THE CONTENT OF THIS REPORT IS RESTRICTED UNTIL PUBLICATION

DOMESTIC HOMICIDE REVIEW
REPORT INTO THE DEATH OF 'Sarah'/2016

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PREFACE

This Domestic Homicide Review (DHR) was carried out following the death of 'Sarah' in November 2015. This was the fifth statutory homicide review carried out in Northumberland. It was carried out in accordance with the Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

We would like to convey our profound sympathy to the family and friends of Sarah and assure them that in undertaking this review we are seeking to learn lessons from this tragedy, and to improve the response of agencies in cases of domestic violence. The Panel would also like to express gratitude to Sarah's parents and friend for their contribution to the review process.

Acknowledgements and thanks also go to members of the Safer Northumberland Partnership and all those who have given of their time and co-operation through this review process as Panel members, Individual Management Review (IMR) authors, and staff members of participating agencies.

1. INTRODUCTION

1.1 Background to the Review

1.1.1 This review relates to the death of 'Sarah' (aged 45), who was killed in November 2015. On the day of the homicide a member of the public contacted Northumbria Police stating they had come across a young male who stated that he had killed his mother. Northumbria Police attended and established that the male was Sarah's 16 year old son 'Michael'. On attendance at his address they found his mother dead with multiple stab wounds.

1.1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Sarah, and her son Michael, prior to the point of her death.

1.2 Purpose of the Review

1.2.1 The purpose of a Domestic Homicide Review as set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter agency working.

1.2.2 DHRs are not inquiries into how the victim died or who is culpable; this is a matter for the criminal courts.

1.2.3 DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action would be initiated, the established agency disciplinary procedures would be undertaken separate to the DHR process. Alternatively, some DHRs may be conducted concurrently, but separately to, disciplinary action.

1.2.4 As far as is possible, DHRs should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.

1.2.5 The rationale for the review process is to ensure agencies are responding

appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

1.2.6 The review also assesses whether agencies have sufficient and robust procedures and protocols in place, which are understood and adhered to by their staff.

1.3 Terms of Reference

1.3.1 As well as the general terms of reference outlined within Appendix 1 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, the following specific terms of reference were agreed by the Panel for this review:

- Where any mental health diagnosis was made in relation to the perpetrator, did this influence the response to any domestic abuse or risk issues; the decision making in addressing wider complex family issues; or the making of referrals to other support services?

- Was the age of the perpetrator and the relationship with his mother a significant factor in responses and decision making, and how did this impact in terms of recognising and addressing risk?

- What influence did the age of the perpetrator have on his behaviour due to adolescence and the related potential behaviour of young people in this age group?

- Did your agency treat this as a complex case and was there an appropriate level of understanding of complex family need? What level of supervision was in place for those professionals dealing with the complex family needs?

- Did the gender of either the victim or the perpetrator influence or impact on the response of agencies? If so, in what way and what was the result of this? Consider responses to concerns, assessments undertaken and risk management actions.

- Did full and relevant information sharing take place? Was there evidence of a multi-agency and coordinated approach to assessment and management of risk? If not, why did this not occur and what were the implications of this as regards effective management of the case?

- Did your agency hold any information provided by broader family networks or informal networks? Was this information responded to and acted upon appropriately?

- Was your agency aware of any influence from social networking or web based sites which may have/did impact on the behaviour of the perpetrator?

1.3.2 The timescale of the review was set from 1st January 2013, when it was believed there may have been early signs of a deterioration in Sarah's son's behaviour, to 16th November 2015. In addition, each IMR considered any relevant events prior to this period, relating to the risk of harm posed by the alleged perpetrator or the vulnerability of either the victim or perpetrator.

1.3.3 The Panel also gave consideration of whether Michael's father should be considered within the review, however information from agencies and Sarah's parents suggested he had not been in contact with the family for a number of years. There was also mention in earlier agency records of Sarah's partner, Michael's step-father, however this relationship appears to have ended prior to the review period.

1.4 The Review Panel

1.4.1 The review Panel membership was as follows:

Ian Billham [Chair 1st meeting]	NCC Strategic Community Safety
Deborah Brown [appointed Chair]	Northumberland Fire & Rescue Service
Jane Bowie	NCC Adult Services
Caley Banks	NCC Children's Services
Allan Brown	NCC Strategic Community Safety
David Charlesworth	NHS England
Jackie Coleman	Northumbria Police
Gary Connor	Northumbria Community Rehabilitation Company
Anna English	NCC Adult Social Care
Rachel Farnham	NCC Children's Services [has now left the authority replacement is Patrick Boyle]
Jan Grey	NTW NHS Foundation Trust
Paul Hedley	Northumberland Fire & Rescue Service
Karen Hughes	Northumbria Probation
Fiona Kane	NHS Adult Safeguarding Clinical Commissioning Group [CCG]
Christine McManus	North East Ambulance Service
Debbie Reape	Northumbria Healthcare Foundation Trust [NHCFT]
Margaret Tench	Northumberland Clinical Commissioning Group [CCG]
Annie Topping	Northumberland Clinical Commissioning Group
Julie Young	NCC Strategic Housing

Kath Albiston	Independent Report Author

1.4.2 The Chair is currently a senior manager with Northumberland Fire and Rescue Service, having responsibility for community safety and community risk planning. The lead officer has responsibility for Safeguarding and is a member of both Northumberland Safeguarding Adults Board and Northumberland Safeguarding Children Board.

1.4.3 The Overview Report Author is a qualified Probation Officer and prior to leaving the Probation Service worked within a joint Police and Probation unit acting as Chair for Multi-Agency Public Protection (MAPP) meetings. Working independently as a consultant and trainer since 2006 she has undertaken a variety of roles within the domestic violence and Safeguarding arena, working with statutory and voluntary sector agencies around the writing of risk assessment tools, policy and procedure, and the training and clinical supervision of staff. She has also undertaken service reviews and scoping exercises in relation to provision of domestic violence services. Alongside her involvement with a number of Domestic Homicide Reviews, the author also currently acts as an 'expert witness', writing domestic abuse risk and vulnerability assessments for public and private law cases.

1.4.4 Neither the Independent Chair nor Overview Report Author has had any previous involvement with Sarah or Michael, or any supervisory responsibility for any of the professionals' work being reviewed.

1.5 The Review Process

1.5.1 The review consisted of the following key meetings:

11/12/15	Meeting of the Northumberland Domestic Homicide Review Core Panel – agreement that case met criteria for a formal review to be conducted.
20/01/16	Initial Panel Meeting – terms of reference finalised.
10/02/16	Initial Individual Management Review (IMR) authors meeting.
25/04/16	Deadline for submission of Agency IMRs.
25/05/16	Panel and IMR authors meeting – presentation of IMRs.
04/07/16	Circulation of the first draft of the Overview Report.
28/07/16	Panel meeting to review the first draft of the Overview Report.
19/10/16	Presentation to the Safer Northumberland Partnership Board.

1.5.2 Individual Management Review (IMR) reports were completed by the following agencies:

- Northumberland Tyne and Wear NHS Foundation Trust (NTW)
- Northumberland County Council (NCC) Children's Social Care (CSC)

- Northumberland County Council (NCC) Education & Skills (Wellbeing and Community Health Services Group),
- NHS Northumberland Clinical Commissioning Group (CCG)
- Northumbria Healthcare NHS Foundation Trust (NHCFT)
- Northumbria Police
- Northumberland County Council (NCC) Housing Services
- North East Ambulance Service Foundation Trust (NEAS)

1.5.3 All IMR authors were independent of the case and had no previous contact with Sarah or Michael, either as a practitioner or through the management of staff involved in the case.

1.5.4 No other agencies on the Panel, or in other third sector organisations where requests for information were sent, identified any relevant contact with either Sarah or Michael in this case.

1.5.5 The review process was not completed within six months due to the complex nature of the review and the time needed to complete fully comprehensive IMRs. In addition, a number of parallel review processes were taking place and it was necessary to ensure that the findings of these were known to, and could be considered within, the preparation of this review report. Details of such processes are outlined below in paragraph 1.11.

1.5.6 Prior to publication of this report all those who had input into the review process were given the opportunity to comment upon the report, and any changes considered necessary were made so accordingly.

1.6 Profiles of Agencies Involved and IMR Methodology

1.6.1 **Northumberland, Tyne and Wear (NTW) NHS Foundation Trust** is one of the largest mental health and disability trusts in England. It works from 100 sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and North Easington and serves a population of 1.4 million.

1.6.2 The NTW NHS Foundation Trust's IMR was undertaken by the Head of Safeguarding and Public Protection, with supervision and approval provided by the Nursing Director Inpatient Service.

1.6.3 In undertaking the IMR all paper and electronic records were examined. In addition, as part of the Serious Incident Investigation, the DHR author together with the Clinical Advisor supported the SI Independent Investigator in the facilitation of an After Action Review (AAR). This is a professional discussion of an event that focuses on performance standards and enables professionals and colleagues, with similar and shared interests, to discover for themselves what happened, why it happened, and how to sustain strengths and improve on weaknesses.

1.6.4 Staff involved were interviewed by the DHR author, SI Investigator and Clinical Advisor. These joint interviews were undertaken as both the DHR and Serious incident Investigation were running concurrently, with the requirement of both to investigate the circumstances surrounding healthcare provision in respect of the tragic incident. The DHR Author, SI Investigator and Clinical Advisor undertook a 'route cause analysis approach'. This analysis was used to identify areas for change and to develop recommendations to deliver safer care.

1.6.5 The IMR for **NCC Children's Social Care (CSC)** was undertaken by the Senior Manager of Specialist Services, and quality assured and approved by Children's Services Advisor In order to undertake the IMR all relevant documents and records were reviewed, interviews took place with seven members of staff, and email/telephone discussions were also had with another three staff members.

1.6.6 The IMR for **NCC Education & Skills (Wellbeing and Community Health Services Group),** was undertaken by the Commissioner for Secondary Education, supervised and quality assured by the Director of Education and Skills. In order to undertake the IMR, school records were scrutinized, and face to face interviews were conducted with four members of staff.

1.6.7 **Northumberland Clinical Commissioning Group (CCG)** is the statutory body responsible for planning, purchasing and monitoring the delivery and quality of local NHS healthcare and health services for the people of Northumberland. All 44 GP practices within the Northumberland area are members of the Northumberland CCG.

1.6.8 The IMR for Northumberland CCG was completed by the named GP (Safeguarding Children) NHS Northumberland CCG, and the report was reviewed and approved by the Safeguarding leads (adult and children) for the CCG. The review was undertaken on behalf of NHS England (NHSE) and NHS Northumberland CCG (CCG) with 'sign off' via both organisations. For the purpose of the IMR, the author reviewed all available GP records regarding the victim and perpetrator, which included correspondence from a number of agencies. The author then interviewed the lead GP (for the family) and Practice Manager, and had further telephone conversations as required, including with the Practice Nurse.

1.6.9 **Northumbria Healthcare NHS Foundation Trust (NHCFT)** manage hospital, community health and adult social care services in Northumberland, and hospital and community health services in North Tyneside. NHCFT provide care to a population of around half a million and have ten hospitals.

1.6.10 The IMR for NHCFT was undertaken by the Named Nurse Safeguarding Children, with supervision provided by the Interim Director of Nursing, who also signed off the completed report. In undertaking the IMR the author

undertook a detailed review of all of the relevant health records in relation to the victim and perpetrator, as well as interviewing two staff members; a third staff member was also asked specific questions about the supervision process by email.

1.6.11 **Northumbria Police** serves a population of 1.5 million people and covers an area from the Scottish border down to County Durham, and from the Pennines across to the North East Coast.

1.6.12 The IMR for Northumbria Police was undertaken by a Major Crime Review Advisor, and was quality assured and approved by Chief Inspector of the Vulnerable Crime Unit. In order to prepare the report, the author accessed all information stored in Northumbria Police's computerised systems, relevant to the victim and alleged perpetrator, and their families; in addition information stored on the Police National Computer (PNC) was accessed. One member of staff was also interviewed.

1.6.13 The IMR for **NCC Housing Services** was completed by the Housing Services Manager, and was reviewed and approved by the Head of Housing. A review of all relevant records was undertaken for the completion of the IMR.

1.6.14 The **North East Ambulance Service (NEAS) NHS Foundation Trust** provides a number of NHS services, and works in partnership with eleven local Clinical Commissioning Groups and twelve Local Authorities. They also work in partnership with the three Fire and Rescue Services, three police forces, eight acute hospital Trusts and local volunteer agencies – St John Ambulance and Red Cross.

The IMR for NEAS was been completed on behalf of the Clinical Care and Patient Safety Directorate for NEAS and undertaken by the Named Professional for Safeguarding Vulnerable Groups, and approved and quality assured by the Director of Clinical Care and Patient Safety. The only relevant contact NEAS had with either the victim or the perpetrator was in relation to attendance on scene on the day of the homicide; for the purpose of the IMR, all information pertaining to NEAS' contact was gathered and reviewed to identify gaps or breakdown in policy and practice.

1.7 Family Input into the Review

1.7.1 Sarah's parents kindly agreed to meet with the Chair of this review and provided valuable insight into the family situation and their family's contact with agencies. Within this meeting they also identified a friend of Sarah's who also contributed to the review process.

1.7.2 The invaluable input of the family and friend of Sarah has been considered throughout the review process, and is outlined in detail in Section 3 of this report.

1.8 Criminal Proceedings

1.8.1 The criminal investigation concluded in April 2016 and Michael pleaded guilty to Manslaughter. It was accepted that Michael was not fit to stand trial due to his mental health, but that he was competent to enter a plea.

1.8.2 The Judge sentenced Michael on the basis of two Psychiatric Reports and a Hospital Order under Section 37 of the Mental Health Act was imposed, with Restrictions but no specified time limit. This means that Michael will be detained for an indefinite / unspecified period, until he is no longer deemed to be dangerous.

1.9 Coroner's Inquiry

1.9.1 There was no Coroner's Inquest in this case due to there being a ruling from the Criminal Court.

1.10 Contact with the Perpetrator

1.10.1 The Panel also gave consideration as to whether an interview with Michael should take place, however this was not deemed appropriate given his current mental state and detention under the Mental Health Act.

1.11 Other Reviews

1.11.1 Parallel to this review process, Northumbria Police also undertook a Quick Time Review regarding their management of this case, and the findings of this are including within analysis of the Police's involvement.

1.11.2 In addition, NTW undertook a Serious Incident (SI) Investigation in line with Department of Health requirements when a serious incident occurs. The purpose of an SI investigation is to consider the adequacy of the care and treatment provided. The SI investigation therefore examined Michael's care provided by specialist mental health services since 2005. The author of this DHR, provided support to the SI Independent Investigator, together with a Clinical Advisor (Consultant Psychiatrist), in undertaking the SI investigation. The SI Independent author, supported by the DHR author and Clinical Advisor presented the outcome of the SI investigation to the Serious Incident Management Review Group of NTW on the 14th April 2016. The findings of this investigation were considered where relevant throughout this DHR review, and the recommendations arising from it were included within the recommendations identified in NTW's IMR.

1.11.3 Finally, NHS England commissioned an Independent Investigator to meet the requirements of a Domestic Homicide Review and Independent Investigation, in accordance with the wider scope of the Serious Incident Framework 2015.

NHS England North and the Safer Northumberland Partnership agreed terms of reference for the Independent Investigator to:

- Provide mental health (CAMHS) and investigative expertise to assist the Review Panel.
- Contribute to the work of the DHR Panel working closely with the Chair and Author, in doing so contribute to the resultant DHR Report for Safer Northumberland Partnership.
- Review any gaps in inter-agency working and identify opportunities for improvement for inter-agency cooperation and joint working.
- Assist the Independent Overview Author to review the chronology of all agency involvement.
- Provide constructive independent challenge to the detail of mental health information being considered by the Review.
- Consider any evidence not recognised by organisations or individuals in contact with the child as perpetrator; not shared with others; or not acted upon appropriately.

1.12 Confidential Information

1.12.1 Michael was assessed by mental health services as not having the capacity to understand a Domestic Homicide Process and therefore his consent to the sharing of information could not be sought.

1.12.2 Full consideration was given to the need to anonymise or redact any necessary information prior to publication, in line with Home Office Guidance for the completion of DHRs.

CONCLUDING REPORT

2 THE FACTS

2.1 Family structure and background

2.1.1 At the time of her death Sarah was residing alone with her sixteen year old son Michael in the Northumberland area. It does not appear that the family had had contact with Michael's father for some time, and Sarah's subsequent partner had left when Michael was young. Sarah worked in two jobs, one as a cleaner and the other as a dinner lady at a local school, whilst also caring for Michael. Support was provided to Sarah and Michael by her parents.

2.2 Narrative Chronology

2.3 In order to understand the events leading up to the tragic death of Sarah, and the contact she and Michael had with agencies, a narrative chronology is outlined below. This is split into two periods, the first outlines any relevant contact prior to the review period, while the second provides an overview of the critical contact during the review period (January 2013 onwards).

Agency contact prior to the review period

2.3.1 In August 2005, at the age of five, Michael was first referred to NTW's Child and Adolescent Mental Health Services (CAMHS) by his GP, after his maternal grandmother sought advice due to concerns that he may be suffering from *Attention Deficit Hyperactivity Disorder* (ADHD). ADHD is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness. Michael did not fit the criteria for CAMHS at that time and they were therefore unable to accept the referral. Later, in May 2007, Michael was placed on a waiting list for CAMHS having being referred again, this time by a Paediatrician requiring an assessment for potential *Autism Spectrum Disorder* (ASD), a condition that affects social interaction, communication, interests and behaviour.

2.3.2 Between June 2007 and January 2008 Michael had assessments undertaken by a Psychiatrist, Community Psychiatric Nurse (CPN), Social Worker, and Physiotherapist. Individual reports were submitted in January 2008 to Northumberland County Council in respect of supporting Michael's statutory assessment of his Special Educational Needs (SEN).

2.3.3 In August 2008, following assessment by a Psychiatrist, it was concluded that Michael did appear to have some ASD traits, although further review was needed to decide on a diagnosis. In December, Sarah and her mother attended a planned appointment with the CAMHS worker to discuss Michael's behaviour as a he was becoming very difficult to manage at home. Sarah informed the worker that Michael had wanted to kill himself, and that the

family situation was breaking down as her partner was finding his behaviour too difficult to cope with. Advice was offered in respect of 'conflicts in parenting'. The family wondered if Michael should be attending a special school and whether medication would assist him.

2.3.4 In January 2009, Michael was again seen by a Consultant Psychiatrist, who concluded that Michael presented as having a mild/moderate Learning Disability (LD) with some ASD features, although Michael did not have a diagnosis of ASD. The Consultant felt that the main priority was to exclude the possibility of a Learning Disability and therefore referred Michael for a cognitive assessment. A Clinical Psychologist finally undertook the full assessment of Michael within appointments between September and October and concluded that no Learning Disability was present. There was also a note to advise that ASD was excluded, although psychometric testing cannot be used to exclude ASD.

2.3.5 In December 2009, the Clinical Psychologist met Michael and his family and provided feedback from the assessment. The Psychologist reported that his aggression was perhaps due to difficulties processing/remembering information, and that this may frustrate Michael and lead to him lashing out or engaging in odd/silly behaviours. Michael was also recorded as having low confidence and self-esteem. Michael was provided reassurance that he did not have a disability. Maternal grandmother asked for an explanation as to what was causing the difficulties for Michael in processing information, questioning whether it was ASD or ADHD. The psychologist explained that a previous autism assessment had been done and was negative, and that the Psychiatrist had excluded the ADHD diagnosis. The family expressed the need for ongoing support with Michael's behaviour in the home. The Psychologist suggested that 'emotion management and self-esteem issues' were important. The Psychologist discussed the outcome of the assessment later the same day with the Psychiatrist and a trial of medication was discussed to help Michael with cognitive abilities and inattention. The Psychiatrist also suggested that the Children Support Team (CST) be asked to support the family with behaviour management.

2.3.6 In April 2010, Sarah had a written letter of complaint to the NTW's Children and Young People's Service (CYPS) Head of Service in respect of the time delay for Michael's diagnosis and treatment. In a later response to this it was acknowledged that the length of time to diagnosis was unacceptable.

2.3.7 Within the same month a referral was received from school requesting an Autism Diagnostic Observation Schedule (ADOS) assessment. However the Psychiatrist felt that there were no indicators to formally interview Michael for ADOS. Michael's communication and social skills difficulties were reported to be in line with his main diagnosis of ADHD/ADD (Attention Deficit Disorder) alongside immaturity and a Learning Disability (LD). Michael was prescribed a psycho-stimulant medication. The Psychiatrist's opinion differed from the

Psychologist's assessment of no LD/ASD, and the Psychiatrist advised that a social skills group would assist.

2.3.8 In June 2010, it was recorded by a staff grade Psychiatrist in a review appointment that Michael's behaviour had improved at home and at school. Monthly telephone contact with a Psychiatrist took place with Sarah in respect of Michael's presentation and slight changes to medication, with a clinic review taking place in September. At that appointment his medication was adjusted in light of his weight loss and him being uncommunicative and unmotivated. Occupational Therapy input was also identified to promote self-confidence, self-esteem and expression of feelings; this was commenced in November.

2.3.9 In September 2010, Sarah and maternal grandmother commenced the 'Triple P' parenting course, and at a review meeting in October reported that they were finding the sessions helpful. At that time Michael was playing more with toys at home, was going out, and his appetite was almost back to normal. The medication appeared to be helping Michael to concentrate. The parenting course was completed in November, and generally received positive comments and evaluation by Sarah and maternal grandmother.

2.3.10 In December 2010, a change in presentation was reported in Michael's psychiatric review appointment by Sarah, her partner and maternal grandmother. Michael was said to be having difficulty 'differentiating reality from fiction', with him assuming the role of characters from cartoons he watched. This was also discussed in the school meeting with professionals and family in January 2011. Michael had a Visual Motor Integration test, a dyslexia screening test and underwent the 'listening programme' at home and school. In July 2011 neither home nor school had noticed any change in concentration, although school did say Michael entered the classroom more calmly.

2.3.11 In August 2011, in a psychiatric review appointment Michael was reported by Sarah and maternal grandmother to be lethargic and slowed down, with mornings of extreme hyperactivity. Michael self-reported as not wanting to talk to his friends or eat and said that he felt 'too calm in himself'. His medication was subsequently changed.

2.3.12 Also in August, the Occupational Therapist (OT) provided the outcome of the assessment to Sarah and maternal grandmother. The assessment indicated that Michael presented with a number of autistic traits but with no diagnosis. The OT reported that whilst an ADOS had never been carried out, there may be sufficient evidence from other assessments and school to support an ASD diagnosis. Family reported that although Michael was responding positively to new medication, they were still concerned about his aggression towards his mother in the mornings.

2.3.13 In the Children and Young People's Service (CYPS) Multi-Disciplinary Team (MDT) meeting, the OT and CYPS worker summarised Michael's care and treatment highlighting that Michael had had 'many assessments and changes to psychiatrist over a number of years'. Whilst a Psychiatrist had previously diagnosed ADHD, school and other assessments had highlighted Autism Spectrum Disorder (ASD) features. Treatment interventions so far had led to some changes in Michael's behaviour, family found it easier to take him out for example, however the MDT wanted further clarity of diagnosis.

2.3.14 In December 2011, the Psychiatrist met with Sarah and maternal grandmother and a formal diagnosis of ASD was given. Michael's medication for ADHD was to remain the same with behavioural interventions rather than medication being the preferred intervention for ASD.

2.3.15 From February 2012 Michael remained in NTW's ADHD service for medication review only.

The Review Period (January 2013 onwards)

It should be noted that due to the extensive contact during this time period it has been impossible to document and outline the detail of all appointments, telephones calls, and correspondence that took place. Provided below is a summary of some key events and appointments.

2.3.16 On 6th February 2013, Michael, aged thirteen, was seen by a Paediatrician, having been originally referred in April 2012 with issues of constipation, which had since resolved. The Paediatrician remained involved to monitor Michaels's growth and weight, and to provide support for the family around the ongoing behavioural issues. During this appointment Michael's family reported difficulties in managing Michael's challenging behaviour, which resulted in the Paediatrician contacting NTW's Children and Young People's Service (CYPS) requesting they undertake a review.

2.3.17 On 11th March 2013, Michael was seen in the CYPS ADHD clinic with Sarah. This was following her having contacted them to request an urgent appointment. The current diagnosis was Attention Deficit Hyperactivity Disorder (ADHD) associated with Autism Spectrum Disorder (ASD). In the appointment Michael was reported to look unhappy and was relatively uncommunicative and cross. His behaviour was said to have deteriorated in recent months after a period of stability. The Consultant's opinion was that it was likely that much of Michael's behavioural difficulty and inflexibility related to his autism rather than ADHD.

2.3.18 On 7th August 2013, Michael was reviewed by his Paediatrician. The family's main concern, and the focus of the appointment was of Michael's increasingly

withdrawn behaviour. The family were aware of additional support groups and had accessed support through Children's Services, but they reported that on the whole they felt like they had been left without services since the diagnosis of ADHD three years previously. The Paediatrician agreed to liaise with other professionals, including the Public Health School Nurse (PHSN) to look at additional input for the family.

