

**An independent  
investigation into the  
care and treatment  
received by a mental  
health service user  
(Ms A) from Tees,  
Esk and Wear  
Valleys NHS  
Foundation Trust**



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Niche Patient Safety is an independent management consultancy that specialises in supporting healthcare providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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# 1 Executive summary

## NHS England's Single Operating Model:<sup>1</sup>

In April 2015 NHS England (North) commissioned Niche Patient Safety to conduct an independent investigation into the care and treatment of Ms A and to review the events that led up to the death of Mr O (22 February 2013). We have also been asked to consider whether the incident on 22 February 2013, which led to the death of Mr O, was either predictable<sup>2</sup> or preventable<sup>3</sup>.

Due to the fact that Ms A had a teenage pregnancy, NHS England (North) requested that we review her maternity pathway to consider if the “appropriate level of support was provided during the antenatal and postnatal period”<sup>4</sup>.

Following this incident a domestic homicide report (DHR)<sup>5</sup> was commissioned by York and North Yorkshire Community Safety Board (published in August 2014). NHS England has asked Niche Patient Safety's investigative team to “review the content and findings of the 2013/4 DHR Report, [and] identify any additional key lines of enquiry”<sup>6</sup>.

This report was written with reference to the National Patient Safety Agency's (NPSA) root cause analysis guidance and utilised root cause analysis (RCA)<sup>7</sup> methodology to both review and analyse the information obtained throughout the course of this investigation.

### The incident:

The incident occurred on 22 February 2013 at the accommodation which Ms A was sharing with Mr O. Prior to the incident Ms A, aged 23, and the victim Mr O, aged 32, had been living together for approximately two and a half years. Ms A had a son, aged seven years, who was at the time living with his maternal grandmother.

It was well documented that Ms A and Mr O's relationship was often volatile and at times abusive and that both were victims and perpetrators of incidents of domestic violence. On the day of the incident, both Ms A and Mr O had been drinking alcohol

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<sup>1</sup> NHS England Delivering a Single Operating Model for Investigating Mental Health Homicides (2013)

<sup>2</sup> Predictability is “the quality of being regarded as likely to happen, as behaviour or an event”. We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. <http://dictionary.reference.com/browse/predictability>

<sup>3</sup> Prevention means to “stop or hinder something from happening, especially by advance planning or action” and implies “anticipatory counteraction”; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring. <http://dictionary.reference.com/browse/predictability>

<sup>4</sup> Revised Terms of Reference, 23 October 2015

<sup>5</sup> Published 25 August 2014

<sup>6</sup> TOR, p2

<sup>7</sup> RCA is a retrospective multidisciplinary approach designed to identify the sequence of events that led to an incident

and an argument developed, resulting in Mr O sustaining a single stab wound to the chest. He was declared dead at the scene by paramedics.

At a Crown Court trial, Ms A admitted to the manslaughter of Mr O but was found guilty of murder and was sentenced to prison for a minimum tariff of 16 years.

Summary of background information:

Ms A's mother reported that her daughter was a "loner" who was prone to become withdrawn and depressed and would often isolate herself from her peers. Both Ms A and her mother reported to us that from a very young age she had poor impulse control and a tendency to react aggressively and impulsively to particular events and people without considering the consequences. Ms A reported that from the age of 13 (2004) she was a regular user of both alcohol and cannabis and was also taking amphetamines and sniffing glue. At the age of 14 Ms A received a police caution for harassment<sup>8</sup> following an incident of bullying of a fellow pupil. She was expelled during this year, but it is not clear if this was the result of this incident. Ms A was then placed in a specialist educational facility, which she attended for two to three days a week until the age of 15, when she became pregnant. From the point Ms A became pregnant to the incident in 2013 she was in receipt of benefits.

Ms A's antenatal and postnatal care:

When Ms A became pregnant (2006), it is unclear if she was, at the time, in an ongoing relationship with the baby's father. At the time when the pregnancy was confirmed,<sup>9</sup> the GP documented that Ms A had a history of cannabis and alcohol misuse and was drinking two bottles of wine a day.<sup>10</sup> It was noted at her initial midwife assessment that she had been referred to "teenage pregnancy and has an educational social worker"<sup>11</sup>. However, we could find no evidence within Ms A's maternity notes or her primary care notes that this had occurred. From the evidence that we reviewed, it appears that throughout her ante and postnatal care she was being seen by adult maternity services either at her GP's surgery, where she was often seen by the same midwife, or at the hospital antenatal outpatients unit. On 8 March 2006 the GP documented that a referral was to be made to social services for support for Ms A and that there was "concern"<sup>12</sup> for her unborn baby. It is not documented what the concerns were, and, again, based on the documentation<sup>13</sup> that we have been able to obtain, there is no indication that a referral was made and no indication of either social services or children's services being involved.

Ms A attended all her antenatal appointments and gave birth to a son. She was discharged to her mother's house, where she and her son lived until she moved into

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<sup>8</sup> OASys November 2013: OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the National Probation Service

<sup>9</sup> 6 February 2006

<sup>10</sup> GP notes, 6 February 2006

<sup>11</sup> Antenatal report, 6 March 2006

<sup>12</sup> GP notes, 8 March 2006

<sup>13</sup> Primary care and hospital 1 maternity notes

social housing (2008). From this point she moved on a total of eight occasions, and apart from one social housing tenancy, she lived in either private sector housing or with Mr O's family.

Ms A's custody of her son:

From 2008 Ms A's mother began to report her concerns about her grandson to children's services and she was granted a full residency order (27 October 2010).

Arising issues, comment and analysis:

During Ms A's pregnancy and following the birth of her son she did not engage with any services, such as Sure Start, that are designed to support young mothers both practically and emotionally. In light of the evidence that we have obtained regarding Ms A's historical impulsive behaviours and volatile and at times abusive relationships, this programme, we would suggest, would have been extremely valuable both during her pregnancy and after the birth to help her develop more mature and appropriate responses both to her parenting and in her relationships. There was also no indication if the community or hospital midwives made any attempt to liaise with the teenage pregnancy service or Ms A's GP either during her pregnancy or after the baby was born.

Governmental guidelines<sup>14</sup> and research indicates that all teenage pregnancies have potentially significant and multiple high risk factors, and therefore the midwife service should routinely be liaising with the mother's GP and any other involved services in order to ascertain a full and ongoing medical and psychological history.<sup>15</sup> This enables a more comprehensive identification and monitoring of risk factors for such a vulnerable patient group. The fact that the midwife was seeing Ms A regularly at the GP's surgery provided, we would suggest, the opportunity for direct liaison with the GP, but this did not occur. Ms A had also given her consent for her mother to be involved; we would suggest this was another missed opportunity where important psychosocial information regarding both Ms A and the home situation could have been obtained. Ms A's mother may have also been able to provide some valuable information to the midwife regarding her daughter's alcohol and drug use.

We would suggest that both Ms A's drug misuse and her very recent and considerable alcohol use should have been considered as significant and ongoing risk factors that should have been communicated by the GP to the midwife service. We would also suggest that this should have been monitored throughout Ms A's pregnancy, as both pose very significant risks to the unborn child and the mother.

