

**REPORT TO NHS ENGLAND (NORTH) OF THE
INDEPENDENT INVESTIGATION COMMISSIONED BY THE
FORMER NORTH EAST STRATEGIC HEALTH AUTHORITY
INTO THE HEALTH CARE
AND TREATMENT OF 'PATIENT I'**

November 2013

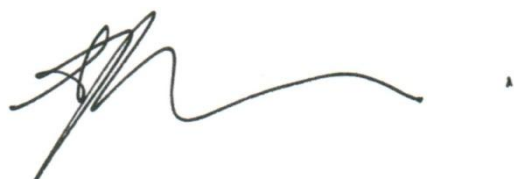
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The panel

The members of the investigation Panel were:

- Mr James Brown – Barrister (Chair)
- Dr Tim Morris – Consultant Child and Adolescent Psychiatrist East Lancashire NHS Hospital Trust
- Mr Ian Franks – Locality Manager Adult Services (Harrogate Locality) Tees, Esk and Wear Valley NHS Foundation Trust

Mr James Brown

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Dr Tim Morris

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Mr Ian Franks

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1. Terms of reference

The investigation panel was appointed by the North East Strategic Health Authority (SHA) to enquire into the health care and treatment of patient I and to prepare a report and make recommendations to NHS England (North) responsible for commissioning investigations at the time of the publication of this report.

The investigation was instigated following the conviction of patient I in January 2011 for the manslaughter of victim I and his subsequent sentence on 7 February 2011 to nine years detention. The investigation was constituted in accordance with Health Service Guidance (94) 27 as amended June 2005 and followed the outcome of a Serious Incident Review undertaken by Northumberland, Tyne and Wear NHS Foundation Trust (NTW) between 31 August 2010 and 1 December 2010.

The investigation panel's terms of reference were:

To examine the circumstances of the surrounding health care and treatment of patient I, in particular:

- the quality and scope of his health care and treatment, in particular the assessment and management of risk;
- the appropriateness of his treatment, care and supervision in relation to the implementation of the multi-disciplinary Care Programme Approach and the assessment of risk in terms of harm to himself and others. This should take into consideration other family members in receipt of services, as well as those who may be in a carer role;
- the standard of record keeping and communication between all interested parties;
- the extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health;
- prepare a report of the findings of that examination for, and make recommendations to, the North East Strategic Health Authority and the new body responsible for commissioning investigations at the time of publication following the future devolvement of the North East Strategic Health Authority.

The investigation panel met on 27 January 2012, 10 and 11 May 2012, 18 and 19 June 2012, 3,4 and 5 September 2012, 5 to 9 November 2012, 7,8 and 9 January 2013, 4 and 5 March 2013 and 13 May 2013.

The panel heard evidence from 14 people and considered a large volume of documentation provided by the relevant agencies which had involvement with patient I. All requests for documentation were met with full cooperation.

Each witness who attended to give evidence had the opportunity to consider transcripts of the evidence they had given and to approve the same for accuracy.

The purpose of the investigation was to consider the circumstances of patient I and his health care and treatment, consider what, if any potential impact these matters had on the events which lead to the tragic and untimely death of victim I and identify areas in which practice can be improved in the future.

It is no part of the function of this investigation to seek to apportion blame. To encourage candour and full contribution to the investigation, professionals who came into contact with patient I are not identified by name. Furthermore, patient I and all those with whom he had a personal relationship will be afforded similar anonymity.

It has been assumed that all witnesses who have given evidence before the investigation panel have provided full and frank disclosure.

The panel wishes to record their profound thanks to Mrs Jayne Quinn, Independent Investigation Coordinator, for her tireless efforts and supreme efficiency.

2. Introduction

On 2 July 2010, patient I killed victim I by stabbing him with a knife. At his criminal trial, patient I denied that he had murdered victim I. Patient I accepted that he had caused the fatal injury to victim I but put forward a defence of provocation. He was convicted of manslaughter and received a sentence of nine years detention in a young offender's institution.

At the time of victim I's death, patient I and his victim were known to each other. Victim I was engaged to the sister of patient I's partner. A group including patient I and his victim were drinking at the home of patient I's partner on the evening of 2 July 2010. A dispute arose between patient I and victim I. The disagreement became physical and spilled out into the garden. At some point patient I went back into the house and armed himself with a kitchen knife. Patient I went back outside and in the course of the ensuing confrontation, he stabbed victim I in the stomach. Victim I died subsequently in hospital of his injuries.

During the course of the investigation, an invitation was extended to the parents of victim I to meet with the panel and provide any information which they felt may be relevant. It is entirely understandable given the devastating loss of a much loved son that they did not feel able to attend.

Patient I's mother attended and gave evidence to the panel. The panel appreciated her attendance and found her evidence relating to patient I's early life and other matters of background helpful when formulating this report.

The panel also spoke to patient I who was fully cooperative and answered the panel's questions fully and willingly.

3. Chronology of key dates and events

To set the panel's ultimate conclusions and recommendations in context, it is necessary to consider in detail certain key dates and events in patient I's life. The chronology will be divided into four separate sections.

Birth to June 2000 (first request for intervention)

Patient I was born in 1991. Patient I has an older sister. Patient I's early home life was not always happy. It would appear that patient I's father was a heroin user and had a history of offending, spending some time in custody. When at home, patient I's father was violent to patient I's mother. Although patient I's mother suggested that such behaviour never took place in patient I's presence, the panel think it is likely that patient I had an awareness of this behaviour, particularly as he grew older.

Patient I accessed formal education at the age of five years.

In the early part of 2000, it is recorded that patient I's father left the family home for the final time. Within the documentation viewed by the panel, there is no record of formal child protection involvement surrounding patient I and his family arising out of the issues relating to patient I's father, his behaviour and its impact upon patient I and patient I's behaviour.

Patient I's mother told the panel that she first noticed issues with patient I when he was a young boy. She was unable to be specific about how old patient I was at the time. Patient I's mother talked of patient I having behavioural traits such as blowing on his fingers or arms, cracking his knuckles or making noises. Other information suggests that problematic behaviour of some degree was evident in school from patient I being about six years old. Unfortunately there is no detail which allows the panel to be more precise in relation to this.

The first formally recorded indication of a problem with patient I's behaviour was on 6 June 2000. Following an approach to the family GP by patient I's mother requesting help with patient I, the GP asked for a report from patient I's class teacher about how patient I behaved whilst he was at school. No such report has been seen by the panel but a subsequent entry in the GP records dated 14 June 2000 gives a glimpse of the issues which the mother raised in relation to patient I's behaviour. The entry

talks of patient I being, '*always uncontrollable*', and, '*violent if thwarted*'. A subsequent entry on 27 November 2000 makes reference to patient I having set a bin on fire.

As a result of the growing concerns about patient I's behaviour, the GP made a referral to staff grade community paediatrician 1 for advice in relation to the potential management and treatment of patient I's behaviour. This led to the start of the involvement of community paediatric services and child and adolescent mental health services (CAMHS). At this point patient I was nine years old.

Commentary

It is hard to be specific at what point patient I began to exhibit what could be described in broad terms as unusual or problematic behaviour. Patient I's mother makes reference to it starting at some unspecified point during his early childhood. A review of the GP records reveals that no formal medical intervention was sought until June 2000, although it is clear that the problems pre-date this time. Patient I was exposed to domestic violence within the home which undoubtedly had some effect on his emotional wellbeing. By November 2000, the behaviour as described by his mother to the GP was sufficient to trigger a referral to community paediatric services.

Referral to community paediatric services via GP on 15 December 2000 to November 2004 when patient I was last seen by staff grade community paediatrician 1

Patient I was referred to staff grade community paediatrician 1 by the family GP. Staff grade community paediatrician 1 saw patient I with his mother on three occasions in the early part of 2001, namely on 15 January 2001, 30 January 2001 and 19 February 2001. Staff grade community paediatrician 1 formed the opinion that specialist intervention may assist patient I. Consequently, a referral was made on 28 February 2001 to the CAMHS known as the Fleming Nuffield Unit (FNU). The letter of referral noted the following:

'patient I had always been uncontrollable and violent when thwarted and the only person who could control him was his father who had left home in 2000. Very angry young man chased people with golf clubs, chased his step brother with a knife to get

his football back. Patient I kicks his sister and fights with her. It is suggested that she (the sister) had a bruised leg and a black eye.'

The referral letter also notes that:

- *'patient I hangs out of the window. No fear of danger*
- *patient I's mother refers to patient I wanting his own way the whole time. She eventually gives in to keep the peace. Patient I's mother unable to put in place any of the behavioural strategies suggested*
- *patient I did not want to attend the clinic and was determined to be uncooperative*
- *patient I's mother stated patient I banged his head at weekend and blamed everyone else threatening them verbally and physically*
- *things getting more difficult as patient I got older. Various family members unable to control patient I with consequence he was becoming more isolated.'*

On 21 May 2001, patient I was seen by a specialist registrar in child and adolescent psychiatry at the FNU who did an initial assessment. The initial assessment noted a number of matters already raised in the letter of referral but also recorded that patient I was, *'oppositional at times, swears frequently, set fire to bin recently, ignores most adults when told off, was rude to teacher recently'*. The specialist registrar followed up his initial assessment by speaking to patient I's class teacher. The teacher noted that patient I was oppositional and highly impulsive. He was unwilling to do the work that was set, found it hard to sit still and had very poor concentration. The teacher suggested that problems had persisted for a number of years.

On 13 June 2001, the specialist registrar in discussion with his supervising consultant child and adolescent psychiatrist 1 concluded that patient I had problems with his attention which may well amount to a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). It was decided that patient I should be given a trial of medication, methylphenidate (Ritalin), to see if this had a positive impact upon his behaviour. In a letter to the GP on 14 June 2001, the specialist registrar commented, *'my general impression is that his attentional and overactive problems may well improve on medication but it is unlikely to ameliorate all behavioural problems'*.

The medication appeared to lead to an improvement in the behaviour of patient I. The initial dose of five milligrams (mgs) twice a day of methylphenidate (Ritalin) was increased to ten mgs twice a day. Patient I was discharged from the FNU on 6 July 2001 and the responsibility for monitoring his medication was taken over by staff grade community paediatrician 1.

