County Durham and Tees Valley NHS

Strategic Health Authority

# REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF KEVIN LITTLEWOOD

COMMISSIONED BY
COUNTY DURHAM AND TEES VALLEY
STRATEGIC HEALTH AUTHORITY

10 December 2003

Panel Members
Mr Neil Robinson MBE, JP, MHSM, Dip.HSM (Chairman)
Mr Terry Anderson, RNLD
Dr Kenneth Day, FRCPsych
Mr William Morgan, BA DASS
Dr Sue Wressell, M.B.B.S, MRCPsych (Specialist Adviser)

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# EXECUTIVE SUMMARY

## Introduction

1. The Independent Inquiry into the care and treatment of Kevin Littlewood was commissioned by County Durham and Tees Valley Strategic Health Authority in November 2002.

2. Department of Health Guidance (HSG(94)27) requires such an inquiry to be held where there has been a homicide committed by a person who has received mental health services. The Guidance suggests that, where a serious violent incident occurs, it is important to learn lessons for the future.

3. The incident at the heart of the Inquiry involved the death of a man in Hartlepool in January 2001. In December 2001 Kevin Littlewood, aged 17 at the time the offence was committed and who had been receiving mental health services, was found guilty of murder. He is currently serving a life sentence in HMP Moorlands, Doncaster.

4. Kevin Littlewood was a patient of Child and Adolescent Mental Health Services from December 1997 until his arrest in February 2001. Since 1999, these services have been part of Tees and North East Yorkshire NHS Trust. He also received services from Hartlepool Social Services, Hartlepool Education Department, Tees Valley Housing Group, Future Steps (now Connexions Tees Valley) and from the primary and emergency health care services.

### Terms of Reference and Method of Working

5. The Inquiry's remit was:

   - To examine all the circumstances surrounding the treatment and care of Kevin Littlewood and by the mental health services in particular;
   - To examine the adequacy of the collaboration and communication between the agencies, and between the agencies and Kevin Littlewood's family;
   - To prepare a report and make recommendations to County Durham and Tees Valley Strategic Health Authority.

6. The Panel met regularly and took evidence from a wide range of witnesses. They also received and considered substantial written documentation from the organisations concerned.

## Issues Considered by the Panel

7. The Panel examined in detail the services provided or considered for Kevin Littlewood and his personal history. An internal investigation and a number of reviews into the case had already taken place. The Panel gave careful consideration to the conduct of these reviews and their findings.

**General Overview and Conclusions**

8. Kevin Littlewood's social and personality profile and behaviour was similar to those presented by a large proportion of youths referred to the Child and Adolescent Mental Health Services. The main concern of all health professionals responsible for his care was the possibility of self harm. In the Panel's view it would have been impossible to have predicted the homicide from Kevin's presentation throughout his involvement with the statutory and other agencies.

9. The overall standard of care, treatment and support provided by the Child and Adolescent Mental Health Services, the lead agency, from the time of Kevin Littlewood's first referral up to his arrest was in the Panel's view satisfactory. There was also much good practice by other agencies and individual professionals responsible for the care and treatment of Kevin Littlewood.

10. On the basis of the evidence before it, the Panel agree with the psychiatric assessments of Kevin Littlewood made during his care, that he was not mentally ill, but was displaying evidence of Adjustment Disorder.

11. The Panel identified a number of areas in which policies, clinical practice and service provision could with benefit be improved. Many have been identified by the Internal Investigation and the Management Reviews and have already been or are in the process of being rectified.

12. The Panel consider it important to draw particular attention to the shortcomings in Care Co-ordination during the months leading up to the homicide. This failure was due, in part at least, to a confusion about roles and responsibilities consequent upon the lack of a clear multi-agency Teeswide Care Coordination Policy following the merger of the North Tees Health Care NHS Trust and South Tees Community and Mental Health NHS Trust. When Trusts merge key clinical policies should be reviewed immediately and new policies issued as a high priority.

13. The Panel commends the Tees and North East Yorkshire NHS Trust, the Hartlepool Borough Council and other involved agencies for their prompt action in initiating an Internal Investigation and Management Reviews and also for implementing the recommendations arising from these.

14. The Panel noted that it may be very stressful for staff and wasteful of resources for a formal and detailed internal investigation to be carried out and for this to be followed some time later by an Independent Inquiry which covers much the same ground. The Panel recommends that the Department of Health reviews its advice on these matters and that County Durham and Tees Valley Strategic Health Authority considers issuing guidelines on the conduct of internal investigations.

**Recommendations**

15. The Panel has made 17 recommendations. These are listed within the relevant sections of this report. For ease of reference, they are also repeated in full in Section 7 of the report.

**Acknowledgements**

16. Finally the Panel wish to place on record its appreciation of the cooperation and honesty of all who gave evidence to this Inquiry. Their distress and shock at what had happened was readily apparent. The Panel was impressed by the willingness of staff from all agencies to learn from this experience and their commitment to improving services.

## SECTION 1.1: MEMBERSHIP OF THE INQUIRY PANEL

**Mr Neil Robinson, MBE, JP, MHSM, Dip.HSM (Chairman)**

- Former Chief Executive, NHS Trust
- Justice of the Peace
- Commissioner, Mental Health Act Commission
- Experience at executive management level in the provision of services for people with learning disabilities
- Extensive involvement with local Church, community and voluntary organisations

**Mr Terry Anderson, RNLD**

- Former Director of Nursing, Northgate & Prudhoe NHS Trust
- Clinical Lead for Community Residential Services with special responsibility for Community Domiciliary Nursing Services throughout Northumberland & Newcastle
- Professional Adviser to the Health Service Ombudsman

**Dr Kenneth Day, FRCPsych**

- Former Consultant Psychiatrist & Medical Director, Northgate & Prudhoe NHS Trust
- Former Senior Lecturer, Department of Psychiatry, University of Newcastle Upon Tyne
- Medical member, Mental Health Review Tribunal
- Author of many books, research and clinical papers and chapters on psychiatric aspects of learning disability

**Mr William Morgan, BA, DASS**

- Former Psychiatric Social Worker and Lecturer in Social Policy, University of Newcastle Upon Tyne
- Associate of the Association of Psychiatric Social Workers
- Member, British Association for Behavioural and Cognitive Psychotherapies
- Lay Member, Mental Health Review Tribunal

**Specialist Adviser to the Panel**
**Dr Sue Wressell M.B.B.S, M.R.C.Psych**

- Consultant Child and Adolescent Psychiatrist, Fleming Nuffield Unit, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust
- Former Head of Clinical Service, Newcastle Child and Adolescent Mental Health Service
- Clinical lecturer, Department of Child Health, University of Newcastle Upon Tyne
- Psychiatry Examiner for the Royal College of Paediatrics and Child Health

## SECTION 1.2: TERMS OF REFERENCE

1. To examine all the circumstances surrounding the treatment and care of Mr Littlewood and by the mental health services in particular:

   i. To examine whether appropriate conclusions were drawn from the relevant agencies' internal investigations and the extent to which recommendations have been implemented.

   ii. The quality and scope of his health and social care risk assessments;

   iii. The appropriateness of his treatment, care and supervision in respect of:

      a) His assessed health and social care needs;
      b) His assessed risk of potential harm to himself or others;
      c) His psychiatric history, including any history of drug or alcohol abuse;
      d) The number and nature of any previous court conviction(s)

   iv. The extent to which the care given to Mr Littlewood corresponded to statutory obligations, relevant guidance from the Department of Health including the Care Programme Approach HC (90) 23/LASSL (90) 11 and discharge guidance, HSG (94) 27 and local operational policies;

   v The extent to which his prescribed care plans were:

      a) Effectively delivered, and
      b) Complied with by Mr Littlewood;

   vi To examine the care provided in the context of the adequacy of operational policies and of staff and service resources available to carry out operational policies.

2. To examine the adequacy of the collaboration and communication between:

   i. The agencies (Tees and North East Yorkshire NHS Trust's Child and Adolescent Mental Health Services, Hartlepool Social Services, Hartlepool Local Education Authority, Hartlepool Primary Care Trust, relevant housing agencies) involved in the care of Mr Littlewood and, or in the provision of services to him, and

   ii. The statutory agencies and Mr Littlewood's family.

3. To prepare a report and make recommendations to County Durham and Tees Valley Strategic Health Authority.

## SECTION 1.3: BACKGROUND TO THE INDEPENDENT INQUIRY

1. On the 24 January 2001 the body of a man was found wedged in the rocks in Hartlepool harbour. It was established that he was a local young man, who was an acquaintance of Kevin Littlewood, and that he had been murdered on the 18 January 2001.

2. On the 12 February 2001 Kevin Littlewood was arrested and charged with murder and theft. He was one of two co-accused though the charges against his co-accused were subsequently dropped. At the trial in December 2001 Kevin Littlewood was found guilty of murder and sentenced to life imprisonment with an order that he should serve a minimum of 9 years before parole could be considered.

3. Kevin Littlewood's legal representatives made no plea of diminished responsibility. The court had access to a comprehensive psychiatric report on Kevin Littlewood, prepared by a Consultant Adolescent Forensic Psychiatrist, at the request of Kevin Littlewood's solicitor.

4. Kevin Littlewood was 17 years old when the offences were committed and is currently a prisoner in HMP Moorlands, Doncaster.

5. Kevin Littlewood was a patient of Child & Adolescent Mental Health Service (CAMHS) from December 1997 up to his arrest in February 2001. He also received services from Hartlepool Social Services Department in 1998, 2000 and 2001. Education was provided by Hartlepool Education Department from 1988 to 2000.

6. On being advised of Kevin Littlewood's arrest and subsequent charge, Tees and North East Yorkshire NHS Trust immediately set up an Internal Investigation to determine the adequacy of the care and support provided by the Trust in the period before and at the time of the incident. This Team reported in March 2002. We comment on this report in Section 4.

7. Internal Management Reviews were also undertaken by the Hartlepool Social Services Department and Hartlepool Education Department, an Independent Review by Future Steps and a Report conducted by St. Paul's Project/Tees Valley Housing Group. We comment on these reports in Section 4.

8. Following Kevin Littlewood's conviction for murder, County Durham and Tees Valley Strategic Health Authority commissioned an Independent Inquiry in accordance with Health Service Guidance (94) 27 which states that where a person receiving mental health services is convicted of homicide "After the completion of any legal proceedings.... it will always be necessary to hold an Inquiry which is independent of the Providers involved".

## SECTION 1.4: METHOD OF WORKING

1. The Independent Inquiry Panel held a preliminary meeting on 7 November 2002 and subsequently met on 23 occasions to take evidence and to formulate and compile this Report.

2. The Panel has spent approximately 1,200 hours interviewing witnesses, reading documents and in discussion. In compiling the Report however the Panel has been mindful of the need to produce a readable Report which clearly and succinctly addresses its remit.

3. A total of 37 people, including Kevin Littlewood's father, were specifically invited and attended to give evidence to the Panel. The Panel also visited Kevin Littlewood in HMP Moorlands, Doncaster and interviewed him in the presence of his solicitor and staff directly involved in his care. A full list of witnesses interviewed is given in Appendix A.

4. Kevin Littlewood's mother and the parents of the victim were also invited to meet the Panel but declined to do so. The victim's father telephoned his comments for consideration by the Panel.

5. Anyone from the involved statutory and voluntary agencies who had not been specifically invited to meet the Panel were encouraged to make representations to the administrator of the Inquiry if they wished to contribute to the investigation. No additional persons came forward.