It was reported to us<sup>16</sup> that since 2006 there have been significant changes in the antenatal assessment processes, such as the introduction of the Vulnerable Mothers Care Pathway<sup>17</sup> and Family Nurse Partnerships.<sup>18</sup> However, midwives still do not

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<sup>14</sup> Department of Health (DH) white paper, *Choosing Health: Making healthy choices easier* (2004)

<sup>15</sup> Department of Health (DH) white paper, *Choosing Health: Making healthy choices easier* (2004), p3

<sup>16</sup> Telephone interview with head of midwife service

<sup>17</sup> Pathway enables professionals to identify where women, children or families are at higher risk of poor outcomes and pregnant women with complex social factors may need additional support

have access to either a patient's GP patient information records or statutory safeguarding agencies' records. They remain solely reliant on information provided by the mother-to-be and their professional observations. We would suggest that this is a significant issue, as there is always the possibility that the mother is an unreliable self-historian, and therefore potential risks to both the mother and the child may be unknown, placing them both at significant risk.

Ms A's relationship with Mr O:

Ms A and Mr O began their relationship in January 2010.<sup>19</sup> The first reported incident of domestic violence between Ms A and Mr O was on 11 February 2010, when Mr O reported to his probation officer that he had sustained a black eye during an argument with Ms A. During a strategy meeting (26 April 2010) it was noted that there was a history of domestic violence between Ms A and Mr O and that they both had ongoing issues with drugs and alcohol. On 17 June 2010 Mr O presented himself to the Urgent Care Centre reporting that his partner had assaulted him while she was intoxicated. Four days later (21 June 2010) Ms A presented herself to her GP, reporting that she was experiencing significant back and chest pain after being attacked. She reported that this attack involved someone pulling her hair. There is no evidence within her primary care notes that Ms A's disclosed or if the GP enquired as to who had attacked her. Police records indicate that they were attended Ms A and Mr O's accommodation on many occasions due to domestic disturbances.

Arising issues, comment and analysis:

The domestic homicide report (DHR) stated that Mr O and Ms A were particularly chaotic individuals who were difficult to engage with, that their relationship was volatile. There were records of eight incidents of violent assault involving Ms A and Mr O and also a number of injuries where it was noted that domestic violence may or may not have been the cause. There were several occasions when police undertook domestic abuse assessments in which Ms A was consistently viewed as the victim. Ms A was offered support by the police's domestic violence unit, but they were either unable to make contact or Ms A refused their support.

Ms A did not disclose any issues of domestic violence to mental health services, but our retrospective analysis indicates that domestic violence was a palpable and ongoing component of Ms A and Mr O's relationship. There is ample evidence to indicate that Mr O and Ms A were both the perpetrators of domestic abuse as well as the victims. The domestic homicide report concluded that the relationship between Ms A and Mr O had many of the dynamics of situational couple violence.<sup>20</sup>

Ms A's forensic history:

Ms A first came into contact with the judicial system when she was 14<sup>21</sup> (2004), when she received a warning for harassment relating to an incident that occurred in

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<sup>18</sup> Family Nurse Partnerships is a voluntary, preventive programme for vulnerable young first-time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two

<sup>19</sup> DHR chronology, 17 January 2010, p8

<sup>20</sup> Situational couple violence is used to identify the type of partner violence that does not have its basis in the dynamic of power and control

<sup>21</sup> 23 May 2004

school. The following year she was convicted in a juvenile court<sup>22</sup> of criminal damage. She received a four-month referral order to a youth offending team. At this time it was noted that she was regularly socialising with known criminals and heroin users. Ms A next came to the attention of the courts in November 2010, when she and Mr O were arrested and charged with theft from a motor vehicle and fraud. This involved stealing a credit card from an unlocked car and spending £990.20. Ms A pleaded guilty. She received a community order and was ordered to pay £445 in compensation and £50.00 court costs. On 2 December 2011 Ms A was arrested for the offence of handling stolen goods. The incident involved Ms A selling some items of stolen jewellery. She pleaded guilty to handling stolen goods and was sentenced to a community order of 12 months (16 March 2012).

At the time of the incident (22 February 2013), Ms A was facing a charge of section 18 wounding<sup>23</sup> relating to an incident that occurred on New Year's Eve (2012), when it was alleged that she had bitten the ear off an individual during a street fight.

Arising issues, comment and analysis:

On no occasion did either community mental health services or probation services seek to gain Ms A's permission to liaise with other involved services. If this had occurred, both services would have been able to obtain a more comprehensive profile that would have deepened their knowledge of Ms A and her difficulties. Such inter-agency sharing of information would have enhanced the identification both of Ms A's risks and of her support needs. As it was, agencies were operating in isolation, and assessments by all agencies were being made based on partial and at times inaccurate information.

Ms A's housing:

In total Ms A moved accommodation on eight occasions, and apart from one social housing tenancy, she lived in a succession of private sector housing. On at least one occasion she and Mr O were evicted due to non-payment of rent, and on another occasion they had to move into Mr O's family home. It was noted that overcrowding was an issue and was contributing to Ms A's mental health issues. One consequence of these multiple moves was that she often had to change her GP and probation services. Ms A's housing difficulties were never highlighted or identified as significant needs or risks within the successive community mental health team (CMHT) FACE assessments<sup>24</sup> or care plans.

Arising issues, comment and analysis:

Securing and maintaining appropriate housing is identified within the Department of Health's strategy 'No health without mental health'.<sup>25</sup> It concludes that inadequate housing and homelessness is a particular issue for people with mental ill-health. It

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<sup>22</sup> 25 November 2005

<sup>23</sup> Section 18 wounding with intent to cause grievous bodily harm

<sup>24</sup> The FACE risk profile is part of the toolkits for calculating risks for young and older people with mental health problems, learning disabilities and substance misuse problems [https://en.wikipedia.org/wiki/FACE\\_risk\\_profile](https://en.wikipedia.org/wiki/FACE_risk_profile)

<sup>25</sup> Department of Health. "No health without mental health: a cross-government mental health outcomes strategy for people of all ages". February 2011 <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

has also been reported that “poor housing conditions and unstable tenancies can exacerbate mental health problems while periods of illness can in turn lead to tenancy breakdown”<sup>26</sup>. In the case of Ms A, it is evident that her poor housing and homeless status was not being identified or given adequate consideration within successive assessments by clinicians; nor was she being provided with adequate support to obtain affordable and secure accommodation. We would suggest that her unstable housing status clearly contributed to the fact that no one agency was able to develop an enduring relationship with Ms A or maintain an overview of her risk, support or psychosocial situation.

Ms A’s psychiatric history:

One of the main difficulties that faced both the primary and community mental health services was that from when Ms A first began to present herself, there was a repeated pattern occurring. She would present herself to her GP, reporting that she was experiencing various mental health issues and at times requesting specific psychiatric medications. She would agree to be referred to community mental health services, but failed to attend either the initial assessment and/or subsequent follow-up appointments. Despite repeated written ‘opt in’ letters and telephone reminders, the usual outcome was that she failed to respond and would be discharged back to her primary care service, only to present herself again, often within a relatively short period of time, asking to be referred once more. Between 2010 and 2013 her GPs made 15 referrals to local CMHT services, requesting assessments and definitive diagnoses to be made, and at times asking for a review of Ms A’s medication.