By 24 October 2001, it was noted that the behaviour of patient I had once again begun to deteriorate. Staff grade community paediatrician 1 noted in a letter to GP1 that patient I had been swearing, spitting, and breaking articles in the family home and was once again showing an unhealthy interest in fire. Also he had been expressing some reluctance to take his medication. The prescription for patient I's medication was continued and staff grade community paediatrician 1 involved an experienced nursery nurse to help with behaviour management and assist patient I with his school work.

The nursery nurse in her evidence to the panel stated that she was involved with patient I initially over a six week period and saw patient I at home and at school. The nursery nurse expressed concerns about patient I's exposure to domestic violence in his early life and the effect which this had upon his behaviour. She described patient I as exhibiting a lot of anger and frustration. The nursery nurse noted that although patient I's mother tried hard, she found it difficult to set and enforce boundaries for patient I. The nursery nurse also noted that patient I appeared to exhibit a number of behavioural tics such as clicking his fingers and clearing his throat.

On 4 March 2002, staff grade community paediatrician 1 decided that as a consequence of the on going issues with patient I's behaviour, that he should be referred again to CAMHS at the FNU since work within the community was having little lasting effect. Staff grade community paediatrician 1 informed GP1 that patient I's behaviour at school was variable, he was refusing to work in class and was making funny noises. It was noted his mother stated that anything could make patient I angry and upset and that he still slept in his mother's bed. Staff grade community paediatrician 1 intended to contact the head of occupational therapy at the FNU with a view to seeking either individual therapy for patient I or broader family therapy.

As a consequence, patient I had six sessions with the head occupational therapist between May and July 2002 and the nursery nurse also attended for weekly sessions. Patient I was reluctant to engage with the head occupational therapist. It would appear that no formal family therapy took place. The reasons for this appeared to be the lack of a designated family therapy team and a reluctance on the part of the mother to engage in this type of therapy.

In anticipation of patient I's move to secondary school, staff grade community paediatrician 1 wrote to the Special Educational Needs Coordinator (SENCO) at the secondary school on 4 July 2002 to outline patient I's background and on-going treatment with medication.

Patient I's transition to secondary school in September 2002 was uneventful. However, on 30 October 2002 a multidisciplinary team meeting was convened and held at patient I's school. The prime concern at this point was a re-emergence of concerns about patient I having an unhealthy interest in fire. No major concerns were expressed about patient I's behaviour at school at this point, although it was noted that he was unable to concentrate for anything other than short periods and that his behaviour was said to be attention seeking.

On 12 November 2002, patient I was discharged from the FNU by the head occupational therapist as a consequence of patient I's lack of engagement. It was noted that there continued to be problems at home with patient I still setting fires and getting into fights with other children.

Throughout this period staff grade community paediatrician 1 maintained an involvement. She regularly offered appointments to patient I to attend her clinic to monitor his medication and behaviour and to offer support to his mother. Sometimes patient I attended and sometimes he did not. However, staff grade community paediatrician 1 was always available to patient I's mother and would often either see her at the appointment alone or speak to her by telephone.

By January 2003, patient I's behaviour at school was becoming more problematic. A recording in the school records dated 29 January 2003 noted that patient I was reported to his head of year, his behaviour was said to be unacceptable and concerns were expressed about his behaviour in, '*many lessons*'.

By the time of his school report in June 2003, it was noted that he made silly noises in class and struggled with the work and to concentrate on it. No major issues were being raised about his behaviour at school. This appeared to coincide with staff grade community paediatrician 1's understanding when she saw patient I and his mother in clinic on 11 July 2003, when she noted that patient I's behaviour at school was said to be satisfactory. Unfortunately, the same could not be said for his conduct at home. Patient I's mother reported that patient I had broken a door, had been physically abusive to his sister and verbally abusive to his mother. It was stated that patient I did not appear to have a sense of danger, the example of him jumping off Cullercoats Pier was cited to illustrate this point.

By the start of the autumn school term of 2003, there was also a marked down turn in patient I's behaviour at school. In September 2003, patient I was sent to the Twilight school (an altered school day between 12 noon and six pm for pupils with discipline issues) following an incident when he pulled down a girl's skirt. A recording on 4 December 2003 of a meeting of the heads of year at the school noted that patient I's behaviour was, '*appalling in three out of five lessons*', and on 16 December 2003 patient I was sent home for three days following his refusal to follow instructions from a member of staff.

Over this period patient I had also failed to engage with staff grade community paediatrician 1. Over the preceding months, he had been offered five appointments and attended only one. At the appointment he did attend he was described as an, '*angry young man*'. Staff grade community paediatrician 1 expressed the view that she was, '*getting nowhere with this young man*', and noted that various suggestions made to patient I's mother such as parents groups were not taken up.

December 2003 also saw patient I's first formal involvement with the Youth Offending Team (YOT). On 30 December 2003, patient I received a final warning following an offence of harassment relating to a neighbour.

Patient I's attendance at appointments with staff grade community paediatrician 1 continued to be poor although staff grade community paediatrician 1 maintained regular contact with patient I's mother. In a letter to GP1 dated 16 March 2004, staff grade community paediatrician 1 noted that patient I's mother had reported three notable incidents:

- patient I broken living room window with his shoe
- patient I head butted his bedroom window which broke causing a cut to his head
- patient I lost a CD /tape. He went upstairs and his mother later discovered him with dressing gown cord around his neck and tied to the window. Patient I said he was trying to frighten his mother.

Staff grade community paediatrician 1 raised the possibility of more specific mental health input and in due course in April 2004 a referral was made by the school to CAMHS which led to the involvement of the primary care nurse (CAMHS). It was felt that patient I would benefit particularly from assistance with managing his anger, lack of concentration and with structuring his time. At this point patient I was attending the Student Support Unit (SSU) at his school as a result of on going issues with his behaviour. It is noted that patient I's mother was struggling to cope with his behaviour. At school, patient I was only in one lesson, he was said to lack social skills and struggled to manage his anger. He was ultimately discharged from his involvement with the primary care nurse (CAMHS) as a consequence of his failure to attend appointments with her since the 8 June 2004.

Patient I continued to be truculent and uncooperative at school and spent a large amount of time in the SSU. It was noted that he had attempted to leave school on a number of occasions by climbing over the fence.

By the autumn term of 2004, patient I's school concluded that they were no longer in a position to meet patient I's educational needs at the school at that time and made a referral to the Linhope Unit (LU), a specialist pupil referral unit separate from the school.

The referral letter dated 12 October 2004 from the head teacher at the school to the head of the behavioural support at the LU gave a helpful summary of the problems which patient I was presenting:

- currently on ten day exclusion from school for persistent disruption and failure to adhere to school rules;
- patient I rejects all attempts to help him with his learning and behaviour;

- several interventions have been tried;
- his moods can be very changeable and he often appears tired and depressed;
- very negative and rejecting view of education;
- he can be very changeable and his inability to cope with any school routine can be exasperating and
- when confronted he becomes extremely aggressive and verbally abusive.

Patient I had what turned out to be his final clinic appointment with staff grade community paediatrician 1 on 29 October 2004.

Although the referral had been made to the LU, he remained at school. A letter dated 25 November 2004 from staff grade community paediatrician 1 to GP1 noted that patient I had persistently refused to attend appointments with staff grade community paediatrician 1 prior to this appointment since April 2004, although staff grade community paediatrician 1 continued to maintain regular contact with patient I's mother. Staff grade community paediatrician 1 retired from practice shortly after this.

Commentary

This period saw patient I's first involvement with community paediatric services and CAMHS. Patient I was seen promptly by staff grade community paediatrician 1 and then, following a period of assessment, appropriately referred on to mental health services. A diagnosis amounting to ADHD was made and medication prescribed. Patient I's behaviour improved to a degree following the prescription of the medication but the medication did not eradicate all issues. This appears to accord with the view of the treating psychiatrist that patient I had other behavioural issues which would not be solved purely by the prescription of medication.

Throughout this period, staff grade community paediatrician 1, maintained a close interest in patient I and his mother. Following patient I's initial discharge from CAMHS, she monitored his medication. In addition, in conjunction with other professionals, she attempted to address patient I's issues through the appropriate involvement of other professionals such as the nursery nurse to address behavioural

issues both in school and in the family home and by means of a further referral to CAMHS in an attempt to secure either individual therapy for patient I or family therapy. Individual therapy from the head occupational therapist did not prove to be successful.

Throughout this period, staff grade community paediatrician 1 showed a high degree of commitment to patient I and his mother. Latterly patient I's attendance was sporadic although staff grade community paediatrician 1 continued to maintain contact with patient I's mother in an attempt to offer what support and guidance she could.

It is clear that patient I struggled within the school environment. In his later years at primary school, he was unwilling to do the work that was set, found it hard to sit still and had very poor concentration.

Once at secondary school, the problems worsened. Numerous strategies were employed in an attempt to contain and improve patient I's behaviour. However, it is clear that he continued to struggle in the school environment. He struggled to concentrate in lessons, he could be disruptive and was often truculent, refusing to do as he was asked and on occasion being verbally aggressive. He was noted to have difficulty managing his anger. There is no evidence that he was physically aggressive or violent to others at school on a regular basis, although it is suggested that he could on occasion be violent to his sister at home. It is noted she was once said to have a black eye.

Attempts were made at school by means of a referral to the linked primary care nurse (CAMHS), to address some of patient I's behavioural issues but these proved unsuccessful due to patient I's failure to engage in a meaningful way. As patient I's conduct became more difficult to contain within the classroom, he spent increasing periods of time in the SSU and there were periods of temporary exclusion.

By the end of this period, a referral had been made to move patient I to a specialist pupil referral unit.

The panel heard evidence from a teacher at patient I's school that there was nothing about his behaviour at school which marked him out as exceptional within the

bounds of what could be expected of someone with patient I's difficulties. In particular, there was no predisposition to physical violence to others.

This period also saw patient I's first contact with the YOT.

