STOKE-ON-TRENT

SAFEGUARDING CHILDREN BOARD

Serious Case Review SOT14 (2)

The report

8th December 2015: v10

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1. Introduction

1.1 Why this case was chosen to be reviewed

1.2 This case was taken to the serious case review sub-committee on 22nd October, 2014. The group decided unanimously that it met the criteria for a serious case review and therefore made that recommendation to the independent chair.

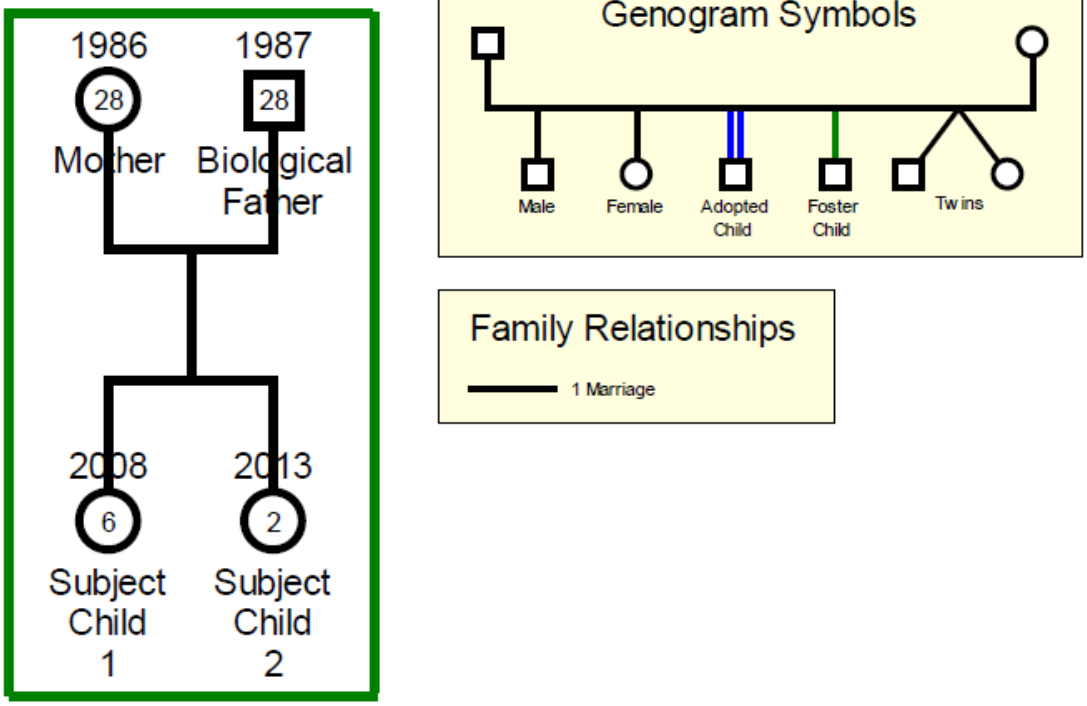
1.3 SOTSCB independent chair made the decision on 25th November, 2014 that the circumstances regarding the death of the children fully met the criteria for a serious case review, as set out in Chapter 4 of Working Together to Safeguard Children, 2013. This was because there were concerns around how agencies worked together and how agencies shared information.

1.4 In this case the mother took her own life after she unlawfully killed her children. Whilst services working with the family are considered in serious case reviews, they are considered in the context of safeguarding children. This is because serious case reviews are about children.

2. The Family

- The mother
- The father
- Subject Child One, aged six years at time of death
- Subject Child Two, aged 1 year 9 months at time of death

2.1 The family was Polish. The parents had lived in England for seven years. Both children were born and brought up in England. The father's level of English was good and there were no issues with written and verbal communication. The mother did not have the same level of understanding or grasp of the English language but she did have a basic understanding and there was no need to involve interpreters.



3. Succinct summary of the case

3.1 From February 2014 the mother had concerns about a lump that Subject Child One had in her neck. The lump was seen by a number of health professionals, all of whom reassured the parents that the lump was not sinister.

