Greater Manchester NHS
Strategic Health Authority

A Summary of an Independent Inquiry Report into the Care and Treatment of X

Produced for Bolton Primary Care Trust and Greater Manchester Strategic Health Authority

November 2002

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Strategic Health Authority

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Acknowledgements

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Fiona Subotsky
Martin Manby, Chair

November 2002

Independent Inquiry into the Care and Treatment of X

Contents **Page**

1 Introduction

1.1 This report concerns a young woman who was convicted of manslaughter following an incident which took place when she was aged sixteen. As the young person was a minor at the time of the incident, the authors of this report consider that the issues under consideration should remain confidential, as far as possible. For this reason the subject of the report is referred to as "X", and other members of her family and persons involved are also referred to anonymously. Professionals involved in the case are referred to by the name of the post held.

1.2 X was convicted of the manslaughter of a woman aged thirty five, who died following a stabbing incident on 14.02.2000, at Manchester Crown Court on 17.07.00. X was sentenced nearly a year later at Manchester Crown Court on 3.07.01 and received a discretionary life sentence (6 years).

1.3 Following sentence, Wigan and Bolton Health Authority commissioned an independent Inquiry in accordance with HSG (94) (27). On 1.4.2002 responsibilities previously carried by Wigan and Bolton Health Authority were transferred to the Greater Manchester Strategic Health Authority and the Bolton Primary Care Trust. Such an Inquiry is a statutory requirement placed on Health Authorities following homicides committed by persons in receipt of Mental Health Services. X had been in receipt of specialist Mental Health Services and was accommodated by Bolton Social Services Department at the time of the incident. A former director of social services and a Child and Adolescent Consultant Psychiatrist were appointed to carry out the Inquiry, with administrative assistance from the Health Authority, in September 2001.

1.4 Terms of reference for the Inquiry were agreed on 12.10.01. Its main focus was the quality and scope of X's health and social care; and the appropriateness of her treatment, care and supervision taking account of her assessed needs, the risk of potential harm to herself and others and her previous psychiatric history and other relevant background issues. The Terms of Reference included the training and development and supervision of staff involved in X's care; and the

identification of areas of learning for clinical and social care and managerial practice arising from the work of the Inquiry. A copy of the Terms of Reference is included at **Appendix i**.

1.5 The Inquiry Panel received documents and files relevant to their investigation between September 2001 and January 2002. Some delays in accessing documents were caused by legal considerations. X eventually provided written consent to the release of her files to the Inquiry Panel on 2.04.2002. Further documentation was provided by the prison hospital where X was detained and by Greater Manchester Police in May 2002.

1.6 The procedures adopted by the Inquiry are included at **Appendix ii**. The Panel met on 9.01.2002, on 5.03.2002 and on 6.03.2002 to interview Health and Social Services staff. Interviews were held with X and with her Consultant Psychiatrist at the prison hospital on 7.03.2002. Interviews with the victim's family and with X's mother were held on 4.04.2002. These interviews were recorded and transcribed and all witnesses had an opportunity to correct or amend the transcriptions of their interview. The Panel held an informal meeting with representatives of Greater Manchester Police on 15.05.2002 to obtain background information. A visit was made to the residential unit where X lived for three and a half years, also on 15.05.2002.

1.7 A chronology recording all relevant significant events was compiled by the Panel, based on the documentation obtained. A detailed report on the investigations carried out by the Inquiry Panel has been produced, however, in the interest of patient confidentiality, this will not be made public. Bolton Primary Care Trust asked the Panel in October 2002 to produce a report summarising its findings which would be made available to the public. This is the summary report.

2 Summary

2.1 This Inquiry was commissioned by Wigan and Bolton Health Authority to review the health and social care provided for X, following her conviction for the manslaughter of a woman aged thirty five who died on 14.02.2000. At the time of the incident X was aged sixteen and was being looked after by Social Services in a residential children's unit.