November 2004 until July 2007(patient I's 16th birthday)

During this period patient I remained at school and attempts were made to manage his behaviour and assist him within the school environment. On 4 January 2005 an initial pupil support meeting set out targets for patient I which included an ability to accept and conform to school expectations and boundaries. To assist patient I, he would receive one to one support on three occasions each week for 30 minutes. It was noted that his attendance was good but punctuality was an issue. However, it appears that he would walk out of class and did not like being told what to do. The opinion was expressed that he was embarrassed by his learning difficulties and that he did not respond well to being placed in the inclusion unit at the school.

Unfortunately, shortly after this meeting there were further episodes of inappropriate conduct by patient I. On 14 January 2005 there was an incident in the corridor before a lesson. Patient I failed to follow instructions and ran off when challenged. He was then described as going, 'berserk', in the head of year's office and then once outside stood on the railings threatening to jump off. He was then extremely abusive to the deputy head teacher. Following a further episode some 11 days later, he was excluded from school for five days. On this occasion, he refused to sit down in his seat and was verbally abusive to the teacher. He refused repeatedly to follow instructions. He then rode around the school premises on his bike. When he was returned to the head of year's office, he became agitated, aggressive and uncontrollable. On two occasions, he threatened to jump off a balcony, ran around and burst into a lesson and then ran around swearing. He was allowed to leave school but scaled the barbed wire fence. Later he returned to school kicking open classroom doors.

At a subsequent exclusion meeting on 2 February 2005, patient I said that he had ADHD but he did not go to appointments because he did not like the doctors including those at the FNU. He said he did not take his medication all the time because it did not make him feel better or different. Patient I said he did dangerous

things to make people laugh and he liked his temper because it allowed him to get his own way. In addition, he said he did not like his father.

This situation leads to patient I being admitted on 10 March 2005 to the LU, which he attended on a daily basis. Unfortunately, this did not lead to any significant change or improvement in patient I's behaviour. He was noted to be uncooperative; he would often leave his lessons and would find regular reasons not to do his work. He was not confident at school and frequently asked to go home. Ultimately, patient I was excluded from LU on 6 July 2005 for persistent verbal abuse to staff at the LU. Although the exclusion was for 11 days, this took patient I to the school holidays and after the summer break he returned to school and was subject to a behavioural management plan at the start of the next academic year.

On his return to school patient I's behaviour was unchanged. He was again temporarily excluded for refusing to follow instructions from his teachers and when he returned to school he refused to engage with the behaviour improvement programme or attend the Twilight school.

Matters came to a head on 9 October 2005 when patient I was permanently excluded from school for taking part in a burglary on school premises. Shortly prior to this patient I had also been convicted of shop lifting. He was subsequently made the subject of referral orders for these offences.

After October 2004, patient I had had no contact with community paediatric services or indeed with any health professional. On 23 September 2005 following a request for medication, GP2 noted that patient I had not been seen by community paediatric services for some time to monitor patient I's medication and wrote a letter requesting that patient I be reviewed. This resulted in a letter from staff grade community paediatrician 2 inviting patient I and his mother to attend for an appointment. This met with no response. GP2 wrote a further letter to staff grade community paediatrician 2 on 16 January 2006 inquiring if patient I had yet been seen. GP2 once again wrote to the community paediatric services department on 21 March 2006 pointing out that patient I had not been seen since October 2004 and that his prescription would have to be discontinued unless he was reviewed.

On 30 May 2006, consultant paediatrician 1 wrote to patient I's mother. It was noted that patient I had been offered an appointment on 15 May 2006 but had failed to attend. GP records from around this time indicated that patient I was reluctant to attend such an appointment.

In any event, on 4 September 2006, patient I was eventually seen by consultant paediatrician 2. The history given was that patient I was spending large amounts of his time in bed and was out in the evening drinking with friends. It is noted that patient I was said to become violent in drink and get into fights. He was said to punch walls when angry but had not been verbally aggressive with members of his family. Consultant paediatrician 2 expressed concerns about patient I being out of education, drinking and getting into trouble. She proposed to follow patient I up in six months and to make inquiries with the educational welfare officer to see what was planned for patient I.

Over the next six to nine months patient I appeared to becoming more heavily involved in drinking and smoking cannabis. He was charged with an offence of criminal damage 5 January 2007. His compliance with the referral order subsequently made was poor with patient I refusing to attend appointments and on 15 May 2007 when he did attend an appointment, he was issued with a final warning for his aggressive behaviour.

On 18 June 2007, consultant paediatrician 2 saw patient I for the last time. In her letter to GP3 she notes that patient I continued to get into trouble with the police and was recently arrested for an offence of drunk and disorderly. She notes that patient I continues to drink excessively. Consultant paediatrician 2 questions whether patient I required his medication to continue now that he had left school. Consultant paediatrician 2 stated that due to his age, she would not routinely see patient I but decided that she would see patient I once more in six months time, in order assess his need for medication and future treatment. This did not ultimately happen and in a subsequent letter dated 29 August 2007, consultant paediatrician 2 having spoken to the YOT, notes on going issues with criminal damage and concludes that the larger problem at that stage was drug and alcohol misuse. Consequently, she concludes that more specialist input is required to address these issues and that there is no continuing role for a paediatrician.

On 8 June 2007, police were called to an incident outside patient I's home. Patient I was verbally abusive to a police officer who had been called to deal with the incident. Patient I was drunk and had been kicking a fence. His mother commented that his drink and drug use had escalated over the preceding six months. Documentation prepared by the YOT for the consequent charge of being drunk and disorderly, indicated that patient I's mother had threatened to ask patient I to leave since she was no longer able to deal with his outbursts. Patient I's drug and alcohol use had escalated over the preceding six months. He was drinking heavily (eight to ten cans at a time), as well as smoking cannabis regularly. More recently he had been taking tranquiliser type drugs. The current offence was said to have been carried out on impulse and out of anger with little self control involved.

It was reported later the same month that following an occasion when patient I had drunk to excess (reportedly 16 cans of lager in four hours), he committed a further act of criminal damage by smashing a window at a friend's house.

Commentary

During this period, patient I was excluded from school. His behaviour within the school environment consisted of a wilful refusal to abide by the rules or to follow directions given by staff at the school. It is clear that patient I's learning difficulties, which he found embarrassing and his difficulty in concentration did not help. It is also likely that his failure to take the medication prescribed for ADHD on a consistent basis contributed to the behaviour described, with the incident of 14 January 2005 being a possible example of this problem.

None of the strategies employed by the school, of which there were a number, had any significant impact on patient I and his ultimate exclusion had an air of inevitability about it.

Following the retirement of staff grade community paediatrician 1, patient I became lost to follow up by the community paediatric services for some time. It is worthy of note that this occurred at a time when significant structural changes were occurring to the manner in which paediatric services within the community were delivered.

Patient I was not seen by a paediatrician for almost two years. Patient I's GP2 attempted to instigate a review in July 2005 and again in September 2005. This did

result in a letter being sent in October 2005 by a community paediatrician. However, when patient I's mother failed to attend, this was not followed up and it was left to the GP to once again chase matters in January and March 2006. Patient I missed an offered appointment in May 2006 and it would appear others subsequently offered. He was finally seen in September 2006. Bearing in mind patient I's reluctance to attend appointments (which had been evident for some time), it is difficult to assert that even if appointments had been offered more regularly that he would have attended.

However, it is clear that little, if any transitional planning, was evident to deal with young persons in patient I's position who had been subject to on going treatment, but who had ceased to be children and were approaching adulthood.

After patient I left school, with time on his hands, he began to drink and smoke cannabis and became more involved in petty crime and anti social behaviour. The offending was characterised by verbal aggression and damage to property and not physical harm to others.

August 2007 until 3 July 2010

On 27 September 2007, the YOT prepared a report to deal with patient I's court appearance the next day for four offences of criminal damage and an offence of theft. Two of these offences related to criminal damage at patient I's mother's home in early August 2007. The offences lead to patient I's mother asking patient I to leave her home. Patient I resided at The Foyer (TF), homeless accommodation, for a number of days before apologising to his mother and returning to her home.

All of the criminal damage offences were committed when patient I was either under the influence of drink or drugs. The offence of theft was a joint offence committed with his new partner when they stole alcohol from a shop. Patient I had just turned 16 and his partner was 24 years old.

Patient I was to be assessed by the Drug and Alcohol Team (DAT), since the view taken was, that at this stage, patient I's offending was linked to substance misuse. It was also identified that patient I had issues with literacy and numeracy and that he should be supported to address these matters.

Unfortunately, patient I's engagement with the YOT was poor. He missed a number of appointments and was charged with an offence of motor vehicle interference. The YOT noted patient I, '*was lacking motivation to change his current unstructured lifestyle*'.

Patient I's last prescription for methylphenidate was supplied in December 2007.

On 6 February 2008, patient I and his partner contacted the midwifery services since his partner was pregnant. Information recorded around this time suggested that both patient I and his partner were heavy users of cannabis, using up to £20 worth a day. A referral was made to Children's Social Services as a result of concerns for the unborn baby.

A profile document prepared by the YOT provided a useful summary of patient I's situation at this point. This document notes:

- *patient I has no constructive leisure activities and spends much of his time either at home or sitting on the streets;*
- *his friends, who are often co accused of the offences with patient I, are several years older than him;*
- *patient I is 16 and his partner is 24. She has some influence on his offending;*
- *patient I has a history of drinking eight to ten cans daily;*
- *patient I used cannabis daily. He purchased this with money which he got from his mother. Patient I had agreed to engage with drug and alcohol services;*
- *his drug use had escalated recently;*
- *he has a history of self harm in past and has threatened to cut himself;*
- *patient I has poor temper control and this is an on going feature of patient I's offending. He lacks insight and*
- *patient I has a night time curfew which he rarely obeys. He should come home at 11pm but comes home at 3am.'*

The pregnancy appeared to be a catalyst for an attempt by patient I to seek to address some of his issues. He was enrolled on a course to assist with his literacy and numeracy and also on a parenting course. He presented himself to his GP's

surgery and sought to restart his ADHD medication, although this was not followed through by him at this stage.

Patient I's daughter was born in August 2008 and there followed a period of relative stability in patient I's life. It would appear his cannabis use was curtailed and then stopped for a period of time. Although there was some suggestion of domestic violence in the relationship recorded in February 2009 when it was said that patient I's partner had been pushed once and that patient I and his partner argued when he was under the influence of drink or drugs, this was not a persistent problem. Such was the progress of the couple that Children's Social Services took the view that the plan in relation to the child could be downgraded from a Child Protection Plan to a Child in Need Plan. At this point, patient I, his partner and the baby were living with patient I's mother.