2.3.19 On 3rd October 2013 Sarah attended an appointment with the PHSN and a previous health assessment from 2012 was partially updated and a new plan agreed. Sarah described Michael's behaviour to include punching a hole in the door out of anger, which caused her to cry and Michael to become remorseful. The outcome of the health assessment did not identify any further role for School health, and the PHSN service subsequently discharged Michael in February 2014.

2.3.20 Michael and his family continued to attend appointments with NTW and Sarah raised ongoing concerns about Michael, including that he had expressed that he did not want to be alive following incidents at school, and that he asked her if she hates him. These scenarios occurred when attempts had been made to put boundaries in place. Sarah also reported that Michael had self-harmed on a couple of occasions following arguments. In early 2014 these concerns included that Michael was becoming more aggressive and Sarah was thus finding it difficult to cope.

2.3.21 At an appointment on 13th January 2014 Sarah and maternal grandmother asked if they could talk to the Doctor alone first before bringing Michael in the room; although it is not clear from notes if this happened. Within this appointment, Sarah described Michael as reasonably settled during the day but exhibiting aggressive and irritable behaviour on waking up, and again around 6pm. This appeared largely related to situational factors, as he was unhappy going to school and then having to leave computer games to go back to Sarah in the evenings. It was agreed that Michael would continue his current medication, but also trial a new medication twice a day for a month.

2.3.22 On 31st January 2014, maternal grandmother rang the department to say that Michael's behaviour had not improved with the new medication, and therefore they were just going to give him the original medication only.

2.3.23 On 14th February 2014, Michael threatened to stab another pupil in a cookery class. There was no evidence of this being shared outside of the school.

2.3.24 On 4th March 2014 Michael was reviewed by his Paediatrician. Sarah reported being unable to control Michael's access to suitable material online or TV, due to him becoming aggressive if he was not allowed to watch or play games that he wanted to. Michael's overeating also continued to be a challenge at home and he was becoming physically aggressive if he was not able to get what he wanted to eat. The Paediatrician agreed to re-refer to Children's Disability Team (CDT) via Children and Young People's Service

(CYPS) in order to help Sarah with strategies to cope with these behaviours.

2.3.25 On 13th May 2014, during a review in the ADHD clinic, Sarah raised continuing concerns about Michael being challenging and aggressive at home. Michael was also reported to have a low tolerance to stress and to have occasionally grabbed Sarah in one of his 'hyper' episodes. His original medication was increased but there was no apparent further exploration of him having grabbed Sarah, or evidence of any advice offered or management plan put in place for if the situation were to arise again. Within the FACE risk assessment[1] it was indicated that there was no apparent risk of harm to others, and low apparent risk of self-harm or suicide.

2.3.26 On 3rd June 2014, Michael drew a picture at school depicting people having been stabbed, legs removed, eyes cut out. He also referred to 'Jeff the Killer', a character associated with the 'Creepy Pasta' website; a ghost and horror website.

2.3.27 On 16th June 2014, Sarah contacted the Children's Social Care (CSC) Blyth locality team advising that she was struggling to cope with Michael's behaviour, including his aggression and self-harm. The duty Social Worker recommended a referral to the Early Intervention Hub (EIH), and consulted with the school to discuss the appropriateness of an Early Help Assessment (EHA) being completed. The Deputy Head Teacher did not think that an EHA was appropriate, as there were no concerns around Michael's behaviour within school. The CSC Team Manager agreed with the EIH referral recommendation and the duty Social Worker made the referral.

2.3.28 On 1st July 2014, the referral was discussed at the EIH and allocated to the Children's Support Team (CST) for an EHA to be completed. On the 3rd July 2014, the case was allocated to a worker within the CST team, who became the CST Lead Professional.

2.3.29 On 10th July 2014, the CST worker undertook a home visit to gather information for the Early Help Assessment. The worker met with Sarah but Michael was not present on this visit. Sarah reported that Michael was generally well behaved in school but that he 'let's himself go' when at home.

2.3.30 On 21st July, the CST worker undertook a further home visit, and once again Michael was not present. Sarah shared that Michael had been on his medication for seven weeks and was calmer since the increase in dosage; although his levels of aggression had increased. Sarah felt that Michael's behaviour was worse first thing in the morning, and it was noted that she had scratch marks on her arms, which she reported were caused by Michael.

2.3.31 On 24th July, Sarah contacted the CYPS Duty Team by telephone, she was

[1] FACE: 'Functional Analysis of Care Environments' is a risk assessment nationally accredited by the Department of Health.

concerned as Michael had self-harmed the day before. He had used a photo frame from his bedroom and tried to cut his arm in anger when Sarah told him he couldn't watch a DVD. Sarah described no blood and no surface cuts. She said the incident has passed and, on the day of the phone call, Michael had attended Martial arts and come home happy. Sarah said her parents were away until Monday, but identified that support was also being provided by the Early Help team. As no increased risks were identified, and Michael was reported to be calm, Sarah was advised to seek help if Michael intended to self-harm again and a telephone number for the Intensive Community Treatment Service (ITCS) was provided.

2.3.32 On the same day, the CST worker undertook a home visit. Sarah shared the self harm incident and also that Michael had spat in her face and grabbed her. The EHA was signed as being completed by the CST worker on this day.

2.3.33 On 28th July, the first Team around the Family (TAF) meeting was held at the family home. Michael, Sarah and maternal grandmother were present and the EHA was shared. Sarah also shared at the meeting that she was worried about Michael's self-harm and she had concerns that he had not taken his medication.

2.3.34 On the 4th August 2014, Sarah contacted CST to say that earlier that day Michael had picked up a knife and threatened her. Two days later, during a home visit, she also expressed concerns around his self-harm. Michael was seen and spoken to and it was noted that he laughed and smirked when talking; however, he did not do this when talking about the knife.

2.3.35 On August 6th, the Consultant Psychiatrist rang Sarah, and she described Michael as aggressive when his medication was wearing off, including 'waving knives'. No exploration took place of Sarah's fear, no safety plan was discussed and the FACE risk profile was not updated. Seven days later at Michael's review appointment with the Psychiatrist, episodes of self-harm at school following fracas with boys were discussed.

2.3.36 On 1st September 2014, during a telephone call to CST, Sarah shared that Michael had self-harmed the previous night by scratching his arm. Michael was spoken to by telephone.

2.3.37 On 2nd September, at the ADHD Clinic Michael's sleep pattern was reported to be disrupted, and he was said to be viewing the 'Creepy Pasta' website at night. Both Sarah and maternal grandmother expressed concern regarding the website and the Nurse suggested the family limit the amount of time Michael spends on the site. No advice was given of how to do this, despite previous information of aggression increasing when Michael is stopped from doing something. Michael was also seen alone and stated he wasn't particularly down and had no suicidal ideation, although Sarah and maternal grandmother felt he was depressed.

2.3.38 During September, during home visits by CST, Sarah shared continuing concerns that that Michael was depressed, did not want to take his medication, and that she had found his tablets hidden. She also reported increased aggression, including that the had thrown an aerial lead at her and 'trashed' her house. Michael was spoken to, and he shared that he felt his mother Sarah was 'on his back'; it was again noted that he was smirking and giggling during the discussion.

2.3.39 On 9th October 2014, an incomplete 999 call was received. On attendance, Sarah informed Officers that Michael suffered ADHD and autism and had become angry when a games console would not work. As she had been on the phone, he had reportedly grabbed it and started pressing random numbers. No offences were disclosed and no further action taken. No Child Concern Notification (CCN) was completed by Officers. In describing this incident to the CST worker the next day, Sarah reported that she had been trying to contact her parents and that Michael took the phone from her and dialled '999'.

2.3.40 On 15th October, at the Paediatrician review appointment, it was observed that Michael had evidence of self-harm on his arms and face area. Michael's family continued to have concerns about his mood, emotional well-being and behaviour. Letters were sent to CYPS and the Disabled Children's Team (DCT) to try to access additional support for the family.

2.3.41 Within the referral to DCT, it was shared that Michael's behaviour at home and at school was becoming increasingly difficult. This was processed by DCT as a 'contact only', and it was agreed that the DCT duty Social Worker would attend the next TAF meeting.

2.3.42 On 18th October, Sarah telephoned CST to share that she was having difficulties with Michael and he was refusing to take his medication. Michael was spoken to by telephone and stated that he had taken it. A week later, Sarah also reported that Michael had called her a 'bitch' and accused her of hiding his tablets. Michael was spoken to and it was noted that he was quietly laughing throughout.

2.3.43 On 28th October, the health records indicate Michael was discussed in an ADHD Clinical Network Meeting. The action was for a Specialist ADHD Nurse to clarify if Michael has been allocated a Care Coordinator regarding the risk of self-harm and, if not, to request this take place. The Nurse spoke with a CYPS Team Manager a week later.

2.3.44 Throughout November, during home visits and telephone calls to CST, Sarah shared that she thought Michael was fixated on the 'dark side' and that he had not been taking his medication; had self-harmed; had pushed her over the settee; had smashed ornaments; and had called her a 'bitch' and a 'whore'. Sarah also said that Michael had covered his face with a substance she thought was bleach, although Michael said it was shampoo.

2.3.45 On 25th November, Sarah attended her first appointment with a Health Psychologist in NHCFT, having been referred from the Diabetes service. She reported being low and stressed and shared her son's diagnosis of ADHD and his difficult behaviour.

2.3.46 On 26th November, the CYPS Duty Team received a further phone call from Sarah, informing them that Michael's behaviour was uncontrollable in the mornings and evenings when his medication was wearing off. He was described as 'aggressive and oppositional', and as self harming superficially when attempts were made to put boundaries in place.

2.3.47 On 1st December 2014, a CYPS worker from the integrated team contacted Sarah to arrange a home visit. The following day the ADHD Clinic Nurse acknowledged that Michael was to be allocated a Care Coordinator from the Integrated Team.

2.3.48 The following day, Sarah shared with CST that Michael was reported to have involved in a small altercation with a man and his dog, in which he was alleged to have kicked the dog. Sarah also shared that Michael was showing her 'dark side' pictures.

2.3.49 On 5th December, two calls to the Police were received at approximately the same time. One from Sarah reporting someone banging on her door, and one from a neighbour reporting Sarah shouting and screaming at Michael. The neighbour also believed Michael may have been beaten. A welfare check was carried out and Michael was safe and well. Sarah stated that Michael's medication was wearing off and he had become verbally aggressive. The neighbour was spoken to and found to be intoxicated. A CCN was raised by the Police and sent as a notification to Children's Social Care.

2.3.50 At school the following day, Michael was goading another student by shouting, 'shoot yourself, slit your throat'. That same day, during a telephone call to CST, Sarah reported that Michael was 'high as a kite' and out of control.

2.3.51 On 7th December, Police received a call from the same neighbour passing a third hand report of possible injuries to Michael's face. Sarah was visited the following day after Michael had gone to school. She stated that Michael sometimes self-harmed when stressed. A check with the school confirmed this, and they reported no concerns for Michael's safety.

2.3.52 On 8th December, the Police Child Concern from the 5th, was received by the Blyth social care locality team. The duty Social Worker consulted with the CST worker and was aware that a TAF meeting was in place. The Social Worker recommended a 'Contact Only' which was agreed by the Team Manager.

2.3.53 On 10th December, the second TAF meeting took place. The meeting was attended by the DCT duty Social Worker. The school and CYPS were invited, but did not attend. It was noted that Michael was present and aware of the meeting; however, he did not wish to make any comments. The concerns that were discussed included Michael's behaviour, the detrimental effect on his mother Sarah, his self-harm, and his fixation on the dark side. This included him having stated that he would become a serial killer when he grew up and that he would kill every member of his family, and then everybody at school, who interferes with his life. The DCT duty Social Worker's written record of the meeting state that 'there are now safeguarding issues-violence, inappropriate material on the internet and self-harm. There is also a possibility of the Risk and Intervention Team being involved'.

2.3.54 On 12 December, the CYPS worker (allocated Care Coordinator) undertook an initial home visit with Sarah and maternal grandmother. Michael was at school and Sarah wanted the opportunity to talk without Michael present. Sarah outlined the ongoing concerns regarding Michael's behaviour and identified that the majority of his aggression was towards himself. Michael was reported to have started boxing club a couple of months ago, which Sarah felt had been very good for him, due to it being a contained and structured environment. She also spoke of having attended a parenting course previously, which she found very helpful, and said that her and her mother were booked on to a challenging behaviour course. Sarah was given ABC charts to write down triggers for Michael's behaviour.

2.3.55 On 30th December, Sarah told CST that Michael had been on his Tablet computer looking at 'Chucky' type images and 'Jeff the Killer'.

2.3.56 On 6th January 2015, Sarah attended her second appointment with the Health Psychologist. Records indicate that she was much more open about the fantasy world Michael has in his head and some of her concerns about the influence social media and the Internet were having on him. Sarah also shared concerns about contacts he had made on Facebook. The Psychologist and Sarah agreed a plan to limit Michael's internet access, although this had previously been described by Sarah as something she could not do due to Michael's volatility if he did not get his own way.

2.3.57 On 8th January 2015, Sarah agreed with CST that she was going to contact NTW regarding Michael's horror/killing fixation and ask them to review his medication. During the following weeks she shared that Michael constantly talked of horrible things, killing, death and stabbing, and that she was struggling to take the internet from him as she was fearful the consequences.

2.3.58 On 20th January, Michael attended an ADHD Clinic appointment with Sarah and maternal grandmother, and continuing concerns were expressed. Within these, maternal grandmother reported that she felt that Michael's aggression was mainly aimed towards Sarah and that she was doing all she could to manage this. Michael was reluctant to talk about risks within appointment. No

further exploration recorded of how Michael 'hurts' Sarah or what safety plan could be put in place. The FACE Risk Profile was completed with the risk of violence/harm to others, the risk of deliberate self-harm, and the risk to a family member scored as two. This scoring indicated 'Significant Risk' and therefore would require a risk management plan in line with policy; this was not completed.

2.3.59 On 30th January, Sarah told CST that she had received a telephone call from school regarding Michael talking about 'Creepy Pasta'. It was noted that Sarah spoke with Michael who agreed to stop talking as much about the 'dark side'.

2.3.60 On 6th February 2015, the CYPS worker held a telephone consultation with both Sarah and the CST worker, who was requesting an update. Sarah was concerned about Michael's continuing dark thoughts and viewing of inappropriate websites. The CYPS worker discussed Internet safety and parental controls on the internet to restrict this kind of viewing, but once more Sarah expressed that she was worried Michael will lash out at her if he is unable to watch these videos; she spoke of him having scratched and pushed her before. Michael was recorded as not having self-harmed for some time, but had stated to Sarah he will self-harm, usually when he does not get his own way.

2.3.61 The CYPS worker has not seen Michael yet but it was recorded that there had been 'little response to interventions'; although it was unclear what these were and how they were being monitored. Following the call with Sarah, the CYPS worker contacted the trust Safeguarding and Public Protection Team, and one of the outcomes of this was to update the risk profile; although this does not appear to have occurred. Finally, it was also documented that 'Sarah has been given behaviour charts to complete' but it was unclear what behaviour was to be recorded or who was responsible for evaluating these.

2.3.62 On 10th February, a review meeting took place at the school with Sarah, maternal grandmother, the Specialist Registrar and the Psychiatrist (who joined the consultation later). The history was given and the situation was updated. Diagnoses were recorded as ADHD and ASD, with noted improvement with increases in medication. Family stated that Michael's behaviour had improved slightly, however he was talking less but understanding more with the medication. Ongoing concerns about self-harm and response to boundaries were noted, as were his dark obsessions and interests. Also reported that just before Xmas holiday 2014 there was an escalation in behaviour, and he had hurt Sarah by 'grabbing her by the throat and throwing things at her, constantly banging on doors'. Michael was reported to have become more introverted and he told doctors that he feels confused rather than anxious. Evidence was also given of poor sleep and spitting out additional medication.

2.3.63 Within the management plan that was agreed following the above meeting, it

was identified that Michael was advised to discuss his dark thoughts with his family and teachers; information was given to the family to help with understanding of Michael's behaviours and support group; medication was discussed, and the doctor was to request CYPS shared care quickly to support Michael and family. There was no evidence that the disclosure from Sarah of being physically assaulted by Michael prior to Christmas was considered in relation to informing other agencies or NTW's Safeguarding (SAPP) team, or that the risk management plan was updated.

2.3.64 Between 24th to 26th February, Michael had conversations with school staff that included him hearing demon voices, wanting to jam someone's head in a washing machine to 'snap their neck', and discussing the date of a teacher's death. On 2nd March, he reported that he had killed three people the night before, 'a doctor, a policeman and an old man', and the following day said he had killed thirteen people that month, listing them all and describing graphic ways in which he had killed them. On 4th March the school telephoned Sarah in relation to this as well as notifying CSC, and the Police.

2.3.65 On 4th March 2015, Michael self-harmed at school using a piece of broken glass and caused superficial cuts. Following the incident, Sarah contacted the CYPS team and asked to speak to the Specialist Registrar as she wished to query Michael's medication. Within this it was discussed that Michael had only agreed to start his new medication that day, and it was immediately following this that the incident of self-harm occurred. Sarah believed he was anxious about taking the medication and probably self-harmed to show her that the medication was not good for him. Sarah agreed to reassure Michael and persevere with giving the medication as described.

2.3.66 In a further telephone call with CST regarding the above, Sarah stated that a boy in school had given Michael some glass and told him to cut himself, and that Michael had thought it was funny. Sarah said that there had been a lot of blood and that Michael had liked this.

2.3.67 On 5th March, the CSC locality team received the above referral from the Deputy Head at Michael's school. The Deputy Head Teacher stated that he felt Michael had progressed to another level and that he needed further assessment. The duty Social Worker telephoned Sarah, the CST worker and CYPS, although the latter was unavailable and a message left.

2.3.68 NTW's duty team also received a call from the school that day, stating that Michael was displaying bizarre behaviours i.e. sitting in the corner of her science lab giggling and laughing talking to and throwing items at a skeleton which he had turned around. When approached about this he explained that he was talking to the skeleton because he wanted to. The school was advised that the CYPS worker would visit the school tomorrow, as planned, to see Michael. The CYPS worker also made contact with CSC's Safeguarding Team.

2.3.69 As a result of the above the duty Social Worker recommended no further action, stating that 'current professional involvement was appropriate and they have been alerted'. The duty Social Worker recommendation was agreed by the Team Manager stating that 'there are concerns around Michael's mental health and current experiences and thoughts. It is clear that there is appropriate mental health professional involvement to support his additional needs'. The Team Manager also advised the duty Social Worker to 'share the information with the DCT in case he met their threshold. Ongoing support through the EHA'.

2.3.70 When the call regarding the above was received by Police from Michael's school on 5th March, a CCN was raised and sent as a referral which was marked as received on 9th March by CSC. No offences were disclosed, therefore no further action was taken by Police.

2.3.71 On 6th March, the CYPS worker visited the school and had an initial discussion with Michael's teacher prior to meeting with Michael. The teacher advised that they had written down some of the things Michael has been saying in class to her and other teachers. These included wanting to stab a doctor with a syringe, and putting a cat in a microwave. The CYPS worker met with Michael, who stated he was unhappy Sarah has taken away his internet and said the only thing he likes doing is watching dark paranormal videos as they make him happy, Michael said he had cut his arms earlier in week because he loves blood. Michael stated he was unhappy and he did not think his medication would help.

2.3.72 On 9th March, the duty Social Worker contacted the DCT and the school and was advised that a review was to be held in school on the 12th March and that the DCT duty Social Worker would be attending, and would report back to the CSC locality team if there was a role identified.

2.3.73 On 12th March, Michael attended the Year 9 transitional review meeting within the school. A Senior Practitioner with DCT also attended, but it appears that the CST worker and CYPS were not invited. The meeting noted Michael's fascination with the 'dark side' and 'death', and that 'he appears to be able to separate fact from fiction, he is a good storyteller and he has a propensity to tend to shock to see what reaction he gets, so he appears to have insight into the consequences of actions'. The meeting notes that this indicates a 'well developed cognitive ability', and the worker from DCT stated that Michael did not have a learning disability, and that it was therefore their professional opinion that Michael has learning difficulties which he appears to be overcoming. He noted that this was not indicative of Michael having a learning disability and thus he would not meet the current DCT eligibility criteria. The outcome of the meeting was for the DCT worker to complete a brief Children and Family assessment to demonstrate the discussions held at the meeting. Michael's case was subsequently closed to the DCT on 22nd April 2015.

2.3.74 On 18th March 2015, during a CST home visit, Sarah shared two incidents: one where Michael has sprayed deodorant over her, and another where he put his hand over her mouth whilst she was preparing tea. Both incidents were noted to have no context and to have come out of the blue. It was noted that Michael was laughing and smirking throughout the visit. Sarah had shared that Michael had photographs of demons saved on his telephone and Michael showed the CST worker the photographs, who noted them as 'low level'. Five days later, in a telephone call, Sarah also reported that Michael had nearly pulled her down the stairs on one occasion and that he had said he was going to burn her.

2.3.75 On 29th March, Sarah reported excessive music from her neighbour to the Police. She believed this was a response to noise from Michael when his medication wore off. On attendance all was quiet and Sarah was advised to contact the council for noise monitoring sheets

2.3.76 On 9th April, Sarah contacted the CYPS Duty Team to discuss her concerns. She reported to a Duty Worker that she was struggling with Michael's behaviour, and that the night before he had 'pinned her arms behind her back, pushed her over then pinned her to the sofa'. She stated this was the worst he had been and that previous aggression had been manageable.

2.3.77 The Duty Worker spoke with the Specialist Registrar about Sarah's conversation, and the Specialist Registrar contacted Sarah by telephone. Sarah discussed current issues with Michael as outlined above. Once again there was no evidence of any action taken as a result of Sarah's disclosure that Michael had assaulted her, either through updating the risk assessment, sharing the information, or contacting NTW's Safeguarding team.

2.3.78 On 14th April, Sarah attended a review with her Psychologist. She discussed Michael's 'dark thoughts' and reports that he had 'been out killing people'. There was no further detail documented.

2.3.79 On 15th April, Michael was seen in the ADHD Clinic and Sarah reported his challenging behaviour over the last few weeks.

2.3.80 On 22nd April, maternal grandmother telephoned CYPS as the family were having problems regarding Michael's medication and wished to speak to someone with medical knowledge; she asked for either the Specialist Registrar or Nurse Prescriber. Sarah was at work, and Michael's maternal grandmother was caring for him. There is no record of this call being returned.

2.3.81 On 22nd April, Sarah reported on-going noise from the neighbour to the Police. She perceived it as harassment due to Michael's autism. Officers attended and found the neighbours intoxicated and shouting in the back garden. They were given words of advice. This was recorded as an Anti-Social Behaviour (ASB) incident and flagged to the Neighbourhood Policing

Team (NPT) for management. The NPT subsequently allocated an Officer as the case worker in respect of the ASB.

2.3.82 On 24th April, Sarah expressed continuing concerns to CST about Michael's medication and concerns that CYPS had not returned her calls. The CST worker shared the information with CYPS who advised that Michael's CYPS worker was still off sick. The same day maternal grandmother called CYPS again, as she felt that the medication that Michael has for his OCD was 'interfering' with the ADHD meds. The Specialist Registrar returned the call and advised a modification of the medication.

2.3.83 On 25th April, an ASB risk assessment was carried out by Northumbria Police. Sarah was assessed as at a high risk of Anti-Social Behaviour against her.

2.3.84 On 27th April, Sarah spoke to the Specialist Registrar within CYPS around her concerns about increasing Michael's medication, which had resulted in her not giving him the additional dose as previously agreed. Extensive discussion took place about rationale for changes in medication, following which a plan for medication was put in place, with Sarah to advise the Specialist Registrar of progress after three days.

2.3.85 On 28th April, the Paediatrician saw Michael for a review appointment, and spoke to the Specialist Registrar within CYPS the following day. The Paediatrician stated her concerns about Michael's disclosure to her that he goes out at night and kills and drinks the blood of animals. He also told her that he was a demon etc. His maternal grandmother told the Paediatrician in confidence that the family are terrified of him as he can be threatening.

2.3.86 There was no evidence of any specific action being taken as a result of the family's report that they are terrified of Michael. The Specialist Registrar discussed that from the previous assessment it was assessed that Michael was a very anxious boy who has a peculiar interest in things that are dark and mysterious, and that this was part of his autism. The Registrar also said that Sarah lacked understanding in her son's difficulties and that Michael tended to control the situation at home. The Paediatrician suggested an MDT meeting, and the Registrar advised this could be convened after a member of the team had been able to undertake further work with Michael. The Specialist Registrar spoke to the Team Coordinator for CYPS regarding the allocation of worker, and the plan was to reallocate a clinician as soon as possible as the currently allocated Care Coordinator was on sick leave.

2.3.87 On 1st May 2015, Sarah was spoken to at length by NPT's Officer regarding on-going support. Sarah perceived that due to Michael making noise from his 'outbursts', the neighbours responded with music noise, albeit on an occasional basis. A CCN was considered but deemed not to be required at the time.

2.3.88 On 4th May, during a home visit by CST, Sarah said that Michael was becoming more aggressive and that he was angrier on the new medication, concerns which she expressed further in a telephone call two days later.

2.3.89 On 5th May, a follow up call was made by the NPT Officer. Sarah reported no further noise from the neighbours and did not wish for police to contact them. Sarah was advised to continue to monitor and report any further incidents directly to the allocated Officer.

