An independent investigation into the care and treatment of Jack by Rotherham Doncaster and South Humber NHS Foundation Trust

Abridged executive summary

First published: February 2020

Authors:
Sancus Solutions:

Lockside Office Park, 8G Lockside Rd, Preston. PR2 2YS

Sancus Solutions wish to thank both Jack's family and Leonne's parents for agreeing to meet with the investigation team. Their contribution has been of great assistance in enabling a deeper understanding of the events that led up to this tragic incident. It is our sincere wish that this report does not contribute further to their pain and distress.

Sancus Solutions' investigation team would also like to acknowledge the contribution and support of staff from Rotherham Doncaster and South Humber NHS Foundation Trust.
.

Date	Version	
7 February 2020	Final	

Contents

1 The incident

1.1 16 January 2017: Jack[1], aged 18 years, was arrested and subsequently charged with the murder of Leonne.[2] Jack was given a life sentence with a minimum term of 24-and-a-half years.

1.2 Leonne's parents reported to Sancus Solutions' investigation team that their daughter and Jack had known each other since childhood.

1.3 At the time of the incident, Jack was a patient of Rotherham Doncaster and South Humber NHS Foundation Trust's (hereafter referred to as RDaSH) Child and Adolescent Mental Health Services (hereafter referred to as CAMHS).

1.4 Prior to the incident, based on Jack's presentation, CAMHS were considering the following mental health diagnoses:

- Impulse control disorder[3] – International Classification of Diseases[4] (ICD) 11 F63.9

- Emerging antisocial personality disorder or other personality disorder[5] with a possible learning disability/borderline learning disability.[6]

2 Commissioning of the investigation

2.1 From 2013 NHS England assumed overarching responsibility for the commissioning of independent investigations into mental health homicides and serious incidents. On 1 April 2015 NHS England introduced its revised Serious Incident Framework[7], which aims:

"To facilitate learning by promoting a fair, open and just culture that abandons blame as a tool and promotes the belief that an incident cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working. Looking at what was wrong in

[1] Jack is a pseudonym
[2] Leonne's parents asked Sancus Solutions' investigation team to identify their daughter by her name
[3] Impulse-control disorder: features are the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the individual or to others. Impulse control
[4] The International Classification of Diseases is the international standard diagnostic tool for epidemiology, health management and clinical purposes. The latest version, referred to as ICD-11, was introduced in June 2018. ICD-11
[5] It is recognised that there are links between early childhood temperament and the development of personality traits in later childhood. Clinicians do not routinely assess aspects of a child's personality as part of a mental health examination. This may stem from a fear of 'labelling' a child should any problems in personality development be noted, particularly those likely to progress to a personality disorder in adult life. NICE guidelines IICD-11 F60.2
[6] 18 October 2016
[7] NHS Serious Incident

the system helps organisations to learn lessons that can prevent the incident recurring."[8]

2.2 The criteria for NHS England's commissioning of an independent mental health homicide investigation are:

"When a homicide has been committed by a person who is, or has been, in receipt of care and has been subject to the regular or enhanced care programme approach or is under the care of specialist mental health services, in the 6 months prior to the event."[9]

2.3 In November 2017, NHS England (North) commissioned Sancus Solutions to undertake an investigation to:

- Review the effectiveness of care, treatment and services (specifically CAMHS) provided by RDaSH and other relevant agencies from Jack's first contact with services to the time of the incident, with particular reference to the transition management to adult mental health services.
- Consider whether the 'voice of the child'[10] was visible through all interactions with services and agencies.
- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement. For the purpose of this investigation, Sancus Solutions' investigation team utilised the following definitions:

Predictability: the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[11]
Preventability: a preventable incident is one for which there are three essential ingredients present: the knowledge, legal means and opportunity to stop an incident from occurring.[12]

[8] NHS Serious Incident p10
[9] NHS Serious Incident p47
[10] The Voice of the Child was a thematic report on Ofsted's evaluation of serious case reviews from 1 April to 30 September 2010. This report covered the evaluations carried out between April and the end of September 2010 of 67 serious case reviews. The main focus of the report was on the importance of listening to the voice of the child. Previous Ofsted reports have analysed serious case reviews and identified this as a recurrent theme. Hearing the Voice of the Child
[11] Munro, E., Rumgay, J., "Role of risk assessment in reducing homicides by people with mental illness". *The British Journal of Psychiatry* (2000), 176: 116-120. Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. Predictability
[12] Preventability – to prevent means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring

2.4 The full terms of reference (hereafter referred to as ToR) and details of Sancus Solutions' investigation team are located in the appendixes lofted at the end of this report.

Involvement of Jack and Leonne's families

2.5 Sancus Solutions' lead investigator and family liaison officer met with both Jack's family and Leonne's parents to discuss the proposed ToR and to discuss the events that led up to this incident.

2.6 Sancus Solutions' investigation team are extremely grateful for the information provided by both families during the course of this investigation at what continues to be a very distressing time for them.

2.7 It is Sancus Solutions' hope that their findings and recommendations provide both families with some answers to their questions and concerns.

3 Background information

3.1 At the time of the incident, Jack was living with his parents and some of his siblings.

3.2 After Jack left school, he enrolled in a three-year bricklaying course at a local further education college. When Jack initially came to the attention of CAMHS, he was about to enter the second year of his course.

3.3 Prior to coming to the attention of CAMHS Jack was a very keen amateur boxer.

4 Summary of Jack's contact with services – 2016-2017

4.1 3 July 2016: Jack telephoned the police reporting that he had in his possession a machete and that he was hearing voices telling him to harm the next person who walked out of a nearby public house. In response to this disclosure, the police deployed an armed response unit and located Jack. The police then accompanied Jack and his mother to the local Accident and Emergency Department (hereafter referred to as A&E).

4.2 Jack's mother reported that prior to this incident, there had been no previous concerns with regard to her son's mental health.

4.3 Following an assessment undertaken by two on-call duty mental health practitioners from the adult crisis service[13], Jack was discharged from A&E and an urgent referral was made to CAMHS.

[13] As this was out of hours, Jack was assessed by the adult crisis service

- 6 July 2016: Jack, accompanied by his mother, attended an initial CAMHS assessment appointment where a CAMHS FACE risk assessment[14] was completed. From this point Jack was being seen regularly by two CAMHS practitioners and a psychologist. Three CAMHS consultant psychiatrists were also involved in the ongoing assessment and monitoring of Jack. A care plan was agreed with Jack and his mother.

4.4 14 July 2016: A care plan was partially completed by one of the CAMHS practitioners.[15]

4.5 22 July 2016: A second CAMHS FACE assessment was completed, and one of the involved CAMHS practitioners also made an entry in Jack's care plan.

4.6 25 July 2016:

- Jack's mother telephoned one of the involved CAMHS practitioners to report that she was concerned about her son, as he was again experiencing disturbing nightmares and had told her that, on one occasion, "he had woken up holding a knife"[16]. Jack's mother also reported that her son had disclosed to her that he had "killed cats"[17].

- On further questioning by the CAMHS practitioner, Jack reported "these killings as being impulsive … and not planned"[18].

- It was documented that Jack "denied having plans to harm his mum, dad or any other member of the public and his parents felt safe at home with [Jack] … [Jack's] mum and dad were very clear that they could maintain [Jack's] safety."[19]

- Jack's mother was asked "to explore the woods at the back of the house to ascertain whether there [was] any evidence of dead cats"[20].

4.7 2 August 2016: At a CAMHS clinical meeting, which was attended by one of the CAMHS consultant psychiatrists, the safeguarding professional and a psychotherapist, Jack's disclosure that he had killed a number of cats was discussed, and it was mentioned that neither the CAMHS practitioner nor Jack's mother believed him. However, it was agreed that both the police and

[14] FACE (Functional Analysis of Care Environments) is a national accredited toolkit used to assess risk and needs in health and social care services and to assess/identify risk factors. It is also used to assess patient-reported outcome measures (PROM) and personal goal achievements FACE
[15] Care plan was not dated or signed and only partially completed
[16] Progress notes 25 July 2016 2.17pm
[17] Progress notes 25 July 2016 2.17pm
[18] Progress notes 25 July 2016 2.17pm
[19] Progress notes 25 July 2016 2.17pm
[20] Progress notes 25 July 2016 2.17pm

the RSPCA needed to be informed about Jack's disclosures. It was also documented that Jack:

"Could possibly [be] experiencing a form of depression/psychotic depression which could explain his apathetic symptoms however this needs further exploration"[21].

4.8 8 August 2016: The CAMHS psychologist began to try to commission a CAMHS forensic assessment for Jack.

- 11 August 2016: At an assessment with one of the CAMHS consultant psychiatrists, it was concluded that Jack was presenting with:

"No systematized[22] psychotic features … risk of suicide – low, risk to others low."[23] It was agreed that Jack would be prescribed a course of the antipsychotic medication risperidone (0.5mg)[24] with a view to increasing the dose if required.[25]

4.9 15 August 2016: A referral was sent to RDaSH's Early Intervention in Psychosis service[26] (hereafter referred to as EIP).

4.10 16 August 2016: An EIP assessment was undertaken, which concluded that Jack was not "presenting with psychosis however there were concerns regarding an emerging anti-social personality disorder"[27], therefore Jack did not meet the criteria for the service. However the assessors reported:

"I would suggest that urgent consideration is given to managing [Jack's] current significant risks and as to whether these can be safely managed in the community … it would be beneficial to seek a further forensic opinion."[28]

4.11 17 August 2016: A referral was made to children's social care services.

4.12 18 August 2016: One of the CAMHS consultant psychiatrists documented that:

"We are all concerned about the escalation which is clearly going on … I said that [Jack] needed to be seen urgently for further risk assessment and agreed

---

[21] Progress notes 2 August 2016 5.03pm
[22] A fixed, false system of beliefs with complex logical structure
[23] Progress notes 12 August 2016 1.18pm
[24] Risperidone is an antipsychotic medication. It is mainly used to treat schizophrenia, bipolar disorder and other psychoses Risperidone
[25] Progress notes 12 August 2016 1.18pm
[26] Early Intervention in Psychosis (EIP) is a mental health service that works with young people aged over 14, who are experiencing a first episode of psychosis. Rotherham EIP
[27] Antisocial personality disorder is characterised by impulsive, irresponsible and often criminal behaviour. Antisocial personality disorder is on a spectrum, which means it can range in severity from occasional bad behaviour to repeatedly breaking the law and committing serious crimes
[28] Progress notes 23 August 2016 1.14pm CAMHS practitioner 1

with [one of Jack's CAMHS practitioners] to contact Tier 4[29] and make a Tier 4 referral."[30]

This referral was not made.

4.13 22 August 2016

- A Multi-Agency Safeguarding Hub[31] (hereafter referred to as MASH) meeting was convened.[32] The involved CAMHS practitioners reported that Jack had capacity and there was no current evidence that his alleged killing of animals was driven by either delusional or psychotic presentation. The meeting agreed that:

  "Social care and CAMHS [would] complete a joint assessment as required under [Section] 17.[33] Early Help to explore the possibilities of allocating [Jack] with an experienced youth worker and [to] enquire with the police regarding the consequences of animal cruelty/causing bodily harm to others.[34]

4.14 24 August 2016: A third CAMHS FACE assessment was completed.

4.15 25 August 2016: Jack text-messaged one of his CAMHS practitioners photographs he had taken of the animals he had killed.

4.16 9 September 2016:

- Jack was seen by another CAMHS consultant psychiatrist, who documented that there had been a significant improvement in Jack's presentation. The following actions were agreed:

- Risperidone to be stopped.

- CAMHS to continue to monitor Jack, and "once [he] appears more settled for a period of time a decision has to be made as to whether [to] close the file or pass him onto adult mental health services"[35].

4.17 21 September 2016: Jack was arrested by the police.

---

[29] Tier 4 acute general adolescent inpatient unit RDaSH Tier 4
[30] Progress notes 18 August 2016 1pm
[31] The Multi Agency Safeguarding Hub (MASH) brings key professionals together to facilitate early, better-quality information-sharing, analysis and decision-making, to safeguard vulnerable children and young people more effectively MASH
[32] Attended by CAMHS practitioners, a social care and Early Help worker, and Jack and his mother.
[33] Section 17 of the Children Act 1989 states that it is the general duty of every local authority to safeguard and promote the welfare of children within their area who are in need; and so far as it is consistent with that duty, to promote the upbringing of such children by their families. Section 17
[34] Progress notes 22 August 2016 11.34am
[35] Progress notes 9 September 2016

4.18 23 September 2016: A joint assessment was undertaken by social care and CAMHS.

4.19 26 September 2016:

During a psychological assessment, Jack reported that: “Since his boxing injury, his thoughts had progressed to harming people.” He also reported that he had taken the machete out with him as he had “intended to harm someone. He disclosed that the voice of his grandfather often moderated his actions.”[36]

- The psychologist concluded that:

“It would be a good idea to further explore the possible traits of psychopathy … which could be the reason why he did not care for others and maybe why he [enjoyed] violence.”[37]

- It was agreed that social care involvement would discontinue and Jack would be referred to adult mental health services.

4.20 29 September 2016: A fourth and final CAMHS FACE assessment was completed.

4.21 7 October 2016: A referral for a CAMHS independent forensic assessment was sent to Youth First.[38]

4.22 18 October 2016:

- One of the CAMHS consultant psychiatrists documented that there were some concerns about Jack’s cognitive functioning[39] and that he may be experiencing a “degree of depression which [may be] resulting in his limited cognitive functioning”[40].

- The entry also documented that based on Jack’s presentation, the following possible diagnosis was currently being considered:

“Antisocial personality disorder, possible learning disability, some autistic traits plus or minus depressive symptomology … we may need to consider further about the antidepressant”[41].

---

[36] Progress notes 26 September 2016 10am
[37] Progress notes 26 September 2016 10am
[38] Conducted by Youth First, which is a specialist community child and adolescent service for high-risk young people with complex needs. The service is run by Birmingham and Solihull Mental Health NHS Foundation Trust Youth First. The forensic assessment was not sent to RDaSH’s CAMHS until after the incident
[39] Cognitive functions are the core skills the brain uses to think, read, learn, remember, reason and pay attention
[40] Progress notes 18 October 2016
[41] Progress notes 18 October 2016 10.26am

4.23 Between October and December 2016, Jack was being seen by the allocated CAMHS practitioners and the psychologist. There were several occasions when Jack failed to attend some of his scheduled appointments.

