An independent investigation into the care and treatment of a mental health service user (S) in Surrey

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Author: Carol Rooney, Head of Investigations

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Niche Health & Social Care Consulting Ltd is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

The independent investigation team would like to offer their deepest sympathies to Elizabeth's family. It is our sincere wish that this report does not contribute further to their pain and distress.

We would also like to thank the families of both Elizabeth and S for their invaluable contribution to our investigation.

Niche Health & Social Care Consulting
1 City Approach
Albert Street
Eccles
MANCHESTER
M30 0BG

Telephone: 0161 785 1001
Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

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1 Executive summary

1.1 NHS England, South commissioned Niche Health & Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (S). Niche is a consultancy company specialising in patient safety investigations and reviews. The terms of reference are at Appendix A.

1.2 The independent investigation follows the NHS England Serious Incident Framework (2013)[1] guidance published by the Department of Health in HSG (94) 27,[2] on the discharge of mentally disordered people, their continuing care in the community and the updated paragraphs 33-36 issued in June 2005.

1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

1.5 We would like to express our sincere condolences to Elizabeth's family.

S's mental health history

1.6 S had a history of self-harm and anxiety symptoms, and was referred to the child and adolescent mental health services (CAMHS) at Oxted Surrey in June 2012 when he was aged 15. This service is part of Surrey and Borders Partnership NHS Foundation Trust (SaBP).

1.7 In June 2012 his mother approached his GP with concerns that S was harming himself by cutting himself most days. S's GP referred him to CAMHS on 7 June 2012.

1.8 His mother phoned the GP on 14 June 2012 asking for help as S's best friend had disclosed that S was planning to kill himself. S was assessed as an urgent referral on 20 June 2012 and received systemic psychotherapy from CAMHS for a year.

1.9 S described symptoms of anxiety and hearing and seeing a character called 'Ed', who talked to him. S was diagnosed as having Autism Spectrum Disorder in February 2013. His self-harm and anxiety symptoms appeared to improve, he was discharged from CAMHS in October 2013, and had no further contact with mental health services until after the offence.

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[1] *Serious Incident Framework March 2013. NHS England*

[2] *Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services*

Family

1.10 S lived at home with his parents and one of his brothers. He has three older siblings, his eldest brother lives with his partner, and his sister was at university, although she lived at home.

Offence

1.11 On 24 January 2014 S stabbed his 17 year old girlfriend Elizabeth in his bedroom at home. On 24 January 2014 S had arranged to meet Elizabeth in the grounds of their school, and they walked together to his house, arriving at about 14.30. S's sister arrived home at about 15.45, by which time Elizabeth was dead. S killed Elizabeth with a knife and dismembered her body with knives and gardening tools.

1.12 After Elizabeth was killed, S then left her body parts in his bedroom, underneath furniture. When his sister returned home he said he needed to talk and told her that "*Ed made me do something bad*".

1.13 S's sister called her mother, and after their parents arrived home S's father called the police. S was arrested and taken into police custody.

1.14 S was later assessed under the Mental Health Act 1983, and on 25 January 2014 was transferred to The Wells Unit, West London Mental Health NHS Trust under Section 2[3] for assessment. He was assessed by staff from Broadmoor high secure hospital on 30 January 2014. The consensus was that he was not suffering from a psychotic disorder, and he was discharged from the Wells Unit after a brief period of assessment.

Sentence

1.15 On 2 October 2014 at Guildford Crown Court S was found guilty of murder and sentenced to life imprisonment, to serve a minimum of 25 years. In sentencing Judge Christopher Critchlow said:

"This is a case of the utmost gravity, the horrific features of which are rarely heard in any court. Nothing this court can say or do, no sentence this court can impose can alleviate the pain suffered by Elizabeth's family for her death in such a terrible manner. There must be a life sentence".

Internal Investigation

1.16 Surrey and Borders Partnership NHS Foundation Trust ('the Trust' hereafter) undertook an internal investigation that has been reviewed by the investigation team.

[3] *Section 2 of the Mental Health Act allows for compulsory detention in hospital for up to 28 days for assessment and treatment http://www.legislation.gov.uk/ukpga/1983/20/section/2*

1.17 The internal investigation for the Trust was led by an experienced investigator from within the organisation, with clinical expert input from a consultant child and adolescent psychiatrist from another Surrey CAMHS service.

Independent investigation

1.18 This independent investigation has drawn upon the internal process and has studied clinical information, police information, witness statements, interview transcripts and policies. We also interviewed clinical and school staff who had been in contact with S, and senior staff from Surrey and Borders Partnership Foundation NHS Trust.

1.19 We have met with S several times to give him an opportunity to contribute to the report, and he raised some concerns some about the treatment he received from the CAMHS team, which we have examined as part of the investigation.

1.20 S's mother met with us and agreed to be interviewed. She provided us with a series of questions about S's care by CAMHS.

1.21 We met members of Elizabeth's family and interviewed them about their experiences and perspective. Her family have requested that she be referred to by her first name in this report. The Thomas family have requested that we included a statement (full statement at Section 3.19). We respect the reflections offered by the family and want to ensure that we provide an opportunity for them to be shared.

1.22 We find that the recommendations made in the internal report did not adequately address the practice issues identified, and suggest further work on the action plan and assurance structures. The recommendations from our independent investigation focus on the improvements that we consider should be made across the system.

1.23 It is our view that the homicide of Elizabeth was not predictable, nor preventable by any actions that Surrey and Borders Partnership NHS Foundation Trust could or should have taken.

1.24 We have however made ten recommendations to promote wider systems learning.

Recommendations

Recommendation 1:
It should be standard practice that CAMHS staff will liaise with schools and arrange multi-disciplinary/agency discussion where appropriate, and actions and outcomes should be recorded. The local operational policy should be amended to include this expectation.

Recommendation 2:
The Trust should ensure compliance with clinical risk management and clinical documentation policies, and audit the effectiveness of this process

Recommendation 3:
The Trust to strengthen how it captures patient and family agreement with their care plans in the Electronic Patient Record, in line with its existing performance indicators on individuals and families receiving a copy of their care plan and people feeling involved in developing their care plans

Recommendation 4:
The Trust should further strengthen the process currently in place to ensure that carer's assessments are carried out as expected in policy.

Recommendation 5:
The Trust should ensure that GPs receive regular updates on mental health care provided by the Trust, including timely discharge letters. Adherence to this expectation should be audited and monitored to ensure compliance

Recommendation 6:
A service should be agreed regarding Autism Spectrum Disorder provision in CAMHS between SaBP and Commissioners.

Recommendation 7:
7a A quality standard regarding the recording, timely assessment and documented outcome of a formal mental state assessment when sought by a CAMHS nonmedical practitioner should be specified.

7b Formal mental state assessments should follow a standard approach and cover expectations surrounding adequate questioning.

Recommendation 8:
Services for young people, including schools and SaBP CAMHS services should raise awareness of inter relationship abuse amongst young people, and ensure that opportunities for education, support and disclosure are available.

Recommendation 9:
The Trust should change the policy and procedure on engagement with and support of families of victims and perpetrators involved in serious incidents to comply with current guidance. This should include the requirement to document decisions made, and clear descriptions of roles and responsibilities.

Recommendation 10:
The Trust should strengthen its process in relation to how it assures itself that the actions from Serious Incidents have been fully operationalised and embedded.

Good Practice

We wish to highlight the following areas of good practice:

1.25 CAMHS staff responded to the GP's urgent referral by telephone on the same day, and S was offered an appointment with CAMHS within a week of the urgent referral.

1.26 Oxted School ensured that S was able to take exams at home, and successfully apply for sixth form.

1.27 Discharge from the CAMHS service was managed sensitively, with a final ending session.

1.28 After the details of the homicide became known to the school, the school arranged for a range of support services to be available to staff and pupils. CAMHS were involved by the school at this stage and later as required to support pupils.

1.29 A medical review of the care and treatment was provided, appropriately carried out by a CAMHS consultant psychiatrist from another CAMH service within the Trust.

1.30 The internal investigation report was adjusted to include S's mother's perspective on the report.

2 Introduction

2.1 S and Elizabeth both attended sixth form at Oxted School, and had been in a relationship since October 2013. On 24 January 2014 S had arranged to meet Elizabeth in the grounds of their school, and they walked together to his house, arriving at about 14.30. S's sister arrived home at about 15.45, by which time Elizabeth was dead. S told his sister that he needed to talk, that "*Ed made me do something bad".* His sister went with him to the bedroom and S told her that Elizabeth was under his bed. S had killed Elizabeth with a knife and dismembered her body with knives and gardening tools. Elizabeth's body was later found under plastic sheeting under his desk.

2.2 S's sister phoned her mother, and after both parents arrived home, S's father called the police.

2.3 Police attended and S was arrested on 24 January 2014 on suspicion of the murder of Elizabeth and taken into police custody. In his room was found a handwritten list of items that included knives, cutting tools, and plastic sheeting. The handwritten list was seen by police as evidence of some degree of planning. A number of knives and cutting tools were also found in his room.

2.4 S was assessed under the Mental Health Act 1983[4] soon after his arrest. He was found to appear detached from events, and he said he did not recall what happened. It was noted that the evidence appeared to indicate that he was the perpetrator, although he did not accept any responsibility for this.

2.5 The assessing psychiatrist considered that he may be experiencing a number of possible psychotic symptoms including visual and auditory hallucinations, and beliefs that others can read his thoughts. He referred to the male voice of 'Ed' and was sometimes on the verge of tears, but otherwise articulate and talkative. He was not judged to be obviously depressed or suicidal, however due to his history of self-harm and the severe nature of the offence he was considered to be a potential high risk to himself and others.

2.6 It was agreed by the two psychiatrists and the approved mental health professional that he required further assessment under the Mental Health Act, and he was transferred to the Wells Unit, a secure adolescent mental health unit at West London Mental Health Trust under Section 2 of the Mental Health Act 1983[5] on 25 January 2014.

2.7 S remained in the Wells Unit until 30 January 2014, and he was discharged from the Mental Health Act back to custody after an assessment by Broadmoor high secure hospital agreed with the Wells Unit team that S was not apparently suffering from a psychotic disorder.

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[4] [4] The Mental Health Act 1983 is an Act of parliament which applies to people in England & Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. *http://www.legislation.gov.uk/ukpga/1983/20*

2.8 S's initial plea was of not guilty, but as he later changed this to guilty there was no trial. The prosecution case was that the murder of Elizabeth was premeditated. He was assessed in prison by a paediatric neurologist, consultant child and adolescent psychiatrist, a consultant psychologist, and a consultant forensic psychiatrist, none of whom recommended either a plea of diminished responsibility, or a medical outcome at court.

2.9 On 2 October 2014 at Guildford Crown Court S was found guilty of murder and sentenced to life imprisonment, to serve a minimum of 25 years.

3 Independent investigation

Approach to the investigation

3.1 The independent investigation follows the NHS England Serious Incident Framework (2013)[6] and Department of Health guidance (94) 27,[7] on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in Appendix A.