During this period Ms A was given various diagnoses (persistent dysthymia, borderline personality disorder, anxiety and mood disorders, and bipolar and eating disorders). The most consistent diagnosis was a borderline personality disorder, although at times other problems became the primary concern, especially to the GPs, for example significant weight loss, which she was reporting was due to her ongoing eating disorder.<sup>27</sup> Both the CMHT and Ms A’s various GPs prescribed a number of antipsychotic and antidepressant medications. This was in line with the NICE guidance regarding psychiatric medications, which may impact isolated symptoms and co-morbid conditions associated with borderline personality disorders. It was not clear how compliant Ms A was with various medications; in August 2011 she reported to a CMHT community psychiatric nurse (CPN) that she had been increasing the dosage of her medication (haloperidol), and when she was admitted to hospital in 2012, she disclosed that she had taken excessive amounts of her prescribed medication alongside other drugs (subutex) that she had bought from friends. At times Ms A would report that the previous medication had not significantly improved her symptoms and therefore she had stopped taking it. She would often request certain medication, reporting either that she had taken it previously and that it had had some good effect (haloperidol), or that she believed that it would help her with particular symptoms that she was experiencing, for example insomnia and anxiety. However, as Ms A did not engage with either primary care or community mental health agencies, they were unable to monitor the effects of such medications over a period of time.

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<sup>26</sup> National Housing Federation <http://www.housing.org.uk/policy/health-care-and-housing/mental-health/>

<sup>27</sup> July 2011

During our interviews with Ms A, we asked her why she had so consistently failed to attend appointments with the CMHT. She reported to us that it was never her intention to attend these appointments or take up offers of therapeutic help. She disclosed that she only attended such appointments in order to obtain certain prescription drugs and that she would not take the prescribed dosage but rather use them for recreational purposes. She also reported that she never disclosed the amount of alcohol she was drinking, as she knew that she would not be prescribed medication. Although this does provide important insight into Ms A and her lifestyle, we would suggest that it does not negate the difficulties that she was experiencing in terms of both her mental health and the various issues that she was managing.

Ms A was last seen by community mental health services on 23 January 2013. A full set of assessments was undertaken. In the mental health clustering tool assessment, it was assessed that Ms A had significant “craving and dependency” issues in relation to drinking and drug taking, with minor issues with regard to depressive moods and aggressive and disruptive or agitated behaviour. The FACE risk assessment assessed that Ms A was at low risk of violence to others, despite it being noted that she was “due in court to answer charges under section 18 wounding with intent”<sup>28</sup>. The assessment went on to document that Ms A had no historical or current ideas of harming others, but that she had current risks of physical harm to others. The assessment also noted that Ms A had a history of non-concordance with medication, non-attendance and poor engagement with services, but it assessed that these were not current risk issues. It was also assessed that she was experiencing “definite problems with relationships”<sup>29</sup>, although there was no explanation as to what exactly Ms A had disclosed about her relationship difficulties. The FACE assessment documented that Ms A “denied any form of abuse”<sup>30</sup>. Ms A’s protective factors were identified as being her mother, her partner and her son. The assessor concluded that Ms A’s risk of violence to others was “low”, as were her risks relating to impulsivity, but that there needed to be further assessments and formulation<sup>31</sup> of her mental health needs. The assessment was to be discussed at the MDT<sup>32</sup> in order to identify the most appropriate course of treatment. A further appointment was arranged for 20 February 2013; however, this appointment had to be rescheduled due to medical sickness.

Arising issues, comment and analysis:

Based on the evidence that we have been able to obtain, it appears that consideration was not given by the CMHT or primary care services to the fact that Ms A’s presenting symptoms may have been related to the fact that she was a teenage mother and therefore vulnerable and at risk. It was noticeable to us that her attendance at the GP increased around the time that her mother was taking over the care of her son and was applying for the residency order. Additionally, in our review

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<sup>28</sup> FACE risk assessment, 23 January 2013, p1

<sup>29</sup> MH clustering tool, p2

<sup>30</sup> FACE risk assessment, 23 January 2013, p6

<sup>31</sup> Formulation brings together all the relevant information (historical and current, familial and psych social history) about a patient and will inform risk assessments, diagnosis and treatment plans

<sup>32</sup> MDT: multidisciplinary team meeting

of the numerous risk assessments and support plans that were undertaken by CMHT, we noted that no consideration was being given to what support Ms A, as a young single parent, may have needed in terms of risk factors, therapeutic intervention and practical support she may have required in terms of accessing her son. There appears to have been no attempt by the CMHT services to liaise with children's services in order to ascertain information or to verify the circumstances of the situation. Such information would have informed both Ms A's support needs and their FACE assessments regarding Ms A's potential risk to children as well as her own risk factors.

Every time Ms A was referred to the CMHT, a complete and comprehensive assessment process was undertaken, which included a FACE risk assessment and the beginnings of a care plan. This was in line with Tees, Esk and Wear Valleys NHS Foundation Trust's clinical risk assessment and management policy (2012). We were informed that to review a patient's previous assessments, which in Ms A's case were extensive, and to complete the assessment process could take a significant amount of time, not only because of the size of the assessments but also because previous information has to be manually transferred onto the latest assessment forms. We would question the value and purpose of so many assessments.

Without exception all the CMHT assessments were based on information self-reported by Ms A, who was, it is now apparent, an unreliable self-historian who provided partial and at times false information, particularly in relation to her mental health symptoms, alcohol use, and the fact that she was in an abusive relationship. There is no evidence to indicate if the CMHT services attempted to seek to obtain Ms A's consent to involve her mother or Mr O in her assessments or to gain her permission to liaise with probation services. Probation was the only agency that had a consistent relationship with Ms A and therefore could have provided some valuable information about Ms A's risks, their concerns about her alcohol consumption and their suspicion that there were issues of domestic abuse within Ms A and Mr O's relationship.

For a patient such as Ms A, who has a history of repeated disengagement after the initial appointment, and due to the time it takes CMHT practitioners to complete the required assessment process, we would like to suggest that the Trust needs to consider piloting an alternative type of assessment and service model. We looked at models used in other clinical disciplines where they use a direct access approach. This is where a patient undertakes a full assessment process on entry to the service. For the following 12 months they are able to contact the service directly when they are experiencing difficulties, and they will be seen within a short time frame where only a brief assessment review is undertaken. A full assessment is undertaken for all patients every 12 months. We would also suggest that it would be helpful if the PARIS system was able to self-populate historical information, especially risk information, from previous assessments onto any subsequent assessments. This would greatly reduce the amount of time that it takes CMHT practitioners to review prior assessments and also ensure that important historical information is being consistently considered.

Tees, Esk and Wear Valleys NHS Foundation Trust's Care Programme Approach policy (2012) identified what support carers should expect from services. Despite it being documented that both Mr O and Ms A's mother were providing significant and

ongoing support to Ms A, there is no documentation that either were offered a carer's assessment.

Review of Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust's serious incident report (SIR):

We concluded that the SIR provided an extensive chronology and in-depth details and analysis of Ms A's involvement with primary and secondary community mental health services. There was also extensive reference to local and national policies and guidelines in relation to personality disorders. The author of the SIR reported to us that he had not been aware that a DHR was being undertaken at the same time as his investigations.

The two CMHT operational managers whom we interviewed informed us that they had developed an action plan for the areas within the SIR that related to their services. Out of the 19 actions, all but one area has been implemented. The outstanding issue is the introduction of a supervision template.