2.3.90 On 7th May, Sarah contacted the CYPS Duty Team by telephone. She reported that the previous day Michael had come home from school and bitten his maternal grandmother, as well as trying to hit his maternal grandfather with the peg bag. He then tried to stab himself with a fork. Sarah requested an urgent appointment and said that these present issues have been apparent for nine weeks, since the introduction of the second medication. The Duty Worker contacted the Specialist Registrar by email, who contacted Sarah by telephone.

2.3.91 On 8th May, Michael was seen in the ADHD clinic, and the ongoing concerns and medication issues were discussed. The family identified that Michael was less aggressive when he went to his to kickboxing class. It was also noted that during the appointment, Michael showed defiance to Sarah, glaring at her and challenging her concerns for him. The Specialist Registrar's impression was that Michael's ADHD was under treated but that his mood had improved; although there was a deterioration in behaviour problems, with puberty potentially having some part to play in his aggression. Michael was thought to have 'poor understanding of the impact of his behaviours on others, tending to adapt everything to his bizarre belief system.' Despite an increase in physical violence reported, towards grandparents as well as Sarah, no risk management plan was put in place or communication with other agencies or NTW's Safeguarding team.

2.3.92 Michael's case was reviewed within NTW by a Team Manager on 12th May 2015 and it was decided that the case would remain with the current medic, as well as a new CYPS worker to be allocated to support additional needs.

2.3.93 On 12th May, Sarah attended a review with her Psychologist. The worsening concerns around Michael's behaviour were discussed and Sarah stated that her own mother was going on two weeks holiday and that this was going to be a trying time for her alone with Michael. There does not appear to have been any further exploration of the support Sarah was going to have at this difficult time to help her cope with Michael.

2.3.94 On 14th May, Sarah telephoned CYPS as Michael had had a few outbursts on new medication. She requested that the Specialist Registrar call back, but there is no record of this occurring.

2.3.95 On 19th May, Michael was seen and spoken to as part of a home visit by CST.

It was noted that he was uncommunicative, sitting with his leg covering his face and looking at his mobile phone. Four days later, Sarah telephoned CST to share that Michael had been 'hyper' the previous evening and that he had scratched her arm and sprayed furniture polish on her dinner. Following this, on 25th May, during a home visit Sarah shared that Michael had spoken of an incident at McDonalds where Michael had stated 'everyone was going to die'. On 27th May, Sarah again telephoned CST and spoke with the Senior Practitioner, stating she had had a difficult night with Michael, who had scratched her arm and tried to punch her. The Senior Practitioner agreed to review the involvement of CST under the EHA.

2.3.96 Sarah then telephoned to speak to NTW's duty team and discussed these concerns with a Team Manager. Sarah was informed that a new allocated CYPS worker would be working with Michael and would contact her to make an appointment when they returned from annual leave the following week. Sarah was also advised of the times that the duty team were available, and the additional hours that ICTS were available. There was also a telephone call to Sarah from the Specialist Registrar the same day, in which it was discussed that Michael continued to be aggressive after stopping the agreed medication. Within this Sarah reported that Michael had hit her as his medication was wearing off, and that when she threatened to call the police he had 'backed off'. He was reportedly worried all night that she might call the police and she said this helped in reducing his aggression. Sarah was advised to involve the police if Michael continued to be violent towards her. There was no sharing of risk information and no update to the FACE risk profile.

2.3.97 On 28th May 2015, Sarah spoke with the Senior Practitioner for the CST. It was noted that Sarah was in a distressed state and that she had struggled with Michael's behaviour since the previous day. Sarah shared that he had grabbed her arms and taken her mobile phone to prevent her from contacting the Police. Sarah said that she had spoken with CYPS for advice around Michael's medication and CYPS agreed for her to alter the times she gives him the medication. The following day, during a home visit, Michael was reported to be stifling laughter and was unable to comprehend Sarah's anxiety. The outcome of the home visit was for a TAF meeting to be convened for 10th July and for the CYPS assessment to start.

2.3.98 On 29th May, Sarah contacted NTW's Duty Team. Sarah reported an argument this morning with Michael in which he was verbally abusive to her and banged doors. Sarah threatened to telephone the police and stated that Michael then grabbed her by the arm. The CYPS worker advised Sarah that the notes would be updated and an email to the Care Coordinator to request they make contact with the family as soon as they are able. They also discussed the need for Sarah to contact the police if she feels her safety is compromised. An email was then sent to the CYPS Worker and the Specialist Registrar. Again no further action was taken regarding the risk and

there is no evidence of a returned call to Sarah from the CYPS worker or the Specialist Registrar recorded in health records.

2.3.99 On 9th June 2015, at her appointment with the Psychologist Sarah reported there had been a 'couple of violent incidents' in the second week of half term, however Michael's behaviour was better now he was back at school. It does not appear that the psychologist explored the violent incidents further.

2.3.100 On 11th June, at an ADHD clinic appointment, ongoing concerns were raised raised around Michael's 'dark ways'. Within this Sarah and maternal grandmother spoke of his fascination with knives, and although Michael denied any intent to use knives as a weapon, the family were concerned he may do something one day. Michael voiced that 'he would obviously plan something' but didn't elaborate and then said 'it has already been done'. The family believed that he was referring to the claims he had been making that during the night he leaves the home and does bad things. He apparently also voiced knowledge of being able to cover up his DNA evidence. When discussing potential criminal offences and prison should he be caught he voiced 'having special powers, being able to escape and knowing friends'. The clinic Nurse informed the family that she would discuss Michael with the team in regards to future management. Medication was unchanged and the FACE risk profile was updated, although no changes to the document.

2.3.101 The following day, the clinic Nurse sent an email to five doctors regarding this appointment, and requesting a mental health assessment. Within this the Nurse reported that they felt that Michael may be experiencing a psychosis. Concerns were also raised in regard to the violence he predominantly displayed towards Sarah, and his lack of remorse. The Nurse noted that they had seen Michael at only three clinic appointments, but that on all these occasions the family had reported the same concerns; the Nurse felt that 'we need to begin to address these issues'.

2.3.102 On 15th June, there was a telephone call to Sarah cancelling Michael's appointment for the following day as his new CYPS worker was on sick leave. No consideration appears to have been given to the concerns raised in the appointment four days earlier.

2.3.103 On 18th June 2015 Michael, accompanied by Sarah and maternal grandmother, was seen by a Psychiatrist. A full history was taken but the Psychiatrist needed to see Michael again to complete the assessment. The ongoing concerns were discussed but Michael reported that he didn't think there was anything, and denied having any particular worries or concerns. It was agreed that a further appointment would take place to continue the assessment; that discussion would take place with the ADHD clinic Nurse and the Paediatrician; liaison with school would occur; and referral would be considered to the EIP (Early Intervention in Psychosis) in relation to medication, once all of the information is gathered.

2.3.104 The following day the Psychiatrist discussed Michael with the ADHD clinic Nurse, who expressed concern that increasing the dose of his ADHD medication may be contributing to his current difficulties. The merits of review by EIP team were discussed, what level of co-morbidity could be managed within the ADHD service, and when it would be appropriate for him to be open to wider team.

2.3.105 On 22nd June, the Psychiatrist contacted Sarah to confirm the next appointment with Michael for 29th June. Sarah reported that the family were due to have an appointment with a nurse from the Team but this hasn't happened as yet. Psychiatrist subsequently discussed Michael with the Team Manager who agreed that Michael did need a Care Coordinator but to date that had not happened as he had been allocated to clinicians who had then unfortunately gone off on sick leave. The Team Manager agreed to take this forward.

2.3.106 On the 26th June, Sarah shared with CST that the previous week Michael had kicked his grandfather.

2.3.107 On 27th June, contact was made by NPT with Sarah. She reported no further incidents with the neighbours, although said that they use foul language towards each other on a day to day basis, both within and outside their premises. Sarah had completed a Homefinder application to apply for a move. She was advised to contact police and report incidents which were affecting her daily life and that of her son.

2.3.108 Michael was seen for his second appointment with the Psychiatrist on 29th June 2015 to complete his assessment. The Psychiatrist spent some time talking to Michael alone and then to Sarah and maternal grandmother, before meeting them all together. Michael spoke about having a difficult weekend with the noise from the neighbours. He also said that things have been happening to him every night since he became a demon, and reported that when he was 13 he sold his soul to the devil. When asked whether he had ever had thoughts about hurting or harming anyone whilst in his human body he said he had wanted to but knows that the police would come and find him, that he would get into trouble and then he would have to go on the run. The Psychiatrists impression was that Michael had a false fixed belief that he was a demon that appeared delusional in intensity. Whilst the Psychiatrist did not feel Michael was floridly unwell there were hints of a broader psychosis in that Michael could hear people talking in other rooms and other 'demons' could read his thoughts. A trial of antipsychotic medication was proposed to see if Michael's experiences would be responsive to the medication.

2.3.109 On 29th June, Sarah shared with CST that Michael had said 'his spirit kills people in the night'. Maternal grandmother was present for the latter part of the visit, and said that Michael had been very difficult; he had been hanging onto her leg, had bitten his arm and had said he was 'Hannibal Lector'.

2.3.110 On 6th July, there was telephone call from Sarah asking to speak to the Specialist Registrar regarding concerns around Michael's behaviour. There was no record of the call being returned.

2.3.111 A Northumberland Homefinder application was received from Sarah on 7th July 2015. In the application she provided details about her reasons for a request to move house and the impact her current home was having on her and her son's health. Further information to support the application was received on 14th, following which the application was assessed by the Vulnerable Persons Support Officer. The assessment was completed in line with the Common Allocation Policy criteria and she was assessed as being in medium housing need. Following this, in August, she was offered a property, but this was then withdrawn in September as the existing tenant withdrew their notice.

2.3.112 On 7th July, during a CST home visit, Sarah shared that Michael was hiding his medication, swearing and telling her to 'Fuck Off', and stating he would kill his family. Sarah stated that Michael's behaviour had been worse in the previous two weeks and informed that he grabs her and her telephone if she threatens to telephone services.

2.3.113 On 10th July 2015, the TAF meeting took place. Sarah shared that she felt Michael's behaviour was becoming worse; he was hiding his medication and was more aggressive towards his grandparents. It was confirmed that Michael would be starting new, anti-psychotic medication, and would be referred to the Psychosis Team (although there was no reference to the status of this), and that a Community Nurse (CPN) would be allocated to assess Michael in the family home and take a wider look at his medication and aggression. School described him as a 'bright boy, doing very well, occasional incidents where he talks about weird beliefs as if to get a reaction from others'. They also reported that Michael did not say 'weird things' to his teacher as he 'would not get the reaction he craved'. It was agreed that CST would remain involved until the CPN had started the assessment. It was noted that Michael did not want to be involved in the meeting.

2.3.114 On the same day, Michael was presented with 'Most Improved Student' award for his class by the school.

2.3.115 On 12th July, Sarah reported further problems to the Police from her neighbour. She wanted the report recorded for information only. She was contacted by the allocated PC the following day and advised to continue with the logs. Housing was contacted by email to arrange a joint visit.

2.3.116 On 15th July, Sarah rang the NTW duty Team with regards to Michael's behaviour, including that the family had to hide knives from him. She was advised that she should call the police if she was concerned, to which she replied that this was 'easier said than done'. Sarah reported that as the family

were going away on Saturday, and that she would like to speak to the Specialist Registrar before. An email was sent to the Specialist Registrar to speak to the family but there was no evidence in the health records of a return call being made to family. Again, no contact was made with NTW's Safeguarding team or other agencies regarding the increasing concerns.

2.3.117 On 27th July, in a conversation with the Specialist Registrar, maternal grandmother reported that the family had returned from holiday early as Michael was very disruptive, smashing the television and breaking other furniture. Once back from holiday he had been isolating himself in his room. The family were desperate to trial him on the anti-psychotic medication and the Specialist Registrar called the GP to sort out ongoing requests for blood tests.

2.3.118 In sharing information about the holiday with CST, Sarah also that Michael had bruised his grandmother's knee by smashing a lap top on it, and that that Michael was constantly swearing at her and had hit her with a lampshade. She said that he was more aggressive and that she could not go on. It was noted that Michael was laughing, smirking and giggling throughout the conversation, even when Sarah was describing her distress.

2.3.119 On 31st July, at the Specialist Registrar appointment with Michael, it was agreed to commence the anti-psychotic medication.

2.3.120 On the 4th August 2015, during a CST home visit, Sarah said that Michael had started his new medication and was much less aggressive, but continued to shout. It was noted that grandparents were going on holiday for two weeks and that CST would remain involved in the absence of the CYPS worker.

2.3.121 On the same day, Sarah reported excessive noise from her neighbour to the Police. The attending Officer advised the neighbour to keep the noise down. The NPT allocated Officer and the Housing Officer conducted a joint visit on 6th August and spoke to the neighbour, issuing him with a warning letter. Sarah was advised to continue to report any problems.

2.3.122 On 6th August, a telephone call was made from Sarah to the Specialist Registrar and Michael was reported to be a little better since beginning medication, described as 'no longer aggressive and a lot calmer.' The Specialist Registrar recorded a general improvement in presentation and instructed Sarah to continue medication. Sarah also reported having called the Police in relation to her neighbours, but no clarification was sought at to what the issues were.

2.3.123 One week later, telephone contact was made by Sarah to update the Specialist Registrar and she reported that she had not seen further improvement since the first week. Michael was still constantly saying he was a vampire, and on one occasion he lost his temper and punched a hole in the

wall. She did however say that he was generally better, as he was less aggressive and not threatening to her anymore. Sarah wanted an update on the CYPS worker that is to be allocated to Michael as she needed extra support to cope with Michael's difficulties. The Specialist Registrar agreed to chase up progress with CYPS Care Coordinator input. There was no mention of the referral to EIP being progressed.

2.3.124 During CST home visits in August, Michael was observed with marks on his arm, and was noted to be 'short' in response to Sarah and to continue to call her names.

2.3.125 On 20th August, Sarah attended the Diabetes clinic, following three missed appointments. At the appointment she disclosed lots of problems with stress due to issues with Michael and problems with neighbours. This does not appear to have been explored further.

2.3.126 On 31st August, Sarah telephoned CST to share that Michael had been up since 3.30am, that his self-harm had started again, and that he was aggressive towards her and others. Sarah expressed a number of concerns, including anxiety about contacting the Police if Michael became aggressive, and about CST closing the case. She also felt she was not being supported by CYPS. The CST visited later that day, and this was the last visit and time that the CST worker saw Michael. The CST worker contacted CYPS and was informed that the new allocated worker for Michael would contact Sarah.

2.3.127 On 1st September 2015, CST telephoned Sarah, who informed them that Michael had prevented her from contacting them the previous day. Sarah agreed to keep a separate telephone for emergency use but the following day she called and said Michael had put her mobile phone into water making it unusable. She also said that Michael had put her into a headlock.

2.3.128 The CYPS worker met with Sarah and maternal grandmother on 3rd September to discuss Michael and his current presentation. Michael was at school. It was recorded that it was evident that both Sarah and grandparents were struggling with implementing boundaries within the home, and they stated they were frightened at what Michael would do if he didn't get his own way. The recent reports of his aggression and other concerns, which have been outlined above, were also recorded in the notes.

2.3.129 The CYPS worker discussed the need to put parental boundaries on access to the internet, and recommended that Michael needs to respect boundaries. Sarah was advised to contact the Police as a means of keeping Michael and herself safe, despite her disclosures of the difficulties in doing this. Sarah also spoke of Michael waving a sharp knife around as if it was a toy, and the worker discussed the need to keep sharp's away from him. There was no evidence of any sharing of information regarding the disclosures of assaults by Michael in the home, or that he was accessing a weapon.

2.3.130 On 9th September, Sarah called NTW's Duty Team as she had problems through night with Michael being aggressive and trying to bite her. She said she wouldn't call the police, due to Michael self-harming by scratching his arms. During the telephone call the allocated CYPS worker took over the discussion with Sarah advising that they would see the family the following day, as well as agreeing to discuss Michael with the Specialist Registrar and the CST worker; who were both contacted by email that day.

2.3.131 On 10th September, the CYPS worker met with Michael and his grandparents at their home address. They discussed his interests, which he identified as including computers, and he stated that he only had one friend who had very similar interests in Vampires. After some discussion Michael informed the worker that he did not like feeling angry and agreed to discuss this in the coming sessions. He also described being depressed. The plan following the session was for the CYPS worker to make an appointment at school to explore anger and more appropriate ways of de-escalation.

2.3.132 On 15th September, there was telephone contact from the CST worker to the CYPS worker and they discussed concerns that the CST were planning to pull out because CYPS were involved with Michael. The CST worker explained they had stayed involved a lot longer than they had planned. The CYPS worker discussed concerns around Sarah being vulnerable and needing additional support, with the CST worker stating that they had supported Sarah but she would not take advice around calling Police when Michael is violent. The CST worker stated that even though they were discharging Michael from their service, Sarah could still call for telephone support. The CST worker agreed to offer one more home visit before discharge.

2.3.133 On 25th September, a final CST home visit was made to complete the case closure with Sarah. The CST closure form completed noted that there remain risk factors that need addressing, with Michael still being aggressive to Sarah and still self-harming. The contingency plan for the identified risks was identified as CYPS; however, it noted that Sarah may need further support.

2.3.134 On 1st October 2015, the CYPS worker provisionally agreed an appointment to work with Michael at school on 6th October. Various attempts were then made by the CYPS worker and Sarah to contact each other. The worker was then contacted by maternal grandmother on 5th October, who reported a lot of difficulties at home. Within this it was recorded that over the weekend Michael had thrown his Tablet computer down the stairs and broken it, and that he had then demanded Sarah's, grabbing it off her and throwing it down the stairs, breaking that one also. It was also noted that he had kicked Sarah several times and that maternal grandmother stated he had tried to choke Sarah, although it was not clear from recording if this was historical. The CYPS worker discussed discipline within the family, and the maternal grandmother stated they were all frightened to implement this as Michael would either kick off or self-harm. The CYPS worker advised that he would

see Michael as planned at school the following day to commence anger work. The risk management of harm to family members does not appear to have been considered, and the FACE risk was not updated.

2.3.135 On 6th October, the CYPS worker had an initial meeting with Michael at school. Within this it was recorded that Michael was difficult to engage, but did give some feedback at times when exploring further what was happening at home. Michael rated himself as an 8 out of 10 of happiness (10 being the best). He discussed how often he was getting annoyed and he stated this was several times per week. There was a discussion between the CYPS worker and Michael regarding compromise rather than bullying. Michael showed his arms in relation to his self-harming, which was recorded as very superficial. The CYPS worker also recorded that the family were unable to provide a structured environment which was reflected in Michael's behaviours, and therefore the family were struggling to manage the increasing intensity of those behaviours. The CYPS worker was to discuss Michael at the LD network meeting that day, although no outcome was recorded of this.

2.3.136 On 10th October, Michael attended a medical review appointment with the Specialist Registrar, accompanied by Sarah and maternal grandmother, with the CYPS worker also in attendance. The family identified that Michael was still presenting with challenging behaviours at home, especially with aggression towards Sarah. Michael did not think that antipsychotic medication has any effect on him at all stating that it had not altered his thinking, which he was pleased about as he continued to believe that he was a demon. Michael claimed that he remains awake at night chatting with people with similar ideologies in America about engaging in demonic activities. Discussion took place around Sarah's inability to put boundaries on Michael and Michael knowing what he was doing. Once again Sarah stressed that she was reluctant to censor his access on the internet for fear that he would act out by being aggressive towards her or that he would self-harm. Within the plan noted following review it was recorded that Sarah agreed (reluctantly) to contact the police if she believed she was at imminent risk of harm from Michael; that there was a need to maintain behavioural strategies and discourage aggression towards Sarah; and the CYPS work to action CSC re-involvement. There was no evidence of this latter point later being actioned.

2.3.137 On 22nd October, the CYPS worker had an appointment with Michael at school. It was recorded that Michael openly stated he had issues around Sarah and wanted to get away from her as soon as he was old enough. Michael also stated he got a lot of satisfaction to seeing Sarah upset and this at times was a kind of driving force for his behaviour.

2.3.138 On 29th October, at a home visit by the CYPS worker, Sarah and maternal grandmother disclosed that Michael had sprayed something of bleach product into Sarah's face, though were not clear of when this happened. The CYPS worker discussed the consequences of this and she could have been blinded

and as such this was a serious incident where Police should have been called. At this stage both were recorded as having played this incident down. No consideration took place of reporting incident to Police or others agencies.

2.3.139 On 31st October, Sarah reported problems with Michael to the Police. She said he was being verbally aggressive and banging his head on the wall. This was managed through the Resolution Without Deployment (RWD) process with Officers contacting Sarah via phone. She reported that due to Michael's mental health she was struggling to cope. A CCN was raised and sent as a referral.

2.3.140 On 2nd November 2015, the above CCN was shared with the CSC Blyth Locality Team. The duty Social Worker telephoned Sarah who was noted as sounding very flat. Sarah shared that the EHA had been closed when the current CYPS worker became the allocated worker. Sarah said that Michael was very aggressive after his medication and that he punches, kicks, hears voices and threatens to kill people. Sarah stated that CYPS think he is psychotic, but said that she did not think he would carry this out. Sarah said that Michael had threatened to kill her. Sarah was advised to continue to telephone the Police. The duty Social Worker recommended a referral to the EIH for the Northumberland Adolescent Service to become involved. The Team Manager agreed with this recommendation. However, the referral was not made to the EIH.

2.3.141 On 3rd November, the CYPS worker returned a call to maternal grandmother who outlined the incident in which the Police were called and Michael's threats to kill Sarah, reporting these were threats he had made on numerous occasions. It was noted that the Police had refused to come out.

2.3.142 Later that day the Safeguarding team and the CYPS worker discussed the case and the CYPS worker was advised to contact Children's services to see if a Social Worker has been allocated to the family. The NTW Safeguarding Practitioner recorded the discussion with the CYPS worker and noted that if Michael's case was not open to CSC, the CYPS was to discuss with the Safeguarding Practitioner and consider a referral for Child In Need, as well considering a referral to Adult Social Care for Sarah.

2.3.143 In the CYPS worker's contact with the CSC Duty Team it was confirmed that there was a need for Michael to be referred to the Northumberland Adolescent Service within Children's Services for an Early Help Assessment to be set up. This recommendation was to go to a Team Manager for a final decision, which would then be actioned as soon as possible. The CYPS worker did not return the call to NTW's Safeguarding Team regarding the outcome of this discussion.

2.3.144 On 9th November, the CYPS worker visited Sarah at her home address. Maternal grandmother was present and Michael was at school. Discussion took place over the events of the weekend where Sarah had called police,

and Sarah stated that things had started to settle once Michael was aware that Police had been called. Sarah reported that Michael had also had a more settled week, although had superficially self-harmed to his arm.

2.3.145 On 10th November, Sarah attended a review appointment with the health Psychologist, but cut it short due to feeling unwell. She reported that she had a 'lot of difficulties with Michaels behaviour and had had to ring police and Children's services and they were supportive'. It was noted that Michael was being treated for Psychosis.

2.3.146 On 13th November a school report sent to Sarah detailing how well Michael had done since September.

The Day of the Homicide

2.3.147 On the morning of 16th November 2015 a call was received into the Emergency Operations Centre (EOC), NEAS, from Northumbria Police requesting an ambulance response in relation to a potential serious incident where a male has made disclosure of murdering his mother. The male was reported to have a superficial wound to his right wrist. The Police were travelling to address at the time of this call, and the ambulance to be dispatched as a precaution.

2.3.148 An update call was then received from the Police when they arrived on scene. Sarah had been found with a stab wound to her back, was unconscious and not breathing. On arrival she was pronounced dead by paramedics.

3 THE PERSPECTIVE OF FAMILY AND FRIENDS

3.1 As has been seen throughout the Chronology, Sarah's parents provided a high level of support to Sarah and Michael, with Sarah's mother often attending appointments and being actively involved throughout Michael's life. In meeting with the Chair of this review, they provided valuable input into the review process. They described how Sarah mentioned the dark thoughts Michael was having, his autism and emotional detachment, and the fact that he threatened to seriously injure or kill family members on regular occasions. Despite their and Sarah's attempts to alert services to these concerns, they felt that there was a lack of Social Work support and no continuity of treatment and support from Health Services. The family further expressed concern that when they attended doctors' appointments they often felt they were rushed, and also had no time to speak with doctors without Michael present. Thus they had little opportunity to discuss the wider impact of his behaviour.

3.2 Sarah's parents also expressed significant concern about the Howard Centre in Blyth, where Michael attended for support. Sarah's mother attended appointments there with Michael and was concerned with what she saw, namely the lack of support for Michael and other children.

3.3 Sarah's parents were also able to identify a number of Sarah's friends, and one such friend was able to be contacted and agreed to take part in the review. Sarah's friend identified that Sarah often indicated that she felt alone, and that people did not want to help her; although she did not want her son taken away from her and therefore did not know what to do for the best. Sarah was often upset and always appeared extremely tired as she was kept up most nights by Michael. She had described to her friend how Michael's behaviour was always worse in the evening; something she felt may be an effect of the medication.

3.4 Sarah also talked to her friend of Michael's unhealthy interest in the internet and that he believed he was a demon. Michael was accessing dark sites and became aggressive if he was asked not to use the internet. As a result, her friend advised her not to have internet connected at the home she was due to move into.