6. Interviews were conducted in private and witnesses were given the opportunity to be accompanied by a colleague or legal or other adviser. The evidence given was tape recorded solely for the purpose of providing an aide memoire to the Panel in compiling its report.

7. Relevant sections of the factual parts of this report were sent to witnesses to check for accuracy.

8. The Panel also considered the report of the Internal Investigation conducted by Tees and North East Yorkshire NHS Trust, the Management Reviews by the Hartlepool Social Services Department and the Hartlepool Education Department, the Independent Review undertaken by Future Steps and the Report conducted by St Paul's Project/Tees Valley Housing Group.

9. In addition many policy and other documents were made available by the Trust and other agencies and several witnesses provided the Panel with copies of relevant documents. The documentary evidence considered is shown in Appendix B.

## SECTION 1.5: ACKNOWLEDGEMENTS

1. The Panel wishes to express its thanks to everyone who contributed to the work of the Inquiry, particularly:

- the helpful contribution made by all the witnesses. The Panel recognised the very real stress imposed by the Inquiry process, particularly given the length of time since the event and the fact that most witnesses had already contributed to searching internal investigations or reviews.

- the co-operation of all the individuals and agencies approached to assist in contacting potential witnesses or to supply background information.

- the assistance and expert advice received from the Specialist Adviser to the Panel, especially her contribution to Panel discussions about the content of this Report as it was being compiled

- the staff at HMP Moorlands, Doncaster for facilitating the meeting with Kevin Littlewood

- Mrs Avril Rhodes to whom grateful thanks are due for her invaluable work in facilitating this Inquiry, providing administrative support and responding to our many demands with unfailing goodwill and efficiency

## SECTION 2: DESCRIPTION OF SERVICES PROVIDED OR CONSIDERED FOR KEVIN LITTLEWOOD

1. The specialist NHS services and those provided by other Agencies used by or considered for Kevin Littlewood are described below. As many of these services continue to exist they are described in the present tense. Some of the NHS services described in this section have undergone re-organisation or have new organisational names and these changes are described in Appendix C.

**Child & Adolescent Mental Health Service (CAMHS)**

2. In 1997 the Child and Adolescent Mental Health Service in Hartlepool and Stockton was part of the former North Tees Health Care NHS Trust. In 1999 as part of a three way merger, these and other local mental health services transferred to the new Tees and North East Yorkshire NHS Trust. The four local services based in Hartlepool, Stockton, Middlesbrough, Redcar and Cleveland were brought together to form a single unified Teeswide Service. This was necessarily a complex process involving both changes in management structures and staff roles and requiring the integration of clinical policies and procedures.

3. The CAMHS provides a multi-disciplinary screening, assessment and treatment service to children and young people up to the age of eighteen with emotional, behavioural and mental health problems and includes the following components:
   - Four multi-disciplinary locality teams
   - Day services based at the Woodlands Unit, North Tees Hospital , Stockton on Tees
   - The Young People's Department, the Roseberry Centre, St Luke's Hospital, Middlesbrough, subsequently relocated to the Newberry Centre for Young People, West Lane Hospital, Middlesbrough.
   - The Options Team for Teesside

*Locality Teams*

4. There are four multi-disciplinary locality teams based in Hartlepool, Stockton-on-Tees, Middlesbrough, and Redcar and Cleveland. These provide assessment, treatment, and support to children and young people living in their catchment area.

*Day Services based at the Woodlands Unit*

5. A specialist day service for the assessment and treatment of children and young people with social, emotional and behavioural problems.

*Young People's Department*

6. The Young People's Department provides multi-disciplinary assessment and treatment for young people with complex or severe psychiatric disorders on an inpatient basis. The admission criteria specifically excludes young people with conduct disorders requiring medium to long term intervention in a semi-secure or secure setting.

*Options Team*

7. The Teeswide Options Team provides an immediate psycho-social assessment to young people up to the age of eighteen years referred by Accident & Emergency Departments within the Tees area following episodes of deliberate self harm (CAMHS Operational Policy October 2000). The Team have a responsibility to liaise with the individual's General Practitioner and other agencies where appropriate.

**Learning Disabilities Service**

8. The Tees and North East Yorkshire NHS Trust provides a lifespan service for people with learning disabilities to a wide geographical area, including Hartlepool. It provides out patient services for both children and adults and inpatient services for adults.

**Cleveland Diversion Team**

9. The multi agency Teeswide Cleveland Diversion Team was established in 1995. It provides multi-disciplinary assessments for adults with a known or suspected mental health problem who are in custody, with the aim of diverting them, where appropriate, to the mental health services. The service is also extended on request to young people aged sixteen and above. The Team works between the criminal justice system, NHS services and other agencies. (Protocol between Cleveland Diversion Team and the CAMHS for the provision of joint assessments of young people when in custody, July 2002).

**Hartlepool Education Department**

10. Sunningdale School, Middlesbrough, which closed in 2000, was a co-educational school for pupils with severe educational and behavioural difficulties maintained by Middlesbrough Local Education Authority. Entry criteria were that pupils' difficulties were sufficiently severe for them to have a Statement of Special Educational Need and that their needs could not be met in mainstream provision. (Policy on Special Educational Needs Provision, Hartlepool Council, undated).

**Future Steps**

11. Future Steps was formed in 1995 to provide information, advice and guidance on careers and further education for young people under twenty-one years of age in Teesside (Background to Future Steps, Operational Policies and Procedures, undated). Future Steps had a special responsibility for all Statemented pupils and to assist those young people at risk of non-participation in learning under the government's "Learning Gateway" initiative. The role of Future Steps was subsumed by Connexions in September 2002.

**Hartlepool Social Services Department**

12. Hartlepool Social Services Department, among its many responsibilities, has a duty under the Children Act 1989 to support children in need under Section 17 and to provide accommodation under Section 20.

**St Paul's Project**

13. This Project was established in Hartlepool in 1984 by Tees Valley Housing Group as a joint initiative with Hartlepool Social Services Department. It provides accommodation, care and support for up to five people aged between sixteen and eighteen who are homeless and vulnerable. The aim is to help the young person to move into independent living.

**Tasker House**

14. Tasker House, Sunderland, is a specialist day college for people between the ages of 16 and 30 with autism and Asperger's Syndrome. It provides a range of academic, vocational and living skills courses for students, some of whom live in associated accommodation. Tasker House and its associated residential services are managed by European Services for People with Autism Ltd, a registered charity.

**Fraser House**

15. Fraser House is a specialist adolescent unit for young people with learning disability. It is managed by Northgate and Prudhoe NHS Trust and is situated in the grounds of Prudhoe Hospital in Northumberland. It provides multidisciplinary assessment and treatment services for adolescents with complex emotional, behavioural or psychiatric problems in addition to learning disability.

## SECTION 3: BRIEF HISTORY OF KEVIN LITTLEWOOD RELEVANT TO THE PANEL'S TERMS OF REFERENCE

1. Kevin Littlewood was born on 19th September 1983 to a working class family on Teesside and is the eldest of three siblings. His parents separated in 1994 when he was aged eleven years and they subsequently divorced. For the next four years he lived with his mother and siblings. In 1998 he moved to live with his father because his mother could no longer cope with the increasing behavioral difficulties he was presenting both at home and at school.

2. Kevin Littlewood left his father's home at the end of June 2000 because of increasing behavioural difficulties. He then lived in a number of temporary lodgings, all of which broke down because of behavioural or coping difficulties. He also spent a short period in foster care which he terminated. In November 2000 he was placed by Hartlepool Social Services Department in the St Paul's Project, Hartlepool, where he was living at the time of the offence and his arrest.

### Education

3. Kevin Littlewood attended St Teresa's primary school from the age of five years transferring to St Aidan's primary school at the age of nine years.

4. In September 1995, at the age of eleven years eleven months, he moved to Brierton Secondary School. Initially he was well behaved but later he became disruptive. He was described as uncooperative, attention seeking, unwilling to accept limits and boundaries and to be verbally aggressive if thwarted. He received a number of fixed term exclusions to the school's Support Unit and in October 1997 was placed full time in the Unit and referred for psychiatric assessment.

5. After a period at the Woodlands Unit an attempt was made to return him to Brierton School but this failed. In January 1999 he was Statemented in accordance with Section 324 of the Education Act 1996 and placed at Sunningdale School where he completed his education. He is reported to have been well behaved and academically quite successful during his first year at Sunningdale but to have deteriorated during his second year when he began to truant frequently. He left school in July 2000 at the age of sixteen years.

### Further Education and Employment

6. During his last two years at school Future Steps provided assessment and advice on further education and life skills. It was considered that local general provision could not meet his needs and a three-year day educational placement was sought and obtained for him at Tasker House commencing in September 2000. Funding for this placement for one year in the first instance was secured from the Further Education Funding Council.

7. Before this placement could be taken up his life style and behaviour had deteriorated, he had been admitted as an inpatient at the Young People's Department and it was decided that he required a residential placement. The offer of a day placement at Tasker House was put on hold and an application for additional funding and negotiations for a residential placement initiated. After showing initial enthusiasm Kevin Littlewood was reported to have stated that he did not wish to attend Tasker House.

### History of Offending

8. Kevin Littlewood's first offence was on 22 August 2000 when he was arrested and cautioned for 'going equipped to burgle'. Later that same month he was arrested and cautioned for being drunk and disorderly. On 25 November 2000 he was arrested and bound over for six months to keep the peace. Five days later he was again arrested for what appears to have been a drunken episode and for carrying an offensive weapon (a screwdriver which he said was for self defence) but no action was taken. On 12 February 2001 he was arrested and

charged with murder and theft and was subsequently convicted of murder and sentenced to life imprisonment in December 2001.

**Alcohol and Substance Abuse**

9. Kevin Littlewood has a history of sporadic drinking and substance misuse since the age of fifteen years. This had never been considered a serious problem. However, during the three months prior to his arrest for murder, episodes of heavy drinking had increased and were causing concern.

**Epilepsy**

10. At the age of four Kevin Littlewood was diagnosed as suffering from photogenic epilepsy. Anticonvulsant medication was commenced but discontinued after three months and he remained fit-free for the next seven years. In August 2000 he was admitted to Hartlepool General Hospital following an epileptic fit and anticonvulsant medication was reinstated. He was referred to a neurologist for further investigation but this did not proceed because he either failed to keep or did not receive appointments due to frequent changes of address. Evidence suggests that he did not take his anticonvulsant medication regularly and he suffered further epileptic fits in October and December 2000 resulting in brief admissions to Hartlepool General Hospital.

**Contact with Psychiatric Services**

11. In October 1997, at the age of fourteen years, Kevin Littlewood was referred to the North Tees Child and Adolescent Mental Health Service by his General Practitioner at the behest of his mother and the school following concerns about his argumentativeness, arrogance and bad temper. He was admitted to the Woodlands Unit, North Tees Hospital as a day patient in March 1998 for assessment and treatment, remaining until December 1998.