2.2 X's behaviour at home and at school had been very difficult by the time she was accommodated by Social Services in April 1996, and there had been allegations of sexual abuse. X was well cared for by two residential units until February 2000, and she received consistent support and therapeutic intervention from the Children and Adolescent Mental Health Services (CAMHS) from 1994 onwards. X had little contact with her family after she was accommodated by Social Services until the death of her brother in November 1998, after which close contact was resumed.

2.3 X's behaviour at school continued to be problematic and part of her education was in special units. X made numerous attempts to harm herself while she was looked after by Social Services and these were dealt with appropriately by the health services. She was also involved in a smaller number of incidents involving a degree of physical violence. Her eventual victim (V) made a formal complaint about X (and other children) in August 1998, and X seriously harassed V in February and March 1999. X's use of alcohol and drugs was problematic at times and had to be monitored by the residential unit. The local police were regularly called to assist when X absconded or when her behaviour was unmanageable, and they responded helpfully. X made some progress at special educational and employment projects, but was unemployed during the months prior to the stabbing incident in February 2000.

2.4 All the professionals involved, who had detailed knowledge of X's background and problems, were surprised and shocked by the stabbing incident. X's diagnosis and treatment by CAMHS had been carried out appropriately. While X's case was regularly reviewed by both CAMHS and Social Services, a more

standardised approach to risk management by the agencies involved is recommended. Recording and documentation were mainly of a good standard, although some gaps in Social Services files were noted.

2.5 Liaison and communication between CAMHS and Social Services was effective. The CAMHS' support for X was maintained after her sixteenth birthday and was eventually gradually reduced and finally terminated in February 2000. X's case demonstrates the need for effective transition between children and adolescent and adult mental health services. The specific mental health needs of sixteen and seventeen year old young people should be prioritised and appropriate provision should be made by health services for them. The importance of these services to vulnerable young people looked after by Social Services, as they prepare to leave local authority care, is emphasised.

2.6 In our view X was well supported by health and social care services, and appropriately placed in a small, well staffed residential unit in the community. There were not sufficient grounds for detaining X in a more secure health or social services establishment. Local agencies need to be proactive in sharing the dilemmas involved in caring for vulnerable young people with community representatives and opinion formers, and in developing strategies which are widely supported.

2.7 The tragic events of February 2000 were reviewed promptly by Social Services. It would have been helpful if the local authority had been able to make contact with the victim's family at this point. The Health Services did not implement their serious serious incident reporting procedures. Action has now been taken to remedy this. Health and Social Services did not formally meet to consider what further action was required at that point, and this kind of joint review is recommended for the future.

2.8 Overall, health and social care services for X were provided to a good standard. The tragic incident of February 2000 could not, in our view, have been predicted. Recommendations are made to improve the joint provision and quality of mental health and social care services for vulnerable young people.

3 Issues Arising, Discussion and Conclusions

3.1 Overall, the quality of the health and social care provided for X was good, and in some respects excellent.

3.2 This finding is worthy of comment. Most inquiry reports with which we are familiar have identified shortcomings in the actions of the agencies involved which contributed to the eventual outcome. In the case of X and her family we have highlighted a number of examples of good practice. Tragic outcomes cannot always be predicted or prevented. Service providers who have striven to promote a high standard of service should be commended and should not be subjected to criticism because events have taken place which were not within their control. We make this point robustly, and the recommendations in the following section about issues arising from this inquiry should be viewed within this context.

General Practitioner

3.3 X was a frequent attender at her GP's surgery. She remained attached to the same general practitioner following being accommodated by Social Services, even though this meant a two bus ride journey across town to see him. The GP knew X and her family well. He was accessible and was equally concerned about her physical and mental health and liaised well with Social Services and with the Children and Adolescent Mental Health Service (CAMHS). X liked the GP and put a premium on the consistent and confidential service which he provided.