3.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

3.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.

3.4 The investigation was chaired by Nick Moor, Director of Niche. The investigation team comprised of Carol Rooney, Senior Investigations Manager and report writer; Dr Ernest Gralton, Consultant Forensic Psychiatrist in Adolescent Developmental Disabilities; Christopher Gill, lay member and family support; and Clare Hughes, Criminal Justice Coordinator, National Autistic Society. The investigation team will be referred to in the first person plural in the report.

3.5 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency guidance.[8]

3.6 The independent investigation team would like to offer their deepest sympathies to Elizabeth's family. It is our sincere wish that this report does not contribute further to their pain and distress.

3.7 We would also like to thank the families of both Elizabeth and S for their invaluable contribution to our investigation. We acknowledge how hard it must have been for them in this tragic situation.

3.8 We have used information from S's clinical records provided by Surrey & Borders Partnership NHS Foundation Trust, West London Mental Health NHS Trust, and the GP practice where S was registered. We also used information from the Surrey Police, Surrey Youth Offending Team Surrey County Council

[6] *Serious Incident Framework March 2013. NHS England*

[7] *Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services*

[8] *National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

Safeguarding strategy meeting held on 29 January 2014, and legal files. We have read the reports prepared for court by a paediatric neurologist, consultant child and adolescent psychiatrist, a consultant psychologist, and consultant forensic psychiatrist.

3.9 We met with Surrey Police to review the case summary, and conducted telephone interviews with S's GP and Youth Offending Team worker.

3.10 As part of our investigation we interviewed the following staff:

Surrey & Borders Partnership NHS Foundation Trust

- Director of Nursing and Quality
- Director of Risk and Safety
- Head of Clinical Risk and Safety
- Lead Nurse for Clinical Assurance
- Consultant CAMHS psychiatrist who saw S
- Consultant CAMHS psychiatrist who clinically reviewed the serious incident report
- Therapist who saw S
- Consultant Psychotherapist
- Director of Children and Young People Service's

Guildford and Waverley Clinical Commissioning Group

- Head of Children's Commissioning
- Associate Director for Quality & Improvement

Oxted School

- Head of sixth form
- Head of house
- Inclusion Team teacher

3.11 These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature.

3.12 Our clinical advisor psychiatrist was unable to meet with the SaBP consultant concerned as part of this investigation, although he was interviewed by the rest of the panel.

3.13 We wrote to S at the start of the investigation, explained the purpose of the investigation and asked to meet him. S gave written consent for us to access his medical and other records. We met with S in prison on two occasions, and offered him the opportunity to meet with us again to discuss the report prior to publication. He made no comments.

3.14 Our lay team member made contact with both families, and remained in contact throughout the investigation. This was to provide support and ensure both families were updated on the progress of the investigation and had an opportunity to ask questions.

3.15 We met with S's mother at the start of the investigation, explained the purpose of the investigation and offered to meet with her to share the report prior to publication. She gave the team a number of questions that the family hoped to have answered, and requested to be interviewed formally as part of the investigation, which was done. We met with S's mother to gather comments on the draft report, and comments made have been incorporated into the report.

3.16 We met with Elizabeth's family at the start of the investigation, explained the purpose of the investigation and offered to meet with them to share the report prior to publication. Elizabeth's mother requested to be interviewed formally as part of the investigation, which was done. We later met with Elizabeth's mother, aunt and sister to gather comments on the draft report.

3.17 The Thomas family have requested that we include the following statement. We respect the reflections offered by the family and want to ensure that we provide an opportunity for them to be shared.

Thomas family statement

Impact statement made by Elizabeth's family.

Elizabeth Rose Thomas was murdered when she was 17 years old.

Had she been here with us today she would be 21 years old, in her third year of her degree at university, and ready for all that her future had to offer.

Instead, we are provided with an independent investigation report into the care and treatment of the 17 year-old-boy that murdered her.

Nothing will take away the pain and immeasurable loss that we carry as Elizabeth's family.

Our family has been totally devastated since 24th January 2014 – and we remain so today.

The experience of the criminal investigation that followed - and the subsequent conviction of Elizabeth's murderer on 2nd October 2014 - was painful, shocking and emotionally exhausting.

It was however, completed within 8 months. This process has taken more than two years since then.

In his summing up, Judge Christopher Critchlow said:

"This is a case of the utmost gravity, the horrific features of which are rarely heard in any court. Nothing this court can say or do, no sentence this court can impose, can alleviate the pain suffered by Elizabeth's family for her death in such a terrible manner. There must be a life sentence".

We left court feeling utterly bereft.

Elizabeth's sister, now an only child, was 14 at the time. She has shown immense courage and maturity. She has given her parents a reason to function in their daily lives. She misses her older sister terribly.

It's desperately unfair that she has had to go through her teenage years without Elizabeth as her friend and mentor.

Our family has been hurt and damaged by the lack of compassion, contact and consideration from Surrey and Borders Partnership NHS Foundation Trust.

At the height of our grief, and in the absence of any information from the Trust, we were left to rely on reports in the press, and questionable rumours in the local community.

We did not know who or what to believe, and this left us more isolated, more exposed and more vulnerable than ever.

We knew that any investigation would not change the unthinkable thing that has happened to us, however we dared to hope that the independent investigation might provide some of the answers we were looking for.

Instead we have been left with even more questions.

And we have experienced a further sense of loss and suffering through a process that has maintained us in our grief, and provided us with *no* assurances that this terrible experience couldn't happen to another family.

Surrey and Borders Partnership NHS Foundation Trust did not consider they had *any* role or responsibility to us a grieving family.

They claimed several factors had influenced their decision not to contact us -

- that Mr S was a recently discharged patient,
    - *as if this should have any bearing on engaging with us after such a terrible incident*
- that there had been no media reporting of Mr S's mental health in relation to the homicide,
    - *which was clearly untrue, as it had been clearly and widely reported that Mr S had been sectioned under the mental health act immediately after the incident.*
- that they didn't want to compromise the criminal investigation,
    - *which cannot be correct, as it didn't prevent them making contact and offering support to Mr S's family and friends before the trial*
- the need to maintain Mr S's confidentiality

- *although there was clear guidance from the NHS at the time to engage with victims' families effectively*

and

- that Elizabeth's family did not live in the area covered by their service.
  - *which is just not a valid reason for not contacting us.*

We were, and remain, completely shocked at their callous and inhumane response.

It is not compassionate, it is not caring, it is not acceptable.

We completely fail to see how our experience reflects the trust vision of -

CARE - communicate, aspire, respond and engage - helping us to remain ambitious passionate and to do the right thing every time

Well, not this time.

It is fine to have a catchy PR slogan – but we believe it has actually got to mean something in practice.

Because the choices and decisions you make every day, can have a devastating effect on people's lives.

Surrey and Borders Partnership NHS Foundation Trust have made a number of statements about its practice and conduct in this case, that do not stand up to scrutiny.

- They state they did complete psychiatric risk assessments and yet no documentary evidence could be found. Without that evidence we have to conclude they **did not** happen.
- We note the report's finding (at paragraph 5.47) that, at a meeting called by Surrey County Council, the Trust's claims to have agreed for other agencies to provide support to the family, were not, in fact, true.
- The Trust states they had good communication with the school yet there is no evidence to support that. Therefore we believe they **did not** communicate with the school.
- Their internal investigation was very brief and didn't adequately address all the problems. It was an investigation following a homicide that was self-congratulating on elements of their services that they were not able to evidence or support.

It is therefore extremely difficult to accept the assurances provided by this organisation.

It remains hard for us to believe anything that this organisation says.

The inspection by the Care Quality Commission published in July 2016 concluded this organisation requires improvement.

Two years on from Elizabeth's murder, they found -

- The Trust Board still does not have thorough oversight of incidents and complaints.
- Their systems for reporting and learning from incidents have weaknesses
- There is still no consistent use of a recognised risk assessment tool, nor consistent recording of patient risk across all core services, and
- In CAMHS there are poor risk assessments.

This is clearly a failure of leadership and management in the Trust.

We do not know what they have learned following Elizabeth's death.

It is hard to feel any reassurance that things have improved at all.

In our view the independent investigation does not go far enough.

Its conclusion that Elizabeth's death was not preventable or predictable is not one that we can agree with.

There was a lack of basic and accepted practice of mental health assessments with regular documented reviews,

There was a lack of consistent risk assessments reviewed regularly.

Had full assessments been undertaken, and had more probing and curiosity regarding "Ed" been made, then it is surely completely reasonable to conclude that a different treatment plan would have been put in place, which may have resulted in a very different outcome.

We believe that whilst detailing some of the omissions in care and documentation, the Report does not acknowledge clearly enough, the truly poor standard of assessment, risk assessment, care planning - as demonstrated by the lack of documentation.

We believe the majority of the recommendations in this report are in response to processes that should form the basis of good health care provision of any secondary mental health service in this country.

We remain convinced that without these aspects of basic care, this service did not see what was in front of their face - a troubled individual, with, at the very least, emerging complicated thoughts and emotions, at a key transitional point in their adolescence, who was discharged from services and only **12 weeks later** committed a despicably cruel act.

Was this not preventable?

We don't think so.

Structure of the report

3.18 A full list of all documents we referenced is at Appendix C.

3.19 The draft report was shared with Surrey & Borders Partnership NHS Foundation Trust, and NHS England prior to publication. This provided an opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed to review and comment upon the content.

3.20 Section 4 sets out the details of the background, and care and treatment provided to S.

3.21 Section 5 examines the issues arising from the care and treatment provided to S and includes comment and analysis, with reference to the terms of reference for the investigation.

3.22 Section 6 provides a review of the trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

3.23 Section 7 sets out our overall analysis and recommendations, and comments on predictability and preventability.

4 The care and treatment of S

Childhood and family background

4.1 S was born in Kent after a normal pregnancy and birth, and is the youngest of four children. The family initially lived in a tied cottage in Kent, where his father worked as a gardener.

4.2 The family moved to Oxted when S was 12, and this change was described by family as difficult for S at the time, he later said he liked living in a town.

4.3 S has stated that he has no childhood memories from before the age of 10, and it was reported by a psychologist who interviewed him in 2014 after the offence that "*he stated his lack of memory ensured that he did not know whether he had experienced any trauma or abuse".*

4.4 His early developmental history was consistent with an autistic disorder with respect to repetitive play and rigid routines; an example of this was at bedtimes where up to 30 soft toys had to be wished goodnight by the parent in an exact order or S would insist they start again.

4.5 S described his interests as films, classical music and reading. He described an interest in films and programmes with dark characters such as Donnie Darko, Psycho, Batman. He said had never enjoyed sport, choosing to stop attending PE in school as soon as he could.

Physical health history

4.6 S had a mild concussion from a head injury aged two with no reported after effects.

4.7 As a baby he had recurring upper respiratory tract infections, and was treated by GPs with antibiotics. There were seven recorded episodes until the age of eight.