Matters began to unravel for patient I in July 2009. On 18 July 2009 patient I punched his partner following a domestic altercation and received a police caution. On 19 October 2009 further concerns were expressed with regard to patient I's behaviour. It was alleged that he had been physically and verbally aggressive over the weekend in the family home and on one occasion had grabbed his partner by the throat. Patient I and his partner were referred to Hill Court (HC), which was homeless accommodation, since it was felt that it was no longer safe for the baby to remain in the care of her parents at that stage. The baby remained with patient I's mother. When interviewed at HC on 26 October 2009, patient I and his partner stated that they were using £200 worth of cannabis per week.

On 10 November 2009, patient I was allocated a trained social worker (social worker 1) attached to the housing team. Her role was to see individuals, to identify their support needs and determine whether a more comprehensive assessment was required. The assessment could lead to social worker 1 offering support, referring an individual to commissioned services or directing the individual to other services including community mental health teams (CMHT) if the criterion for care coordination was met. The purpose of social worker 1's role was to fill the gaps where individuals did not meet the criteria for referral to a CMHT. This was the case for patient I.

Social worker 1 showed a significant degree of commitment to patient I. Social worker 1 immediately sought an appointment for patient I with GP3 to seek a referral to the adult ADHD clinic with a view to recommencing patient I's medication. Social worker 1 also pursued the issue of housing for patient I as well as trying to sort out his benefits and sought courses to assist with patient I's literacy issues.

On 27 November 2009, there was an incident at HC. There was an argument between patient I and his partner. Patient I was said to be intoxicated. In due course, patient I left HC to live at TF, while his partner and their child went to live at other accommodation.

On 7 December 2009, patient I's GP made a referral to the adult ADHD clinic seeking an appointment. On 15 December 2009 a response was received from the clinic stating that patient I would be placed on the waiting list.

During this period social worker 1 also attempted to get patient I to access assistance with his substance misuse problems.

A recurring theme over this period was that patient I's willingness to access services and accept the assistance that was being offered had a direct correlation to the status of his relationship with his partner.

Over the Christmas period 2009 patient I remained at TF. There was at least one episode of self-harm and patient I's medical records note that he attended the Accident and Emergency Department at hospital on 1 January 2010 for treatment.

In the early part of January 2010, social worker 1 was once again proactive in seeking to assist patient I. Social worker 1 sought to bring forward patient I's appointment at the ADHD clinic.

The coordination of assistance for patient I whilst living at TF, homeless accommodation, was not assisted by regularity with which key workers left post and had to be changed. Patient I was fortunate to have the consistent presence of social worker 1 who maintained a degree of oversight.

Despite encouragement, patient I would not go to see his GP and was unwilling to complete the Domestic Violence Perpetrators Programme (DVPP) which he had commenced with Barnardos. Social worker 1 also was in contact with Children's

Social Services on patient I's behalf in order to progress his supervised contact with his daughter.

On 28 January 2010 it was noted that patient I had separated from his partner. He claimed to be abstinent from cannabis, and agreed to a referral to the voluntary drug and alcohol service, North East Counsel for Addictions (NECA). Social worker 1 made a priority referral the next day. Despite being offered two appointments subsequently, patient I failed to attend either.

On 16 February 2010, patient I's partner was evicted from her accommodation at Praxis, homeless accommodation, since in breach of the rules she had permitted patient I to stay there. Later the same day she was permitted to remain upon the basis that she agreed that patient I would not be allowed access again.

On 18 February 2010, an incident occurred involving patient I at TF. Patient I and his partner had been drinking in the city centre. On his return to TF, patient I got into a physical fight with another resident who patient I believed had, '*trashed*', his room. The other resident alleged patient I was carrying a knife. However, following the police investigation, patient I was released from police custody the next day and no further action was taken. There was no evidence that patient I had produced a knife. A recording in the Adult Social Services records noted that patient I was, '*not buying in to anything*'. As a result of this incident a child protection referral was made and a risk assessment undertaken of patient I's contact. Patient I's contact to his daughter was supervised by Children's Social Services.

On 26 February 2010, social worker 1 made an application for supported housing for patient I.

On 2 March 2010, patient I was offered an appointment at the ADHD clinic due to a cancellation by another patient. Patient I was unable to attend since he had a meeting with Children's Social Services.

On 3 March 2010, social worker 1 wrote to the clinic asking for patient I to be seen as soon as possible.

Social worker 1 completed a Functional Analysis of Care Environment (FACE) risk assessment plan on 8 March 2010 in relation to patient I. This was a comprehensive document and the following matters of relevance were noted in relation to patient I:

- *'significant risk of self-harm;*
- *low apparent risk of harm to others;*
- *no risk to the general public;*
- *smashed windows in the past recently damaged some property in his room at TF;*
- *patient I does not wish to attend DVPP;*
- *18 February 2010 patient I arrested following argument at TF with another resident over a mobile phone. Suggestion that patient I carrying knife but no evidence;*
- *low mood lack of appetite refused to see GP. Cut wrists over Christmas. His partner states patient I threatened self-harm in the past and*
- *patient I feeling low re level of contact with his daughter.*

Actions taken to reduce risk:

- *attending NECA. He enjoys this and seeks more frequent contact;*
 - *cancelled a number of appointment for DVPP. Appointments to be rearranged;*
 - *referred to ADHD clinic. Patient I wishes to attend;*
 - *regular contact with social worker 1. Patient I is seeking support.*
- Positive*
- *attending appointments with key worker at TF.*

Triggers:

- *disengages from services and does not keep appointments;*
- *using cannabis or increase use of alcohol;*
- *lack of contact with his partner and his daughter;*
- *inconsistent messages from his partner and*
- *not eating.*

Action Plan:

- *continued support from staff within supported accommodation;*
- *meaningful activities so that he has structure to his day and*
- *contact care coordinator if he disengages from Services or increases cannabis, alcohol use or engages in self harming behaviours.'*

A case record dated 15 March 2010 presented a more positive picture. Due to significant efforts by social worker 1 and patient I's key worker at TF, patient I appeared more motivated and optimistic. Patient I no longer wanted to leave TF. He had a good relationship with his key worker. The key worker had listed all patient I's appointments for him including DVPP. The key worker intended to buy a diary for patient I so he did not, 'double book', appointments. Further, patient I completed numeracy and literacy level one qualifications and was enrolled on a daily living course for one hour each week. Further, patient I was to go to Newcastle College with a view to enrolling on a catering course to commence in September. Social worker 1 agreed to meet patient I and his key worker monthly to see how matters progressed.

Unfortunately within a week, at a core group meeting on 22 March 2010 patient I was saying that he wished to move out of TF and was refusing to attend NECA.

On 30 March 2010, patient I received an appointment for the adult ADHD clinic and he duly attended on 6 April 2010. Patient I was seen at the clinic by consultant child and adolescent psychiatrist 2, who recommended that the GP should prescribe Concerta XL 27mgs daily. In a follow up letter to patient I's GP, consultant child and adolescent psychiatrist 2 noted the following:

- *'patient I's current difficulties were forgetfulness, inattention and to an extent he had difficulty following conversations and attending appointments;*
- *this behaviour was said to be typical of ADHD. This compromised his ability to comply with the child protection plan for his daughter;*
- *patient I had problems with explosive behaviour and had been charged with offences of domestic violence;*

- *patient I had a history of drug use and has attended drug and alcohol services. He should attend NECA but has missed his last two appointments;*
- *some patient I friends had died of drug overdoses. He had nightmares about this and*
- *the initial diagnosis letter at age nine refers to tendency to somatise. He had chest pains blamed heavy cannabis use for numbness of the tongue.'*

A shared care protocol for the prescription of medication was sent to GP3 and subsequently returned by him on 11 May 2010 confirming his agreement.

On 18 May 2010, patient I attended a follow up appointment at the adult ADHD clinic. He said that the medication had no effect. The dosage was increased to 54mgs and patient I was to be followed up in a week's time. This did not happen. At the same interview the Mini International Neuropsychiatric Interview for Bi Polar Disorder Studies was completed. This did not reveal anything new of significance.

An entry in the Adult Social Services records dated 26 May 2010 noted that patient I's engagement with services started to wane. Patient I missed ten appointments on the DVPP and did not engage well at the last session he attended. Also, social worker 1 noted that patient I had missed some sessions with her.

On 25 May 2010, it was confirmed that patient I and his partner were back together as a couple. Concerns were expressed at a Child Protection Case Conference on 2 June 2010, in relation to patient I's presentation. His mood was said to fluctuate and he displayed verbal aggression when challenged. Social worker 1 made various attempts to encourage patient I to attend appointments with her and his key worker but he failed to attend. Social worker 1 noted patient I had very negative feelings as after a period of improvement things had gone downhill again. It was said that patient I struggled with the number of people involved and this may be due to issues from his childhood.

On 5 June 2010, it was alleged by the sister of patient I's partner that patient I had threatened her with a knife. It is important to note that this was information which subsequently came to light in the course of the police investigation commenced after

the death of victim I and was not brought to the attention of any professional before this.

By the time of a further core group meeting on 10 June 2010, it was reported that patient I had not taken his medication for some two weeks. He complained that it made him feel sick.

The next day on the 11 June 2010, social worker 1 contacted the adult ADHD clinic. Social worker 1, in an email to consultant child and adolescent psychiatrist 2's secretary stated patient I had not taken his medication for two weeks as he had run out. She said that this appeared to be because the dose was increased and he used his existing supply rather than getting more. However, patient I subsequently confirmed that he had been advised to get more medication from his GP by consultant child and adolescent psychiatrist 2 and not to wait until he next saw consultant child and adolescent psychiatrist 2. Patient I said he did not do this because he did not feel that the medication helped him at all.

In the weeks that followed, patient I continued to display a lack of motivation. He talked of wishing to see more of his daughter but appeared unmotivated to do what was necessary to achieve this, namely commit to NECA, follow the treatment plan in relation to his ADHD medication and complete the DVPP. Further, he missed appointments with social worker 1 despite her best efforts to engage him and failed to commit to his place at TF by spending a number of nights away from the accommodation thus placing himself at risk of eviction.