4.24 3 November 2016: A referral was sent to RDaSH's adult mental health services.

1 December 2016: The adult mental health service's assessment was undertaken. The assessor concluded that he "Could not elicit any evidence of on-going mental disorder"[42] and therefore was "unable to identify any appropriate care pathway"[43] for Jack.

4.25 2 December 2016: The independent CAMHS forensic assessment was undertaken. The assessors verbally reported to the CAMHS psychologist that in their opinion, Jack may have been presenting with symptoms of an antisocial personality disorder.[44] There was no evidence of a current mental disorder that required an inpatient admission on either a voluntary or a compulsory basis.

- The psychologist asked the assessors if there was anything that CAMHS should be actioning while they were waiting for their report. The assessors advised that no additional action was required[45], but that:

"The college may want to have a more formalised plan with [Jack] in terms of his risky behaviour e.g. what would happen if he took a weapon to school."[46]

4.26 5 January 2017:

- Jack was last seen by a CAMHS practitioner. During the session Jack reported that he had lost any enjoyment in his daily activities and that he did not "care about any consequences to hurting others"[47]. However, he also:

"Strongly denied that he was having specific thoughts to harm any individual or himself … and gave assurances that he would not act upon his thoughts to harm another person"[48].

[42] Letter to GP 8 December 2016
[43] Progress notes 1 December 2016 1.28pm
[44] Antisocial personality disorder (ASPD). The diagnostic system DSM-IV characterises antisocial personality disorder as a pervasive pattern of disregard for and violation of the rights of others that has been occurring in the person since the age of 15 years, as indicated by three (or more) of seven criteria, namely: a failure to conform to social norms; irresponsibility; deceitfulness; indifference to the welfare of others; recklessness; a failure to plan ahead; and irritability and aggressiveness ASPD
[45] Progress notes 2 December 2016
[46] The assessment report was not received by RDaSH CAMHS until after the incident
[47] Progress notes
[48] Progress notes

- The CAMHS practitioner reported to Sancus Solutions' investigators that after this session, she had supervision with her line manager where it was agreed that as there was no change to Jack's risks, no further action (for example, a review of his risk assessment or care plan) was required. This discussion was not documented.

4.27 9 January 2017: The CAMHS practitioner attempted to contact Jack by phone to arrange a follow-up session. Jack did not answer, so she left a voicemail message.

The next section provides a brief summary of Sancus Solutions' investigation team's findings and recommendations with reference to the following NHS England ToR:

"Review the effectiveness of care (specifically CAMHS), treatment and services provided by the NHS and other relevant agencies from [Jack's] first contact with services to the time of the incident.

Review the appropriateness of the treatment of [Jack] in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern."[49]

5 Jack's assessment at the Accident and Emergency Department

5.1 As the chronology indicates, Jack first came to the attention of RDaSH CAMHS after he and his mother were brought to A&E by the police. While Jack was in A&E, he was assessed by two members of the adult crisis team, who partially completed a Full Needs Assessment.

5.2 Following this incident, the attending police submitted a Safeguarding Adult Alert Referral Form (CID/70) to RDaSH's adult mental health services.[50] This was forwarded to RDaSH's CAMHS' named safeguarding nurse, who was satisfied that the appropriate support was being actioned.

5.3 The Standard Operating Procedure for the RDaSH Out of Hours Service for the Children and Young People's Mental Health Services at the time directed that:

"The practitioner should complete a comprehensive and new risk assessment."[51]

[49] NHS England's ToR p1
[50] Safeguarding Adults South Yorkshire's Adult Protection Procedures CID 70
[51] Out of Hours Service for Children and Young People's Mental Health Service (CAMHS) Standard Operating Procedure (January 2014) p3. This policy has subsequently been reviewed 25 September 2018

This did not occur, and a Full Needs Assessment was only partially completed.

5.4 The Full Needs Assessment form that was being used at the time by the assessor in A&E was a generic psychosocial assessment tool that was being used for both adults and children/young people who presented at A&E. Sancus Solutions' investigation team were informed that since this incident, RDaSH have introduced a specific assessment tool for children/young people that is now being utilised in A&E.

5.5 Following the initial assessment, the A&E assessor reported, in a letter to Jack's GP, that she:

"Did not think that [Jack] posed a risk to anyone, he denied any thoughts to harm himself and he has not done so tonight. He has capacity to distinguish his own thoughts from the voices."[52]

5.6 Sancus Solutions' investigation were concerned that although the initial A&E assessment of Jack's risk to others was based on very limited information, the assessors were aware of the following very recent and significant risk factors:

- Jack had been in possession of a weapon.
- Jack had disclosed that he had a formulated plan to kill someone.
- Jack had reported that he was experiencing command audio hallucinations that were telling him to harm people.

Sancus Solutions' investigation team would suggest that all of these factors were indicating that Jack was presenting with very significant and recent risks of harm to others, which should have been highlighted in the correspondence with Jack's GP.

5.7 Sancus Solutions' investigation team would also suggest that until a more comprehensive risk assessment had been undertaken, these known and significant risk factors should have prompted the A&E assessors to identify that Jack's risk of harm to others was at the very highest level.

5.8 Although the decision by the A&E assessors to refer Jack to CAMHS was a proportionate response to his presentation. However Sancus Solutions' investigation team were concerned that the referral cited that the referral was required as Jack "was clearly in some distress due to his nightmares and lack of sleep"[53], rather than because of the very recent known and significant risk

[52] Discharge summary and Full Needs Assessment 3 July 2016
[53] A&E assessment 3 July 2016

events. All of which were indicating not only that Jack was posing a significant risk of violence and harm to others, but also that he was in a very vulnerable state of mind.

5.9 It was reported to Sancus Solutions' investigation team that when a young person who is near their 18th birthday presents at A&E, they are given the option as to whether they wish to be referred to CAMHS or adult mental health services. There is no documented evidence that Jack was given this choice, even though he was approaching his 18th birthday.

5.10 It was also reported to Sancus Solutions' investigation team by one of the adult crisis team who undertook Jack's assessment that she had and continues to have concerns about being required to undertake assessments on young patients such as Jack, as she did not feel that the team had adequate training and the required skill base.

5.11 In Sancus Solutions' investigation team's review of the Capacity Framework section of RDaSH's Standard Operating Procedure, it was noted that it does not identify specific training for adult mental health practitioners to ensure that they have the required skill base to undertake assessments of the needs and risks of young people in A&E. Sancus Solutions' investigation team would suggest that this is a deficit that needs to be addressed in order to ensure that the adult mental health practitioners who are required to undertake out-of-hours assessments on young people have the required skills and competencies.

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Recommendation 1

RDaSH should introduce either training and/or a mentoring programme for their adult mental health practitioners who are required to undertake out-of-hour assessments of young people in Accident and Emergency Departments, to ensure they have the required skills, competencies and knowledge base to undertake assessments of the needs and risks of young people.

Evidence of the introduction of this training should be provided to Sancus Solutions at their assurance review.

5.12 As Jack had not been involved in mental health services prior to this A&E admission, Jack and his mother were the only sources of information available to the A&E assessors. Sancus Solutions' investigation team would suggest that one of the issues in completing such an initial assessment is that the assessor is solely reliant on the self-reporting of the patient and any family

members who are present and cannot know how reliable they are as self-historians.

5.13 Sancus Solutions' investigation team were informed that since this incident, RDaSH's patient record system has been transferred to SystmOne[54]. One of SystmOne's facilities is that it allows healthcare professionals, such as A&E mental health practitioners, to access certain parts of a patient's other medical records, for example primary care and entries made by other RDaSH services. It was reported to Sancus Solutions' investigation team that this facility allows A&E assessors to obtain additional information about a patient to inform their initial assessment, thus enabling the formulation of a more comprehensive and accurate assessment of a patient's needs and risks.

5.14 However, it was reported by both RDaSH's practitioners and operational managers that there are still some issues in accessing information/entries made by other sectors. Sancus Solutions' investigation team were assured that these issues were currently being addressed.

5.15 Jack's primary care team reported that this facility is helpful to them, as previously they would have to wait either until they received written correspondence, such as discharge letters from A&E or a community mental health service, or until the patient presented themselves at the surgery, before they became aware of the involvement of other services or sectors.

5.16 However, it was also reported by Jack's primary care team that as there is no electronic alert facility to alert them that an entry has been made by another sector, they are still often unaware when a significant entry/event has occurred or been entered onto the system.

5.17 Sancus Solutions' investigation team would suggest that in order to resolve this issue and to facilitate prompt information sharing between services, when an RDaSH practitioner makes a significant entry – such as a risk assessment or a treatment plan – on SystmOne, they should make direct contact with the patient's primary care service to inform them that a significant new entry has been made in a patient's records. This could be done for example by email or a telephone call.

[54] SystmOne is an electronic patient record system that allows other healthcare providers, such as GPs, who use the same patient record system to access some parts of other services' patient records Systm One. Previously RDaSH was using an electronic patient records system called Silverlink Silverlink

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Recommendation 2

When RDaSH practitioners and clinical staff make a significant entry in a patient's SystmOne records, such as a risk assessment or a change in the treatment plan, they should alert the patient's primary care service, by email or telephone, that an entry has been made.

Evidence of this being introduced should be provided to Sancus Solutions at their assurance review.

6 Risk assessments and risk management

"Review the adequacy of risk assessments and risk management, including specifically the risk of the Service User harming themselves or others.

Review and assess compliance with local policies and protocols, national guidance and relevant statutory obligations."[55]

6.1 Jack was described by the involved CAMHS practitioners and the team manager who were interviewed as part of this investigation as a complex patient, and they stated that they had very limited experience of managing this type of case.

6.2 Four CAMHS FACE risk assessments were completed by CAMHS practitioners.

6.3 The following is a brief summary of the CAMHS FACE risk assessments:[56]

[55] NHS England's terms of reference

[56] The CAMHS FACE assessment directs the assessor to assess and document both a patient's historical and current risk factors and then numerically score the patient's current: Risk of violence/harm to others, Risk of suicide, Risk of deliberate self-harm, Risk of severe self-neglect and Risk of accidental self-harm. The numerical scoring available to the RDaSH assessor is as follows: 0 – No apparent risk: no history or warning signs indicative of risk. 1 – Low apparent risk: no current indication of risk, but patient's history and/or warning signs indicate possible presence of risk. Necessary level of screening/vigilance covered. Required precautions covered by standard care plan, i.e. no special risk prevention measures or plan required. 2 – Significant risk: patient's history and condition indicates the presence of risk and this is considered to be a significant issue at present, i.e. a risk management plan is to be drawn up as part of the patient's care plan. 3 – Serious apparent risk: circumstances are such that a risk management plan should be drawn up and implemented. 4 – Serious and imminent risk: the patient's history and condition indicate the presence of risk and this is considered imminent, e.g. evidence of preparatory acts. Highest priority to be given to risk prevention.

- 1 July 2016: The first CAMHS FACE risk assessment was completed after the initial CAMHS assessment.

  Assessment summary: Is there evidence of a history of significant risk behaviour: yes. Involved in [a] serious incident in the past 3 months: yes.

  Current risk status
  Risk of violence/harm to others 2 = significant risk
  Risk of suicide 1 = low apparent risk
  Risk of deliberate self-harm 1 = low apparent risk
  Risk of severe self-neglect 1 = low apparent risk
  Risk of accidental self-harm 1 = low apparent risk.

  Person(s) potentially at risk: Self. Staff members. General public. Parents.

  Clinical symptoms indicative of risk: No historic symptoms of risk were highlighted, but current risks highlighted were: "Ideas of harming others. Voices experiences or hallucinations and Impulsivity/lack of impulse control."[57]

  Narrative section: "When [Jack] hears these voices he feels like he is a host and that all he feels is angry and feels like he wants to hurt or kill someone."[58]

  Risk management plan: [Jack] was advised to talk to his family, take pain relief for his headaches and, if required, contact the Single Point of Access[59] (hereafter referred to as SPA) team or present himself at A&E.

- 22 July 2016: A second CAMHS FACE assessment was completed by one of the involved CAMHS practitioners.

  Assessment summary: remained unchanged.

  Current risk status: The following changes were made:
  Risk of violence/harm to others had been reduced to 1 = low apparent risk.
  High risk of relapse now 1 = low apparent risk.

  Person(s) potentially at risk: This remained the same.

  Clinical symptoms indicative of risk: Ideas of harming others and voices, experiences or hallucinations had both moved from current to historic. Focus and concentration difficulties were now identified as a historical risk.

[57] FACE risk assessment 11 July 2016 p2
[58] FACE risk assessment 11 July 2016 p2
[59] RDaSH's CAMHS Single Point of Access (SPA) team is responsible for triaging all the requests for support that come into the service SPA

Narrative section: “Denied hearing voices. Past symptoms of hearing voices, [Jack] was concerned that he would act on these thoughts although he did not want to and [had] contacted the police to say that he was concerned about himself.”[60]

Behaviour indicative of risk: Physical harm to others, use of carrying weapons and reckless or unsafe behaviour were now identified as being historic. Reckless or unsafe behaviour was now identified as both a historic and a current risk (neither had been identified within the initial FACE assessment).

Forensic history: Physical harm to others: Use/carrying of weapons – now identified as both a historic and a current risk.

Other risk factors/non-convicted offences: Jack “had disclosed that he will get into fights in the general public. He has said that he enjoys hurting people physically when he is fighting.”[61]

There was an additional entry that was not dated:

“Has killed animals … [Jack] stated that he does not feel any remorse in regard to his actions. [Jack] worries that he would kill a member of the public but has not made any plans to do so at present.”[62]

Risk management plan and actions to be taken in the event of risk becoming triggered: These sections were not completed.

- 24 August 2016: A third CAMHS FACE risk assessment was completed by the same CAMHS practitioner.

Assessment summary: This remained unchanged.

Current risk status: Remained unchanged, except for: Risk of violence/harm to others had increased to 2 = significant risk.

Person(s) potentially at risk: remained unchanged.

Clinical symptoms indicative of risks: Ideas of harm to others was now assessed as being both a historic and a current risk.

[60] FACE risk assessment 22 July 2016 p2
[61] FACE risk assessment 22 July 2016 p3
[62] FACE risk assessment 22 July 2016 p3

Forensic history, behaviour indicative of risk and personal circumstances indicative of risk: All risk factors and narrative sections remained unchanged.