4.8 S was diagnosed with psoriasis at the age of three, and had episodes of abdominal pain and vomiting, at ages five, nine and fourteen and fifteen. He was kept in hospital overnight aged five, and diagnosed as a possible grumbling appendix, which settled without treatment.

4.9 In 2012 there were several episodes of vomiting, and a GP referral to paediatrics was made in April 2012, though tests showed nothing abnormal. He was prescribed Omeprazole[9] for two weeks. He was seen again by his GP in May 2012 and December 2012 as vomiting had recurred, but nothing abnormal was detected.

[9] *Omeprazole is a medicine which is used in a number of gastric conditions - an example is treatment of reflux oesophagitis, or gastric or duodenal (upper intestinal) ulcers. http://drugs.webmd.boots.com/drugs/drug-342-Omeprazole.aspx*

4.10 One older brother had a history of daily seizures from early childhood, which became less frequent reducing to monthly in early adulthood. Both maternal grandfather and great grandmother were reported to have had epilepsy.

4.11 S reported having a 'blackout' and waking up on a bench in a park in August 2012, with '*unexplained superficial scratches/abrasions to his face and chest anteriorly'.*[10] He went home and his parents called the police, and he was taken to East Surrey Hospital accident and emergency department.

4.12 S was seen at accident and emergency by a CAMHS duty worker, who also saw S's parents. S said at the time that he couldn't remember anything except waking up with injuries. His parents later told the CAMHS staff that they were concerned that he may have caused the injuries himself.

4.13 The police opinion at the time was that it was very likely he had caused his own injuries, particularly given it was a hot day and S had no apparent after effects of having lain unconscious in the sun. This was later discussed with S by his therapist at CAMHS, and he continued to state he had no any awareness of what happened.

4.14 In another therapy session in October 2012 S reported having self-harmed. He said he walked to the bench where he had a 'blackout' then cut himself, but didn't know why he had harmed himself. This and his reversed sleep pattern was discussed, and information on sleep hygiene was sent to him afterwards. When he next saw the therapist a week later, he said he had managed to correct his sleep pattern back to normal and was feeling better physically and emotionally.

4.15 S was seen in prison for a court report by a consultant paediatric neurologist in 2014, whose opinion was that he could not exclude complex partial epilepsy and recommended that he was seen by a neurologist with a special interest in this area.

Schooling and relationships

4.16 S attended primary school in Kent, and when the family moved to Oxted he changed secondary schools. He had been attending secondary school in Sevenoaks, which entailed getting early transport, which he did not like. He denied ever being bullied at school, or being in trouble of any kind such as truanting.

4.17 The new secondary school was much larger than he was used to, which he described as difficult at first, but was generally in the first or second set. S joined Oxted school at the end of Year 8/beginning of Year 9. There were concerns about social withdrawal and attendance in June of Year 10 (2012), and letters were sent to family. Initially his absences were explained as flu and stomach upsets, later his mother told the school that he had been self-harming. The school was considering sending a referral to CAMHS, but S's mother informed the school that she had spoken to the GP and a referral to

[10] *Surrey & Sussex Healthcare Trust AED paediatrics discharge summary page 1.*

CAMHS was made in June 2012 after a friend of S's apparently told her that he had planned to kill himself.

4.18 S attained GCSEs at Grade C and above in Astronomy, Art, Literature and English in year 9, earlier than usual. S had a long period of absence in Year 11, after declining attendance, and made a conscious decision to stop attending in November 2012. His attendance was described by teachers as about 27%. The school communicated with his mother, and were told about his CAMHS attendance, and reported not wanting to put extra pressure on him, taking the lead from his mother. S had however applied for sixth form by December 2012.

4.19 A letter was sent by CAMHS in May 2013 to the school advising of the diagnosis of ASD, but no other medical details were provided. This meant that S could not have access to formal tutoring at home. However it was understood by the school that he wanted to take GCSE exams at home, but couldn't attend school. The school's approach was described as wanting to support him because he was bright and academically able. Staff who had been present for invigilation described S as being ready for the exams at home, and working quietly until finished.

4.20 S sat the remaining GCSEs at home with invigilation, and said he didn't do as well as he would have liked, but considering he had not studied much, he was happy enough with his results. S wanted to attend sixth form and was required to meet teaching staff to negotiate what subjects he wished to do. This was agreed with the school on the basis of his GCSE grades. S wanted to study psychology, and was initially attending on a probationary basis, but was reported to be doing well when this was reviewed after a trial period.

4.21 S was studying applied Science, Politics and Psychology. His sixth form attendance was over 90% and S was noted by his form teacher to be 'more like his old self' in school. He was also described as doing well with the social aspects of school, and was involved with a group of friends in sixth form.

4.22 S had friends at school of both genders, but was reported to be involved with a group of girls who self-harmed at times. We have gathered information from S, his family, Elizabeth's family, school staff and CAMHS professionals to try to gain insight into S's relationships.

4.23 In therapy sessions in June 2012 S referred to the break-up of a relationship with a girl from school (A) whom he said he had strong feelings for. This break up and S's feelings afterwards were often a focus in his therapy sessions with the CAMHS therapist and it was seen as a time of personal crisis. S has reported that his self-harm started in January 2012 and that he first saw the character 'Ed' at that time. It was reported that S sent A pictures of cuts to his face and body in August 2012, and also phoned her to say he was going to kill himself.

4.24 S had been seeing a girl from school B, for about six weeks at the beginning of year 11, in September 2012. This girl has since reported that S told her not

to be surprised if he kills someone one day, and that on one occasion he had put his hands around her throat restricting her breathing.

4.25 In October 2013 a relationship began with Elizabeth, who attended the sixth form and was in two of his classes.

4.26 It was reported that friends asked her why she bothered with him, and that she said she was '*fighting for him'*. A communication from S to Elizabeth in early January 2014 suggests that she may possibly see *"a lot of similarities to the personality of Dexter"* [11] and himself.

Arising issues, comment and analysis

4.27 We are conscious that some of this information was not available at the time to either the school, parents or to CAMHS. The school staff reported that they did not have any detailed medical information about S, and were guided by not wanting to put further pressure on him, based on his mother's feedback about his self-harming.

4.28 The school had an inclusion team,[12] ASD Pastoral Support Worker and was actively part of the county wide 'Targeted Mental Health in Schools' programme (TaMHS)[13] which aimed to '*skill up school staff in the support of pupils with emerging mental health and emotional needs and provide access to early advice and consultation from a mental health professional'*.

4.29 We found evidence that CAMHS workers from SaBP had provided some training for staff at Oxted School, and were available as resources for inclusion team staff. However we heard from school staff that training in mental health is very limited, often due to resourcing issues. Access to external expert clinical supervision was also considered a need for teaching staff who are involved in the care of a young person with mental health difficulties. Recommendations about training for school staff is beyond the remit of our report, but we would refer back to the TaMHS scheme described above.

4.30 In the care of S, the school received one letter from CAMHS in May 2013, informing of his diagnosis of ASD, a year after he had started attending. Despite his attendance dropping to around 27%, the school continued to offer the opportunity for S to attend when he could and agreed to arrange the

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[11] *Dexter is a US TV series about a Miami police forensics expert who 'moonlights' as a serial killer of criminals whom he believes have escaped justice. http://www.imdb.com/title/tt0773262/*

[12] *Inclusion teams have expertise in Special Educational Needs, behaviour, removing social barriers and developing emotional well-being. Legislation in the UK prohibits discrimination in education and supports inclusive education. http://www.csie.org.uk/inclusion/legislation.shtml*

[13] *http://www.healthysurrey.org.uk/your-health/mental-wellbeing/camhs/professionals/tamhs/ Fully funded core training packages focused on raising mental health awareness and attachment are offered to schools via borough-based Primary Mental Health Workers (PMHW), with the opportunity for additional work, for example regular PMHW attendance at pastoral meetings. TaMHS was originally part of a three-year national initiative led by the Department for Children, Schools and Families.*

invigilation for his GCSE exams at home, despite having very little information to go on. We consider this to be a good example of school inclusion practice.

4.31 There was however a lack of shared information and knowledge about the details of S's difficulties, and this should have been better co-ordinated by CAMHS staff.

Recommendation 1:
It should be standard practice that CAMHS staff will liaise with schools and arrange multi-disciplinary/agency discussion where appropriate, and actions and outcomes should be recorded. The local operational policy should be amended to include this expectation.

4.32 After the details of the homicide became known to the school, the school arranged for a range of support services to be available to staff and pupils. CAMHS were involved by the school at this stage and later as required to support pupils.

Mental health history and treatment

4.33 There is a family history of depression and possible bipolar disorder, on the maternal family's side. We were told that S's maternal grandmother was institutionalised for mental health difficulties, and S's mother describes her own mother as 'possibly bi-polar'. There is a history of depression and suicidal behaviour in S's maternal grandfather. S has told professionals that there is no mental illness history in the family, and it may be that he was not aware of this history. His mother has said she is estranged from the family.

4.34 In May 2012 S's mother contacted his GP and reported that he had been self-harming, and access to the ASD Pastoral Support Worker was suggested. In June 2012 his mother attended the GP surgery and said S's self-harm had increased; he was cutting his arm with a pencil sharpener blade most days. A referral to the local primary care child and adolescent mental health service (CAMHS) operated by SaBP was made by letter.

4.35 S's mother called the GP two days later, as a friend of S's had been in contact with her saying S was planning to kill himself. The CAMHS duty team were contacted and made telephone contact with S's mother, arranging an urgent appointment for S within a week.

4.36 S's first appointment at SaBP CAMHS on 20 June 2012 was attended by S, his mother and sister. This is a 'Tier 3' CAMHS service,[14] for young people who present with moderate and severe mental health problems that are causing significant impairments in their day-to-day lives. A '*Presenting Situation and Referral Outcome decision*' form was completed by the assessing clinician C. S talked of feeling '*really bad all the time'*, with difficulty in concentrating, feeling angry and violent and that he had felt this way for

[14] *NHS England Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3): https://www.england.nhs.uk/wp-content/uploads/2015/01/mod-camhs-tier-2-3-spec.pdf*

about a year. He described himself as being happy for about three months with girlfriend A but broke up a week earlier (June 2012) and is now "*devastated*". He had been self-harming by cutting his wrist two or three times a day.

4.37 It was agreed after a multidisciplinary discussion that S would be offered a regular meeting for therapeutic support with a therapist to help regulate feelings. Later in the notes a six week review after individual counselling is mentioned.

4.38 A care plan was written on 22 June 2012 which recorded that S's view of his need was to '*improve self-esteem, improve mood, stopping self-harm, relationships with peers become healthier'*. A contingency plan had been agreed that Mum would remove all medications and contact CAMHS in office hours or take S to accident and emergency if there was a crisis. Warning signs were listed as '*increased low mood*, *social isolation, friends informing mother S is low and intending to hurt himself'*.

4.39 There is no review or end date to the care plan, and because it was within the Electronic Patient Record (EPR)[15] notes, there was nowhere for to S to sign his agreement to the plan. It is noted in the clinical record that S was happy with 'open counselling' where he could talk about incidents that arise, and focus on areas of his life he hoped to feel different about.