On 21 June 2010, patient I was drunk and attempted to climb into TF via a drain pipe. A few days later on 25 June 2010, patient I was expressing feelings of hopelessness and threatening to kill himself. The view was taken that this was not a clear or credible suicide risk.

On 30 June 2010, a letter was sent by consultant child and adolescent psychiatrist 2's secretary offering another appointment to patient I for the 13 July 2010 at 3pm.

The next day, information was received that patient I had been evicted from TF. Further investigation revealed that he had not been evicted but had gone to his mother's home out of choice.

When spoken to on 2 July 2010, patient I stated he was much happier living at his mother's home. Social worker 1 discussed with patient I the need for him to reduce his alcohol intake and maintain a positive relationship with his mother. Later that day the tragic events described earlier in the report took place.

An email sent by social worker 1 on the same date to the social worker for patient I's daughter provided a telling summary of patient I's situation. She wrote, *'I will continue to look through housing options for patient I from his mums. However, I will expect patient I to start engaging and if he doesn't, I will have to withdraw my support as I can't justify keeping this case on really. I am of the opinion that patient I requires a lot of support, however he has had the opportunity of lots of support yet chooses not to engage in it.'*

Commentary

Over the early part of this period, patient I's offending behaviour increased. However, it was of a nature that was not uncommon for other young persons of patient I's age. Offending behaviour surrounding the use of cannabis or alcohol which then lead to criminal damage, offences of theft and broader anti social behaviour did not in the words of the YOT representative, 'put up a red flag', for anything more sinister in the future. An attempt was made to refer patient I onto drug and alcohol services but this was met with a reluctance to engage. Even when patient I failed to comply with the terms of his sentences, there was limited scope for enforcement of the court orders and no real power to compel him to comply with treatment for his perceived overuse of drugs and alcohol.

By December 2007, patient I had received his last prescription for methylphenidate. It is likely by this point that patient I's commitment to taking the medication was variable and he may well have ceased taking it altogether.

Following the discovery of the pregnancy of patient I's partner, he did attempt to address some of his many issues which included heavy cannabis use. There followed a period of relative stability. Unfortunately by late summer 2009, matters had deteriorated and patient I was again smoking cannabis heavily. By the end of 2009 he found himself in homeless accommodation. His relationship with his partner was on and off and was often a source of conflict and upset for them both.

This set of circumstances resulted in patient I's introduction to social worker 1, a social worker attached to the housing team. Over the months that followed, social worker 1 showed unstinting commitment to patient I often in the face of indifference and fluctuating levels of cooperation. Social worker 1's role was ideal for someone in patient I's position who did not qualify for clearly defined intervention such as via a CMHT. She identified the whole raft of issues which patient I had and identified the services which may have assisted patient I in dealing with them if he had been more willing to engage.

In many ways patient I received a bespoke service.

Patient I had recommenced his medication for ADHD in April 2010. Although it appears that by May 2010 patient I had again stopped taking his medication, this was not as a result of patient I having insufficient medication but as a result of a reluctance on his part to take it. It is impossible to make any link between patient I not taking his prescribed medication and the subsequent incident.

There appears to have been no clear indicator in the weeks prior to the tragic death of victim I that such an episode was reasonably foreseeable or that any professional involved could have done anything to prevent it.

4. Health care and treatment of patient I as a child

Following patient I's initial involvement with CAMHS, ADHD was identified as a likely diagnosis. Before turning to the issue of patient I's specific treatment, it is necessary to define ADHD and say a little about the condition.

ADHD is characterised by persistence in symptoms of inattention, hyperactivity and impulsivity to a greater degree than expected for a particular developmental age. Inattention is apparent with ease of distraction, loss of focus in tasks, difficulty following instructions. Hyperactivity is apparent through fidgeting, constant motion and difficulty keeping quiet. Impulsivity is apparent in impatience, difficulty in restraining emotional reactions and acting without thinking through the potential consequences.

ADHD is considered a developmental disorder. In order to make the diagnosis, symptoms have to be present from a young age (usually before seven years). Symptoms can then continue through to adulthood. Some symptoms do change but there continues to be an impairment of functioning. Adult ADHD is increasingly recognised and services have been developing to meet this need. Service development is patchy with different levels of service in different parts of the country.

The first National Institute for Clinical Excellence (NICE) guide to using methylphenidate (TA13) in ADHD was published in 2000 and then this guide was updated and replaced by TA98, ***Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults (2008)***. The NICE guideline (TA98) gives authoritative advice about a broad range of issues in ADHD including assessment, treatment, adult ADHD and commissioning services.

ADHD is frequently associated with other disorders (co-morbidity). ADHD increases the risk of offending through the associated development of conduct disorder, illicit drug use and peer delinquency. Up to 40% of people with ADHD also have conduct or oppositional disorders.

Initial assessment and treatment as child 2001 to June 2004

Patient I was initially referred to CAMHS in February 2001 at the age of nine years and seven months. Staff grade community paediatrician 1 recommended a referral via GP1 because of behavioural difficulties that had not responded to behavioural management strategies. Patient I had a comprehensive assessment by CAMHS. A diagnosis of ADHD was thought to be likely. Other problems (oppositional and defiant behaviours) were noted but no additional diagnosis made.

Treatment was initiated for the ADHD with medication. The head occupational therapist who was part of the CAMHS team offered some intervention. Patient I was transferred to staff grade community paediatrician 1 for on going management of his treatment.

Commentary

The intervention offered was reasonable for the resources available. The assessment and intervention was in line with the prevailing standard offered at that time. There would have been a potential opportunity to offer more focussed treatment for his oppositional behaviour at this early stage, such as a structured parenting programme. A more comprehensive formulation including a formal diagnosis of the co morbid difficulties may have allowed a broader range of treatment interventions to be offered since it was noted that the Ritalin was unlikely to ameliorate all the behavioural problems.

Patient I then had on going treatment management by the staff grade community paediatrician 1 and this was initially considered to be successful.

Patient I was once again referred to CAMHS in July 2001 by staff grade community paediatrician 1 at age ten. He was offered some psychological therapy. It was arranged that the nursery nurse would see patient I at home. Six to eight sessions were arranged to help with behavioural management. Unfortunately, engagement with this therapy was limited. During this time patient I was treated with a low dose of medication. He refused to increase the amount of medication that he was taking to a higher recommended dosage.

Family therapy was discussed but there was very limited availability of this intervention at this stage.

Commentary

The psychological therapy was relatively brief for the level of problem exhibited and therefore was unlikely to change the behaviour. It is unclear what psychological treatment model was used. It did not appear that there was a coordinated multidisciplinary team approach. The individual practitioners involved did arrange interventions as an additional treatment to that which would usually be available.

In March 2002, patient I was referred back to CAMHS as his behaviour continued to cause concern.

There did not seem to be a full re-assessment. Patient I continued with medication as a treatment for his ADHD. Some concern about anxiety was noted. Individual psychological input with play based therapy was arranged but did not prove effective in bringing about change. There was limited engagement in the individual sessions. Patient I then refused to see the practitioner on two occasions and was therefore discharged. There was on going input via multidisciplinary meetings. It was noted that patient I's engagement was better when home visits were undertaken. There were clear behavioural issues, but he did start sleeping in his own bed.

Commentary

There seemed to be limited consideration of the reasons for patient I's non-attendance for specialist therapy and whether alternative input could be provided either in a different type of therapy or from a different practitioner. Developing a positive, caring and trusting relationship with the child or young person and their parents is a first step in ensuring their engagement with services and in maintaining continuity of individual therapeutic relationships.

Throughout 2003, patient I continued with his medication. It was not possible to increase the dose as the doctors wished as he refused to take more medication. Medication at a low dose did have a positive impact but it appears that patient I only took it in an inconsistent way. As he became older, it seems that his adherence to medication became poorer. It was increasingly difficult to follow up patient I. Staff

grade community paediatrician 1 made frequent attempts to see patient I and continued to do so despite his reluctance. Significant behavioural problems continued and there were concerns about patient I's level of emotional disturbance. He was reported to be found in a cupboard with a noose around his neck on 6 May 2004. Following this, staff grade community paediatrician1 arranged for a specialist CAMHS nurse to see patient I. There were two appointments but then he refused to see her. A pattern had developed of a lack of engagement with proposed interventions, intermittent attendance and poor compliance with suggestions to improve patient I's situation. Patient I last sees staff grade community paediatrician 1 in September 2004. Staff grade community paediatrician 1 then retired and although there was an expectation of further follow up there was a gap in patient I's contact with health services.

Commentary

*Reasonable attempts were made to intervene directly with patient I at an early stage. There is no clear evidence that patient I's mother was offered consistent and structured input to help her manage and improve patient I's behaviour. Training for parents using structured evidenced based schemes was not available locally at that time. Relevant NICE guidance was not published until 2006 (**Parent-training/education programmes in the management of children with conduct disorders: Technology appraisals, TA102**)*

At that time the assessment and treatment plan for ADHD was limited by the lack of appropriate resources. ADHD is well recognised as having multiple comorbidities and therefore these should also be clearly assessed and addressed. The treatment plan should be founded upon the best available evidenced based treatments. ADHD is one of the highest predictors of antisocial behaviour and is associated with offending.

There was not an overall care plan which had been developed with regard to patient I, and his mother, which included a profile of his needs, risks to self or others or indeed any further assessments that may have been needed.

There was a lack of comprehensive treatment options available, for example, family therapy in Newcastle had not yet developed beyond a special interest group. There were no formally trained family therapists.

The services that were offered seemed dependent on key people and their relationships rather than a structured commissioned service. In patient I's case there was delivery of services beyond what would usually be expected at that time. Treatment was coordinated across departments namely, community paediatric services, CAMHS, GP and the school through informal but well established arrangements, with care coordinated by the community paediatricians. Staff grade community paediatrician 1 continued to try to see patient I despite non engagement and an overall lack response to treatment.

A diagnosis of a conduct disorder is strongly associated with poor educational performance, social isolation, and in adolescence, drug and alcohol misuse and increased contact with the criminal justice system. This association continues into adult life with poorer educational and occupational outcomes as well as involvement with the criminal justice system (as high as 50% in some groups).