3.2 On Friday, 3rd October 2014 the father took the mother to see GP1 because of her low mood and she was also expressing thoughts of harming herself and harming/killing the children. Whilst GP1 made an urgent telephone referral to the mental health service during his appointment with the family, he did not make a specific referral to Children's Social Care. This was not done until the Single Point of Access professional made a referral on the Sunday 5th October 2014. During the course of the next few days the mental health service and Children's Social Care were involved with the family. The mental health service undertook an assessment and concluded there was no role for them and gave the mother information about a mental health charity she could access. In view of this Children's Social Care deemed the case to be a "child in need" case, as opposed to "child protection" (see glossary) and following managerial oversight had not allocated the case prior to the Sunday, 12th October 2014 when the mother killed both the children and then herself.

4. Parallel processes

4.1 Following the children and the mother's death the police undertook a criminal investigation examining elements of homicide. The investigation concluded with a comprehensive file of evidence submitted to the Crown Prosecution Service. Given the circumstances there was clearly no further action that could be taken criminally and a file of evidence was subsequently prepared for and submitted to HM coroner North Staffordshire and Stoke-on-Trent. The inquest date of all three concerned is yet to be fixed.

4.2 The directorate governance lead for community directorate for North Staffordshire Combined Healthcare NHS Trust undertook a serious incident investigation following the deaths.

4.3 The investigation has concluded and actions are being undertaken but it is not a public document.

4.4 Individual staff practice in this case has been considered, as it always is when serious case are undertaken, and the review team considers appropriate action is being undertaken by relevant agencies.

5. Timeframe under review

5.1 Systems reviews consider how safeguarding systems and practices within a local authority area operate and we test out how safe and effective they are. Therefore when considering where to start the review we do not go back many years because systems will have changed. This does not mean that family history is overlooked but what is relevant is whether the professionals working with the family during the period under review know about the family history.

5.2 In this case it was agreed that the period under review would start from 28th February, 2014, which was the date the mother took Subject Child One to the GP with concerns about a lump in her neck.

5.3 This review concluded on the date on which the tragic events occurred (12th October 2014).

5.4 The review team has examined the changes in operations within the Single Point of Access Team that have been made up to the date of the final review team meeting which took place on 27th July 2015. Changes in operations have been noted in this report.

6. Timeline of events

Date:	**Event**:
28/02/14	Child 1 taken to GP surgery with a neck lump
07/04/14	Child 1 seen by a paediatric surgeon for neck lump at Hospital 1
27/05/14	Child 1 ultrasound scan of neck at Hospital 1
24/06/14	Child 1 seen by consultant paediatrician- oncology clinic at Hospital 1. Parents also concerned re chronic mouth breathing and loud snoring
01/07/14	Child 1 had an MRI scan at Hospital 1
07/07/14	Child 1 seen in clinic by general surgeon at Hospital 1 re lump
08/07/14	Child 1 seen in paediatric oncology clinic at Hospital 1 and then discharged
19/08/14	Child 1 seen ear, nose and throat clinic at Hospital 1 – referral from paediatrics due to neck lump
07/09/14	MRI undertaken under general aesthetic of Child 1's neck lump at Hospital 2
22/09/14	Child 2 attended the GP surgery, then the Emergency Department at Hospital 1 following her putting breadstick in her eye
03/10/14	Referral to Adult Mental Health Service (Single Point of Access Team) from GP1 re the mother's low mood, thoughts of suicide and killing/harming her children, following her appointment with GP1
05/10/14	Adult Mental Health Service contacted the mother who did not want to participate in a mental health assessment. Both parents declined support
05/10/14	Single Point of Access Team made referral to children's services Emergency Duty Team. Emergency Duty Team visited, one Approved Mental Health Professional and one social worker
06/10/14	Single Point of Access Team completes telephone assessment. Mother denied suicidal ideation and thoughts to harm children.
06/10/14	Children's services Emergency Duty Team referred to one of their safeguarding teams for further assessment under s.17, Children Act 1989
06/10/14	Mother contacted oncology department asking for result from MRI done on 07/9/14 on Child 1 by Hospital 2.
07/10/14	Unannounced home visit by Single Point of Access Team – continuation of the mental health assessment. No requirement for secondary mental health services. Mother signposted to Mind, mental health charity.
09/10/14	Adult mental health assessment completed. The case to be closed to the Adult Mental Health Service because the mother had been signposted to MIND and it was considered there was no requirement for secondary mental health services.
12/10/14	The mother killed her two children at the family home and then killed herself.