4.40 A 'Risk Summary' form was entered on EPR on 20 June 2012. In the 'harm to self' section 'self-injury or harm', 'suicidal ideation' and 'act with suicidal intent' are indicated as present, and a risk formulation in this section notes that S self-harms by cutting, has told friends that '*life hasn't been worth* living' and they have alerted others. He was described as having a complicated relationship with a circle of girls, some of whom self-harm. It was also noted that S was '*keen for help and wanted to manage his feelings differently'*. Mother and sister were said to be very supportive of S.

4.41 Harm from others, harm to others, accidents, or other risk behaviours were not identified as risks in the other sections. The summary notes that S is keen for help. Suicidal ideation is expressed to friends in a complicated relationship. '*No active suicidal ideation'* was noted. It was noted that '*family are aware of safeguarding measures and who to contact if concerned'*. There is no update to this risk assessment.

4.42 We acknowledge that there is evidence of review and response to S's changing needs in the narrative, and we do not believe that the issues related to the lack of detailed documentation in the EPR had any relevance to the progress of S's treatment, or to the homicide itself. However, the requirement to update risk assessments is a basic tenet of practice, and the Trust should be assured that staff are compliant with policies. The Trust Clinical Risk Management Policy dated September 2011 requires that risk assessments are updated at every care plan review (and or CPA review) until discharge,

[15] *RiO is an electronic clinical record keeping system in use by the Trust at the time of the incident and widely across mental health units.* http://www.servelec-healthcare.com/AboutUs/AboutUs.html

and a record of all reviews is maintained in the case files. This did not occur in this case. It is of particular concern that 'harm to others' was not revisited after S talked about 'Ed' telling him to be angry and aggressive in March 2013.

Recommendation 2:
The Trust should ensure compliance with clinical risk management and clinical documentation policies, and audit the effectiveness of this process

4.43 S was seen by a systemic therapist for 24 separate sessions between June 2012 and October 2013. Four of these sessions were also attended by the team consultant child and adolescent psychiatrist.

4.44 At his first session S talked about themes around relationships and friendship networks, and difficulties in managing contact with his ex-girlfriend A, who was at the same school. He described low self-esteem and how he would like to be happier, and stop self-harming. It was noted that he invited others to see his self-harm possibly hoping they would rescue him.

4.45 S described himself as 'different' and a 'geek' and enjoying being different, he also talked about 'obsessions' with 'batman' and was difficult to distract from this. The therapist has noted a query about whether S may have Autism Spectrum Disorder (ASD)[16] at the second appointment.

4.46 Over the next three sessions, until 16 August 2012, the focus was on managing feelings and relationships with others, including his feelings about A. S said he had not self-harmed since July, and was engaging with ways of coping with intense feelings and responses to distress. He was noted to be more in control of his thoughts and feelings, and able to distract himself from intense feelings, rather than self-harm. It was later noted that S had not in fact stopped self-harming at this time.

4.47 S was seen by the CAMHS weekend assessment service at East Surrey Hospital on 17 August 2012. S said he went for a walk and sat down on a bench, then three hours later 'came round' on the floor near the bench with cuts to his face, arms and chest. His parents were initially concerned that he had been mugged, and called the police.

4.48 S told the duty CAMHS worker that he did not know what had happened to him, and denied using any drugs or alcohol. The duty worker also saw his parents without him, and they said they were concerned that he may have caused the injuries to himself and talked of ongoing concerns about his mental health and risk to himself. His parents asked for more direct intervention with S such as detaining him in hospital. It was suggested they speak to his CAMHS therapist about these.

[16] *Autism spectrum disorder (ASD) is a condition that affects social interaction, communication, interests and behaviour. It includes Asperger syndrome and childhood autism.* http://www.nhs.uk/Conditions/Autistic-spectrum-disorder/Pages/Introduction.aspx

4.49 S was kept in hospital overnight and observations were all normal, including electrocardiogram and blood pressure. The discharge summary sent to the GP suggested '*CAMHS follow up as planned*'.

4.50 S's mother asked for an appointment with the therapist on the following Monday to discuss her concerns. As she was not available, the consultant CAMHS psychiatrist Dr B saw her without S. Dr B attempted to reassure his mother that he would not manage S any differently from therapist C and agreed it was likely that S had harmed himself.

4.51 S's mother spoke to the therapist C by phone before the next session with S; she was concerned that S was showing people his injuries and in her view appeared to be enjoying the attention. S had also apparently told his mother that C had told him to self-harm if he needed to, which C confirmed was not true. C explained to S's mother how S might have interpreted their conversation. When working with S it was important he felt able to let C know if he had self-harmed and not to feel ashamed as it was an important communication. Although they were working on ways to help him explore his distress and alternative ways of managing it, it was important a therapeutic relationship was created to enabled S to let C know, rather than keep it hidden through shame or potential to want to please C.

4.52 S was given opportunities by C to discuss the events of the weekend, and described how family thought he may have been mugged, and also their thoughts that the injuries were self-inflicted. He showed C pictures of his injuries, and described showing his friends in the hope that they would understand what had happened to him. He denied any current thoughts of self-harm or active suicidal ideation. A six week review was due to be held on 29 August 2012.

4.53 At the review meeting on 29 August it was acknowledged by S and his mother that S appeared happier, less isolated and they were more connected as a family. Feedback was given about S's positive progress in considering new ways of responding to feelings. It was agreed that the next appointment they would look at markers for discharge. There was no discussion recorded about exploring a diagnosis of about ASD.

4.54 At the next (eighth) session S talked about feeling low, and very angry intermittently, associated with a cycle of communication with friends where he conveyed his distress and it ended in an argument. He had scratches on his neck which he said the cat did when he was asleep. At his next session he admitted that he did it himself and described how he had told his ex-girlfriend and other friends he was going to hurt himself. At this point he said he had intended to kill himself and took 10-12 paracetamol and scratched his neck, then went to sleep. He alluded to a complex decision making process around self-harm which he said he would share with C in the future. He also referred to an interest in Satanism which C offered to explore in the future. The risk assessment was not updated. At interview for this investigation, C is very clear that, at the time, that there was no evidence S was engaging with or wanting to engage with such practices. It was acknowledged that it should have been explicitly documented in the electronic notes that this was attended

to and there was no indication that it was a preoccupation, obsession or practices S participated in at the time. C is unaware of any new information or evidence (from family, S or school) that suggests this was a significant concern during the CAMHS episode, at the time of the tragedy or since then.

4.55 Two sessions later in October 2012, S discussed how he makes decisions to self-harm. He described seeing a man whose name is 'Ed', who is tall and wears a black coat, and he first appeared in January 2012 during a difficult time with ex-girlfriend A. S said he told S to start smoking, and occasionally self-harm but had never told him to hurt others, or to kill himself. No pattern was identified and it did not seem to be related to mood. S described seeing and hearing 'Ed'. C advised that she would discuss this with Dr B.

4.56 Dr B met S on 19 December 2012 (18th session) to discuss 'Ed'. S described 'Ed' as coming to him in a dream the previous January, when he was particularly stressed in relation to friendships. He was then able to see him and talk to him, although 'Ed' was mostly around when S was on his own, he was clear that 'Ed' does not talk about him in the third person. The notes record "*no reason to raise further concerns as it could be attributed to anxiety. Agreed S would let us know if Ed changed in any way and became more of a concern to S".* There is contact with his mother by telephone and contact with both parents is noted in the EPR. The purpose of this appears to be predominantly information gathering and getting objective feedback about his mental state and behaviour at home. His ASD diagnosis was discussed with his parents on the 11 Feb 2013. However it is unclear whether the voice of Ed was discussed at that time with parents and explained that it was felt to be a manifestation of anxiety related to his ASD.

4.57 Clinical notes record that in early December 2012 S and his parents had at been given questionnaires to complete with regard to a diagnosis of ASD, and had opportunities to ask questions and discuss the detail with C and Dr B. S is noted to have a self-reported score of 24 on the Australian questionnaire. This is a clinician rated questionnaire, which can be used for assessments of autism.[17] [18] The relevant NICE Guideline 128 'Autism *Diagnosis in Children and Young People'* was issued in September 2011[19]. This recommends that the diagnosis of Autism is made on ICD-10 or DSM IV criteria, however they do not recommend a specific instrument. The use of the Australian Questionnaire was used as an additional assessment to support the diagnosis using ICD-10 or DSM IV criteria, although this is not explicitly stated in the EPR notes.

[17] *http://www.aspennj.org/pdf/information/articles/australian-scale-for-asperger-syndrome.pdf*

[18] *Australian Scale for Asperger Syndrome (ASAS, Garnett and Attwood, 1995), a clinician rated questionnaire, which can be used for adult assessments. Asperger's Syndrome: A Guide for Parents and Professionals. Attwood T, 1998*

[19] *Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum. https://www.nice.org.uk/guidance/cg128*

4.58 The subsequent NICE Guideline[20]142 '*Autism, Recognition Referral Diagnosis and Management of Adults on the Autistic Spectrum'* published in June 2012 does give guidelines on additional diagnostic tools but the Australian Questionnaire is absent from this list. However as S was an adolescent, the relevant guidelines were No 128, noted above. We suggest however that Adult NICE guidelines may be more clinically relevant to older adolescents than those intended for children.

4.59 A discussion with S and his parents was recorded where it was agreed to put individual therapy on hold while the ASD assessment took place. The parents are noted to have agreed because "*significant changes had been made and the need was less."* Notes of a phone call in early January 2013 to S's mother record that his mother said it had been a good Christmas, S had been brighter and more open, including talking about 'Ed'. There are undated screening forms completed by S and parents in the notes, but no record of analysis.

4.60 A positive diagnosis of ASD was made by Dr B in February 2013, and it was agreed a letter to the GP would be written by Dr B that S and parents could share with the school. A support pack was discussed and given to parents, with information about support. S later spoke about being relieved at having a diagnosis, and had shared it with friends, he said he felt pleased because there were many qualities to the diagnosis. It was noted that '*S did not identify any help needed re ASD'*. He was offered the opportunity to attend a young people's group for ASD but declined.

4.61 In March 2013 (21st session) S said that 'Ed' has told him to be angry and aggressive, without describing who this may be aimed at. S was clear that 'Ed' doesn't exist, but he had become integral to his life. The therapist recorded the view that 'Ed' served as an outlet for feelings of anxiety, frustration and anger, and invited S not to externalise 'Ed'. He described isolating himself because of anxiety, being anxious in crowds and small spaces. Ongoing help focussed on anxiety with a different worker was discussed but S wasn't sure about meeting a new worker, and further sessions were agreed.