3.5 As regards the level of risk posed to her, Sarah also admitted to her friend that her son tried to strangle her on one occasion. The friend also felt that the family relied heavily on CYPS with Sarah mentioning them often. Sarah also told her that she had spoken with the Police, who seemed concerned that she did not have an allocated Social Worker.

4 ANALYSIS OF AGENCY INVOLVEMENT

4.1 Detailed below is the analysis of agencies' involvement with Sarah and Michael. This is taken both from individual agency IMRs, as well as consideration by the author of this report of each agency's involvement within the broader context identified by this review, including the perspective provided by family and friends.

4.2 In considering the involvement of all agencies, and the IMR's completed by them, it was noted that there was often reference to the issue of domestic abuse; as was outlined in the terms of reference and indicated by the nature of the Domestic Homicide Review Process. However, Panel discussion noted that due to Michael being under the age of 16, the situation did not fit the current definition of domestic abuse, but would more appropriately be defined as Adolescent to Parent Violence and Abuse (APVA). All references to domestic violence therefore refer specifically to the issue of APVA, and the recognition that Sarah was a victim of abuse by Michael. Furthermore, the issues around APVA are addressed specifically within the lessons learned and conclusions.

4.3 Northumberland, Tyne and Wear NHS Foundation Trust (NTW)

4.3.1 Michael had significant involvement with NTW from a young age, with his first referral being at the age of five. Within the years considered by this review his contact was with a number of services within NTW in relation to assessment and ongoing treatment. He was diagnosed as having, ADHD, Autistic Spectrum Disorder (ASD), Moderate Learning Difficulties and Psychosis. Information provided throughout the chronology highlighted that there were often delays in assessment taking place to inform a diagnosis and the associated care provision.

4.3.2 As regards Michael's care and treatment, NTW have a Care Coordination Policy, which applies to all professionals working in CYPS. This sets out the principles and framework for assessment and care planning for children and young people receiving mental health or learning disability services. The Care Coordination policy distinguishes between children whose needs are enhanced and those who are not deemed to be.

4.3.3 Enhanced level Indicators that are identified in the policy, and can certainly be seen to have applied to Michael based on his presentation in 2014/15, are:

- Complex behaviour and emotional difficulties *requiring more than one specialist intervention* from Trust services with a higher degree of service coordination. This may take the form of more frequent interagency or interdisciplinary communication or review and shared decision-making.

- *Acute mental health problems* with a high degree of clinical complexity
- *Current or potential risks including suicide, self-harm, harm to others, relapse history, self-neglect, non-concordance (non-compliance), child protection*

4.3.4 As can be seen from the above, Michael did meet the criteria for enhanced care, however was not classed as doing so by clinicians involved in providing his care and treatment. The Trust policy determines children on enhanced care, as a minimum, will be reviewed by the Care Coordinator. This should involve the child and where appropriate their family and / or any identified carer and all members of the care team. The review should include the completion of an initial care plan, review progress of care plan, review assessment of risk and review crisis/contingency plan and agree changes with child and family. The IMR author for NTW identified that throughout Michael's contact these standards were not met; this was due to the lack of appreciation regarding the level of Michael's need and risk, as well as the absence of any Care Coordination at an enhanced level.

4.3.5 As regards such Care Coordination there was evidence of drift and delay in the allocation a Care Coordinator, with no one identified between March 2015 and August 2015. In the absence of a Care Coordinator Michael's ongoing care was managed by the Specialist Registrar, with a CYPS worker being allocated responsibility during the period immediately leading up to the tragic incident. The IMR author confirmed that the CYPS team in Northumberland did have the capacity to allocate a Care Coordinator during this time and the lack of this occurring was due to sickness absence within the team. In addition, the author felt that the allocation of the CYPS worker was based on the need to support Michael and Sarah with a behavioural approach, without consideration being given to the knowledge and skills required by the worker around issues of complexity and risk.

4.3.6 From January 2015, there were also documented indicators that Michael was displaying symptoms of a psychosis, and as a result a medical review was requested and undertaken by the Specialist Registrar. At that appointment medication was prescribed to assist with obsessions. However, Michael's symptoms continued to worsen and a further request was made in June 2015 for a mental health assessment. The Psychiatrist's impression after assessment and the gathering of information was a probable diagnosis of psychosis. A recommendation was made to the Specialist Registrar to make a referral to the Early Intervention in Psychosis (EIP) service and for Michael to commence an anti-psychotic medication, with associated medication monitoring in respect of symptoms. This referral to EIP was never made and was a missed opportunity for further support and intervention.

4.3.7 In October 2015 Michael was still presenting with aggression towards Sarah, and there was a continued perception that Sarah had an inability to put boundaries on Michael. This perception had persisted throughout their

contact with services, despite the increasing concerns her and her mother identified around his behaviour, as well as their identification of the lack of impact, and increasing risk, associated with attempts to put such boundaries in place.

4.3.8 On reviewing Michael's clinical presentation as part of the NTW review, the Clinical Advisor indicated that it was probable that Michael developed a psychosis whilst being treated with stimulant medication (for his ADHD) above the licensed maximum dose. Psychosis is a recognised side effect of the medication, and the NICE guidelines for ADHD recommend stopping the stimulant medication and utilising alternative medication to manage ADHD symptoms. Any increase to a higher dose should only have been under direction of a specialist. The prescribing doctor was not a specialist, he was a locum staff grade Psychiatrist who was initially working with weekly supervision and often shared clinics with another Psychiatrist. However, when this Psychiatrist went on sick leave, the direction from a specialist did not occur and represented a significant omission. In interview, the Specialist Registrar described having little experience of treating psychosis and did not actively treat Michael's diagnosis of psychosis. Michael was started on 5mg of anti-psychotic medication in July and remained on the same dose until November 2015. The medication prescribed did not follow NICE guidelines and the dose of medication was never titrated against the presenting symptoms to ensure a response.

4.3.9 It was the IMR author's opinion that in the main the clinicians involved identified Michael's aggression towards Sarah as being due to his mental health diagnoses of ADHD/ASD, therefore a rationale was given for his presentation. This was a significant omission that resulted in silo thinking and focus on a medical model for Michael, with no consideration of the impact on Sarah and her family. The author highlighted that while practitioners should try to understand what is going on in any situation, it is also necessary to recognise that there is no excuse or rationale for abusive behaviour. In relation to this, at no point was the violence within the home seen as domestic abuse from son to mother. Within interviews undertaken with staff, they were clearly able to recognise that should any parent assault their child this would be identified as abuse, and as such would result in an automatic referral to CSC, as well as notification to the police; whether or not the parent had mental health problems. However, they struggled to identify that a child with mental health problems being aggressive to his mother was also domestic abuse, and thus should be responded to in the same manner.

4.3.10 The age of the perpetrator was also identified as having perhaps influenced this perception and the associated decision making e.g. *the Specialist Registrar's impression was that Michael had under treated ADHD with improved mood, but deterioration in behaviour problems with puberty potentially having some part to play in his aggression*. There was evidence throughout the timeline that Sarah and maternal grandmother were extremely

proactive in seeking help for Michael, and they also expressed feeling intimidated, giving examples of extreme defiance and disclosing an escalating pattern of violence from him. The strength and size of Michael as an adolescent targeting his mother with physical aggression was not risk assessed or safety planned. In addition, his use of the internet in looking at "dark websites" was often also seen as a normal adolescent behaviour, as well as a symptom of his ASD being an obsessional trait. However, the content was not readily researched or explored in relation to how this may be interacting with his increasingly presenting psychosis.

4.3.11 The above lack of identification of Michael's behaviours as domestic abuse is particularly relevant given that the assessment and management of clinical risk were central issues within this homicide. The NTW clinical risk assessment for a child/young person is contained in the Care Coordination section within the Children and Young Peoples Services Policy. This document sets out clear standards relating to clinical risk assessment and management for those who use NTW services. The policy states that 'risk assessment is an ongoing, dynamic process and is required as a minimum at set stages of a young person care pathway'.

4.3.12 In relation to the services received by Michael the approved risk assessment tool for NTW was the FACE (Functional Assessment of Care Environment) assessment. Most assessment tools act as guides to clinical judgment. The Policy identifies that clinical risk assessments should be undertaken as part of initial assessment; when significant changes to areas or levels of risk occur; as part of the review process; when there are major changes/incidents, including any that are communicated by other professionals / agencies; or when concerns are alerted by parents or carers. In all these circumstances the risk assessment and any risk management plan needs to be reconsidered.

4.3.13 Within the timeline for this report many risk issues were reported by the family and other agencies to NTW staff. The IMR author provided a useful summary of issues identified in records in relation to both potential and actual violence:

- October 2013: information received by the Psychiatrist from the School Nurse that Michael on *two occasions scratched himself, also an incident where he punched a hole in the bathroom and said he hated his mother.*
- January 2014: information to CYPS service that *Sarah would like the appointment quicker as Michael is becoming more aggressive and he is being difficult to cope with.*
- March 2014: information received from Paediatrician that Michael *could become physically aggressive, which Sarah found difficult to handle. Another area of challenging behaviour noted was that of Michael wanting to watch violent television programmes or play violent computer games, and he had also threatened to stab a pupil at school.*

- May 2014: Information provided by the family in an ADHD appointment that Michael *has a low tolerance to stress and has occasionally grabbed mum in one of his 'hyper' episodes.*
- August 2014: information received from Sarah where Michael was *described as aggressive when (medication) is wearing off. Can be calm without it but has also 'waved knives' and has seemed depressed when taking it.*
- October 2014: information provided by the Paediatrician that *Michael was said to still easily get angry at both home and school and recently the police had been called.*
- November 2014: information received from Sarah that *Michael is aggressive and oppositional.*
- January 2015: information received from maternal grandmother and Sarah that *maternal grandmother is particularly concerned about his 'dark thoughts' and he will make statements about being evil. The most difficult time of day to manage is when his medication wears off at about 6pm. This is when his level of aggression towards mum seems at its worse and when the self-harming becomes an issue due to anxieties and upset that he has hurt his mum.*
- February 2015: information received by CYPS from Sarah about M's dark thoughts, *Michael has been watching inappropriate viewing of "you tube" and site called "Creepy Pasta" he has been making comments both at school and at home about harming the prime minister and wanting to put someone's cat in the microwave. He has made reference to and continues to talk about torture and death. Sarah agreed she found it difficult to put boundaries in place and that she was frightened of Michael as he had scratched and pushed her before.*
- February 2015: information shared in appointment by family that Michael *was hurting Sarah by grabbing her by the throat and throwing things at her, constantly banging on doors.*
- March 2015: information received from social worker via school that Michael *has made a number of statements to school about killing the president, stabbing doctors with syringes.*
- March 2015: information provided by school regarding Michael including *wanting to stab a doctor with a syringe, putting a cat in the microwave.*
- April 2015: information from Sarah to CYPS duty team, Michael's *behaviours are aggressive in nature and he is hiding his medication, last night he pinned her arms behind her back, pushed her over then pinned her to the sofa.*
- April 2015: information received from Paediatrician that Michael informed her the day previously that *he goes out at night and kills and drinks the blood of animals, he also told her that he was a demon etc. His maternal grandmother told in confidence that the family are terrified of him as he can be threatening.*
- April 2015: information received from Sarah of an incident where Michael had *frightened his peers by telling them that he will take their souls.*

- May 2015: Information received from Sarah that the day previously *Michael came home from school and bit his maternal grandmother and tried to hit (her) with the peg bag. He then tried to stab himself with a fork.*
- May 2015: information received by family in ADHD clinic that Michael *bit his maternal grandmother for the first time recently and was laughing all the while he was doing it.*
- May 2015: information received from Sarah to Duty Team that *Michael hit out at her… as his medication was wearing off*
- May 2015: information received from Sarah to Duty Team that she *threatened to call the police and then Michael grabbed her by the arm.*
- June 2015: information received from family within ADHD appointment that *Michael often describes himself as having a demon inside him or being a demon and that this will never change. He seems to have a fascination with knives and although he denied today any intent to use knives as a weapon family are concerned he may do something one day.*
- June 2015: information received from family in psychiatric assessment that he specifically *talks about killing a lot, each morning wakes up and tells them that he has killed someone overnight when they know he has not left the house. They are also concerned about his level of aggression. When asked directly agreed to talk about the things that he has been saying about killing people.*
- July 2015: information received to Duty Team from Sarah that *Michael throwing things at her and jumping on top of her. Family has had to hide knives because of his behaviour.*
- August 2015: information received by telephone from Sarah to the Specialist Registrar that *Michael is still constantly saying he is a vampire etc. and on one occasion he lost his temper and punched a hole in the wall.*
- September 2015: information provided to CYPS worker from family that *they are stating they are frightened at what Michael will do if he doesn't get his own way. There have been recent reports that Michael is very aggressive towards Sarah, having got her in a head lock most recently. His aggressive behaviour when not getting his own way has also resulted in him either smashing things, destroying mums home phone by throwing it in water or pouring liquids over them. Most recent reports of Michael waving a sharp knife around as if it is a toy.*
- September 2015: Duty Team informed by Sarah that *Michael being aggressive and trying to bit Sarah.*
- September 2015: information received from Sarah to CYPS worker, *recent event of waking up at 3 am and then waking up the whole house, which resulted in him attacking Sarah.*
- October 2015: information provided by family to CYPS worker that over the weekend Michael *threw his Tablet computer down the stairs and broke it, he then demanded Sarah's, she refused him this and as such he grabbed it off her and threw it down the stairs, breaking that one also. He has kicked Sarah several times and maternal grandmother stated he has tried to choke her (Sarah).*

- October 2015: information provided to the Specialist Registrar from family that *Michael had physically restrained Sarah when she had threatened to call the police because of his aggression towards her.*
- October 2015: information received from family to CYPS worker that *Michael had sprayed something of bleach product into Sarah's face.*
- November 2015: information received from family to CYPS worker that *Sarah had called the police over the weekend when Michael had become threatening and stating he was going to kill her, which is something that he has done on numerous occasions.*

4.3.14 As well as further demonstrating the extent to which the family alerted professionals to increasing concerns around Michael's behaviour, this timeline also clearly indicates that his level of risk, including aggression and assaults, had markedly increased in both frequency and severity in 2015, with 23 incidents/concerns in 11 months. This correlates with the emerging clinical picture over 2015 that indicated a deterioration in Michael's mental health. Within this period the FACE risk assessment was undertaken on four occasions, namely 20/1/2015, 6/2/2015, 11/6/2015 and 3/11/2015, although the risk profile over 2015 did not change. There were clearly occasions where changes of risk warranted the creation of a new risk assessment and this did not occur. The IMR author identified that use of the FACE risk tool was limited, documentation did not provide an understanding of risk at critical points, the risk management plan was inadequate and those staff involved with Michael did not fully understand the risks he posed.

4.3.15 Within the above there was also limited evidence to suggest that a comprehensive consideration of risk was was made following telephone contact between maternal grandmother and the CYPS worker on 3rd November 2015, shortly before the homicide. Michael's presentation, as described by maternal grandmother, indicated continuing symptoms of mental health deterioration that was indicative of the risks to others being more immediate. The risk assessment was updated utilising the FACE tool without Michael having been seen. While the documentation completed identified the risk of violence / harm to others as being significant, this was not assessed in the context of potential psychosis, nor considering the possibility that Michael would act on his false beliefs that included him being a demon and killing his mother; these beliefs had been apparent for some time. This was a fundamental matter as one of the key indicators in determining future risk is the past behaviour of the individual.

4.3.16 Despite the disclosures of escalating harm and associated assaults to Sarah being documented in the health records, the consideration that this information was significant to the nature of the risk posed to Sarah was not recognised by the CYPS worker or the Specialist Registrar. The family were identified as a protective factor who could meet Michael's needs; however, they were clearly struggling to manage, informing staff of their concerns

regularly. Michael was understandably outside of their control due to his psychotic symptoms.

4.3.17 The IMR author concluded that overall the standard of risk assessments lacked credibility, and was not accurate or adequate. These limited assessments and formulation of risk status did not consider multi-disciplinary nor multi agency input to a shared risk management plan. The understanding that Michael's potential psychosis was impacting on his presenting risk to self and others was absent. There was no assurance that any immediate risks were fully explored or acted upon despite Sarah, maternal grandmother and other professionals providing information of Michael's presentation at any given time.

4.3.18 In respect of Safeguarding advice, there were three occasions where this was referenced in Michael's health records. The first of these occurred on 6th February 2015 and NTW's Safeguarding Practitioner advised the CYPS worker to gather multi agency information from school and Children's Social Care, and to consider a potential referral for support if not already in place. Such advice was appropriate, knowing that an appointment with a psychiatrist was imminent in respect of Michael's current presentation. The completion of an Incident report and to update the Face Risk assessment was also required. The IMR author noted however that the FACE Risk Management Plan Profile remained the same, and that an incident report was not completed as per request and per NTW's Safeguarding Policy.

4.3.19 The second occasion Safeguarding advice was indicated was documented within the FACE risk document on 11th June 2015. The IMR author examined the contacts with NTW's Safeguarding Duty team for this date and no contact was evident, nor was any entry made on to Michael's records of any advice given, indicating that the team were not contacted. Safeguarding advice could have been provided directly to Children's Social Care, however again there is nothing documented in the health records, as would be usual practice if this was the case.

4.3.20 The last occasion Safeguarding advice was sought was 3rd November 2015. In interview for the IMR the NTW Safeguarding practitioner was clear that the advice given on this date was based on the verbal information provided by the CYPS worker. The Safeguarding practitioner felt that within this the level of concern, level of aggression, and potential psychosis in relation to Michael's presentation, was not articulated or shared with them. Discussion was primarily regarding Sarah's inability to manage Michael's behaviour, indicating that there was nothing new in his presentation. The CYPS worker was also seeking advice without having seen Michael on that day to fully assess the situation. It was noted also that no return call was made to NTW's Safeguarding practitioner regarding the outcome of the discussion with Children's Social Care, as had been agreed. It was the IMR author's opinion that had the CYPS worker informed the Safeguarding practitioner of the

outcome of the conversation with the Social Worker, a professional challenge would have been made of the CSC decision that an Early Help Assessment was the appropriate course of action.

4.3.21 Within the above it is evident that there was limited involvement with NTW's Safeguarding and Public Protection team to assist with the risk management plan. There were no Safeguarding incident reports completed after each disclosure of abuse by Michael, and the Safeguarding team were unaware of the increase in aggression, level of violence towards the family, and the presenting psychotic symptoms. On the two occasions that advice was requested, full risk information was not shared by the CYPS worker. As such there was no consideration of Sarah's vulnerability in relation to Michael's behaviour and any referrals that needed to made as a result of this.

4.3.22 There was also no effort to consider engagement with other agencies to manage risk either inside or outside the home. This included no consideration to routinely report to the police when assaults were disclosed to staff by the family, with limited exploration of what was happening within the home. The reactive safety plan for Sarah to contact the police was very narrow, and failed to recognise both the significant stress and heightened risk this placed on her. Even after this plan failed, as demonstrated by Sarah calling the Police and not receiving a visit, it was not reviewed or updated. The CYPS service failed to share cumulative information with the police therefore the police intelligence would be limited. It was identified in the IMR that had staff reported every incident of actual and potential violence (including Michael carrying a weapon) directly to the police, this may have influenced Northumbria Police's response on the day that Sarah called them. A more active response by Police on this day would also have been more likely, had they been informed by NTW that this was part of the safety planning agreed with Sarah.

4.3.23 There were also incidents when other agencies directly expressed their concerns to CYPS. One example of this was on 28th April 2015, when the Paediatrician expressed her concerns to the Specialist Registrar of a recent appointment with Michael, and the family's disclosed fear of him. The IMR author felt that the suggestion by the Paediatrician, of a multi-disciplinary meeting to discuss the case, was not given enough consideration.

4.3.24 The lack of multi agency working can also be seen to have resulted in NTW having an unclear picture of exactly what steps agencies, such as CSC, were taking. Overall, there was no evidence of implementation of any strategies to decrease the likelihood of risk behaviours occurring or that the antecedents were understood. It was the IMR author's opinion that the clinical risk management in this case was inadequate, failing to meet the needs of Michael and Sarah.

4.3.25 Finally, within all of the above it has also been demonstrated that the views of Sarah and maternal grandmother do not appear to have been considered. The family ensured that Michael attended all planned appointments as well as contacting the CYPS service when they had concerns regarding his deteriorating mental health in order to try and keep him safe and well. There appears to have been an absence of active listening to the concerns that were being communicating on a regular basis, including occasions when calls were not returned. The family were not effectively listened to by staff when disclosures were made, or in addressing their concerns regarding their fears and anxieties associated with implementation of behavioural boundaries to manage the risk.

4.3.26 NICE guidelines relating to ADHD and Psychosis and Schizophrenia in children and young people indicate that healthcare professionals should ask families or carers about the impact of the young person's diagnosis on themselves and other family members, and discuss any concerns they may have. Professionals should offer family members or carers an assessment of their personal, social and mental health needs. There was no evidence of a carers assessment being offered to the family as well as no evidence of a contemporary assessment of carers needs either being in place or initiated.

4.3.27 In addition, it was also not clear from the documented health records whether within appointments offers were made to see Michael or the family alone, a concern that was noted by the family as part of this review process. In cases such as this where there are significant concerns being expressed, the opportunity for all those involved to be seen independently is critical in relation to both providing appropriate support and assessing the level of risk; which has been demonstrated did not occur in this case.

4.3.28 In considering why the failings outlined above occurred, the IMR author identified that the staff involved with Michael were aware of NTW's relevant polices, including the Safeguarding and Public Protection policies and, the Domestic Abuse policy. However, as they failed to fully recognise and assess the risk, or recognise the domestic abuse from Michael to Sarah, they did not then complete adequate risk management plans. The author concluded that it was reasonable given their level of training and knowledge to fulfil these expectations.

4.3.29 Staff interviewed also clearly identified that the CYPS service have care pathways in place to manage the presenting needs of cases similar to Michael's. Michael had input from the Neuro developmental network, the Learning Disability network and ought to, but did not, have active input through the Complex Mental Health network (and referral to EIP). The Clinical Network model is utilised to break down the barriers between teams to allow expertise to follow the young persons need, with the role of the Care Coordinator bringing it into a coherent whole. Michael's care was fragmented and there was no evidence of this having occurred, thus the nature of his

complex mental health presentation had not been fully exposed or explored to the clinical network.

4.3.30 Finally, as regards supervision of staff, the prescribing locum doctor (the Specialist Registrar) was part of wider Consultant meetings but did not have any one to one supervision. There was no evidence to indicate they had been supervised in line with Trust policy for locum doctors. Neither is there a record in Michael's notes to suggest Michael was discussed at meetings with Consultants or that the Specialist Registrar had sought an opinion from a learning disability child and adolescent Psychiatrist.

4.3.31 The CYPS worker was provided regular clinical supervision, as per policy, from the allocated Clinical Supervisor. In interview the Clinical Supervisor was not aware of Michael, as the CYPS worker had not brought the case to supervision, suggesting they did not see Michael as a case of concern to present.

Report of the Independent Advisor to the DHR Panel regarding NTW's involvement

The Independent Advisor's report mirrored issues identified by NTW within their IMR.

In relation to assessment and treatment, it was identified that Michael had undergone numerous assessments and reviews which provided ample opportunity to develop and formulate a diagnosis during his earlier years, and more recently during the development of a psychosis. It was noted that historical reports of unacceptable delays to formally assess and diagnose him, made it feasible to argue that this led to further delays in appropriate care provision.

The report went on to identify that there were a number of missed opportunities to coordinate Michael's care and treatment, which were exacerbated by a lack of care coordination and no evidence of a shared or multi-agency risk assessment or management plan. The report noted that it was difficult to ascertain how Michael was treated aside from medication.

In specific relation to risk assessment, it was stated that there was little doubt that the risk assessments and resulting management plans were not completed as per NTW policy, or in line with acceptable practices related to communication, coordination and implementation of management interventions. In particular, information sharing in relation to the risks posed to and by Michael was wholly inadequate, and the standard of risk management plans did not provide specific guidance on who was to do what and when. As a result, there was no evidence of a comprehensive assessment of risk completed at any stage of the Michael's care and treatment, and risk management Plans were not fit for purpose, inaccurate in terms of information recorded, and often not relevant to known risks.

As regards Care Planning, there was only one Care Plan available, which was seen to be of a poor quality, in that it did not address known need, and would have been unlikely to enhance the approach to his care and treatment. This factor was further exacerbated by the fact that there did not appear to be any effort to include / communicate this to other professionals, apart from his GP. There was also no evidence that the concerns of Michael's family were addressed, the family or Michael's perspectives explored, or that the Care Plan was shared with them.

The Investigator concluded that despite Michael qualifying for an enhanced care package, presenting with a range of complex needs, undergoing multiple formal and informal assessment processes, and potentially receiving multi-agency involvement, he and his family did not have a coordinated multi-agency Care Plan specific to their needs, as would be expected.

Conclusions regarding NTW's involvement

A number of omissions and failings were identified within the NTW IMR and these were summarised into four key areas of practice:

- **Care and Treatment**

In respect of Michael's presentation, he met the criteria within NTW's policy for an enhanced level of care but was not classified at such a level reflecting a poor judgement of the level of need. The lack of exposure to appropriate challenge and support offered through the mental health clinical network, in addition to a lack of understanding and recognition of the significance of clinical symptoms, restricted access to clinically effective intervention and monitoring. Therefore, Michael's full presentation not being explored in the mental health clinical network was a significant omission.