7. Organisational learning and improvement

7.1 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

7.2 Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children. (Working Together 2013)

7.3 Stoke-on-Trent Safeguarding Children Board identified that this serious case review held the potential to shed light on particular areas of practice including addressing the following questions:-

- How rare is it for someone to act out their intrusive rather than delusional thoughts to kill someone? (See glossary for the difference between the two).
- The use of interpreters?

8. Methodology

8.1 Statutory guidance requires serious case reviews to be conducted in such in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

8.2 It is also required that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;

- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.

8.3 In order to comply with these requirements SOTSCB has used the SCIE Learning Together systems model (Fish, Munro & Bairstow 2010). The serious case review has been quality assured by SCIE.

8.4 Reviewing expertise and independence

8.5 The serious case review has been led by two people, one of whom was independent of the organisations whose actions are being reviewed. Joanna Nicolas is an independent child protection consultant who is accredited to carry out SCIE Learning Together reviews, and has extensive experience in leading serious case reviews. She has been a social worker for 19 years. Carole Preston is the Stoke-on-Trent Safeguarding Children Board Manager (SOTSCB). She has had 25 years' experience in social work, in a variety of roles and has been the Board Manager since 2006. Carole has been trained in the SCIE Learning Together methodology.

8.6 The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

8.7 Statutory guidance requires that serious case review reports be written in plain English and in a way that can be easily understood by professionals and the public alike. Writing for multiple audiences is always challenging. In the appendix we provide a section on terminology. Our aim is to support readers who are not familiar with the processes and language of safeguarding and child protection work.

8.8 LSCBs and SCIE are both keen to improve the accessibility of serious case review reports and welcome feedback and suggestions for how this might be improved.

8.9 Participation of professionals

8.10 The review consisted of two groups of professionals, the review team which consisted of a senior manager from each of the agencies involved during the period under review, none of whom had had line management of the case, and the two lead reviewers.

8.11 Review Team

Joanna Nicolas	Independent lead reviewer
Carole Preston	Internal lead reviewer. SOTSCB Board Manager
Safeguarding Lead	North Staffordshire Combined Healthcare NHS Trust
Strategic Lead, Inclusion	People Directorate – Learning Services
Head of Safeguarding Children	Staffordshire and Stoke-on-Trent NHS Partnership
Designated Nurse, Child Protection	Stoke-on-Trent Clinical Commissioning Group
Strategic Manager Vulnerable Children	People Directorate
Head of City-Wide Locality Working	People Directorate
Deputy Chief Nurse	University Hospital North Midlands
Crime Policy Review and Development Team Manager	Staffordshire police

8.12 The case group was made up of the key frontline professionals who had been working with the family during the period under review.

8.13 The case group

Adult mental health social worker. Duty lead 3-5/10.14	North Staffordshire Combined Healthcare NHS Trust
Registered nurse in mental health. SPOA duty call taker on 3.10.14	North Staffordshire Combined Healthcare NHS Trust
Adult Mental Health social worker. Undertook assessment 7.10.14	North Staffordshire Combined Healthcare NHS Trust
Approved Mental Health Practitioner. Sessional.	Social Care's Emergency Duty Team. People Directorate
Adult Mental Health Social Worker	North Staffordshire Combined Healthcare NHS Trust
Registered Nurse in Mental Health. Undertook telephone assessment 06/10/14	North Staffordshire Combined Healthcare NHS Trust
Play and Learning Practitioner	Play and Learning Team. Children's Centre
Social Worker	Social Care's Emergency Duty Team. People Directorate
Practice Manager	Safeguarding team. People Directorate
Practice Nurse 1	GP practice
Practice Nurse 2	GP practice
GP1. Locum GP. Saw mother, father and Child 2 on 03/10/15	GP practice
GP Practice Safeguarding Lead	GP practice
Health Visitor	Staffordshire and Stoke-on-Trent NHS Partnership
School Nurse	Staffordshire and Stoke-on-Trent NHS Partnership
Year One Teacher	Subject Child One's school
Support Assistant	Subject Child One's school
Paediatric Oncologist	University Hospital North Midlands