Children and Adolescent Mental Health Service

3.4 The CAMHS provided X with a consistent and overall effective service for five years until the stabbing incident took place. Her case was supervised throughout this period by a Consultant Child Psychiatrist (CCP) who reviewed her therapeutic care and treatment regularly, supervised the nurse therapist staff and

liaised effectively with Social Services. X had two extended periods during which she was seen weekly by nurse therapists, and their work was carefully recorded and supervised. The therapy provided opportunities for X to talk about her family, including her relationship with her mother and sisters and the loss of her brother after his death. This aspect of the service received by X was commendable. The therapeutic services provided by CAMHS were extended beyond X's sixteenth birthday and were gradually phased out in the months prior to the stabbing incident. It would have been appropriate for contingency plans to have been made for X to contact the Adult Mental Health Services as required when her contact with CAMHS was ended. The CAMHS service should have followed Health Services procedures in recording the stabbing of V and the subsequent arrest of X as a major incident and this would have triggered follow-up procedures.

Social Care

3.5 The Social Services Department provided extensive family support services to X's family in the four years prior to her being accommodated in April 1996. Child Protection concerns were investigated and fully documented. Allegations of sexual abuse upon X were reported and investigated; and a member of the Child Protection team provided therapeutic sessions to explore these allegations between November 1994 and June 1995. Although evidence on which to base criminal prosecutions against the alleged perpetrators was lacking, X's own view (in 2002) was that she did not understand why she had not been believed and, why action had not been taken against those she considered responsible. Our view is that it is probable that X was sexually abused and that these experiences may have impaired X's self-confidence and her ability to develop trusting relationships during the period in which she was accommodated by Social Services.

3.6 X was provided with respite care between November 1994 and April 1996 and this helped her family to function during this period. In the six months prior to X being accommodated by Social Services CCP advised the department that the CAMHS service could not become involved in treatment while X was living with

her family and that, in his view, it would be advantageous for X to be accommodated. There were clear indications that X's behaviour at school was disturbed and both X and her mother signalled their wish for X to be looked after by Social Services. Social Services had to balance these factors with their responsibility to maintain the family unit as long as this did not compromise X's welfare. Social Services acted promptly to plan for X to be accommodated following an acute deterioration in the relationship with her mother in April 1996.

3.7 After a short period in a foster home X was looked after in two residential units for the whole of the time she was accommodated by Social Services. This was appropriate, as residential care was the placement of choice for X and substitute family care would have been unacceptable to her mother. X's needs were assessed during an initial turbulent three month period at the Home (CH1) at which X was first placed. The assessment concluded that X should be transferred to a small group home (CH2) in October 1996, where the stable and experienced staff team provided an excellent standard of care for her over the next three and a half years. Continuity of care by residential staff was ensured. The Home's records confirm that appropriate boundaries were set for X and that the staff responded consistently and appropriately to X's frequently challenging behaviour: incidents were carefully recorded and reasons for and responses to the incidents, including sanctions, were regularly discussed by the staff with X.

3.8 Residential management staff took the lead responsibility for assessing X during the period she was accommodated at CH1 and staff at CH2 provided much of the momentum for the management of X's case, assisted by efficient day to day recording of X's care and by the use of recorded monthly summaries. Records in the fieldwork file were incomplete and copies of Statutory Review forms were at times difficult to access, adding to the impression that residential staff took the lead in organising X's care. However, overall the contributions made by residential and fieldwork staff were complementary and X's needs were met well.

Service Co-ordination

3.9 Liaison between Social Services and the Children and Adolescent Mental Health Service (CAMHS) in the case of X and her family was effective. X and her family

and Social Services were able to access relevant and appropriate mental health services under the direction of an experienced consultant child psychiatrist over an extended period. X's social workers were able to contact CCP directly when X's behaviour warranted this and CCP provided detailed follow-up reports to the Social Services fieldwork team, and was also available to provide advice to residential staff. Social Services considered that the standard of service provided for X was one of the best examples of liaison with the CAMHS, and their view was that some other young people may have fared less well than X in this regard. Consultancy by CAMHS to support residential staff looking after young people with complex needs was being developed during the period under review. Social Services management were aware of the need to invest resources in joint commissioning of appropriate services, including mental health services, for young people under their supervision, including accommodated young people.