We were informed that it is the responsibility of TEWV's Patient Safety Team to coordinate SIRs and to monitor the subsequent action plans. We were also informed that both historic and current recommendations from SIR action plans are entered into a database. This enables the identification both of who has responsibility for the implementation of each action and of themes and root causes which inform future policy and operational developments within the Trust.

There is currently one outstanding recommendation from the SIR: "there should be a mechanism to identify people with multiple referrals but [who] fail to engage." We were informed that TEWV's proposed action is to "include system development for recurrent DNA into the revised risk management procedures currently being developed and will be incorporated into the Clinical Risk and Harm Minimisation project which is due for completion in June 2016". TEWV's Associate Director of Nursing, Quality and Risk has the responsibility for monitoring this project.

Domestic homicide report (DHR):

We agreed with the DHR's conclusion that on the occasions when agencies did become aware of incidents of domestic violence between Ms A and Mr O, they were managed in isolation. Additionally, the involved agencies did not identify the complex issues within Ms A and Mr O's relationship, where situational couple violence was a key dynamic. Despite it being known that both Mr O and Ms A had substance misuse issues, there was no referral made to specialised services. However, there were several issues either that were unknown at the time of the DHR or that the authors did not highlight as significant issues. These included Ms A and Mr O's lack of secure and affordable accommodation, which we have suggested left them both vulnerable in terms of their housing needs and would have also exacerbated Ms A's instability and social isolation. Also, they did not identify that Ms A began to present herself to primary care and CMHT after she lost custody of her son; therefore, this was not seen as a significant contributory factor to her mental health and complex psychosocial situation.

Tees, Esk and Wear Valleys NHS Foundation Trust's progress on the implementation of the domestic homicide report's action plan:

With regard to the three recommendations made by the authors of the DHR in relation to TEWV it was reported to us that one remains outstanding. This is: "there should be mechanisms within the Trust to identify people who have multiple referrals but fail to engage with services". TEWV's current action plan (January 2016) notes that the development work this refers to sits within the Clinical Risk and Harm Minimisation project. We were informed that the draft policy is due for completion June 2016.

#### Predictability:

We have concluded that the death of Mr O on 22 February 2013 was not predictable by TEWV mental health services. However, from the evidence that we have obtained, it was clear that as the events of that night unfolded, there were several significant key triggers and risks present. Both Ms A and Mr O were drinking alcohol extensively and over a considerable period of time, which had previously led to impulsive behaviours and Ms A reported that she had a significant addiction to subutex. At some point an argument developed between Ms A and Mr O and escalated to such an extent that Ms A's brother removed himself from the room. We now know that previously such a combination of events had often led to incidents of violence where either Ms A or Mr O sustained physical injuries. Given such a history, where such a volatile combination of risk factors were present, we would suggest that it was predictable, or at least a real possibility, that at some point the violence was likely to increase to such a level that significant injuries would occur to either of them.

#### Preventability:

We have concluded that based on what was known at the time by services, the incident itself was not preventable. However, had a more inter-agency approach been adopted, then information could have been shared, and a more comprehensive profile of Ms A's presenting issues, risks and support needs could have been identified. Additionally, we would suggest that community mental health practitioners should have more proactively considered how they could have addressed Ms A's repeated pattern of presenting in crisis and then disengagement.

#### Concluding comments:

What was clearly evident to us was that Ms A was a very vulnerable young woman, who had complex needs and due to her lifestyle was at high risk to herself and within her relationships. The difficulties that practitioners were facing were how to engage such a vulnerable young adult within the restraints of the CMHT's service model, where a full risk assessment has to take place at every new referral. We felt that not only were such assessments time-consuming, but they resulted in missed opportunities where a deeper understanding of Ms A's needs and risks could have been obtained and where she could have been engaged in a therapeutic relationship.

## Recommendations:

**Recommendation 1:** Tees, Esk and Wear Valleys NHS Foundation Trust's community mental health services should undertake domestic violence training in order to improve both their understanding of and their responsibilities for reporting and taking the appropriate action in relation to suspected and known incidents of domestic violence.

**Recommendation 2:** The involved primary care services should undertake domestic violence training in order to improve both their understanding of and their responsibilities for reporting and taking the appropriate action in relation to suspected and known incidents of domestic violence.

**Recommendation 3:** For patients who have had a teenage pregnancy or who have been involved in custody issues, Tees, Esk and Wear Valleys NHS Foundation Trust's practitioners should take this into consideration when assessing their risk and support plans.

**Recommendation 4:** Tees, Esk and Wear Valleys NHS Foundation Trust, local primary care services and their commissioner (CCGs) should agree a referral form to be used when primary care referring a patient to Tees, Esk and Wear Valleys NHS Foundation Trust's community and inpatient mental health services.

**Recommendation 5:** Tees, Esk and Wear Valleys NHS Foundation Trust should consider undertaking a pilot project in one of their community mental health services that offers an alternative support pathway for patients who are difficult to engage with and who only require support at points of crisis or when there are any changes in their risk factors.

**Recommendation 6:** Tees, Esk and Wear Valleys NHS Foundation Trust should consider if it is possible for their patient electronic system PARIS to self-populate historical risk information automatically into any subsequent assessment forms.

**Recommendation 7:** A review should be undertaken of the current Multi-Agency Information Sharing Protocol that is in place within Tees, Esk and Wear Valleys NHS Foundation Trust's area to ensure that all services are operating within the protocol.

**Recommendation 8:** Tees, Esk and Wear Valleys NHS Foundation Trust's risk assessments and recovery support plans should always identify and consider a patient's housing situation. Where a patient is experiencing housing issues, this should be identified and considered as a significant risk factor and one that requires multi-agency intervention and support.

**Recommendation 9:** Staff who are interviewed as part of a Trust's serious incident investigation should be offered the opportunity to have a one-to-one meeting with the investigative panel.

**Recommendation 10:** We would recommend that Tees, Esk and Wear Valleys NHS Foundation Trust follows the National Patient Safety Agency's RCA investigation guidance with regards to the collection and storage of interview notes.

**Recommendation 11:** Authors of serious incident reports should include evidence within their reports of the methodology that is being utilised; for example when utilising root cause analysis methodology a fishbone (Ishikawa) diagram and/or 5 Whys should be included within the report.

**Recommendation 12:** Tees, Esk and Wear Valleys NHS Foundation Trust should undertake a review of the difficulties the Patient Safety Team had in providing the investigation team with an up to date action plan on this case. To ensure that the issues that have been highlighted within this report have now been fully resolved.

**Recommendation 13:** Tees, Esk and Wear Valleys NHS Foundation Trust should provide NHS England (North) with evidence of the completion of the outstanding recommendation from the domestic homicide report.

Niche Patient Safety's condolences to the family of the victim:

Niche's investigation team would like to offer their deepest sympathies to the family of Mr O. It is our sincere wish that this report does not contribute further to their pain and distress.

Niche's investigation team would also like to thank the families of both Mr O and Ms A for their valuable contribution to this investigation.

Acknowledgement of participants:

Niche's investigation team would like to acknowledge the contribution and support that the staff from Tees, Esk and Wear Valleys NHS Foundation Trust have provided throughout the course of the investigation.