8.14 There was on-going interaction between the two groups to test out accuracy, developing analysis and findings.

8.15 Perspectives of the family

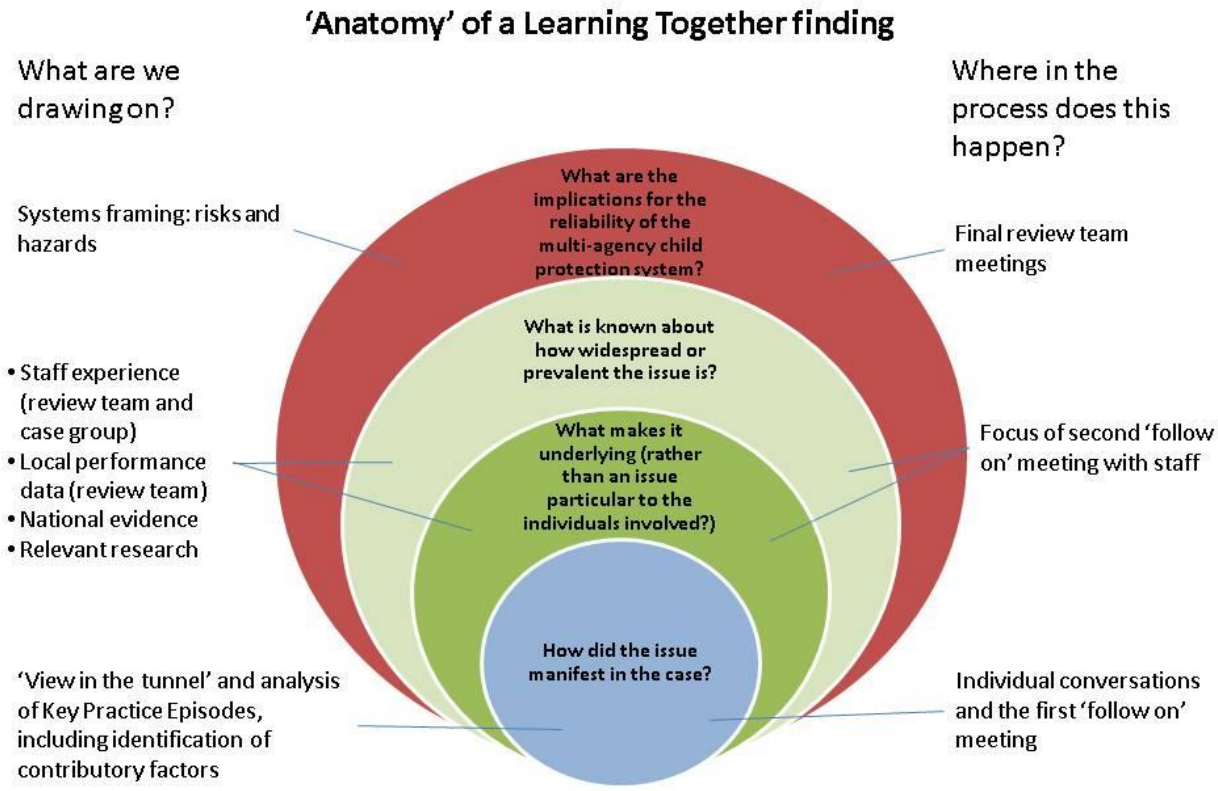
8.16 It is a family's choice whether they contribute to a serious case review. Every effort is made to engage with the family because their contribution is recognised as extremely important and makes for a much richer review. The father of the deceased children contributed to this review.

8.17 Methodological comment and limitations

8.18 During the serious case review Stoke-on-Trent was the subject of an unannounced inspection of children's services by Ofsted and on occasions that did impact on the involvement of some members of the review team and Carole Preston, as the internal lead reviewer and LSCB Board Manager. Despite this the review has gone smoothly with the case group being fully engaged with the process and being honest and open with the review team. Apart from the absence through Ofsted the review team have been very well engaged with the process.

8.19 The process has been extremely well supported by a highly efficient administrator and that has aided the process hugely.

9. The findings:



9.1 Introduction

9.1.1 Statutory guidance requires that serious case reviews provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of reoccurrence. These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

9.1.2 This section contains two priority findings that have emerged from the serious case review. The findings explain why professional practice was not more effective in protecting the children in this case. Each finding also lays out the evidence identified by the review team that indicates that these are not one-off issues but systemic within Stoke-on-Trent. These findings will resonate with other local authorities. Evidence is provided to show how each finding creates risks to other children and families in future cases, because they undermine the reliability with which professionals can do their jobs.