4.62 Dr B joined the 22nd session on 8 April 2013; S was planning to start back to school, and it was agreed that Dr B would make contact with school staff to discuss support, and C would try to meet with S and his year tutor to ascertain what further support was needed or could be provided in school. Neither of these were carried out. 'Ed' was discussed at this meeting and the notes record "*explored 'Ed' and no further concerns in relation to his experience of 'Ed' and likelihood to be anxiety related".* We were subsequently told at interview that it was agreed that a meeting between CAMHS and the school was not needed, partly because S's mother was very proactive in keeping the

[20]*Autism: recognition, referral, diagnosis and management of adults on the autism spectrum. https://www.nice.org.uk/guidance/cg142*

school informed, from the CAMHS perspective. It was acknowledged that this decision should have also been documented clearly.

4.63 A review by phone took place with S's mother on 13 August 2013; S had done exams at home, was reported to be doing well, and appeared happier. He was offered a review appointment for 28 August 2013.

4.64 At this session S was described as in good spirits, talking of feeling in a very different place, generally happier and less troubled. He described feeling that he is managing distress differently and also is not being invited into more complex relationships. He talked of looking forward to sixth form and felt it would be a very different experience. The notes record that a mutual decision was made to end the work, with one final appointment jointly with Dr B.

4.65 A phone call to S's mother was made by C in September, and she reported S was 'great', had been to school every day and made new friends. The feedback was he was doing well and attending sixth form was good for him. A final end date of 18 October 2013 was agreed.

4.66 S was seen for a final (24th) session by C and Dr B; he was described as able to acknowledge changes he had introduced into his life and how hard he had worked. Some reflection on having a diagnosis of ASD was described. S said he was enjoying sixth form and was in a happier place and more in control. He was able to discuss how he would manage if things became difficult, and how to access further support if he needed it. It was left that CAMHS would close his case, and C would do a letter (presumably to his GP) that would be copied to his parents. This was not done.

Contact with criminal justice system

4.67 S had no contact with the criminal justice system before 24 January 2014.

5 Arising issues, comment and analysis

5.1 We address each element of the terms of reference in separate sections, supporting our analysis with evidence as appropriate.

Review the engagement, assessment, treatment and care that S received from Surrey and Borders Partnership NHS Foundation Trust from his first referral in June 2012 up to the time he was discharged in October 2013.

and

Review the personalised care planning and risk assessment, policy and procedures and compliance with national standards and best practice. Review to what degree was S and his family involved in agreeing his care.

5.2 CAMHS staff responded to the GPs urgent referral by telephone on the same day, and S was offered an appointment with CAMHS within a week of the urgent referral, which is very good practice.

5.3 The assessing CAMHS therapist C saw S with his mother and sister, and completed a 'presenting situation and referral outcome decision' form in the EPR and it was agreed this would be discussed at the multidisciplinary team meeting and contact would be made with S's mother. This was good evidence of a responsive service. Once a plan was agreed, S was seen weekly initially, and then fortnightly.

5.4 A care plan was written on 22 June, two days after the assessment meeting, but with no review date. There was no obvious mechanism for S to sign his agreement to this because it is electronic. The notes record broad agreement by S and his mother with the aims and format of sessions, but no formal discussion of the care plan. A review at six weeks is mentioned, but although there was a review meeting at six weeks, the care plan was not formally reviewed or updated. There was a further review planned in August 2013 after a three month break and again the care plan was not formally reviewed. As mentioned in the internal review, no discharge letter was sent to the GP.

5.5 The SaBP *care planning and assessment procedure incorporating care programme approach* policy dated July 2012 contains the following requirements:

- a letter confirming the decision to allocate to a CPA level should be sent to the service user and GP
- care plans should be developed in collaboration with service users, the care plan must be completed in full, signed to agree the content and dated by the CPA care coordinator and the person it relates to,

- a letter or discharge plan of how to re-refer to services, crisis and contingency action plan and details of any continuing needs and how these are to be met and;

- at discharge the GP should be sent a letter at least four weeks in advance of discharge

None of these were met in this case.

Recommendation 3:
The Trust to strengthen how it captures patient and family agreement with their care plans in the Electronic Patient Record, in line with its existing performance indicators on individuals and families receiving a copy of their care plan and people feeling involved in developing their care plans

5.6 The SaBP *care planning and assessment procedure incorporating care programme approach* policy dated July 2012 states anyone identified as a carer should be offered a carers assessment. There is no evidence that this was done.

Recommendation 4:
The Trust should further strengthen the process currently in place to ensure that carer's assessments are carried out as expected in policy, and audit compliance with this requirement.

Recommendation 5:
The Trust should ensure that GPs receive regular updates on mental health care provided by the Trust, including timely discharge letters. Adherence to this expectation should be audited and monitored to ensure compliance

5.7 The SaBP *clinical risk management* policy and procedure dated September 2011 requires the risk assessment to be reviewed at least at each care plan review, and also following any "*significant social or mental health changes*". While professionals are expected to make considered judgments about the impact of changes on risk assessment, we consider that there should have been an updated risk assessment at least at each review, and also at the time of the 'blackout' in August 2012, and at the first mention of 'Ed' in October 2012. S's mother expressed her concern to professionals after the August 2012 incident and had asked if he should have more directive intervention, and was assured it did not change the treatment plan.

5.8 It is clear however that risk was given attention and review during the treatment progress. For instance when 'Ed' was first discussed in October 2012, it was noted that there were no commands to harm himself or others. However conversely when S talked of 'Ed' becoming louder and telling him to be angry and aggressive in March 2013, this was not explored. We consider that a risk assessment review should have been indicated at this point. S himself has later stated that he had told CAMHS that 'Ed' was telling him to harm people. At interview we asked both clinicians directly if S had said this, and it was refuted. We can only assume that recollections of this detail differ between individuals, but clinicians stated vehemently that had there had been any expression of harm to others this would have triggered a risk assessment and care plan review. However we note that the risk assessments and care plans were not reviewed within the requirements of Trust policy. We have addressed this in Recommendation 2.

Review the engagement of services with S after his diagnosis with Autism Spectrum Disorder in 2012/2013 and consider the appropriateness of the pathways and treatment options he received in line with national standards and best practice.

5.9 The consideration given to a possible diagnosis of ASD was raised with the consultant psychiatrist, and a screening assessment made using a recognised tool.[21] The use of the Australian Questionnaire as an adjunct to the diagnosis of ASD was permissible, and although it is arguable that there are better tools, the diagnosis of ASD is likely to be correct. The issue really is the status of the voice of 'Ed' and whether this warranted additional investigation as an illness co-morbid with his ASD. Given that there was both a strong history of epilepsy in the family and there is an increased incidence of epilepsy in people with ASD, investigations to try and exclude complex partial seizure activity were probably warranted. The other consideration should have been whether he was in the prodromal stage of a co-morbid mental illness.

S was seen by Dr B to complete a diagnosis, following information and questionnaires from S and family. A report was promised to the school, which was not done. We consider that the notes should have reflected more information on the assessment process used, the ASD symptomatology that S experienced, and what significance these may have had for his understanding of his presentation. He and his family were given an information pack, and it is noted that he declined to attend a support group.

5.10 We note that at the time SaBP CAMHS were not commissioned to provide ASD input beyond assessment, diagnosis and signposting. This level of service is not uncommon with regards to ASD nationally, however the draft *Children and Young Peoples Service, Specialist CAMHS Services Surrey Wide Operational Policy* dated August 2012 clearly records ASD in the list of presenting conditions, and it is not listed as an exclusion. However the (undated) SaBP *Child and Adolescent Mental Health Service Assessment for Autistic Spectrum Disorders Information Booklet for Parents/Carers* states that

[21] *Australian Scale for Asperger Syndrome (ASAS, Garnett and Attwood, 1995), a clinician rated questionnaire, which can be used for adult assessments. Asperger's Syndrome: A Guide for Parents and Professionals. Attwood T, 1998*

'*Our CAMHS service does not routinely offer follow-up appointments post diagnosis unless there are specific mental health concerns'*.

5.11 Within the SaBP CPA Policy there are descriptions of a pathway in place to provide services for young people with first episode psychosis but not for ASD. We interviewed Clinical Commissioning Group representatives who described a revision of the pathway for ASD which is currently being developed.

5.12 The NICE guidance however clearly states: '*The overall configuration and development of local services (including health, mental health, learning disability, education and social care services) for children and young people with autism, should be coordinated by a local autism multi-agency strategy group (for people with autism of all ages) in line with Autism in children and young people (covering identification and diagnosis) (NICE clinical guideline 128) and Autism in adults (NICE clinical guideline 142)'.*[22]

5.13 Our opinion is that the assessment for ASD was adequate, but we consider that there should have been more exploration of the particular features of ASD that S exhibited, and support for him in managing their impact. It is accepted that the CAMHS service was not at the time commissioned to provide a pathway of care to young people with ASD, however we suggest that the Trust and CCG should clarify what services should be commissioned to meet NICE guidance for this particular patient group.

Recommendation 6:
A service specification should be agreed regarding Autism Spectrum Disorder provision in CAMHS between SaBP and Commissioners.

Review the communication between agencies and services.

5.14 The notes record that there was an intention to contact the school to meet with form teachers and S, and give more detailed information about his difficulties so that school support could be provided. It was known that he was attending very rarely, and may have to take exams at home. We have only located one letter from CAMHS to the school in May 2013 with brief information about ASD diagnosis. School staff at interview stated they had no other contact from CAMHS. We consider that there should have been more direct engagement with the school in this case.

5.15 No discharge summary was sent to the GP after treatment finished in October 2013. Lack of priority given to this was suggested as a possible reason, along with the workload of the CAMHS service at the time. It was noted in the internal investigation that both S and his parents understood clearly that treatment had finished, and there was a final ending session, which is good practice. There was a short information letter about discharge sent to the GP

[22] *Autism: The management and support of children and young people on the autism spectrum*

NICE guidelines [CG170] Published date: August 2013https://www.nice.org.uk/guidance/cg170/chapter/1-Recommendations

in September 2014, with no details. A summary report of treatment and discharge was never sent to the GP.

5.16 We were told that attention is now given to feeding back to GPs and that practice has changed in this team. However there was no awareness of how this might be monitored. In a different SaBP CAMHS team it was reported that GPs are regularly contacted to give feedback on the outcome of the initial assessment, and always on discharge. We were told there is however no formal system for monitoring that these are done.

5.17 The Surrey CAMHS service has undergone a significant redesign since S accessed the service, completed toward the end of 2014. The number of teams has been reduced and there is now a clearer emphasis on procedural and process issues for managers within CAMHS services. The expectation now would be that a service manager would have detailed oversight of caseload management, and would be expected to pick up on whether all process issues were carried out correctly, such as communicating with referrers and GPs. A caseload tracker has been in place since 2014 that allows service managers to check the progress of treatment by clinicians in their team, but there is no tracking of feedback to GPs.

Review if the Trust sought sufficient information and provided appropriate support, care and treatment regarding the voices S heard and the self-harm and anxiety that he suffered.

5.18 The internal investigation notes that the treatment model was not explicitly referenced, although there were 'extensive notes' made. It is clear from the notes that attention was given to S's management of distress, self-harm, coping with relationships, peers and family. S was seen by a systemic therapist, however there was no record of any overall formulation of his presentation, systemic or otherwise.