## 2 Offence

- 2.1 At the time of the incident (22 February 2013), Ms A was facing a charge of section 18 wounding<sup>33</sup> relating to an incident on New Year's Eve (2012), when it was alleged that she had bitten the ear off an individual during a street fight.
- 2.2 Prior to the incident Ms A, aged 23, and the victim Mr O, aged 32, had been living together for approximately two and a half years. Ms A had a son, aged seven years, who was at the time living with his maternal grandmother.
- 2.3 Ms A often identified to mental health services that Mr O was a significant support in her life. It was well documented that their relationship was often volatile and at times abusive. It was also apparent that alcohol was a significant precipitating factor to many of the incidents between them.
- 2.4 On the afternoon of the incident, Ms A and Mr O were seen on CCTV purchasing vodka and some soft drinks before returning to their flat. Ms A's brother arrived later that afternoon, and then he and Mr O went out and bought more alcoholic beverages.
- 2.5 When they returned to the flat they began to listen to music and also ordered a takeaway meal. An argument between Ms A and Mr O occurred and at some point a vase was broken. Ms A's brother then left the lounge area, as he reportedly felt uncomfortable witnessing the argument.
- 2.6 When he returned, Mr O was bleeding extensively from a chest wound. Mr O was conscious and told him to ring for an ambulance. Ms A's brother then left the flat and went to his mother's house. Ms A rang the emergency services.
- 2.7 When police officers arrived, Mr O was lying on the sofa in the lounge, and Ms A was pressing a sock on his chest wound.
- 2.8 The police and then subsequently the paramedics tried to resuscitate Mr O for 25 minutes before he was declared dead at the scene.
- 2.9 Mr O died from a single stab wound to the chest which passed through the apex of his heart and his liver, causing extensive blood loss.
- 2.10 A forensic examination of the accommodation found that a knife was missing from a knife block and was located behind some utensils on the kitchen worktop. This was believed to be the weapon that caused the fatal injuries to Mr O. Mr O's T-shirt and blood stains were found on the floor by the bin in the kitchen, indicating that this was where the incident had occurred.
- 2.11 It was concluded that based on this evidence, the incident had occurred in the kitchen, and at some point Mr O either walked or was carried to the lounge area and to the sofa, which is where police and paramedics found him.
- 2.12 Both the 999 operator and the police reported that Ms A appeared intoxicated.

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<sup>33</sup> Section 18 wounding with intent to cause grievous bodily harm

- 2.13 At a subsequent Crown Court trial, Ms A admitted to the manslaughter of Mr O but was found guilty of murder and was sentenced to prison for a minimum tariff of 16 years.

### 3 Independent investigation

#### Approach to the investigation

- 3.1 From 2013 NHS England assumed overarching responsibility for the commissioning of independent investigations into mental health homicides and serious incidents. On 1 April 2015 NHS England introduced their revised Serious Incident Framework,<sup>34</sup> which:

“Aims to facilitate learning by promoting a fair, open, and just culture that abandons blame as a tool and promotes the belief that incidents cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring.”<sup>35</sup>

- 3.2 Identified within the Serious Incident Framework are the following criteria for the commissioning of an independent investigation:

“When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced care programme approach, or is under the care of specialist mental health services, in the 6 months prior to the event.”<sup>36</sup>

- 3.3 In April 2015 NHS England (North) commissioned Niche Patient Safety to undertake an independent investigation into the homicide of Mr O. However, several issues developed during the course of Niche’s investigations which have caused some unavoidable delays in the completion of the report.

#### Purpose and scope of the investigation

- 3.4 The Terms of Reference (ToR) for this investigation are located in appendix 2.

- 3.5 Briefly the ToR for this investigation are to:

- “Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user’s first contact with services to the time of their offence;
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern;

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<sup>34</sup> NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, 1 April 2015

<sup>35</sup> NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, p10

<sup>36</sup> NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, p47

- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others;
- Review the Trust’s internal investigation and assess the adequacy and robustness of its findings, recommendations and resultant action plan; and
- Review the progress that the Trust has made in implementing the action plan.”<sup>37</sup>
- We have been asked to consider whether the incident on 22 February 2013, which led to the death of Mr O, was either predictable<sup>38</sup> or preventable<sup>39</sup>.

Supplementary to Core Terms of Reference:

- 3.6 Due to the fact that Ms A had a teenage pregnancy, NHS England (North) requested that we also review her maternity pathway to consider if the “appropriate level of support was provided during the antenatal and postnatal period”<sup>40</sup>.
- 3.7 Following this incident a domestic homicide report (DHR)<sup>41</sup> was commissioned by Scarborough Community Partnership. The review was commissioned within the scope of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews introduced in August 2013. The DHR report was published in August 2014. We have been asked to:
- “Support Tees, Esk and Wear Valleys Trust to develop a comprehensive outcome focused action plan which also takes into account DHR’s findings and recommendations.
  - Review the content and findings of the 2013/4 DHR Report; identify any additional key lines of enquiry required for this investigation.
  - Cross reference and compare DHR findings with investigation findings and conclusions, where appropriate concur with DHR commentary and findings.”

## Niche’s investigation team

- 3.8 This investigation was led by Grania Jenkins, Senior Investigator for Niche Patient Safety.

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<sup>37</sup> Revised Terms of Reference, 26 October 2015

<sup>38</sup> Predictability is “the quality of being regarded as likely to happen, as behaviour or an event”. We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. <http://dictionary.reference.com/browse/predictability>

<sup>39</sup> Prevention means to “stop or hinder something from happening, especially by advance planning or action” and implies “anticipatory counteraction”; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring. <http://dictionary.reference.com/browse/preventability>

<sup>40</sup> Revised Terms of Reference, 23 October 2015

<sup>41</sup> Published 25 August 2014

- 3.9 Due to the complexities of this case, the following professionals contributed to the investigation: Dr Ian Davidson provided clinical advice; Carol Dudley provided safeguarding advice; and Professor Liz Hughes provided advice on dual diagnosis issues.
- 3.10 The report has been peer-reviewed by Carol Rooney, Niche's Senior Investigations Manager, and Nick Moor, Niche's Director.
- 3.11 Niche Patient Safety is a leading national patient safety and clinical risk management consultancy which has extensive experience in undertaking complex investigations following serious incidents and unexpected deaths. Niche also undertakes reviews of governance arrangements and supports organisational compliance with their regulatory frameworks across a range of health and social care providers.
- 3.12 For the purpose of this report, the investigation team will be referred to in the first person plural and Niche Patient Safety will be referred to as Niche.
- 3.13 This report was written with reference to the National Patient Safety Agency's (NPSA) root cause analysis guidance. Root cause analysis (RCA) methodology has been utilised to review the information obtained throughout the course of this investigation.
- 3.14 RCA is a retrospective multidisciplinary approach designed to identify the sequence of events that led to an incident. It is an iterative<sup>42</sup> structured process that has the ultimate goal of preventing future adverse events by the elimination of latent errors. It also assists in the identification of common risks and opportunities to improve patient safety and informs recommendations regarding organisational and system learning.
- 3.15 The prescribed RCA process includes data collection and a reconstruction of the event in question through record reviews and participant interviews.
- 3.16 As part of the investigation process we have utilised an RCA fishbone diagram to assist the investigative team in identifying the influencing and multiple contributory factors which led to the incident (the fishbone diagram is located in appendix 1).
- 3.17 Where appropriate we have referred to the relevant Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) policies that were in place at the time of the incident in 2013 as well as those that have been subsequently revised. We have also referred to the relevant Department of Health (DH) best practice<sup>43</sup> guidelines and to NICE<sup>44</sup> guidance.