Mental health services for young people

3.10 This report has highlighted the more limited availability of mental health services for young people aged sixteen and seventeen, and problems of transition between mental health services for children and young people, and services for adults. Accommodated young people are likely to be particularly vulnerable, as recognised in recent Care Leavers' legislation. This legislation underlines the importance of consistent and continuing support to these young people from the age of fourteen / fifteen through to young adulthood, with continuing after-care between the ages of eighteen and twenty one, and beyond. Effective mental health services are vital to meet the needs of these and other vulnerable young people.

Management and Supervision of X's behaviour in a local community home

3.11 The chronology compiled by the Panel records a number of occasions when X was involved in disputes with her neighbours, including her eventual victim (V). There are also records of frequent occasions in X's last year at CH2 when the police were called to the Home to assist with X's behaviour. V's family had

concerns about the level of supervision provided by the Home. The police, for whom requests for assistance from children's homes about children and young people misbehaving or being out late can be a relatively low priority, knew X well: she, along with a number of other children in residential units, regularly required police involvement.

3.12 Social Services had the difficult task of balancing X's needs to become more independent and form her own friendships, with the requirement to ensure that she received proper guidance and supervision. V had become sufficiently exasperated with the behaviour of children at the unit, including X, by the summer of 1998, to ask for the home to be closed. Following a series of incidents in February and March 1999 in which X's behaviour to V had been very aggressive and provocative, the Home intervened in April / May 1999. Following a meeting with X and the Housing Department there was no further evidence of X harassing V until the stabbing incident. From the Home's point of view, the action they had taken seemed to have had the desired result, and neighbour disputes were not a prominent feature of X's final months at CH2. Although X's behaviour was problematic and challenging this did not meet the threshold for considering Secure Accommodation. X's behaviour was characterised by persistent attention seeking and by more or less serious incidents of self-harm requiring referral to the Accident and Emergency Department. Such behaviour was within the competence of the Home to manage and did not reach the level where an application to a court for a Secure Accommodation Order was a realistic consideration.

3.13 In placing X in a small community home, Social Services were pursuing a positive policy to meet her needs. Other social services departments would have been likely to have adopted a similar approach, although some would have had less access to appropriately staffed residential units. Social services management's recollection was that X's behaviour was not particularly exceptional, compared with that of other very demanding accommodated young people. X's behaviour did not include the kind of violence that might have led to court convictions and which could have prompted consideration of a more restrictive and more secure placement. Nor is there any certainty that staff in a

more specialist unit would have been better able to ensure X's welfare. Such a placement would probably have been further away from X's family home, making the kind of frequent family contact which X eventually achieved more difficult.

3.14 We remain thoughtful about the gap between appropriate professional considerations (that X's needs were best met in a community residential unit) and public perceptions that young people such as X would be better looked after in more secure environments. The resources of the local police force were stretched by X's provocative behaviour, and X's eventual victim was for a time seriously harassed by her. The authority had to temporarily close the residential unit (CH2) and to move the children away from the home, faced with hostile publicity after the stabbing incident.

3.15 There are no easy answers to these dilemmas. We have expressed our clear support for and confidence in the kind of residential care provided for X. Social services and health authorities regularly experience opposition to actual and planned provision for community homes and centres for people, including children and young people, with high levels of need and vulnerability. They also have to consider the potentially higher costs of more specialist or more environmentally secure provision. Community provision needs to be well run (which we consider CH2 to have been) with well developed policies for integration with the local community. The target should be for authorities to be pro-active with community leaders and the press, promoting understanding and support for the needs of vulnerable young people and adults, based on recognition of their rights and citizenship. Best outcomes are likely to be achieved by clearly focused community development activity, with contributions by local practitioners, health and social services management, and by elected members of local authorities and members of health authorities and trusts, leading to greater shared acceptance, understanding and ownership of the problems of vulnerable young people and adults. In making these observations, we do not under-estimate the contributions of local residents who at different times befriended and supported X (and her peers at CH2) and contributed to her development.