No one was clear on accountability regarding Michael's overall care and its coordination. A weakness in the system was identified that allowed Michael, who had been identified as requiring additional support, to be allowed to 'drift' as a result of staff sickness.

In respect of Michael's deteriorating presentation there was also a failure to recognise and actively treat the emergence of psychotic features that were possibly caused by the prescribing of high doses of a stimulant medication. A referral to the EIP service (as had been advised) would have facilitated a greater level of expertise to consider any diagnostic uncertainty and medication issues. More widely, prescribing practice and monitoring was identified by the IMR author as weak, and it was also noted that at no point was consideration given to undertaking a full mental health assessment on an inpatient basis. This may have offered an opportunity to support formulation and diagnosis, identify needs, monitor the response to medication and provide a more effective care and treatment programme.

- **Risk assessment and multi-agency risk management plans**

Limited risk assessments were undertaken, as well as no continuity of clinicians involved to understand the changing risk. There was no evidence that any immediate risks disclosed were fully explored or shared, and risk assessments and formulations undertaken failed to identify the requirement for referrals/notifications to other agencies in order to develop a robust multi agency risk management plan. A comprehensive understanding of the potential underlying psychotic nature of any presenting risk was also absent. The risk assessment was therefore below an expected standard of psychotic aetiology and the associated risks. The single agency risk management plan failed to offer any coordinated mitigation to manage Michael's aggression and assaults, despite information received from individual clinicians of the concerns.

There was also a failure to recognise Sarah as a victim of domestic abuse and the risk posed by Michael in this context was not understood. Within this there was evidence of inaction when disclosures were made and an expectation that Sarah could keep herself safe. There was an overreliance on Sarah reporting to the Police, even after this had not resulted in a response, and little understanding of the increasing risk to Sarah of such a strategy. There was also no evidence that staff understood why it would be difficult for the family to raise concerns of Michael's risks in his presence due to them being fearful of reprisals.

- **Safeguarding/Incident reporting**

There was evidence of silo working in this case, with no due consideration of the need to protect the wider family. There was limited contact with NTW's Safeguarding team to raise concerns around increasing violence and aggression concerns, and to assist and inform decision making for referrals/signposting to other agencies. When the Safeguarding team were contacted, the clinicians failed to describe or articulate the risk. No incident reports were completed despite multiple disclosures.

- **Carers assessment and Think Family**

There was no evidence of a carer's assessment being offered or considered for a family who were understandably struggling to care for Michael. The impact Michael's deteriorating mental health and associated violence was having on the family was also not considered. There were no active discussions with Sarah and maternal grandmother to discuss what choices they had as victims, what actions they could take, what resources were available and where they could get help and support.

- **Preventability and Predictability**

In light of the above the IMR for NTW directly addressed the issues of preventability

and predictability in relation to NTW's involvement. It was concluded that due to the issues identified above, Michael's long history of increasingly aggressive behaviour had not been adequately assessed or managed. As a result, the risk was deemed to be more immediate rather than implied, and as such there was seen to be a high degree of predictability in relation to Michael's behaviour. Michael's behaviour, words and more recent actions were seen to have deteriorated over many months, and these concerns were readily communicated to staff by Sarah and maternal grandmother. Based on the evidence available, it was concluded that the incident in November 2015, when Michael killed Sarah, could be considered a predictable act.

Whilst it was noted that it is impossible to be absolute in preventing the future outcome of a course of action, on balance it was identified that there was evidence to suggest that an alternative course of action by the clinical team could have prevented the incident. This included the identified weaknesses by CYPS in the provision of care and treatment responsibilities, and the fact that Michael was not receiving appropriate interventions for his psychosis. It was identified that through omission, no effective steps were taken to prevent recurring and escalating violence. Based on this evidence, it was considered that the killing of Sarah by Michael could be considered a preventable act.

Recommendations identified within NTW's IMR:

- The CYPS service will review their safeguarding responsibilities to assure themselves that they are fulfilling their requirements within trust safeguarding and public protection policies and are receiving advice supervision and support when required.
- Review current practice with regard to the Early Help agenda.
- A clinical review of a sample of x cases of children, who are seen within the ADHD clinic and have additional needs that require Care Co-ordination have a care co-ordinator who has the skills to meet their needs.
- Specialist Care Triumvirate Management Team should further review the clinical practice of those individuals identified by the Investigating Officer and clinical advisors to ensure that the early interventions already initiated in the process of undertaken the review are sufficiently robust to ensure patient safety.
- All community CYPS practitioners will be offered a specific workshop with a focus on assessing and managing risk to others and factors impacting on decision making.
- The CYPS service will review their responsibilities to support parents in their caring role to assure themselves that parents' needs are met and that staff responsibilities to report acts of domestic violence are understood.
- Review current practice with regard to prescribing within team and adherence to guidance.
- NTW should review their position relating to post incident contact with family members following homicide with immediate effect to ensure consideration

and decisions on a case by case basis. This should have regard for the police support framework provided through Police liaison officers.

- The outcome of this investigation should be made available to the patient's grandparents and an apology offered regarding shortfalls in the provision of appropriate standards of care and treatment.
- To ensure that appropriate training is available and the systems for escalation are understood.

Recommendations identified by the Independent Investigator:

Recommendation 1: Care Coordination, multi-agency working and care planning.

- NTW re-acquaint staff with the existing policy on Care Coordination in order to understand the organisation's and their own professional responsibilities in the assessment, planning and implementation of an appropriate package of care. An essential pre-requisite of this recommendation is an assurance that all staff fully understand what the policy advises with regards to Multi-agency assessment, specialist interventions and the practice of Care Coordination.
- Agreed interventions within care plans are evidence based and fulfil SMART criteria. For this to be inclusive it is imperative that all professionals are aware of the importance of involving the family / Carers at all stages of the process.
- NTW provide assurance that recording and communication practices are adhered to most notably in the context of updating records, developing and communicating formulations, care plans, risk management plans and review processes.

Recommendation 2: Risk Assessment and Risk Management planning

- At the very least staff are reacquainted / re-trained in the various elements of the Clinical Risk Assessment and Management Strategy with particular reference to understanding the principles of a structured clinical approach to risk behaviours.
- NTW plan how they intend to provide staff with the knowledge to practice in the area of Risk assessment and management with special regard to not only the processes but the current evidence base related to Assessment, Management and mitigation of risk behaviours.
- In line with the above recommendations, communication practices reflect the need to constantly reassess and re-evaluate risk management practices and that professionals practice should reflect these. This, it is recommended would contribute to reviewing and improving the quality of care provided.

Recommendation 3: Prescribing practices, Diagnosis and Mental Health Assessment.

- There was clear evidence, especially from the assessment and implementation information available that questions were raised with regard to developing a diagnosis and the effect on care packages, the potential

	implications of prescribing practices and monitoring, and Mental State examination and review. At this stage the Investigator had not had the opportunity to have the views of a psychiatrist on this, but this process was planned to occur in the months following the report.

4.4 **NCC Children's Social Care (CSC)**

4.4.1 Michael became known to CSC following contact by Sarah on 16th June 2014 to say that she was struggling to cope with his behaviour. The duty Social Worker recommended a referral to the Early Intervention Hub (EIH) and when the case was discussed at a EIH meeting on 1st July Michael was allocated to the Children's Support Team for an Early Help Assessment to be undertaken; a CST worker was allocated and remained the CST Lead Professional throughout the review period.

4.4.2 Following the above, between 3rd July 2014 and 25th September 2015, the date that the CST closed the case, there were 3 Team around the Family (TAF) meetings, and a total of 53 planned home visits. Within these there was just one where no one was at home, and Michael himself was present at 30 of these. There were also 21 telephone contacts with CST by Sarah, most of which she initiated.

4.4.3 It was the IMR author's view that following the initial referral in June 2014, the decision to refer to the EIH and undertake an Early Help Assessment (EHA) under the support of the CST, was appropriate. The EHA was completed by the CST worker on 24th July 2014. A key omission identified in the completion of the EHA and formulation of the plan was that CYPS were not consulted at this early stage. This was a lost opportunity to share the EHA, check which other professionals were involved, seek clarity regarding the role of CYPS, and confirm any other supports that CYPS were providing.

4.4.4 In addition to the above no professionals were invited to the initial TAF meeting, held on 28th July 2014. This was a further missed opportunity to gather key information, and agree on a co-ordinated multi-agency EH plan to support the family; this lack of multi-agency working was a key theme throughout the involvement of CSC.

4.4.5 Whilst the IMR author agreed with the initial decision for an EHA, there were very early indications, even from before the EHA was completed, that the family may require support from statutory social care. Examples of this included reports in late July/early August 2014 that Michael had self-harmed, spat in his mother's face, grabbed her, and threatened her with a knife. The concerns then continued to escalate with Michael not taking his medication, being verbally and physically aggressive, and demonstrating controlling behaviour towards his mother.

4.4.6 Within the supervision that was provided to the CST worker at this time, the IMR author felt that there was not sufficient detail given to the risks or the importance of his mental health. In addition to this, there was no evidence of clear guidance or practice challenge. In a supervision that took place on 6th August 2014, it was noted that Michael's self-harm was superficial and, while this may have been true, there was little further exploration of this with partner agencies and no accurate assessment of the self-harm and the reasons for Michael's behaviour. The Deliberate Self Harm and Suicide Care Pathway could have been considered, which may have resulted in the case being referred to a social care locality team.

4.4.7 The supervision sessions also noted that CYPS were providing some support and monitoring Michael's medication. However, there did not seem to be any clarity regarding the CYPS role, and whether Michael was just being seen for his medication review. In addition to this, there was no evidence of support or clarity regarding the Lead Professional's role in co-coordinating, following up or challenging other professionals, particularly CYPS.

4.4.8 Although Michael was seen throughout this early period, this was mainly as part of the home visits to Sarah. The discussions and conversations with Michael appeared to be brief and limited, largely due to him not wanting to engage. Therefore, little was known about Michael's views and experiences of family life. In addition to this, there does not seem to have been any consideration to seeing Michael in other settings where he was more settled, such as school, or out in the community. There was no evidence of any planned direct work, or use of tools to facilitate this process. Working Together (2012) points to the importance of this in assessment work and highlights the need to gain 'an understanding of the child's view of their situation, how this affects them, what they would like to change and what they would like to stay the same. To gather a meaningful rather than superficial understanding of this, the professional is encouraged to spend time with the child using appropriate approaches and tools for communicating with children'.

4.4.9 On 15th October 2014, further concerns were raised when the Paediatrician made a referral to the Disabled Children's Team (DCT). The Enquiry and Referral Administrator (ERA) checked the system, noted that there was an EHA in place, and enquired about the TAF meeting. However, there was no evidence that the ERA discussed the referral with the Duty Social Worker or showed them the referral letter. Furthermore, the CST worker was not consulted and there was no discussion with the family or any other professional. On the basis of this very limited information, the referral was processed as a 'contact only' and it was agreed that the DCT Duty Social Worker would attend the next TAF meeting. The DCT Duty Social Worker should have been involved in the referral process, and there should have been consultation with the Paediatrician, the CST worker, and Sarah.

4.4.10 It was the IMR author's view that the outcome of this referral should have been for a Children and Family assessment to have been undertaken by the DCT or the social care locality team; or a joint assessment between the two teams. This was an early lost opportunity to assess and support Michael at a more appropriate level and to ensure a more formal, coordinated multi-agency plan of support to the family.

4.4.11 On 10th December 2014, the second TAF meeting took place. There was clear evidence from the CST and DCT workers' written records of the concerns that were discussed at the meeting. There also appears to have been some difference of opinion and ambiguity regarding a decision from the meeting to make a referral to the social care locality team, or who should be responsible for making the referral. It was the IMR author's view that the DCT worker, who was an extremely experienced practitioner, should have made this referral. However, a referral to the social care locality team was not made and this was a further lost opportunity to assess and support Michael at a more appropriate level.

4.4.12 Following the initial period outlined above, there continued to be significant concerns regarding Michael and his behaviour, similar to those noted previously. There were also increasing concerns regarding the web sites Michael was accessing and the reference to horror/killing, death, stabbing and the 'dark side'. There also appeared to be ongoing confusion regarding the role of CYPS and their involvement with the family, and there was no evidence of these concerns having been escalated.

4.4.13 On 5th March 2015, a referral was received from the Deputy Head Teacher to the social care locality team, followed by a Police Child Concern Notification received on 9th March 2015. There was evidence of two duty Social Workers involved in the triage which included a telephone call with Sarah, the CST worker and CYPS (who were not available). Following this however the duty Social Worker recommended no further action, which was agreed by the Team Manager, stating that 'current professional involvement was appropriate and they have been alerted'. The Team Manager acknowledged that there were concerns around Michael's mental health, but that 'it is clear that there are appropriate mental health professional involvement to support his additional needs'. The duty Social Worker and the Team Manager had no information from CYPS to support their recommendation and decision. This reinforced the IMR author's view that there was confusion regarding the role of CYPS, their involvement with the family, and that there was a lack of coordinated multi-agency support to the family.

4.4.14 The locality team duty Social Worker also consulted the DCT. However, this contact was with the DCT Enquiry and Referral Administrator (ERA) and not with the DCT duty Social Worker. This mirrored the flawed DCT duty process in relation to the referral made by the Paediatrician in October 2014. The ERA informed the duty Social Worker of the review in school on the 12th March

2015, and had a conversation with the Senior Practitioner within the DCT who agreed to attend the school review. It is not clear what level of detail was shared by the DCT ERA with the Senior Practitioner, however, it did result in them being concerned enough to agree to attend the school meeting.

4.4.15 During interview for the purpose for the IMR, the DCT Senior Practitioner described the ERA as the 'gatekeeper' and first contact for the DCT. They described the ERA as being very familiar with DCT's criteria, and going above and beyond their role, but also seeking advice from the team. The IMR author identified that the ERA role within the DCT needs to be reinforced, as it is not a gatekeeping role and therefore the worker should always be sharing the referral information with the DCT duty Social Worker for a recommendation to be made to the Team Manager. The current arrangement does not appear to follow established duty procedures.

4.4.16 This referral in March 2015 was another missed opportunity to escalate Michael's case and it was the IMR author's view that on this occasion a multi-agency strategy meeting should have been held to formally share the referral information and to consider the need to undertake a Section 47 child protection enquiry.

4.4.17 While the Senior Practitioner with the DCT attended the school meeting on 12th March, although both the school and the DCT were aware of the CST worker's involvement with the family, he was not invited to the meeting. The Senior Practitioner with the DCT also did not review ICS or consult with anyone before attending the school meeting, and was only able to stay for 20 minutes, due to other work commitments. The Senior Practitioners' attendance at the meeting seemed to be primarily focused on the fact that Michael did not have a learning disability and therefore did not meet the DCT eligibility criteria. It was a concern that they did not appear to consider Michael's wider needs and the Safeguarding concerns that had been referred by school. There was also no evidence of the Senior Practitioner feeding back the outcome of the meeting to the social care locality team. The IMR author identified that they would have expected such an experienced Senior Practitioner to have raised the concerns with a Team Manager, had a further discussion with the social care locality team, or suggested a further meeting to share the concerns and ensure that the family were supported at the most appropriate level.

4.4.18 Although the DCT Senior Practitioner was very clear that Michael did not meet the criteria for the DCT, as an outcome from the meeting he agreed to complete a brief Children and Family assessment in order to demonstrate the discussions held at the meeting, and to place Michaels name on the DCT Transitions database. The subsequent assessment was based solely on the information shared at the school meeting, and the DCT Senior Practitioner did not arrange to see Michael or his family to complete the assessment, and did not consult with the CST worker or CYPS. In addition to this, key elements of

the assessment: health, behaviour, emotional, needs, risk and analysis, were either blank or not addressed. The assessment was therefore based on limited information.

4.4.19 In examining the current criteria for the DCT, the IMR author identified that it has the potential to miss out identifying wider needs and Safeguarding concerns; it was also identified as not being well understood by those within social care locality teams and other professionals. Furthermore, while the Transitions database and DCT's attendance at some meetings can be helpful, this can also cause further confusion for professionals and families regarding clarity of roles, accountability and support being provided.

4.4.20 On 30th April 2015, the Paediatrician telephoned the DCT Senior Practitioner to query the DCT criteria and the transitions process. It was recorded that the Paediatrician did not understand the criteria. However, the chronology for this review has highlighted that the Paediatrician notes indicate that following an appointment with Michael they were concerned, had spoken with CYPS, and recorded that they may contact CST in order to arrange a meeting with everyone involved with the family. The DCT Senior Practitioner's case notes however recorded this solely as a 'general enquiry'. This was potentially a further lost opportunity to review the status and progress the case.

4.4.21 Between 12th March 2015 and the 10th July 2015, the date of the next TAF meeting, there continued to be significant concerns regarding Michael and his behaviour, similar to those noted previously. The incidents during this period appear to be more centred on Michael targeting his mother, such as spraying deodorant over her, placing his hand over her mouth, almost pulling her down the stairs, threatening to burn her, being nasty to her, hitting her arms, scratching her arm, grabbing her arms and preventing her from contacting the Police. On 7th July 2015, Sarah shared that Michael was hiding his medication, swearing, and stating he would kill his family.

4.4.22 These were all Safeguarding concerns that should have been shared and escalated and a referral made to the social care locality team. There were also ongoing issues regarding the role of CYPS and their involvement with the family, with the continuing theme around the medication not working and the need for the medication to be reviewed. There was no progress made regarding the CYPS assessment being undertaken and in March 2015, it was noted that Sarah had put in a complaint regarding CYPS. There was no evidence of supporting Sarah with the complaint or of escalating the concerns to NTW regarding CYPS.

4.4.23 On 27th and 28th May 2015, Sarah telephoned CST and spoke with the CST Senior Practitioner, who agreed to review the involvement of CST under the EHA. On 3rd June 2015, supervision took place between the CST worker and the Senior Practitioner however, the supervision note was brief and made no reference to a review of the case, other than noting the TAF meeting planned

for 10th July 2015. On 10th July 2015, at the TAF meeting, it was confirmed that Michael would be starting new, anti-psychotic medication, and he would be referred to the Psychosis Team and that a Community Nurse would be allocated. Once again, this should have prompted a closer examination of the status of the case, the plans and supports in place from CST.

4.4.24 It was the view of the IMR author that any review of the case at this stage, or earlier, should have resulted in a referral to the social care locality team to convene a multi-agency strategy meeting. It was also identified that the Senior Practitioner should have attended and chaired the TAF meeting held on 10th July 2015. This would have been a further opportunity to ensure that the case was managed at the most appropriate level and that the relevant professionals required were actively involved in supporting the family.

4.4.25 On 25th September 2015, a final home visit was undertaken by the CST worker to complete the case closure. The CST closure form notes that there remained risk factors that need addressing. Despite the EHA being in place for two years, there was very little evidence of the impact of the CST intervention and the CST worker had not been able to engage in any meaningful work with Michael. The IMR author's view was that the case should not have been closed and should have been stepped up to a referral to the social care locality team for statutory social care support.

4.4.26 Following closure of the case, a further referral was received by the social care locality team, from the Police, on 2nd November 2015. Four Social Workers were involved in this referral triage and recommendation. Whilst relevant checks were made, no one person had an overview or understanding of the case. A telephone call was made to Sarah and the information she shared was concerning, which should have influenced the referral outcome. One Social Worker consulted with the CST worker and another Social Worker emailed the CYPS worker, however, there was no evidence of a discussion with this worker taking place. Following this a recommendation was made for a referral to the EIH for the Northumberland Adolescent Service to become involved, which was agreed by the Team Manager; the referral was never made. In light of everything that had preceded this referral, the decision at this point should have been made to complete a Children and Family assessment and for the social care team to support the family. This would have provided a further opportunity to review the case within a statutory team and to consider Michael's needs, alongside multi-agency partners, either within a Child in Need or Child Protection framework.

4.4.27 As well as the missed opportunities regarding escalation and multi agency working, it can also be seen that at no point was Sarah identified as being a victim of domestic abuse from Michael. This is despite his patterns of verbal, physical, aggressive, emotional, controlling and coercive behaviour towards his mother. This was evident in 2014, but more so throughout 2015. During

interview for the IMR, the CST worker stated that they did not consider domestic violence in the relationship between Michael and his mother, and would never have envisaged the death of Sarah. All professionals interviewed for this DHR, whilst they had attended training on domestic violence, indicated that they had not considered this to be a risk in this case, despite the evidence to the contrary.

4.4.28 When information regarding domestic abuse and violence and aggressive behaviour was disclosed there was little further exploration of this and no assessments were undertaken in relation to Sarah's experience of the abuse or the risk Michael posed to her. In addition, no consideration was given to sharing the information with other agencies such as the Police or CYPS, no referrals were made to the Risk Management Group for Michael, although it is accepted that he may not have met the criteria, and no consideration was given to referral Safeguarding Adults, or other support services in relation to Sarah. Indeed, it appears that the risk posed by Michael was neither recognised nor considered.

4.4.29 As regards oversight of Michael's case, during the fourteen month period of contact with the family, the CST worker received formal supervision with the CST Senior Practitioner on a total of 9 occasions, with this becoming less frequent from March 2015 onwards, a time when the concerns were escalating. The IMR author noted that in this case the supervisions were brief and provided an overview of the case without linking with key incidents or concerns. In addition to this, the they did not seem to make reference to previous supervisions or actions and there was little or no reference to Michael's views. Although the Senior Practitioner agreed to review the case, there was no evidence of this taking place. The role of the Lead Professional was focussed on supporting Sarah; however, given the complexity of the case, the Senior Practitioner could have given clearer advice and support and been more actively involved. The Senior Practitioner or Team Manager could have chaired some of the TAF meetings and intervened to ensure attendance. In addition to this, the TAF meetings should have taken place more regularly, every 3-4 months, or more frequently depending on multi-agency attendance and complexity. This may have provided an opportunity to fully review the case and explore a referral to the social care locality team and escalate the concerns to NTW regarding CYPS.

4.4.30 While the CSC IMR identified that agencies did not always attend meetings when invited, it was also noted by other agencies that when they were not able to attend they did not always receive feedback regarding the outcome of the meeting. In order to facilitate good information sharing and multi-agency working, while agencies should always make every effort to attend it would also be good practice to ensure that details regarding the key issues discussed and outcomes of the meetings are shared with all agencies who are known to be involved.

Conclusions regarding NCC Children's Social Care's involvement

- Whilst support was being provided under an EHA and EH Plan, the CST worker provided regular and consistent support to Sarah.
- While this was initially an appropriate framework for supporting the family, it quickly became apparent that this was not the most appropriate framework, however such concerns were not acknowledged and escalated to the social care locality team to provide assessment and support under a statutory framework. A number of missed opportunities to do so were identified including when referrals were received in October 2014, March 2015 and November 2015.
- The undertaking of assessment, such as the EHA and DCT's Child and Family Assessment, and the triage of referrals and decision making, did not always seek and consider full information that was available, resulting in little evidence of a holistic picture that would have highlighted the increasing concerns and the need to escalate the case.
- There was limited direct contact with Michael and his views and experience of the situation remained largely unknown.
- Sarah and her family's reports of increasingly aggressive and violent behaviour by Michael were not fully explored and it was not considered as domestic abuse. Within this no risk assessments were undertaken regarding the risk to the family, information was often not shared with other agencies, and no multi agency risk management measures were considered to protect Sarah and her family.
- There was no evidence that the TAF and other professionals had a shared understanding of what was behind Michael's presentation.
- On one occasion, in March 2015, a worker from the DCT attended a school meeting but the the Lead Professional (CST worker) was not invited. This indicated a lack of understanding of the central role of the Lead Professional in coordinating the TAF and other professionals.
- Although there had been three TAF meetings, there was not good multi-agency representation, either through lack of invites or lack of attendance. This resulted in key information being missing from education and CYPS. There was no strong evidence of planned and coordinated multi-agency work to support the family, which should have been led by the Lead Professional.
- Whilst TAF meetings did take place, the initial EHA and EH Plan had not been updated throughout the CST worker's involvement and there did not seem to be any evaluation of impact.
- Michael's self-harming behaviour appeared to be minimised and the deliberate Self Harm and Suicide Care Pathway had not been considered. This could have been a further opportunity to consider the risks within a formal multi-agency strategy meeting forum.

Recommendations identified within NCC Children's Social Care's IMR:

- Children's social care and adult safeguarding to raise awareness and widely distribute the Home Office guidance regarding Adolescent to Parent Violence and Abuse (APVA) and request that this is disseminated within teams, discussed at team meetings, team briefs and referenced at relevant training. The Home office document will be available on the NSCB and Adult Safeguarding websites.
- Children's social care and adult safeguarding to implement a clear procedure and pathway to ensure that all referrals regarding adolescent to parent violence and abuse are responded to appropriately and consistently, identifying the risks around domestic violence, to ensure that the adult victim is safeguarded and protected and that the most appropriate assessment, intervention and multi-agency support is in place to safeguard, protect and support the child or young person and their family.
- The Home Office guidance regarding Adolescent to Parent Violence and Abuse (APVA) to be incorporated into the Single Point of Access (SPA) procedure and pathway to reflect the learning from this review and support a consistent, timely and appropriate response regarding adolescent to parent violence and abuse.
- The Disabled Children's Team should review the role of the Enquiry and Referral Administrator and duty Social Worker within the team, to include clarity and expectations around the duty Social Worker role in attending Team around the Family meetings and Transitional School Review meetings.
- To review the purpose of the Transitional Database held within the Disabled Children's Team.