5.19 Within the notes we found evidence of attention to the detail of S's presentation with regard to emotional regulation, self-harm and the presence of 'Ed' in the following ways:

- Exploring the meaning of self-harm and its relational context, exploring if S was using self-harm as a way of managing emotional distress.
- Identification of mood, thoughts, feelings and physical sensations of anxiety. Developing an emotional language. Scaling /mood-indications. Slowing processes down to regain control and understanding, and exploring unhelpful patterns. Mental health promotion and emotional wellbeing including sleep hygiene.
- Anxiety and mood regulation strategies were explored and discussed.
- The role, presence and impact of Ed was explored and ways of managing this.

- On many occasions the approach and effectiveness of treatment was reviewed with S and his mother, and possible alternative approaches were discussed.

5.20 Consultant psychiatrist reviews were requested in December 2012 and April 2013 after S presented 'Ed' in sessions. At the psychiatric assessment in December S was advised to say if things changed in any way.

5.21 'Ed' was first mentioned by S in October 2012 (11th Session) when he told C that he is often guided to harm himself by this character whom he can see, and described his appearance. S said that 'Ed' first appeared in January 2012 in a dream; he told S to start smoking and occasionally self-harm, but had never told him to hurt others. It was clarified that 'Ed' was not there when S had the 'blackout' in August 2012. S could not identify a pattern and it did not appear to be mood related, and he was concerned that he could see 'Ed' as well as hear him. C advised that she would discuss with Dr B.

5.22 This was reported to have been discussed in the MDT meeting. An appointment was made with Dr B for December 2012. The appearance and experience of 'Ed' was discussed, and it was concluded that 'Ed' appeared when S was very stressed in relation to friendships. S described 'Ed' as a comfort, and talked to him at times. The question of whether the character asked him or encouraged him to do negative things was explored. At this meeting S said he did not, however this contradicts S's previous statements that 'Ed' encouraged him to smoke and harm himself .It was ascertained that 'Ed' did not talk about him in the third person. Dr B's opinion was that this was a manifestation of anxiety, and there was no reason to raise further concerns unless 'Ed' changed in any way. S was not concerned about any impact on his life at this stage and agreed to let CAMHS know if there was any change.

5.23 S's concerns about 'Ed' were again discussed on 21 March 2013 with C, and with Dr B and C on 8 April 2013 (22nd/second last session). S said that 'Ed' told him to be angry and aggressive, but was clear that 'Ed'' does not exist. Exploration is described around what kinds of situations provoke these kinds of thoughts. It is recorded that S said he had no thoughts of self-harm and was not actively suicidal. There was no recorded exploration of any thoughts or intentions around anger and aggression, however it is clear that extensive therapeutic support was given to S around emotional regulation and this encompassed many feelings, including anger. At the 8 April meeting with Dr B, it was noted that 'Ed' was explored but there were no further concerns and it was likely to be anxiety related. If the EPR record is taken at face value and S is not reported as making any specific threats to harm related to 'Ed' (which he subsequently says is untrue) there was insufficient evidence to refer to an adolescent forensic service.

5.24 In our opinion patients with ASD who report hallucinations or other quasi psychotic or dissociative symptoms, particularly those with a strong family history of epilepsy, require further investigation, particularly to try and exclude organic causes. There should also be evidence in the EPR record of a specific mental state examination related to these phenomena carried out by a consultant psychiatrist.

5.25 We consider that S was provided with a high standard of therapeutic engagement and input to help him with self-harm and anxiety. While the care plans could have been written in a more collaborative way, it is clear from the extent of the notes that treatment was planned and reviewed in conjunction with S and his mother.

5.26 With respect to the formulation and interventions for the 'voices' that S described, we would expect to see evidence of a detailed mental state exploring the nature of the voices and other phenomena related to 'Ed'. This may have been undertaken by the consultant psychiatrist leading to the conclusion that these were not thought to be related to a co-morbid mental disorder, but there is no specific record of this in his EPR notes.

Recommendation 7:
7a A quality standard regarding the recording, timely assessment and documented outcome of a formal mental state assessment when sought by a CAMHS nonmedical practitioner should be specified.

7b Formal mental state assessments should follow a standard approach and cover expectations surrounding adequate questioning.

Consider the wider safeguarding issues in terms of self-harm and potential for harming others and review if the Child and Adolescent Mental Health Service team fully appreciated these risks.

5.27 The notes record that risk management and harm minimisation was a continuous theme, though documented in session notes rather than as a formal revision of the risk assessment. There are records of discussion regarding triggers, precipitants and protective factors, and distraction methods were explored and discussed. S was requested to be accompanied by family to appointments in the initial stages of therapy to support his safety. Crisis and contingency plans including for emergencies and out of hours contact were documented and agreed (verbally) with parents. There were phone calls to S's mother to review and feedback during CAMHS involvement.

5.28 The SaBP policy '*Safeguarding Children and Children Visiting Inpatient wards/Units'* dated November 2013 has a section on 'Young Children/People Who May Pose a Risk to Others', and contains these two statements only:

- *If children, who are known to have committed offences or to have behaved in a harmful way towards another child, are admitted to your area of work, the person in charge must inform the Line Manager.*

- *A risk assessment and management plan must be made for supervising the child or young person during their admission and stay on the ward or attendance at out-patient's clinic following consultation with Children's Services*.

5.29 We consider that there were no particular safeguarding issues in this case that should have been attended to in relation to S's self-harm. There were no indications of any abuse in the family, concerns such as bullying or exploitation in school, or any relationships in which S appeared to be vulnerable.

5.30 Professionals showed a good understanding of their responsibilities with regard to safeguarding, and were able to evidence training and case supervision.

5.31 In relation to the potential for harm to others, we consider that the policy above does not provide sufficient guidance with respect to young people who may be considered at risk of harm to others.

5.32 There were no indications given that S may be at risk of harm to others, apart from one occasion when he said that 'Ed' tells him to be angry and aggressive. We consider that this could have been explored in more depth at the time, rather than the focus being on encouraging him not to 'externalise' 'Ed'. As outlined in section 4.72, S has subsequently told us that he did tell CAMHS that 'Ed' told him to hurt people. At interview we asked both clinicians directly if S had said this, and it was refuted. We can only assume that recollections of this detail differ between individuals, but clinicians stated vehemently that had there had been any expression of harm to others this would have triggered a risk assessment and care plan review.

5.33 Since the homicide, information has come to light that indicates S had talked of ideas about killing someone, and had on at least one occasion put his hands around a girl's neck until she couldn't breathe. He had also described himself as similar in personality to the fictional character in the *'Dexter'* series. What is clear is that this information was not shared with anyone either directly responsible for S such as parents or school, or CAMHS. S himself did not disclose these events or beliefs to the CAMHS team. When we interviewed S he denied any interest in '*Dexter*' and said it was merely one of many DVDs he watched.

5.34 It is of concern that this controlling and abusive behaviour[23] was not disclosed to any adults.

Recommendation 8:
Services for young people, including schools and SaBP CAMHS services should raise awareness of inter relationship abuse amongst young people, and ensure that opportunities for education, support and disclosure are available.

[23] *The term 'domestic violence and abuse' is used to mean any incident or pattern of incidents of controlling behaviour, coercive behaviour or threatening behaviour, violence or abuse between those aged 16 or over who are family members or who are, or have been, intimate partners. NICE Guideline: Domestic violence and abuse. https://www.nice.org.uk/guidance/qs116*

5.35 We conclude that while CAMHS could have explored the 'Ed' phenomenon in more depth in relation to harm to others, there was information that S had not disclosed to them and that was not disclosed until after events of 24 January 2014. We are mindful of the potential for hindsight bias[24] here, and would like to reiterate that no clinical indications of harm to others were evident to services at the time S was seen by CAMHS**.**

Review the documentation and record keeping of key information by the Child and Adolescent Mental Health Service against best practice and national standards and if record keeping is an issue within the Trust.

5.36 See discussion above of documentation, record keeping and policy adherence at section 5.4 to 5.8.

Review the communication between S's family and the Trust including the sharing of information regarding risks to S to inform risk assessment and management.

5.37 S's mother accompanied him to his initial sessions, and was part of discussions about next steps. Parents were invited to be part of the six week review in August 2012 and both parents were seen in December 2012 to discuss the ASD assessment. The notes also record phone calls made to S's mother to update her, or respond to a query. She was seen by Dr B at short notice after the August 2012 'blackout' incident.

5.38 Contingency plans were agreed with parents around removing accessible medication and razors, and emergency contact advice was given. Parents were seen together in February 2013 to be given feedback about the outcome of the ASD assessment.

5.39 S's mother has told us that she would have preferred more feedback and updates during S's treatment. We consider that the family were communicated with to a good standard during S's treatment, excepting that a carer's assessment should have been offered, as previously stated at 5.6.

5.40 In relation to involvement in the internal investigation, SaBP wrote to S's mother, then the internal report author met with S's mother in April 2014 with the intention of having her input into the internal report. The report was shared with S's mother before finalising, and some changes were made at her request. S's mother acknowledged that she was offered support by SaBP, but would have liked to have had support specifically offered for her other children and husband also.

Fully assess and review the Trust's engagement with the victim's family, before and after the incident, including information sharing and

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[24] Hindsight bias occurs when people feel that they "knew it all along," that is, when they believe that an event is more predictable after it becomes known than it was before it became known. Hindsight bias embodies any combination of three aspects: memory distortion, beliefs about events' objective likelihoods, or subjective beliefs about one's own prediction abilities. Roese NJ, and Vohs KD (2012) Hindsight Bias. Perspectives on Psychological Science 7(5) 411–426.

involvement in the internal investigation, measured against best practice and national standards.

5.41 The victim's family did not receive any communication from the Trust until January 2015, a year after the homicide took place. The explanation given was that S was discharged from the Trust services, there was no reference to mental health issues in the initial information, and it was difficult to decide whether the fact that S had been in contact with mental health services should be disclosed. The Trust also clarified that a decision was made not to make any contact during the Court proceedings.

5.42 We were told that Surrey police had been asked to convey that the Trust would like to offer any support that may have been helpful at that time. For whatever reason, it would appear that these wishes did not reach Elizabeth's family. A meeting was arranged in March 2015 with the Medical Director of SaBP and Elizabeth's mother and aunt.

5.43 The SaBP '*incident management'* policy dated August 2011, appendix 12 'Guide to being Open' provided guidance on communicating with people who use services who have been harmed. There was no guidance within the policy with regard to communicating with families of someone who may have been harmed by a service user.

5.44 The National Patient Safety Agency (NPSA) developed the guidance to 'Being open'[25] within healthcare organisations in November 2009, with the expectation that this would be implemented across the NHS. 'Being open' provides a best practice framework for all healthcare organisations to create an environment where patients, their carers, healthcare professionals and managers all feel supported when things go wrong and have the confidence to act appropriately. The framework gives healthcare organisations guidance on how to develop and embed a 'Being open' policy that fits local organisational circumstances.