12. On discharge he was followed up by the North Tees Child and Adolescent Mental Health Service, principally by a Primary Mental Health Link Worker, with support from the Hartlepool Social Services Department and back up from the Consultant Psychiatrist. During the summer of 1999 he received counselling in anxiety management on an individual basis from his Primary Mental Health Link Worker. In September 1999 his discharge from the service was being planned, however, before this took place his father contacted the Primary Mental Health Link Worker in October 1999 and expressed concern that Kevin was becoming depressed. The Primary Mental Health Link Worker maintained contact with Kevin Littlewood and his father until December 1999 when it was felt that no further appointments were necessary. Kevin Littlewood was subsequently discharged on 9 December 1999 but resumed contact with the Primary Mental Health Link Worker in January 2000 after concerns were expressed by his school.

13. On 29 August 2000 he was admitted to the Roseberry Centre, the Young People's Department, St. Luke's Hospital, Middlesbrough following an assessment by the Options Team after having taken an overdose. He was discharged after one month and returned to the care of the Hartlepool CAMHS locality team (the Primary Mental Health Link Worker and from October 2000 a Community Psychiatric Nurse) and his former Consultant Psychiatrist as an outpatient. He remained under their care until February 2001 when he was arrested for murder and remanded in custody.

14. In September 2000 he was referred to the Consultant Psychiatrist in Learning Disability for Hartlepool for assessment. He concluded that continuing in CAMHS would best meet Kevin Littlewood's needs at that time. A referral was also made to Fraser House Adolescent Unit, Prudhoe Hospital for possible admission but after a scrutiny of his clinical notes it was concluded that this would not be an appropriate placement for him as he was not considered to have a Learning Disability.

15. During the last three months of 2000 and the early part of 2001 Kevin Littlewood's co-operation with the psychiatric services was erratic, he frequently missed appointments, was generally uncooperative and at times his whereabouts was unknown. He made several attempts at self harm following which he was assessed by the Options Team. He was also arrested on a number of occasions and was assessed by the Cleveland Diversion Team.

**Contact with Hartlepool Social Services Department**

16. Hartlepool Social Services Department were first contacted in April 1998 by Kevin Littlewood's mother because of concerns about his behaviour. The case was closed in July 1998 when Kevin Littlewood moved to live with his father who did not want further Social Services Department involvement because he considered that Kevin was now settled and was continuing to receive services from CAMHS.

17. A second referral was made in June 2000 by Durham Initiatives in Shared Care (DISC) because Kevin Littlewood was about to be made homeless. The Social Services Department arranged accommodation, initially a short period of foster care and then supported accommodation at the St. Paul's Project. Social work support was provided from this time until his conviction.

## SECTION 4: INTERNAL INVESTIGATION AND REVIEWS

1. In February 2001 the Chief Executive, Tees and North East Yorkshire NHS Trust, in accordance with the Northern and Yorkshire Regional Untoward Incident Policy, initiated an Internal Investigation.

2. In addition, all the other agencies involved in Kevin Littlewood's care agreed to undertake their own Reviews. These included:

   a) Hartlepool Primary Care Trust;
   b) Hartlepool Borough Council's Social Services and Education Departments;
   c) Tees Valley Housing Group;
   d) Future Steps.

3. It was agreed by the above agencies that these reports would be drawn together to form a multi-agency report. This could not be undertaken for legal reasons until the trial was completed and was further delayed because Kevin Littlewood withheld permission for the exchange of records until after his trial. Subsequently a decision was made to await the outcome of the Independent Inquiry before completing the multi-agency report. A Kevin Littlewood Management Review Group was set up to oversee this process.

4. The agreed main terms of reference for the Tees and North East Yorkshire NHS Trust's Internal Investigation and agencies' Reviews were:

   1. *To review KL's involvement with the agencies providing services in Hartlepool examining (a) referral, (b) assessment, (c) plan of care including review of the plan and compliance with the plan;*
   2. *To determine the adequacy and appropriateness of care provided prior to, and at the time of the arrest including (a) multi-disciplinary and multi-agency inputs (b) communication and joint working between disciplines and agencies involved (c) evidence of risk assessment;*
   3. *To examine compliance with relevant statutory obligation, national guidance and local policies, paying particular attention to the Care Programme Approach, the Children Act 1989, and relevant education provisions;*
   4. *To determine the appropriateness of the level of service provided in relation to the assessment of risk;*
   5. *To ascertain the adequacy of contact with and involvement of KL's family*
   6. *To comment on any issues of resource which are considered relevant to the care offered / provided;*
   7. *To identify any areas for improvement and areas of good practice;*
   8. *To produce a report with findings, conclusions and recommendations to include an action plan.*

5. Hartlepool Primary Care Trust formed the view that since all contact with Kevin Littlewood had been through his General Practitioner, the General Practice should provide a report. The Practice was advised by the Medical and Dental Defence Union of Scotland not to comply with this request unless the inquiry was a formal one. The Practice accordingly declined to comply but has given evidence to this Independent Inquiry.

### COMMENTS

6. The Panel commends the agencies for deciding to undertake a multi-agency Review. However the Panel could see no good reasons for the decision to delay the publication of the multi-agency report until after the publication of the Independent Inquiry report. This has meant that the opportunity for an early review of multi-agency working has been lost.

7. In the Panel's view, having established and agreed terms of reference, it would have been helpful if the Kevin Littlewood Management Review Group which led the multi- agency review had monitored the ways in which the reviews by individual agencies were carried out.

**Tees and North East Yorkshire NHS Trust Internal Investigation**

8. Membership of the Trust's Investigation Team was:

The Head of Patient Liaison and Communication (Chair)
The Consultant Child and Adolescent Psychiatrist/Associate Medical Director CAMHS
The General Manager CAMHS
The Senior Nurse CAMHS
The Serious Untoward Incident Co-ordinator
A Non-Executive Director
A Consultant Clinical Psychologist

9. The Investigation Team reviewed the records and interviewed the staff members of the Trust who were closely involved with Kevin Littlewood's care. The Internal Investigation Team produced a comprehensive report with a total of 27 recommendations and an action plan which is being implemented. This is being monitored through the Trust's Clinical Governance programme.

10. The report addressed the following areas:

a) The Child and Adolescent Mental Health Services;
b) Nursing care;
c) The Options team;
d) The Cleveland Diversion Team;
e) The Care Programme Approach;
f) Psychological assessment;
g) Medical care;
h) Interaction with other agencies.

11. The Internal Investigation Team concluded that Kevin Littlewood was typical of many of the young people who received services from the CAMHS team and that his offence could not have been predicted.

12. The Team commented favourably on the treatment, care, record keeping and multi-agency case reviews in the Woodlands Unit and the Roseberry Centre and on the documentation produced by the Cleveland Diversion Team.

13. The Team was concerned that, following his transfer back to the Hartlepool CAMHS from the Newberry Centre, opportunities to engage with Kevin Littlewood had been missed and that there had been grounds for calling a Care Programme Approach Review in the last quarter of 2000. They also concluded that there was confusion within the CAMHS team regarding responsibility for the implementation of the Care Programme Approach policy, the terminology used, and staff roles. The Investigation Team's report was highly critical of these failures.

**COMMENTS**

14. The Panel noted that it may be very stressful for staff and wasteful of resources for a formal internal investigation to be carried out and for this to be followed some time later by an Independent Inquiry which covers much of the same ground. Where it seems likely under current guidance that an Independent Inquiry may be required, the emphasis of the internal inquiry should be a focused and targeted investigation to establish the chronology of events, identify and obtain statements from the key staff members and other witnesses involved, identify and secure copies of essential documents, identify and rectify any major service deficits and identify and address any professional or other staffing issues.

15. The Panel considers that the Internal Investigation produced a very detailed and comprehensive report and made relevant and appropriate recommendations for improving services. However, the layout of the report made it difficult to follow, there was a lack of an executive summary and a contents page and the report was undated.

16. The Internal Investigation team fulfilled its terms of reference insofar as it was able but in the Panel's view some aspects of the Internal Investigations' terms of reference were wide and required multi-agency input which was delayed because of reasons stated above. The Trust's Investigation Team would have had no jurisdiction in relation to other agencies.

17. In the Panel's view the procedure adopted by the Internal Investigation Team may have reduced objectivity and unnecessarily impeded the chances of obtaining a balanced picture. No witness was interviewed by the full Team. Witnesses were interviewed mainly by small teams of service managers and, in the case of the consultant psychiatric staff, only by the Associate Medical Director.

18. In the Panel's view the Action Plan drawn up by the Internal Investigation Team was comprehensive, appropriate and addressed the issues identified. The Panel has seen updates of the Action Plan and revised policies and information leaflets and is satisfied that good progress is being made in the implementation of the recommendations. The Panel was informed that implementation of the Action Plan is being monitored through the Trust's Clinical Governance programme.

**Hartlepool Social Services Department's Management Review**

19. The Assistant Director, Children and Families, Hartlepool Social Services Department conducted a Management Review following the agreed terms of reference in February 2002. This involved examination of the case file records and interviews with the staff members involved in the care of Kevin Littlewood.

20. The overall conclusion of the Review was that the involvement of the Social Services Department in 1998 and between June 2000 and February 2001 was appropriate.

21. The Review found that the accommodation provided for Kevin Littlewood was appropriate to his needs and that support by the staff of the Social Services Department and the St Paul's Project was consistently applied. Multi-agency support was considered to have been good and coordinated through the Care Programme Approach. The Social Services Department considered that it provided the key worker function. Overall it was concluded that there had been a high level of contact with Kevin Littlewood and regular and appropriate contact with his family.

22. The Review did, however, find a lack of documented and integrated planning from November 2000 to January 2001. The production of a care plan for Kevin Littlewood as a Child in Need was not completed within the required timescales. No separate risk assessments had been carried out by Social Services staff, but issues of concern were raised at Care Programme Approach meetings. Drug and alcohol services were noted to have been available in Hartlepool but were not triggered in relation to Kevin Littlewood when they may have been of benefit to him.

23. The Review concluded that it was difficult to see from the evidence how the Social Services Department could have anticipated the alleged actions resulting in Kevin Littlewood's remand and court appearances.

24. The following recommendations were made:

a) To consider the appointment of a key worker who can coordinate services across a variety of planning mechanisms where there are a number of statutory agencies involved in the provision of services;
b) To consider the integration of services for young people across the Social Services Department, Health, and Education at the casework level in order that referral, assessment and care planning processes can be made consistent. This integration to include protocols on overlapping between planning under Children in Need and the Looked After Systems and the Care Programme Approach;
c) To review existing monitoring/auditing of case files to ensure care review systems address multi-agency involvement and to clarify multi-agency planning and to ensure that procedures are followed within timescales;
d) To clarify risk assessment processes within care planning.

**COMMENTS**

25. The first recommendation above is not clear. The Panel assumes that it refers to the appointment of a key worker across the planning mechanism and if so the Panel agrees with this recommendation but consider, that the term key worker is confusing used in this context.

26. The Panel noted that no action plan was attached to the Review, as agreed in the terms of reference. The Panel was told in evidence that progress has been made in implementing the recommendations of the Review.

**Hartlepool Education Department's Management Review**

27. The Review was carried out by the Assistant Director of Education. All departmental files related to Kevin Littlewood were examined. Discussions were held with the Special Educational Needs Manager and the two Educational Psychologists who had been involved with Kevin Littlewood. The Review was undated.

28. The Review concluded that all aspects of Kevin Littlewood's care by the Education Department had been appropriate except for the failure to comply with the statutory timescale in respect of Kevin Littlewood's assessment. This was not thought to have led to any delays in securing his placement at Sunningdale School.