9.1.3 First, an overview is provided of professional practice in this case. This clarifies the view of the review team about how timely and effective the help that was given to Subject Child One and Subject Child Two and their family was, including where practice was below expected standards.

9.1.4 A transition section reiterates the ways in which features of this particular case are common to other work that professionals conduct with other families and therefore provides useful organisational learning to underpin improvement.

9.2 Appraisal of professional practice in this case: a synopsis

9.2.1 The review team explored whether frontline professionals should have considered the use of interpreters however we have concluded that there is strong evidence that the mother's level of English, supported by her husband, was sufficient for professionals to have communicated with her in writing and verbally in English, without the use of interpreters. The review team was told by all the professionals who had contact with the father that his English was very good and this was confirmed in our meeting with him. Therefore the conclusion of the review team is that the decision that professionals made around the use of interpreters was the correct one.

9.2.2 The review team considered in great detail the fact that the mother had expressed views of harming/killing her children and had thought about how she might do that. It is recognised that there is a continuum. At one end of the spectrum there will be mothers who say in frustration or anger "I could murder you", or a variation of that sentiment but it is perfectly clear that will never happen. At the other end of the spectrum there is the mother who expresses a concern that she will harm/kill her children and then actually follows through. There is contradictory research[1] as to the state of a mother's mental health prior to killing her children. In this case there was no known evidence of a history of mental ill health or any evidence of mental ill health during the assessment period prior to the incident. We have therefore concluded that there is no specific finding in respect of the mother's comments and then action.

9.2.3 The mother first took Subject Child One to the GP in February, 2014 with concerns about a lump in the child's neck. Over the next few months Subject Child One was seen by a number of medical experts, including a paediatric oncologist and an ear, nose and throat consultant. She also had two MRI scans. The mother was given constant assurance that whilst there were some concerns about the lump because it may have been causing Subject Child One to snore, it was not cancerous, or anything else sinister. The mother found this hard to accept and clearly caused her anxiety. The conclusion of the review team when considering how health professionals dealt with the mother's concerns was that they recognised the mother's level of anxiety and responded sensitively and went out of their way to allay

[1] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2174580/

her concerns. It would be easy to speculate that the mother killed her children and then took her own life because of health concerns about her children however that would be pure conjecture and there is absolutely no evidence that this was the case.

9.2.4 The father made an appointment to see the local GP on 3rd October, 2014 because he was worried about his wife. The mother told GP1 she was having thoughts of harming/killing her children and suicide ideation. GP1, who was a locum GP, spent half an hour with the family because he recognised the mother's level of need and the mental health issue, which was good practice.

9.2.5 GP1 contacted the mental health access team with the family present, known as the Single Point of Access (SPOA) Team. The parents left the surgery with the impression they were going to be contacted that day by the mental health service because GP1 had asked for that to happen. The call-taker from the SPOA team had not given that explicit guarantee although she did tell the doctor that with urgent referrals service-users will be contacted within four hours and she would try to get someone from the team to telephone the mother that day. The call taker also asked GP1 if he wanted the mother seen that day, he said yes and the SPOA call-taker said she would make a note of that. At the time in the SPOA team there does not appear to be a written policy, this appears to be custom and practice at that point (there is a policy now along with Key Performance Indicator's for it).

9.2.6 Neither GP1 nor the SPOA call-taker thought it necessary to make a referral to Children's Social Care, which they should have done, despite the mother having thoughts of killing her children. It is the view of the review team that if a referral had been made to Children's Social Care on that day it would have been treated correctly as a section 47 investigation i.e. child protection.

9.2.7 It is extremely concerning that although the referral was made on the Friday, it was not acted upon until the Sunday. It has not been possible to establish where in the system the referral was for that period of time. It is the responsibility of the duty lead to oversee all referrals that come into the team. All referrals come in through the duty desk.