Descriptive summary of main risks identified, person's view of risk and risk formulation: Remained unchanged.

Risk management plan and actions to be taken in the event of risk becoming triggered: These sections were not completed.

- 30 September 2016: A fourth and final CAMHS FACE risk assessment was completed by the same CAMHS practitioner.

Assessment summary: Remained unchanged.

Current risk status: High risk of relapse now increased to 2 = significant risk.

Person(s) potentially at risk: Remained unchanged, but the following narrative section was completed:

No specific person at risk
Denied plans or intentions to harm others
Denied any plans or intention to harm animals.

Clinical symptoms indicative of risk, behaviours indicative of risk and forensic history and notes: This remained unchanged apart from the following addition in the forensic history notes section:

"Reviewed 28-9-2016 [Jack] said that he wished that he had not contacted the police when he experienced command hallucinations to harm others with a machete. [Jack] said that partly this was due to being hassled by the police and that also if he had not been stopped he believed that he would have acted on his intention. When asked why he would have acted on them he replied 'to see what it felt like'."[63]

Personal circumstances indicative of risk: This remained unchanged, although the notes section documented details of Jack's recent arrest.

Care related indicators, descriptive summary of main risk identified, personal view of risk, risk formulation: These sections remained unchanged.

Risk management plan and actions to be taken in the event of risk becoming triggered: This section was not completed.

[63] FACE risk assessment 30 September 2016 p4

6.4 It was evident both within Jack's patient records and in Sancus Solutions' interviews with the majority of the involved CAMHS practitioners that very early on in their assessment of Jack, both his presentation and his potential risk factors evoked such concern that it was agreed that:

- A referral for an assessment to a Tier 4 inpatient unit was required.
- Jack would only be seen in the presence of two CAMHS practitioners (although the evidence indicates that after this decision was made, there were multiple occasions when he was seen by a single practitioner).
- A forensic assessment was required.

6.5 During 2016 and as part of the action plan for RDaSH's CAMHS Local Transformation Plan (LTP), a CAMHS FACE assessment pro forma[64] was developed and introduced. The trust also began to undertake regular weekly data quality monitoring of CAMHS FACE assessments. Sancus Solutions' investigation team concluded that the introduction of a CAMHS-specific FACE assessment[65] clearly indicated RDaSH's understanding of the importance of developing a risk assessment tool that provided greater levels of scrutiny and an ongoing and coordinated multidisciplinary approach to the identification, assessment and management of risk as an integral part of the child/young person's overall treatment plan.

6.6 Both RDaSH's risk and care planning policies and their FACE risk training literature emphasised that as part of their duty of care, practitioners and managers should be utilising the trust's FACE assessment tool to:

- document and consider historic and current risk factors to inform their ongoing clinical formulations and judgements
- provide a narrative of all risks identified
- identify who was at risk, to consider and document what actions were required to minimise such risks
- highlight protective factors

---

[64] FACE is a portfolio of assessment tools designed for adult and older people's mental health settings. It includes both screening and in-depth levels of assessment. The tools meet both CPA and Health of the Nation Outcome Scales requirements. Five sets of risk indicators are coded as present or absent, and then a judgement of risk status (0-4) in seven areas (including violence, self-harm and self-neglect) is made. Scope for service user and carer collaboration is built into the system. Best Practice in Managing Risk

[65] Functional Analysis of Care Environments (FACE) tool developed for calculating risks for people with mental health problems, learning disabilities and substance misuse problems. The FACE approach to outcomes is to embed outcome measurement in routine practice rather than treat it as a separate parallel activity. Consequently, outcome measures are included within the FACE assessment tools so that measures of outcome can be readily derived from our tools. FACE outcome measures include measures of health and social well-being, quality-of-life outcomes measures, PROMs (patient-reported outcome measures) and personal goal achievement FACE

- develop a risk formulation and management plan.

  RDaSH's policies and training reiterated that all of the above had to be reviewed when the situation changed and/or when new information was obtained.

6.7 The policy also directed that all FACE risk assessments:

"Should be developed by multidisciplinary and multi-agency teams, operating in an open, democratic and transparent culture that embraces reflective practice and supports their patients in their recovery"[66].

6.8 What was clearly evident to Sancus Solutions' investigation team in their review of the assessment, documentation and management of Jack's known risks was that although it was well documented that the involved CAMHS practitioners promptly identified that Jack was presenting with considerable and multiple risk factors, there were many significant and concerning deficits in the CAMHS FACE assessments that were completed. For example:

- Jack's known risks were not being consistently documented and considered.

- Significant and multiple sections of the FACE assessments were not completed.

- There was inconsistency between the successive CAMHS FACE assessments with regard to the documentation of both the known previous historic risks and emerging current risks.

- Risks that were highlighted as being either historic or current were not being consistently documented or fully explained within the respective narrative sections.

- There was no documented evidence to indicate if Jack's parents or his siblings were asked to contribute, without Jack being present, to the CAMHS FACE assessments.

- There was no obvious rationale for when the CAMHS FACE assessments were being reviewed, despite additional and ongoing disclosures being made by Jack and his parents.

- The last FACE assessment was completed on 30 September 2016, and it was not reviewed again despite ongoing and new disclosures being made by Jack and his parents, or in response to the psychiatric and psychological

[66] RDaSH's Clinical Risk Assessment and Management Policy March 2015 p4

assessments that were subsequently undertaken. For example, the EIP speciality doctor who concluded that Jack was presenting with a:

"Callous unconcern for [the] feelings of others … Gross and persistent disregard for social norms … very low tolerance to frustration and a low threshold for discharge of aggression including violence … I would suggest that urgent consideration is given to managing [Jack's] current risk and as to whether these can be safely managed in the community."[67]

As this was the only comprehensive psychiatric assessment undertaken, Sancus Solutions' investigation team would suggest that it should have triggered an immediate review of Jack's CAMHS FACE assessment.

6.9 RDaSH's risk training guidance stated clearly that:

"It is important that the descriptions [of risks] are as detailed and objective as possible, and that they indicate the source of the information … and whether there is direct evidence for the risk behaviour … or whether, in the absence of such direct evidence, which behaviours or attitudes give cause for suspicion or concern … Where possible provide objective detail in respect of the behaviour, its circumstances and setting conditions; whether, in respect of previous risk behaviour, there were at the time, any 'warning signs'; when and/or over what period it occurred; and other people involved as victims or perpetrator."[68]

6.10 Given the emerging and potentially serious nature of Jack's risks to others, the CAMHS FACE assessments should have been regularly reviewed by both a senior manager and the involved consultant psychiatrists to ensure that his developing risks were being adequately documented and considered and that the appropriate actions were being taken in order to attempt to mitigate the risks to Jack, his family and the general public. Reviews would also have helped to ensure that Jack and his family were being provided with the appropriate support.

6.11 Sancus Solutions' investigation team concluded that not only were the completed CAMHS FACE assessments non-compliant with RDaSH's policy and training guidance, but also as the emerging picture of Jack's escalating and concerning risk factors developed, there should have been ongoing and comprehensive reviews of Jack's CAMHS FACE assessments.

[67] Entry in progress notes 23 August 2016 1.14pm
[68] Taken from RDaSH's Important Information When Completing FACE Risk Profiles briefing

7 Risk management plans

7.1 Apart from the initial CAMHS FACE assessment, the assessments of Jack did not have risk management plans in place, and they were not reviewed at each CAMHS FACE assessment or when additional risk information became apparent, for example when photographic evidence confirmed that Jack had killed animals.

7.2 RDaSH policy clearly stated that:

"The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the patient in response to crisis."[69]

7.3 It was evident to Sancus Solutions' investigation team that rather than using the CAMHS FACE assessment pro forma, practitioners were using Jack's patient records to document his risks, protective factors and risk safety plans.

7.4 Sancus Solutions' investigation team would suggest that this unstructured and inconsistent approach to risk identification/assessment/documentation and risk planning meant that important risk information and risk planning was not accessible to the involved CAMHS practitioners and service managers without a time-consuming interrogation of Jack's patient records.

Risks to Jack's family

7.5 It was consistently identified within the CAMHS FACE assessments that were completed that Jack's parents were 'persons potentially at risk'. However, there was no detailed documentation as to what this risk might be or what actions were needed to mitigate the potential risk. There was also no evidence to indicate if the risks were discussed with Jack's parents.

7.6 Additionally, as Jack's parents were considered to be potentially at risk, Sancus Solutions' investigation team would suggest that his siblings should also have been identified as being at risk, as it was known that a number of them were living in the family home and they were a significant part of their brother's support structure.

7.7 Sancus Solutions' investigation team concluded that a full description of the potential risks to all of the members of Jack's family should have been documented in the successive CAMHS FACE assessments. Additionally, risk management plans should have been completed, with actions to mitigate the identified risks to Jack's parents and siblings.

[69] RDaSH's Clinical Risk Assessment and Management Policy March 2015 p19

8 Animal cruelty

8.1 Since the 1970s, research has consistently reported that childhood cruelty to animals should be viewed as "the first warning sign of later delinquency, violence, and possible future criminal behaviours"[70]. Some research has also cited the following motive(s) in children harming animals:

- "Mood enhancement: animal abuse is used to relieve boredom or depression
- Posttraumatic play (i.e., re-enacting violent episodes with an animal victim)
- Rehearsal for interpersonal violence (i.e., 'practicing' violence on stray animals or pets before engaging in violent acts against other people)"[71].

8.2 Clearly, such research is not suggesting that every child who expresses such thoughts or who is known to have hurt animals is either being abused or will commit serious juvenile and/or adult criminality. However, what such research and guidance are advising is that when such disclosures are being made, they should be viewed as a red flag [72] and prompt further investigation and/or assessment.

8.3 Jack's recent history of cruelty to animals was being comprehensively documented in both his CAMHS patient records and in the social care assessment.[73] The latter concluded that Jack "displays elements of control and power in relation to his animal killing, releasing a self-thrill once he has killed".[74]

8.4 Until photographic evidence was obtained of the animals that Jack was reporting that he had killed, there was uncertainty being expressed by both the CAMHS practitioners and his mother regarding the validity of Jack's disclosures.

8.5 Jack's mother was asked, on a number of occasions, to obtain evidence of her son killing animals; however, Sancus Solutions' investigation team would suggest that given the complex dynamic within the family in response to what were clearly their escalating concerns about Jack's mental health and the consequences of his actions – for example, police involvement and possible prosecution – it was perhaps understandable that Jack's mother repeatedly avoided looking for this evidence.

---

[70] Children who are cruel to animals
[71] Children who are cruel to animals
[72] Children who are cruel to animals
[73] Social care assessment 26 August 2016
[74] Social care assessment 26 August 2016

8.6 Sancus Solutions' investigation team concluded that the CAMHS practitioners should not have asked Jack's mother to obtain the evidence; rather, they should have immediately reported Jack's disclosures to the police and/or the RSPCA, whose role it was to investigate such potential crimes.

8.7 It was noted that until Jack's last appointment, when he disclosed experiencing bullying and possible grooming by a local known paedophile, he had not made any disclosures regarding traumatic or abusive childhood experiences. Sancus Solutions' investigation team suggest that this disclosure should have alerted the involved practitioners and managers to the possibility that Jack had been a victim of abuse and that there was a connection between the killing of animals and possible childhood trauma. These disclosures should have prompted more inquiry but also a review of Jack's CAMHS FACE risk assessment.

9 Information sharing

9.1 RDaSH's Clinical Risk Assessment and Management Policy at the time repeatedly reiterated the importance of involving and communicating with other agencies in the assessment of risk. It stated:

"Patient risk assessment is a dynamic and continuous process. Involvement of the patient (and where possible their families or significant others), advocates, and practitioners from a range of services and organisations will help to improve the quality of risk assessments and decision-making."[75]

9.2 One of the recommendations in the Royal College of Psychiatrists' Rethinking Risks report was that:

"Communication of the risk-management plan between teams, services and agencies is essential. Timely communication with primary care regarding the treatment plan, including any risk-management issues of critical importance, should include details of risk to self, or others, diagnosis, treatment, indicators of relapse and communication of any interventions that may mitigate identified risks. The details of any agreed risk-management plan are equally vital."[76]

9.3 Although there was evidence that the CAMHS practitioners had some verbal communication with Jack's college, there was no evidence that any of the other involved agencies, such as Jack's GP and his college, were asked to contribute to the CAMHS FACE assessments.

9.4 Prior to the forensic assessment, the only direct communication with the college was made on 24 November 2016 by the psychologist, who outlined

[75] RDaSH's Clinical Risk Assessment and Management Policy March 2015 p10
[76] Rethinking Risk p6

the findings and conclusions from the various psychological assessments that were undertaken in September 2016.

9.5 Sancus Solutions' investigation team also noted that communication from CAMHS to Jack's GP was very intermittent, and what correspondence there was did not provide a comprehensive account of the CAMHS FACE risk assessments that were completed, the emerging risks or the CAMHS practitioners' increasing concerns regarding Jack's disclosures.

9.6 Only the letter from the EIP speciality doctor provided a precise and detailed summary of the risks identified and assessed. The letter concluded that:

"I would suggest that urgent consideration is given to managing [Jack's] current risks and as to whether these can be safely managed in the community."[77]

Despite this level of concern being expressed, it did not prompt any further direct communication between CAMHS and Jack's GP as to how this risk was to be managed by both agencies.

9.7 Although this report focuses on the role and responsibility of RDaSH's services, Sancus Solutions' investigation team would suggest that all the other involved agencies had a statutory responsibility for both sharing information and participating in developing a multi-agency approach to the management of Jack, who was presenting with mental health difficulties and who it was assessed on several occasions may have been presenting a risk to others. All of the involved services could have initiated a dialogue between the involved agencies in order to facilitate the sharing of risk information and to agree a multi-agency strategy and support structure for both Jack and his family.

10 Management and supervision

10.1 As has already been stated, some of the involved practitioners reported that they recognised that Jack was presenting with very complex and unfamiliar risk factors. Nevertheless, Sancus Solutions and the authors of RDaSH's SIR have concluded that there were significant deficits in the assessment, documentation and management of Jack's risk factors. This has led Sancus Solutions' investigation team to interrogate the role of the service's management team who were providing the supervision and to review the policies and quality assurance processes that were in place at the time.