29. No formal risk assessment took place as this was not required as part of the statutory assessment process. Nevertheless the Educational Psychologist's report highlighted aspects of Kevin Littlewood's behaviour which may have placed him or others at risk. The Educational Psychologist was also aware that he was receiving psychiatric care.

30. The only recommendation made by the Review was that the Education Department continue to improve the number of Statements completed within the statutory timescale. The action necessary to bring this about has been included in the Education Department's Special Education Needs Action Plan for 2000/2003.

**Future Steps' Independent Review**

31. In May 2001 the Customer Services Manager carried out a confidential Review of Future Steps' involvement with Kevin Littlewood.

32. The report of the Review consists entirely of a chronology of Future Steps' involvement with Kevin Littlewood. It contains no assessment of the quality of the work undertaken or the appropriateness of it and it draws no conclusions or makes any recommendations. The report is undated.

**COMMENT**

33. The failure of the Future Steps' Review to follow the agreed terms of reference and to make any recommendations reduces the value of the Review. The Panel was unable to establish the degree of independence of the Review and there was no indication of which staff had been interviewed.

**Tees Valley Housing Group's Review**

34. The Supported Housing Co-ordinator produced a brief undated report of the St Paul's Project's involvement with Kevin Littlewood.

35. The report is based on interviews with staff and a reading of all files and log books. The report makes clear that St Paul's staff were concerned about Kevin Littlewood's mental and physical well-being and that this was communicated to the Social Services Department and CAMHS. The report notes that staff at St Paul's were concerned about Kevin Littlewood's friendship with a male person older than himself and that they attempted to dissuade him from associating with this person. The report concludes that records of Kevin Littlewood's care were of a high standard and that no gaps had been found in the care provided to Kevin Littlewood.

**COMMENT**

36. The report on the St Paul's Project did not follow the agreed terms of reference but usefully documents the concerns of the staff about Kevin Littlewood's behaviour, lifestyle and lack of cooperation with his daily programme.

**RECOMMENDATIONS**

37.

- The Department of Health should review its advice on the need for a formal Internal Investigation when an Independent Inquiry is required in accordance with HSG (94) 27 "Guidance on the discharge of mentally disordered people and their continuing care in the community".

- The County Durham and Tees Valley Strategic Health Authority should consider issuing guidelines relating to the conduct of Internal Investigations taking into account the comments of the Independent Inquiry Panel.

- The Multi-agency Review should produce its report as a matter of urgency. This should particularly address the issues of care coordination, primary responsibility and terminology used across the agencies as recommended in "Getting the Right Start: National Service Framework for Children – Emerging Findings, 2003".

- Multi-agency reviews should always include mechanisms for ensuring consistency between individual agencies' contributions and for monitoring.

- The Tees and North East Yorkshire NHS Trust should review its procedures for the conduct of Internal Investigations and give consideration to requiring that in future witnesses are interviewed by the full panel unless there are compelling reasons for not so doing.

## SECTION 5.1: PSYCHIATRIC DIAGNOSIS AND COGNITIVE FUNCTIONING

1. Kevin Littlewood was first assessed by a Consultant Child & Adolescent Psychiatrist at Hartlepool in December 1997. The differential diagnosis was Attention Deficit Hyperactivity Disorder (ADHD), depression consequent upon a dysfunctional family background, Asperger's Syndrome or temperament problems.

2. Following six months' intensive assessment as a day-patient in the Woodlands Unit it was concluded that he was immature and emotionally brittle. He was described as a very anxious child lacking in confidence who had difficulty in coping with social situations. The possibility of underlying Learning Disability (Mental Retardation) raised by psychological testing was rejected on the grounds that he had performed poorly on testing and that the results did not truly reflect his ability level as observed in the unit and at school. No evidence was found to support a diagnosis of ADHD or Asperger's Syndrome and there was no evidence of depression or other major psychotic illness.

3. A further in-depth psychiatric assessment was carried out in September 2000 by the clinical team at the Roseberry Centre. They concluded that he was a vulnerable young man with limited social and coping skills and he was given a primary diagnosis of Adjustment Disorder. Following further psychological testing he was also given a secondary diagnosis of mild learning disability which led to a referral to the Learning Disability services. No evidence was found of mental illness, autism or Asperger's Syndrome.

4. The Educational Psychologist who assessed Kevin Littlewood in relation to possible placement at Tasker House stated in her report supporting the application that he did exhibit the core features of Asperger's Syndrome. This was an initial assessment and an in-depth assessment would have been conducted following admission.

5. Questions concerning Kevin Littlewood's level of intellectual functioning were first raised at school in February 1998 and later by CAMHS. His intellectual functioning was formally tested on four occasions with the following results:

6. February 1998: Educational Psychologist, Hartlepool - British Ability Scales II

   A wide scatter of abilities was found with a variety of verbal, non verbal and spatial skills at a level well within the average range for his age group.

7. July 1998: Clinical psychologist, CAMHS – Wechsler Intelligence Scale for Children (WISC)

   Full scale IQ 55, verbal IQ 61, performance IQ 55
   Scores that placed him in the mild learning disability range.

8. September 1998: Educational psychologist, Hartlepool – British Ability Scales II

   A wide scatter of abilities was found on some of the subtests on which he had previously performed well. Higher scores were recorded on two of the subtests

9. August 2000: Clinical psychologist, CAMHS – Wechsler Adult Intelligence Scale (WAIS)

   Full scale IQ 65, verbal IQ 71, performance IQ 64. Scores that placed him in the mild learning disability range.

10. In interpreting the results, the psychologists who had administered the tests, and those from Prudhoe Hospital and the Internal Investigation Team who had reviewed them, all concluded that Kevin Littlewood was a youth of low average intellectual ability. It was their opinion that the marked variations in his test performances were the consequence of variations in his

motivation and mental state at the times of testing. This opinion was supported by the descriptions of his mood and behavior at the times of testing and by reports of his inconsistent educational performance and general presentation at school.

**COMMENTS**

11. Kevin Littlewood initially presented diagnostic problems and there was ongoing uncertainty about his level of intellectual functioning. He was thoroughly assessed as a day patient and as an inpatient by two psychiatric teams and their overall conclusion was that Kevin Littlewood was a vulnerable youth who was displaying evidence of an Adjustment Disorder (International Classification of Diseases F43.2). They also concluded that he was not suffering from a mental illness and excluded the possibility that he was suffering from autism or Asperger's Syndrome on clinical grounds at an early stage. On the basis of the evidence before it the Panel agrees with the psychiatric diagnosis of Adjustment Disorder.

12. Kevin Littlewood's cognitive functioning was assessed on a number of occasions by both educational and clinical psychologists with varying test results. The Panel accepts that views presented by educational and clinical psychologists and psychiatrists that Kevin Littlewood's test performances were considerably influenced by his motivation and mental state at the times of testing and that notwithstanding the fact that many test results fell within the mild learning disability range his true level of intellectual functioning lies within the low average range.

13. The Internal Investigation report commented critically on the psychological assessments carried out by the clinical psychologists as follows, the.. "reports lacked detail and information regarding KL's general presentation and there was little or no psychological opinion/ formulation", (Para 8.5.1, Tees and North East Yorkshire NHS Trust, Internal Investigation report). The report also criticised the fact that the assessment in August 2000 was carried out by two trainee clinical psychologists who were not supervised. The Panel agrees with these criticisms and was pleased to learn that these matters have been addressed in the Action Plan and by the issuing of a revised policy.

14. The Panel accepts that although psychiatric opinion was that Kevin Littlewood was not suffering from Asperger's Syndrome the decision to refer him to Tasker House was reasonable on the grounds that within the limited range of options available this was considered to be the most suitable placement to meet his needs at that time.

15. Referral to the Hartlepool Learning Disability Service and to Fraser House for assessment was also, in the Panel's view, appropriate. The conclusion that CAMHS could offer Kevin Littlewood a more appropriate service was also reasonable in the light of his clinical presentation and his history at that time.

## SECTION 5.2: BEHAVIOUR AND RISK ASSESSMENT

### Behaviour

1. The report from Brierton School supporting psychiatric referral in 1997 describes Kevin Littlewood as a generally uncooperative, disruptive and disrespectful boy of average ability. Bullying of younger pupils in association with other pupils is mentioned but no actual physical aggression.

2. Staff at the Woodlands Unit noted that talking about acts of aggression and violence seemed to excite Kevin Littlewood. They were of the opinion that he focused on these as a way of shocking and gaining attention. An example was a boast that he had stolen and killed a hamster that proved unfounded upon investigation.

3. Kevin Littlewood is not recorded as making any significant verbal threats or displaying physical aggression to others at the Woodlands Unit, Sunningdale School, the Roseberry Centre or at St. Paul's Project. He was described by the staff at all of these establishments as being an emotionally immature, anxious and rather vulnerable youth who displayed attention seeking behaviour and who sometimes responded to frustration and anger by injuring himself in a minor way and by taking overdoses.

4. There was no evidence in the documentation available to the Panel nor from witnesses' statements of severe or repeated acts of cruelty, sadistic violence or explosive violent outbursts.

5. In May 1998 Kevin Littlewood's mother had described him to the staff at the Woodlands Unit as being physically aggressive and confrontational at home and had mentioned two episodes of brandishing knives at his siblings. This is repeated in her contribution to the Parents Views Section of the Statement of Special Educational Needs Form completed in August 1998 when she adds her concern that he may hurt himself or someone when he loses his temper. Unfortunately the Panel did not have an opportunity to explore these comments with Kevin's mother as she failed to respond to the invitation to meet the Panel.

6. On the 20th September 2000 Kevin Littlewood's father wrote to the Consultant Psychiatrist at the Roseberry Centre expressing his concerns about his son's mood swings, his panic attacks, his self harming and destructive behaviours, and his inability to properly look after himself. He expressed the view that his son required 24 hour care. The only reference in this letter to harm to others was the statement that when upset Kevin Littlewood hit himself and could hurt himself or others. In his evidence to the Panel Kevin Littlewood's father stated that his son had never behaved violently towards him although he was at times destructive towards property.

### Risk Assessment

7. According to Tees and North East Yorkshire NHS Trust policy a risk assessment was triggered by an episode of self harm, arrest and involvement of the Cleveland Diversion Team, and admission to a psychiatric unit.

8. At the time of Kevin Littlewood's involvement with the mental health services, the Options Team and the Cleveland Diversion Teams operated Risk Assessment Policies. Each Team had designed and used its own Risk Assessment Proformas.

9. The Risk Assessment Proforma used by the Cleveland Diversion Team is very comprehensive and measures four dimensions of risk - self harm, suicide, violence and vulnerability. However it is highly complex, involves a complicated scoring system, is accompanied by an extremely detailed user guide and did not seem to be fully understood by some members of the Cleveland Diversion Team who gave evidence to the Panel.

10. Risk assessments were carried out on Kevin Littlewood on two occasions by the Cleveland Diversion Team. Firstly, on 1 December 2000 following his arrest in the community by the police for threatening to physically assault another youth, when he was assessed as presenting a significant risk of violence to the intended victim. However it was eventually decided that he was drunk and he was released without further action. Secondly on 9 February 2001 shortly before his arrest when he was assessed as at risk of deliberate self harm if remanded in custody.

11. The Assessment Profile Form used by the Options Team consists of a structured case history proforma. There is a section entitled 'deliberate self harm' and one on 'other significant information.' but no specific section on violence. The aide memoir accompanying the form contains detailed guidance. Risk assessment in the Options Team is essentially a matter of professional judgment.

