SERIOUS CASE REVIEW

Relating to Alex

Date of birth: 7th January, 2005
Date of death: 23rd December, 2014

OVERVIEW REPORT

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CONTENTS

SERIOUS CASE REVIEW OVERVIEW REPORT: ALEX

1. INTRODUCTION

Table 1: Summary of family members:-

Key Relationships to Alex
Mother
Father
Sister
Maternal grandfather
Maternal grandmother
Mother's partner

1.1 Summary of the circumstances leading to the Serious Case Review

The Lincolnshire Safeguarding Children Board (LSCB) agreed on the 17th of February, 2015, to commission a Serious Case Review (SCR) into the death of Alex, a white British boy, who it was understood, died on the 23rd December, 2014. The inquest was open and adjourned at the time of Alex's death, and formally closed on the 2nd December, 2015, following the completion of the criminal trial. Alex was 9 years old at the time of his death. He was drowned in the bath of his home by his maternal grandfather whilst under his care and supervision. Alex was taken to Hospital and was pronounced dead. On the police's attendance a disclosure was made by maternal grandfather, resulting in his arrest on suspicion of the murder of Alex. At this time it was made clear by other family members that Alex's death had been a deliberate act by maternal grandfather. The family had to reconcile with the sudden loss of Alex and the knowledge that this loss was due to the actions of a key member of their family.

1.2 Context to the Serious Case Review

There are several aspects that make this SCR exceptional. Firstly, there is limited history of inter-agency involvement with Alex and his sister, with the majority of services surrounding maternal grandfather and not the child subject to this review. The focus of the multi-agency working was with maternal grandfather, primarily to address his mental health and offending

behaviour. Therefore, the majority of the agency analysis focuses on the multi-agency care and support offered to maternal grandfather as the perpetrator. It should be noted that the LSCB gave detailed consideration to whether a child or adult review process should be followed, with a multi-agency decision concluding that the child SCR criteria had been triggered. Secondly, there was limited agency concerns raised regarding the care of both children. Alex presented as a typical child receiving low level support, primarily focused on his educational needs. Therefore, Alex did not present as a vulnerable child, to the contrary, he presented as a happy, caring and lively child.

Over several years, maternal grandfather experienced fluctuating mental health needs, with a long offending history, for many years in the context of alcohol dependency. In summary, prior to Alex's death in December 2014, maternal grandfather was admitted in July 2014 to an acute inpatient ward for review of his medication and assessment of his cognitive state and remained as an inpatient, however, with hindsight he should have been discharged home at a much earlier stage. When maternal grandfather was discharged from the care of this unit in December 2014, the discharge was completed in a manner that did not consider best practice, policy or procedure. The role of the Treating Consultant Psychiatrist is now clear upon the completion of Lincolnshire Partnership NHS Foundation Trust's (LPFT) Agency Narrative Report (ANR) and a Root Cause Analysis investigation (RCA); however, this issue was unclear at the point of discharge and was not aligned to or consistent with a planned multi-disciplinary Care Programme Approach process. There will be discussion around some useful learning and recommendations for practice development as there is evidence to suggest that there were key missed opportunities, in particular regarding the completion of robust risk assessments focused on public protection. However, it needs to be highlighted that the only individual responsible for the tragic death of Alex is maternal grandfather. The evidence indicates that he was violent, abusive and highly manipulative. Maternal grandfather made the decision to undertake this act and as a result has now been found guilty and convicted of murder. The degree of his violence towards Alex could not have been predicted or prevented by professionals or members of his family.

1.3 Serious Case Review Process

1.3.1 As outlined, the LSCB agreed on the 17th February, 2015, to commission a SCR into the death of Alex. The scope of this SCR was to cover the timeframe from the 1st July, 2013 to the date of Alex's death on the 23rd December, 2014. The rationale for this review period was

due to a SEN review resulting in Alex progressing to School action plus due to a change in his educational needs.

1.3.2 Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires LSCBs to undertake reviews of serious cases in accordance with procedures as set out in *'Working Together to Safeguard Children' (HM Government, March 2015)*. The Serious Case Review criteria apply to all children, including those with a disability and are set outlined in *Regulation 5 of the Local Safeguarding Children Boards Regulations* (2006):

(*1) The functions of a LSCB in relation to its objective (as defined in section 14(1) of the Act) are as follows –*

(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a Serious Case Review is one

Where –

(a) Abuse or neglect of a child is known or suspected; and

(b) Either –

(i) The child has died; or

(ii) The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the Child.

Working Together 2015 states that SCRs and other case reviews should be conducted 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.*

1.3.3 The Agency Narrative Reports: The authors of the ANRs which analyse their agency involvement with the family were senior practitioners or senior managers, who had not had direct contact or management involvement with Alex or his family.

1.3.4 On the 25th February, 2015, the National Panel and Ofsted were notified of the decision to commission a SCR.

1.3.5 The scoping meeting was convened on the 1st April, 2015, to establish the Terms of Reference, process and timeline.

1.3.6 It was agreed that there would be no engagement with the family until the criminal process had concluded. During the trial in November 2015, maternal grandfather changed his plea to 'guilty' and was subsequently sentenced to a minimum of 22 years in prison. Maternal grandfather originally pleaded diminished responsibility, but during the trial he changed his plea to guilty following the psychiatric assessment which noted his responsibility for this crime. It was agreed following the trial that transcripts of the expert medical assessments should be obtained to inform the review process. Following the presentation of expert evidence during the criminal trial, LPFT decided to commission an independent forensic report. Therefore, their ANR was reviewed to take account of this independent report.

1.3.8 The family interviews were completed on the 16th May, 2016.

1.3.10 The SCR panel meetings were held on the 1st April 2015, 22nd May 2015, 21st October 2015, 4th February, 2016, 7th April 2016, 13th July 2016 and 2nd December 2016.

1.3.11 On the 8th December, 2016, the LSCB Strategic Management Group convened to sign off the final SCR Report.

1.4 The particular questions outlined within the Terms of Reference are summarised below:-

1. **Resources Policies and procedures**

- *To examine the referral/assessment input and discharge/closure mechanism alongside the decision making processes to establish if agency input was sufficiently resourced and robust enough to meet the needs of Alex and his family.*
- *Did the policies and procedures of agencies reflect the relevant legislation and guidance available at that time, and were they adhered to?*

2. Risk Management

- *To examine the risk management process to establish where appropriate risk assessment tools were used as per internal and external polices and procedure.*

3. Information gathering, sharing and defensible decisions

- *To ensure that decisions made were informed by the information available, evidenced based, and the risk and protective features were appropriately balanced.*
- *Was there effective and timely information sharing between the respective agencies and the family?*
- *To consider whether there were opportunities for inter and intra-agency working that were missed at the time of agency input into the family.*

4. Competencies training development

- *To identify whether the agencies staff in this case had the required competencies and confidence to carry out their role, and to identify any relevant training or development need that may improve future practice.*

5. Line management advice and guidance

- To establish whether staff in this case sought, and were given, appropriate levels of supervision, advice and guidance during the decision making processes when working with this family

6. Culture

- *To identify within the agencies whether there were issues of an organizational culture which prevented objective assessment of presenting concerns and needs when working with the subjects.*
- *Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family? Were these explored and recorded?*

7. Communication

- *To establish if the inter and intra-communication processes were efficient and effective and involved the family.*
- *Was the voice of the child heard through agencies engagement with the family?*

Based on the nature of agency involvement with this family, a decision was undertaken to focus on a 'mixed' methodology including, agency narrative, review of case files, formulation of an inter-agency chronology, staff interviews and family interviews. However, the LSCB was also mindful that if any agency considered that there was any relevant

information outside this timescale, it would be included in their ANR. A review of each agency report and the terms of reference are outlined within section 3 of this report.

1.5 **Independent Panel and Independent Overview Author**

1.5.1 The membership of the SCR Panel was agreed by the SCR Subgroup, which consisted of senior managers and/or designated professionals from the key statutory agencies, who had no direct contact or management involvement with the family.

1.5.2 **The Serious Case Review Panel members were:-**

AGENCY	**ROLE**
Independent Chair of the SCR panel	Children's Services Manager, Action for Children & Chair
Children services	Service Manager
Youth Offending Service	Head of Service
Lincolnshire Police	Quality Auditor and SCR Author
Clinical Commissioning Groups	Consultant Nurse Safeguarding Children and Adults
Lincolnshire Partnership NHS Foundation Trust	Consultant Nurse Safeguarding & Mental Capacity
Humberside, Lincolnshire, North Yorkshire (HLNY) Community Rehabilitation Company NPS- Lincolnshire	Lincoln and Gainsborough CRC Team Manager
LCC Education Representative	Team Leader Inclusion and Attendance
United Lincolnshire Hospital Trust	Named Nurse for Safeguarding

1.5.3 **Independent Overview author**

The Independent Overview Author is Ceryl Teleri Davies has compiled the Overview Report and contributed to the Integrated Action Plan produced by the Lincolnshire Safeguarding Children Board. The author is a qualified Solicitor and Social Worker, with a Master's degree in both work areas, a postgraduate diploma in Community and Criminal Justice, and qualifications in Mental Health. She has extensive practice-based experience across social care, criminal justice and mental health services, including work on a multi-agency basis to

support children, young people and vulnerable adults at practitioner, middle and senior management level. Ceryl Teleri Davies is not employed by any of the LSCB Agencies.

2. SUMMARY OF THE FACTS AND FAMILY INFORMATION

2.1 Brief Family History

2.1.1 Alex lived with his mother and sister in a two storey terraced house, bordered by other identical properties, and located within a densely populated residential area close to a city centre. As expected of a city centre, the area is surrounded by local amenities, shops and good transport links. The picture that emerged from agency records and the records of meetings with the family members is one of a supportive network of maternal family members all living within the local area.