NCC Children's Services Recommendations for NSCB

- The NSCB will review and revise the early help procedures and guidance to include the following key elements:
    - The threshold for undertaking an Early Help Assessment; to include an escalation policy, for all professionals, linked to the updated multi-agency Thresholds Document. The escalation policy should cover the opening, stepping up/down and closing of the case and should include seeking guidance/supervision and exercising professional judgement.
    - The role of the Lead Professional and the contribution and expectations of the Team Around the Family.
    - Agreement that NTW, where appropriate, will take on the role of the Lead Professional.
    - The visiting frequency of the Lead Professional and other relevant professionals, to include planned and meaningful direct work with the child or young person.

- The Early Help Assessment, plan and reviews, to include: the duration of the Early Help Assessment, linking with the escalation policy.

- The role of the Team Around the Family meeting, including multi-agency attendance, information sharing, professional contribution, timely and smart actions and the distribution of minutes.

- The formal supervision arrangements in place for the Lead Professional and members of the Team Around the Family to include: the frequency of formal supervision, reflection and professional challenge, the role of the Lead Professional's line manager in chairing Team Around the Family meetings, where progress is not being achieved or sustained within 6 months.

- The Early Help Module: to ensure that this is fully compatible with the statutory social care module, so information can to be accessed and reviewed between the Early Help and statutory social care elements of ICS. The Early Help Assessment template and Early Help module on ICS should incorporate a chronology that is used in order to capture and analyse the key events and the child's journey and experience.

- To review the single and multi-agency training that is available to Children's Services staff regarding domestic violence, to ensure that this includes adolescent to parent violence and abuse, mental health and self-harm to ensure that lessons learned from this case are incorporated.

- To explore multi-agency training with NTW to ensure a greater understanding of the role of professionals and interventions within NTW.

- Once the current review of the Suicide and Self Harm Pathway is complete, key messages from this DHR and for the Suicide and Self Harm pathway to be re-launched with training for all Children's Services staff.

Further recommendations for NCC Children's Social Care as a result of this review:

- Within the review of training, outlined with the IMR recommendations, CSC should ensure that staff are aware of the need to act upon reported incidents of violence and abuse through the undertaking of appropriate risk assessments, referral to appropriate risk management procedures, and consideration of the need to share such information with other agencies.
- To review procedures relating to the feedback of information following multi-agency meetings, including TAF, to ensure that feedback is disseminated to all those actively working with the case.

4.5 **NCC Education & Skills (Wellbeing and Community Health Services Group)**

4.5.1 During the period of the review, known concerns regarding Michael's behaviour within school were recorded as first occurring in February 2014, when he threatened to stab another pupil in a cookery class. Following this, in June 2014, he drew a picture at school depicting people having been stabbed, legs removed, and eyes cut out; then in December, he goaded another student saying 'shoot yourself, slit your throat'. All of these were dealt with internally and it is not clear whether they were considered together, and any emerging pattern identified, although it is recognised they occurred over a twelve-month period. The IMR author identified that the school only involved outside agencies when Michael's behaviour became extreme, and that the staff felt confident in their own ability, and adequately trained, to manage the complex behaviour that Michael displayed. It was also noted that Michael had relatively few incidences of inappropriate behaviour recorded compared to some other students, and so did not stand out as being a particular concern.

4.5.2 The above raises the question of whether staff can become inured to such behaviours, which may in turn impact on an objective assessment of risk being undertaken. The danger of having a process in which some concerns are solely recorded internally, is that this results in a level of subjectivity being exercised around whether they are 'serious enough' to share. As stated, such decisions can also be influenced by a certain 'normalising' of presentations in environments in which staff are regularly presented with concerning or challenging behaviours. Furthermore, in not sharing the behaviours with other agencies, this results in potential missed opportunities for behaviours to be considered in a wider context against information available from other sources. Such sharing could have occurred through the raising of Child Concern Notifications. The IMR author noted that it is important that the school shares any relevant information with outside agencies, so that decisions around children such as Michael can be based on an accurate and full picture of needs.

4.5.3 In relation to this early period, it was also noted in the CSC IMR that when the school were contacted in June 2014 they identified that they did not feel an Early Help Assessment was necessary, as Michael's behaviour was not problematic within school. However, as noted above, there had been two recent incidents, in which Michael had made threats to another pupil and also drawn a concerning picture. The Education IMR also indicated that the school were unaware of the threats Michael had made toward his mother until March 2015, thus it is unclear as to what information was shared with them around the reasons for the EHA, and therefore on what they based their belief that an EHA was not necessary.

4.5.4 In February 2015 a number of further presentations in Michael's behaviour were noted. This included three incidents between 24th and 26th February in which he spoke to different members of school staff regarding hearing demon voices, wanting to 'snap (people's necks), and the date of a staff member's death. Once more these incidents were dealt with internally, raising the same issues as identified above.

4.5.5 Shortly after this, on 2nd and 3rd March 2015, the concerns escalated further with Michael reporting that he had killed three people the night before, and then graphically describing how he had killed thirteen people that month. On 4th March, he also self-harmed using a piece of glass. In response to these incidents the school telephoned Sarah, as well as notifying CSC (4/5th March) and the Police (5th March). While the notification included all information from these incidents, it was not sent until 4th March, following the incident of self-harm; therefore, it is unclear as to whether without such self-harm the incidents on 2nd and 3rd March would not have been notified.

4.5.6 From the perspective of the school the risk Michael posed seemed to diminish from mid-2015, as his behaviour and application in lessons improved. Such improvement meant that staff were happy that their interventions, and those of other agencies, were having a positive effect. This raises the question as to the extent to which the school were kept informed of the ongoing concerns, although it has been identified in other agencies' IMRs that a lack of information sharing did take place. The IMR for Education noted that on the occasions when multi-agency work did take place, in most cases the school were kept informed of the outcomes via letters which were held within Michael's school file. However, on one occasion when they were unable to attend the TAF meeting on 10th December 2015, they did did not receive any communication regarding outcomes. Also, while a member of school staff was present at the TAF meeting on 10th July 2015, no subsequent communication was received. Outcomes from the Team Around the Family meeting in July 2015 may have indicated a change to anti-psychotic medication; crucial information for the school if they were to manage Michael's behaviour appropriately. It was also not clear if the school would have been made aware of any issues presenting during the summer holidays.

4.5.7 The IMR author did not identify that there were any indicators apparent to staff members of the ongoing concerns within the family home regarding domestic abuse. Sarah and her mother attended school meetings regularly and it was noted that they were also often spoken to at the school gates, although such conversations would not be recorded. Sarah's parents confirmed that they did attend meetings at the school however, Michael travelled to school by bus, and therefore conversations could not have taken place at the school gates. There was no evidence that any direct disclosures of concerns were made by Sarah or her mother to the school staff. However, as raised it does appear that the school were involved in multi-agency

meetings that would have highlighted the difficulties that were occurring at home. There is no evidence that these were further pursued by the school and any attempts made to address the home situation with Michael and his family. Given that Michael's behaviour within the school was reported to have improved during this time, this could have been an opportunity to address the ongoing concerns within an environment in which Michael was reported to be responding positively.

Conclusions regarding NCC Education and Skills' involvement

- Michael's behaviour within school was not considered to be a concern until March 2015. Prior to this the three incidents identified in February, June and December 2014, and a further three incidents in February 2015, were not considered serious enough to warrant sharing outside of the school. This was a missed opportunity to contribute to building a more complete picture of Michael's behaviour.
- When significant concerns presented in March 2015, these were appropriately shared with CSC, the Police and Sarah. It is not clear if the reports of Michael having killed people would alone have prompted such sharing, as this occurred following the incident of self-harm.
- There were no further incidents of concern within school following March 2015, and Michael's behaviour within this setting was reported to have improved.
- It is not clear to what extent the school were aware of ongoing concerns and, when they were made of these at multi-agency meetings, to what extent they were considered and Michael and his family engaged to address these.

Recommendations identified within NCC Education and Skills' IMR:

- It is not clear whether staff at the school were aware that domestic violence may have been taking place. Training staff in spotting the signs of domestic abuse (APVA) may mean that in future cases appropriate agencies can be informed more quickly and with greater certainty.
- Whilst the record-keeping of the school was very detailed the school should ensure that a single management system is used to collect all information regarding incidents linked to students, rather than in separate behaviour logs. This may aid the spotting of behaviour patterns in future.
- The school should also ensure that relevant information is shared systematically between staff within school and with outside agencies through the use of Safeguarding Children processes. A multi-agency approach to the most suitable way to achieve this is required. Consideration of who is responsible for collating such information is necessary.
- The school should consider a formal recording of conversations with parents/carers to aid the transfer of relevant and timely information between staff within school and outside agencies.

- On two occasions (10 December 2014 and 10 July 2015) the school did not receive any formal communication regarding outcomes from multi-agency meetings that had taken place. Whilst the responsibility for distributing those outcomes lies with the host of the meeting, the school may consider an internal process that follows up missing communications. This would ensure the school always has a full picture of activities undertaken by other agencies which may impact upon the school.
- The school may wish to instigate a process by which they ask parents for a summary of how each child has been during the school holidays. This may flag up any changes in behaviour or attitude that may impact upon school performance.

Further recommendations for NCC Education and Skills as a result of this review:

- Where concerns are known regarding the home environment, the school should identify how this can be addressed within the school environment and attempts made to engage the young person and his family.

4.6 **Northumberland Clinical Commissioning Group**

4.6.1 The GP's contact was primarily with Sarah and her mother, and the GP identified having known Sarah for 'years and years', and of her being 'devoted to' Michael.

4.6.2 Sarah was diabetic and had associated weight problems, exacerbated by 'comfort eating'. As a result of this, she was seen regularly and received extensive support from the Practice Nurse, the diabetic secondary care team and Health Psychology. However, there does not appear to have been any significant consideration given to any links between her identified comfort eating and her stressful home life. This is despite a number of presenting opportunities in which either Sarah herself identified problems, or issues were raised in correspondence from other health services working with Michael.

4.6.3 On 3rd December 2013, Sarah saw the Practice Nurse for diabetic-chronic disease monitoring. She confirmed that that she had problems that drove her to comfort eat and it is documented that she felt 'down due to family problems'. A depression questionnaire was undertaken which would be part of chronic disease monitoring. The result and the outcome of the questionnaire were not documented. The IMR author asked the GP and practice nurse if template driven chronic disease monitoring reduced GP contact and increased the likelihood of social problems being missed. The GP response was that *'The practice nurse feels that the template driven monitoring does not present a barrier as she also uses free text after the template and she often flags social concerns with the GP who usually sees the patient.'* Although this does not appear to have happened in this case.

4.6.4 Sarah also presented with depression to the GP, who prescribed anti-depressants. There seems to have been little further exploration regarding the underlying causes and the GP stopped seeing her a few months after starting antidepressants, despite the fact that the practice continued to receive correspondence describing an escalation in her son's behaviours and violence towards her. Sarah also informed the GP she felt unsupported by CYPS. In response to this, the GP suggested that she ask for a social worker to be allocated. While the GP made a correct assessment that more needed to be done to support, they should have followed up the lack of support directly instead of expecting mother, who was known to be under stress, to do this herself.

4.6.5 The IMR author noted that if Sarah and Michael's GP records had been considered together, the timelines of their respective problems would have highlighted the extreme difficulties within the household. This would have raised concerns for the well-being of both mother and child and should have resulted in a 'think family' approach.

4.6.6 In relation to contact with Michael, during the IMR interview the GP reported having seen the family when Michael was young in order to get a referral to the mental health team, describing this as '*a battle'.* After this point however, once CYPS were involved, the GP's input with Michael diminished and he was not seen by the GP over the full period of the review.

4.6.7 Throughout this time Michael's mental health and behaviour issues were identified by a number of agencies, and was shared with his GP in the form of correspondence from various professionals. These professionals included the Paediatrician, Psychiatrist, Children & Young Person's Service (CYPS), School Nurse, Community Disability Team (CDT) and Community Psychiatric Nurse (CPN). The correspondence highlighted Michael's extremely concerning thoughts, beliefs, behaviours (including access to disturbing internet web sites), and violence, which was mainly directed towards Sarah. Reasons for why his behaviour was challenging were unclear from the letters and the reasons suggested ranged from parenting style, puberty, and medication,

4.6.8 The extent of the concerns being shared within this correspondence has been outlined throughout this report. At each stage that these were shared with the GP, they presented opportunities to follow them up and consider issues of domestic abuse, undertake an assessment of risk, and consider what support needed to be offered. Despite this the information shared neither prompted further discussion with Sarah at her regular appointments, or lead the GP to try and establish contact with Sarah or Michael outside of these.

4.6.9 The IMR author identified that the GP could have actioned any of the letters received from the Paediatrician, Psychiatrist or Mental Health Teams by either asking the child to attend an appointment or by offering his mother an appointment and asking her what was happening at home. However, the GP commented in interview that they had assumed '*everything was in hand'* as Michael was attending CYPS appointments, thus assuming that other services were dealing with the problems. In this case the GP assumed there were health professionals involved who were more qualified to undertake risk assessment and management plans for Michael's deteriorating behaviour and mental health. This led however to inaction on the part of the GP with regards to making a primary care risk management plan. The IMR author noted that GP practices should identify vulnerable patients and not assume that these patients can be managed adequately without direct GP input and support on a regular basis. In relation to this the IMR author also noted that is a rare occurrence in primary care to see a child with suicidal ideation or self – harm, and any child who is known to have expressed suicidal thoughts should also be seen regularly by the GP, in order to make sure that the child and family are supported and ensure the services supporting the family are adequate. This should include regular liaison with any mental health services and others involved.

4.6.10 Within the above, there was also a clear failure to recognise Michael's violence as domestic abuse towards an increasingly vulnerable mother. As a result of this, no risk assessment was undertaken and no consideration given regarding a referral to Safeguarding or support services was made. During interview for the IMR, the GP acknowledged there had been no recognition of this as a case of domestic abuse. This was despite Sarah directly expressing fear of her son. The IMR highlighted that persistent enquiry, including routine enquiry around domestic abuse should be encouraged. The argument for routine enquiry is certainly supported by this case in which it has been seen that the prompts for selective enquiry do not appear to have been picked up on. Such prompts included the third party reports from other agencies, as well as Sarah's own chronic health problems and depression.

4.6.11 The evidence suggests that the situation was seen as a child with mental health and behavioural issues, and the IMR author felt that domestic abuse was not considered because Michael was a child. Although challenging behaviour is well described in children undergoing puberty and there is a variation of severity of behaviour and types of behaviours to be expected, this behaviour was escalating and pathological. However, the age of Michael appears to have hindered recognition of the domestic abuse he was demonstrating towards his mother, and this the identification of this as APVA. The IMR author felt that had the perpetrator been an adult male instead of a child, it would have been more likely that this would have been recognised as abuse.

4.6.12 The IMR identified that the GP involved has not had any recent training regarding domestic abuse, but did receive such training in 2014. Most GPs in Northumberland have received training in domestic abuse and its relevance to Child Safeguarding, however the training does not explicitly cover children as perpetrators. The author identified that it was likely that the following barriers played a role in the GP failing to consider domestic abuse:

- This was a less common and unclear presentation of the domestic abuse victim and perpetrator.
- Michael was a teenager and there was confusion between 'normal' teenage anger and challenging behaviour, and the pathological behaviour shown by the perpetrator, which spilled over into dangerous violence towards his mother and grandmother.
- The perpetrator had ADHD and ASD and there was also documentation that he had learning difficulties These diagnoses provided a reason for everyone to tolerate more serious challenging behaviour without acknowledging the co-existence with domestic abuse.
- He was loved dearly by his mother and grandparents who minimised the severity of the violence in the maternal home thus not alerting professionals to the extent of the danger to the mother. In relation to this latter point however, it should be noted that over time Sarah and her mother increasingly reported their fear of Michael, the escalating behaviour towards Sarah, and her difficulty in managing this.

4.6.13 Clear recognition of a form of domestic abuse would have resulted in greater consideration of risk management measures that may have needed to be taken. Also, given Sarah's physical and mental health problems, consideration could also have been given as to whether a Safeguarding Adults referral may have been appropriate.

4.6.14 In this case, the IMR author felt that the approach seemed to be that of professional optimism. They identified that had this family been discussed at the weekly multi-disciplinary Supporting Families meetings, the benefit of professional curiosity and peer reflection and challenge, may have resulted in further assessment and referral. Supporting Families meetings enable GP's to discuss the management plans for certain families with GP colleagues, practice nurses, health visitors and other staff in contact with family members. They provide an opportunity for any member of the practice to raise concerns or issues. In addition, if other health professionals (outside primary care) involved with the child had been aware of 'Supporting Families' meetings within the GP practice, they may have suggested the family be discussed through this route and could have attended themselves.

4.6.15 The IMR stressed that any known domestic abuse within a family should alert any health practitioner to ensure that the appropriate pathway is followed. These cases must always be discussed at 'Supporting Families' meetings and codes applied to records accordingly. In relation to this latter point, the

GP had a key opportunity to ensure the child's and mother's GP records had up to date and comprehensive problem lists such as worsening behaviour, depression, Obsessive Compulsive Disorder, self-harm and violence. This would have ensured that any colleagues reviewing either mother or son could quickly gauge the issues facing the family and that the situation was deteriorating. Coding of important patient problems or events in the GP records is good practice and supports creating a comprehensive and up to date problem list. The problem lists for both Michael and Sarah were out of date and did not accurately reflect what was happening in their lives. This was a missed administrative opportunity to provide a full picture, leading to perhaps further curiosity and action.

4.6.16 The IMR author concluded that to improve practice GPs should hold the child and family in mind as one entity and 'Think Family'. They should allow themselves to believe that serious problems may be present or developing even within families that they have known for many years and feel they know well.

Conclusions regarding Northumberland CCG's involvement

- Sarah was seen regularly and was well supported in the management of her diabetes and weight problems. However, there was little exploration of the underlying causes of both her overeating and depression and how these may be linked to stresses at home.
- Correspondence to the GP practice, as well as behaviour noted by the mother and grandmother, showed a clear escalation in Michael's disturbing behaviour but did not prompt the GP to take any active steps to address this with the family.
- Michael was not seen during the time period of the review. The GP in this case assumed everything 'was in hand' due to CYPS being actively involved. Given the escalating concerns attempts should have been made to establish contact.
- There is little evidence of a 'Think Family' approach, with the links between Michael's escalating behaviour and Sarah's health concerns not having been made, and no assessment of the risk posed by Michael to Sarah undertaken.
- The GPs failed to recognise the concerns as domestic abuse, despite reports of assaults by Michael against Sarah and her expressed fear of him. This appears to have been influenced by Michael being seen as a child with ADHD/ASD and associated behavioural problems. This appears to have led to the 'acceptance' of certain behaviour and a failure to consider them as domestic abuse and thus identify, and take steps to manage the risk to Sarah.
- The family were never discussed at the weekly Supporting Families meeting. Families identified as being vulnerable or having complex needs, and where children have challenging and aggressive behaviours which parents are unable to cope with, should always be included in these meetings.
- Coding and record keeping of the GP records did not mirror what was

happening with the family.

Recommendations identified within Northumberland CCG's IMR:

- All GP's and practice nurses should have an increased awareness of Domestic Abuse (DA) and Adolescent to Parent Violence and Abuse(APVA)

All Single Agency Training (SAT) provided for primary care staff should include recognition of children as perpetrators of domestic abuse. This case should be discussed to illustrate this.

- Improve GP awareness and understanding of children with mental health issues registered with the practice.

Circulate a list of child mental health codes to all GP practices and highlight the issues regarding GP record coding from this case. This should be done via an alert and through SAT.

- GP practices to broaden the scope of existing safeguarding ('Supporting families') meetings to discus cases that involve children who are known to be violent and/or aggressive.

To be shared at GP Network and incorporated into all SAT as a case scenario. GP practices may consider inviting health professionals such as mental health workers to attend 'Supporting Families' meetings where appropriate. Raise awareness of 'Supporting Families' meetings with other agencies in order for them to link in to the 'Think Family' approach.

- All children with serious mental health issues should be visible within the GP practice and their thoughts and wishes (as well as those of their families) documented. This good practice should be visible in the child and family GP records.

GP Practices to audit the contact they have with children that are known to them with serious mental health diagnoses including those with violent and aggressive behaviour. These children should have appropriate and regular primary care 'face to face' contact. These mental health reviews should incorporate their physical, mental, social and safeguarding circumstances. This information should be clearly documented in the GP records.

- Where a patient discloses fear of or actual violence perpetrated by someone known to them, this should be documented with a clear plan of action.

This should be included in SAT, briefings and via an alert.

- GP's should take appropriate action when it is known a child or adult is accessing

illegal, harmful, abusive or particularly violent web sites on the internet including those involving radicalisation. GPs may need to discuss their concerns with other agencies or even make referrals into Safeguarding if it is agreed that there is concern about the welfare of the child, their family, or the public.

Health WRAP training for all GPs and practice nurses to raise awareness of the Government 'Prevent' programme. In order to support GP practices with their role and responsibility with regards to preventing children from online exploitation, information about the Child Exploitation and Online Protection Centre (CEOP) 'thinkuknow' programme should be circulated to all GP practices, with specific reference to the available online training 'Keeping Children Safe Online (KCSO)'.

- GP's should not make assumptions regarding the care of any of their patients without establishing the facts. This could involve speaking directly to the patient, their family and lead professional involved. This must include regular updates.

This will be covered using case examples during SAT and GP network meetings as a theme.

Further recommendations for Northumberland CCG as a result of this review:

- Northumberland CCG to encourage the use of routine enquiry in practices and to ensure that practices have systems in place to prompt selective enquiry when there are ongoing chronic health issues, mental health concerns, or evidence of violent behaviour within the family.

4.7 **Northumbria Healthcare NHS Foundation Trust (NHCFT)**

4.7.1 In relation to NHCFT's contact, Sarah was known to Diabetic services, where records suggest she had been seen regularly since 2009. Commencing in November 2014, she was also being seen by a Psychologist from the Health Psychology Service on a monthly basis.

4.7.2 Michael was under review by a Paediatrician. He was referred to the service in 2012 and, although the initial referral issues had resolved, he remained on six monthly review to monitor his weight and growth.

4.7.3 Michael's maternal grandmother was identified by NHCT as a key person within Michael's life. She provided care for Michael while Sarah worked, and attended most appointments with Michael and his mother. She provided information to support Sarah's concerns and was seen to be proactive throughout all aspects of Michaels's life.

4.7.4 The IMR identified that Sarah shared information at both her own and Michael's appointments regarding the family situation. However, the staff involved in this case did not have a complete picture of the family as the

Paediatrician was unaware of the Psychologist's involvement, and while the Psychologist was aware that CYPS were involved, they did not know about the Paediatrician. This was as a result of the information Sarah chose to share in her appointments and may be reflective of a number of such cases in NHCFT.

4.7.5 In relation to Michael's contact, it was documented that Sarah had been describing problems with his behaviour from the age of five years old. At the age of ten, his behaviour was described as having oppositional qualities, however he was well behaved when he gained attention. His behaviours changed as he aged but his violent 'dark' thoughts were not known to Northumbria Healthcare until April 2015, when Michael was fifteen.

4.7.6 There were a number of key points where concerns were expressed within appointments with the Paediatrician, these were:

- 7th August 2013: the family reported Michael's behaviour was becoming unmanageable and identified they lacked support.
- 15th October 2014: Michael was observed to have self harmed to his arms and face.
- 28th April 2015: Michael disclosed that he goes out at night and drinks the blood of animals; Michael's maternal grandmother reported that the family were terrified of him.

4.7.7 In response to these concerns the Paediatrician made appropriate referrals to CSC in the first two instances, in order to try and get additional support for the family. In the latter occasion they shared concerns with the Specialist Registrar at CYPS and suggested a multi agency meeting, although as has been outlined previously this did not occur.

4.7.8 Following the contact in 2013, a missed opportunity occurred during the subsequent involvement of the Public Health School Nurse (PHSN). Within this appointment Sarah described Michael's behaviour to include punching a hole in the door out of anger. There was nothing in records to suggest this disclosure was explored further or any specific actions taken as a result of it. The new health assessment was also not completed in its entirety and the IMR author identified that it appeared superficial and lacking in detail; which may account for the subsequent lack of intervention by the PHSN service. There was a plan to update CYPS about Michaels self-harm; to contact the school to complete some social story work; and to contact Youth link to explore further support. Following this however the PHSN services discharged Michael in February 2014, and there was no evidence of any direct work from the service in relation to behaviour or support strategies, despite the clear message of a family struggling.

4.7.9 A similar missed opportunity for further exploration can also be seen during the appointment with the Paediatrician on 15th October 2014. Within this there is no evidence of any further discussion around Sarah's disclosure that police had attended the home the week before.