9.2.8 When the referral was first picked up on Sunday, 5th October 2014, it was responded to without further delay.

9.2.9 The worker from the SPOA Team was rightly concerned about this case and referred to the emergency duty team for further assessment. The family were visited that day by an approved mental health professional and emergency duty social worker from the emergency duty team. The review team accepts that without the benefit of hindsight it is understandable why, from this point Children's Social Care considered the case to be children not in need of immediate protection because the mother's presentation and the father's support gave the professionals reassurance that the perceived risks had diminished. In addition to this, the following Thursday, 9th October, Children's Social Care were informed by the mental health service that

they were closing the case, thus giving a clear message to Children's Social Care that in their professional opinion there were not sufficient concerns about the mother's mental health for them to remain involved.

9.2.10 Following the joint visit on the Sunday the mental health service continued to assess the mother's mental health via a telephone assessment. The review team considers it poor practice that the continuation of the assessment was undertaken over the telephone. It should have been a face-to-face interview with a professional with expertise in mental health. Further to this incident the North Staffordshire Combined Healthcare NHS Trust has introduced a Key Performance Indicator to ensure that all crisis referrals receive face to face assessment within 4 hours.

9.2.11 Subsequent to this incident the North Staffordshire Combined Healthcare NHS Trust has revised their operational policy which now has additional clarity with referrals and response time.

9.2.12 There then followed an unannounced visit by a member of the SPOA team, on the Tuesday. Based on the evidence available the review team accepts that nothing from either of those contacts suggested that the mother's mental health was deteriorating, or that she required a service from the secondary mental health service.

9.2.13 The review team consider it poor practice that on two occasions the parents were led to believe by professionals they would be visited by other professionals either the same day, or the next day and in neither case did it happen within the timescale set out. The first occasion was the parents believing a mental health worker would visit them on Friday, 3rd October 2014. Secondly it was believed by the family that Children's Social Care would visit them on Monday, 6th October 2014.

10. Findings in detail

10.1 In what ways does this case provide a useful window on our systems?

10.2 When considering this question we consider 6 typologies as lines of enquires. These are:-

1. Tools - what have we learnt about the tools and their use by professionals?

2. Responses to incidents/Crises - are there particular patterns we have identified about how professionals respond to incidents?

3. Longer term work – are there particular patterns we have identified about ways of working over a longer period with children and families?

4. Management Systems - are any elements of management systems a routine cause for concern in any particular ways?

5. Family-professional interaction - what patterns of ways that professionals are interacting with different family members are discernible, and do they introduce risk into our systems?

6. Innate Human biases - are there common errors of human reasoning and judgement evident that are not being picked up through current set ups?

10.3 Our findings in this case fit into three of the categories of the typology, responses to incidents/crises, longer-term work and management systems.

10.4 Reviewing the way that professionals responded in this case is a useful test for how effectively we in Stoke-on-Trent understand levels of risk and the interface between different agencies.

11. Summary of findings

11.1 The review team has prioritised two findings for SOTSCB to consider. They are:-

Finding One There is a pattern in Stoke-on-Trent of professionals making assumptions about other teams/agencies roles, responses and remit, which can leave families vulnerable and both professionals and families with false expectations.
Finding Two At the conclusion of the serious case review process the Review Team found that many improvements have been made to the Single point of Access Team. At the date of the final Case Review meeting held on 27th July 2015, there were a number of concerns about how the team operates.

11.2 Responses to incidents/Crises - are there particular patterns we have identified about how professionals respond to incidents?

11.3 Finding One

11.4 There is a pattern in Stoke-on-Trent of professionals making assumptions about other teams/agencies roles, responses and

remit, which can leave families vulnerable, and both professionals and families with false expectations.

11.5 How did the issue manifest in this case?

11.6 The conversation between GP1 and the SPOA call-taker was made in the family's presence and the family left with the impression they would be contacted later that day by the mental health service.

11.7 When the Emergency Duty Team social worker and the approved mental health professional visited the family on the Sunday evening they told the family they would be visited the following day by a children's social worker from a safeguarding team. This visit did not take place. The following day the incoming manager reviewed the case and in light of the assessment concluded that there were no immediate concerns identified this as a child in need case which would be allocated in due course. The manager was unaware of the commitment made for a social worker's visit that day.

11.8 How do we know it is an underlying issue and not something unique to this case?

11.9 The review team and the case group have all confirmed that there are different levels of understanding as well as sometimes a lack of understanding cross-agency and within agencies about different teams/agencies roles and responsibilities. Although not the sole cause of this issue it is recognised that the constant changes of staff, structures, teams, professionals titles, team titles and team bases exacerbates the confusion.