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<sup>42</sup> Iteration is the act of repeating a process with the aim of approaching a desired goal, target or result

<sup>43</sup> DH (March 2008), Refocusing the Care Programme Approach Policy and Positive Practice and Code of Practice Mental Health Act 1983 (revised)

<sup>44</sup> NICE: National Institute for Health and Care Excellence

3.18 As far as possible we have tried to eliminate or minimise hindsight or outcome bias<sup>45</sup> in both our investigation and our analysis of the information which was available to primary and secondary care services at the time of the incident. However, where hindsight informed our judgements, we have identified this.

3.19 As part of this investigation we interviewed the following individuals:

TEWV staff:

- two locality managers;
- two consultant psychiatrists;
- three team managers;
- Occupational Health Practitioner;
- two senior practitioners from CMHT;
- one advanced practitioner from CMHT;
- Director of Quality and Governance;
- Head of Patient Safety;
- Associate Director of Nursing (safeguarding);
  
- Primary Care GP;
- NHS England's Director of Nursing;
- Director of Public Health (North Yorkshire); and
- Local Supervising Authority Midwife (Cumbria, North East of England and Yorkshire and the Humber Local Supervising Authority).

3.20 Interviews were managed with reference to the National Patient Safety Agency's (NPSA) investigation interview guidance.<sup>46</sup> We have adhered to the Salmon/Scott principles.<sup>47</sup>

## Domestic homicide report (DHR)

3.21 Where we referred to information that we obtained from the DHR, we have cited it within the respective footnotes.

## Anonymity

For the purpose of this report:

3.22 The identities of all those who were interviewed have been anonymised and they will be identified by their professional titles.

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<sup>45</sup> Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)

<sup>46</sup> National Patient Safety Agency (2008) Root Cause Analysis Investigation Tools: investigation interview guidance <http://www.nrls.npsa.nhs.uk>

<sup>47</sup> The 'Salmon process' is used by a public inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry, whose report, among other things, set out principles of fairness to which public inquiries should seek to adhere

3.23 Services have been anonymised and are referred to by their service type only.

3.24 The patient is referred to as Ms A and the victim as Mr O.

### **Involvement of Ms A, members of her family and members of Mr O's family**

3.25 The NHS's Serious Incident Framework directs that all investigations should:

“Ensure that families (to include friends, next of kin and extended families) of both the deceased and the perpetrator are fully involved. Families should be at the centre of the process and have appropriate input into investigations.”<sup>48</sup>

3.26 As part of all Niche's investigations we will always try to obtain the views of the patient and the families of both the victim and the perpetrator, not only in relation to the incident itself, but also their wider thoughts regarding where improvements to services could be made in order to prevent similar incidents from occurring.

3.27 We met with Ms A on two occasions.<sup>49</sup>

3.28 We also met with members of Mr O's family<sup>50</sup> and Ms A's mother.<sup>51</sup>

3.29 We have been extremely grateful for the information they provided, as it has been essential in assisting us to develop the chronology of events that led up to the incident itself. They also provided valuable background information on the lives of both Ms A and Mr O that was not known to services at the time of the incident.

3.30 It is our intention to offer the families of both Mr O and Ms A the opportunity to be provided with a copy of our report, and if they wish we will meet with them to provide verbal feedback on our findings and recommendations.

3.31 We will also offer Ms A a copy of our report, and if she wishes we will meet with her to provide feedback on our findings and recommendations.

### **Structure of the report**

3.32 This report has been divided into various sections. Where it is required, some sections have an arising issues and commentary subsection, which provides either additional information that we have obtained and/or a commentary on and analysis of the issues that have been highlighted in that section.

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<sup>48</sup> NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, p48  
<https://www.england.nhs.uk/patientsafety/serious-incident>

<sup>49</sup> 13 August 2015, 12 November 2015

<sup>50</sup> 12 August 2015

<sup>51</sup> 11 November 2015

- 3.33 At the end of each section there are the associated recommendations. There is also a full list of all the recommendations in section 16.
- 3.34 We have provided a full chronology from the point Ms A first began to present herself to primary and secondary community mental health services. This is located in appendix 3.

## 4 The care and treatment of Ms A

### Childhood and family background

- 4.1 Ms A is the youngest child; she has one sibling, a brother, who was 18 months older. Ms A's parents separated when she was four. She reported to us that she has remained in contact with her father.
- 4.2 Ms A's mother reported to us that her daughter developed an infection soon after she was born, which resulted in her having partial deafness in one ear.
- 4.3 We obtained Ms A's primary care notes from 1993. At the age of two Ms A was diagnosed with asthma, but there is no evidence that she was using inhalers regularly or that she experienced any ongoing symptoms. We did note that she was diagnosed fairly regularly with chest infections that required antibiotic treatment.
- 4.4 At the age of three Ms A was admitted to hospital following what was documented as an "accidental ingestion of paracetamol"<sup>52</sup>. The discharge summary noted that it was "explained to parents to keep medicines in a locked cupboard"<sup>53</sup>. No further action was taken.
- 4.5 At the age of five<sup>54</sup> Ms A was admitted to hospital as an emergency admission with abdominal pains. The following day it was documented that her parents discharged her against medical advice. In the same year Ms A was seen by an out-of-hours doctor following what was documented as an "assault"<sup>55</sup> in which she sustained a minor head injury; several cuts, which required suturing; and bruising to her eye and face. There was no further information documented regarding the circumstances of the assault.
- 4.6 When Ms A was six (1996) a referral was made to children's mental health services. The reason for the referral was that Ms A's concentration was "poor"<sup>56</sup>. It was documented that her teacher was concerned that this might be due to Ms A's hearing. An audiogram indicated that Ms A had a significant

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<sup>52</sup> Discharge summary, 19 September 1993

<sup>53</sup> Discharge summary, 19 September 1993

<sup>54</sup> 11 June 1995

<sup>55</sup> GP notes, 24 May 2005

<sup>56</sup> South Tees Community Mental Health Trust, 20 January 1996

hearing loss in her right ear; no further action was taken as she did not attend two further appointments. She was then discharged back to the GP.<sup>57</sup>

- 4.7 On 11 March 1998, when Ms A was eight, at her mother's insistence the out-of-hours GP visited the family home. Ms A was presenting with flu and croup symptoms which were not responding to children's paracetamol medication. The GP noted "anorexia". There were no further details documented for us to ascertain if the GP was merely referring to her not eating due to her current presenting symptoms or if he was noting that she was significantly underweight.
- 4.8 When we asked Ms A about her memories of her childhood, she reported that she recalled that it was a happy one and that she had everything that she had wanted, including horses.
- 4.9 However, Ms A's mother reported to us that from a very young age her daughter was a "loner". She was prone to become withdrawn and depressed and would often isolate herself from her peers. Ms A's mother reflected that she did wonder if this was, at least partly, due to her daughter's hearing loss.
- 4.10 Ms A's mother also reported to us that as a child her daughter was presenting with what she described as "OCD"<sup>58</sup> symptoms, such as cleaning and obsessively checking her weight. Both Ms A and her mother reported to us that from a very young age she had poor impulse control and a tendency to react aggressively and impulsively to particular events and people without considering the consequences.
- 4.11 In 2004,<sup>59</sup> when Ms A was 14, the police were called to the family home<sup>60</sup> during an incident involving Ms A and her mother. The police did refer the incident to Child Protection Services, who subsequently contacted Ms A's mother by telephone. Ms A's mother reported that the situation at home had now settled and that she was receiving ongoing support. It was not noted who was providing this support, but the case file documented that this was to be considered an isolated incident. Ms A was not interviewed as part of the children's services investigation.
- 4.12 On 21 May 2005 Ms A was brought into the Accident and Emergency (A&E) department by a member of her family, having sustained an injury to her eyebrow. She reported that she had been assaulted by a girl with a baseball bat.
- 4.13 In 2006 Ms A received a criminal charge for vandalism and was referred to a three-month youth offending programme. At this time it was noted that she was regularly socialising with known criminals and heroin users.