Prevention and Prediction

3.16 X's separation from her family, her probable experience of sexual abuse, her impulsivity and her use of harmful substances were all indicators that she was a particularly vulnerable young person. Her carers had ample evidence of her self-harming behaviour, although residential staff had to assess how far this was "genuine", and how far it was driven by attention-seeking or how it linked to X's tendency to create drama. Nonetheless the dangers were real and were accentuated by X's psychological reaction following her brother's death. Both her consultant psychiatrist and residential staff recognised that it was in the area of self harm that X was most at risk.

3.17 Had X made a more serious suicide attempt the professionals involved would have been less surprised and shocked than they were by the tragic stabbing incident. X's capacity for aggressive and threatening behaviour, and earlier incidents involving a degree of physical violence, have led us to conclude that further violent behaviour on her part was possible, although the eventual fatality could not have been predicted. X's experience of a high standard of residential care and her access to effective therapeutic services may have partly contained her tendency towards violence. Without both, the dangers X presented to others would have been greater. Residential staff found her behaviour provocative and intimidating rather than physically threatening, and this view was shared by her nurse therapists. Staff at CH2 considered that her behaviour had mellowed in the period leading up to the stabbing incident, and her mother confirmed that she had seemed settled rather than agitated or particularly aggressive at that stage. X's behaviour away from the oversight of the residential staff or other service providers was less predictable, particularly when she was under the influence of alcohol or other potentially harmful substances.

3.18 It is not easy to see how the risks which X presented to herself and to other people could have been significantly reduced. Although we consider that formal risk management procedures, co-ordinated between the agencies involved, would have been appropriate, we also acknowledge that X's case was regularly reviewed by both CAMHS and Social Services. Although a clearer pathway

between children and adolescent and adult mental health services could have been helpful to X, she was not a person who was slow to seek out specialist help when she thought this was necessary. The key issue for X was her level of trust in the service providers. Neither longer-term in-patient acute hospital care nor secure accommodation were realistic options for X at any stage; and we have found nothing to suggest that X's condition was mis-diagnosed, nor that alternative pharmacological treatments would have been appropriate. X preferred one to one support (to which she had access) to group therapy, and she may not have been keen to join the kind of group based anger or behaviour management programmes being developed by Youth Offending Teams, had they been available. Without a court order (which did not exist) her attendance could not have been enforced. It seems doubtful that her attendance at the substance misuse programme made much impact on her behaviour.

3.19 X had time on her hands in the months before February 2000. Full time involvement in education or employment would have helped to keep her busy, and would have reduced the time she had available for non-constructive or potentially dangerous activities. Here, however, the argument becomes circular, as it was X's impulsive behaviour, which probably had its roots in her early family experiences, which made it difficult for her to remain committed to education or employment programmes.

3.20 Young people like X, with complex family and psychological histories, living in the community without consistent parental support, are always likely to be vulnerable. Such young people need access to well co-ordinated health and social care services of the kind and of the quality that X for the most part enjoyed. The recommendations in the final section of this report are designed to further improve and refine the quality of well co-ordinated mental health and social care services for young people; but they will not eliminate the risks inherent in the lifestyles of vulnerable young people as long as they have some freedom of choice about their associates and their pursuits.

4 Commendations and Recommendations

4.1 *Comments on points of good practice found (commendations) and recommendations are set out under issues which are raised in the original terms of reference and those commonly found to be important in similar inquiries. Recommendations are in* ***bold italics***.

Quality and Scope of Care

Health Care

4.2 CAMHS provided a consistent and overall effective service for five years until the incident took place, which offered expertise, community, responsiveness and good communication. The GP provided an excellent continuous service which was very available, and was pivotal in health care.

Social Care

4.3 Social Services provided relevant family support services to X's family and high quality accommodation services to X between 1992 and 2000.