11.10 How widespread is the issue?

11.11 The review team and the case group have all confirmed this issue is a regular occurrence across teams and agencies in the City because some agencies appear to be in a constant state of change. This is not an issue unique to Stoke-on-Trent. It is a common finding from serious case reviews across the country and although not the sole cause it is recognised that the national austerity measures are impacting across local provisions.

11.12 Families may live in one local authority but access services from another. It is important to note that the Mental Health Access Team however works across the city and North Staffordshire local authorities and makes no demarcation in the consistency of the service provided.

11.13 How prevalent is the issue?

11.14 This confusion potentially has the ability to impact on other cases however it must be acknowledged that a considerable amount of work has been undertaken in one particular area of multi-agency working. The LSCB has led on the revision of the existing threshold criteria for the guide to Levels of Need. This document clearly sets out the range of universal, specialist and statutory services available in the City and how those services can be accessed. The LSCB recently undertook a small sample survey to ascertain professional understanding of this document and the results of the survey concur with this finding that further work needs to be undertaken to clarify professionals' roles, responsibilities and the correct support option for the child and their family.

11.15 Why does it matter? What are the implications for the reliability of the safeguarding system?

11.16 The most effective way to improve outcomes for children and their families is by all the relevant teams/agencies working together and professionals working in partnership with families. It is unlikely we will be able to achieve that if professionals do not understand each other's roles, responsibilities and other teams/agencies remit. One of the consequences of this will be that professionals may not be able to provide accurate information about local service support and may give parents misleading information, which is frustrating for families.

Finding One

There is a pattern in Stoke-on-Trent of professionals making assumptions about other teams/agencies roles, responses and remit, which can leave families vulnerable, and both professionals and families with false expectations.

Summary

Through this review we have established that there may be professional confusion about each other's roles, responsibilities and teams/agencies remit. This confusion will lead to ineffective multi-agency working and will also impact on how professionals work with children and their families.

Questions for consideration by the Board

1. How confident is the Board that teams/agencies working across the City understand each other's' roles, including responses, responsibilities within referral pathways?
2. In a time of considerable change and reorganisation how confident is the Board that each team/agency is kept up to date with those changes?
3. How can the Board test out that when agencies reorganise, risk factors caused by a lack of understanding of each other's responses/roles and agencies are mitigated against?

11.17 Finding Two

11.18 Management Systems - are any elements of management systems a routine cause for concern in any particular ways?

11.19 At the conclusion of the serious case review process the Review Team found that many improvements have been made to the Single point of Access Team. At the date of the final Case Review meeting held on 27th July 2015, there were a number of concerns about how the team operates.

11.20 How did the issue manifest in this case?

11.21 The SPOA team is made up of health and social work professionals with a range of knowledge, experience, responsibility and skill levels.

11.22 The duty system that was in place at that time was confusing and inconsistent. There was no electronic system in place. There was a tray system in place, these were coloured, according to the work required. All new referrals and priority work went into the red tray. Then there was a yellow tray for those referrals that had been seen and were a work in progress and then there was a green tray that was for referrals that had been assessed and were awaiting appointments etc. There were no standard operating procedures for how to use the tray system. There were a number of more experienced workers in the team who took on the role of duty lead, each had their own way of dealing with the trays, some liked the workers to put a file "across" the tray, if it was urgent. The tray system described in this report which was in use at the time of the incident is no longer in operation and ceased to be so directly following the incident. North Staffordshire Combined Healthcare NHS Trust have evidenced that there has been an electronic system in place since January 2015.

11.23 The first contact to the team was made by GP1 on the Friday. The SPOA call taker was a mental health nurse. It is not clear what happened to the referral following the telephone call and for the next two days but the file was effectively lost in the system and no action was taken by the team. The mental health social worker who "discovered" the file on the Sunday had been in the SPOA team since August. It was his first weekend duty shift. The mental health social worker recognised the referral had not been actioned and that there was a potential safeguarding concern and made a referral to the Local Authority's (social care) emergency duty team. That evening an approved mental health professional and an experienced social worker visited the family. The following day a telephone assessment took place by a mental

health nurse. Having reflected on the telephone assessment this worker thought a face-to-face assessment was required and the family was visited the following day by another mental health social worker. It should be noted that the North Staffordshire Combined Healthcare NHS Trust's internal investigation have accepted that the referral document was not actioned in a timely way and that there were no systems in place, at the time of this incident, to track referrals.