[77] Letter to GP 24 August 2016 p4

10.2 There were three occasions when CAMHS' senior operational manager was made aware of concerns that were being expressed with regard to Jack's risks:

- When it was decided that such were the concerns regarding Jack's risks that a forensic assessment was required. Although nothing was documented, it has been assumed that the service's management team would have had to have given their approval for funding to have been sought from RDaSH's Clinical Commissioning Group (hereafter referred to as CCG). Therefore, they would have been alerted to the concerns regarding Jack's recent history and potential risk factors.

- On 31 October 2016, when the psychologist documented that she had discussed Jack's non-attendance at his scheduled appointments with CAMHS' operational manager. It was agreed that they would "follow the disengagement policy and notify the referrers and inform the police that [Jack] had disengaged from the service"[78].

- On 5 January 2017, when, following the last meeting with Jack, CAMHS practitioner 2 reported that she had a supervision session with the service's operational manager where she discussed Jack's presentation and both his new disclosures and his mother's report that her son was "still experiencing thoughts to harm animals and people and the urge [was] getting harder to control"[79].

  Sancus Solutions' investigation team would suggest that all of the above were opportunities for the service manager to have comprehensively reviewed Jack's presentation, his risk assessments and the overall management of this case. If this had been undertaken, the service manager would have been able to identify that:

- The CAMHS FACE assessments were not being systematically completed and their content and quality were non-compliant with RDaSH's policies and guidance.

- There was a lack of interagency communication.

- No CAMHS FACE assessments were completed after 30 September 2016.

10.3 The CAMHS practitioner reported that following her last meeting with Jack, she had discussed him in a supervision session with her line manager and the

[78] Progress notes 31 October 2016 11.30am
[79] Progress notes 3 January 2017 10.59am

decision was made that there was no action required with regard to risk management. This was despite Jack disclosing that he had :

- Been a victim of historical and previously unidentified sexual abuse.
- Recently been involved in an incident where he had used significant physical force against a peer.

In addition, prior to the meeting, Jack's mother had expressed her concerns about her son's urges, which she reported "were getting harder to control"[80]. This was a significant disclosure, as it was well documented that previously, Jack's mother had often minimised or denied her son's potential risks. Additionally, the CAMHS team were waiting for the results of the forensic assessment.

10.4 The decision made in this supervision session that no further action was required was not documented. RDaSH's Clinical Supervision Policy clearly states that when a patient is discussed in supervision:

"Supervisees must make entries into individual patient/client case notes of any action plans discussed pertaining to that individual."[81]

10.5 Sancus Solutions' investigation team would suggest that all these factors should have alerted the supervisor, who was the CAMHS operational manager, to the fact not only that Jack's risks had previously been insufficiently assessed but also that the emerging risk information required a formal and immediate review of Jack's CAMHS FACE assessment and that consideration should have been given to arranging a further psychiatric assessment.

10.6 At the time, RDaSH's Clinical Supervision Policy stated that one of the functions of clinical supervision was to identify and manage clinical risk:

"The identification and management of clinical risk is a key Trust responsibility and is achieved through an on-going process of assessment to identify any potential harm to patients, staff and the public. The process is on-going and dynamic, and for it to be truly effective, all members of the multi-disciplinary team involved in the patient's care need to contribute … Managers should use these arrangements to ensure all team members are confident and competent in undertaking clinical risk assessments, and they should address any development needs that may arise."[82]

[80] Progress notes 3 January 2017
[81] Supervision of Clinical Staff Policy p8
[82] Supervision of Clinical Staff Policy p7

10.7 It was repeatedly reported to Sancus Solutions' investigation team that there had been frequent discussions within the team about Jack's presentation, his risk factors and what action was to be taken. Although Sancus Solutions' investigation team does not doubt that these discussions occurred, the lack of documented evidence has meant that it has not been possible to validate this information.

10.8 Sancus Solutions' investigation team were of the opinion that the evidence is indicating that not only was there inadequate assessment and documentation of Jack's risks, but there was also inadequate managerial supervision of this case. Sancus Solutions' investigation team agree with the conclusion reached by the authors of RDaSH's Serious Incident Report[83] that:

"The risks posed by [Jack] were not shared, coordinated or collectively managed by those directly involved in providing care and treatment. In particular escalation of risk that occurred early January 2017 was not shared outside of discussion with the pathway lead, [and] the lack of risk management plans resulted in no guidance on what to do in a situation of escalated risk."[84]

11 RDaSH risk audits[85]

11.1 RDaSH's Clinical Risk Assessment and Management Policy identified that the responsibility for effective management of clinical risk is delegated to the Director of Nursing and Quality, who liaises with the Care Group Directors and the Medical Director. The Quality Assurance Sub-Committee is responsible for:

- the authorisation of clinical risk assessment and management tools/processes used within the trust
- undertaking an annual review of the above
- commissioning an annual audit of the implementation of the policy.

[83] After the incident RDaSH commissioned a level 2 investigation, which was undertaken by an independent investigator
[84] RDaSH SIR p67
[85] RDaSH's Clinical Risk Assessment and Management Policy identified that the responsibility for effective management of clinical risk is delegated to the Director of Nursing and Quality, who liaises with the Care Group Directors and the Medical Director. The Quality Assurance Sub-Committee is responsible for the authorisation of clinical risk assessment and management tools/processes used within the trust, undertaking an annual review of the above, and commissioning an annual audit of the implementation of the policy.

11.2 Sancus Solutions' investigation team were provided with the two CAMHS clinical risk audits that RDaSH have undertaken since this incident.[86]

The first audit report was published in August 2016: "15 records were audited across the 3 localities. Records were audited against a set of core questions based on Trust policies, previous audit results and action plans, recurrent issues raised through CQC Inspections and from Trust data sources such as incidents, complaints and claims etc."[87] The outcome of this audit was 'inadequate'. The CAMHS service involved with Jack was not part of this audit.

- The second audit[88] was an extensive audit[89] and covered the CAMHS service involved with Jack. A random sample of patient records[90] was reviewed as well as the risk training records for the respective teams.[91] The audit concluded that the overall rating was "76.1% – requires improvement, poor results were achieved in relation to patients having risk management plans."[92]

- The most significant deficit that Sancus Solutions' investigation team noted from this audit was the risk training undertaken by the CAMHS practitioners involved with Jack: only 12 of the clinical practitioners had received risk training in the last three years, and out of "40 staff members who had not had the training, [only] 12 were booked on"[93] to the next training event.

  RDaSH's policy stipulates that risk training is mandatory for all clinical staff at their induction and subsequently every three years. However, there was no explanation or analysis within the audit report as to why there was such low attendance on what is mandatory training within the CAMHS service.

11.3 It was reported to Sancus Solutions' investigation team and also documented as an ongoing action in RDaSH's latest Serious Incident Report (August 2018) that the CAMHS Clinical Pathway leads are currently "dip testing … records which indicate that FACE risk assessments are being completed … [There is] continued discussion within team meetings, leadership meetings

[86] The first audit did not include the CAMHS service involved with Jack
[87] RDaSH audit report August 2016
[88] Published in October 2018
[89] With a total of 249 records being audited across the 28 teams/wards
[90] The CAMHS service involved with Jack was part of this audit. In total, 40 patient records were audited
[91] The objectives of the audit were to ensure: "That risk assessments are current and fully completed. That historical risk has been considered. That all identified risks are transferred into the relevant Risk Management Plan, which should be fully completed. That the patient and carers' views of current clinical risk are considered and recorded. That patients who are having an episode of leave, or being prepared for discharge, have their Risk Assessments updated to reflect this. That the risk factors/warning signs have been completed. That all staff have relevant Clinical Risk Assessment training i.e. STORM."
[92] RDaSH audit report October 2018 p2
[93] RDaSH SIR p68

and supervision, [and] where there have been any inputting errors training is provided for individual practitioners."[94]

11.4 It was clearly evident to Sancus Solutions' investigation team that since this incident and the publication of RDaSH's Serious Incident Report, there has been a considerable amount of senior management monitoring of compliance within CAMHS with regard to the standard of risk assessment and risk management. However, Sancus Solutions' investigation team were concerned that during their interviews, most of the involved practitioners and managers failed to identify that their assessments, documentation and management of Jack's risks were inadequate and, moreover, non-compliant with RDaSH's policies and best practice guidelines. Therefore, Sancus Solutions' investigation team were concerned that the lessons learnt within RDaSH's Serious Incident Report do not appear to have prompted any further learning or reflection by those involved practitioners.

11.5 One of the reasons why this report has undertaken such an extensive review of and commentary on the assessments and management of Jack's risks by RDaSH's CAMHS is that Sancus Solutions' investigation team have concluded that it was the central contributory factor that led up to the incident. As to whether there was a direct correlation between these deficits and the incident that occurred in January 2017, this will be discussed in the preventability and predictability section of this executive summary report.

11.6 Sancus Solutions' investigation team have made a recommendation in this report that will enable RDaSH to gain a more in-depth understanding of how risk is being identified, assessed and managed within the involved CAMHS.

11.7 Potentially Dangerous Person (PDP)[95]Given the challenges that Jack was presenting to CAMHS, Sancus Solutions' investigation team were of the opinion that consideration should have been given to reporting Jack to the police as a PDP, as he clearly met the following referral criteria for a PDP:

"Where a community psychiatric nurse (CPN) shares information with the police that a patient with mental ill health has disclosed fantasies about committing serious violent offences. The patient is not cooperating with the current treatment plan, and the CPN believes serious violent behaviour is imminent."[96]

11.8 Such a course of action would have been helpful, because as part of their responsibility the police would have developed an intelligence profile and

[94] RDaSH action plan August 2018 p4
[95] A PDP is a person who is not currently managed in one of the three multi-agency public protection arrangements (MAPPA) categories, but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm. PDP
[96] PDP

coordinated a multi-agency risk assessment. Such an assessment would have included the identification and assessment of:

- "the nature and pattern of the individual's behaviour
- the nature of the risk
- who is at risk (e.g. particular individuals, children, vulnerable adults)
- the circumstances likely to increase risk (for example, issues relating to mental health, medication, drugs, alcohol, housing, employment, relationships)
- the factors likely to reduce risk
- all relevant medical evidence available and consideration of whether there is a reasonable medical explanation for the behaviour displayed"[97].

11.9 Additionally, if Jack had been referred and accepted as a PDP, a risk management strategy would have been developed by the police and other involved partner agencies, who would have be able to share information, manage the ongoing risks, and provide additional criminal justice support to both Jack and his family.

The next section will address the following NHS England ToR:

"Review the appropriateness of the treatment of [Jack] in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern. Review and assess compliance with local policies and protocols, national guidance and relevant statutory obligations."[98]

12 Psychiatric and psychological involvement

12.1 Over the course of RDaSH's CAMHS' involvement with Jack and his family, three CAMHS consultant psychiatrists and an EIP speciality doctor were involved in the assessments and treatment of Jack. Sancus Solutions' investigation team were informed that the allocation of a psychiatrist was usually made based on the area that the patient was resident in. However, in this case, due to various holiday periods being taken by the allocated locality psychiatrist, Jack was assessed and monitored by the available CAMHS consultant psychiatrists.

12.2 In Sancus Solutions' investigation team's opinion, it was evident that there were inconsistencies in relation to the various CAMHS consultant

[97] PDP
[98] NHS England's terms of reference

psychiatrists' assessments and their responses to Jack's presenting risk factors and mental health symptoms. For example:

- Such were the concerns regarding Jack's presenting risks that one of the involved CAMHS consultant psychiatrists directed that a referral should be made for a Tier 4 assessment (18 August 2016). This did not occur and there was no documented evidence to indicate why a Tier 4 referral was not made.

- One of the CAMHS consultant psychiatrists made the decision to trial the antipsychotic risperidone, yet at the next appointment, another CAMHS consultant psychiatrist concluded that Jack was not presenting with any identified mental health issues and stopped this medication.

- There also appeared to have been no documented action taken by the involved CAMHS consultant psychiatrists in response to the EIP speciality doctor's advice that consideration needed to be given to whether Jack's risks "could safely be managed in the community"[99].

12.3 Sancus Solutions' investigation team concluded that although this multi-psychiatric involvement was unavoidable, it resulted in no one CAMHS psychiatrist developing and maintaining a longitudinal overview of Jack's presentation, treatment plan and escalating risk factors.

12.4 The only clinical overview that was being maintained was by the psychologist, who clearly made considerable efforts to assess Jack from a psychological perspective. She also secured the funding from the CCG and made considerable efforts to coordinate the forensic assessment.

Clinical meetings

12.5 There was only one record of Jack being discussed at the weekly clinical meeting led by CAMHS consultant psychiatrist 2[100]. At this meeting it was agreed that a further assessment of Jack's risks was required and that he would be discussed at the next clinical meeting. There was no further documented evidence to indicate if Jack was discussed at the next or subsequent weekly clinical meetings led by any of the involved CAMHS consultant psychiatrists.

12.6 It was reported to Sancus Solutions' investigation team that since this incident, the CAMHS service now have monthly complex patient meetings where patients who, like Jack, are presenting with complex care and risk concerns are discussed. These meetings are attended by adult and CAMHS mental health services, operational managers, safeguarding professionals,

[99] Progress notes copy of letter to Jack's GP dated 23 August 2016
[100] 2 August 2016

and clinicians. Other agencies, such as the police or social care, who are involved with a patient, are also invited to attend.

12.7 Sancus Solutions' investigation team were also informed that the three CAMHS consultant psychiatrists chair a weekly clinical meeting. The purpose of this meeting structure is to:

"Provide an arena whereby clinical staff can obtain a multi-disciplinary perspective on their cases … to promote effective care planning and risk management for clinical cases"[101].

12.8 However, it was reported by one of the CAMHS consultant psychiatrists that attendance at these meetings still remains inconsistent; therefore, it is difficult to develop and maintain a consistent overview of the patients. Clearly, the lack of capacity among CAMHS practitioners, including the CAMHS safeguarding nurse, to attend these clinical meetings is an issue that needs to be addressed.

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Recommendation 3

RDaSH should undertake a review of the current CAMHS weekly clinical meetings in order to facilitate the attendance of the practitioners and the CAMHS named professional safeguarding children officer.

Evidence of a review of the clinical meetings should be provided to Sancus Solutions at their assurance review.