Multiple agencies may be involved in the care and treatment of children with conduct disorders, which presents a major challenge for current services in the effective coordination of care across agencies. With hindsight, a comorbid diagnosis of conduct disorder could properly have been made in patient I's case at this stage and may well have lead to a more effective and better integrated treatment plan.

Patient I as an adolescent (teenager) November 2004 (aged 13) – 2007 (aged 16)

Once staff grade community paediatrician 1 left there was no follow up of medication or other intervention. Patient I was in essence lost to specialist follow up. This resulted in a 23 month delay in him being seen. His GP continued to prescribe medication; although it is unclear how often patient I took this medication. A number of factors contributed to this period of lack of intervention. There was a change in the role of community paediatric doctors along with a number of locum appointments. There was a change in the structure of the service, with the community paediatric team becoming part of general paediatrics, with the

practitioners becoming primarily hospital rather than community based. There was an organisational separation of child physical health from child mental health. Changes in personnel meant that individual relationships were lost. There was a lack of integration of services.

Patient I's behaviour was becoming more difficult, he was more disruptive, exhibiting behavioural problems as he moved through adolescence. He was using drugs and alcohol. There was a reported poor adherence to prescribed medication. There was limited interest from patient I in engaging in services.

During this period, when he had limited contact with health services, it is not possible to say whether the deterioration was due to non adherence to treatment for ADHD. However, even if other appointments and interventions had been offered it is unlikely that patient I would have engaged with them.

As patient I had then become 16 it was decided he should be transferred to adult services. It proved difficult to arrange the transition to adult mental health services, as there was no available service. There was an inconsistency with regard to the age at which different services finished and other services started. There were differences across and between agencies.

Commentary

The number and frequency of medical reviews of patient I was insufficient throughout this period. The main reasons for this situation were the non-attendance of patient I at planned reviews and changes in staffing. As a young person it would be expected that he would be brought to appointments but where this was not possible other opportunities to review him should have been taken, for example, in the school setting.

There should have been a more robust process in place for monitoring medication between services. Patient I was being prescribed a controlled drug. A clear system should be in place to ensure that specialist reviews take place. As a guide, young people taking stimulant medication should be reviewed by a specialist practitioner yearly as a minimum, with height, weight, blood pressure and pulse being monitored more frequently.

*Transition from young persons to adult services is a well recognised difficulty and this issue had a significant impact in patient I's case. 'Poorly planned transition from young people's to adult-oriented health services can be associated with increased risk of non adherence to treatment and loss to follow up, which can have serious consequences. There are measurable adverse consequences in terms of morbidity and mortality as well as in social and educational outcomes'. **Transition: getting it right for young people. Improving the transition of young people with long term conditions from children's to adult health services (March 2006).***

Unfortunately this guidance, which was produced at the time of patient I's transition, whilst recognising the problems for CAMHS, specifically excluded provision of mental health service from its recommendations.

In particular, an anticipated withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in children and young people and also from their parents or carers. It is important to ensure that such changes, especially discharge and transfer from CAMHS to adult services, are discussed and planned carefully beforehand with all involved.

Transition from children's to adult services remains a major concern in young people with mental health problems. Commissioners will need to consider how best to ensure that services are provided for children across all age groups, as service configuration and the timing of transition to adult services may vary locally. A single age for all services would be helpful and in line with a broad range of policies including the change in compulsory school leaving age this should be 18 years of age.

CAMHS and adult services should work jointly to provide assessment and services to young people. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

In an ideal world there would be integrated service across social services, education and health so that there are no barriers to movement between different pathways. The needs of the young person rather than the particular service boundaries should be paramount.

5. Health care and treatment of patient I as an adult

2007 onwards

On 17 April 2008, patient I presented at his GP surgery in an attempt to restart his ADHD medication. Unfortunately patient I failed to attend a follow up appointment and the issue of his medication and treatment for ADHD once again fell into abeyance.

As has been noted earlier, the next concerted effort to address patient I's ADHD commenced following the involvement of social worker 1 in late October 2009. On 17 November 2009, social worker 1 spoke to GP3 which led to patient I being referred to the adult ADHD clinic on 7 December 2009 and he was placed on the waiting list.

On 2 March 2010, he was offered a cancellation appointment at short notice but could not attend. On 7 March 2010, social worker 1 sought a more urgent appointment and patient I was ultimately seen at the clinic on 6 April 2010.

At the time that patient I was referred to the adult ADHD clinic by his GP, the service was just being established. It had limited resources and the commissioning arrangements for service were not clear.

The consultant child and adolescent psychiatrist 2 and his team at the adult ADHD clinic did complete a comprehensive assessment including co morbid features. Whilst there was a wait for this assessment, patient I was offered an appointment within 18 weeks and was seen 19 weeks after the referral.

There was a detailed proforma in use at the clinic to aid this process. Completion of this proforma was inconsistent, with some sections incomplete at the initial appointment. There is evidence that patient I was helped to complete a standardised questionnaire.

Following the assessment, treatment was arranged promptly. There was a further assessment by consultant child and adolescent psychiatrist 2 and his team on 18 May 2010. At that follow up appointment there was a full assessment and thorough review of co morbid symptoms using a structured approach (MINI). This review of co morbid symptoms did identify antisocial features but at that time there was no

indication of significant predictable risk. A physical examination was not recorded, before medication was initiated but the GP was requested to complete this. A written shared care agreement with GP3 was agreed.

Medication (Concerta XL) was recommended and subsequently prescribed at the recommended dosage. There was a clinical management plan to gradually increase this dose. It appears that it was not clear to patient I who would prescribe the medication between clinic appointments.

There was some difficulty with arranging further appointments. The clinic was only commissioned for a limited number of appointments. The clinic did however respond to requests for further appointments. Responses appeared timely and were well within the usual expectation for NHS clinics. Patient I was offered additional appointments beyond the agreed contract with commissioners, based on clinical need. There was some confusion about the expected standard of clinical contact as described in the commissioned service compared with the written shared care protocol. The clinic appeared to be adhering to the shared care agreement which offered a higher standard of clinical care than the service had been commissioned to provide.

It is unclear whether on the day of the offence patient I had taken his medication. However, the nature of the medication used (Concerta XL) is such that if he had taken the medication as prescribed it would not be having a clinical effect at the time of the day that the offence took place. Concerta XL is a long acting stimulant medication and is designed to act for between eight and 12 hours.

Alcohol and drug treatment was offered by the appropriate agencies. Patient I did seem to get control of his substance misuse and his alcohol usage was not at the level of dependency. He did occasionally binge on alcohol and get drunk such as at the party where the incident happened.

Commentary

There was consultant level input by an appropriately trained and experienced practitioner. A comprehensive assessment was carried out, including for co morbid difficulties.

The main concern was the lack of a comprehensive service commissioned for individuals with these difficulties. Patient I's care depended on clinicians offering services outside of the commissioned parameters. It was unclear at the time what level of shared care was in operation with the GP.

There should be a robust process in place for monitoring medication between services.

It is of concern that it appears that the commissioning of the adult ADHD service has not developed beyond the point of an interim service in the last five years.

6. Risk assessment and risk management

Risk Management

In his forward to *Best Practice in Managing Risk (2007)*, Louis Appleby commented:

'Safety is at the centre of all good health care, this is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety, a good therapeutic relationship must include both sympathetic support and objective assessment of risk'

Positive Risk Management

Decisions about risk management involve improving the service user's quality of life and plans for recovery while remaining aware of the safety needs of the service user, their carers and the public.

Positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners and will make risk management more effective. Positive risk management can be developed by using a collaborative approach.

Over defensive practice is bad practice. Avoiding all possible risks is not good for the service user or society in the long term and can be counterproductive, creating more problems than it solves. Any risk related decision is likely to be acceptable if:

- it conforms with relevant guidelines;
- it is based on best information available;
- it is documented and
- the relevant people are informed.

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at this time.

These general points are useful to bear in mind when assessing the specific circumstances of patient I and the approach taken to risk assessment in his case.

Patient I had been in contact with:

- Community Paediatric Department 2001 to 2007.
- CAMHS from 2001 to 2004.
- YOT from 2007 to 2010.
- Housing from 2009 to 2010.
- Adult ADHD from 2009 to 2010.

Each of these services considered risk. Formal risk assessments were undertaken by YOT and housing. The formal risk assessment undertaken by social worker 1 was supplied to the adult ADHD clinic and formed part of their assessment.

The risk profile used by YOT was the young offender assessment profile (ASSET).

ASSET is a national format which the Youth Justice Board expects YOT to use in their work with all young people who come into contact with the service.

It is used for all work carried out by the YOT following:

- a final warning;
- in preparing a court report and
- following sentence from court.

The ASSET form will be completed at different stages during the time the YOT is in contact:

- at the start;
- during the work or programme undertaking and
- at the end of the period of work.

ASSET also defines what work should be carried out and how it is progressing.

ASSET consists of a number of different parts:

- a main ASSET Assessment;
- a Serious Harm Risk Assessment and
- Young People Assessment.

The ASSET form has been in an electronic format since 1 October 2000 and used by YOT teams since then in this format.

Commentary

The ASSET form used with patient I was completed regularly and the scores updated throughout contact with YOT services by using of the information received by liaising with various agencies to ensure a complete picture of patient I.

There was no sharing of this information between different departments of the same local authority, due to different IT systems being in place and an absence of a data sharing agreement between different agencies that were part of the same overall organisation. Although the panel recognised that there was communication between YOT and social services.

The ASSET assessed all areas of patient I's life and raised any issues which were prevalent at the time and which could have had an impact on his behaviour and day to day life. In the early documented evidence, the scores relating to his mental health were rated as zero in 2007, but in late 2007 there was a score based on his substance misuse and his ADHD diagnosis. The source of this information was his mother who reported that on several occasions patient I had threatened to harm himself. This was not subsequently confirmed by patient I when asked about this in an interview with the YOT.

There is an indicator relating to serious harm to others and this has been adequately assessed and evaluated, against the criteria and scored at zero.

Once patient I had ceased using Valium or alcohol the assessor still rated him at two due to the fact he was still using cannabis in 2008.

When patient I attended the ADHD clinic, the MINI 5.0 was completed.