11.24 How do we know it is an underlying issue and not something unique to this case?

11.25 The review team has found that although many improvements have been made to the SPOA team following this tragedy as, at the date of the final Case Review meeting on 27th July 2015, there were a number of concerns about how the team operates these are set out in 11.26 to 11.31.

11.26 The SPOA team has approximately ten workers who take on the role of duty lead. The review team has been told by one SPOA team member that the process still varies depending on the duty lead at the time.

11.27 There is a hierarchy in the team that may impact on the functioning of the team.

11.28 Since this case the SPOA team has implemented a 24 hour duty system. Currently the team has to physically move every evening to another office because two teams combine to offer the out of hour's service. This is only a temporary arrangement until the team moves to a permanent location in the near future.

11.29 The role of the Duty lead has been clarified since this case and now involves: triaging new referrals for which there is a clear process, co-ordinating and allocating new referrals and work that comes in during the shift, providing leadership and supervision to junior staff, managing bed management calls and often acting as a first point of contact. Depending on levels of clinical activity and service need, if there is capacity, the Duty Lead may support other staff on duty by helping with taking phone calls, seeing walk in's and assisting with duty screenings, though this is at the discretion of the Duty Lead, and would not be an expectation or requirement if the Duty Lead was busy with their own workload.

11.30 The review team has been told by one SPOA team member that she rarely has supervision, although there is evidence that other members of the team have monthly supervision, in line with the Trust policy.

11.31 Those taking the calls on duty may be newly qualified, or have no specialism in mental health and therefore may be ill-equipped to deal with complex mental health needs.

11.32 How widespread is the issue?

11.33 This finding is only in consideration of the SPOA team

11.34 How prevalent is the issue?

11.35 This finding is only in consideration of the SPOA team.

11.36 Between June 2014 and June 2015 the SPOA team undertook a total of 5,041 assessments.

11.37 Why does it matter? What are the implications for the reliability of the safeguarding system?

11.38 The SPOA team is the front door service to all adult mental health services in the city and North Staffordshire. If there is not the expertise in the team to recognise levels of risk and if clear, robust systems are not in place, some of the most vulnerable people in our community will not have their needs met and levels of risk will not be accurately ascertained.

Finding Two
At the conclusion of the serious case review process the Review Team found that many improvements have been made to the Single point of Access Team. At the date of the final Case Review meeting held on 27th July 2015, there were a number of concerns about how the team operates.

Summary
We know from research of the importance of early help when concerns are first presented. If those concerns are not addressed effectively in the first instance, concerns can quickly escalate into crises. During the period under review Stoke-on-Trent and North Staffordshire's front door team for all mental health services was not working effectively and there is evidence that in some aspects this is still the case.

Questions for Consideration by the Board

1. How will the Board assure itself that the North Staffordshire Clinical Commissioning Group recognises and is addressing the current weaknesses in the front door mental health service it commissions from North Staffordshire Combined Healthcare NHS Trust?

Appendix One

Glossary of Terms and Acronyms

Child in Need - Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is a Disabled Child.

Child protection – Section 47(1) of the Children Act 1989 states that: Where a local authority have reasonable cause to suspect that a child who lives, or is found, in the area and is suffering, or is likely to suffer, significant harm, the authority shall make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

Delusion - a false belief regarding the self or persons or objects outside the self that persists despite the facts. Not in keeping with cultural norms (ie religious/spiritual beliefs etc).

An intrusive thought - an unwelcome involuntary thought, image, or unpleasant idea that may be upsetting or distressing, and can feel difficult to manage or eliminate.

LSCB- Local Safeguarding Children Board

Secondary mental health service – Once the SPOA team have concluded their assessment if the service-user is considered to have a higher level of complexity, in terms of their mental health needs, they will be referred to the secondary mental health service.

SCIE – Social Care Institute for Excellence

KPI – Key Performance Indicators

SOTSCB – Stoke-on-Trent Safeguarding Children Board

SPOA – Single point of access team. The front door of mental health team that covers Stoke-on-Trent and North Staffordshire.

Working Together to Safeguard Children, 2013. The statutory guidance for inter-agency working to safeguard and promote the welfare of children.