12.9 One of the observations made by Sancus Solutions' investigation team was that it was reported that such were the concerns about Jack that he was regularly being discussed within the office setting, and some decisions were made in this informal setting without being fully documented in Jack's patient records. Sancus Solutions' investigation team would suggest that this culture is poor practice and lacks any governance structure. Sancus Solutions' investigation team would suggest that if a more robust and accessible weekly meeting structure was in place, it would provide a venue to facilitate discussions and decision making as well as routine monitoring of patients and the decisions that are being made.

[101] Rotherham CAMHS Clinical Meeting document December 2014 and revised January 2016 p1

13 Diagnosis

13.1 Throughout Jack's presentation to CAMHS, it was being documented that both he and his parents reported that since he was a child, Jack had had difficulty in regulating his emotional responses to situations, which often manifested itself in episodes of aggression and impulsivity. Jack also disclosed that from a young age, he had been killing small animals and that in the months preceding the incident these urges were escalating to fantasies about harming other people.

13.2 During the course of CAMHS' involvement, a number of mental health diagnoses were being considered/suggested:

- early onset psychosis (11 August 2016)
- impulse-control disorder (19 August 2016)
- emerging dissocial personality disorder[102] (16 August and 18 October 2016).

13.3 Other differential diagnoses were also being considered, such as learning disability, autistic traits and plus or minus depressive symptomology (10 October 2016). It was also assessed that Jack appeared to lack empathy or remorse for his actions.

13.4 The independent forensic assessment concluded that they could not confirm a personality diagnosis without further assessments being undertaken.

13.5 Although a definitive diagnosis may have been helpful, Sancus Solutions' investigation team would suggest that the priority was to identify and understand Jack's emerging risks, support needs and to provide the appropriate therapeutic and, if deemed necessary, pharmaceutical interventions.

14 Therapeutic interventions

14.1 Although it was documented that Jack was presenting with a significant degree of distress and anxiety, apart from the regular meetings with the CAMHS practitioners and Jack being provided with some Dialectical Behaviour Therapy (DBT)[103] worksheets, there was no further reference to

[102] The Diagnostic and Statistical Manual 5th Edition (DSM-V) excludes adolescents from a personal disorder diagnosis before the age of 18 years DSM and the International Classification of Diseases 10th edition (ICD) excludes this diagnosis before the age of 16 or 17 years ICD

[103] Dialectical behaviour therapy (DBT) is a specific type of cognitive-behavioural psychotherapy developed in the late 1980s by psychologist Marsha M. Linehan to help better treat borderline personality disorder. Since its development, it has also been used for the treatment of other kinds of mental health disorders NICE DBT

any type of ongoing psychological therapeutic intervention being considered or provided to Jack.

14.2 The National Institute for Health and Care Excellence[104] 2013 (hereafter referred to as NICE) recommends that for young people between the ages of 11 and 17 years who are presenting with symptoms of antisocial and conduct disorders, consideration should be given to providing a multimodal intervention and multi-systemic therapy. This involves both the child/young person and their parents/carers, as the latter's participation is viewed as:

"An important part of the intervention because the focus is on changing the environment around the young person, which can then help to change the young person's behaviour"[105].

14.3 There was no documentation to indicate that consideration was given to providing Jack and his family with this type of therapeutic intervention.

14.4 It was reported to Sancus Solutions' investigation team that due to Jack's age, the fact that he was to be referred to adult mental health services and the fact that CAMHS were waiting for the forensic report to be undertaken, the focus was not on providing therapeutic interventions but on undertaking various psychological assessments and maintaining his and others' safety.

14.5 However, Sancus Solutions' investigation team concluded that given that there was such a delay in securing a forensic assessment and when it was reported to CAMHS that Jack did not meet the criteria for adult mental health services. The only service that was in a position to provide him with therapeutic interventions, however short term, was CAMHS, and therefore consideration should have been given to accessing more psychological and therapeutic support – such as psychoeducational therapy on the nature of his episodes of stress-induced psychosis, and/or emotional literacy therapy – to help him to develop his emotional literacy, identify his triggers and support him to develop more appropriate ways of managing his anger. However, it was reported that RDaSH CAMHS does not provide multi-systemic therapies.

14.6 It was consistently documented that Jack was being encouraged by the involved CAMHS practitioners to use boxing as a distraction technique. This was despite Jack disclosing, on several occasions, that he enjoyed hurting his opponent. Sancus Solutions' investigation team would suggest that far from this activity being therapeutically beneficial, it was actually encouraging him

[104] The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE
[105] NICE

and providing him with the opportunity to experience what he described as "a thrill of hurting other people during the fights"[106].

15 Pharmacological interventions

15.1 As has already been stated, on 11 August 2016 one of the involved CAMHS consultant psychiatrists prescribed Jack a course of the atypical antipsychotic medication risperidone[107] (0.5mg). The entry in Jack's patient records stated that the treatment plan was for Jack to continue taking the risperidone and that this would be reviewed in four weeks' time.[108]

15.2 One of the involved CAMHS practitioners documented (17 August 2016) that it was hoped that this medication would "decrease his arousal levels regarding agitation and possible violence"[109]. However, there was no documented evidence that the reason for this course of treatment was explained to either Jack or his parents.

15.3 The British National Formulary for Children (hereafter referred to as BNFC)[110] states that risperidone is licensed for short-term treatment (up to six weeks) of persistent aggression in children and young people who are presenting with symptoms of conduct disorder.[111]

However, the BNFC's suggested time frame was not followed, as the treatment was withdrawn on 4 September 2016 by another CAMHS consultant psychiatrist.

15.4 The NICE guidelines at the time also stated that:

"Pharmacological interventions should not be offered for the routine management of behavioural problems in children and young people with a conduct disorder. … Risperidone may be considered for the short-term management of severely aggressive behaviour in children and young people with a conduct disorder who have problems with explosive anger and severe emotional dysregulation and which has not responded to psychosocial interventions."[112]

---

[106] Progress notes 11 August 2016
[107] The British National Formulary for Children (BNFC) states that risperidone is licensed for short-term treatment (up to six weeks) of persistent aggression in children and young people who are presenting with symptoms of conduct disorder
[108] Progress notes entry 30 August 2016
[109] Progress notes entry 17 August 2016
[110] The British National Formulary for Children is the standard UK paediatric reference for prescribing and pharmacology, among others indications, side effects and costs of the prescription of all medication drugs available on the National Health Service. BNFC
[111] Conduct disorders are characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations. NICE
[112] NICE

15.5 As has already been documented, there was little in the way of psychosocial or therapeutic interventions being provided to Jack prior to this medication being prescribed.

15.6 The NICE guidance also recommended that:

- Prior to commencing this medication, there should be a comprehensive assessment and diagnosis as well as a baseline physical health review.[113]

- The patient's response to this new medication, especially during the initial titration period, should be monitored and documented.[114]

- The prescribing physician should record the indications and expected benefits and risks as well as the expected time for a change in symptoms and possible side effects, and the patient and their parents/carers should be advised of the symptoms of neuroleptic malignant syndrome.[115]

15.7 Sancus Solutions' investigation team were unable to locate any evidence to indicate if any baseline physical health checks were completed prior to Jack being prescribed risperidone. Neither was there any documented evidence that any ongoing monitoring of Jack's response to the medication – either physically or in terms of a reduction in his mental health symptoms – was being undertaken by the prescribing physician.

15.8 Sancus Solutions' investigation team could also find no documented evidence to indicate if Jack or his mother were asked, prior to the medication being stopped, about his compliance or whether they had observed any positive benefits or negative side effects.

16 Communication with Jack's GP

16.1 Sancus Solutions' investigation team noted that a letter to Jack's GP, advising them of the prescribing of risperidone, was dated 18 August 2016, but the GP surgery's date stamp indicated that the letter was received on 5 September 2016.

16.2 There was no evidence that the GP was informed of the decision to stop the risperidone.

16.3 It was noted by Sancus Solutions' investigation team that all the correspondence from CAMHS to Jack's GP had a significant time lapse

[113] That included: weight and height; pulse and blood pressure; various blood tests – for example, fasting blood glucose; neurological assessment; and lifestyle assessments – for example, physical activities and nutrition
[114] Titration is the process of determining the medication dose that reduces your symptoms to the greatest possible degree while avoiding as many side effects as possible
[115] Neuroleptic malignant syndrome (NMS) is a life-threatening idiosyncratic reaction to antipsychotic drugs characterised by fever, altered mental status, muscle rigidity and autonomic dysfunction. NMS

between the date on the CAMHS letter and when it was date-stamped by the GP's surgery. Clearly, such a delay in the GP receiving important information, such as commencing or terminating medication, is concerning, as they have the primary and ongoing responsibility for their patients and for the identification and monitoring of possible side effects.

16.4 A patient's GP also needs to be alerted so that they can consider possible contraindications with other medication that they may prescribe to the patient. Therefore, Sancus Solutions' investigation team would again suggest that email correspondence should be used to promptly alert a patient's GP to any prescribing or cessation of medication by a CAMHS physician (recommendation 2).

17 Care planning

This section addresses the following NHS England ToR:

"Examine the effectiveness of the Service User's care plan including the involvement of the service user and the family."[116]

17.1 Jack was allocated a care coordinator from the CAMHS service, although from December 2016 she was unavoidably absent and another CAMHS practitioner assumed this role.

17.2 As has already been stated, Sancus Solutions' investigation team were of the opinion that given the complex risk factors that Jack was presenting and until the outcome of the forensic assessment had been obtained, the role of care coordinator for Jack should have been held either by someone at senior service manager level or by one of CAMHS' consultant psychiatrists. Additionally, as concerns about Jack's potential risks of harm to others became more apparent, and the delay in obtaining a forensic risk assessment continued, CAMHS should have been convening multi-agency meetings to monitor Jack's escalating risk factors and to review the support that was being provided. All the involved agencies – the GP, the college, the police and the RSPCA – should have been invited to attend, and a multi-agency risk management plan should have been developed.

17.3 There were only two entries on Jack's care plan:

- First care plan – this was not dated but appears to have been completed sometime in June 2016 and was only partially completed. For example, the sections 'plan to manage risk', 'crisis contingency plans' and 'how, when and

[116] NHS England ToR p1

where' were not completed. There was no date documented as to when the plan was to be reviewed.

- Second care plan –was only partially completed and was a direct copy of some sections from the CAMHS FACE assessment.

  There was no evidence to indicate if Jack, his family or the other involved agencies were asked to contribute to either care plan.

17.4 The NICE guidance on the management and support of children/young people with conduct disorders and their families emphasises the importance of comprehensive care planning. The guidance directs that care planning should involve the child or young person and their parents or carers and any other involved agency. The care plan should also include:

"A profile of their needs, risks to self or others, and any further assessments that may be needed. This should encompass the development and maintenance of the conduct disorder and any associated behavioural problems, any coexisting mental or physical health problems and speech, language and communication difficulties … any personal, social, occupational, housing or educational needs, the needs of parents or carers [and] the strengths of the child or young person and their parents or carers."[117]

17.5 Sancus Solutions' investigation team were informed that CAMHS do not use the Care Programme Approach[118] (hereafter referred to as CPA) that is used in the trust's adult mental health services.

17.6 RDaSH's Care Programme Approach Policy (hereafter referred to as CPA) clearly outlines how clinical assessment and care planning need to be assessed and documented within the CPA; however, it does not address care planning within RDaSH's CAMHS. Therefore, Sancus Solutions' investigation team does not have a point of reference to comment on the care plans that were developed for Jack. Nevertheless, it was evident that the two entries in the care plans were not robust or comprehensive enough for a young man who had such a complex presentation.

17.7 It was noted that as with the ongoing documentation of risks, Jack's patient records were being used to document care plans. However, there was little consistency as to when his care needs were being documented, and in addition this information was not easily accessible.

---

[117] NICE

[118] CPA was introduced in 1991 to establish a multi-agency approach to health and social care, setting out arrangements for the care of people with mental health problems in the community. CPA aims to facilitate closer and integrated working, enabling a coordinated approach to care delivery and the recovery process. Additional care standards were also detailed in the 1999 Mental Health National Service Framework. CPA

17.8 When questioned about the absence of a CAMHS care planning policy, Sancus Solutions were provided with a paper called Care Planning Principles and Standards (5 June 2015), which was in place at the time of the incident. These standards clearly stated that "care planning is fundamental to meeting standards of quality and safety"[119] and that the use of CPA was expected in "specialist CAMHS, particularly for older children typically from 16 years onwards, those with serious mental illness/complex needs or individuals likely to require transition to adult services"[120].

17.9 Clearly, the evidence is indicating that neither the care plans that were completed nor the use of Jack's patient records to document care plans met the comprehensive set of standards that were outlined in this document.

17.10 As with the CAMHS FACE assessments, Sancus Solutions' investigation team were concerned that the significant deficits in the care planning for Jack were not highlighted by the supervising CAMHS manager. It was also concerning that the issues were not being identified via any of RDaSH's routine performance and quality audits, which would have been taking place as part of their normal quality assurance programme.

17.11 Rather than making several recommendations with regard to improving the practitioners' and the services' approach to FACE risk assessments and the care planning of this CAMHS service, Sancus Solutions' investigation team recommend that RDaSH should undertake a further interrogation of the current standards that are operational within this service by carrying out a comprehensive qualitative audit. Such an audit should include cross-referencing particular cases to the relevant practitioner's clinical supervision notes, weekly clinical meetings and, where relevant, the monthly complex patient meetings.

17.12 Also, the lack of a comprehensive CAMHS operational policy was noted, so Sancus Solutions' investigation team have recommended that RDaSH should develop an overarching operational policy that includes comprehensive guidelines for completing CAMHS FACE assessments and care plans.

17.13 Additionally, to address the deficits within CAMHS with regard to risk assessments, RDaSH should convene a team risk training event for the CAMHS team, which all clinical and managerial members of staff are required to attend.

[119] RDaSH Care Planning Principles and Standards 5 June 2015 p3
[120] RDaSH Care Planning Principles and Standards 5 June 2015 p3

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Recommendation 4

RDaSH should undertake a comprehensive audit of the Rotherham CAMHS FACE assessments and care plans. This audit should be cross-referencing cases to the relevant practitioner's clinical supervision documentation and, where relevant, the minutes of the weekly clinical meetings and monthly complex patient meetings.

Evidence of RDaSH undertaking the audit of CAMHS patient records should be provided to Sancus Solutions at their assurance review.