2.1.2 For several years maternal grandfather was involved in incidents which required police intervention, it is evidenced that he regularly committed crime and had both alcohol and mental health related problems. Over the years, maternal grandfather's mental well-being and behaviour resulted in him spending increased time in various mental health settings on a voluntary basis. He resorted to violence and abuse on several recorded incidents against people other than his family and he also caused difficulties for maternal grandmother (his ex-wife) with his persistent, often uninvited presence. For much of her adult life, despite being divorced from maternal grandfather for some 28 years, she continued to offer continued support.

2.2 Overview of the integrated chronology of events and agency involvement

2.2.1 The aim of this section is not to reproduce the full integrated chronology, but to highlight significant events to illustrate an account of what is known in agency records. The following extracts from the integrated chronology are the overview author's view of the significant practice events which occurred prior to Alex's death. An outline of the fringe learning will be provided in section 4 of this report.

2.2.2 The Terms of Reference stipulated the time frame to be examined as from the 1st July, 2013, to the date of Alex's death on the 23rd December, 2014, essentially a period of approximately 17 months prior to Alex's death.

2.2.3 In summary, the emerging picture revealed that Alex dearly loved his family. He remained within one primary school; his progress reports presented a picture of an enthusiastic young boy who was able to form positive relationships with children and adults. He faced some challenges in school, but was offered support via Special Educational Needs (SEN)[1] input, including a targeted support plan. On the 9th December, 2014, Alex's proposed statement of educational needs was issued. One of his school progress reports described him as a "*kind and caring boy, who has many friends and has developed a fantastic attitude to learning".* The picture is of a young boy who had good attendance, positive peer relationships and an enthusiastic approach to learning, but who sometimes found it challenging to cope with the pace of learning and environmental distractions.

2.2.4 Maternal grandfather's mental health records reveal a significant degree of diagnostic uncertainty, with several psychiatric diagnoses, including anxiety, recurrent depression, personality disorder and bipolar affective disorder. However, in October 2013 he was described as "*very well"* and not reporting any phenomena consistent with affective or psychotic problems, or self-harm/suicidal/homicidal ideation. Maternal grandfather was concordant with prescribed medication. He was described as "*reconciled with family"*" and currently living in warden supported housing.

2.2.5 In April 2014 maternal grandfather voiced his concern when Clomipramine (his anti-depressant at the time) became unavailable across the UK. The GP and maternal grandfather both separately alerted LPFT to this information however, the response was insufficient. The psychiatrist advised the GP to commence an alternative anti-depressant. In what would appear to be a result of human error no Psychiatrist outpatient appointment was arranged to review the new antidepressant. On the 16th

[1] Special educational provision is the additional or different help given in school to children with special educational needs.

April, 2014, the GP surgery contacted a staff grade doctor to inform them that maternal grandfather had contacted the Integrated Community Mental Health Team (ICMHT) because of his anti-depressant being stopped. The staff grade doctor advised a type and dose of anti-depressant to be prescribed on an interim basis until maternal grandfather received a review appointment. This was followed through by the GP and the GP went on to increase the dose of anti-depressant, but it was not recorded by the staff grade doctor and no follow up appointment was offered to maternal grandfather. There then followed a decline in his mental health over a three-month period ultimately leading to hospital admission. This information is key as prior to the discontinuation of Clomipramine maternal grandfather had been discharged from Trust services and had been stable and well for 18 months. If he had been reviewed as planned by a Consultant Psychiatrist within the community, soon after the 14th April, 2014, then it is likely the newly prescribed anti-depressant would have been amended if required. This review could also have initiated the 'fast track' mechanism for maternal grandfather to receive support from the Trust's ICMHT services during a period of medication transition. If this review had taken place, maternal grandfather's deterioration within the community may have been slowed or prevented.

2.2.6 In July 2014 during a home visit, maternal grandfather presented as shirtless and unkempt. His mood appeared mildly agitated as he highlighted his inability to cope with living independently. He presented as both subjectively and objectively depressed, self-neglectful and socially isolated. It is noted that there were morbid thoughts but no suicidal ideation, intent or risk to self or others was deemed present. He highlighted that he was estranged from his daughter. An urgent out-patient appointment was arranged for maternal grandfather with the Home Treatment Team to offer support in the interim period. On the 29th July due to increased concerns, continual decline and a clinical impression of maternal grandfather as suffering a severe depressive episode, a decision was made that his risks could only be managed within inpatient care. However, despite his presentation as severely depressed as soon as he was admitted to hospital, his symptoms disappeared as he had obtained what he wanted, i.e. admission. He did not require this form of care and there is evidence that some of his behaviour was goal directed to prevent his discharge, including complaining of anxiety or tightness in his head, verbal aggression, resisting plans to move him on and rolling around on the floor. There is no evidence that these

maladaptive behaviours were related to a mental illness but rather were related to his goal to get his own way. Despite this, his period in some form of inpatient care continued until December 2014.

2.2.7 On the 27th August, 2014, maternal grandfather was rude and abrupt to another vulnerable patient on the ward. When approached to explain his behaviour, he became hostile, shouted and swore at LPFT staff. He later received a call on the patient phone, at which point he was again hostile and swore at staff and refused to take the call. This example illustrates the nature of maternal grandfather's behaviour towards others.

2.2.8 On the 12th September, 2014, mother rang the ward to enquire about maternal father; he refused to talk to her. He was often dismissive of his family despite their continued support and attempts to maintain contact with him. Mother was advised that he did not wish to talk to her, at which point she became tearful and upset. He does mention his daughter on several occasions to LPFT staff, in particular that he was worried about her. The following day maternal grandfather was transferred to an open rehabilitation ward due to pressures on acute bed availability.

2.2.9 On the 22nd September, 2014, maternal grandfather was seen and reviewed by his Treating Consultant Psychiatrist in the company of a Staff Nurse. He discussed pressure in his head and that he would like a change in medication and wished to remain in inpatient care. The Doctor discussed with maternal grandfather about first having some blood tests, ECG and MRI to check for any physical conditions prior to reviewing his medication. Maternal grandfather stated he did not want any tests done but wanted his medication changed and stated "*you are not listening*". He reacted by jumping out of his chair and attempted to strangle the Psychiatrist with both his hands. On police attendance the victim and staff at the unit did not wish to make any complaint, but explained that the unit's facilities were unsuitable for maternal grandfather. At the scene, maternal grandfather was detained under Section 136 of the Mental Health Act and taken directly back to the previous hospital's Section 136 suite for an assessment. Maternal grandfather was admitted informally back on to the acute

inpatient unit. The Psychiatrist who was assaulted later contacted the police stating that she wished to make a complaint and was now off work as a result of this incident. As a result of the official complaint of assault, a crime of Common Assault was raised, which was later superseded by the murder charge.

2.2.10 From the 29th September, 2014, discharge planning was discussed with maternal grandfather. During this period he continued to state that he did not feel ready to go home, as he wanted to go into residential care. It is noted that mother had stated that she wished for maternal grandfather to live nearer to them. Maternal grandfather held the belief that his daughter and ex-wife were going to clean his home on a regular basis if he returned to live in the community. He had previously refused contact with both women and it appears that he had now selected to re-engage with them on his terms, further demonstrating his manipulation. He also stated that once he was discharged from hospital, mother was going to visit him more regularly to help him stay on top of the cleaning, however, it appears that mother had not agreed to undertake a 'deep clean' or indeed regular cleaning of his home.

2.2.11 On the 17th October, 2014, mother and maternal grandmother visited maternal grandfather in hospital; they both stated that his housing situation was of concern. He refused to see either of them, but agreed that they could attend for the ward round on the 23rd October, 2014. On the 19th October, 2014, maternal grandfather began to discuss his wish to self-discharge as he wanted to leave the ward. He also stated that he wished to live with maternal grandmother, but she refused his request as she did not feel able to cope with managing his needs. On the 25th October, 2014, maternal grandfather asked to be placed in seclusion so that he could shout and vent some frustrations. Once in seclusion he laid on a mattress. Maternal grandfather later advised that the police were required as he was not well. He explained that he should not be on the ward, appeared annoyed and hostile, swore at staff and stated that they did not understand. On 30th October, 2014, mother informed the unit that maternal grandfather had re-established contact with her in the last few days.

2.2.12 During early November 2014 mother and maternal grandmother began to clean maternal grandfather's home and offered support to assist him resettle in the

community. Maternal grandfather initially refused to leave the ward and asked again whether or not he could stay with his ex-wife. On the 24th November, 2014, mother telephoned the ward to express her concerns regarding her father's planned discharge from hospital as she felt he was not well enough and required a lot of input. Later that day he returned from unescorted voluntary leave with mother and maternal grandmother to the ward, but had initially refused to return. He also repeatedly asked mother if he could stay with her for a few days, but was advised that she did not have the room for him. Both women expressed concerns that maternal grandfather may '*up the ante*' of his attention seeking behaviour to get his own way as he liked being in hospital and did not like his home. This demonstrates the family's insight into maternal grandfather's manipulative behaviour. He left the ward that afternoon again on unescorted voluntary leave and attended mother's home; she agreed that he could stay overnight.