Appropriateness of Care

Health Care

4.4 CAMHS' care was appropriate for X's presentation of symptoms, assessed diagnoses of "attachment disorder", circumstances, and wish for treatment. There was a flexible response to the consideration and provision of a range of appropriate treatments including individual and group therapy and medication, which are commended. Other health care from the GP and the hospital was also flexible, non-judgemental and appropriate.

Social Care

4.5 Social Services responded to X's early presentation of need in a family with multiple needs with conferencing review and family support. When X alleged sexual abuse this was investigated and X was seen over a period of time by a social worker for further discussion. While both X and her mother signalled their wish for X to be looked after by Social Services, this had to be balanced with the responsibility to maintain the family unit as long as this did not compromise the children's welfare. Social Services acted promptly to plan for X to be accommodated when the need became acute. After assessment X was appropriately placed in a small group home in the community, allocated a field social worker and kept under review.

Inter-Agency Issues

4.6 Social Services appropriately consulted CAMHS at an early stage and subsequently CAMHS made their possible and actual contributions clear and worked appropriately with the residential and field social workers involved.

User and Carer Involvement

Health Care

4.7 CAMHS' reviews of progress and further treatment planning usually involved X and her social workers and sometimes her mother.

Social Care

4.8 Social Services involved X and her family appropriately in decision making. Formal reviews always involved X and her mother was always invited. X's mother resisted Social Services attempts to encourage her to resume contact with X for two years, after X was accommodated in April 1996.

Risk Assessment and Risk Management: Procedures and Practice

Health Care

4.9 On presenting to A & E with self-harm X was admitted to hospital and seen there subsequently by a CAMHS professional as is recommended good practice.

It is recommended that the Deliberate Self Harm (DSH) assessment protocol is revised to give greater weight to issues of substance misuse and of potential risk to others and from others as well as the risk to self, ensuring that these points are documented.

CAMHS should consider using formal risk screening on all cases, as would be required in adult mental health services.

Social Care

4.10 Risk to X and her siblings from others, within and outside the family, was initially considered appropriately through the multi-agency Child Protection system, under the formal standard headings of emotional abuse, physical abuse, sexual abuse and neglect. Actions were taken to support both X and other family members. In the children's home incidents involving X were recorded and discussed properly with her, and subsequently discussed at reviews. Appropriate boundaries were set for X, with consideration given to her developing maturity.

Interagency Issues

4.11 ***Each agency (CAMHS, Social Services, Community Health, Primary Care, Education, Judiciary) must ensure that the other agencies involved in a high-risk case (not subject to the Child Protection Review system) are informed of risky incidents. The development of the use of chronologies to assist in identifying high risk behaviours is strongly recommended. A computerised chronology system such as advised by "The Bridge" may be***

appropriate. An adaptation of the Care Programme Approach might also be suitable.

Serious Incident Management

Health

4.12 ***CAMHS should have clear serious incident reporting and investigating policies in place which are both part of their Trust's procedures and in line with the clinical governance arrangements of the local adult mental health service.***

Social Services

4.13 It is appropriate (as happened in this case) for such a serious incident to be discussed with the Social Services Inspectorate for advice on whether a Part 8 Review is advisable.

Interagency Issues

4.14 ***A serious incident involving a minor in receipt of specialist health and social care should be the subject of formal communication between professionals and managers of both services.***

a) To co-ordinate follow-up with the young person and his/her family and the victim/victim's family and

b) To establish whether any lessons might be learned

c) The importance of establishing sympathetic contact with the victim's family is stressed, subject to appropriate legal advice.

4.15 ***The agencies should decide whether referral to the Area Child Protection Committee (ACPC) is appropriate to consider whether any follow-up action is necessary.***

4.16 ***National guidelines on Homicide Inquiries should be clarified as to the necessity and nature of such inquiries especially when a minor is the subject.***

Documentation and Communication

Health Care

4.17 The high standard of CAMHS recording in terms of session and supervision recording, clarity, and quality of communication is commended.