4.7.10 In general, however, the IMR author noted that the records showed that the Paediatrician had an understanding of the complex nature of the family's needs. At numerous appointments the Paediatrician sought clarity on the support Sarah had available and looked for what additional support could be added. As already identified, they also appropriately referred to the PHSN, CLDT, and requested a multi-agency meeting. The Paediatrician was aware that there were other professionals involved in Michael's care and sought to ensure they were provided with the information that had been shared with her in respect of Michaels 'dark thoughts' on the same day. The IMR author felt that the Paediatrician was perhaps falsely reassured when she was informed that many of the ideations Michael was expressing were already known to his Psychiatric Consultant, and thus that further assessment was necessary before pulling together the Multi-agency meeting which the Paediatrician had requested.

4.7.11 As regards the Psychologist's contact with Sarah, records clearly showed an understanding of the issues the family were facing, and the self-reported support and strategies mother was employing were documented at each appointment. There was an overview description of Michael's current behaviours and an acknowledgement that they were causing Sarah stress. Some of the specific incidents reported by Sarah were:

- On 6th January 2015, she spoke of the fantasy world Michael had in his head and her concerns about the influence social media and the Internet were having on him, including contacts he had made on Facebook.
- On 14th April 2015, she discussed Michael's 'dark thoughts' and reports that he had 'been out killing people'.
- On 12th May 2015, she expressed concerns about how she would cope with his behaviour while her mother was on holiday.
- On 9th June 2015, she reported there had been a 'couple of violent incidents' in the second week of half term.

4.7.12 In relation to the disclosures on January 2015 there was little further exploration of these with Sarah and no discussion by the Psychologist with colleagues about the potential implications of this disclosure. It was agreed within the appointment that Sarah would implement stricter controls over the computer, however she did not share that she had previously felt unable to do this due to Michaels's aggressive behavior. This was shared two weeks later at Michael's Psychiatric appointment, so was unlikely to have been an implemented action. In interview the Psychologist did not recall specifically being told about a concerning relationship on Facebook but felt the advice to limit access was an appropriate response and would Safeguard Michael.

4.7.13 Similarly, on 14th April there was no evidence of further exploration of the disclosures made be Sarah. There was also no information sharing with CYPS, or other agencies, to concur with what Sarah had reported and ensure that an appropriate risk assessment was carried out and plan put in place. The IMR author explored this further with the Psychologist who explained that Michael was due to be assessed by CYPS, where he would be seen by a Psychiatrist to assess the content and meaning of 'Dark Thoughts'. The Psychologist did not consider it to have any Safeguarding implications, as the family and school were aware, and CYPS were to explore these thoughts further. Further supervision was not sought as Sarah had described the supports she had in place, and they were felt by the Psychologist to be appropriate.

4.7.14 The IMR author identified that from a Safeguarding Children perspective, what was missing in the Psychology records was recognition that there were aspects of Michael's behaviours which had a Safeguarding element to them. These issues warranted more exploration, or discussion with a colleague during a supervision session. Michael was a vulnerable boy and the Facebook influences could have indicated a number of concerning possibilities including grooming for sexual exploitation or radicalisation. The Psychologist reported that she knew other people were involved and were addressing the concerns, however the author felt that information sharing needed to take place irrespective of who was involved.

4.7.15 The IMR identified that there is a structured supervision framework for Health psychologists where complex cases are discussed, however the cases and actions are not documented. The author identified that the Psychologist had reflected on this case and was planning a more robust approach to supervision documentation, and the criteria around which cases they bring to supervision. The IMR author recommended that a template for recording case discussion and action be implemented across the whole service.

4.7.16 Within the Psychologist's contact, there is also no evidence of any consideration being given to any risk posed to Sarah by Michael, particularly following her disclosure on 9th June of Michael's violent incidents. There is nothing to indicate that the nature of these 'incidents' was explored further, who they may have been directed to, any risk posed, and any risk management actions that may be needed, such as referral or information sharing.

4.7.17 The IMR author identified that in speaking with the Psychologist and Paediatrician they both identified that domestic abuse was not considered as a feature in this family, as Michael was Sarah's child and she had not directly expressed a fear of him or reported physical violence against her. However, as outlined there was significant documentation about Michael's violent outbursts and his aggressive behaviour. The violent behaviour was

frequently attributed to Michael 'not getting his own way' or being asked to do something he didn't want to; often a trait of ADHD.

4.7.18 The Paediatrician was concerned about Michael's behaviour but acknowledged that they did not view the situation as one of domestic abuse. They felt that their own lack of recognition was primarily to do with the relationship between the victim and perpetrator, and Michael's young age, and was not connected to Michael's diagnosis of ADHD. Similarly, the Psychologist was clear that Michael's diagnosis of ADHD did not influence their view.

4.7.19 As a result of the situation not being recognised as domestic abuse, or Sarah seen as being at direct risk, no risk assessment around this took place and no consideration was given to referral to domestic abuse services or to multi-agency risk management processes, or Safeguarding Adults. There was also no direct discussion with her as to whether she considered herself to be a victim of a domestically abusive situation. Sarah was reported to minimise the violence in her own appointments, and the Psychologist was of the belief that the situation was not one of on-going violence but more a description of an escalation at the final appointment. However, the IMR author believed that there was enough information shared with the psychologist throughout the appointments to indicate that it was an on-going picture of violence.

4.7.20 Within NHCFT this is the second case within a short period of time which has involved Health Psychology and the follow up of Safeguarding Children issues. This staff group work predominantly with the adults, undertake level 2 Safeguarding Children training, and therefore do not have specific Safeguarding Children supervision. The author is recommending an annual Safeguarding Children supervision session accessed within Health Psychology to share learning from Serious case reviews, local contexts to national issues, consider changes to policies or procedures, and offer an opportunity for wider discussion around complex cases, with a children's element, which may have been brought to individual supervision.

4.7.21 Overall within her contact with NHCFT, the picture of Sarah was of a mother who loved her son, and at each appointment she would describe his behaviours but would also talk about the support she had from various services and how she was managing it, in effect minimising the impact on herself. The IMR author felt it would be very difficult for her to truly reflect how she felt about Michael's violence, and she never disclosed being frightened of him. The professionals involved did not explore her statements about his violence in any depth, and thus did not have a true picture of what was happening.

4.7.22 The training that NHCFT currently provide does not prompt practitioners to consider very young people and possible violence towards their parents as a form of domestic abuse (APVA).

Conclusions regarding NHCFT's involvement

- Sarah shared concerns regarding Michael's behaviour in both her own appointments with the Health Psychologist, and Michael's appointments with the Paediatrician.
- Michael's Paediatrician was proactive in assessing need at each appointment and was actively trying to engage the appropriate support for the family. When concerns were raised in relation to Michael she shared them appropriately and in a timely manner.
- Michael's increasingly concerning behaviour was not seen as a Safeguarding issue by the Psychologist and therefore no sharing of information took place, including no notifications or referrals to CSC.
- During the family's contact with NHCFT Michael's behaviours were escalating and a number of key contacts have been identified where NHCFT staff could have been more inquisitive in their questioning around Michael's behaviour and explored disclosures made by Sarah further.
- Despite Michael's documented behaviour within the home, the situation was not identified as one of domestic abuse. It appeared that Michael's age and the nature of the mother/son relationship may have influenced this lack of recognition.
- No risk assessments were completed or considered in relation to Michael's reported behaviour and the potential risk to Sarah. In addition, no consideration was given to further referral for support, or to multi agency risk management processes such as Safeguarding.

Recommendations identified within NHCFT's IMR:

- Changes made to training and guidance to ensure practitioners have a greater understanding of Domestic abuse in its wider context and be able to support those identified at potential risk of harm.
- Health psychology has access to all information pertaining to their clients which may be held in main hospital records or on alert systems.
- Health psychology to ensure cases involving concerns with children are discussed with peers and advice sought from Safeguarding Children team.
- Health psychology can evidence cases discussed during supervision and actions agreed. Peer supervision session for Paediatricians to include discussion about long standing chronic cases.

4.8 Northumbria Police

4.8.1 Northumbria Police's contact with Sarah and Michael was primarily in relation to concerns expressed by Sarah regarding her neighbours. This was dealt with as Anti-Social Behaviour and managed by the Neighbourhood Policing

Team with a harm reduction plan. Within this Sarah was allocated an Officer and there was evidence of good practice in terms of the work undertaken, including regular contact and liaison, and joint visits with Home for Northumberland.

4.8.2 The ongoing monitoring of the situation resulted in a joint visit being made to Sarah's neighbours and a warning letter being issued. The police procedure Anti-Social Behaviour: Community Protection Notice (CPN) states that:

'Before a CPN can be issued, a written warning must be issued to the person committing the anti-social behaviour. The written warning must make clear to the individual that if they do not stop the anti-social behaviour, they could be issued with a CPN'.

4.8.3 A CPN would have then followed the warning letter, however, as Sarah and Michael were about to move this was no longer considered necessary.

4.8.4 It was identified that Sarah perceived her neighbour's behaviour to be a direct result of Michael's autism, and the noise he made when his medication was wearing off. As such, while the ASB concerns appear to have been managed appropriately overall, the neighbour's behaviour should have been considered under the definition of hate crime.

4.8.5 A hate crime is defined as: '*Any criminal offence which is perceived by the victim or any other person, as being motivated by a hostility or prejudice based on a personal characteristic'.*

4.8.6 A hate incident is defined as: '*Any incident which may or may not constitute a criminal offence, which is perceived by the victim or any other person, as being motivated by a hostility or prejudice based on a personal characteristic. Hate' does not mean that the perpetrator is motivated by hatred. Hate includes where the victim is being exploited or threatened because of a personal characteristic'.*

4.8.7 Northumbria Police has a Hate Crime Strategy and Hate Action Plan as well as a documented Policy and Procedure. All hate crimes, incidents and offenders are 'flagged' within the internal computer system and all hate crimes are referred to the Crown Prosecution Service for decision around whether to proceed with charges.

4.8.8 As Michael fit the protected characteristics due to his disability, Officers should have considered the incidents as hate incidents. On being interviewed for the IMR, the allocated Officer from the NPT, identified that they had not considered this to be a hate incident, purely noise nuisance, therefore no further work was done in relation to this aspect. This was a missed opportunity that may have also assisted in alerting other agencies to the full extent of the problems that Sarah was experiencing due to Michael's deteriorating behaviour, and the possible repercussions to the family as a

whole.

4.8.9 In relation to Police contact around Michael himself, there was one occasion on 9th October 2014 when no CCN was raised after an incomplete 999 call was made after Michael had become upset. This was a missed opportunity to fully inform Children's Services, although the IMR author identified that this would not have affected Northumbria Police's escalation policy of 3 CCNs in 3 months, or 4 CCNs in 12 months, which would have triggered an alert to Children's Services.

4.8.10 After the incident reported by the school in March 2015, this information was correctly shared with Children's Services through a CCN. An email was also sent to the Prevent Team. However their remit is 'to identify the early warning signs from potentially vulnerable individuals who may be at risk of being radicalised'. Michael was not classed to be in any danger of radicalisation and as such no action was taken.

4.8.11 As regards Michael's risk to Sarah, there was one incident that should have been dealt with as domestic abuse. This was on 31st October 2015, when Sarah contacted police reporting that Michael had been verbally aggressive towards her and was, in her words, 'out of control'. While Sarah did state that Michael was calming down while she was making her initial report, the incident should have been identified as domestic abuse. This is demonstrated by the information that was contained within the CCN, which stated '16 yrs. old now, growing in stature and strength and she is beginning to feel completely overwhelmed by the caring role due to Michael's behaviour. She rang as a result of Michael screaming, shouting and banging his head off the wall. Whilst he was not physically aggressive towards her, Sarah felt overpowered and at the end of her tether. The situation quietened when she rang police but it is felt from a fairly long conversation with her that the situation in the home is becoming too much for Sarah and she desperately needs further support re Michael's behaviour.'

4.8.12 Northumbria Police have a duty of positive action in relation to investigating domestic abuse and safeguarding victims, which means that an incident of domestic abuse should always result in officers attending the scene and carrying out a thorough and proportionate investigation. As such had this been correctly identified, Officers should have attended rather than it being passed to the Resolution Without Deployment (RWD) team for telephone contact.

4.8.13 After the homicide, a quick time review was carried out in relation to this incident and a number of emails were sent to Northern Command Officers and Communications Team leaders and managers in response of domestic violence and their responsibilities in relation to this. They were also reminded to always ask the age of the abuser (Michael had just turned sixteen) to determine the right course of action and the notice of the relevant authorities.

4.8.14 In addition, a meeting with Area Command and Communications management was held on 2nd December 2015, and four issues were identified in relation to the incident. These were that it was opened with a crime code but then switched to Resolution Without Deployment, which was not in line with Communications guidance; it was not identified as domestic abuse but as a frustrated parent dealing with a difficult son who had medical issues; the situation did not fit with force policy in relation to the submission of an Adult Concern Notification (ACN); and the individual call handler lacked empathy and soft skills and low level of service.

4.8.15 As a result of this meeting the following actions were identified and an urgent action plan implemented to record and monitor the recommendations.

- Communications policy to be reviewed in relation to incidents opened with a crime code.
- Training to be delivered around domestic abuse identification when the incident involves sons/daughters and aggravated by medical issues.
- Submission of CCNs and ACNs to be reviewed when incidents involve parents 'not coping' and when medical issues are a compounding factor.
- The individual call handler to be spoken to re lack of empathy, soft skills and low level of service. This latter point was completed by December 2015.

4.8.16 Had the incident been recognised appropriately as domestic abuse this should also have resulted in an Officer attending and completing the MARAC (Multi Agency Risk Assessment Conferences) DASH risk assessment with Sarah. As it would have been the first reported incident and there were no physical injuries or damage to the property reported, the IMR author identified that, even using professional judgement, it was unlikely that Sarah would have been assessed as high risk. However, had Sarah herself identified the history of concerns when completing the risk assessment then this could have have resulted in her being assessed as high risk.

4.8.17 The IMR author also identified that within the above there are implications for working and training around parents and children with disabilities and mental health illnesses. This is needed to enhance the recognition of the effects and impact on the carer and wider family as well as the consideration of this on risk assessments and support mechanisms.

Conclusions regarding Northumbria Police's involvement

- There was evidence of good practice in the level of contact and action taken from the allocated Neighbourhood Policing Team Officer in relation to the issues of Anti-Social Behaviour. There was also good liaison around this with Homes for Northumberland.
- The ASB incidents should have also been considered as a potential hate crime and as a result his raises questions about awareness, knowledge and training of identification of Hate Incidents & Hate Crime; particularly in cases where the

incident/crime is not immediately apparent as such and involves Officers viewing the incidents within a wider context.

- There was a missed opportunity to submit a CCN after the 999 call on 9th October 2014.
- The incident on 31st October 2015, when Sarah called the Police regarding Michael's behaviour, should have been recognised as a Domestic Abuse incident. The failure to do so, led to it inappropriately resulting in Resolution Without Deployment. This meant that Sarah was not seen and there was a missed opportunity for further enquiry and the DASH risk assessment to be undertaken which may also have led to further support and/or multi agency referral such as MARAC.

Recommendations identified within Northumbria Police's IMR:

- To raise awareness of and ensure adherence to the Policies & Procedures in relation to Child Concern Notifications, Domestic Abuse & Hate incidents.
- Implement case audit process with regards to Hate Incidents & Hate Crime, Domestic Abuse incidents and Child & Adult Concern Notification submissions.
- Ensure Resolution Without Deployment model has a Policy & Procedure in place which includes when and in what circumstances (RWD) is appropriate.
- Review intelligence management to ensure that when a particular department receives information/intelligence, which concerns matters outside of their remit, that a system exists in order to pass this to the relevant department for actioning.

4.9 **NCC Housing Services**

4.9.1 Sarah's contact with Housing Services was limited and solely in relation to her Homefinder application. Within this contact she was not identified as experiencing domestic abuse.

4.9.2 The Northumberland Homefinder application form asks the applicant to identify the reasons for moving from a list of reasons with check boxes that have to be ticked. When completing the housing application Sarah had indicated the reasons for requiring re-housing were 'experiencing harassment' and 'problems with the neighbours'. The box 'experiencing domestic violence' was not checked. As a result, this did not flag the risk posed to Sarah from Michael.

4.9.3 However, in the housing application, Sarah did make reference to involvement with the Police and someone from the Council's Community Safety Team. The IMR author identified that further enquiries were not made with them to determine the level of risk posed to the family by the neighbours. As such the assessment was based purely upon the information provided on the application and the supporting documents. Additional information being sought may have resulted in an assessment of increased risk, which may in turn have increased the banding award for the family, resulting in an earlier

opportunity for re-housing. There is nothing to indicate however that this would have impacted in terms of the risk posed to her by Michael.

4.9.4 It is unlikely however that even if further information had been sought this would have identified the specific risks around domestic abuse, given that the source of such further information would have been the Police, who themselves had not identified such a risk.

Conclusions regarding NCC Housing Services involvement

- Housing Services had extremely limited involvement with Sarah and her family during the period of the review.
- No information was known about domestic abuse or the risk posed to her by Michael, as Sarah did not identify this on her housing application form.
- Sarah had requested a move based on the problems she was experiencing with her neighbours.
- As Sarah identified the involvement of the Police and Community Safety, more information could have been sought from them which would have contributed to the assessment of risk relating to the neighbours. This may have resulted in Sarah having higher priority for re-housing, although there is no evidence that this would have impacted in terms of the specific risks being addressed within this DHR.

Recommendations identified within NCC Housing Services' IMR:

- Learning from this case will be disseminated to the Homefinder Registration and Assessment team through a learning event in their next team meeting (which took place on 09/05/16). This will discuss the opportunities for improved investigation and questioning of information provided on applications and increased information sharing to help in the assessment of risk and need.
- A review of the Northumberland Homefinder application form will be completed to determined if it is possible to help support applicants to self-assess their circumstances and determine if they are victims of Domestic Abuse where they may not view themselves as such.
- Outcomes from this training will be monitored through regular case reviews on a 1 to 1 basis with team members, with any common themes and good practice.

4.10 **North East Ambulance Service (NEAS)**

4.10.1 The only relevant involvement NEAS had was on the date of the homicide. In relation to the 999 calls placed, following the initial call placed by the Police while on route, an ambulance response was generated. Following the update from the Police and once on scene, the call response is upgraded and an ambulance was dispatched and arrived on scene twelve minutes thirty seconds after the initial call.

4.10.2 The IMR author identified that all calls received are triaged via NHS Pathways, which is a suite of clinical content assessments for triaging telephone calls from the public, based on the symptoms they report when they call. The author concluded that in this case the response was appropriate based upon the information provided during the calls from the Police. This has been verified by the Clinical services Manager responsible for the EOC call handlers. On arrival the crew assessed and examined Sarah as per protocols and completed the necessary documentation.

4.10.3 Due to the very limited involvement of NEAS no learning or recommendations were identified.

4.11 Equality and diversity issues

4.11.1 As part of the review process, consideration was also given throughout to issues of equality and diversity. In the case of Michael and his family, no specific issues were identified in relation to religion or sexual orientation. It was noted however that Michael's age and gender may to some extent have impacted in the way in which the case was responded to by agencies, primarily by nature of the relationship between perpetrator and victim, and him having been a child at the time of his contact. In addition, the vulnerability of both Sarah and Michael has been significantly demonstrated. These issues have been discussed where relevant throughout the report.

4.11.2 It was also noted that Michael was of dual heritage, with information from the GP indicating that his father was black Zimbabwean. None of the IMRs identified that Michael's race or ethnicity was seen to have impacted in relation to either his vulnerability. There were no occasions on which it was identified that this was, or should have been, actively considered in relation to agency contact and responses. This was however considered further within Panel discussion, to ensure that all agencies were confident that any issues of race were given full consideration and that this in no way impacted in relation to agency responses. All Panel members confirmed that this had been actively considered in their review of practice.

5 LESSONS LEARNED AND CONCLUSIONS

5.1 In undertaking this review of the events and actions that occurred leading up to the tragic death of Sarah, a devastating picture has emerged of a woman, and her family, trying to support and protect her young son as his mental health, and associated behaviour, deteriorated.

5.2 Sarah's contact with agencies demonstrated a mother devoted to her son, who, with the help of her own parents, fought hard to provide a safe environment for him, whilst also managing her own health difficulties and maintaining two jobs. As Michael's behaviour worsened, the increasing despair of the family can be seen as they tried to make agencies understand the depth of their concerns and the difficulties they were having in managing these. Despite these attempts, focus was often placed by agencies on Sarah's parenting and the need to control Michael's behaviour, even when his presentation clearly demonstrated increasing risk, and indicated that the interventions needed were beyond those of behaviour management.

5.3 Michael's difficulties had presented from an early age and it has been highlighted that, prior to the period of this review, there were delays and often a lack of consensus or clarity regarding diagnosis. As Michael grew, his behavioural difficulties escalated, with signs of psychosis becoming apparent throughout 2015. Seen within this was his belief that he was a demon, and his obsession with killing and death. Such thoughts may also have been exacerbated by his obsession with 'dark' internet websites.

5.4 As the situation deteriorated, both Michael's self-harm and the increasing risk to Sarah can be seen. Reports of abuse and assaults by Michael increased and included him swearing at his mother, hitting her, throwing things at her, grabbing her by the throat, threatening her with a knife, and stating that he was going to kill her. This culminated in the tragic events of November 2015, in which Sarah's parents lost their child at the hands of their mentally unwell grandson; who, once he is well, will also have to come to terms the devastating impact of his own actions.

5.5 In reviewing agencies contact with Michael and Sarah, what has emerged is a picture in which there were a number of failings and inadequacies that left Sarah and her family vulnerable, and without a coordinated and robust plan by agencies to manage the risks posed by Michael. As a result, a number of lessons to be learned have been identified throughout this report and are summarised below.

5.6 **Inadequate assessment and treatment of Michael's mental health.**

5.7 As has already been outlined in detail, NTW's response to Michael's mental health was identified as inadequate in relation to his assessment, care and

treatment. This included delays in early assessment of presenting concerns, lack of care coordination, and a failure to recognise and actively treat the emergence of psychotic features. Within this there was also a lack of adequate risk assessment and management, a theme which was mirrored in other agencies' responses.

5.8 **Failure to identify domestic abuse, specifically Adolescent to Parent Violence and Abuse, and to fully recognise the risk posed by Michael.**

5.8.1 Throughout the review period, and particularly in 2015 as Michael's mental health deteriorated, it has been identified that there were numerous incidents of concerns or disclosures regarding Michael's aggressive, threatening and violent behaviour, primarily towards Sarah. Not only was this behaviour described, but also the family's fear of Michael directly expressed. Few of the disclosures made were actioned by the undertaking or updating of risk assessments and risk management plans, alerting other agencies to the concerns, or the making of Safeguarding referrals. In addition, within CSC, when referrals were made or concerns expressed directly by Sarah, decisions were not taken to escalate management of the case to statutory involvement. While some information sharing was seen, this was often sporadic and left an overall incomplete picture.

5.8.2 This failure to fully recognise the risk has been identified by agencies to have been influenced by a number of potential factors. Firstly, it was seen that there was at times a 'medicalisation' of Michael's behavioural problems, seeing them as a result of his ADHD, and resulting in a focus upon behaviour management. This can be seen in the repeated references by both NTW and CSC to parenting strategies, referrals to parenting groups, and reference to Sarah's inability or unwillingness to put controls in place. This is also perhaps reflected in the school's belief that Michael's behaviour was not of concern in school, and therefore that an Early Help Assessment was not needed. Within these responses there was evidence of a lack of recognition of both the extent to which Sarah and her mother had already engaged with parenting support, and Sarah's reports that she was finding controls difficult to implement due to Michael's increasingly violent behaviour, and her fear of what he may do.

5.8.3 Secondly, the impact of Michael's age and his relationship with the primary target of his abusive behaviour can be seen, and is demonstrated by the fact that no agency recognised the context as one of domestic abuse. The nationally used definition of domestic abuse is 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'. While this definition does highlight familial violence, it nevertheless focuses on those aged 16 or over and perhaps does not therefore prompt practitioners to consider the wider implications of child to parent violence.

5.8.4 In relation to this, the first large scale study of Adolescent to Parent Violence and abuse (APVA) in the UK was conducted by the University of Oxford between 2010 and 2013 (Condry and Miles). Practitioners and parents interviewed in this study described the abuse as often involving a pattern of aggressive, abusive and violent acts across a prolonged period of time. As well as physically assaulting their parents, those interviewed said their teenage children had smashed up property, kicked holes in doors, broken windows, had thrown things at their parents and made threats. Verbal abuse and other controlling behaviours were also commonly present. Within this statistical information from the Metropolitan Police Service was also used and all reported incidents of adolescent to parent violence, where perpetrators were thirteen to nineteen years old, were considered over a one year period. Within this, 77% of all parent victims were seen to be female, and 87% of perpetrators male; while 66% of all cases involved son to mother violence. A new Home office document: 'Information guide: adolescent to parent violence and abuse (APVA)' recognises the complexities of these cases and provides guidance for all agencies. The guide recognises that there is currently no legal definition of adolescent to parent violence and abuse, although sites research indicating that this is an increasingly recognised as a form of domestic violence. The document also contains a wealth of guidance for frontline practitioners.