2.2.13 On the 25th November, 2014, maternal grandfather returned with mother and maternal grandmother where he was agitated, his family were clearly distressed and asked to leave the ward. Maternal grandfather then assaulted a male nursing assistant by punching his head. Maternal grandfather was placed in the de-escalation room as he was becoming increasingly aggressive. The police were advised that he was an informal patient and not acutely unwell. Maternal grandfather was arrested for Common Assault, taken into custody, and bailed to return to Lincoln Police Station. Later the same day the Psychiatrist spoke with mother and maternal grandmother and they expressed concern about maternal grandfather hurting someone. They were informed about the assault on the nursing assistant earlier that day and also informed about the previous assault on a staff member. There is no evidence in agency records that the details of that previous assault were shared with the family. The LPFT ANR also reflects that on this date, mother and maternal grandmother reported concerns to the acute inpatient unit that maternal grandfather posed a risk to others. The example of threatening others with a knife was given to staff and concerns raised about vulnerable residents at his accommodation. Both raised concerns about him whilst on unescorted voluntary leave and that they were frightened of him turning up at their properties. They also identified the presence of his grandchildren at his daughter's home, but that they did not think that he would harm his grandchildren. All of these factors represented a change in risk status, as staff had been made aware that maternal

grandfather now had access to his grandchildren and they perceived a risk to the family and public. He was now a proven risk to LPFT staff from two separate assaults. If this information had been considered and assessed then the risk assessment should have been updated.

2.2.14 On the 6th December, 2014, maternal grandfather told the Trust staff that he would not be able to survive outside of hospital and again complained about pains in his head. He was offered reassurance that he would not be discharged if professionals were not confident that this was the right option. Maternal grandfather did not appear to accept this and stated that he held a belief that he is a "*one off case*". Despite his recent assaults on staff, his non-adherence with his discharge plan and continuous resistance to discharge and re-settle in the community, his risk of harm to himself and others was assessed as *'low'*.

2.2.15 On the 9th December, 2014, a comprehensive multi-disciplinary ward review was undertaken, which noted the concerns from the family and discussed maternal grandfather's risk to others, with the decision reached that he was not suitable for early discharge. Therefore, the plan of the MDT was to discharge maternal grandfather only following a period of further leave.

2.2.16 On the 10th December, 2014, maternal grandfather attempted to assault a nurse whilst discussing the planned home leave for that day. Trust staff believed this triggered the assault, rather than any physical or mental health concerns. Maternal grandmother attended the ward to collect him for planned leave but was advised not to take him as on a previous occasion he had attempted to physically assault her. The police attended and spoke to maternal grandfather, however stated that they could not arrest him as he had not actually committed an assault. He later became aggressive again and attempted to throw a table at staff members whilst stating that he wanted to be arrested. It was then decided that maternal grandfather should be discharged from the ward due to the number of violent incidences towards staff when leave from the ward or discharge was discussed, with the Treating Consultant Psychiatrist stated that the incidences were not due to his mental health. There were no concerns with regards to his capacity and there was no evidence of acute mental illness during his admission to the unit. As a result a decision was reached to discharge him due to level of risk to

staff. That same day there was a plan recorded that the police would attend the following to prevent a breach of a peace. Also, the community mental health follow up was arranged to his home address.

2.2.17 On the 11th December, 2014, Police officers attended to prevent a breach of the peace. Despite a comprehensive review of this case for the ANR, there was a lack of clarity regarding the authorisation of maternal grandfather's discharge. The Root Cause Analysis (RCA) completed and the RCA Panel have now established the Treating Consultant Psychiatrist on the day of maternal grandfather's discharge. It appears that the process of discharge was contrary to the Trust's Clinical Care Policy and was undertaken due to the concerns regarding the escalating violence towards staff and as he did not require a placement within an acute inpatient unit. It appears that there was a breakdown in communication, and a lack of consistency in decision making, in particular the clarity of the role of the Treating Consultant Psychiatrist. Whilst there was a full risk assessment completed prior to discharge it failed to identify any wider risks other than to LPFT staff.

He was discharged to his home address, but subsequently arrived at mother's property where he stayed the night and later refused to leave. Mother became concerned due to her family and work commitments. It was agreed that maternal grandfather was to stay with maternal grandmother over the Christmas period, but not indefinitely.

2.3 **Information from the Family**

2.3.1 To enable the family to participate in the review, the SCR timescale accommodated the parallel criminal proceedings. Father had elected not to be part of this review process. Mother and maternal grandmother were invited to participate in the SCR and on the 16th May, 2016, the overview author met with both women. Due to the nature of this SCR, listening and gathering the views of the family was essential. Not only did this meeting allow the author to fully understand the context of Alex's life, but also assisted in placing him in the forefront of this review.

2.3.2 It is pertinent to note that throughout this review process, mother and maternal grandmother have presented themselves with the upmost dignity. Both women began

by explaining the sense of loss felt by the school and community as a whole. However, the support of the school has been of great comfort to them, with great praise for the school's efforts, support and guidance. Indeed, they described how the school have been 'exceptional' and did 'everything to help Alex'. Alex was described as a lively, happy, inquisitive and unique boy who did not ask for anything. Mother described that he was very kind and would openly share whatever he had. Essentially, his 'special spark' was loved by all.

2.3.3 Maternal grandfather had often shared time with them as a family, including attending family holidays. They were of the view that maternal grandfather would not harm a member of their family. They both explained how he had often been verbally abusive, but never physically violent towards them. They described the exceptional and harrowing impact of Alex's death on them as a family, not only the loss of Alex, but also the fact that this loss was a result of maternal grandfather's actions.

2.3.4 Firstly, they expressed how LPFT staff members did not listen to their views, in particular regarding the quality of services offered to maternal grandfather. They explained how they repeatedly raised concerns regarding maternal grandfather's deteriorating mental health, with a junior doctor responding that '*they could cross that bridge when they come to it'*. These concerns included increased agitation, his inability to cope, a significant decline in his self-care skills and personal hygiene. As family members, they felt that they had the knowledge and understanding of maternal grandfather's needs to be able to voice their concerns.

2.3.5 Secondly, they raised concerns regarding the consistent sharing of information with them. The key example provided was regarding maternal grandfather's discharge, in particular as they had been advised that he would not be discharged. They continued to be unclear regarding the accountability of this decision and the actual identity of the Treating Consultant Psychiatrist who undertook the decision to discharge him. They question the purpose of his escorted discharge into the community by a police officer. Also, they query why information was not shared with them regarding his assault by attempting to strangle a Doctor, in particular as it was known that there have young children within their family. They feel that a key piece of the jigsaw was

missing here regarding the adequate communication of risk and safeguarding concerns, not only to them as family members, but also to the wider public.

2.3.6 Thirdly, they described several occasions when they were treated by the LPFT staff members. They felt that information was not shared with them until the point when a request was received for them to clean his flat in preparation of his discharge home. Communication was then focused on the length of time it would take them to clean his flat. In addition, they were left for 3 hours waiting to attend a ward round without any form of communication with them as his family. As maternal grandfather was an adult deemed to have mental capacity, the flow of information shared with the family would be dependent on his wishes and feelings. The Trust could only share information with the family when maternal grandfather agreed and therefore he could dictate the degree of their involvement. However, it cannot be known if the family would have responded differently if the abusive episodes towards staff on the ward would have been shared with them.

2.3.7 They felt that they clearly voiced their concerns regarding his presence at their home and his continual request to live in either of their homes. They felt that he was discharged without the appropriate plan or communication with his family; he also did not have the appropriate supply of medication. During the post discharge home visit, maternal grandmother explained that he did not speak. Maternal grandmother was advised that she could receive the required medication from the crisis team, but the crisis team did not attend the arranged appointment and she had to collect his medication. Instead, the crisis team telephoned maternal grandfather and did not mention his lack of medication. Therefore, their key question and concerns focus on the quality of the care and treatment plan and the preparation for his discharge. As a result of this review, they are eager that constructive lessons are learnt, to focus on service developments and good practice.

2.3.8 The family voiced that maternal grandfather was very much part of their family and often attended family holidays. The family loved maternal grandfather, despite the emotional burden he placed on them; they continued to offer him care and support as a family. However, they were not fearful of him either on an individual level or on behalf of the children. Despite the exceptional impact of this loss on their family, their

sincere description of Alex animated his characteristics in such a heartfelt and dignified manner.

3. ANALYSIS: THE AGENCY NARRATIVE REPORTS (ANRs) & THEMES

All the ANRs addressed the Terms of Reference of the SCR. The ANRs were informed by agency records, procedures and as required interviews with key professionals. All reports were helpful in drawing clear analysis of agency involvement and any lessons to be learnt. The SCR Terms of Reference identified several themes to be examined:-

- *Resource, Policies and Procedures;*
- *Risk Management,*
- *Information gathering, sharing and defensible decision,*
- *Competencies training development,*
- *Line management advice and guidance*
- *Culture,*
- *Communication.*

3.1 **LINCOLNSHIRE PROBATION TRUST:** With regards to maternal grandfather's offending history, the Lincolnshire Probation Trust was involved with maternal grandfather from the 22nd July, 2011 until the 21st January, 2013 whilst he was subject to an 18 month Community Order for an offence of affray. The Order contained supervision requirement and a 6 month mental health treatment requirement. At the time of this offence for affray, maternal grandfather was living in supported accommodation and the offence involved him threatening an elderly female victim with a knife when she refused to give him what he wanted (a cigarette and a cup of tea). Evidence suggests that this Community Order progressed well, with the mental health treatment requirement expiring on the 21st February, 2012. Whilst this Community Order was successfully completed, maternal grandfather had made threats to other residents at the supported living accommodation and as a result was on his final warning in terms of residing at this address. The police attended and spoke to both parties, it was felt that the threats were not genuine and he was not convicted for this offence. At the end of this Community Order it is noted that maternal grandfather had achieved a significant degree of stability and was assessed as posing a medium risk of serious harm to the public. According to probation records he was abstinent from alcohol, was complying

well with his mental health treatment/medication and had a good relationship with his daughter and grandchildren. The Probation Trust had no further contact with maternal grandfather following the expiration of this Order on the 21st January, 2013.