12. Risk assessments were undertaken by the Options team on three occasions in 2000 and on one occasion in 2001 following Kevin Littlewood's admissions to Accident & Emergency having taken an overdose. On the 14 May 2000 he was assessed as presenting a low risk of self harm. This assessment is recorded in the report of the Internal Investigation but no supporting documentation was available to the Panel. On the 28 August 2000 he was assessed as presenting a high risk of self harm or suicide and admitted to the Roseberry Centre. On 24 November 2000 following a further overdose he was again assessed as presenting a high risk of self harm or suicide but when seen by a Consultant Psychiatrist the following day was judged not to be suicidal. No comment was made in these assessments of the risk of violence to others. There was no provision for this on the assessment pro-forma nor any requirement to do so in the accompanying aide memoire.

13. On 25 January 2001, after the murder was committed but before he was arrested, Kevin Littlewood had taken another overdose but he refused hospital admission. The following day he was assessed by the Options Team at St Pauls' Project and found to be at a low risk of self harm or suicide.

14. Whilst a patient at the Roseberry Centre in August and September 2000, Kevin Littlewood is reported to have scored high on two assessments of self harm and low on two assessments of aggression and violence to others. The Panel did not see the actual assessments but have had sight of an undated Suicide Indicator and a Violence/Aggression Indicator which was being piloted in the YPD at that time and which combines a tick list and clinical comments.

15. The Panel could find no documentary evidence of any formal Risk assessments having been carried out by the Hartlepool Locality CAMHS team.

**COMMENTS**

16. The Panel is satisfied that risk assessments were regularly and appropriately carried out on Kevin Littlewood by the Options Team and the Cleveland Diversions Team in accordance with the existing Tees and North East Yorkshire NHS Trust's policies at the time.

17. On only one occasion was Kevin Littlewood assessed as presenting a significant risk of aggression on formal risk assessments. On all other occasions he scored low on this dimension. Without exception all professional witnesses expressed their surprise and shock on learning of the homicide and their disbelief that Kevin Littlewood could have committed such an act. The main concern of all professionals at all times had been the risk of self harm.

18. It was argued by those giving evidence to the Panel that the use of different Risk Assessment Procedures and Proformas by different teams within the service was justified on the grounds that a different emphasis was required because of the specific roles of each team. The Panel is not persuaded by this argument and is of the view that a single Trustwide system for children and young people would be more satisfactory and easier to operate.

19. The Panel is concerned to note that the Options Team Risk Assessment proforma did not include a specific section on the risk of violence to others.

20. The Panel also noted that the Trust's Risk Assessment Procedures are essentially single incident assessments. There is no formal procedure for reviewing and assessing cumulative risk based upon a number of recently occurring incidents.

21. The Panel accepts, on the basis of the evidence of the history and assessments undertaken, that the conclusion reached by all the professionals involved in Kevin Littlewood's care that he did not present a significant risk of violence to others was reasonable and that the subsequent homicide could not have been predicted.

**RECOMMENDATIONS**

22.

- The Tees and North East Yorkshire NHS Trust should undertake a speedy review of its current Risk Assessment Policies and Procedures with a view to:

- producing a single comprehensive Trustwide Risk Assessment Policy and Procedure for CAMHS and the Options Team which includes the assessment of the risk of violence to others;

- ensuring that the Cleveland Diversion Team Risk Assessment policy and procedure is compatible with the CAMHS/Options Team risk assessment policy and procedure for the sixteen-eighteen age group;

- ensuring that the revised policies and procedures are comprehensible, easy to use and include provision for a cumulative assessment of risk.

- Training for implementation of risk assessment policies and procedures should be multi-disciplinary and multi-agency.

## SECTION 5.3: TREATMENT, CARE, SUPPORT AND COMPLIANCE

1. Kevin Littlewood was first referred to the Hartlepool CAMHS service in December 1997, aged fourteen years. An initial assessment was carried out by the Consultant Child Psychiatrist for Hartlepool on 21 January 1998. A definitive diagnosis was not reached and he was admitted to the Woodlands Unit for further assessment.

**Woodlands Unit, North Tees General Hospital**

2. Kevin Littlewood commenced attending the Woodlands Unit on 10 March 1998 for two afternoons a week. After an initial period of ten sessions a definitive diagnosis was made and a care plan formulated which identified his emotional, behavioural and educational needs. He then attended on a five day week basis. He was reported to be generally cooperative and responded well to the care package although it was noted that sometimes his behaviour was immature and attention seeking. His progress was monitored and documented at weekly team meetings.

3. A multi-agency case review held on 4 June 1998 concluded that although Kevin Littlewood had responded well to treatment his educational needs could not be fully met at the Woodlands Unit. It was therefore planned that Kevin would return to Brierton School in the September of that year and would be discharged in July 1998 but offered some support during the school holidays.

4. However Kevin informed his carers that he did not wish to return to Brierton School because he was frightened of being bullied. A further multidisciplinary case review was held on 23 July 1998 when it was decided that he would remain at the Woodlands Unit until Hartlepool Education Department identified a suitable educational placement. Subsequently he was Statemented and placed at Sunningdale School on 4 January 1999. Follow up and support continued to be provided by CAMHS and included six sessions of anxiety management from his Primary Mental Health Link Worker.

**Young Peoples Department (YPD), St Luke's Hospital, Middlesbrough**

5. Following an overdose on the 28 August 2000 Kevin Littlewood was assessed in hospital by the Options Team and the duty Consultant Psychiatrist as being at significant risk of self harm and was admitted to the YPD for assessment. He remained there for four weeks. He settled quickly, was not a management problem and was said to be compliant, responsive and cooperative. At a case review on 12 September 2000 it was concluded that the diagnosis was Adjustment Disorder in a vulnerable young person and that there was no evidence of any major mental illness. Psychological testing suggested that he was functioning in the mild learning disability range.

6. Further case reviews were held during September 2000 when it was decided that:

   a) residential accommodation would be sought from ESPA. (A day placement at Tasker House had already been offered and funded);
   b) a referral be made to Fraser House;
   c) a referral be made to the local Learning Disabilities Service in Hartlepool, of the Tees and North East Yorkshire NHS Trust.

7. Kevin Littlewood was discharged from the Young Peoples Department on 27 September 2000 following a Care Programme Approach (CPA) meeting attended by representatives of all the involved agencies and Kevin. His CPA status was set at the *Minimal* level. A detailed and comprehensive report and care plan was sent to his GP and other involved professionals. He was placed into foster care by the Social Services Department, pending the outcome of the assessments for specialist residential placement. Follow up at this stage was by his Care Coordinator, the Consultant at the YPD, and his existing Primary Mental Health Link Worker from Hartlepool CAMHS.

He only attended one of several appointments offered. The residential and educational placements were being pursued by Future Steps.

8. The outcome of the referrals to Fraser House and the local Learning Disabilities Service was that both considered that they could not meet his needs (see Section 3). At the end of October 2000 following further case reviews Kevin Littlewood's care was transferred back to the CAMHS in Hartlepool. The care plan was that:

a) the existing application for a placement at St Paul's Project should proceed;
b) Kevin be advised and encouraged to keep his appointments with CAMHS and Future Steps personnel;
c) the application for a residential placement to ESPA remain on hold.

***Hartlepool CAMHS***

9. Kevin Littlewood remained under the care of the Hartlepool locality CAMHS until the time of his arrest. In October 2000 there was a change from the Primary Mental Health Link Worker to a Community Psychiatric Nurse who was named as the key worker but was not designated as the Care Coordinator. Attempts made to organise a joint handover visit failed because Kevin Littlewood did not keep the appointments. No CAMHS team meetings or multi-disciplinary case reviews were held and contact between staff and agencies involved was either by letter or telephone. Over this time Kevin Littlewood's compliance with appointments declined with all agencies.

**Options Team**

10. Kevin Littlewood was seen four times by the Options Team following overdoses in May, August, and November 2000 and January 2001. On each occasion members of the Team assessed Kevin Littlewood and liaised with other CAMHS colleagues. On one occasion there was confusion about responsibility for undertaking the psychiatric assessment between the Options Team Consultant Psychiatrist and local CAMHS team Consultant Psychiatrist which was quickly resolved.

**Cleveland Diversion Team**

11. Kevin Littlewood was seen on two occasions by the Cleveland Diversion Team and each time he was assessed and the correct documentation completed. On one occasion there was difficulty in accessing expert child and adolescent psychiatric nursing advice.

**General Practitioner Services**

12. Kevin Littlewood was registered with a GP practice in Hartlepool from early childhood. He was treated for epilepsy and later referred to CAMHS. Links were maintained between CAMHS and the GP through letters from the Consultant Psychiatrist, Primary Mental Health Link Worker and the Community Psychiatric Nurse. The GP was invited to case reviews but was never able to attend. She received reports on the outcome of the meetings.

**Social Services Department**

13. Kevin Littlewood was first referred to the Social Services Department for a short period in 1998. He was re-referred at the end of June 2000 and assigned a social worker and identified as a Child In Need. He was in the Looked After System during the period when he was briefly in foster care in October 2000. The social worker and a support worker visited Kevin and kept in contact by telephone with him and with other professionals and his parents and recorded these contacts. At all times these arrangements were of a voluntary nature and depended entirely on Kevin Littlewood's cooperation. Social services staff were invited to, and attended, most of the multi-agency case reviews which were arranged by CAMHS.

14. In the period from the end of June to the end of August 2000 the Social Services Department assisted Kevin Littlewood in finding bedsit accommodation. Following discharge from the YPD foster care was provided for Kevin Littlewood as a short term measure prior to longer term supported residential care being found. He terminated this himself after a short period and moved to live with a friend. The Social Services Department continued to seek accommodation for Kevin Littlewood and in November 2000 arranged a placement at the St Paul's Project.

15. At St Paul's Project a programme was put in place to help Kevin Littlewood improve his daily living skills but he did not cooperate. The St Paul's Project staff were concerned about Kevin's lifestyle, the company he kept, the lack of structured day activities and his drinking and drug habits. They found Kevin very difficult to manage, felt that he was inappropriately placed in the Project, and that they had received insufficient advice about his management from the health and social services staff.

**Future Steps**

16. A Special Needs Career Adviser from Future Steps was assigned to Kevin Littlewood during his last year at Sunningdale School. The Adviser explored the local options for further education and training, none of which were felt to be suitable because of Kevin Littlewood's special requirements. Future Steps took the lead in making an approach to Tasker House and applying for funding. They also attempted to arrange suitable day activities locally but this failed because Kevin did not cooperate. Future Steps lost contact with him in mid-October 2000 after he failed to keep appointments. The Special Needs Careers Adviser was not informed of Kevin's whereabouts by the other agencies who did know where he was residing. In particular Future Steps were not made aware that he had moved into the St Paul's Project in November 2000.

**European Services for People with Autism (ESPA)**

17. During Kevin's last year at Sunningdale School it was agreed between the various statutory agencies that Tasker House would be an appropriate placement. This initiative was pursued by Future Steps and a funded day place was secured for a start in September 2000. Kevin visited Tasker House on a number of occasions and at this stage was reported to be enthusiastic about attending.

18. Following his admission to the Roseberry Centre in August 2000 ESPA decided to put his day placement on hold until his behaviour and lifestyle stabilised. At the same time a clinical decision was made at the Roseberry Centre that he needed a residential placement. Future Steps followed up such a placement with ESPA and the Consultant made informal inquiries about funding. It is documented that a residential place if secured would not be available until September 2001 at the earliest.