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<sup>57</sup> 21 January 1997

<sup>58</sup> OCD: obsessive-compulsive disorder symptoms

<sup>59</sup> 22 July 2004

<sup>60</sup> Information obtained from the domestic homicide chronology

- 4.14 During her initial assessment Ms A reported that she had stopped smoking cannabis but was continuing to drink alcohol on a daily basis and was selling her personal belongings in order to fund her increasing drinking habit.
- 4.15 Ms A also reported that when she was feeling bored her alcohol consumption would increase and that currently she was drinking two to three bottles of wine a day. It was documented that Ms A's mother had identified that her daughter's drinking was the main problem, that she was consistently coming home late and that she was often very aggressive to her.
- 4.16 The youth offending programme treatment plan was to provide education and advice to Ms A on harm minimisation with regard to her drinking.
- 4.17 After two home assessment visits (9 January and 21 January 2006), Ms A failed to attend the next scheduled appointment (27 January 2006). On 7 February 2006 the GP informed the service that Ms A was pregnant and that a referral had been sent to social services and teenage pregnancy services.
- 4.18 The youth offending programme's discharge summary<sup>61</sup> documented that it had been very difficult to engage with Ms A, as she did not want any further intervention, and in the light of teenage pregnancy services now being involved, the case was closed.
- 4.19 On 18 May 2006 Ms A was brought into A&E by a family member. She reported that she had been assaulted by a 19-year-old girl and a 28-year-old woman<sup>62</sup> who had repeatedly punched her. She sustained bruising and a laceration above her eyebrow to which steri-strips were applied, and she was then discharged.

## Education

- 4.20 Both Ms A and her mother reported that from the age of 13 (2004) she began to associate with the wrong crowd and was a regular user of both alcohol and cannabis. Ms A reported that during this time she was also taking amphetamines and sniffing glue.
- 4.21 When we interviewed Ms A she identified that from this point she lost interest in her schooling, as she "couldn't think properly anymore", and that this feeling continued until the incident itself in 2013.
- 4.22 Ms A called herself the "class clown" and she was subject to several periods of exclusion from secondary school. At the age of 14 she received a police caution for harassment<sup>63</sup> following an incident of bullying of a fellow pupil. She was expelled during this year, but it is not clear if this was the result of this incident.

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<sup>61</sup> 13 February 2006

<sup>62</sup> A&E admission assessment, 18 May 2007

<sup>63</sup> OASys, November 2013: OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the National Probation Service [https://en.wikipedia.org/wiki/Offender\\_Assessment\\_System](https://en.wikipedia.org/wiki/Offender_Assessment_System)

- 4.23 Ms A was then placed in a specialist educational facility, which she attended for two to three days a week until the age of 15, when she became pregnant.
- 4.24 She was also working on a placement at a Sure Start<sup>64</sup> centre with young children but was asked to leave due to her ongoing drug use.
- 4.25 Ms A left school without any qualifications.
- 4.26 We were unable to ascertain if she was ever provided with any special educational support for her partial deafness.
- 4.27 From the point Ms A became pregnant to the incident in 2013, she was in receipt of benefits.

## 5 Ms A's antenatal and postnatal care

- 5.1 At the age of 15 Ms A became pregnant. It is unclear if she was, at the time, in an ongoing relationship with the baby's father. When we reviewed the available maternity notes, the only reference to the baby's father was in the initial assessment, where it was documented that he was Caucasian (white) and 19 years old.
- 5.2 Ms A's mother attended the initial assessment appointment (6 March 2006) and the baby's father was present in the delivery room when his son was born.
- 5.3 At the time when the pregnancy was confirmed (6 February 2006), the GP documented that Ms A had a history of cannabis and alcohol misuse and was drinking two bottles of wine a day.<sup>65</sup> It was also documented that she had reported to the GP that she had stopped drinking "4 days ago because she was concerned re pregnancy and didn't want to hurt the baby"<sup>66</sup>.
- 5.4 At the initial midwife booking appointment (6 March 2006) it was documented that although this was an unplanned pregnancy, Ms A was "happy"<sup>67</sup>. It was also documented that she had been referred to "teenage pregnancy and has an educational social worker"<sup>68</sup>. However, we could find no evidence within Ms A's maternity notes or her primary care notes that this had occurred. From the evidence that we reviewed, it appears that throughout her ante and postnatal care she was being seen by adult maternity services either at her GP's surgery, where she was often seen by the same midwife, or at the hospital antenatal outpatients unit.

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<sup>64</sup> Government initiative providing centres for child care and early education and family support <https://www.gov.uk/find-sure-start-childrens-centre>

<sup>65</sup> GP notes, 6 February 2006

<sup>66</sup> GP notes, 6 February 2006

<sup>67</sup> Hospital 1 antenatal assessment, 6 March 2006

<sup>68</sup> Antenatal report, 6 March 2006

- 5.5 On 8 March 2006 the GP documented that a referral was to be made to social services for support for Ms A and that there was “concern”<sup>69</sup> for her unborn baby. It is not documented what the concerns were, and, again, based on the documentation<sup>70</sup> that we have been able to obtain, there is no indication that a referral was made and no indication of either social services or children’s services being involved.
- 5.6 At the 24-week appointment the community midwife documented that Ms A had been given a Sure Start<sup>71</sup> form to complete. Ms A reported to us that after her son was born she had attended a Sure Start programme and that she had found it helpful.
- 5.7 On 17 August 2006, at a regular antenatal assessment appointment, Ms A reported that she was experiencing back and abdominal pain. As there was a concern that she might have been in pre-term labour, she was admitted to the Community Delivery Suite. Steroid treatment commenced, and after her symptoms settled she was discharged.
- 5.8 Later that month (31 August 2006) Ms A was again admitted to hospital, as there was a concern that she was presenting with a possible spontaneous rupture of her membranes. However, her symptoms resolved without medical intervention and she was discharged.
- 5.9 A scan indicated that she was placenta previa<sup>72</sup> and that her baby was in breech position. The baby remained in this position and he was born by elective Caesarean section, with a spinal epidural. His birth weight was 8lb 1oz.
- 5.10 Ms A was discharged to her mother’s house, and until 20 October 2006 she was monitored by the midwife, at which point her case was transferred to the health visitor’s service.
- 5.11 As we have not been able to access Ms A’s baby records (known as red book<sup>73</sup>), we are unable to ascertain if Ms A engaged with the health visitor’s service and, if she did, how long they maintained involvement with her.