3.2 **THE POLICE:** Lincolnshire Police is an organisation employing approximately 2000 staff, around 1100 of which are Police Officers. Within Lincolnshire Police, the Public Protection Unit (PPU) has responsibility for a number of aspects of policing, not least of which is Child Abuse Investigation, but in this regard it is limited to intra familial abuse and offences committed by persons in positions of trust. Other sexual offending against children is investigated by mainstream Criminal Investigation Department (CID) Detectives, supported where appropriate by PPU staff.

The PPU is a specialist unit of highly trained staff and is responsible for the management and investigation of crimes involving:

- Safeguarding Adults;
- Safeguarding Children;
- Sex and Dangerous Offender.

The Public Protection Unit can also advise on investigations of Domestic Abuse, Honour Based Violence and Forced Marriage.

To provide an accurate picture of the level of police involvement with maternal grandfather, details beyond the scope of the terms of reference require consideration, as between April 1996 to December 2015 there were 92 recorded incidents of police attendance involving maternal grandfather. These incidents cover a variety of crimes and occurrences, ranging from concerns for safety, mental health issues, suicide attempts, anti-social behaviour, theft, arson, drink related offences, public order offences, criminal damage and assaults. Thirty-two of these relate to theft from shops and drink related offences; many of the thefts were committed whilst in drink, where aggression was shown towards staff or members of the public. There were also a number of assaults and Public Order Offences which were committed whilst under the influence of alcohol. In addition, there are recorded incidents of maternal grandfather reported missing, where he was dealt with by way of Section 136 of the Mental Health Act. There are also recorded incidents of maternal grandfather as the victim of assault. There were several occasions when the police attended maternal grandfather's accommodation to undertake a welfare check due to concerns raised regarding his

whereabouts, wellbeing or presenting mood. Therefore, this was a citizen who was well-known to the police due to his persistence offending and often chaotic lifestyle.

On the 22nd September, 2014, whilst inpatient within NHS mental health rehabilitation centre, maternal grandfather assaulted a Psychiatrist. The allegation was that maternal grandfather had grabbed hold of the doctor around her throat, whilst saying that voices have told him to do so. On the police attendance the victim and staff did not wish to make any complaint, but explained that this particular NHS facility was unsuitable for maternal grandfather. As a result, maternal grandfather was lawfully detained under Section 136 of the Mental Health Act and assessed. This was a missed opportunity for Trust staff and the Police to share information and work together effectively. Maternal grandfather had assaulted a member of Trust staff and was removed from the unit by the Police. At this point, it would have been pertinent to assess maternal grandfather's mental capacity in relation to the assault. This would have established the appropriate decision making for responding to maternal grandfather. There is no evidence that the Trust completed a formal capacity assessment or took the lead with the Police to suggest that a capacity assessment was required in relation to this assault. The assaulted Psychiatrist later changed her mind and just under a month after this assault contacted the police. She stated that she was off work as a result of the attack and wished to make an official complaint. A crime of Common Assault was raised and efforts were made to interview maternal grandfather. A decision was later undertaken that it was 'not in the public interest' to proceed as by then he was charged with Alex's murder. This incident demonstrated the actual and potential risk of harm maternal grandfather presented. Whilst the degree of his violence was not predictable, a 'pause and a review' and re-assessment of his needs by LPFT may have assisted in analysing his risk of harm to others.

Prior to Alex's death, maternal grandfather was dealt with by the Police as a result of attacks on staff within the acute inpatient ward. Firstly, on the 25th November 2014, whilst maternal grandfather was an inpatient, the police received a report from the Trust stating that maternal grandfather had assaulted a male nursing assistant by punching him in his head. The police attended and initially assisted staff to remove maternal grandfather from the ward to a separate room as he was becoming increasingly aggressive. Maternal grandfather was arrested for Common Assault, taken into custody, and bailed to return to Lincoln Police Station. A decision was later undertaken not to charge maternal grandfather for this assault as it was not deemed to be in 'public interest' to pursue this further as by this time he was already charged with murder. Secondly, on the 10th December, 2014, maternal grandfather

attacked another member of Trust staff, and had been restrained by staff and taken to his room. Whilst in the medical room in the company of a staff member receiving his medication, maternal grandfather pushed aside the medicine trolley, raised both his fists and went towards the staff member. He was taken hold of and restrained before any assault took place. The police attended and spoke to maternal grandfather who apologised to the member of staff and was advised to calm down. Maternal grandfather had been assessed as having capacity and being well enough for discharge and as he was due to leave inpatient services, the staff on the ward believed that this had triggered the assault.

The final Police involvement prior to Alex's death was on the 11th December, 2014, when they were asked to attend to prevent a breach of the peace on maternal grandfather's discharge from inpatient care. To summarise, maternal grandfather was well known to Lincolnshire Police as detailed in the comprehensive history of police involvement. However, despite this documented knowledge of maternal grandfather's behaviour and the impact his behaviour had on others, the police had no direct involvement with Alex or maternal grandfather's family (with relation to maternal grandfather's behaviour).

Resources Policies and procedures: - All incidents attended were assessed and if necessary crimed, with any subsequent arrests dictated by the procedures and guidelines of the Police and Criminal Evidence Act 1984 (PACE).

Over the years, maternal grandfather has been arrested on several occasions, none of which had any direct connection with Alex or his sister. With regards to maternal grandfather, Section 136 of the Mental Health Act was initiated on 2 occasions relating to maternal grandfather, firstly, in 2009 and subsequently in 2014. As previously outlined, there was a missed opportunity for joint working between the Trust and Lincolnshire Police to assess and establish capacity in relation to this offence.

Risk Management: - No relevant matters identified.

Information gathering, sharing and defensible decisions: - The decision to crime incidents and arrest as a consequence was correctly based on the information and evidence the officers had at the time.

Competencies training development: - All required training, guidance and support were provided by the Police, with broader and specific training development offered and encouraged.

Line management advice and guidance: - All officers are trained in Children's Safeguarding risk assessing and PACE. It would appear that all necessary training, development, advice and supervisory guidance for staff were implemented appropriately.

Culture: The Police are clear within their ANR that there are no presenting cultural issues of concern. Whilst this may be the case, as outlined below there needs to be a focus on shifting the culture of jointly working with LPFT to address assaults and violence suffered by them in the course of their employment.

Communication: Overall, there were several examples of good timely communications between the Police and other agencies involved with the family**.** There was also a lack of joint working with LPFT when dealing with the violent/abusive treatment of their staff. On a positive note, a key outcome of this review is an agreement to facilitate joint working between the Police and LPFT regarding the dealing of violent incidents against LPFT staff.

3.3 **EDUCATION: SCHOOL**

From the 13th October, 2008, Alex attended a local mixed primary school with approximately 240 students on roll. His nursery progress reports commented that he "*had settled well at nursery, that he was enthusiastic when playing, a very quiet boy but who was confident around adults"*. In his Reception Class, Alex was described as "*being a very enthusiastic child*", who showed a keen interest in all aspects of his classroom activities and a real desire to want to do well in tasks he was set. He showed great motivation to learn and a willingness to try new activities. He was further described as a young boy who was developing a wider group of friends and showed a full range of feelings whilst having a clear understanding of right and wrong. His attendance was 96% in Reception class and he received praise for making a positive contribution to the year group. By Year 3, continued to be described as a "*polite, caring and capable boy"* who was naturally inquisitive and well liked within the class. A confident reader and a capable mathematician who lacked focus at times when left to work independently. It is clear from the school reports that Alex engaged well with all of his subjects, taking part in class trips and workshops. He was described as a child with "*exceptional enthusiasm"*, who had the ability to be a great all-rounder enjoying other achievements at school such as tennis, football and taking part in a chess tournament. The Head Teacher at the time (2012/13) stated that: "*Alex is a lovely lad with a fantastic smile"*.

In February 2013 Alex was referred to receive additional support in school, but this referral was nothing out of the ordinary in supporting children in schools. A range of support strategies were discussed with the school and implemented to support Alex with his learning. Alex's attendance in Year 4 was 91% and his report describes him as being "*lovely, funny and extremely entertaining"*. However, the report also describes that he sometimes struggled to cope with the high demands of the work in Year 4, but continued to be extremely inquisitive and ask some fantastic questions. He found Maths to be the easiest lesson as he particular liked shapes. Alex described that when he 'grew up' he would like to be either a policeman or a computer programmer. To achieve this, Alex stated he would need to get "*A grades and be good at school*".

From July to September 2014, there were continued discussions around Alex's educational needs and the requirement of a statutory assessment of his educational needs. In December 2014 a draft statement of educational needs was issued with specific targets agreed for Alex. His end of term progress report in 2014 noted that he was a "*capable child who at times struggled with the high demands of work in Year 4"*. There is evidence that the school offered several forms of support packages throughout Alex's education, which was clearly echoed by the family as they felt that the support offered and provided by the school had been exceptional.

Resources Policies and procedures: - Prior to July 2013, Alex's needs had been assessed and managed internally by the School, using School Action and School Action Plus support. This method of support allows schools to increase or reduce resources when there is some improvement or change in progress. This is the correct process that all schools adopt when assessing and addressing a child's needs in school. The records held by the school do not appear consistently detailed. The introduction of Educational Health Care Plans will go some way in ensuring that records are detailed.

A referral to the Educational Psychology Service was promptly made and the evidence collated to apply for a statement of special educational needs. The referral for assessment was received by the Lincolnshire County Council on the 23rd July, 2014, and the Proposed Statement was issued on the 9th December, which was 13 days outside the deadline. There is no further information held to explain this delay.

Risk Management: With regards to Alex's progress in school, his needs were assessed using the appropriate methods as part of ongoing assessment of his development and progress. Support was offered by internal and external agencies in a task orientated manner, with a transparent picture of Alex's needs fully gleaned when the Statutory Assessment of his needs was completed and reviewed.