19. However Kevin Littlewood indicated his unwillingness to take up a place at Tasker House and would not cooperate with the necessary assessments to secure a residential placement. The lack of these assessments precluded the application for a residential placement being progressed.

**COMMENTS**

20. In the Panel's view, Kevin Littlewood's assessment, care planning, review of progress and the overall service he received while attending the Woodlands Unit was appropriate and of a high standard.

21. The Panel was impressed by the high level of professionalism shown by Kevin's first Primary Mental Health Link Worker, throughout his involvement with Kevin from his appointment when Kevin was admitted to The Woodlands Unit through until October 2000, when he left the CAMHS team.

22. In the Panel's view the assessment carried out by the YPD was thorough and of a high standard and the discharge plan and follow up arrangements were appropriate.

23. In the light of Kevin Littlewood's documented reluctance to attend Tasker House and the anticipated delay in obtaining an ESPA residential placement the Panel was concerned to note that no other possible suitable options were explored. The Panel was impressed by the commitment of the staff of the St Paul's Project but it was clear that they were unable to fully meet his complex needs.

24. Until November 2000 the multi-disciplinary and multi-agency approach to care planning was good. During the crucial months leading up to the arrest there is evidence that Kevin Littlewood failed to keep appointments with all agencies who were providing him with support, that his general behaviour was deteriorating and that some staff were expressing concern about his welfare. No one agency had a comprehensive picture of Kevin's problems and needs at this time and there was no opportunity taken to discuss these issues at a multi-agency meeting. This matter is discussed in more detail in Section 5.4.

25. Future Steps carried out their role satisfactorily until contact was lost with Kevin Littlewood during October 2000. The failure by other agencies to inform Future Steps that Kevin was residing at the St Paul's Project resulted in a missed opportunity to attempt to engage Kevin in meaningful day time activities, support and further training. The Panel considers that Future Steps could have been more proactive in attempting to locate Kevin Littlewood.

26. The Panel was of the view that accommodation found by Hartlepool Social Services Department for Kevin Littlewood from July 2000 until his admission to the YPD was unsatisfactory and did not adequately meet his needs. As a Statemented young person who had been recognised as vulnerable for some time he needed a greater level of support than could be provided in bedsit accommodation. It appears to the Panel that this actively contributed to Kevin's deterioration during July and August 2000.

27. The Panel was concerned to note that members of the Cleveland Diversion Team who had no experience in adolescent psychiatry were unable to obtain advice from CAMHS staff due to what appeared to be a misunderstanding of roles.

28. The Panel was concerned to note that, due to policy ambiguities, there was confusion between the Options Team and CAMHS as to who was responsible for the emergency assessment of patients already known to CAMHS following self harm.

29. The Panel considered whether or not compulsory powers under either the Children Act 1989 or the Mental Health Act 1983 should have been used in the case of Kevin Littlewood by the statutory Authorities. The Panel noted that on two occasions the possibility of the use of the Mental Health Act 1983 had been raised. In the view of the Panel the grounds for the use of such powers under either Act were not present.

**RECOMMENDATIONS**

30.

- The Panel recommends that the Multi-agency Review should critically examine communication and information sharing policies and procedures across agencies, including staff training, with a view to identifying areas where these could be improved.

- Social Services and related agencies should review the range and nature of accommodation available for vulnerable young people like Kevin Littlewood, with a view to ensuring that there is access to an adequate spectrum of provision to meet the needs of this client group.

- The Tees and North East Yorkshire NHS Trust should ensure that the Cleveland Diversion Team has access to appropriate specialist psychiatric advice when assessing sixteen to eighteen year olds. *The Panel is pleased to note that this matter has been satisfactorily addressed in a new protocol drawn up between CAMHS and the Cleveland Division Team (Teeswide Child and Adolescent Mental Health Service – Appendix 9, updated August 2002).*

- The Tees and North East Yorkshire NHS Trust should review its policies and procedures in relation to CAMHS and the Options Team to ensure that there are clear guidelines as to who is responsible for the emergency assessment of patients already known to CAMHS following self harm. *The Panel is pleased to note that a new Trust protocol has been introduced addressing this.*

## SECTION 5.4: CARE CO-ORDINATION AND THE CARE PROGRAMME APPROACH

1. The Care Programme Approach (CPA) was introduced in 1991 with the aim of coordinating the treatment and care of people aged sixteen and over receiving specialist psychiatric services in the community. It was updated in 1999 ("Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach", Policy booklet NHS Executive).

2. The essential elements of the CPA are:

   a) systematic assessment of health and social care needs including an assessment of risk;
   b) an agreed action plan;
   c) regular review and monitoring of needs and progress.

3. The local CPA policy in place when Kevin Littlewood was assigned a CPA level in September 2000 was that agreed by the South Tees Community & Mental Health NHS Trust and the Social Services Departments of Redcar & Cleveland, Middlesbrough, and North Yorkshire and effective from February 1999. When he was transferred back to Hartlepool in November 2000 the CPA Policy operating then was that agreed between North Tees Health Care NHS Trust and Stockton Social Services Department in 1998.

4. A Teeswide protocol for users of mental health services transferring between Local Authority and Trust boundaries was implemented in January 1999 and applied to those on *mid/full* CPA.

5. Following the merger of the various NHS Trusts that now form the Tees and North East Yorkshire NHS Trust on 1 April 1999, a new Care Coordination policy was agreed between the Trust and Hartlepool, Middlesbrough, Redcar & Cleveland, Stockton and North Yorkshire Social Services Departments. This was implemented in December 2000 and superceded previous policies.

6. There were four distinct differences between the North Tees Health NHS Trust and South Tees Community and Mental Health NHS Trust Care Programme Approach policies:

*Terminology*

7. The South Tees policy used the term Care Programme Coordinator and the North Tees policy used the term Key Worker. The Teeswide protocol used both terms.

*Levels of CPA*

8. The South Tees policy, following national guidelines, identified two levels of CPA:

   *Minimal* - people who have limited disability and/or health care needs arising from their illness, low support needs and are likely to remain stable

   *Full* - people with more severe mental health problems who are likely to require more than one type of service or whose needs are less likely to remain stable. Criteria which would lead to a full CPA are:
   a) those on the Supervision Register;
   b) those on Supervised Discharge;
   c) severe and/or enduring mental health needs;
   d) eligible for aftercare under Section 117, of the Mental Health Act 1983;
   e) three or more admissions to a psychiatric hospital for three months or more;
   f) continual current stay in a psychiatric hospital for three months or more;
   g) formal admission of 28 days or more or repeated short term orders;

h) evidence of significant risk history or current risks;
i) history of defaulting from or non-compliance with planned aftercare.

9. The North Tees policy identified three levels of CPA:

*Minimal* - where only one professional was involved, the person was stable and did not present significant risk, and required minimal active intervention

*Intermediate* - where intervention requires more than one professional or agency, more complex needs requiring active input beyond a basic level of support, and the person is assessed as presenting a degree of risk

*Full* - meet one or more of the following criteria:
a) multiple or complex needs;
b) a diagnosis of dementia;
c) a recent inpatient admission requiring active treatment for three months or longer, three or more emergency admissions to an inpatient assessment or treatment unit within a 12-month period;
d) behavioural/social/medical problems and a history of poor compliance;
e) presenting significant risks including a serious suicide attempt and have a diagnosis of mental illness;
f) meet the criteria for placement on the Supervision Register;
g) be subject to Supervised Discharge provisions;
h) be subject to Section 117 aftercare or on Section 17 leave under the Mental Health Act 1983.

*Procedures for changing the CPA level*

10. The North Tees CPA Policy did not specify any procedure for a change in CPA level in terms of a procedure to follow whereas the South Tees Policy required, in Section 14, that a change from *minimal* to *full* should be discussed by the Multi-Disciplinary Team and should be followed by a formal CPA review.

*Minimum age*

11. The North Tees CPA Policy applied to young people aged fourteen and over and the South Tees CPA policy applied to those aged sixteen and over.

**The Care Programme Approach and Kevin Littlewood**

12. There were in force in the period covering Kevin Littlewood's care between July 1999 and December 2000 the two CPA policies and the multi-agency protocol described above. This was a transitional period following the merger and processes and all existing policies were being reviewed.

13. When Kevin Littlewood was discharged on 26 September 2000 from the Young Peoples' Department he was placed on *minimal CPA* and his Care Co-ordinator was identified on form CPA 1 as the Consultant Adolescent Psychiatrist in charge of his care at the Young Peoples Department. Four key workers were identified in the discharge summary sent to the General Practitioner and copied to the Consultant Psychiatrist Hartlepool CAMHS - the Consultant Psychiatrist, YPD, the Social Worker, the Primary Mental Health Link Worker and Special Needs Careers Adviser, but not the Care Coordinator. The General Practitioner was also sent CPA 1 which identified the name of the Care Co-ordinator.

14. In November 2000 Kevin Littlewood reverted to the care of the Consultant Child, Adolescent & Family Psychiatrist for the Hartlepool area. In the letter arranging this transfer from the Consultant Adolescent Psychiatrist at the YPD to the Consultant Psychiatrist in the Hartlepool locality team Kevin Littlewood's CPA level was not mentioned, nor was the identity of the

Care Co-ordinator, although the Panel was informed that the CPA 1 Form was placed in the CAMHS notes. The South Tees Community and Mental Health NHS Trust CPA policy (Para 10.1.18) is explicit in requiring, "that any change of CPC [Care Programme Co-ordinator] is made in consultation with the patient, relative/carer and the care team and that there is a full and thorough handover to the new CPC at any time that the role is transferred (either temporarily or permanently)". In correspondence with the General Practitioner the Hartlepool Consultant identified the Community Psychiatric Nurse as Kevin Littlewood's key worker but there is no evidence that the issue of the transfer of care coordination was addressed.

15. On 13 November 2000 Kevin Littlewood took an overdose and was admitted to Hartlepool General Hospital. His Consultant Psychiatrist was informed of this admission and on the 21 November 2000 requested the Community Psychiatric Nurse to:

a) arrange a further risk assessment;
b) place Kevin on *Full* CPA;
c) inform Social Services and invite them to a CPA meeting;
d) organise an urgent appointment with the Consultant;
e) update the Consultant on Kevin's social circumstances.

16. A risk assessment was carried out by the Options Team. Kevin was not placed on *Full* CPA, the CPA review did not take place and he was not seen by the Consultant until 11 December 2000.