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Recommendation 5

RDaSH's CAMHS should develop an overarching operational policy that includes comprehensive guidelines for completing CAMHS FACE assessments and care plans.

Evidence of RDaSH introducing guidelines for completing FACE assessments and care plans within their CAMHS operational policy should be provided to Sancus Solutions at their assurance review.

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Recommendation 6

RDaSH should convene a team risk training event for the Rotherham CAMHS team, which all clinical and managerial members of staff should be required to attend.

Evidence that CAMHS team risk assessment training has taken place should be provided to Sancus Solutions at their assurance review.

18 ‘The Voice of the Child’ and the Think Family Agenda

This section addresses the following NHS England ToR:

“Consider whether the ‘voice of the child’[121] and The Think Family Agenda[122] was visible through all interactions with services and agencies.”[123]

18.1 Although Jack was approaching his 18th birthday, he was allocated to children’s services. In the months that led up to the incident, the involved services – CAMHS, children’s social care services, Jack’s GP, the police and the college – had at least partial information about Jack and to a lesser degree information about his family and the complex situation that was emerging.

18.2 Although there were frequent occasions when Jack’s mother attended appointments, there were also occasions when Jack was seen alone by the CAMHS practitioners. However, there was no indication that the use of Family Early Help Assessments (hereafter referred to as FEHAs)[124] was being considered.

18.3 FEHAs are used to:

“Assess the needs of children, young people and families to determine the need for early help, and the actions to be taken to improve outcomes, based on a holistic view of the needs of the family”[125].

The only direct reference made to the support needs of Jack’s parents within his CAMHS patient records was in a summary of the initial Strategy Meeting (22 August 2016)..The following was documented:
“Discussed what level of support [Jack’s] family would need in regard to managing [Jack] and whether [his] parents could maintain [his] safety and engage openly with services.”[126]

---

[121] The Voice of the Child report arose out of the findings from a number of Serious Case reviews. Its key findings were: “the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings. Agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute. Parents and carers prevented professionals from seeing and listening to the child. Practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child. Agencies did not interpret their findings well enough to protect the child.” Voice of the Child

[122] The Think Family Agenda was introduced in 2010. It recognised and promoted the importance of a whole-family approach, which was built on the principle of ‘Reaching Out: Think Family’[122]. Its underpinning principle was that there was: “No wrong door – contact with any service offers an open door into a system of joined-up support. This is based on more coordination between adult and children’s services. Looking at the whole family – services working with both adults and children take into account family circumstances and responsibilities.

[123] NHS terms of reference p1

[124] The Family Early Help Assessment (FEHA) tool was developed by the Children’s Advice team from the nationally published Common Assessment Framework (CAF) FEHA

[125] FEHA

[126] Progress notes entry 2016

18.4 It was documented that Jack's parents were assessed as a protective factor and that they agreed to regulate Jack's access to potential weapons and the opportunities for him to go out unaccompanied. However, as has already been identified, Jack's parents were also assessed in successive CAMHS FACE assessments as being at risk, although details of why this assessment was made were not documented, nor was there any ongoing documented monitoring of this potential risk or any management plan to mitigate it.

18.5 However, there was no reference to the support needs of Jack's siblings, although it was documented that they were living in the family home and were part of their brother's support structure. There was also no evidence of Jack's siblings being invited to contribute to any of the assessments that were undertaken by either CAMHS or children's social care services.

18.6 It was not documented if Jack was being asked if he wanted his parents to be present during assessment and support sessions. Sancus Solutions' investigation team would suggest that a young person should be asked at each session if they want their parents to be present, and their response should be documented.

18.7 Sancus Solutions' investigation team would suggest that in order to ensure that an ongoing holistic family assessment is undertaken and that the voices of both the child and those within the family unit are being heard, all members of the family should be given regular opportunities to meet with the involved practitioners individually. This would ensure that all those who are involved within the family and are being affected by the situation have the opportunity to discuss their feelings and experiences as well as facilitating any disclosures that they may feel unable to make within the wider family context. Such a practice would then be comprehensively embedding the ethos underpinning both the Think Family and the Voice of the Child agendas.

19 Safeguarding and the involvement of children's social care services

This section addresses the following NHS England ToR:

"Consider if any issues with respect to safeguarding were identified, adequately assessed and acted upon."[127]

19.1 Sancus Solutions' investigation team concluded that the decision made by the CAMHS practitioners to refer Jack to children's social care services was proportionate to the escalating concerns that were developing. There was

[127] NHS England ToR

also a prompt response to the referral, and an initial strategy meeting was convened (22 August 2016).

19.2 It was agreed at the initial meeting that a further assessment under Section 17 of the Children's Act 1989[128] was required, and a comprehensive social care assessment was undertaken by a social worker at Jack's home.

19.3 The assessor concluded that "at this stage"[129] there was no current role for social care, as Jack was being seen weekly by CAMHS, a psychological profile was being completed by CAMHS and Jack was to be referred to adult services.

19.4 The decision was taken at the subsequent strategy meeting (8 September 2016) that the threshold for significant harm to Jack was not met, and the case was closed. However, the following action plan was agreed, which included:

- The youth offending team would be contacted to establish if they could offer any further support to Jack with regard to his offending behaviour. There was no indication in Jack's patient records that the youth offending team was contacted.
- A further assessment under Section 17 of the Children's Act 1989[130] was required, and a comprehensive social care assessment was undertaken by a social worker at Jack's home.

19.5 Sancus Solutions' investigation team would suggest that this was a proportionate response to the emerging situation. However, what was not documented was who was going to initiate and monitor these actions.

19.6 It was noted that the strategy meeting did not appear to have invited or consulted with Jack's GP, nor was there any evidence that the GP received the minutes from the two strategy meetings. Sancus Solutions' investigation team would suggest that the lack of engagement with Jack's GP was a significant and concerning omission.

[128] The local authority has two important duties with respect to children in need under Section 17: to safeguard and promote their welfare; and to promote wherever possible their upbringing by their families. The act defines a child in need as follows: a child who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority; or a child whose health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or a child who is disabled Section 17
[129] Rotherham Children's Social Care Services single assessment, social care p9
[130] The local authority has two important duties with respect to children in need under Section 17: to safeguard and promote their welfare; and to promote wherever possible their upbringing by their families. The act defines a child in need as follows: a child who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority; or a child whose health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or a child who is disabled Section 17

19.7 After these strategy meetings, there was very little multi-agency working or information sharing occurring until the Youth First assessment team brought the college and some of Jack's CAMHS practitioners together for the assessment.

20 RDaSH CAMHS

20.1 There were several occasions when Jack mentioned to CAMHS practitioners that he had a cousin whom he felt he "would be capable of killing"[131].

20.2 There was no indication that the involved CAMHS practitioners tried to ascertain further information about this cousin, such as his age or the contact Jack was having with him. Nor was this individual identified as being a potential risk in the CAMHS FACE assessments that were completed.

20.3 There was also no documented evidence that this possible threat to the cousin was discussed with other involved senior CAMHS clinicians or at the weekly clinical meetings.

20.4 The speciality doctor who undertook an EIP assessment advised CAMHS to involve RDaSH's named professional for safeguarding children. There was no documented evidence that this occurred, nor was there any other evidence to indicate that Jack was discussed with CAMHS' named safeguarding professional[132] in order to identify or consider if there were any potential safeguarding concerns that required action.

20.5 Sancus Solutions' investigation team were also concerned that following Jack's disclosure that at the age of 11 years he and his cousin had been groomed by a man, whom he referred to as a paedophile and who had been convicted of sex offences, no action was taken by either the practitioner or her supervisor, such as seeking advice from the CAMHS safeguarding professional.

20.6 Sancus Solutions' investigation were concerned about the lack of proactive safeguarding action, especially as RDaSH's Safeguarding Children Policy clearly states:

"Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part … Everyone should work using a Child centred approach: for services to be effective they should

[131] FACE risk assessment 22 July 2016 p6
[132] RDaSH's Safeguarding Children Policy 26 February 2016 stated that the role of the CAMHS named safeguarding professional was to provide expert safeguarding and child protection knowledge, advice, training, supervision and support to practitioners across the trust, and to provide safeguarding leadership to all staff/volunteers within the organisation. It is the role of the named professional to advise staff of any issues that may impact the trust's compliance with Section 11 of the Children Act 2004 p6

be based on a clear understanding of the needs and views of children. … Should staff/volunteers require advice or support at any stage of the referral process this can be sought from their line manager or the Named Nurse/Professional."[133]

20.7 The lack of response to potential safeguarding issues further strengthened Sancus Solutions' investigation team's recommendation that the CAMHS named safeguarding professional should attend the weekly clinical meetings, as they will then be in a position to promptly identify any potential safeguarding concerns, provide guidance to clinical staff and operational managers, and monitor the progress of any agreed actions. Their presence will also ensure that safeguarding thinking and understanding is consistently underpinning the practices of all the CAMHS practitioners.

21 Adult mental health services referral and assessment

This section addresses the following NHS England ToR:

"Review the effectiveness of care (specifically CAMHS), treatment and services provided by the NHS and other relevant agencies … with particular reference to transition management to adult services."[134]

21.1 Although it was agreed at an early stage that Jack would be referred to adult mental health services, the actual referral was not made until 7 November 2016.

21.2 Sancus Solutions' investigation team were informed by the adult mental health practitioner who undertook the assessment (1 December 2016) that the referral form was handwritten and difficult to read. Sancus Solutions' investigation team accessed this form and concurred that it was poorly written. However, the investigation team located another referral form which was typed and included the EIP assessment, the distress and tolerance plan (not rated), and a brief summary of Jack's historic and present mental health symptoms. It was not evident if the assessor had access to this form.

21.3 As CAMHS practitioner 1 was absent from work, only Jack and his mother attended the assessment[135].

21.4 The assessor also reported to Sancus Solutions' investigation team that he did not have access to Jack's electronic patient records due to there being no

[133] RDaSH's Safeguarding Children Policy 26 February 2016 pp4-6
[134] NHS England's ToR
[135] The SIR documented that CAMHS practitioner 2 informed the assessor that CAMHS practitioner 1 was absent from work and that she had offered to attend but was told this was not necessary. This was not reported to Sancus Solutions' investigation team by the assessor and was not documented within Jack's records

shared access to records between different services/modules. It was reported that this is still the case.

21.5 The assessor also reported that based on his assessment and the information that he had access to, it was unclear if Jack had the emotional tolerance and resilience that was required of patients in order for them to benefit from the type of talking therapies that were available within the Intensive Community Therapies team.

21.6 In the letter to Jack's GP, the assessor concluded that he "could not elicit any evidence of on-going mental disorder and [he] could not identify an appropriate care pathway"[136], and therefore he was discharging Jack from the service. There was no documented evidence that the assessor sought further information about Jack prior to making his decision.

21.7 At the time of Jack's referral and assessment to adult mental health services, RDaSH's Transition Policy – Children and Young People's Mental Health to Adult Mental Health Services recognised that:

"The transition from child to adult services can be a difficult time for young people … It is important that any required transition process is managed sensitively and collaboratively to support continued engagement of the young person and their parents/carers and safe and effective service delivery. The involvement of the young person and their carers, collaborative working and effective communication between everyone involved is central to successful transition arrangements."[137]

Apart from the initial referral form, there was no evidence to indicate that any of the above transition process and support was undertaken or provided to Jack. The reason(s) for this remained unclear to Sancus Solutions' investigation team, as this transition policy had been in place since July 2013.

21.8 Sancus Solutions' investigation team would suggest that given the complexity of Jack's presentation and the ongoing uncertainty regarding his mental health diagnosis and potential risk factors, it was even more important that a planned and managed transition was actioned. It was also essential that ongoing mental health provision was available until such time as Jack's mental health and his risks were fully understood and were being safely managed.

21.9 As to the reason(s) why Jack was not assessed as being suitable for adult mental health services, research and governmental strategies – such as

[136] Letter to Jack's GP 8 December 2016
[137] RDaSH's Transition Policy – Children and Young People's Mental Health to Adult Mental Health Services (1 July 2013) p4

Future in Mind, and the Children and Young People's Mental Health and Wellbeing Taskforce – repeatedly concur that:

"Many young people, even when in acute need of help, fail to meet the entry criteria of statutory mental health services. They encounter a high clinical threshold (i.e. they may not be deemed to be unwell enough) … which can appear arbitrary and to disregard the complexity of adolescent development."[138]

21.10 Clearly, there was and still is no automatic access for CAMHS patients to adult mental health services. This is a significant disparity with children's physical health, where there is an automatic transfer of children to adult services.

21.11 Additionally, as the thresholds and entry criteria for adult mental health services becomes increasingly more focused on episodic treatment with identified outcomes, Sancus Solutions' investigation team would suggest that given the additional complexities of young adulthood, many of these patients may not be able to meet such rigid criteria and therefore are being excluded from continued adult mental health support.

21.12 At the time of CAMHS' involvement with Jack, NHS England published a model specification for transitions from CAMHS to adult mental health services[139] that refers specifically to young people who do not meet the threshold for adult mental health services. It suggests that some of these people may be best supported by youth counselling services and that the commissioners should be ensuring that such services have age-appropriate services that "are coproduced with young people; and enable holistic and integrated person-centred care planning and delivery"[140].

21.13 With regard to CAMHS' management of Jack, when it became evident that adult mental health services would not accept him onto their pathway, there was no documented plan evident as to what was the proposed support or treatment plan. This must have created considerable anxiety and concern for all involved, especially Jack and his family. Again, Sancus Solutions' investigation team would suggest that once it had been decided that Jack would not be eligible for adult mental health services, the situation should have been escalated and managed by the service's operational manager and one of the CAMHS consultant psychiatrists.

---

[138] Youth Access March 2017

[139] Model Specification for Transitions from Child and Adolescent Mental Health Services, NHS England. January 2015. NHS England

[140] Model Specification for Transitions from Child and Adolescent Mental Health Services, NHS England. January 2015. NHS England

22 Forensic assessment

This section addresses the following NHS England ToR:

"Consider any issues relating to the forensic assessment and resource issues locally."[141]

22.1 From 8 August 2016, as there was increasing evidence and concern being expressed that Jack was killing animals and there was a potential risk of harm to others, it was agreed that a forensic assessment was required:

- to assess this particular risk
- to assist in Jack's diagnosis and in identifying his future mental health support needs.