Information gathering, sharing and defensible decisions: There appears to be continuous communication regarding Alex's educational needs, which were well known. Alex's progress was monitored, with the required assessments and observations completed.

Competencies training development: All required training, guidance and support were provided by the school, with broader and specific training development offered and encouraged.

Line management advice and guidance: - Alex had access to a teaching assistant and additional support as per his assessed educational needs.

Culture:-The school was aware of how to identify and meet the needs of Alex. The family praised the school's culture, support and guidance throughout.

Communication: - The records indicate that the school showed a good level of engagement throughout and liaised effectively with mother throughout. His voice is also effectively captured throughout their meetings, which illustrated his personality, likes and dislikes.

3.4 **PRIMARY HEALTHCARE: GP SURGERY**

The relevant family members were registered with two separate GP Practices in Lincolnshire. Alex, mother, maternal grandmother and sister were registered with one Practice, whilst maternal grandfather was registered with another Practice. With regards to the children, Alex's sister attended the surgery on an infrequent basis for minor illnesses only, but Alex was not seen by the GP during the scoping period of this review. Alex was up to date with

his immunisations and vaccinations, with no concerns expressed by the GP regarding either child's health or wellbeing.

Maternal grandfather's GP records indicate that he was deregistered from the practice on the 26th September, 2014, with a rationale recorded that he had left the area, following the receipt of information that he was no longer resident at his address. It appeared that an administrative error occurred resulting in maternal grandfather's records being closed and subsequently deducted from the GP list. However, the records never left the GP surgery because the transference process of records is in response to a new GP requesting the notes from the existing GP. There being no request, the records stayed on file and could be re-opened at any time. This is an established process, whereby this was a human error as opposed to systems failure, however, this did not have any impact in this particular case.

There is nothing within the GP records suggesting that maternal grandfather had a prolonged episode without access to his anti-depressants or any other prescribed medication. The contact that maternal grandfather had with the GP and the prescription of medication was within normal and expected practice. In fact, the GP demonstrated good liaison with LPFT throughout. When the GP became aware that Clomipramine, the anti-depressant that maternal grandfather was initially prescribed was no longer available, advice was sought in a timely manner from a specialist who provided an alternative anti-depressant to be prescribed. The records show that this was actioned with immediate effect via an urgent referral, ensuring that there was no gap in provision of anti-depressant therapy.

The report provided by the GP relating to the other adults of the family provides an overview of involvement with the GP. Each individual family member was managed by the GP regarding their health and wellbeing, which includes no reference to Alex either directly or indirectly.

GP Primary Care Resources Policies and procedures: - As detailed within the fringe learning (see section 4.), the matter regarding the referral management system will be addressed following a review of this system and the audit of the process.

Risk Management: - It is good practice to respond to parental concern, however, despite an electronic system implemented to trigger a reminder to refer, the referral as requested by

mother for Alex to receive a Paediatrician assessment was not actioned. Despite this, there was no direct impact on Alex. It is positive that the GP Practice is reviewing their referral management system.

Information gathering, sharing and defensible decisions: - As outlined, there was limited contact between the GP and Alex as he did not attend for any appointments during the review period.

Competencies training development All relevant processes for arranging training and development of GP practice staff were implemented.

Line management advice and guidance:-No relevant information, concerns or learning identified.

Culture: It is apparent that the GP practice knew the family well and had developed a relationship over a period of several years. The agreement to action a referral request in the absence of an actual consultation suggests confidence and a lack of formality that develops within trusting relationships. The GP's acceptance to make a referral in the absence of a face to face contact would strengthen the evidence of a developed professional relationship between the GP and this family.

Communication: - The long standing relationship with the GP and the family suggests the GP was aware of the health and wellbeing issues regarding the adult family members. As Alex did not see the GP or experience significant health concerns within the scope of this review, his voice is obviously not evident.

3.5 **UNITED LINCOLNSHIRE HOSPITAL NHS TRUST (ULHT)**

ULHT had very limited contact with the family. On the 3rd September, 2014, a letter was sent to mother confirming that an appointment had been made for Alex to be assessed by a Community Paediatrician on 22nd September, 2014. Upon researching ULHT's involvement with Alex, the ANR Author reported a lack of clarity in relation to the informal processes currently in place between the Community Paediatrics Team (employed by ULHT) and the

Community Health Trust (LCHS) for the arrangement of appointments and storing of clinical records. However, this did not appear to have a particular impact in this case.

3.6 **LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST (LPFT).**

The Trust was established on 1st June, 2002, when social care and health services, formerly provided by Lincolnshire County Council and Lincolnshire Healthcare NHS Trust, were brought together to create a new mental health and substance misuse services for adults. The Trust was authorised as a Foundation Trust on 1st October, 2007. Lincolnshire Partnership NHS Foundation Trust (LPFT) provides a range of health and social care services for people of all ages. The Trust provides care and treatment for a local population of some 735,000 people within Lincolnshire.

In addition to this SCR, an internal Root Cause Analysis (RCA) investigation was commissioned by the Chief Executive of the Trust. The aim was to undertake a multi-disciplinary review of the care and treatment provided to maternal grandfather and to identify whether there was any aspect of the care and management that could have minimised the likelihood, prevented the event, or minimised the death of Alex.

Maternal grandfather accessed the Trust's mental health services frequently between the years of 1997 and 1999. He was again in frequent contact between 2005 and 2014. He received services from multiple specialities including a single contact with the Trust forensic team in 2006, Primary Care, Crisis Home Treatment, Integrated Community Mental Health Team, Psychology and Psychiatric out-patient services. He had twelve admissions to acute or rehabilitation in-patient units between 2007 and 2014. A variety of psychiatric diagnoses including anxiety, recurrent depression, personality disorder and bipolar affective disorder were made during maternal grandfather's contact with the Trust, with these diagnoses primarily given in the context of his alcohol use. Maternal grandfather had reported that he had been abstinent from alcohol since 2009.

Maternal grandfather's anti-depressant medication was consistently prescribed by the GP until the 16th April, 2014, when the GP practice manager communicated with the secretary of an LPFT psychiatrist stating that maternal grandfather had rung the ICMHT as he had not received his Clomipramine (which the GP practice were unable to obtain due to manufacturing issues within the UK). The LPFT psychiatrist advised the prescription of

Venlafaxine (anti-depressant) by the GP until maternal grandfather obtained a review appointment. This prescription was continued until the 21st July, 2014, when a telephone communication between the GP and maternal grandfather identified maternal grandfather's increasing symptoms of depression. The GP referred maternal grandfather to the older age community mental health team for a dementia assessment and completed an urgent referral to the ICMHT. Maternal grandfather was seen by the psychiatrist on the 29th July, 2014, and is admitted informally to an acute inpatient unit. The period when maternal grandfather's anti-depressant medication was changed signified a key period of decline in his mental wellbeing. If he had been reviewed as planned by a Psychiatrist within the community, soon after the 14th April 2014, then it is likely the newly prescribed antidepressant would have been reviewed by the Trust and amended if required. This review could also have initiated the 'fast track' mechanism for maternal grandfather to receive support from LPFT during a period of medication transition. If this review had taken place, his deterioration within the community may have been slowed or prevented.

Mother and maternal grandmother stated that they did not have prior concerns for the safety and wellbeing of her two children when in the care or company of maternal grandfather. As expected, in his role as maternal grandfather, he spent time in the company of his daughter and his grandchildren and attended family holidays. However, whilst they feel that he may not have necessary been a risk to the children, they did raise on the 24th November, 2014, that he may '*up the ante*' in some way to get his own way as he liked being in hospital and did not like his home. On 25th November they also highlighted what the Trust's RCA panel considered to be public safety concerns. Not only does this demonstrate the family's insight into maternal grandfather's manipulative behaviour, but also that they did raise general concerns with LPFT staff on at least two occasions. During the family interview on the 16th May, 2016, both women reiterated this view and their reflections that they felt that not all the necessary information regarding maternal grandfather's risks were adequately shared with them as his family. Following on from this point, there are also issues relating to the care and treatment offered to maternal grandfather, which was another concern raised by the family. For example, they believe that he was discharged in an unplanned manner, without even the clarity of the professional functioning as the Treating Consultant Psychiatrist who sanctioned this discharge. Listening and addressing the concerns raised by the family around maternal grandfather's deterioration, and completing a comprehensive risk assessment with the

required professional curiosity may have provided the opportunity for family members to further share the details of their concerns and their experiences shaping their perspective.

On several occasions maternal grandfather appeared irritable, agitated and neglected his hygiene. During his inpatient period he repeatedly complained of tightness in his head. However, as the court transcripts of the expert witness testimony illustrates there were no identified physical or mental health concerns identified to trigger these headaches. In fact, the expert view demonstrated that maternal grandfather was manipulative. During his inpatient period, maternal grandfather appeared fixated with his wish to move into residential care as he felt he could not cope with living on his own and felt "*lonely*". Alternatively, he wanted to be placed within a maximum security hospital as he felt he had a personality disorder. He commented that he would be better as long as he was "*locked up*" and that he "*should be taken away*". The chronology illustrates the journey of maternal grandfather's declining mental wellbeing between April to July 2014, the pressure this placed on his family and his manipulation of the situation, which was not assisted by the services he was offered during this period. There was a lack of defensible risk assessments to inform the discharge planning process and to fully consider and analyse the risks that he posed to others. A review of the Trust's safeguarding screening tool about children was not undertaken, which resulted in superficial and ill-informed risk and vulnerability management. There were several incidents when there were sufficient triggers to warrant a more comprehensive review of the risk assessment to others, for example, on the 25th November, 2014, when there was a missed opportunity to review and evaluate all of the known information following another assault on a Trust staff member. In fact, this information contextualises mother and maternal grandmother's concerns that he would "*up the ante*" and be a risk to others. Within this dynamic, rather than considering the wider risk to the public which includes Trust staff, the safety of the wider public was not identified.

