes of the child are not accounted for unless actual care is observed to be affected by them. Thus if a child is provided with good food, clothes and a safe house the assessment tool will provide a positive score therefore this will provide a baseline assessment and give a measure of improvement or deterioration.

**Framework for the Assessment of Children in Need and their Families.** (jointly issued by the Department of Health, the Department for Education and Employment and the Home Office, 2000) has drawn heavily on research and accumulated practice experience about the developmental needs of children. All the scales are relevant to different aspects of resilience and so the practitioner can select which ones he or she deems most appropriate. [http://www.dh.gov.uk/en/Publications\\_and\\_statistics/Publications/Publications\\_Policy\\_And\\_Guidance/DH\\_4008144](http://www.dh.gov.uk/en/Publications_and_statistics/Publications/Publications_Policy_And_Guidance/DH_4008144)

**Rosenberg Self-Esteem Scale.** The Rosenberg scale contains 10 items which are answered on a four point scale: from strongly agree to strongly disagree. The scale was developed from a sample of 5,024 high school juniors and seniors from 10 randomly selected schools in New York State.

**The Resilience Scale.** The Resilience scale was created by Gail Wagnild and Heather Young in 1987 and is a 25 item Likert scale with possible scores ranging from 25 to 175. The higher the score, the stronger the resilience.

**Local Safeguarding Childrens Board:** set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality

**Personality Disorders** are a class of personality types and enduring behaviors associated with significant distress or disability, which appear to deviate from social expectations particularly in relating to other humans. These behavioral patterns in personality disorders are typically associated with substantial disturbances in some behavioral tendencies of an individual, usually involving several areas of the personality, and are nearly always associated with considerable personal and social disruption. A person's personality has different parts (or 'traits'), such as openness, sociability, confidence, impulsivity, introversion among many others. Most of these personality traits are present in everyone to some degree. It is the unique variation in degrees and combinations of personality traits that make us who we are. Personality develops from inherited genes and life experiences, particularly in childhood.

**Care Programme Approach.** CPA is a term for describing the process of how mental health services assess a patient's needs, plan ways to meet them and check that they are being met. It includes the appointment of a care coordinator.