5.45 The 'Being open' framework did not give any direct advice or guidance in the circumstances of a service user harming someone else, and in this sense the SaBP policy of 2011 was compliant with 'Being open', and the policy was followed. However in an unusual case of such seriousness, it would be reasonable to expect that decisions around communicating with the victim's family would be discussed at a senior level, which was not done.

5.46 We were unable to find any documentation of these discussions, but at interview this was explored with senior Trust staff. It was explained to us that several factors influenced the decision not to contact Elizabeth's family: the fact that S was not a current SaBP service user and had not been seen for three months, the absence of any information in the media that mental health was an issue in the homicide, the need to maintain S's confidentiality in terms

[25] *Being Open, saying sorry when things go wrong, communicating patient safety incidents with patients, their families and carers. http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726*

of his mental health treatment history, and the complicating factor that Elizabeth's family did not live in the area covered by SaBP services.

5.47 A multi-agency Section 47[26] Strategy meeting was called by Surrey County Council on 29 January 2014, to discuss the care of S after his arrest, and this meeting was attended by Trust staff. Senior staff stated that a decision was agreed at this meeting that police liaison officers and 'Victim Support' would be offering support to Elizabeth's family and that the Trust would not contact them directly. The Trust could not locate copies of the notes of the meeting, there were no notes made in S's EPR record following the meeting, and the member of staff who attended had left the service. We have seen the minutes of this meeting, and there is no record of a discussion about support by the Trust for Elizabeth's family. We have to conclude that this was not discussed at this meeting and a decision was made not to contact Elizabeth's family by the Trust.

5.48 Elizabeth's family were very aware of expectations of being open and the duty of candour and have been distressed by the lack of contact made by the Trust. They did have contact and support from police liaison and Victim Support. The family were aware of some aspects of S's mental health care through their daughter's contact with him, and knew that he had been seen by SaBP services. The family are left with a feeling of 'too little too late' in relation to the contact made by the Trust in January 2015, and were aware that the suggestion of meeting had come from NHS England independent investigations department, and from the charity Hundred Families,[27]who had offered some support.

5.49 The revised SaBP '*incident management'* policy and '*incident management procedure (including guidance on liaising with bereaved families)* dated July 2015 gives clearer guidance on '*Ensuring all Serious Incident (and other incidents that are formally investigated) reports are robust in their conclusions and disclosed to those affected (including any victims and their families) in a timely manner in accordance with the Being Open guidance and the contractual duty of candour requirements'*. This policy gives clearer indications that victims' families should be engaged with, but does not address the question of support and early communication.

5.50 Since 1 April 2015 all registered providers must meet the new CQC Regulation 20: Duty of candour[28] . The aim of this regulation is to '*ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must*

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[26] Where there are child protection concerns (reasonable cause to suspect a child is suffering or likely to suffer significant harm) local authority social care services must make enquiries and decide if any action must be taken under section 47 of the Children's Act 1989. http://www.workingtogetheronline.co.uk/chapters/chapter_one.html

[27] Hundred families is a charity that works with the Criminal Justice System, the Health Service and other organisations to support victims and to embed real learning in order to prevent these tragedies from happening in future. http://www.hundredfamilies.org/difference/

[28] Regulation 20: Duty of candour, Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare. http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body'.

5.51 The NHS Commissioning Board issued the 'Serious Incident Framework' in 2010, and an updated version in 2013 contains the expectation:

Ensure that all serious incidents are disclosed to those affected in a timely manner, appropriately reported and investigated, with the findings being shared with those involved in accordance with the Being Open guidance and the contractual duty of candour requirements.

5.52 We conclude that there were sufficient best practice guidance and regulatory expectations that should have steered the Trust towards a decision to contact Elizabeth's family, even if only to establish contact, acknowledge the situation and be open. We would also add that decisions of this importance should have a clearly documented decision trail that can be accessed in the future when necessary.

Recommendation 9:
The Trust should review the policy and procedure on engagement with and support of families of victims and perpetrators involved in serious incidents, and provide clear guidance on contact and support that meets the requirements of the duty of candour and the March 2015 Serious Incident Framework. This should include the requirement to document decisions made, and clear descriptions of roles and responsibilities.

6 Internal investigation and action plan

6.1 The terms of reference for this element of the investigation require that we:

Review the Trust's internal investigation report and to assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

- ***If the investigation satisfied its own terms of reference***
- ***If all key issues and lessons have been identified and shared***
- ***Whether recommendations are appropriate, comprehensive and flow from the lessons learnt***
- ***Review progress made against the action plan***
- ***Review processes in place to embed any lessons learnt***

6.2 SaBP were first made aware that S was taken into custody on 25 January 2014 by the Forensic Medical Examiner who was asked to assess him in police custody. There were inaccuracies in the detail of what was recorded in the notes, related to where S was discovered and by whom, possibly due to receiving information second hand. The information that S had been arrested for the suspected murder of a female friend was recorded. Attempts were made to contact his parents, but they were unavailable having been moved from the family home by police.

6.3 The Trust conducted a Level 2 Root Cause Analysis[29] (RCA) investigation into the care and treatment of S, completing this in May 2014, with some involvement of S's mother. The investigation was carried out by an experienced Clinical Risk and Safety Manager.

6.4 The terms of reference for the internal investigation were as follows:

- To identify the root cause of the incident/ event using fishbone or five whys technique
- To identify contributory factors
- To put forward recommendations for future improvement
- To identify actions and leads to complete the actions

6.5 The report is constructed as an RCA, with contributory factors listed. There is a separate section where a medical review is provided, appropriately carried out by a CAMHS consultant psychiatrist from another area The final report was not formally shared with the medical reviewer but was reviewed in the

[29] *Root Cause Analysis investigations in the nhs identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for patients.* http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

final draft form with the Divisional QAG of which he has membership and had receipt of the circulated report.

6.6 There is a fleeting reference to the victim Elizabeth only, and an absence of any discussion of victim family issues.

Contributory factors

6.7 These are listed in the accepted format, with the findings under each heading. The inclusion of S's mother's perspective on the report is good practice. **We will address those we believe are inaccurate or incomplete.**

Risk factors: the report indicates that risks of harm to himself or others was assessed. The notes record appropriate discussions of risk to himself and to others, but the risk assessment documentation was not updated after initial assessment in June 2012, despite at times an increase in risk to himself being noted, particularly after the August 2012 event. **There is no evidence that risk of harm to others was assessed after the initial meeting, and this was not reviewed after disclosure by S of 'Ed' telling him to be angry and aggressive.**

Communication: regular communication between the school and the CAMHS therapist which was of a good standard was noted. **We have not found any evidence of such communication, and we question this statement.** There is one letter only from the therapist to the school in May 2013, confirming a diagnosis of ASD. It had been agreed that Dr B would update the school in February 2013 after a review meeting which was not done. There was no other correspondence with the school in SaBP files, or Oxted school files. School staff interviewed stated they had no contact apart from the letter, and got information from S's mother only. **This is not, in our opinion, evidence of good communication with the school.**

It is also noted that '*formal written communication with S's GP was not in place at point of discharge'*. The GP in fact received an administration letter in September 2014 informing of S's discharge in October 2013, **and never received a formal discharge letter with clinical information.**

Treatment and care: **we cannot concur with the statement that the diagnosis, treatment and interventions appear wholly appropriate. We agree that he was provided with good quality therapeutic support and intervention, but believe that his symptoms as described merited further formal clinical examination by a psychiatrist, particularly with reference to exploration of the voices he described.** The internal report notes this only as a care and delivery problem that could have been better documented.

6.8 No root cause was identified from the Trust perspective, with which we agree. The contributory factors identified have been issues that have come to light during the investigation, where practice could have been improved. We do not consider any of these to be 'causal' factors. We do not believe they have had any direct influence on the homicide of Elizabeth.

Lessons learnt and action planning

6.9 The internal report made two recommendations:

1. Clinical records to reflect a formal mental state examination has been undertaken and documented clearly.

2. Following discharge from a service timely information should be sent to the GP.

6.10 We agree with these two recommendations, although we also make wider recommendations. However we consider that the actions taken to address these two issues are not sufficiently detailed or robust enough to change practice or ensure lessons are learned.

6.11 For recommendation 1 an audit of case notes was developed and carried out in August 2014. This showed that out of five CAMHS EPR notes examined, three showed a formal mental state as recorded, but not in two others.

6.12 A template discharge letter to GPs was developed as the actions from recommendation 2. This template letter was accepted as the action, and it was noted that it should be included in future clinical audits of notes. **No evidence of change in practice was provided.**

6.13 The Trust's mechanism for tracking the completion of serious incident action plans, and their actions taken to embed any lessons learnt were explained. Following agreement of the report and actions with the Clinical Commissioning Group, and senior management level review, the actions agreed are cascaded to Divisional Quality Action groups (QAG) where it is considered appropriate. There is also a system of quality 'deep dives' planned over the year, where a range of quality issues are reviewed by the Clinical Risk and Safety teams, with Board reports following. We were shown examples of action notes for serious incidents, and notes of the local Quality Action Groups.

6.14 While we accept that the action plan has been signed off as completed by both the Trust and the CCG, we were unable to locate evidence of any improvement in the provision of timely GP discharge letters by CAMHS teams. **There was no evidence of practice change in the area of documented format mental state assessments in CAMHS**. CAMHS clinicians interviewed were unaware of how this might be measured and reported on. Senior staff conveyed their belief that practice will have changed locally, supported by the local QAG, but there was no assurance system to evidence this. We were told there was a clear practice change with the monitoring and discussion of lessons learnt and practice change included in team meeting records. We would expect to see a more formal 'line of sight' for the Trust Board to receive assurance of lessons learned and practice changes

embedded. The CQC report of October 2014[30] noted that there was not an effective system to ensure that changes were made to treatment or care provided, by the analysis of incidents.

6.15 Our overall view is that the report did not answer its own on terms of reference, taking the information above into consideration, and the action plan has not resulted in lessons being learned.

Recommendation 10 :
The Trust should strengthen its process in relation to how it assures itself that the actions from Serious Incidents have been fully operationalised and embedded.

[30] *Surrey and Borders Partnership NHS Foundation Trust Child and Adolescent Mental Health Services Quality Report* *https://www.cqc.org.uk/sites/default/files/rxx_coreservice_child_and_adolescent_mental_health_services_surrey_and_borders_partnership_nhs_foundation_trust_scheduled_20140805.pdf*

7 Overall analysis and recommendations

7.1 The internal investigation by SaBP identified some areas of learning, which we support and have expanded upon. We have made ten recommendations for wider systems learning.

Predictability and preventability

7.2 We do not consider that on the information available at the time, the incident on the 24 January 2014 was predictable or preventable. Predictability is '*the quality of being regarded as likely to happen, as behaviour or an event*'.[31] An essential characteristic of risk assessments is that they involve estimating a probability. 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.[32] The information shared by S at the time of his care with SaBP did not include reference to harming others, neither his own thoughts nor any conveyed by the voice of 'Ed'. We are aware that S contests this now, but through our reviews of the notes and interviews with CAMHS staff, we are assured that if any reference to harm to others was raised by S it would have been acted upon. While we have identified that documentation could have been more detailed, we do not consider that this had any impact on the homicide.