**COMMENTS**

17. Clearly there had been a progressive deterioration in Kevin Littlewood's life style and mental stability in the three months from November 2000 onwards as illustrated in the chronology below:

3 Nov 00 Epileptic fit. Accident & Emergency Hartlepool General - not admitted
9 Nov 00 Epileptic fit. Accident & Emergency Hartlepool General - not admitted
13 Nov 00 Overdose. 11 days admission to Hartlepool General Hospital
24 Nov 00 Discharged and commenced living St Pauls Project
25 Nov 00 Arrested. Breach of peace - bound over
30 Nov 00 Arrested. Drunk and in possession of offensive weapon -no further action taken
8 Dec 00 Insomnia. Attended GP - hypnotic prescribed
12 Dec 00 Back Pain. Attended GP - analgesic prescribed
15 Dec 00 St Pauls staff & Social Services staff - concerns about one of Kevin's regular visitors to the hostel
29 Dec 00 Back Pain. Attended GP - analgesic prescribed
30 Dec 00 Epileptic fit. Admitted Hartlepool General – discharged himself on 2 Jan
5 Jan 01 Attended Accident & Emergency Hartlepool General complaining of back pain
12 Jan 01 Back Pain. Attended GP - analgesic prescribed
18 Jan 01 Homicide committed
25 Jan 01 Attended GP requesting further supply analgesics
25 Jan 01 Overdose. Attended Accident & Emergency Hartlepool General, he refused hospital admission. Dealt with by Deputising GP
12 Feb 01 Arrested for murder

18. The failure to respond to the request to upgrade Kevin Littlewood's CPA status from *minimal* to *full* in November 2000 constituted a serious breach of the CPA policy. Upgrading to *full* CPA status would have meant that a multi-disciplinary case review would have had to have taken place. This would have provided a much needed opportunity to review Kevin's mental state and behaviour and future care needs and to revise his care plan.

19. In the Panel's view the failure of the CPA process following Kevin Littlewood's return to Hartlepool owed much to the confusion that existed in relation to the terminology used and other differences in the CPA policies that were in use in local areas. The Panel noted that the key CAMHS staff involved in Kevin Littlewood's care at that time were very experienced professionals. Under the existing CPA policies any with concerns about Kevin Littlewood's care could have requested a CPA review but none did.

20. The Hartlepool Social Services Department's Action Plan for Kevin Littlewood as a Child in Need (the Children Act 1989) was developed separately from the assessment of his needs through the Care Programme Approach. The Panel considers this to be very undesirable in the care of young people with complex needs where it is essential to have an overall agreed care package and to identify which agency has primary responsibility for each different component of the care package.

**RECOMMENDATIONS**

21.

- When Trusts merge, key clinical policies should be reviewed immediately and, where appropriate, new policies issued as a matter of high priority.

- . The Care Coordination and Care Management policy should:
    a) clarify terminology in use across the Trust and associated agencies;
    b) establish protocols to ensure that Care Coordinators are made aware of all events relating to a particular patient as soon as possible;
    c) make clear the indications and procedures for calling an emergency review;
    d) clarify the number and definitions of CPA levels;
    e) clarify the minimum age at which CPA applies ;
    f) establish clear transfer arrangements between locality teams;
    g) include a clear and efficient system for conveying information about the Care Coordinator and CPA status to all professionals involved in the person's care;
    h) identify the role of primary care in the CPA process.

*The Panel is pleased to note that a revised Care Coordination policy published in February 2003 satisfactorily covers all the above points.*

- The Panel recommends that mandatory training be introduced for all staff of all disciplines and in all agencies involved in the CPA process.

## SECTION 5.5: COMMUNICATION AND COLLABORATION BETWEEN THE STATUTORY AGENCIES AND KEVIN LITTLEWOOD'S PARENTS

1. From the evidence available to the Panel it appears that there was good communication between Brierton School and Kevin Littlewood's mother when his behaviour began to give rise to concern. Referral for psychiatric assessment by the General Practitioner in October 1997 was prompted by concerns expressed by his mother and the school staff.

2. Kevin's mother was fully involved in the Statementing of special educational needs of Kevin prior to his transfer to Sunningdale School, a move which she supported. Her views on his needs and an account of the problems he presented are made clear in her contribution to the Statement.

3. After Kevin became a day patient at the Woodlands Unit in March 1998 the evidence is that his mother was invited to and attended the multi-disciplinary case reviews held and received information about his progress and support from the staff.

4. The Panel was unable to obtain Kevin's mother's views on the services provided to her and Kevin as she did not respond to an invitation to meet the Panel.

5. Kevin's father was involved in case reviews and received support and advice from the Consultant Psychiatrist, the Primary Mental Health Link Worker and other staff at the Woodlands Unit. In his evidence to the Panel Kevin's father was very complimentary about the Woodlands Unit commenting that they had helped Kevin a lot and had provided good support, so much so that he terminated Social Services Department involvement in July 1998 as he felt that this was no longer needed. The Unit had been particularly helpful in providing a full time placement throughout the school summer holidays in 1998 and also in facilitating a phased introduction to Sunningdale School later that year.

6. Kevin's father was fully involved in the Statementing process which led to Kevin's placement at Sunningdale School and in full agreement with this move. He had limited contact with the School and told the Panel that he only found out by accident that Kevin was not attending regularly in 2000.

7. Kevin's father told the Panel that he was becoming increasingly alarmed at Kevin's behaviour during the Spring and Summer of 2000 and eventually sought help from Hartlepool Social Services Department when he felt he could no longer manage him at home. He said that he was not at all satisfied with the accommodation the Social Services Department subsequently found for Kevin. It was his view that Kevin required a 24 hour staffed facility not bedsits. He did not consider that the St Paul's Project adequately met Kevin's needs and thought that he required a more structured and secure environment. In his view Kevin's mental and physical health were deteriorating and he expressed his frustration to the Panel at not being able to get the help he felt Kevin required and what he perceived as the inaction of the Social Services Department.

8. Although generally satisfied with the care that Kevin received at the Roseberry Centre Kevin's father felt that he was unable to adequately get his point over in case reviews. As a result he wrote a letter to be read out at the case review held on the 20 September 2000 setting out his concerns, describing in detail the problems Kevin presented at home and reiterating his opinion that Kevin required 24 hour care. He decided not to attend this review and did not receive a written reply to his letter. Kevin's father told the Panel that he had thought that his son was mentally ill and that he did not accept the diagnosis made by the Roseberry Centre nor the decision to discharge him from hospital. In late November 2000 he wrote to Kevin's social worker reiterating these views and he informed the Panel that again he received no reply.

9. After Kevin was discharged from the Roseberry Centre Kevin's father told the Panel that communications with health and social services were initially very satisfactory. He was particularly appreciative of the support he and Kevin received from the Primary Mental Health Link Worker with whom they both had a good relationship. However during the three months leading up to Kevin's arrest, communications deteriorated. He told the Panel that he was not always informed of incidents involving Kevin, that he had little contact with the social worker and that he never met Kevin's new Community Psychiatric Nurse. He said it was some time after Kevin had moved into St Paul's Project before he was telephoned by the social worker informing him of this move. However, when the Panel examined the social services file there was documentary evidence that Mr Littlewood and Kevin Littlewood's mother were both informed by telephone of the move to St Paul's on 15 November 2000.

**COMMENTS**

10. The Panel was impressed by the level of communication and support offered to Kevin's parents by Brierton School and the Woodlands Unit and by his Primary Mental Health Link Worker.

11. In the Panel's view it is unfortunate that the otherwise excellent service provided to Kevin Littlewood by the Roseberry Centre was marred by his father's feeling that his views were not properly taken into account by the staff. We appreciate that this was in the main due to differences of opinion between him and the professionals as to the nature of Kevin's problems and the role of the Roseberry Centre. He may have been less frustrated had more time been spent with him explaining Kevin's diagnosis and problems and the rationale of his care plan. The Panel of course acknowledges that it is sometimes impossible to achieve a complete commonality of views on diagnosis and care plans between professionals and relatives.

12. The less than satisfactory communication between the statutory agencies and Kevin's father during the three months prior to Kevin Littlewood's arrest for homicide was in the Panel's view a consequence of several factors the most important of which was a failure of the Care Programme Approach (see Section 5.4)

13. The Panel was disappointed to find that that there was no evidence of any reply to Kevin's father's letters or the offer of a meeting to discuss the content of his letters from the professionals involved.

14. The Panel noted that there seemed to be no evidence that Mr Littlewood was informed of his rights as the nearest relative by the Social Services Department, under Section 13(4) of the Mental Health Act 1983 to request that an Approved Social Worker consider making an application for admission to hospital in respect of Kevin in view of his expressed concerns about his son's mental health and his view that Kevin needed to be in hospital.

**RECOMMENDATIONS**

15.

- The Tees and North East Yorkshire NHS Trust and associated agencies should make every effort to ensure that parents and carers are enabled to express fully their views about the care needs of their relatives at case reviews.

- The Tees and North East Yorkshire NHS Trust and the Hartlepool Social Services Department should ensure that letters from relatives regarding patient care are replied to fully and within a set time limit.

- Hartlepool Social Services Department should always ensure that a patient's relatives, who are of the opinion that hospital admission is necessary, are informed of their statutory rights under Section 13(4) of the Mental Health Act 1983.

## SECTION 6: GENERAL OVERVIEW AND CONCLUSIONS

1. Kevin Littlewood's social and personality profile and behaviour was similar to those presented by a large proportion of youths referred to the Child and Adolescent Mental Health Services. The main concern of all health professionals responsible for his care was the possibility of self harm. There was nothing exceptional or significant in his history or profile indicative of the possibility of future serious violence. Repeated formal and documented risk assessments identified self harm but never a significant risk of violence towards others. Homicide by its very nature is highly unpredictable and is a rare phenomenon in adolescence. In the Panel's view it would have been impossible to have predicted the homicide from Kevin's presentation throughout his involvement with the statutory and other agencies.

2. The overall standard of care, treatment and support provided by the Child and Adolescent Mental Health Services, the lead agency, from the time of Kevin Littlewood's first referral up to his arrest was, in the Panel's view, satisfactory. Thorough psychiatric assessments were carried out at both the Woodlands Unit and the Roseberry Centre, regular well documented multidisciplinary case conferences were held and comprehensive care plans were formulated and he received excellent support from his Primary Mental Health Link Worker. There was also much good practice by other agencies and individual professionals responsible for the care and treatment of Kevin Littlewood.

3. The Panel identified a number of areas in which policies, clinical practice and service provision could with benefit be improved. These together with our recommendations are detailed in the body of the report. Many have been identified by the Internal Investigation and the Management Reviews and have already been or are in the process of being rectified.

4. The Panel considers it important to draw particular attention to the obvious shortcomings in Care Co-ordination during the months leading up to the homicide when Kevin Littlewood's behaviour and lifestyle were progressively deteriorating and he was not cooperating with services being provided. These shortcomings were due, in part at least, to a confusion about roles and responsibilities consequent upon the lack of a clear multi-agency Teeswide Care Co-ordination Policy following the merger of the North Tees Health Care NHS Trust and South Tees Community and Mental Health NHS Trust. When Trusts merge key clinical policies should be reviewed immediately and new policies issued as a high priority.

5. The Tees and North East Yorkshire NHS Trust, the Hartlepool Borough Council and other involved agencies are to be commended for their prompt action in initiating an Internal Investigation and Management Reviews and also for implementing the recommendations arising from these.

6. The Panel noted that it may be very stressful for staff and wasteful of resources for a formal internal investigation to be carried out and for this to be followed some time later by an Independent Inquiry which covers much of the same ground.

7. Finally the Panel wishes to place on record its appreciation of the cooperation and honesty of all who gave evidence to this Inquiry. Their distress and shock at what had happened was readily apparent. The Panel was impressed by the willingness of staff from all agencies to learn from this experience and their commitment to improving services.

## SECTION 7: SUMMARY OF RECOMMENDATIONS

The Panel has made a total of 17 recommendations. These recommendations are listed in the relevant sections of the Report. This summary draws together all the recommendations for ease of reference. For the context to each recommendation, please refer to the appropriate section.