Whilst it is now accepted that maternal grandfather did not require inpatient care, this was not the view shared by the LPFT Psychiatrist two days prior to maternal grandfather's discharge. On 9th December, 2014, there was a comprehensive multi-disciplinary ward review (MDT) led by the Treating Consultant Psychiatrist, where the plan for discharge after a period of leave was planned. This Psychiatrist was new to this post and had recently taken over as maternal grandfather's inpatient Treating Consultant Psychiatrist. The expressed fears and concerns of his family and maternal grandfather's risk to others was discussed and reviewed.

Maternal grandfather's family were recorded to be '*concerned, as he had previously made threats towards them, adding to his risk of violence*'. A risk assessment update to 'risk to others' was recorded as '*low currently but previous severe assaults indicate potential risks for future'*. It is recorded that maternal grandfather was not suitable for early discharge. There was no formal meeting to review his risk prior to discharge despite significant concerns and evidence of his risk of harm to others. It should also be borne in mind that concerns were raised by his family regarding maternal grandfather's behaviour and the potential vulnerability of other residents. Also, maternal grandfather's use and manipulation of his daughter and ex-wife demonstrated his attitude towards both of them and his selfish tendencies despite their unconditional support and assistance. Whilst the Trust staff appeared willing to engage mother and maternal grandmother to assist maternal grandfather to return home, it appears that their concerns went unheard and become 'invisible' in the scheme of returning maternal grandfather home and thus removing him from the unit.

On 12th December, 2014, mother rang the maternal grandfather's social worker and informed her that he had arrived at her house and she had allowed him to stay for one night, and on that day she did not know what to do as he was refusing to leave. Mother did not feel she could manage him in her home due to family and work responsibilities. The Trust staff attempted to come up with a plan and rang her back, at which time maternal grandmother was planning on assisting him to return home. On 14th December the Trust community staff rang mother and she confirmed that maternal grandfather was temporarily staying with maternal grandmother. On 15th December a home visit was agreed with maternal grandmother for the 16th December, but she was unavailable and so agreed home visit for the 18th December. On the 18th December a face to face seven-day follow-up appointment was undertaken and completed by the Crisis and Home Treatment Team and Integrated Community Mental Health Teams from maternal grandfather's home area at maternal grandmother's home. There is no evidence of a robust review of risk despite his change in circumstances from the intention to live at home to staying with his family despite the known history of incidents whilst on acute inpatient ward. However, this was a joint home visit with a social worker and a nurse present due to the potential risk to professionals. Between the 18th December and 21st of December, three telephone calls were made to maternal grandfather as attempts to offer him face to face visits. All three calls went unanswered until the 22nd December when contact was made by telephone with a Crisis Nurse. Maternal grandfather was discharged unseen after he declined to see the Crisis team and denied any risk to self or others. Therefore, the follow-up visit

failed to robustly evaluate the known risks posed to the family and the wider community. The lack of focus on defensible risk management did not consider maternal grandfather's history, in particular his pattern of recent violent behaviour and the risks to the wider public.

Resources Policies and procedures: - The policies, procedures, good practice and statutory guidance for all staff were up to date. Therefore, the missed opportunities identified were not a result of a lack of procedures, knowledge or resources, but were rather environmental and cultural in nature. This illustrates that simply noting a contractual or strategic commitment to safeguarding is insufficient if the culture in this case does not support the operationalisation of this into everyday practice. Throughout maternal grandfather's treatment there was a general lack of robust consideration of risk management and effective multi-agency working in line with the Trust expectations, policies and procedures in this case.

Risk Management: Robust and effective risk management tools were implemented to assist clinical staff to undertake defensible risk assessment. However, the risk assessments completed throughout maternal grandfather's mental health care did not defensibly measure his actual or potential risk to others. Risk assessments were ineffective in analysing maternal grandfather's historical and presenting behaviour to inform a robust risk management plan for the wider public. The evidence reflects insufficiently robust risk identification, assessment and review processes which represented a common factor that influenced core decision-making processes throughout maternal grandfather's care. Reiterated below is the key finding of the RCA which found,

"..that that there were missed opportunities to fully assess and manage the clinical presentation and associated treatment and risk processes. This led to subsequent failures to provide consistent and robust care and risk management plans, by both individual practitioners and the broader multi-disciplinary team. This resulted in a level of decision-making and care delivery that fell short of the standard of care expected by the Trust".

Despite assaults on two staff members and two other attempts there continued to be a lack of due regard to the requirement to consider the wider risk to others. In light of this, maternal grandfather continued to demonstrate his abusive and violent behaviour with limited consequences considered. Therefore, despite actual evidence of violence and harm, concerns voiced by his family that he would '*up the ante'* to get his own way and a change in his circumstances, maternal grandfather's presenting needs and risks were not sufficiently re-

assessed or evaluated. Trust staff had observed his attitude and behaviour towards his family, in particular his manipulative tendencies. Despite all of these concerning variables, his risk to the wider public and family were not analysed.

The quality of the risk assessment further deteriorated prior to maternal grandfather's discharge from inpatient care. This is evident on the 9th December, 2014, when a comprehensive multi-disciplinary ward review led by a Consultant Psychiatrist noted Maternal grandfather's "*risk to others"*" as "*low currently but previous severe assaults indicate potential risks for future*" and confirms that he was unsuitable for early discharge. It is questionable whether the presenting evidence and risk equated to "*low risk"*, in particular as the assaults were repeated and recent. Also, no additional specialist advice, for example, advice on risk from the Trust specialist community forensic team which are routine risk management steps/processes to be accessed when evaluating this degree of actual and potential risk of harm. However, despite the decision that maternal grandfather would not be discharged until after a further period of home leave, two days later he was indeed discharged from the acute inpatient ward to the community. What is of concern and illustrates the practice and culture of this inpatient setting in this case is the lack of a robust risk assessment of the risk to the wider community, whilst the risk to the inpatient ward staff was evaluated. Assessing the risk to staff members in itself is not an issue, however, assessing the risk to staff and ignoring the wider risks is of concern. Whilst the evidence now reflects that maternal grandfather was in the incorrect placement (i.e. inpatient care), it remains unclear why he remained in this placement for this length of time, in particular as this is a scarce resource.

Following his discharge, there was a lack of evaluation of the information received directly from maternal grandfather and his family around his refusal to leave their homes and his demands to stay in their homes, as well as a time when he had refused to return to the unit. The 7 day follow up visit in the community following discharge lacked the robust approach required to consider the impact of this violent behaviour and indeed his manipulation of his family members, this was based on the updated discharge risk assessment information which had not considered wider public risks. There was a lack of professional curiosity to review the information beyond the superficial presenting needs as the outcome of this visit was noted as raising "*no particular concerns*". This is despite the lack of any form of robust risk assessment, his recent abusive and violent behaviour whilst an inpatient, and the professional

judgement on the 9th, December, 2014, that he should not have been discharged at this time. The context of his behaviour was an established pattern of recent aggression to LPFT staff, assaults (the attempted strangulation of a Psychiatrist) and the in the author's view the lack of value of the family's contribution and the wider knowledge of their knowledge of his behaviour. The professional foresight, instinct and drive to evaluate maternal grandfather's risk assessment to others in a fluid and dynamic manner was missing at the point of discharge and essentially led to a lack of consideration of risk management by using multi agency public protection processes.

Information gathering, sharing and defensible decisions The issues regarding the lack of defensible information sharing was not due to policy, procedures or training as the required systems were implemented. The evidence demonstrates that not all decisions made by Trust staff in relation to the care of maternal grandfather, were fully informed by or made after consideration of all available information and evidence. Instead, they were based upon risk assessments that did not analyse wider risks to others. As a result, the risk and protective factors for working with maternal grandfather and his family were not balanced effectively against one another. If the risk assessment process had been completed effectively, there would have been consideration of the risk to the wider community.

There is evidence that the Trust shared information with the Police, GP and indeed with the family when maternal grandfather eventually consented. Despite this, the lack of acknowledgment of the concerns that the family says they shared impacted on the quality of the information shared and how this information was operationalised to ensure the risks to others were robustly managed. Key decisions were undertaken without the foundation of a robust assessment informed by multi-agency information, which is evidenced by the fact that he was within the incorrect placement to meet his needs for a period of 4 months. There was also poor recording of the decision making between the ward consultants and the ward team upon discharge on the 11th December, 2014.

Competencies training development All the required training and development were offered on a continuous basis to the Trust staff. However, at the time of Alex's death; out of the 29 staff working on the acute inpatient ward only 14 (48%) were compliant with their mandatory safeguarding children level 3a, which included domestic abuse competencies. The Trust has implemented a new clinical risk framework after having consulted with a number of

key national policies and publications on best practice in assessing and managing risk. The new risk framework focuses clearly on risk to others and prompts staff to consider safeguarding screening tool information when assessing risks. It also reminds staff that they need to complete and update their safeguarding screening tools in light of their risk assessment and management plan. All the acute inpatient unit staff have been trained on this new risk assessment model and it is fully embedded.

Line management advice and guidance: - The Trust RCA panel found, "*concerns in relation to management and supervision in terms of leadership, accountability, assurance and managing of staff competency within clinical areas"*. Of concern to the panel was, "*an absence of evidence supporting sufficient presence and oversight*" particularly in relation to the acute inpatient unit. This was in terms of, "*ward level managerial input and accountability for clear practice leadership, engagement and quality assurance/service monitoring*". The panel found a, "*failure of effective and robust ward level management overview and supervision of service quality and decision making processes".* This lack of management oversight is evident, as even basic practice guidance was not followed.