This indicated an anti social personality disorder. This assessment was completed by a member of child and adolescent psychiatrist 2's team when patient I attended the ADHD clinic on the 18 May 2010, but the review of the symptoms did not indicate any risk to others or himself.

The FACE assessment calculates risk presented by people with mental health problems.

This assessment tool was used by the homeless service, which is not standard practice, but was used in conjunction with care coordination documentation to provide a comprehensive assessment. This was evidence of good practice and the information was shared with the adult ADHD clinic.

The panel agreed that the risk assessments that were undertaken throughout patient I's contact with services were appropriate and captured the risk at the time. These were updated with good documentary evidence throughout patient I's contact with all agencies involved. However, the ASSET risk assessment was not formally shared between services, due to the absence of a data sharing agreement. It was the case however, that evidence obtained from other agencies during the course of other inter agency meetings and discussions meant that the risk assessment was updated regularly.

7. Commissioning of services

Commissioning Arrangements

Commissioning arrangements for adults with ADHD are included in the NICE guidance published in 2008. This document makes the case for commissioning a service for the diagnosis and management of ADHD in adults. It identifies the specific service requirements and with this in mind helps the local service to determine the service for the local populations with robust governance arrangements.

There are a few adult ADHD services within the UK that are delivering this specific provision. Often young people leave CAMHS services with no care plan for the transition into adult ADHD services. This can leave young adults vulnerable and requiring continued care which is not available.

Insofar as the service within the context of this investigation was concerned, there was what was described as, '*a business case stage one feasibility interim adult ADHD service*', as revised in March 2009. This was developed after discussion at a local level and followed the national guidance for commissioning arrangements for ADHD services which was published subsequently.

The local trust developed an uncommissioned adult ADHD service to meet the local need. The service in existence in 2009 was being purchased on a cost per case basis and this was never included formally within the local Primary Care Trust (PCT) contracts. This service began in April 2009 and was commissioned on an interim basis in July 2010. It has been acknowledged that there had been a lot of joint working with the PCTs around this to develop a region wide service for adult ADHD. However, there was no agreement to develop a region wide service but the local trust continued to provide an interim service. There was still no region wide service and a final commissioning decision has not been made about the local service at the time of writing this report.

Shared care agreements were in place with the local GPs which were signed by the GP practice. The NTW Trust had worked with North of Tyne PCT to develop the agreed assessment service and this could only operate if GPs then accepted

responsibility for the longer term care and prescribing. A number of shared care protocols were drafted however, there was not one version which had general agreement and applicability.

In February 2011, NTW Trust put forward a further proposal to commissioners for the same model of service but with an increased cost to enable the Trust to put more staffing resources into the service.

In January 2012, a revised service specification was received by the commissioners for discussion. Work was still on going to make a business case to provide a treatment service for adult ADHD with some amendments made to the proposed service. At the time of writing this report, these had not been agreed and the service still operated on the original level of funding on an interim basis.

Commentary

In the case of patient I, as a young child, when considering the resources available and standards operating at the time he received adequate care with services from community health and the CAMHS with a shared care agreement with his local GP. However, at times he was not in contact with services over his adolescent years due to:

- *being discharged from CAMHS service following diagnosis of ADHD and successful treatment;*
- *changes in staffing and structure within community paediatric services and*
- *a lack of clear planning to facilitate the transition from children health services to adult health services*

There was a non commissioned service which the local mental health services from CAMHS and Adult Social Services developed for adult ADHD.

The panel found that there was a proposed business case produced by the local mental health services which was based on the commissioning guidelines for ADHD.

The local mental health services identified the issues of local need for this service which was developed on the basis of the cost of one assessment and one follow up appointment. However, this was often changed upon the basis of the needs of the specific individual to provide one assessment and additional follow up appointments.

In the case of patient I he had been referred and he was fast tracked and an appointment was offered at short notice.

The commissioners were aware of the local service and were in dialogue with the mental health trust; however, there were discussions at a commissioning level which determined a joint approach to delivering this service across the North East of England from the two local mental health trusts.

This occurred due to changes in the local commissioning arrangements and restructuring within the workforce. The panel agreed that the service specification was based on the commissioning guidelines and that the local service was adequate. At the time of writing this report the service was still being delivered without any robust funding or commissioning arrangements.

Any service provided in relation to the treatment of adult ADHD should be based upon clear and explicit agreement with adherence to the relevant NICE guidance.

8. Conclusions

Having considered all the information, the panel reached the following conclusions:

1. The responsibility for the death of victim I lies with patient I.
2. The killing of victim I was an unpredictable act which could not have been anticipated or prevented.
3. Patient I was a young man with behavioural and emotional problems which were first noted when he was in primary education. The causes of the patient I's behavioural problems were likely to be multifactorial, with the domestic violence that he witnessed in the home, his mother's difficulty with setting consistent boundaries for patient I and the diagnosed condition of ADHD all playing a role.
4. Patient I had a likely diagnosis of ADHD. In addition, he exhibited the symptoms of behavioural disorders with oppositional defiance disorder and a conduct disorder being valid diagnoses on the basis of the evidence available with hindsight. At no time did patient I appear to have a serious mental illness such as schizophrenia, bipolar disorder or severe or recurrent depression.
5. The types of behavioural problems exhibited by patient I could be summarised as follows:
 - struggled with school and learning;
 - lacked social skills;
 - at times struggled to manage his anger. He could use abusive and aggressive language. He committed acts of criminal damage. Violence was rarely directed at others though latterly there is evidence of him assaulting his partner and, when younger, his sister;
 - impulsivity and
 - difficulty in accepting boundaries and instructions.
6. The intervention offered to patient I and his family via the health care services whilst patient I was a child were broadly appropriate. Services were offered in a logical sequence. The referral from the GP on to community paediatric services was appropriate. An appropriate assessment of patient I at CAMHS was undertaken.

The decision to prescribe medication to address the symptoms consistent with a diagnosis of ADHD was justified. It was also appropriate to attempt additional interventions including the engagement of a nursery nurse to attempt direct work to improve patient I's behaviour. Later attempts at individual therapy via the occupational therapist were also appropriate even though they met with limited success. In summary, patient I's mental health treatment was reasonable and in accordance with standards operating at the time but was not necessarily to the standard which one would expect now if clinicians were complying with the requisite NICE guidance.

7. In the period from 2000 until 2004 staff grade community paediatrician¹ was dogged in her determination to secure the appropriate treatment for patient I. Her commitment was impressive even when faced with variable engagement on the part of patient I. Following the subsequent fragmentation of community paediatric services which occurred sometime shortly after staff grade community paediatrician 1's retirement in late 2004, patient I was lost to follow up with health services for the best part of two years. It is difficult to say that if a vigorous attempt had been made to maintain contact with patient I that it would have led to any better engagement on his part. Although it is a shame that patient I did not have more consistent contact with health services at this time, it is impossible to conclude that this had any direct impact on the ultimate outcome.

8. None of patient I's behaviour as a child called for more formal mental health intervention, such as an inpatient treatment.

9. Significant attempts were made within the school setting to deal with patient I's issues. Whilst at primary school community paediatric services and CAMHS involvement has already been noted. A nursery nurse went into school as well as visiting patient I at home in an attempt to improve his behaviour. There was coordination between staff grade community paediatrician 1 and the SENCO at school to assist with patient I's transition to secondary school. Whilst at secondary school various strategies were attempted to manage patient I's behaviour including a referral to secure the involvement of a primary health nurse (CAMHS) but with no sustained success. It is clear that patient I's ability to engage at school was effected by his unwillingness to take his ADHD medication consistently. Further, it is clear

that patient I did have a degree of learning difficulty although this was never the subject of a formal assessment. It is obvious that patient I was embarrassed by this and his poor behaviour was at least, in part, an attempt to avoid having to confront the task of doing his school work. The evidence from the school SENCO was that there was nothing exceptional about patient I, the biggest problem was getting him to work. Patient I's behaviour at school could be described as truculent and uncooperative although he could be verbally aggressive and on occasion damage property, there was no evidence of him being violent to others within the school.

10. It was of concern to the panel that when patient I fell out of education that little seems to have been done to engage or monitor him. In reality there was little or no oversight of him.

11. The panel also concluded that it was unfortunate that despite patient I being seen by numerous health care and medical professions over the time that he was in formal education, that no professional thought it appropriate to undertake a formal assessment of his learning abilities and consequently failed to determine whether patient I had a learning disability.

12. Patient I's criminal offending prior to his conviction for the manslaughter of victim I could properly be characterised as low level. His criminal convictions indicated that he was convicted mainly for offences of criminal damage or theft, a number of which were committed when he was affected by drink or drugs. He had no convictions for assault but did receive a caution for the common assault of his partner. There was nothing in patient I's offending behaviour which marked him out as significantly different from other young persons of his age and social background who come into contact with the YOT. To quote the YOT worker who gave evidence to the panel, *'there was no red flag'*, that would have indicated a clear and demonstrable risk of a potential for serious violent offending in the future. It is likely that high caseloads did contribute to breaches of sentence orders made with regard to patient I not being pursued as vigorously as they might have been. However, even if they had been it is unlikely that this would have made much difference to patient I's compliance. Further, there is no link between this failure and patient I's subsequent conviction for manslaughter. The panel did conclude that there was evidence that the proforma ASSET which was used to collate information and assess risk was not always used

appropriately. Some information was, '*pulled through*', from the document completed on the previous occasions rather than completed afresh each time. A change in a risk score since the time that the risk profile was last completed did not necessarily trigger a particular course of action. The panel were told that both of these issues have since been addressed. Similarly, the availability of psychological input to the YOT has now been arranged on a more regular basis. The situation in place at the time of patient I's initial contact with the YOT was that a CAMHS worker was seconded for two days each week whereas now a full time worker is employed.

13. The actions of Children's Social Services when they became involved with patient I and his partner following the discovery of her pregnancy were appropriate. Children's Social Services correctly identified the issues which presented a risk to the unborn child and following the birth of the child took appropriate action to safeguard her well being. Children's Social Services appropriately identified the relevant issues relating to patient I and his partner at the time and directed them towards the services which could address those issues. Appropriate risk assessments were undertaken.