### SECTION 4: INTERNAL INVESTIGATION AND REVIEWS

1. The Department of Health should review its advice on the need for a formal Internal Investigation when an Independent Inquiry is required in accordance with HSG(94)27 "Guidance on the discharge of mentally disordered people and their continuing care in the community".

2. The County Durham and Tees Valley Strategic Health Authority should consider issuing guidelines relating to the conduct of Internal Investigations taking into account the comments of the Independent Inquiry Panel

3. The Multi-agency Review should produce its report as a matter of urgency. This should particularly address the issues of care coordination, primary responsibility and terminology used across the agencies as recommended in Getting the Right Start: National Service Framework for Children – Emerging Findings, 2003.

4. Multi-agency reviews should always include mechanisms for ensuring consistency between individual agencies' contributions and for monitoring.

5. The Tees and North East Yorkshire NHS Trust should review its procedures for the conduct of Internal Investigations and give consideration to requiring that in future witnesses are interviewed by the full panel unless there are compelling reasons for not so doing.

### SECTION 5.2: BEHAVIOUR AND RISK ASSESSMENT

6. The Tees and North East Yorkshire NHS Trust should undertake a speedy review of its current Risk Assessment Policies and Procedures with a view to:
    a) producing a single Trustwide Risk Assessment Policy and Procedure for CAMHS and the Options Team which includes the assessment of the risk of violence to others;
    b) ensuring that the Cleveland Diversion Team Risk Assessment policy and procedure is compatible with the CAMHS/Options Team risk assessment policy for the sixteen-eighteen age group;
    c) ensuring that the revised policies and procedures are comprehensible, easy to use and include provision for a cumulative assessment of risk.

7. Training for implementation of risk assessment policies and procedures should be multi-disciplinary and multi-agency.

### SECTION 5.3: TREATMENT, CARE, SUPPORT AND COMPLIANCE

8. The Panel recommends that the Multi-agency Review should critically examine communication and information sharing policies and procedures across agencies, including staff training, with a view to identifying areas where these could be improved.

9. Social services and related agencies should review the range and nature of accommodation available for vulnerable young people like Kevin Littlewood, with a view to ensuring that there is access to an adequate spectrum of provision to meet the needs of this client group.

10. The Tees and North East Yorkshire NHS Trust should ensure that the Cleveland Diversion Team has access to appropriate specialist psychiatric advice when assessing sixteen to

eighteen year olds. *The Panel is pleased to note that this matter has been satisfactorily addressed in a new protocol drawn up between CAMHS and the Cleveland Division Team (Teeswide Child and Adolescent Mental Health Service – Appendix 9, updated August 2002).*

11. The Tees and North East Yorkshire NHS Trust should review its policies and procedures in relation to CAMHS and the Options Team to ensure that there are clear guidelines as to who is responsible for the emergency assessment of patients already known to CAMHS following self harm. *The Panel is pleased to note that a new Trust protocol has been introduced addressing this.*

**SECTION 5.4: CARE CO-ORDINATION AND THE CARE PROGRAMME APPROACH**

12. When Trusts merge key clinical policies should be reviewed immediately and where appropriate new policies issued as a matter of high priority.

13. The Care Co-ordination and Care Management policy should:

a) clarify terminology in use across the Trust and associated agencies;
b) establish protocols to ensure that Care Co-ordinators are made aware of all events relating to a particular patient as soon as possible;
c) make clear the indications and procedures for calling an emergency review;
d) clarify the number and definitions of CPA levels;
e) clarify the minimum age at which CPA applies;
f) establish clear transfer arrangements between locality teams;
g) include a clear and efficient system for conveying information about the Care Co-ordinator and CPA status to all professionals involved in the person's care;
h) identify the role of primary care in the CPA process.

*The Panel is pleased to note that a revised Care Co-ordination policy published in February 2003 satisfactorily covers all the above points.*

14. The Panel recommends that mandatory training be introduced for all staff of all disciplines and in all agencies involved in the CPA process.

**SECTION 5.5: COMMUNICATION AND COLLABORATION BETWEEN THE STATUTORY AGENCIES AND KEVIN LITTLEWOOD'S PARENTS**

15. The Tees and North East Yorkshire NHS Trust and associated agencies should make every effort to ensure that parents and carers are enabled to express fully their views about the care needs of their relatives at case reviews.

16. The Tees and North East Yorkshire NHS Trust and the Hartlepool Social Services Department should ensure that letters from relatives regarding patient care are replied to fully and within a set time limit.

17. Hartlepool Social Services Department should always ensure that a patient's relatives, who are of the opinion that hospital admission is necessary, are informed of their statutory rights under Section 13(4) of the Mental Health Act 1983.

## LIST OF WITNESSES

**Patient and Family**
Mr Kevin Littlewood, Patient
Patient's father

**Tees & North East Yorkshire NHS Trust**
Assistant Medical Director, (CAMHS)
Consultant Clinical Psychologist
Consultant Psychiatrists (CAMHS and Learning Disabilities)
Corporate Affairs Manager
Management staff, Teeswide CAMHS
Nursing staff Hartlepool CAMHS
Nursing staff, Woodlands Unit and Young Peoples Department
Nursing staff and Co-ordinators, Options Team

**Primary Health Care Service**
General Practitioner, Hartlepool

**Northgate and Prudhoe NHS Trust**
Consultant Clinical Psychologist

**Hartlepool Social Services Department**
Asst Director, Children and Families
Social worker

**Hartlepool Education Department**
Principal Educational Psychologist and Senior Education Officer
Educational Psychologists

**Sunningdale School**
Teaching staff

**Future Steps**
Special Needs Careers Adviser

**The Independent Sector**
Chartered Psychologist

**National Probation Service, Teesside**
Social workers (Cleveland Diversion Team)
Psychiatric nursing staff (Cleveland Diversion Team)

**Tees Valley Housing Group**
Project Leader and Project Workers, St Paul's Project, Hartlepool

**Cleveland Police**
Chief Superintendent, Hartlepool

## LIST OF DOCUMENTS AND REFERENCES CONSIDERED

1. Tees and North East Yorkshire NHS Trust: Internal Investigation into an Incident involving KL: Regional Reference 2001/63, undated

2. Papers and Records relevant to the above report, made available by Tees and North East Yorkshire NHS Trust including:
   - Case files and correspondence from the Child & Adolescent Mental Health Service (CAMHS) including the Options Team
   - Documentation completed by the Cleveland Diversion Team
   - Terms of reference for the internal investigation
   - Transcripts of interviews undertaken to compile the report
   - Contributions to the report
   - Action plans and updates completed subsequent to the report
   - Sources and references used to compile the report
   - Trust policies on serious untoward incidents, the Care Programme Approach, Care Co-ordination, operational policies, assessment documentation, clinical governance and protocols
   - Job descriptions
   - Press cuttings

3. Papers and records made available by the Cleveland Diversion Team, Crown Prosecution Service, through Kevin Littlewood's General Practitioner, Hartlepool Social Services Department, Hartlepool Education Department, Future Steps, European Services for People with Autism Ltd., and the Tees Valley Housing Group including:
   - Case files, correspondence and records of meetings
   - Referral and assessment guidance
   - Prescribing information
   - Policy documents
   - Contributions made to the Multi-Agency Management Review including chronologies and reports summarising involvement with Kevin Littlewood
   - Notes of Management Review meetings
   - Literature describing the organisations and organisational charts
   - Outline of Allegation and issues for judge and defence

4. Psychiatric Reports prepared in respect of Kevin Littlewood for the defence solicitor, dated 5 September 2001 and by the Forensic Psychiatry Service, Tees and North East Yorkshire NHS Trust for HMP Moorlands, Doncaster, dated 27 September 2002

5. Transcript of mitigation and sentence, dated 14 December 2001

***References***

6. Barnard J et al (2001) Ignored or Ineligible: The Reality for Adults with Autistic Spectrum Disorders, National Autistic Society, London

7. Cavadino, P (1996) Children who Kill: An examination of the treatment of juveniles who kill in different European countries, Waterside, San Diego and San Francisco

8. Cleveland Diversion Team Review, dated December 1999

9. Department of Health (2001) An Audit Pack for Monitoring the Care Programme Approach, published by the Department of Health, London. Available at http://www.doh.gov.uk/mentalhealth/auditpack.htm

10. Department of Health (2003) Getting the right start: National Service Framework for Children, Emerging Findings, published by the Department of Health, London. Available at http:// www.doh.gov.uk/nsf/children.htm

11. Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach, Policy Booklet, NHS Executive, 1999

12. Health Service Guidelines: HSG (94) 27 "Guidance on the discharge of mentally disordered people and their continuing care in the community", dated 10 May 1994

13. King, A et al (2002) Serving Children Well, a new vision for children's services, Local Government Association Publications, London

14. Powell A, (2002) Taking Responsibility: Good Practice Guidelines for Services – Adults with Asperger Syndrome, National Autistic Society, London

15. Sereny, G (1995) The Case of Mary Bell: A portrait of a child who murdered, Pimlico, London

16. WHO (1992) The ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines (CDDG) WHO, Geneva

17. Wilson P (1973) Children who Kill, Joseph, London

## ORGANISATIONAL CHANGES IN MENTAL HEALTH AND GENERAL HEALTH SERVICES IN TEESSIDE 1997-2001

1. From 1997 to 2001 Kevin Littlewood received care from CAMHS (Child and Adolescent Mental Health Services). Over this time major organisational changes took place affecting health services on Teesside. The changes are described below.

### Mental Health Services

***North Tees Health Care NHS Trust***

2. Until 1999 this provided mental health services including CAMHS for Hartlepool and the Stockton on Tees area, north of the River Tees.

***South Tees Community & Mental Health NHS Trust***

3. Until 1999 this provided mental health services including CAMHS for Middlesbrough and Redcar and Cleveland, south of the River Tees.

***Tees and North East Yorkshire NHS Trust***

4. On 1st April 1999 a new NHS Trust with responsibility for all mental health services in Teesside, East Durham, Scarborough, Whitby and Ryedale was formed. This replaced the former South Tees Community & Mental Health NHS Trust and included mental health services previously under the management of the North Tees Health NHS Trust.

5. The geographical area covered by the Trust includes Hartlepool, Stockton on Tees, Middlesbrough, Redcar & Cleveland and North Yorkshire. The CAMHS service was brought under one management team with four locality teams for Hartlepool, Stockton-on-Tees, Middlesbrough, and Redcar and Cleveland.

***CAMHS Inpatient Services***

6. The Young Peoples' Department, Roseberry Centre at St Lukes Hospital, Middlesbrough was the location of the inpatient unit that provided services for the whole of Teesside including Hartlepool. It re-located to the Newberry Centre for Young People at West Lane Hospital in Middlesbrough during September and October 2000. These inpatient services were managed by the South Tees Community & Mental Health NHS Trust until 1999 and are now managed by the Tees and North East Yorkshire NHS Trust.

### General Hospital Services

***North Tees & Hartlepool NHS Trust***

7. This was formed in 1999, merging the former North Tees Health NHS Trust and the Hartlepool & East Durham NHS Trust.

8. North Tees General (Stockton-on-Tees) and Hartlepool General Hospitals and South Cleveland Hospital (Middlesbrough).
North Tees and Hartlepool General Hospitals have been renamed the University Hospital of North Tees and the University Hospital of Hartlepool and, together, are managed by North Tees & Hartlepool NHS Trust. South Cleveland Hospital is now called the James Cook University Hospital and is managed by the South Tees Hospitals NHS Trust.