7.3 Prevention[33] 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 be the knowledge, legal means and opportunity to stop the incident from occurring. Information has come to light from other young people since the homicide, which suggests that S had thoughts of harming others, had talked about killing someone one day, and had made some harmful actions towards other girls. S did not share these with either the school, parents or CAMHS, although he had ample opportunity. We do not consider therefore that the homicide of Elizabeth was preventable by SABP services.

7.4 With hindsight S's mother reflected that when S finished at CAMHS and joined sixth form he seemed more confident than he had ever been. At the time she and the family were pleased that he seemed to have settled into sixth form, was doing well at school and had stopped self-harming. After a long period of S being withdrawn and self-harming this seemed a real improvement, which had been acknowledged by teachers and CAMHS staff. This was a reasonable view at the time, in the absence of S disclosing more information about his thoughts of violence.

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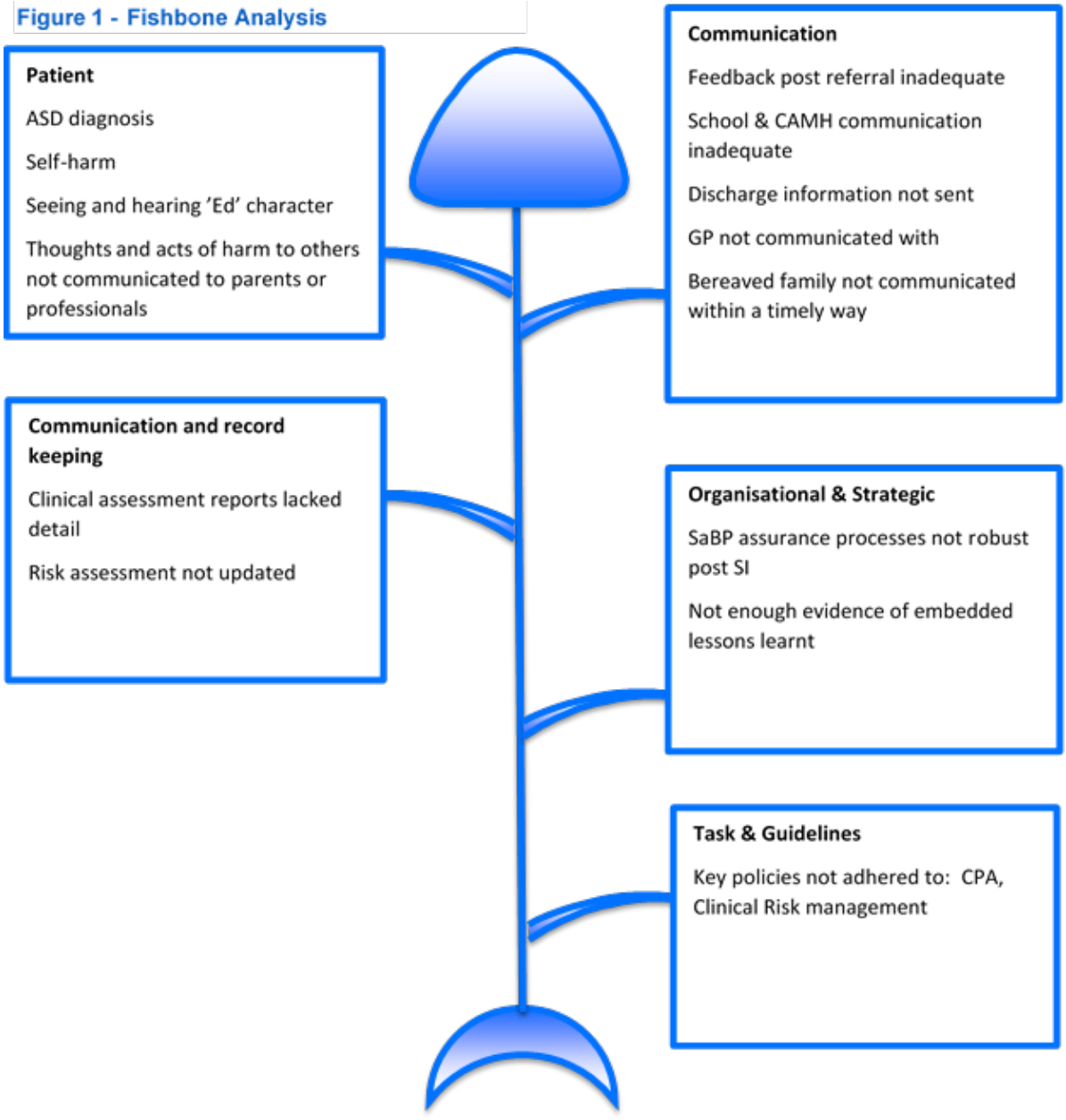
[31] *http://dictionary.reference.com/browse/predictability*

[32] *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*

[33] *http://www.thefreedictionary.com/prevent*

7.5 The Fishbone Analysis in Figure 1 below sets out the key issues we have identified.

Figure 1 - Fishbone Analysis



Recommendations

Recommendation 1:
It should be standard practice that CAMHS staff will liaise with schools and arrange multi-disciplinary/agency discussion where appropriate, and actions and outcomes should be recorded. The local operational policy should be amended to include this expectation

Recommendation 2:
The Trust should ensure compliance with clinical risk management and clinical documentation policies, and audit the effectiveness of this process

Recommendation 3:
The Trust to strengthen how it captures patient and family agreement with their care plans in the Electronic Patient Record, in line with its existing performance indicators on individuals and families receiving a copy of their care plan and people feeling involved in developing their care plans

Recommendation 4:
The Trust should further strengthen the process currently in place to ensure that carer's assessments are carried out as expected in policy.

Recommendation 5:
The Trust should ensure that GPs receive regular updates on mental health care provided by the Trust, including timely discharge letters. Adherence to this expectation should be audited and monitored to ensure compliance

Recommendation 6:
A service should be agreed regarding Autism Spectrum Disorder provision in CAMHS between SaBP and Commissioners.

Recommendation 7:

7a A quality standard regarding the recording, timely assessment and documented outcome of a formal mental state assessment when sought by a CAMHS nonmedical practitioner should be specified.

7b Formal mental state assessments should follow a standard approach and cover expectations surrounding adequate questioning.

Recommendation 8:
Services for young people, including schools and SaBP CAMHS services should raise awareness of inter relationship abuse amongst young people, and ensure that opportunities for education, support and disclosure are available.

Recommendation 9:
The Trust should change the policy and procedure on engagement with and support of families of victims and perpetrators involved in serious incidents to comply with current guidance. This should include the requirement to document decisions made, and clear descriptions of roles and responsibilities.

Recommendation 10:
The Trust should strengthen its process in relation to how it assures itself that the actions from Serious Incidents have been fully operationalised and embedded.

Appendix A – Terms of reference

To identify whether there were any gaps or deficiencies in the care and treatment that S received, which could have been predicted or prevented the incident on 24 January 2014 from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring.

- Review the engagement, assessment, treatment and care that S received from Surrey and Borders Partnership NHS Foundation Trust from his first referral in June 2012 up to the time he was discharged in October 2013

- Review the engagement of services with S after his diagnosis with Autism Spectrum Disorder in 2012/2013 and consider the appropriateness of the pathways and treatment options he received in line with national standards and best practice

- Review if the Trust sought sufficient information and provided appropriate support, care and treatment regarding the voices S heard and the self-harm and anxiety that he suffered

- Consider the wider safeguarding issues in terms of self-harm and potential for harming others and review if the Child and Adolescent Mental Health Service team fully appreciated these risks

- Review the personalised care planning and risk assessment, policy and procedures and compliance with national standards and best practice. Review to what degree was S and his family involved in agreeing his care

- Review the communication between agencies and services

- Review the communication between S's family and the Trust including the sharing of information regarding risks to S to inform risk assessment and management

- Review the documentation and record keeping of key information by the Child and Adolescent Mental Health Service against best practice and national standards and if record keeping is an issue within the Trust

- Review the Trust's internal investigation report and to assess the adequacy of its findings, recommendations and implementation of the action plan and identify:
    - If the investigation satisfied its own terms of reference
- If all key issues and lessons have been identified and shared

    - Whether recommendations are appropriate, comprehensive and flow from the lessons learnt
    - Review progress made against the action plan
    - Review processes in place to embed any lessons learnt

- Having assessed the above, to consider if this incident was predictable or preventable and deliberate on relevant issues that may warrant further investigation and comment

- To fully assess and review the Trust's engagement with the victim's family, before and after the incident, including information sharing and involvement in the internal investigation, measured against best practice and national standards.

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.

- Review the progress that the trust has made in implementing the action plan.

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from S's first contact with services to the time of his offence.

- Review the appropriateness of the treatment of S in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.

- Review the adequacy of risk assessments and risk management, including specifically the risk of harming himself or others.

- Examine the effectiveness of the care plan including the involvement of the service user and the family.

- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.

- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

- Consider if this incident was either predictable or preventable.

- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.

- Assist NHS England in undertaking a brief post investigation evaluation

Appendix B – Profile of the Trust and service

Surrey and Borders Partnership NHS Foundation Trust is the provider of health and social care services for people of all ages with mental health problems, drug and alcohol problems and learning disabilities in Surrey and North East Hampshire.

Care is delivered care across 140 services, all of which are registered with the Care Quality Commission.

The Trust employs 2,300 staff across 56 sites, serving a population of 1.3 million. Services are provided in community settings, hospitals and residential homes with an emphasis on providing local treatment and support close to people's homes wherever possible.

The Trust was formed on 1 April 2005 following the merger of Surrey Hampshire Borders NHS Trust, Surrey Oaklands NHS Trust and North West Surrey Partnership NHS Trust. We achieved Foundation Trust status on 1 May 2008, and there are over 5,000 public members.
CAMHS teams, made up of health and social care professionals, provide assessment and treatment to children and young people up to the age of 18 with mental health problems. Community teams and Primary Mental Health teams work in four sectors across Surrey and NE Hampshire.

Appendix C – Documents reviewed

- Case notes for S from GP, SaBP and North West London NHS Trust

SaBP documents

- CAMHS policies in place covering the period relevant to prevention &/or the assessment and management of self-harm and suicidal behaviour in October 2012 and current.
- Organisation chart including board oversight & operational management of CAMHS
- CAMHS treatment model, multidisciplinary structure and model of supervision
- CAMHS approach to working with schools
- Safeguarding policy
- CPA policy
- Risk assessment policy
- Current SI reporting and investigation policy & for 2012 /2013
- Full updated internal action plan including any appendices
- Trust's evidence file of changes since the implementation of the action plan

Other documents

- Defence case files, including pre court psychiatric reports
- Youth Offending Team pre-sentence report
- Surrey police case summary
- Surrey Children's services Section 47 meeting notes