Culture: There were issues in relation to organisational culture in this case that affected the objective and robust assessment of the presenting concerns and needs of maternal grandfather. Once the clinical formulation and associated risks had been decided at the point of admission i.e. that the mental health problem was not acute and the presenting need was social in nature, no alternate formulation was then considered or appropriate discharge arrangements undertaken. Therefore, the professional judgement was static, rather than fluid and dynamic. This perception was most evident on the acute inpatient ward, as staff did not deviate when presented with information and behaviours that potentially conflicted with the existing clinical view. When dealing with acute mental health illness this should not be the case. This was of serious concern given that the foundation of a risk assessment relates to the fact that risk is dynamic, with the review of risk assessments a prerequisite to successful risk management. This flawed view of maternal grandfather's risk to others focused solely upon his risk to Trust staff and failed to anticipate the potential for maternal grandfather to be a risk to his family or the wider community. This included a lack of adherence to Trust Policies and Procedures as outlined across the agency report in relation to risk assessment, information sharing and communication.

This demonstrated an endemic culture in this case that prevented objective, responsive and analytical assessment and care planning. This culture proved crucial and functioned as a blockage to good practice as contact with maternal grandfather was clouded by a static judgement. There was evidence of a staff culture of maternal grandfather '*being the same as he always was'*, which is destructive when aiming to work within an environment where it is essential that risk is seen as dynamic. It was unhealthy and risky practice to regard maternal grandfather's escalating violence and abuse as presenting the '*same as he always was*'.

Communication: - The same themes noted within the risk management and information sharing sections are applicable here. Essentially communication, information sharing and risk assessments were ineffective. The several examples of poor communication are outlined within the 'missed opportunities' e.g. the poor communication during the discharge planning stage. Not only were the risk assessments inaccurate and flawed, but opportunities to communicate on a multi-disciplinary and a multi-agency basis remained unidentified and unexplored.

The Trust missed the opportunity to hear the voice of the family and to adopt a multi-agency approach focused on strength based principles or '*Think Family'*. This flaw was evident by a lack of robust assessment throughout maternal grandfather's treatment. There was no wider evaluation or prediction of risk beyond the superficial, even when maternal grandfather was voicing his own concerns/fears about his behaviour and intention to harm others. The overwhelming lack of communication is evident in the decision to discharge maternal grandfather following a professional judgement indicating otherwise and a following two assaults and two attempted assaults on Trust staff. Not only did the judgement to discharge lack a robust professional rationale, it appears that this was to the consideration of the protection of Trust staff. Whilst it was correct to consider the risks to staff members, the risks to his family and the wider community should also have been reviewed. There was also a comprehensive breakdown in communication, when even the role and responsibility of the Treating Consultant Psychiatrist was unclear.

4. LEARNING ON THE FRINGE

During this review one example of learning on the fringe was captured. On the 9th November, 2013, there is a written request by mother asking the GP to undertake a referral to the Community Paediatrician. The GP stated that he would undertake a referral despite having no

direct contact with Alex. There is no evidence that a referral was undertaken by the GP. The GP acknowledged that the referral had not been actioned by him, and states that the only explanation can be due to an oversight on his behalf. Although a face to face contact did not occur between the GP and Alex, a task had been generated by the reception staff within Alex's record to advocate that a referral was required. This should have drawn to the attention of the GP to the need to respond to the request to undertake the referral. There appeared to be an electronic and administrative trigger to ensure that referrals were completed in a timely manner. However, due to human error and competing work pressures, this system did not appear to be a robust mechanism for referral management. The GP is the gatekeeper of access to health services and accordingly, referral to specialist health services is a major component of their work. If this referral had not been proactively actioned by others, this specialised support and guidance may not have been implemented to assist Alex. This GP Practice is currently developing a referral management system to address this issue. Best practice would also be to audit the revised referral process to quality assure its robustness.

5. **CONCLUSION**

The only individual responsible for the tragic death of Alex is maternal grandfather. The evidence indicates that he was violent, abusive and highly manipulative. He prioritised his needs above everyone else and went to great lengths to get what he wanted. Based on his history and escalating violent behaviour, maternal grandfather should have been assessed as a risk of harm to others. Robust professional practice and the required degree of curiosity may have led to the identification of the risk of serious harm to others. Whilst the risk of serious harm to adults was predictable, the risk to children or indeed his family was not evident. However, maternal grandfather was an informal patient and there were no grounds identified to detain him within this setting. Equally so, it is questionable whether or not he should have been placed within an acute inpatient setting at all during this period. Whilst it may have been the appropriate decision to admit him to this unit, within 6 days of admission he was assessed to have no cognitive impairment and not to be significantly depressed.

Whilst several agencies provided services to this family, the key focus of this review is on the services provided to maternal grandfather by LPFT. There were several missed opportunities for LPFT to respond differently. These missed opportunities demonstrate a lack of defensible judgement and professional foresight. Specifically, the risk assessment and discharge planning process were flawed to the degree that maternal grandfather was discharged without

a full analysis and risk management plan of risk to others. These learning points demonstrate a culture in this case that was focused on the needs of the staff members, which filtered through all core aspects of their work associated with the role of the Treating Consultant Psychiatrist, risk assessment, care management, assessment and review. Whilst little will be of comfort to mother or maternal grandmother, it should be acknowledged that they attempted on two recorded occasions to voice their concerns. This needs to change with a focus required on promoting the voice of carers and their families. The overarching culture of each organisation should be focused on an approach grounded in principles focused on a holistic strength based approach, where the needs of all family members are considered in a visible manner. However, it should also be acknowledged that not all risks can be prevented, but robust risk assessments can manage and mitigate risk factors.

To summarise, there are several key points of learning for LPFT. Firstly, the lack of competent practice and professional curiosity resulted in a lack of robust risk assessment. The discharge planning lacked any form of basic defensible risk assessment, planning or analysis of the presenting risks to the wider public. Secondly, the culture within this particular inpatient ward in relation to this case perpetuated an ethos focused on a lack of ownership, in particular in establishing the Treating Consultant Psychiatrist. Thirdly, despite the presence of comprehensive policies, procedures and training; the organisational culture functioned as a barrier to assessing maternal grandfather in a dynamic manner. Finally, these learning points resulted in the lack of visibility of the family's needs and the safeguarding concerns that required managing on a multi-agency basis. Therefore, the flow of practice from the planning, assessment, to his discharge, lacked the required professional curiosity, governance and management oversight to recognise his risks and listen to the voice of this family.

In conclusion, I wish to reiterate that the responsibility for Alex's death lies with maternal grandfather, who demonstrated a callous unconcern for the feelings of others, who is manipulative and would do anything to achieve what he wanted, which was to be locked up and cared for. By the time of his discharge on the 11th December, despite the nature of the practice informing this discharge, it was evident that he should have already left acute inpatient care. Despite his actions and wish to remain in hospital, there was no reason for him to remain in the hospital, as he was not suffering from any mental illness. However, there were limited indicators of the risk he posed to specifically to children and the degree of his violence towards Alex could not have been predicted or prevented. By his own admission during the trial process, once within the community, when he perceived his daughter thwarted

his desire to be allowed to stay with her in her home, he cruelly took Alex's life. His action to kill Alex occurred 11 days following his hospital discharge and clearly did not take place in the presence of psychosis or another severe mental illness. Although it is agreed that he does have a diagnosis of personality disorder, this did not impair his decision making at this time. Given the nature of this act no agency or any member of his family could have predicted or prevented such an outcome. This was not as a result of any mental health illness; maternal grandfather made the decision to undertake this particular action and as a result has now been found guilty and convicted of murder.

6. IMPLEMENTATION OF LEARNING

6.1 Recommendations by the Independent Overview Report Author

Recommendation 1: GP: Primary Care

In order to evaluate the suitability of applying the GP ANR recommendations (see appendix, section 3) to the whole of the GP community in Lincolnshire, an audit sample to be undertaken across a cross-section of GPs. As these recommendations relate to core aspects of a GP's role, the findings from this audit should inform the extent of the requirement to disseminate this learning across the GP community.

Recommendation 2: Police and LPFT

The police and LPFT to establish an agreement to address the required standard of practice, communication and timescales when addressing the violence and abuse to LPFT staff within the workplace. In particular, a process needs to be formulated to address cases when staff do not wish to make a complaint when assaulted in the workplace.

Recommendation 3: LPFT

3.1 LPFT to consider at service transition points, there is clear evidence in the clinical notes with regards to the offer of advocacy and support to both patient and carer to ensure they are offered choice and control over their care arrangements. Specifically:

- At admission;
- At transfer to rehabilitation services;
- At discharge to CMHTs.

3.2 The process of disseminating the importance of the comments/complaints process/policy to be reviewed and re-launched to all staff members.

3.3 An audit to be undertaken of the 7 day review following discharge from inpatient care to focus on the quality of the recording, the outcome of the visit, the consideration to risk and vulnerability management and the needs of the family as a whole.