5.8.5 This case has highlighted the need across all agencies for an increased awareness of Adolescent to Parent Violence and Abuse, and for it be considered as a form of domestic abuse. In addition, it highlighted the lack of clear referral pathways in such cases, where MARAC criteria would not be met. As such a number of both local and national recommendations were identified.

National Recommendation

Home Office/Safelives to consider the current definition of domestic abuse and the age criteria for referral into MARAC, in light of the learning from this review, and identify whether this can be amended to reflect issues in relation to APVA.

Local recommendation 1 (for all agencies involved in the review):

All agencies to ensure that the Home Office document relating to APVA is disseminated to all relevant staff, and that the key learning and guidance within this is incorporated into relevant existing training around domestic abuse, Safeguarding, risk assessment and management.

Local recommendation 2:

Safer Northumberland Partnership to coordinate a piece of work to identify the most appropriate referral pathways in future cases of APVA, and for this

information to be disseminated to staff within all agencies.

5.9 **Lack of care coordination, full information sharing and a robust multi agency approach to risk management.**

5.9.1 It has been seen that multiple agencies were involved with Michael and Sarah and information sharing between them did take place. However, this was often sporadic and resulted in no one agency holding the full picture.

5.9.2 The lack of appropriate risk management and response to concerns can be seen, in part, as a direct result of the lack of recognition and assessment of the risk and therefore failure to consider the need for risk management actions including Safeguarding referrals, or referral to other risk management processes for Michael or Sarah. However, in addition to the lack of recognition of the risk, it would also appear that there were occasions when agencies presumed that others agencies were already aware of the risk, or that such agencies were managing it. As a result, further or repeated concerns were not always shared or raised as potential Safeguarding issues. Had this occurred however the extent of the concerns would have been more starkly highlighted, and may have contributed to an escalation of responses.

Local recommendation 3 (for all agencies involved in the review):
All agencies to ensure that all relevant staff are aware of the need to consider Safeguarding referrals, even when other agencies are already involved or it is believed concerns have already been raised.

5.9.3 Discussion also took place within the Panel as to whether Northumberland's Risk Management Group (RMG) would have been an appropriate place to refer Michael had the increasing risk been correctly identified. The RMG is a multi-agency group that considers those young people at high risk through issues such as self-harm, exploitation etc. It was identified that Michael did not meet the standard profile, but that he would likely have been considered if he had been referred and the concerns shared. However, given that he did not meet the standard profile this did raise questions about whether, even if the risk had been fully identified, agencies would have known they could refer. This should be addressed within work undertaken through recommendation 3 to consider appropriate referral pathways.

5.9.4 A further area impacting upon the lack of robust risk management was the lack of care coordination. As the primary agency engaged with Michael, NTW had identified the need for a care coordinator. However as has been demonstrated, due to staff sickness and a lack of response to this, he was left for five months with no active care coordinator. This led to the lack of a robust approach to the management and coordination of his medication and the increasing concerns regarding his behaviour.

5.9.5 Similarly, within CSC, whilst a Lead Professional was allocated, they were not always recognised or responded to as such, and this was demonstrated through the fact that they were not always consulted for information in the decision making process, including not being invited to meetings.

5.9.6 Such a lack of coordination may also have contributed to the fact that when information sharing did take place, it was often haphazard and limited. Examples can be seen when referrals were made to CSC and decisions were made without contact with all key professionals involved including those within internal services i.e. between DCN and CST; in NTW when risk assessments were completed without consulting other agencies; and concerns that were raised being shared with some agencies and not others. Even within the more formal multi-agency process of the TAF meeting, there were gaps identified in the information sharing. This included agencies either not being invited or agencies not attending, and a lack of follow up in the sharing of the outcomes of these meetings. In addition, it was noted that none of the agencies reported any of the disclosed assaults to the police, despite constant advice from NTW and CSC to Sarah to contact the police. In addition, while both CSC and NTW identified that Sarah calling the police was the way in which the risk was to be managed, neither informed the Police of this and supplied them with relevant information, which would have informed, and perhaps influenced, their subsequent actions when Sarah did call them on 31st October.

Local recommendation 4 (for all agencies involved in the review):
All agencies to ensure that where other agencies are identified as part of a strategy to manage risk, full and appropriate information is shared to the relevant agency to ensure an appropriate response.

5.9.7 All of the above led to many agencies working with partial pictures both of the risk, but also of who else was involved and what was being undertaken to manage the risk. All agencies have made recommendations within their own IMRs to address these gaps but the importance of this must be stressed, as it has been a lesson learned within many recent local reviews. All agencies should consider the extent to which they ensure that cases are managed in such a way as to identify all other agencies involved, and set up systems for the clear sharing of information.

5.10 **Lack of full exploration of concerns being raised by the family, and lack of consideration given to further support that they may have needed.**

5.10.1 A significant feature revealed by this review was the wealth of information provided by Sarah and maternal grandmother. As has been outlined such concerns were not always appropriately acted upon, and there appears to have been limited attempts to explore them further. During interview for this review, Sarah's parents also expressed how during Michael's appointments

with health services, they often did not have time to talk to health staff alone, thus resulting in limited opportunities for an even fuller picture of the risk to be shared. In addition, there is little evidence of any attempts by agencies to consider further support that Sarah or her mother may have benefitted from, outside of contact with agencies whose primary role was in relation to Michael. There was also a great emphasis given to Sarah exerting parental control and putting boundaries in place, despite the information she was provided that clearly demonstrated her to be a victim of abuse at the hands of her son. These issues were highlighted by the absence of any form of carers' assessments being offered, or signposting to third sector support agencies.

Local recommendation 5 (for all agencies involved in the review):
All agencies to review current practice to ensure that parent's views, and those of other relevant family members or carers, are taken into account within assessments, that they are being offered the opportunity to be seen alone, and that carers' assessments and/or signposting or referral to support services are being offered.

5.11 **Michael's 'invisibility'**

5.11.1 Throughout this review a lot of information has emerged regarding the circumstances leading up to Sarah's death, however much of this relates to Sarah, her family, and professionals' perspectives. What is noticeably absent is Michael himself. It has been identified that he was not see by his GP during the period of the review, and no proactive attempt was made to bring him in despite much information from other health services being shared with the GP. In addition, throughout CSC's contact Michael was present at only 30 out of 58 visits. Even in those agencies where Michael was seen directly, such as NTW, there is little evidence within recordings of Michael's perspective or views having been sought to inform assessments and interventions.

5.11.2 While it is recognised that Michael may not have been easy to engage it is critical that any assessments relating to the well-being and/or behaviour of a child, seek that child's view and make them central to the assessment process.

Local recommendation 6 (for all agencies involved in the review):
All agencies working directly with children to ensure that workers are equipped with skills and tools to actively seek and record the views of children and to incorporate these into assessments and accompanying plans. To ensure also that those providing supervision for staff robustly challenge whether children's views have been sought and recorded.

5.12 **Lack of consideration given to the interplay between Michael's behaviour and his internet use.**

5.12.1 Within a number of agencies involvement reference was made to Michael's use of the internet, in particular his use of the CreepyPasta website. Research undertaken for this review, revealed this to be a website associated with previous tragedies in America, including when a young girl in Indiana stabbed her stepmother to death, supposedly at the behest of CreepyPasta character; and when two Wisconsin 12-year-olds stabbed their 12-year-old friend nineteen times, and later stated that they were trying to kill the girl in homage to another fictional character on CreepyPasta.

5.12.2 While much discussion took place about the impact of this website on Michael, it was recognised that despite the reports to a number of agencies, no specific exploration took place as to what exactly the website was in order to understand the potential impact on Michael's behaviour. In particular, NTW identified that this resulted in no consideration of the potential interplay between the website and his psychosis.

5.12.3 Within the above it can be seen that, despite concerning presentation in which Michael made reference to his use of this website, little consideration seems to have been given to the potential impact of this. The Panel considered whether potential issues of radicalisation had been considered and whether workers were fully aware of the potential impact of exposure to certain internet content may have on a vulnerable young person such as Michael.

Local recommendation 7 (for all agencies involved in the review):
All agencies to ensure appropriate training is provided to staff regarding the potential risks associated with internet use, particularly in relation to the interplay with mental health issues, vulnerability and issues of radicalisation. To ensure that such consideration of such issues are prompted in any risk assessments undertaken.

5.13 **Could Sarah's homicide have been predicted or prevented.**

5.13.1 Much evidence was revealed to this review to suggest that in the year leading up to Sarah's death there was a steady escalation in Michael's aggressive and violent behaviour, particularly towards Sarah, and a concurrent worsening in his mental health, including increasing indicators of psychosis. This included ideation around killing and death, and reported threats that he would kill Sarah. In addition, Sarah and her family expressed their fear of Michael. A number of agencies, particularly NTW, had sufficient information to indicate an increasing and very real risk. Had full and robust risk assessments been carried out, including the gathering of information from

other sources, it is likely that the potential for serious harm or death could have been predicted, and Sarah identified as a potential victim.

5.13.2 It has also been identified that there were a number of missed opportunities in which risk was not recognised, full assessments were not taken, full information sharing did not take place, and referrals were not made. As a result, no sufficiently robust multi agency risk management plans were put in place. Had these opportunities been taken and more robust intervention occurred, while the exact impact cannot be known, it is reasonable to conclude that death of Sarah may have been preventable, particularly had Michael received appropriate interventions for his psychosis.

6 SUMMARY OF RECOMMENDATIONS

6.1 A number of specific agency recommendation have arisen either through completion of IMRs or as a result of the overall review process; these are summarised below. In addition however, the key learning points that have arisen are relevant for all agencies working with potential victims and perpetrators. In light of this it is recommended that all agencies consider existing procedures and staff training to ensure that the key lessons learned from this review are fully incorporated and embedded in practice.

6.2 Summary of recommendations arising from this review

National Recommendation

Home Office/Safelives to consider the current definition of domestic abuse and the age criteria for referral into MARAC, in light of the learning from this review, and identify whether this can be amended to reflect issues in relation to APVA.

Local recommendation 1 (for all agencies involved in the review):

All agencies to ensure that the Home Office document relating to APVA is disseminated to all relevant staff, and that the key learning and guidance within this is incorporated into relevant existing training around domestic abuse, Safeguarding, risk assessment and management.

Local recommendation 2:

Safer Northumberland Partnership to coordinate a piece of work to identify the most appropriate referral pathways in future cases of APVA, and for this information to be disseminated to staff within all agencies.

Local recommendation 3 (for all agencies involved in the review):

All agencies to ensure that all relevant staff are aware of the need to make Safeguarding referrals, even when other agencies are already involved or it is believed concerns have already been raised.

Local recommendation 4 (for all agencies involved in the review):

All agencies to ensure that where other agencies are identified as part of a strategy to manage risk, full and appropriate information is shared to the relevant agency to ensure an appropriate response.

Local recommendation 5 (for all agencies involved in the review):

All agencies to review current practice to ensure that parent's views, and those of other relevant family members or carers, are taken into account within assessments, that they are being offered the opportunity to be seen alone, and that carers' assessments and/or signposting or referral to support services are being offered.

Local recommendation 6 (for all agencies involved in the review):

All agencies working directly with children to ensure that workers are equipped with skills and tools to actively seek and record the views of children and to incorporate these into assessments and accompanying plans. To ensure also that those providing supervision for staff robustly challenge whether children's views have been sought and recorded.

Local recommendation 7 (for all agencies involved in the review):

All agencies to ensure appropriate training is provided to staff regarding the potential risks associated with internet use, particularly in relation to the interplay with mental health issues, vulnerability and issues of radicalisation. To ensure that such consideration of such issues are prompted in any risk assessments undertaken.

NTW

Recommendations identified by the Independent Investigator will be further developed with NTW and detailed in a robust action plan. In summary, recommendations are as follows:

Care Coordination, multi-agency working and care planning.

- NTW re-acquaint staff with the existing policy on Care Coordination in order to understand the organisation's and their own professional responsibilities in the assessment, planning and implementation of an appropriate package of care. An essential pre-requisite of this recommendation is an assurance that all staff fully understand what the policy advises with regards to Multi-agency assessment, specialist interventions and the practice of Care Coordination.
- Agreed interventions within care plans are evidence based and fulfil SMART criteria. For this to be inclusive it is imperative that all professionals are aware of the importance of involving the family / Carers at all stages of the process.
- NTW provide assurance that recording and communication practices are adhered to most notably in the context of updating records, developing and communicating formulations, care plans, risk management plans and review processes.

Risk Assessment and Risk Management planning

- At the very least staff are reacquainted / re-trained in the various elements of the Clinical Risk Assessment and Management Strategy with particular reference to understanding the principles of a structured clinical approach to risk behaviours.
- NTW plan how they intend to provide staff with the knowledge to practice in the area of Risk assessment and management with special regard to not only the processes but the current evidence base related to Assessment, Management and mitigation of risk behaviours.
- In line with the above recommendations, communication practices reflect the need to constantly reassess and re-evaluate risk management practices and that professionals practice should reflect these. This, it is recommended would contribute to reviewing and improving the quality of care provided.

Prescribing practices, Diagnosis and Mental Health Assessment.

- There was clear evidence, especially from the assessment and implementation information available that questions were raised with regard to developing a diagnosis and the effect on care packages, the potential implications of prescribing practices and monitoring, and Mental State examination and review. At this stage the Investigator had not had the opportunity to have the views of a psychiatrist on this, but this process was planned to occur in the months following the report.

NCC Children's Social Care

- Within the review of training, outlined with the IMR recommendations, CSC should ensure that staff are aware of the need to act upon reported incidents of violence and abuse through the undertaking of appropriate risk assessments, referral to appropriate risk management procedures, and consideration of the need to share such information with other agencies.
- To review procedures relating to the feedback of information following multi-agency meetings, including TAF, to ensure that feedback is disseminated to all those actively working with the case.

NCC Education & Skills (Wellbeing and Community Health Services Group)

- Where concerns are known regarding the home environment, the school should identify how this can be addressed within the school environment and attempts made to engage the young person and his family.

Northumberland CCG

No additional recommendations identified.

Northumbria Healthcare NHS Foundation Trust (NHCFT)

No additional recommendations identified.

Northumbria Police

No additional recommendations identified.

Housing Services, Northumberland County Council

No additional recommendations identified.

NEAS

No additional recommendations identified.

6.3 **Individual agency recommendation identified within IMRs**

NTW

- The CYPS service will review their safeguarding responsibilities to assure themselves that they are fulfilling their requirements within trust safeguarding and public protection policies and are receiving advice supervision and support when required.
- Review current practice with regard to the Early Help agenda.
- A clinical review of a sample of x cases of children, who are seen within the ADHD clinic and have additional needs that require Care Co-ordination have a care co-ordinator who has the skills to meet their needs.
- Specialist Care Triumvirate Management Team should further review the clinical practice of those individuals identified by the Investigating Officer and clinical advisors to ensure that the early interventions already initiated in the process of undertaken the review are sufficiently robust to ensure patient safety.
- All community CYPS practitioners will be offered a specific workshop with a focus on assessing and managing risk to others and factors impacting on decision making.
- The CYPS service will review their responsibilities to support parents in their caring role to assure themselves that parents' needs are met and that staff responsibilities to report acts of domestic violence are understood.
- Review current practice with regard to prescribing within team and adherence to guidance.
- NTW should review their position relating to post incident contact with family members following homicide with immediate effect to ensure consideration and decisions on a case by case basis. This should have regard for the police support framework provided through Police liaison officers.

- The outcome of this investigation should be made available to the patient's grandparents and an apology offered regarding shortfalls in the provision of appropriate standards of care and treatment.
- To ensure that appropriate training is available and the systems for escalation are understood.

NCC Children's Services

- Children's social care and adult safeguarding to raise awareness and widely distribute the Home Office guidance regarding Adolescent to Parent Violence and Abuse (APVA) and request that this is disseminated within teams, discussed at team meetings, team briefs and referenced at relevant training. The Home office document will be available on the NSCB and Adult Safeguarding websites.
- Children's social care and adult safeguarding to implement a clear procedure and pathway to ensure that all referrals regarding adolescent to parent violence and abuse are responded to appropriately and consistently, identifying the risks around domestic violence, to ensure that the adult victim is safeguarded and protected and that the most appropriate assessment, intervention and multi-agency support is in place to safeguard, protect and support the child or young person and their family.
- The Home Office guidance regarding Adolescent to Parent Violence and Abuse (APVA) to be incorporated into the Single Point of Access (SPA) procedure and pathway to reflect the learning from this review and support a consistent, timely and appropriate response regarding adolescent to parent violence and abuse.
- The Disabled Children's Team should review the role of the Enquiry and Referral Administrator and duty Social Worker within the team, to include clarity and expectations around the duty Social Worker role in attending Team around the Family meetings and Transitional School Review meetings.
- To review the purpose of the Transitional Database held within the Disabled Children's Team.

NCC Children's Services Recommendations for NSCB

- The NSCB will review and revise the early help procedures and guidance to include the following key elements:

    - The threshold for undertaking an Early Help Assessment; to include an escalation policy, for all professionals, linked to the updated multi-agency Thresholds Document. The escalation policy should cover the opening, stepping up/down and closing of the case and should include seeking guidance/supervision and exercising professional judgement.

    - The role of the Lead Professional and the contribution and expectations of the Team Around the Family.

- Agreement that NTW, where appropriate, will take on the role of the Lead Professional.

- The visiting frequency of the Lead Professional and other relevant professionals, to include planned and meaningful direct work with the child or young person.

- The Early Help Assessment, plan and reviews, to include: the duration of the Early Help Assessment, linking with the escalation policy.

- The role of the Team Around the Family meeting, including multi-agency attendance, information sharing, professional contribution, timely and smart actions and the distribution of minutes.

- The formal supervision arrangements in place for the Lead Professional and members of the Team Around the Family to include: the frequency of formal supervision, reflection and professional challenge, the role of the Lead Professional's line manager in chairing Team Around the Family meetings, where progress is not being achieved or sustained within 6 months.

- The Early Help Module: to ensure that this is fully compatible with the statutory social care module, so information can to be accessed and reviewed between the Early Help and statutory social care elements of ICS. The Early Help Assessment template and Early Help module on ICS should incorporate a chronology that is used in order to capture and analyse the key events and the child's journey and experience.

- To review the single and multi-agency training that is available to Children's Services staff regarding domestic violence, to ensure that this includes adolescent to parent violence and abuse, mental health and self-harm to ensure that lessons learned from this case are incorporated.

- To explore multi-agency training with NTW to ensure a greater understanding of the role of professionals and interventions within NTW.

- Once the current review of the Suicide and Self Harm Pathway is complete, key messages from this DHR and for the Suicide and Self Harm pathway to be re-launched with training for all Children's Services staff.

NCC Education & Skills (Wellbeing and Community Health Services Group)

- It is not clear whether staff at the school were aware that domestic violence may have been taking place. Training staff in spotting the signs of domestic abuse (for victims and perpetrators) may mean that in future cases appropriate agencies can be informed more quickly and with greater certainty.

- Whilst the record-keeping of the school was very detailed the school should ensure that a single management system is used to collect all information regarding incidents linked to students, rather than in separate behaviour logs. This may aid the spotting of behaviour patterns in future.

- The school should also ensure that relevant information is shared systematically between staff within school and with outside agencies. A multi-agency approach to the most suitable way to achieve this is required. Consideration of who is responsible for collating such information is necessary.

- The school should consider a formal recording of conversations with parents/carers to aid the transfer of relevant and timely information between staff within school and outside agencies.

- On two occasions (10 December 2014 and 10 July 2015) the school did not receive any formal communication regarding outcomes from multi-agency meetings that had taken place. Whilst the responsibility for distributing those outcomes lies with the host of the meeting, the school may consider an internal process that follows up missing communications. This would ensure the school always has a full picture of activities undertaken by other agencies which may impact upon the school.

- The school may wish to instigate a process by which they ask parents for a summary of how each child has been during the summer holidays. This may flag up any changes in behaviour or attitude that may impact upon school performance.

Northumberland CCG

1. All GP's and practice nurses should have an increased awareness of Domestic Abuse (DA) and Adolescent to Parent Violence and Abuse(APVA)

   All Single Agency Training (SAT) provided for primary care staff should include recognition of children as perpetrators of domestic abuse. This case should be discussed to illustrate this.

2. Improve GP awareness and understanding of children with mental health issues registered with the practice.

   Circulate a list of child mental health codes to all GP practices and highlight the issues regarding GP record coding from this case. This should be done via an alert and through SAT.

3. GP practices to broaden the scope of existing safeguarding ('Supporting families') meetings to discus cases that involve children who are known to be violent and/or aggressive.

To be shared at GP Network and incorporated into all SAT as a case scenario. GP practices may consider inviting health professionals such as mental health workers to attend 'Supporting Families' meetings where appropriate. Raise awareness of 'Supporting Families' meetings with other agencies in order for them to link in to the 'Think Family' approach.

4. All children with serious mental health issues should be visible within the GP practice and their thoughts and wishes (as well as those of their families) documented. This good practice should be visible in the child and family GP records.

GP Practices to audit the contact they have with children that are known to them with serious mental health diagnoses including those with violent and aggressive behaviour. These children should have appropriate and regular primary care 'face to face' contact. These mental health reviews should incorporate their physical, mental, social and safeguarding circumstances. This information should be clearly documented in the GP records.

5. Where a patient discloses fear of or actual violence perpetrated by someone known to them, this should be documented with a clear plan of action.

This should be included in SAT, briefings and via an alert.

6. GP's should take appropriate action when it is known a child or adult is accessing illegal, harmful, abusive or particularly violent web sites on the internet including those involving radicalisation. GPs may need to discuss their concerns with other agencies or even make referrals into Safeguarding if it is agreed that there is concern about the welfare of the child, their family, or the public.

Health WRAP training for all GPs and practice nurses to raise awareness of the Government 'Prevent' programme. In order to support GP practices with their role and responsibility with regards to preventing children from online exploitation, information about the Child Exploitation and Online Protection Centre (CEOP) 'thinkuknow' programme should be circulated to all GP practices, with specific reference to the available online training 'Keeping Children Safe Online (KCSO)'.

7. GP's should not make assumptions regarding the care of any of their patients without establishing the facts. This could involve speaking directly to the patient, their family and lead professional involved. This must include regular updates.

This will be covered using case examples during SAT and GP network meetings as a theme.

Northumbria Healthcare NHS Foundation Trust (NHCFT)

- Changes made to training and guidance to ensure practitioners have a greater understanding of Domestic abuse in its wider context and be able to support those identified at potential risk of harm.
- Health psychology has access to all information pertaining to their clients which may be held in main hospital records or on alert systems.
- Health psychology to ensure cases involving concerns with children are discussed with peers and advice sought from Safeguarding Children team.
- Health psychology can evidence cases discussed during supervision and actions agreed. Peer supervision session for Paediatricians to include discussion about long standing chronic cases.

Northumbria Police

- To raise awareness of and ensure adherence to the Policies & Procedures in relation to Child Concern Notifications, Domestic Abuse & Hate incidents.
- Implement case audit process with regards to Hate Incidents & Hate Crime, Domestic Abuse incidents and Child & Adult Concern Notification submissions.
- Ensure Resolution Without Deployment model has a Policy & Procedure in place which includes when and in what circumstances (RWD) is appropriate.
- Review intelligence management to ensure that when a particular department receives information/intelligence, which concerns matters outside of their remit, that a system exists in order to pass this to the relevant department for actioning.

Housing Services, Northumberland County Council

- Learning from this case will be disseminated to the Homefinder Registration and Assessment team through a learning event in their next team meeting (which took place on 09/05/16). This will discuss the opportunities for improved investigation and questioning of information provided on applications and increased information sharing to help in the assessment of risk and need.
- A review of the Northumberland Homefinder application form will be completed to determined if it is possible to help support applicants to self-assess their circumstances and determine if they are victims of Domestic Abuse where they may not view themselves as such.
- Outcomes from this training will be monitored through regular case reviews on a 1 to 1 basis with team members, with any common themes and good

NEAS

None identified.

Appendix 1: Overview of Services within Agencies

Northumberland, Tyne and Wear (NHS Foundation Trust)

Child and Adolescent Mental Health Services (CAMHS)
Children and Young People's Service (CYPS)

Children's Social Care (CSC)

Children Support Team (CST)
Disabled Children's Team (DCT)

Appendix 2: Abbreviations Key

A&E	Accident and Emergency
ACN	Adult Concern Notification
ADHD	Attention Deficit Hyperactivity Disorder
ADOS	Autism Diagnostic Observation Schedule
ASD	Autism Spectrum Disorder
CAADA	Coordinated Action Against Domestic Abuse
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CCN	Child Concern Notification
CST	Children Support Team
CYPS	Children and Young People's Service (CYPS)
DASH	Domestic Abuse, Stalking and Honour Based Violence risk assessment
DCT	Disabled Children's Team
DHR	Domestic Homicide Review
EHA	Early Help Assessment
EIH	Early Intervention Hub
GP	General Practitioner
MAPPA	Multi Agency Public Protection Arrangement
MARAC	Multi Agency Risk Assessment Conferences
MATAC	Multi Agency Tasking and Coordinating Group
NCC	Northumberland County Council
NEAS	North East Ambulance Service (NHS Foundation Trust)
NFRS	Northumberland Fire and Rescue Service
NHCFT	Northumbria Healthcare NHS Foundation Trust
NTW	Northumberland, Tyne and Wear (NHS Foundation Trust)
TAF	Team Around the Family