It is recommended that systematic audit of CAMHS files takes place (if it does not already) to help ensure maintenance of high standards.

Social Care

4.18 In the children's home there was an excellent and efficient system of day to day recording of X's care and monthly summaries, which is commended. Records in the fieldwork file were incomplete and copies of Statutory Review forms were not readily available, which made the Panel's work more difficult.

It is recommended that Social Services should review their file policy to ensure that fieldwork records and statutory review forms are complete and clearly identified.

Interagency issues

4.19 Letters from the CAMHS consultant ensured regular update to other professionals involved, especially the GP and the field social worker. Telephone calls and joint meetings were also documented.

CAMHS should send copies of correspondence to residential staff as well as the field social worker as the personnel are different and there is a separate file.

4.20 Social workers clearly kept in touch formally and informally with CAMHS.

Social Services formal systems for circulating review or conference minutes should include the GP as the primary health care giver, as well as the community paediatric service and CAMHS, if involved.

Transition from Adolescent to Adult Services

Health Care

4.21 ***Appropriate mental health services need to be in place for 16 and 17 year olds. Transition or contingency arrangements should be made for the use of adult mental health services well before the need arises and in consultation with all relevant parties. CAMHS should develop a policy on transfer arrangements in general with Adult Mental Health Services.***

Social Care

4.22 ***Access to appropriate mental health services, including access to services for adults, should be integrated into Social Services' leaving care policies and procedures.***

Interagency Issues

4.23 ***Young people "looked after", in the transition phase, and receiving mental health care should have their needs reviewed jointly between agencies. This should include primary health care and education. The outcome should be a care plan available to all including the young person.***

Organisational Issues

Health

4.24 ***Where, as in this case, adult and child mental health services are not managed by the same organisation, CAMHS should ensure there is good liaison with adult mental health services between both professionals and managers to promote knowledge of good practice and appropriate patient care.***

Social Services

4.25 The provision of small well-staffed community units for looked after young people is commended.

Interagency Issues

4.26 ***Opportunities to promote good understanding between CAMHS and social services as to their respective priorities, philosophies and resources should be developed at both strategic and operational levels.***

Resource Issues

Health

4.27 ***Mental health services for 16 and 17 year olds should be specifically commissioned. Sufficient in-patient adolescent psychiatric beds need to be available so that the dilemma of either risky care in the community or inappropriate care in adult units can be avoided.***

Social Services

4.28 ***Resources linked to the Department of Health's Quality Protects initiatives and to recent Care Leavers' legislation should be used to ensure that***

appropriate educational opportunities and specialist mental health and drug and alcohol services are available for accommodated young people when planning for independence is underway.

Interagency Issues

4.29 ***There should be further development of jointly commissioned services helping to ensure good quality services for "looked after children" as they have high mental health needs.***

4.30 ***The Youth Offending Team (YOT) system could be developed to promote multi-agency appraisal and intervention for young people involved in offending and anti-social behaviour who are at high general risk.***

Staff Supervision and Development

Health Care

4.31 CAMHS had good supervision structures in policy and practice which are commended and should continue as should seeking training and consultation in specialist evidence-based treatments.

4.32 ***There should be further training for all CAMHS staff in risk assessment which should include child protection/vulnerability issues, deliberate self-harm and suicidality, violence assessment and substance misuse assessment and management.***

Social Care

4.33 Social Services had an effective review and supervision structure in place although field work file documentation of this was patchy.

4.34 ***There should be further training for all Social Services staff especially those dealing with looked-after adolescents in risk assessment which should include child protection/vulnerability issues, deliberate self-harm***

and suicidality, violence assessment and substance misuse assessment and management.