14. The service provided to patient I by social worker 1, the social worker connected to the housing team, was exceptional. Due to patient I's presenting problems, he did not qualify for a CMHT care coordinator since his mental health issues were not sufficiently complex as to require one. Similarly, patient I's offending behaviour was not such as to demand more intrusive intervention. In many ways patient I's needs fell below the level at which any type of more intensive formal intervention would occur. The role of social worker 1 within the housing team was to fill the gaps left by other services. The individuality of this role was its strength. Social worker 1 was encouraged to have a degree of autonomy which allowed her to identify and involve various other different organisations. Social worker 1 completed an appropriate and full initial assessment. Social worker 1 identified the need to engage patient I with the adult ADHD service. However, she identified that patient I's needs were broader than purely medical. She attempted to address issues with patient I's substance misuse, literacy, housing, benefits, employment and training, as well as attempting to assist patient I in his involvement with Children's Social Services in relation to his daughter. The panel concluded that she properly identified patient I's needs and which services may be able to assist him. She persisted in her attempts to assist

patient I and encourage his engagement at times when other's would, quite understandably, have decided that in the face of such sporadic commitment nothing further could be done. The panel have been able to see clearly what was done by her and why, since her record keeping was first class. The only criticism which the panel could make of patient I's involvement with Adult Social Services in general and Housing in particular, was that patient I's key workers when he lived at TF did change with worrying frequency. Such a lack of consistency would not have helped when trying to form a collaborative working relationship with patient I. Saying that, the panel accepts that this can be an issue with individuals working in this sector and there is often little that can be done about it. Clearly this was beyond the control of social worker 1.

15. As has been indicated, patient I's engagement was by and large sporadic and on his own terms. The panel finds that all agencies offered patient I sufficient opportunity to engage with their services. Some went well beyond that. There was an issue with the DNA (did not attend) policy with regard to children within children's health services as it was not clear. Where discharge is made because of a failure to attend, it should be clear what the reasons for discharge are. Alternative provision should be considered and any safeguarding issues addressed. The panel, having reviewed NTW's DNA policies with regard to adults, concluded that they were generally appropriate. The extent to which support can be offered is constrained by an individual's right to refuse to engage. This is particularly so in circumstances where compulsory treatment is not indicated.

16. The panel discovered a continuing issue in relation to transitional planning for young persons who have received treatment as children and who were approaching adulthood. There appeared to be different age, '*cut offs*', for different services. This appears to have been an issue that has been the subject of debate for some time without any ultimate conclusion having been reached. Insofar as patient I was concerned, the change in the way that community paediatric services were delivered did not help and the result was that patient I became lost to follow up for a period of time.

17. In terms of the adult ADHD clinic, the panel found that patient I was offered an appointment in accordance with the NHS guidelines namely within a period of 18

weeks from referral to treatment. When patient I was seen for assessment and treatment appropriate clinical practice was observed. He was properly assessed for ADHD and any comorbidity was considered. The panel concluded that there was nothing within the information available to the clinician at the time which indicated the need for a more detailed assessment of risk or which pointed towards any serious mental illness which presented a risk to the public at large. The adult ADHD clinic itself was staffed at an appropriate level in terms of the provision of consultant level practitioners. However, it is clear the clinic's capacity was not sufficient to meet the general level of demand which was relatively significant. It is clear, however, that patient I was offered the appropriate level of intervention for his assessed needs. In fact patient I received a higher level of intervention than the service was contracted to provide. As an interim service, it was not fully integrated into broader service provision and this may not be consistent with the care programme approach.

18. The panel concluded that the failure of patient I to attend a follow up appointment as envisaged after patient I's appointment on 18 May 2010 had no effect on the ultimate outcome. In any event patient I was expressing a reluctance to take his prescribed medication.

19. The panel found that it was difficult to draw any conclusions as to whether or not patient I was taking his medication at the time of the incident which led to the death of patient I. Even if he had been doing so, the nature of the drug is that its effects would be reducing by that time of the evening. It must also be remembered that there was clear evidence that patient I had been drinking heavily at the time and there also appeared to be traces of cannabis within his system when samples were taken by the police from patient I later that evening.

20. One area which did require clarification was in relation to prescribing protocols. The panel concluded that around this time it was unclear who was responsible for the provision of the appropriate medication for use in the treatment of ADHD. The situation appeared to be uncoordinated in that a number of protocols appeared to be in place at the same time. It appeared that there was no standard protocol agreed for use within the SHA area.

21. The larger concern for the panel related to the issue of the commissioning decisions made in relation to the service. The panel concluded that the debate as to

whether or not to commission this service has been on going for at least five years and there is still no final decision at the time of writing this report. It does seem clear that a decision now needs to be made one way or another. There appears to be good evidence of the need for the service. The NICE guidelines from 2008 gives clear guidance as to how such a service should be set up.

22. Patient I on occasion drank and used cannabis to excess. However, it does not appear that he had an addiction to either of those substances. Patient I told the panel that his alcohol consumption did increase following the decision of social services to limit his contact with his daughter. Patient I claimed that he consumed alcohol on a daily basis at this time. It is clear that he could be aggressive when in drink. He was referred to voluntary drug and alcohol organisations. His engagement was sporadic. The panel concluded on the evidence available his alcohol use did not qualify for a more formal form of coercive treatment. Referrals were made to the appropriate organisations and despite encouragement to attend and despite others arranging appointments for patient I he did not commit to attendance. No agency involved can be blamed for this.

23. Interagency cooperation in terms of proactive data sharing did not occur between the various agencies at this time, although it would appear that the relevant information could be obtained if it was pursued. Different agencies still operated within their own systems. For example at the time Adult Social Services did not have access to the YOT files even though they worked within the same umbrella organisation namely Newcastle City Council. There was an informal exchange of information and case discussion between community paediatric services and CAMHS which was useful but was lost following the retirement of staff grade community paediatrician 1.

24. In broad terms the panel concluded that there was nothing to suggest that any of the risk assessments undertaken by the various agencies involved with patient I were flawed in their ultimate conclusions, namely that patient I objectively presented a low risk of serious violence or harm to others. There were improvements which could have been made to the process of risk assessment in some areas.

25. The panel ultimately concluded that due to the level and nature of patient I's presenting problems, the best that could be achieved was that any service which

patient I came into contact with should address his needs, offer assistance and assess what, if any, risk patient I posed. The panel found that each of the services that he was involved with performed their function, at the very least, adequately. Some services, namely the community paediatric services in the time of staff grade community paediatrician 1 and Adult Social Services through the work of social worker 1, offered patient I a service of high quality and went far beyond what would normally be expected.

9. Recommendations

Risk assessment

Where a risk assessment tool is to be used, there should be clear guidance as to when a more detailed risk assessment is triggered. This should include when and how such information is shared between various agencies.

Data sharing

There are now more rigorous data sharing arrangements in force than were evident at the time of the incident. This is not to imply that previous arrangements had any direct or indirect causal link to the death of patient I.

It would be of great assistance if all agencies involved with a young person such as patient I had access to all relevant records via an electronic system. This would present a more rounded picture of the particular individual to the professional involved. Further this would allow a more thorough risk assessment which, in turn, would make the identification of any appropriate services more straightforward. Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion and could be supported by more effective data sharing.

Health care treatment of patient I as a child

Where treatment is being offered to a child such as was offered to patient I, such treatment should be evidence based and should comply with the appropriate NICE guidelines. In addition there should be a clear written care plan in relation to that treatment.

Formal assessment of a child moving through special needs provision

Patient I was never the subject of a psychological assessment of his cognitive ability even though the issue of a potential learning disability was raised on a number of occasions. It is recommended that it would be appropriate for there to be a formal assessment of any learning issues of a child moving through special needs provision to ascertain whether he or she has a learning disability or difficulty to aid with the identification of appropriate services.

Core group/team around the child

It is clear that school attempts were made to involve all relevant agencies in discussions on a regular basis about the various presenting problems which patient I exhibited. A system which involves health, YOT, education, police, social care is clearly of benefit. A more rigorous and regularised protocol for carrying this into effect needs to be agreed and appropriately resourced. It is clear that such a system has particular application in larger schools whose catchment area includes pupils with higher than average levels of YOT involvement and social problems.

Transitional planning

It is recommended that the transition from child to adult health care should be set at the statutory school leaving age. School leaving age was 16. It is due to become age 17 in 2013 but will be at age 18 from the year 2015 onwards. Transition has been a long standing issue and it would make practical common sense for all agencies to work to one age. There are examples of best practice within the region. One example given to the panel was for services relating to children with disabilities and how the transition from childhood to adulthood was managed within that sphere. Clearly a formula which brings together services to assess an individual's on going needs and to identify any services required as that person moves into adulthood.

Adult ADHD service

Despite discussions being instigated in 2008 about an adult ADHD service, the service remains an interim one and a final commissioning decision is yet to be taken. It is clear that the demand for the service is significant. The panel recommends that such a service is commissioned. In any event, a decision on whether or not the service is commissioned should be taken as a matter of urgency. Any service which is commissioned should comply with NICE guidelines. This should include the creation of a clear prescribing protocol with application across the region. The absence of a clear commissioning decision runs the risk that the service which patients receive will not meet their overall needs as envisaged by the care programme approach.

10. List of abbreviations

CAMHS: Child and Adolescent Mental Health Services

ADHD: Attention Deficit Hyperactivity Disorder

GP: General Practitioner

YOT: Youth Offending Team

DAT: Drug and Alcohol Team

FNU: Fleming Nuffield Unit

CMHT: Community Mental Health Team

DNA: Did not attend. This relates to the policy to deal with patients who failed to attend appointments with services

PCT: Primary Care Trust

NCC: Newcastle City Council

FACE: Functional Analysis of Care Environment. Risk assessment

ASSET: Name given to type of risk assessment used by YOT

MINI: Mini International Neuro Psychiatric Interview for Bi polar disorder studies

NTW: Northumberland, Tyne and Wear NHS Foundation Trust

Children's Social Services: The department of the local authority dealing with child protection

Adult Social Services: The department of the local authority dealing with adult social care

TF: The Foyer, homeless accommodation

HC: Hill Court, homeless accommodation

LU: Linhope Unit, special pupil referral unit

NECA: North East Counsel for Addictions