6.2 **What's Changed?: LPFT**

In light of the context of this review, the focus of this section is on reviewing the change and developments in LPFT. The internal Trust RCA identified 30 recommendations, which were themed and incorporated under the following headings:

- Professional Practice
- Risk Assessment and Procedure
- Care Pathway, Treatment/Care Plans
- Staff Management
- Performance Management
- Ensuring Performance Compliance (audit, monitoring and supervision)
- Raising Policy Awareness
- Amendments to Policy
- Community Mental Health Team Operational Policy
- Pharmacy/Medical Advice

Since the recommendations were shared, a 'ward improvement plan' has been designed which incorporates all the actions that were under the headings above. This plan is working to effect and embed extensive positive change. A copy of this improvement was shared with the LSCB business manager and the independent author of the Serious Case Review for the purpose of providing assurance against the ward related concerns that were detailed within the LPFT ANR. During this improvement process there has been a complete restructure of the Trust's operational services. Some of the improvements completed include the assigning of a Team Manager to oversee the improvement plan, the development of an acute care pathway model with associated treatment pathways based on NICE guidance, the completion

of a skills gap analysis of the clinical team, the employment of a Delayed Transfer of Care social work post, and the implementation of initiatives from *Triangle of Care toolkit* to better engage Carers with decision making.

6.3 Progressing Recommendations and dissemination of learning

6.3.1 As the commissioner of this SCR, the LSCB will monitor the progress of the resulting recommendations and action plan.

6.3.2 Any future related inter-agency training and learning events will incorporate the key learning and good practice examples from this SCR.

6.3.3 The key messages will be presented and shared with statutory partner during a LSCB meeting.

6.3.4 Each agency safeguarding lead will disseminate key lessons to be learnt within their own agencies.

6.3.5 Key messages will also be disseminated at the LSCB sub-group meetings.

Ceryl Teleri Davies

Independent Overview Author

8th December, 2016.

APPENDIX 1: Recommendations from the ANRs

The ANRs have provided evidence of actions already undertaken in response to individual agency recommendation. These recommendations have been identified by each ANR author in their own reports and have been signed off at a senior level within the respective agency. The Board accepts responsibility for overseeing and ensuring their implementation.

1. **POLICE**

No recommendations outlined within the Police ANR.

2. **EDUCATION:**

No recommendations outlined within the Education ANR.

3. GP: PRIMARY CARE:

Recommendation 1: *The GP practice should review the process for referrals and develop explicit policy/practice guidance within 3 months from date of request. The policy should be compliant with the guidance; Delegation and Referral (GMC 2013) and include:*

- *The distinction between the rationale of making referrals following face to face consultation and in situations where this may be overridden.*
- *The timeliness of referrals from consultation to actioning.*
- *The practice responsibility regarding DNA (non-attendance at the appointment) including where safeguarding concerns / vulnerability are identified*
- *The referral outcome reporting.*

Recommendation 2: *The practice should provide assurance of a robust quality assurance process to ensure early identification of administration errors / time delays in:*

- *Executing referrals.*

Recommendation 3: *The GP practice where maternal grandfather was registered should provide assurance of a robust quality assurance process regarding:*

- *Deduction of patients in accordance with available Guidance (Removing Patients from the Practice list –Medical Protection Sept 2013.*

4. UNITED LINCOLNSIRE NHS HOSPITAL TRUST:-

Recommendation 1: *Community Paediatrics Business Manager, Community Paediatricians and Information Governance representatives from ULHT to work with relevant LCHS colleagues in order to formalise the current administrative and storage arrangements for the ULHT Community Paediatrics function. Estimated timescale for completion of Formal agreement is 31st March 2016.*

Recommendation 2: *Community Children's Team Matron to devise a function to 'alert' Professionals to the existence of additional Nursing Documentation. Timescale for completion is 31st January 2016.*

4. LPFT:-

Recommendation 1: Professional Practice

Fast Track Protocol: *There is a thorough review of the Fast Track Protocol and process to include:*

- *Ensuring trigger and response cascades are robust;*
- *Allowing effective return to service for service users;*
- *Adequate controls and safeguards to ensure medication reviews are undertaken as required;*
- *A provision for timely access to consultant advice;*
- *A process for identifying a care coordinator (lead professional), for previously discharged service users returning under fast track going directly into acute/in-patient services.*

Recommendation 2: Risk Assessment and Procedure

- *For the ward consultant, team leader, ward manager and identified risk champion for a particular Ward to fully engage in the roll out of the Trust's new clinical risk assessment training programme and associated CQUIN.*

- *In-patient consultants, team leaders, the CRHT leaders and ward managers of a particular ward and a rehabilitation centre to ensure, through management supervision, that all staff fully understand and meet the required standards of the new Trust Clinical Risk Assessment Protocol*

    - *For Ward consultants, team leaders and ward manager to ensure appropriate forums for discussing clinical risk, such as ward MDTs and CPA reviews, take account of perspectives of all relevant parties: patient, family, carers. There needs to be a shared understanding of formulation of risk, explicitly recorded and disseminated.*

    - *For these teams there is a detailed quality impact review of the new risk assessment process within 2 months of this report. Ensuring key issues and actions are completed and the new procedure fully embedded.*

Recommendation 3: Care Pathway, Treatment/Care Plans

- *The acute service medical and management team review and develop a clear and robust ward review pathway/protocol/process, aligned with the named nurse model. The quality and content of the information presented must:*

    - *Support safe and effective clinical decision making;*
    - *Be clearly documented in the clinical record;*
    - *Include/be supported by empirical data/formal assessment outcomes specific to clinical need;*

- *Reflect the level of clinical complexity at presentation, using standardised condition specific assessments when indicated;*
- *Record a clear clinical rationale where service user statements/decisions are not aligned to their care plan.*

- *That at service transition points, there is clear evidence in the clinical notes with regards to cross team discussion/agreement. Specifically:*

- *At admission;*
- *At transfer to rehabilitation services;*
- *At discharge to CMHTs.*

To include reasons for admission/discharge/transfer and differing clinical opinions.

- *That all patients, at admission, are classified as requiring CPA and associated processes. To be reclassified as non-CPA a formal review must be undertaken.*

- *That the full care pathways between Trust acute, rehabilitation and CMHT are fully reviewed. Specifically:*

- *All patients are clinically assessed prior to transfer;*
- *Service and medical management to be assured that stated standards are being met.*

Recommendation 4: Staff Management

- *That the named nurse model, as applied to acute Mental Health ward setting is reviewed against alternative current best practice nursing models based on national bench mother's partnering evidence.*

- *A named consultant responsible for a patient's care should be clearly identified and known to the patient and ward staff at all times. To include annual leave and locum cover, and points of transfer.*

- *That the professional/medical leave policy and process is reviewed, formalised and disseminated through all management and clinical lines; and that medical cover arrangements on a particular Ward are reviewed and the required levels of cover provided to maintain safe practice, at all times*

- *For a particular Ward to have a substantive ward manager appointed as soon as possible, to provide strong, visible and stable leadership and management presence.*

- *Formal performance management and/or disciplinary processes should be considered in issues relating to failures in the following domains:*

- *Clinical risk assessment processes;*
- *Trust policy in relation to CPA standards;*
- *Discharge and liaison standards;*
- *Safeguarding pathways and processes.*

Recommendation 5: Ensuring Performance Compliance (audit, monitoring and supervision)

- *That ward consultants, team leaders and ward managers ensure all staff are compliant with CPA training.*

- *Team leaders ward managers and medical managers ensure a process for monitoring the quality of assessment and care planning is recorded through management supervision of named nurses (or equivalent).*

- *That there is an audit of MDT review entries within 2 months of this report to ensure standards are met, specifically:*

  - *Clinical rational recorded where there is non-alignment between service user and care plan;*

  - *Inclusion of formal reviews of medication;*

  - *There is a review of the MDT ward review process to ensure earlier identification of service users for review; to better support full attendance and engagement of external parties. This review is audited after 2 months of this report to ensure issue is addressed.*

Recommendation 6: Raising Policy Awareness

- *All in-patient staff confirm their awareness of the requirements of the Trust's Assessment and Care Planning Policy and, specifically:*

- *Care plans are created collaboratively;*
- *Care plans are derived from appropriate assessments.*

    - *The full MAPPA process to be reviewed and embedded to improve service awareness, access and use.*

    - *That the Trust's policy for Assessment and Care Planning (including CPA) is re- issued in a lessons to be learned learnt report across the Trust.*

    - *Ward consultants/doctors and ward managers ensure that recording of MDT meetings, including ward rounds and CPA review, is done in line with Trust policy.*

    - *All ward staff are up to date with mandatory safeguarding policy.*

Recommendation 7: Amendments to Policy: The following Trust policies are reviewed:

Clinical Care Policy

- *discharge/transfer procedure;*
- *admission procedures;*
- *timescales for CPA transfer;*
- *clinical risk screening;*
- *reviewing clinical risk assessment.*

To ensure service specific review of risk occurs at key transition points. All in-patient and community staff to confirm their awareness of the amended policy.

CMHT Operational Policy *is reviewed and revised to ensure:*

- *Alignment with Clinical Care Policy;*
- *Service eligibility criteria for teams are clear;*
- *Internal referral processes and routes are agreed and stated;*
- *The ICMHT referral form is included in the policy;*
- *Information on service interface is added – section 7;*
- *These are agreed and disseminated between all in-patient and community services.*

Recommendation 8: Pharmacy/Medical Advice

The role of routine pharmacist in relation to MDT decision making is reviewed.

Recommendation 9: Safeguarding

- *15.1 The Trust measure the use of the safeguarding screening tools across all services against the Safeguarding Policy to ensure that they are being accurately and routinely completed and reviewed.*

- *15.2 For the Named Doctor to review the junior doctor's training provision specific to Trust services and in line with the Trust's safeguarding training matrix and intercollegiate competencies (2014).*

- *15.3 A joint training session will be attended by the Trust's Safeguarding Champions and Risk Champions to highlight the issues identified within the RCA and ANR; including how risk is dynamic and requires reassessment in a family situation with lessons on how to embed this learning developed and led by Trust Champions, monitored by the risk and safeguarding governance systems. The Consultant Nurse for Safeguarding and the Named Doctor for Safeguarding Children will develop and lead this session.*