Interagency Issues

4.35 ***Joint training opportunities between agencies should be offered, especially on risk assessment and management issues.***

Future Planning

4.36 ***At the point in the future when return to the community is being planned for X, there should be consultation between all agencies including the current health provision, social services and the police, to review what has emerged about psychosocial risks and needs at the various stages of X's life; and to plan how X can best be supported to minimise risk to herself and others.***

5. Inquiry Panel Membership

Martin Manby (Chair) was director of social services for the London Borough of Greenwich (1982 – 1990); and then for the City of Sheffield (1990 – 1997). Since 1998 he has been director of the Nationwide Children's Research Centre (Huddersfield).

Dr Fiona Subotsky is a Consultant Child and Adolescent Psychiatrist at the South London and Maudsley NHS Trust working primarily with adolescents. She was Medical Director of the Bethlem and Maudsley NHS Trust (1996 – 1999) and is on the Executive of the Royal College of Psychiatrists.

Appendix i

WIGAN AND BOLTON HEALTH AUTHORITY

INDEPENDENT INQUIRY INTO THE TREATMENT AND CARE OF X

TERMS OF REFERENCE

1. With reference to the incident which took place on the 14th February 2000, to examine the circumstances of the treatment and care of X, by the child and adolescent mental health and social care services, in the context of local systems, national guidance and statutory obligations; in particular to review:

   (i) the quality and scope of her health and social care.

   (ii) the appropriateness of her treatment, care and supervision in view of:

      (a) her assessed health and social care needs;
      (b) her assessed risk of potential harm to herself and others;
      (c) any previous psychiatric history, substance misuse and any history of offending and criminal convictions.

   (iii) the extent to which X's prescribed treatment and care plans were:

      (a) documented;
      (b) agreed with her and her carers;
      (c) communicated appropriately within and between relevant agencies, carers and family;
      (d) carried out;
      (e) complied with.

2. To examine the appropriateness of the training and development of those involved in the care of X and the supervision and monitoring of performance.

3. To identify any areas of learning for clinical and social care and managerial practice arising from the work of the Inquiry.

4. To prepare a report of the Inquiry's findings and make recommendations as appropriate on health and social care issues to Wigan and Bolton Health Authority or its successor organisation.

12.10.01

Appendix ii

WIGAN AND BOLTON HEALTH AUTHORITY

INDEPENDENT INQUIRY INTO THE TREATMENT AND CARE OF X

PROCEDURE ADOPTED BY THE INQUIRY

1 Every witness of fact will receive a letter in advance of their appearance to give evidence informing them:

(a) of the terms of reference and the procedure adopted by the Inquiry
(b) about the issues to be covered
(c) inviting them to provide written materials to support their evidence if they wish to do so
(d) that when they give oral evidence they may raise any matter they wish, and which they feel may be relevant to the Inquiry
(e) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation, or anyone else they may wish to accompany them
(f) that their evidence will be recorded and a copy sent to them afterwards for them to sign.

2 Any points of potential criticism will be put to a witness of fact, whether orally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

3 Advice and evidence may be sought from professional bodies and other interested parties about relevant issues.

4 Anyone else who feels they may have something useful to contribute to the Inquiry may make written statements for the Inquiry to consider.

5 The Inquiry will be held in private.

6 The findings of the Inquiry and any recommendations will be reported to the Health Authority who will decide on publication. Records and transcripts of evidence will not be made public.

7 Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments that appear within the narrative of the Report and any recommendations will be based on these findings.

8 At the conclusion of the Inquiry, the Inquiry records including witness statements and copies of transcripts of oral evidence will be held securely by the Health Authority as custodians under seal.

19.12.01

Appendix iii

KEY TO ABBREVIATIONS USED IN THE REPORT

Abbreviation	Individual/Subject
A&E	Accident and Emergency
ACPC	Area Child Protection Committee
CAMHS	Children and Adolescent Mental Health Services
CCP	Consultant Child and Adolescent Psychiatrist
CH1	Children's Home 1
CH2	Children's Home 2
EB2	Elder Brother 2
GP	General Practitioner
SW1	Social Worker 1
SW2	Social Worker 2
V	Victim
X	Patient
YOT	Youth Offending Team