As such an assessment was not available within RDaSH, considerable effort was made by the psychologist to try to secure an assessment, initially locally and then nationally. An initial enquiry was made to Youth First on 27 September 2016. CCG funding was secured, and the referral was submitted on 7 October 2016.

22.2 Sancus Solutions' investigation team were of the opinion that the considerable delay in securing a forensic assessment did have a significant impact on the treatment provided to Jack, as it resulted in a reluctance to provide any focused interventions, such as psychological therapies.

22.3 Sancus Solutions' investigation team were also of the opinion that when Jack's risks began to escalate, and after it had become apparent that there was going to be a significant difficulty in securing a forensic assessment for him, actions should have been taken, for example:

- The difficulties in securing a forensic assessment should have been escalated to CAMHS' senior managers, whose role should have been to try to source a more timely assessment.
- Additionally, given that there was limited experience within CAMHS of the type of complexities and risks with which Jack was presenting, senior managers should have been holding the overall responsibility for this case. They should also have been regularly monitoring the case management to ensure that there were both robust risk assessments being undertaken and comprehensive risk management plans in place.

[141] NHS England Terms of Reference p1

- Given the level of risks/complexities and to ensure consistency in Jack's treatment and clinical management, the case should have been held by one of the CAMHS psychiatrists rather than the psychologist.

- When this named consultant psychiatrist was not available to see Jack or advise staff, there should have been a robust and prompt reporting structure in place to ensure that they were being promptly updated about any actions/decisions taken. All actions/decisions taken in the absence of the lead clinician should have been comprehensively documented within Jack's patient records.

- The case should also have been discussed at every clinical meeting, and the decisions made in these meetings should have been fully documented by the responsible consultant psychiatrist in the patient records.

- CAMHS FACE assessment reviews should have been undertaken at each meeting with Jack and/or when new information/observations became available.

- Until the forensic assessment had been undertaken, Jack's risks to others should have been consistently assessed at the highest level.

Regional changes in forensic CAMHS service provision

22.4 In January 2013, the Community Forensic Child and Adolescent Mental Health Services (FCAMHS) report, which was prepared for the Department of Health, stated that:

"There [was] patchy geographical provision of dedicated specialist community FCAMH services across the UK. Significant areas of England and Scotland appear to have no provision for this type of service."[142]

22.5 One of the recommendations was that:

"Action is needed to address gaps in provision and to ensure that children and young people with complex forensic mental health needs have access to appropriate community based services in addition to the existing network of medium secure in-patient units, local tier 3 CAMHS and other therapeutic services."[143]

22.6 As part of their children and young people mental health transformation programme, NHS England commissioned a report into the development and reconfiguration of regional specialist community Forensic Child and

[142] A map of current national provision p21
[143] A map of current national provision p4

Adolescent Mental Health Services (hereafter referred to as FCAMHS).[144] In 2018 a new joint regional Yorkshire and Humber FCAMHS[145] was launched.[146]

22.7 Alongside the provision of secure inpatient units, this service provides:

"Specialist mental health assessment, including forensic assessment where appropriate … Case formulation and intervention in high risk cases where there is a need for specialist opinion to ensure that young people presenting high risk of harm to others or self are managed in the most appropriate way. … Development of joint working arrangements with CAMHS and other children's services (including community learning disability and autism services) to support the management of high risk and complex cases."[147]

22.8 Obviously, as this is such a new resource in the region, having only been operational since 2018, it has not been possible for Sancus Solutions' investigation team to comment on how effective it would have been in the management of Jack. However, if this service had been in place at the time Jack was presenting with escalating risks and concerns, it would have significantly reduced the time it took for CAMHS to source an FCAMHS assessment. It would also have been a valuable resource to CAMHS in terms of providing ongoing specialist forensic advice.

23 Capacity

This section addresses the following NHS England ToR:

"Consider if there were any issues in relation to capacity or resources that impacted the ability to provide services to the Service User."[148]

23.1 Sancus Solutions' investigation team were informed that the recruitment and retention of staff at the time of Jack's involvement with CAMHS was an issue and that a significant number of agency staff were being used. However

[144] Services were to be organised in defined geographical regional areas and would be available for children up to the age of 18 years who had forensic and 'complex non-forensic' presentations – in other words, either they were presenting a forensic history or there were concerns that they were presenting a "high risk of harm towards others and … there [was] major family or professional concern [about them]".
[145] Alongside the provision of secure inpatient units, the service now provides "specialist mental health assessment, including forensic assessment where appropriate … Case formulation and intervention in high risk cases where there is a need for specialist opinion to ensure that young people presenting high risk of harm to others or self are managed in the most appropriate way. … Development of joint working arrangements with CAMHS and other children's services (including community learning disability and autism services) to support the management of high risk and complex cases Yorkshire and Humber FCAMHS
[146] Involving: South West Yorkshire Partnership NHS Foundation Trust. Humber Teaching NHS Foundation Trust. Sheffield Children's NHS Foundation Trust. Tees, Esk and Wear Valleys NHS Foundation Trust. RDaSH CAMHS is in this service's catchment area.
[147] Service specification p4
[148] NHS England Terms of Reference

Sancus Solutions' investigation team noted that all of the involved clinicians were permanent staff members of the CAMHS service.

23.2 All the CAMHS' practitioners who were interviewed, as part of this investigation, reported that although at the time their patient lists were considerable Jack was seen promptly. Additionally it was noted that any contact made by Jack's parents to members of the CAMHS team was responded to in a timely way.

23.3 Therefore, Sancus Solutions' investigation team concluded that the resource issues RDaSH's CAMHS were experiencing did not have an impact on the service provided to Jack and his family.

23.4 Therefore Sancus Solutions' investigation team concluded that the resource issues CAMHS were experiencing at the time did not have an impact on the service provided to Jack and his family

23.5 Sancus Solutions' investigation team were provided with evidence that since this incident there have been a number of significant actions implemented by RDaSH to improve staff morale, develop and improve CAMHS' reputation, and improve their treatment pathways. These actions have included listening to the hearts and minds of RDaSH's staff through Listening into Action, which aims "to engage and empower healthcare teams to drive measurable improvements to the quality and safety of patient care, enabled through an annual delivery framework, a shift in culture and leadership, and alignment of support services"[149].

24 Predictability and preventability

24.1 Throughout the course of this investigation, Sancus Solutions' investigation team have remained mindful of one of the requirements of NHS England's ToR, which is that they need to consider "if the incident that resulted in the death was either predictable or preventable"[150]. Sancus Solutions' investigation team have used the following definitions:

Predictability: if a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.

Preventability: means to "stop or hinder something from happening, especially by advance planning or action" and implies anticipatory counteraction.

[149] Listening into Action
[150] NHS England ToR p2

Predictability

24.2 In the six months prior to the incident, there was increasing evidence of and concerns being expressed regarding Jack's mental health presentation and his potential escalating risk behaviours, which it was thought might result in him causing significant harm to others. These included:

- There was evidence that Jack had a history of killing animals, which had escalated in the months prior to the incident.
- Jack had been in possession of a weapon and had, on at least one occasion, a formulated plan to kill a stranger.
- Jack made frequent disclosure/references to the fact that he was having thoughts of harming people, including a member of his extended family, although he never disclosed an actual formulated plan.
- It was assessed that Jack was exhibiting poor impulse control and had a significant history of poor emotional regulation.
- Although no formal mental health diagnosis had been made, it was suggested that Jack was presenting with antisocial personality traits and that he lacked feelings of remorse or guilt for his activities and fantasies.
- At times, Jack's mother was expressing her concerns about her son's behaviours and risks, and on one occasion she reported that she had removed his access to knives.
- In the weeks prior to the incident, Jack disclosed that he had attacked one of his friends. His mother reported that he was becoming more socially isolated from his peers and that he had told her that the urges to harm animals and people were "getting harder to control"[151]. He had also disengaged from the one pursuit (boxing) that she had previously reported had helped him to regulate his aggression and anger.
- Apart from his family, there was little evidence to indicate that Jack had any significant protective factors.
- It was thought that Jack might not be disclosing the full extent of his plans regarding harming animals and/or people.

24.3 Nevertheless, using the definition of predictability, Sancus Solutions' investigation team have concluded that, regardless of the risks and the concerns that were being expressed, based on the available evidence, it was

[151] Progress notes entry 3 January 2017

not predictable that on that night of in January 2017, Jack was going to fatally attack Leonne.

24.4 However, Sancus Solutions' investigation team have concluded that there was enough supporting evidence to agree with the conclusion reached by the authors of RDaSH's Serious Incident Report (hereafter referred to as SIR) that it was highly predictable that "[Jack] would at some point be involved in further acts of violence"[152].

Preventability

24.5 In Sancus Solutions' investigation team's consideration of the preventability of this incident, the following two questions have been asked:

- Based on the information that was known, were Jack's risk factors and support needs being adequately assessed and addressed by the involved agencies?

- Based on the information that was known at the time, was the incident that resulted in the death of Leonne preventable?

  For a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.[153]

24.6 Sancus Solutions' investigation has identified considerable areas of concern and significant deficits with regard to:

- risk assessment and management plans
- the provision of psychological therapies
- the lack of senior management care coordination
- the lack of a coordinated psychiatric approach
- information sharing and interagency communications
- the delay in obtaining a forensic assessment.

  Sancus Solutions' investigation team have concluded that based on the information that was known, Jack's risk factors and support needs were not being adequately assessed and addressed by the involved agencies.

[152] SIR p103
[153] Preventable

24.7 As to whether the death of Leonne on that night could have been prevented, as has been previously stated, there had been no disclosures made by Jack that he had any association with Leonne or that he had plans to hurt her or any of his peers. Although the involved services were consistently highlighting their concerns that there was a significant possibility that Jack's risks were going to escalate, they did not have the knowledge of who may be his victim or when an incident may occur.

24.8 The only possible means by which this incident might have been prevented from occurring was if the CAMHS consultant psychiatrist's assessment that Jack needed to be referred to Tier 4 services had been actioned. A Tier 4 assessment might have provided an additional assessment and/or concluded that the potential risk(s) to others was so great that Jack could not be safely managed or treated in the community.

24.9 If Jack had refused to be admitted as an informal patient, then consideration might have been given to assessing him under the Mental Health Act 1983. However, it was reported to Sancus Solutions' investigation team that it was unclear if Jack's behaviours were due to a mental illness, and therefore it was uncertain if he would have been assessed as being detainable under the criteria of the Mental Health Act 1983.

24.10 Therefore, based on the information that was known at the time and the possible actions that were available to the involved service in response to Jack's disclosures, Sancus Solutions' investigation team have concluded that the incident on 15 January 2017 that led to the tragic death of Leonne was not preventable.

25 RDaSH Serious Incident Report

This section addresses the following NHS England ToR:

"Critically review the internal investigation, consider the chronology of contacts and service access leading up to the homicide in doing so."[154]

25.1 Immediately following the incident, RDaSH's CAMHS' named safeguarding practitioner completed an extensive chronology of CAMHS' involvement with Jack. Sancus Solutions' investigation team were informed that this was carried out so that RDaSH could promptly review their involvement in order to identify if there were any immediate actions that were required. Due to the

[154] NHS England Terms of Reference

seriousness of the incident, RDaSH then commissioned an independent investigator to complete a Level 2 serious incident investigation.[155]

25.2 Sancus Solutions' investigation team concluded that the SIR was an extremely comprehensive and robust investigation. The report's recommendations were proportionate and Specific, Measurable, Attainable, Relevant and Time bound (SMART).[156]

25.3 Sancus Solutions' investigation team were provided with RDaSH's latest action plan, which addressed the recommendations from the SIR. Although the action plan clearly highlights the progress that has been made in implementation, Sancus Solutions' investigation team did have some concerns that given that the SIR was presented to RDaSH in September 2017, there are still eight actions on amber and one is assessed as being on red.

25.4 Sancus Solutions' investigation team recommend that prior to the publication of this report, RDaSH provides an up-to-date action plan to NHS England that incorporates the recommendations of both the SIR and Sancus Solutions' investigation.

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Recommendation 7:
Prior to the publication of this report, RDaSH should provide an up-to-date action plan of the progress made in implementing the recommendations of their outstanding Serious Incident Report.

[155] NHS England Serious Incident Framework, April 2015: serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. A level 2 investigation is a comprehensive internal investigation, which may involve independent/external scrutiny NHS England Serious Incident Framework

[156] SMART

26 Duty of Candour[157]

26.1 It was reported to Sancus Solutions' lead investigator that neither Jack's nor Leonne's family were contacted post incident or during the SI process.

26.2 Due to the seriousness of the incident, a post-Incident Coordination Group (ICG) was convened, with representatives attending from the commissioning CCG, RDaSH, the police, the involved GP practice, the local authority and NHS England. The purpose of an ICG is for the involved services to share information, coordinate any internal investigations and take any immediate learning from an incident. RDaSH reported that this decision had been made at the ICG[158], which was convened immediately after the incident.[159]

26.3 Jack's family reported to Sancus Solutions' investigation team that they were frustrated that they had not been invited to be involved in RDaSH's serious incident investigation and that to date they had not had any contact from the trust. They reported that this has not only caused them considerable frustration during what has been an extremely difficult time, but has led to them losing confidence in RDaSH's credibility.

26.4 Sancus Solutions' investigation team would suggest that clearly one of the main difficulties with this type of investigation is that families are being asked to be involved in such investigations when they are in the midst of their own personal deep bereavement, and they will often still be in a state of trauma. Sancus Solutions' investigation team would suggest that RDaSH should consider providing all families involved in serious incidents with a family liaison officer, who would both provide support to families and ensure that they are kept updated as to the progress of the trust's serious incident investigation.

---

[157] Every NHS trust has a statutory responsibility in relation to Duty of Candour[157], the Being Open principles and the ethical duty of openness that applies to all incidents and any failure in care or treatment. Duty of Candour applies to incidents in which moderate harm, significant harm or death has occurred. The guidance followed Sir Robert Francis QC's call for a more open and transparent culture in the wake of the failures in patient care at Mid Staffordshire NHS Foundation Trust. CQC Regulation 20 requires all providers to be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. Regulation 20 also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support and providing truthful information and an apology when things go wrong. Duty of Candour

[158] A Post-Incident Coordination Group (ICG) was convened, with representatives attending from the commissioning CCG, RDaSH, the police, the involved GP practice, the local authority and NHS England. The purpose of an ICG is for the involved services to share information, coordinate any internal investigations and take any immediate learning from an incident.

[159] The initial ICG was convened on 27 January 2017. In the minutes, it was documented that: "Given that there is an ongoing police investigation, it would be prudent to provide a chronology of contact rather than speaking to staff/family."

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Recommendation 8:
RDaSH should consider the viability of recruiting a family liaison officer, who would be the single point of contact and provide support for families throughout the serious incident investigation process.

Evidence of this should be provided to Sancus Solutions at their assurance review.

27 Learning event

This section addresses the following NHS England ToR:

"Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together."[160]

27.1 If RDaSH and the other involved agencies agreed that this would be helpful and would facilitate learning from this incident, Sancus Solutions' investigation team would be happy to convene a briefing event for all the services and practitioners – including senior managers – who were either directly or indirectly involved in the care and treatment of Jack.

27.2 The aim of this event would be to review Jack's care and to highlight areas identified by this investigation as requiring improvement.

27.3 The event would also give the involved practitioners and operational managers the opportunity to reflect on their involvement and practice.

27.4 Sancus Solutions' investigation team would invite the families of Jack and Leonne to contribute to this learning event in any way that they felt was manageable for them. This would hopefully give them the opportunity to communicate with the involved practitioners and senior managers about their experiences of the involved services and where they feel improvements could be made.

28 Concluding comments

28.1 This is clearly a very tragic event which continues to deeply affect the lives of all those involved. Although this investigation report has highlighted some deficits in the care and treatment of Jack by CAMHS, However Sancus Solutions' investigation team is not suggesting that any individual practitioner was directly responsible for this tragic event.

[160] NHS England TOR

28.2 The aim of these independent investigations is to identify where there have been particular practice concerns and to highlight when a trust's policies and governance structures are not robust enough. Additionally, these investigations aim to ensure that lessons are learnt in order to improve future delivery of services to vulnerable young patients.

28.3 Sancus Solutions' investigation team hope that the findings and recommendations of their investigation will contribute to the learning and development of all the involved agencies and practitioners and to improve their practices and service delivery to vulnerable young people and their families.

28.4 It is also the hope of Sancus Solutions' investigation team that the findings and recommendations within this report will provide Jack's and Leonne's families with at least some resolution to their questions and concerns.

29 Recommendations

All recommendations are for Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Recommendation 1

RDaSH should introduce either training and/or a mentoring programme for their adult mental health practitioners who are required to undertake out-of-hour assessments of young people in Accident and Emergency Departments, to ensure they have the required skills, competencies and knowledge base to undertake assessments of the needs and risks of young people.
Evidence of the introduction of this training should be provided to Sancus Solutions at their assurance review.

Recommendation 2

When RDaSH practitioners and clinical staff make a significant entry in a patient's SystmOne records, such as a risk assessment or a change in the treatment plan, they should alert the patient's primary care service, by email or telephone, that an entry has been made.
Evidence of this being introduced should be provided to Sancus Solutions at their assurance review.

Recommendation 3

RDaSH should undertake a review of the current CAMHS weekly clinical meetings in order to facilitate the attendance of the practitioners and the CAMHS named professional safeguarding children officer.
Evidence of a review of the clinical meetings should be provided to Sancus Solutions at their assurance review.

Recommendation 4

RDaSH should undertake a comprehensive audit of the Rotherham CAMHS FACE assessments and care plans. This audit should be cross-referencing cases to the relevant practitioner's clinical supervision documentation and, where relevant, the minutes of the weekly clinical meetings and monthly complex patient meetings.
Evidence of RDaSH undertaking the audit of CAMHS patient records should be provided to Sancus Solutions at their assurance review.

Recommendation 5

RDaSH's CAMHS should develop an overarching operational policy that includes comprehensive guidelines for completing CAMHS FACE assessments and care plans.
Evidence of RDaSH introducing guidelines for completing FACE assessments and care plans within their CAMHS operational policy should be provided to Sancus Solutions at their assurance review.

Recommendation 6

RDaSH should convene a team risk training event for the Rotherham CAMHS team, which all clinical and managerial members of staff should be required to attend.
Evidence that CAMHS team risk assessment training has taken place should be provided to Sancus Solutions at their assurance review.

Recommendation 7

Prior to the publication of this report, RDaSH should provide an up-to-date action plan of the progress made in implementing the recommendations of their outstanding Serious Incident Report.

Recommendation 8

RDaSH should consider the viability of recruiting a family liaison officer, who would be the single point of contact and provide support for families throughout a serious incident investigation process.
Evidence of this should be provided to Sancus Solutions at their assurance review.

Appendix A: Terms of Reference

Terms of Reference for Independent Investigations under NHS England's Serious Incident Framework 2015 (Appendix 1)

The Individual Terms of Reference for independent investigation 2017/1724 are set by NHS England North and will be endorsed by Rotherham Safeguarding Children Board. These generic terms of reference will be developed further in collaboration with the offeror and affected family members. However the following will apply in the first instance;

- Involve the families of both the Victim and the Service User as fully as is considered appropriate, in liaison with the police and other support organisations
- Critically review the internal investigation, consider the chronology of contacts and service access leading up to the homicide in doing so;
- Review the effectiveness of care (specifically CAMHS) treatment and services provided by the NHS, and other relevant agencies from the Service User's first contact with services to the time of the incident with particular reference to transition management to adult services
- Identify and consider key episodes of care and contact from multi-agency partners, including education and primary care
- Consider whether the 'voice of the child' was visible through all interactions with services and agencies
- Review the appropriateness of the treatment of the Service User in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern
- Review any gaps in interagency working, identifying opportunities for improvement for interagency cooperation and joint working
- Consider if any issues with respect to safeguarding were identified, adequately assessed and acted upon
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together
- Review the adequacy of risk assessments and risk management, including specifically the risk of the Service User harming themselves or others
- Consider any issues relating to the forensic assessment and resource issues locally
- Consider if there were any issues in relation to capacity or resources that impacted the ability to provide services to the Service User
- Examine the effectiveness of the Service User's care plan including the involvement of the service user and the family
- Review and assess compliance with local policies and protocols, national guidance and relevant statutory obligations
- Consider if this incident was either predictable or preventable

- Provide a written report to NHS England that includes measurable and sustainable recommendations
- Assist NHS England in undertaking a brief post investigation evaluation

Supplemental to Core Terms of Reference

- Support the commissioners where required to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, and others with a legitimate interest.

- Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CGG and Trust and feedback the outcome of the assessment to NHS England North and NHS Improvement.

Appendix B: Interviews

As part of this investigation, Sancus Solutions' investigation team interviewed:

- Principal Clinical Psychologist, Rotherham CAMHS (referred to as CAMHS psychologist)
- 2 CAMHS Consultant Psychiatrists
- Speciality doctor, Early Intervention Service.
- Social Worker and Approved Mental Health Practitioner,
- Intensive Community Therapies team manager
- CAMHS Service Manager
- CAMHS Head of Clinical Psychology, Psychological Therapy Support
- Community Psychiatric Nurse Liaison and Diversion team
- CAMHS Named Safeguarding Professional
- Deputy Director of Organisational Development
- Children's Care Group Director
- Team Manager, Early Intervention (in Psychosis) and ADHD Clinic
- Children's Care Group Director
- Chief Operating Officer
- Acting Head of Services, Rotherham Metropolitan Borough Council Children and Young People's Services
- Social Worker, Rotherham Metropolitan Borough Council Children and Young People's Services
- NHS England Director of Nursing, Yorkshire and Humber
- Community Forensic CAMHS Medical Director, Youth First Birmingham and Solihull Mental Health NHS Foundation Trust (telephone interview)
- Primary care GP (telephone interview)
- Author of RDaSH Serious Incident Report.

Sancus Solutions' interviews are managed with reference to the National Patient Safety Agency (NPSA) investigation interview guidance.[161] Where there has been the potential for perceived criticism of individuals or their actions, we have adhered to the Salmon/Scott principles.[162]

For the purposes of this report, the identities of all those who were interviewed have been anonymised and they have been identified by their professional titles. Where appropriate, this report will refer to the relevant RDaSH policies that were in place at the time of the incident, as well as those that have been revised in response to the findings and recommendations from RDaSH's serious incident internal report. Sancus Solutions obtained and reviewed evidence from:

- Jack's primary and secondary patient records
- RDaSH's serious incident report
- RDaSH's SIR's action plan
- RDaSH's policies and procedures that were in place at the time of the incident as well as those that have subsequently been reviewed
- National best practice guidelines and governmental strategies.

[161] National Patient Safety Agency (2008) Root Cause Analysis Investigation Tools: Investigation interview guidance NPSA

[162] The 'Salmon Process' is used by a public enquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry, whose report, amongst other things, set out principles of fairness to which public enquiries should seek to adhere. Salmon/Scott

Appendix C: Sancus Solutions' investigation team

- **Grania Jenkins** was the lead investigator for this highly complex investigation. Grania has a background as both a practitioner and a senior manager for adult and children's and young people's mental health services. She has also worked in senior management positions in performance and quality within the health and social care sectors. Grania has extensive experience of undertaking high-profile and complex homicide investigations, under NHS England's Serious Incident Framework, in which the victim and/or perpetrator was a child/young person. Grania holds a police qualification for investigating complex and serious crimes (PiP 2) and has undertaken training in family liaison support.
- **Dr Tim Diggle** is a clinical forensic CAMHS psychologist. He is a registered Consultant Clinical Psychologist with the Health and Care Professions Council (HCPC) and a Responsible Clinician, having been approved under Section 12(2) of the Mental Health Act (1983). Tim also undertakes specialist psychological forensic assessments, assists in mental health formulations and implements a range of psychological treatments to patients and their families. He has also published research and academic papers on early intervention of psychological support to children and young people. Tim's role in this investigation has been to review and comment on the care and treatment provided by RDaSH's CAMHS. He also participated in the interviews of CAMHS clinical practitioners and service managers.
- **Dr Claire Short** is currently a consultant psychiatrist in an inner-city CAMHS service. She has extensive experience of working within CAMHS with children and their families who have very complex needs. Claire has a wide range of experience within the CAMHS speciality, including training, and more recently in the management and support of children and their families 'at the edge of care'[163]. Claire's role in this investigation has been to review CAMHS' care and treatment of Jack and the events that led up to the incident.
- **Ray Galloway**: prior to retirement, Ray was a detective superintendent in the police force. He was then appointed as one of the independent investigators into the activities of Jimmy Savile. In this investigation, Ray has acted as the critical friend, providing a level of independent scrutiny to the investigation, and was also the independent point of contact for both families.
- **Tony Hester** is one of the directors of Sancus Solutions. Tony has over 30 years' Metropolitan Police experience in specialist crime investigation. Since 2009, Tony has coordinated and managed numerous domestic homicide reviews for Sancus Solutions where the mental health of the perpetrator and/or victim has been a

[163] At the edge of care

significant and contributory factor. Tony has provided the quality control and governance oversight of the investigation process.

Appendix D: References

- Annual report of the Chief Medical Officer, Mental Health problems in children and young people Mental Health Problems
- Care Quality Commission Inspection Report (published March 2017) CQC inspection report
- Community Forensic Child and Adolescent Mental Health Services (FCAMHS): a map of current national provision and a proposed service model for the future (January 2013) a map of current national provision
- Department of Health (DH) and NHS England (2015). Future in mind. Promoting, protecting and improving our children and young people's mental health and wellbeing Future in Mind
- Department of Health (2000). Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach. Effective care coordination
- Department of Health (2007). Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services Best Practice in Managing Risk
- Future in Mind – improving mental health services for young people (March 2015) Future in Mind
- Independent Mental Health Task Force to the NHS England. The Five Year Forward View for Mental Health (February 2016).Five Years Forward
- National Collaborating Centre for Mental Health – Antisocial Behaviour and Conduct Disorder in Children and Young People. The NICE Guidelines on Recognition, Intervention and Management (2013) National Collaborating Centre for Mental Health
- National Institute of Health and Care Excellence (NICE) guideline CG28 for the identification and management of depression in children and young people NICE
- National Society for the Prevention of Cruelty to Children (NSPCC). Assessing Children and Families (2014) NSPCC

- National Society for the Prevention of Cruelty to Children (NSPCC). Understanding the Links: child abuse, animal abuse and domestic violence (October 2007) NSPCC

- National Society for the Prevention of Children (NSPCC). Animal abuse and child maltreatment (October 2007) NSPCC

- NHS England Community Forensic Child and Adolescent Mental Health Service including Secure Outreach service specification (August 2017) NHS England service specification

- NHS England National Collaborating Centre for Mental Health and the National Institute for Health and Care Excellence: Implementing the Early Intervention in Psychosis Access and Waiting Time Standard Guidance (April 2016) Early intervention

- NHS England Model Specification for Transitions from Child and Adolescent Mental Health Services January 2015 NHS England

- NHS England Service Specification: community forensic child and adolescent mental health service (including secure outreach) Service specification

- NHS South West Strategic Clinical Network: Commissioning better CAMHS in the South West (October 2015) Commissioning better CAMHS services

- NICE guidelines for antidepressants in children and young people NICE

- NICE guidelines for Antisocial behaviour and conduct disorders in children and young people overview April 2014 NICE

- NICE guideline for Antisocial Personality Disorder. Treatment, management and prevention (March 2018) NICE

- NICE guidelines: Psychosis and schizophrenia in children and young people NICE

- Public Health England Improving young people's health and wellbeing: A framework for public health January 2015 Public Health

- Royal College of Psychiatrists (2013). Building and sustaining specialist CAMHS to improve outcomes for children and young people Royal College of psychiatrists

- Royal College of Psychiatrists (August 2016). Rethinking risk to others in mental health services Rethinking Risk

- Royal College of Psychiatrists. CAMHS Quality Network (QNCC) QNCC

- Royal College of Psychiatrists (2014). Standards for Crisis and Intensive Response in CAMHS Standards
- Royal College of Psychiatrists (August 2016). Standard for Early Intervention Psychosis Services EIP standards
- Royal College of Psychiatrists (November 2016). What really matters in children and young people's mental health What Really Matters
- Social Care Institute for Excellence (May 2012). Think child, Think parent, Think family Think Family
- Think Family Agenda (December 2011). Think Family
- Youth Access (March 2017). Young, Adult – and Ignored. Youth Access March 2017