## Arising issues, comment and analysis

- 5.12 During our review of the pre and postnatal care that Ms A received, we referred to various research projects and governmental strategies (for example the Department of Health’s (DH) white paper ‘Choosing Health:

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<sup>69</sup> GP notes, 8 March 2006

<sup>70</sup> Primary care and hospital 1 maternity notes

<sup>71</sup> The core purpose of Sure Start children’s centres is to improve outcomes for young children and their families, with a particular focus on those in greatest need. They work to make sure all children are properly prepared for school, regardless of background or family circumstances. They also offer support to parents

<sup>72</sup> Placenta previa occurs when a baby’s placenta partially or totally covers the opening in the mother’s cervix

<sup>73</sup> Red book: personal child health record. Where a baby’s weight, developmental progress, health checks and immunisation programme is recorded <http://www.eredbook.org.uk>

Making healthy choices easier' (2004)) that were in place at the time of Ms A's pregnancy. We paid particular attention to:

- the prevention of teenage pregnancies;
- the improvement in the outcomes for teenage parenting; and
- the sexual health of this particular high-risk patient group.

5.13 We have also reviewed Ms A's pre and postnatal care in light of the National Service Framework for Maternity Services (2004). Such strategies and frameworks indicated the need for a more multifaceted approach to be adopted by practitioners in order to:

- "Support young people to resist pressure to have early sex through improved sex and relationship education and supporting parents in talking to their children about these issues
- Increase the uptake of contraceptive advice by sexually active teenagers
- Support young parents to improve the health and social outcomes for them and their children."<sup>74</sup>

5.14 A number of risk factors were identified as increasing the likelihood of teenage pregnancy, including high-risk sexual behaviours, low educational attainment, and social or economic disadvantage due to location,<sup>75</sup> all of which were present in Ms A's situation. The following interventions were aimed at reducing teenage pregnancy and supporting teenage parents:

- "Good antenatal care can improve health outcomes for mother and child and is cost-effective. Home visiting, parental and psychological support can improve health and welfare outcomes for mother and child."<sup>76</sup>

5.15 The DH also issued new guidance in 2004 on improving access to contraceptive and sexual health advice services as well as increasing choice and continuity of care for teenage mothers through multi-agency working. It aimed to target social exclusion, associated with teenage pregnancy and parenthood, by providing educational support, further education and training, income support, or housing assistance. Such programmes were to provide:

- "Skills/self-esteem approaches to equip young parents with the necessary social skills in terms of relationships and decision-making;
- Abstinence programmes that either wholly or partly promote an abstinence message;
- Programmes involving parental participation; and
- Interventions to reduce domestic violence and improve relationships."<sup>77</sup>

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<sup>74</sup> Department of Health (DH) white paper, *Choosing Health: Making healthy choices easier* (2004), p3 <http://www.publications.parliament.uk/pa/cm200405/.../cmhealth/358/358ii.pdf>

<sup>75</sup> Highlights north east of England, where Ms A lives, as an area of particular economic disadvantage

<sup>76</sup> Department of Health (DH) white paper, *Choosing Health: Making healthy choices easier* (2004), p3

<sup>77</sup> Department of Health (DH) white paper, *Choosing Health: Making healthy choices easier* (2004), p16

- 5.16 At the time, such services were being delivered via the Sure Start programme, which Ms A only appeared to have engaged with after her baby was born. We were not able to ascertain if any maternity or primary care services were monitoring or encouraging Ms A to attend prior to the birth as part of her preparation for parenthood.
- 5.17 In light of the evidence that we have obtained regarding Ms A's historical impulsive behaviours and volatile and at times abusive relationships, this programme, we would suggest, would have been extremely valuable during her pregnancy and after the birth to help her develop more mature and appropriate responses both to her parenting and in her relationships.
- 5.18 Both the initial midwife assessment and the first handwritten maternity notes documented that Ms A was to be placed on a "high dependency pathway of care"<sup>78</sup>. Although the assessment does not identify the reason(s) why she was placed on this pathway, as she had no significant health problems, we can probably assume that it was because this was a teenage pregnancy. However, as the individual clinicians are now no longer in post and there is no documentation regarding the reasons behind these decisions, we have been unable to ascertain what risks and/or psychosocial factors these assessments were being made on.
- 5.19 While reviewing Ms A's maternity notes, we noted that her level of dependency was consistently high until her 25-week appointment, when, at this and at several subsequent appointments (12 June, 31 July and 6 September 2006), she was assessed as having a low level of dependency.<sup>79</sup> This raised a number of questions for us. It was unclear what potential risk(s) had reduced sufficiently enough to warrant such a reduction. Indeed, the 6 September assessment followed Ms A's admission to hospital for treatment for a possible pre-term labour. Additionally, if she had been assessed as high dependency due to the fact she was a pregnant teenager, she should have remained at high dependency throughout the pregnancy, regardless of any of her physical health issues.
- 5.20 We also noted that several of the assessments were not dated and/or signed (10 April, 10 July 2006, and the 31- and 36-week appointments (not dated)). Also, in the assessment that took place on 9 September 2006, the assessment of the level of dependency was not completed.
- 5.21 There is also no indication of whether the community or hospital midwives made any attempt to liaise with the teenage pregnancy service or Ms A's GP. We would suggest that all teenage pregnancies have potentially significant and multiple high risk factors, and therefore the midwife service should have routinely been liaising with the mother's GP and any other involved services in order to ascertain a full and ongoing medical and psychological history.

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<sup>78</sup> Hospital 1 antenatal assessment, 6 March 2006

<sup>79</sup> At this time the difference between high and low assessment care pathways was that the high dependency focuses in greater detail on the potential physical risk factors, such as risk for thromboembolism, and therefore the pregnancy required more extensive histology and physical monitoring with regard to the health of the unborn baby and the mother

- 5.22 If this had occurred in Ms A's care it would have enabled a more comprehensive identification and monitoring of risk factors for such a vulnerable patient. The fact that the midwife was seeing Ms A regularly at the GP's surgery provided, we would suggest, the opportunity for direct liaison with the GP, but this did not occur.
- 5.23 Ms A had given her consent for her mother to be involved; we would suggest that this was another missed opportunity where important psychosocial information regarding both Ms A and the home situation could have been obtained. She may have also been able to provide some valuable information to the midwife regarding her daughter's alcohol and drug use.
- 5.24 We have been unable to access any information from the teenage service, although the DHR documented that Ms A was referred to the teenage pregnancy service (Advice, Resource and Counselling Service) in February 2006 but that she missed appointments with the adviser and did not take up any of the services offered to her other than advice relating to her benefit entitlement. It was reportedly noted that Ms A's mother spoke to the adviser and expressed her concern that the baby's father.<sup>80</sup> This information does not appear to have been passed on to the agencies that were monitoring Ms A during her pregnancy.
- 5.25 In the initial antenatal assessment pro forma, there is a section which asked about the mother's smoking/drinking/social history; in the section "recently used drugs" it was documented that Ms A had "no" recent history of drug use. It was unclear what the definition of "recent" was. We also noted that there was no question relating to the mother's current or past alcohol consumption.
- 5.26 There was no indication that the GP reported Ms A's considerable and very recent alcohol history in his referral to maternity services, despite the fact that the youth offending programme had just written to the GP, reporting in their discharge summary that Ms A was, at the time, drinking two to three bottles of wine a day and that she had reported that her alcohol consumption would increase when she was no longer experiencing the desired effect. This information was documented in the GP notes (6 February 2006) when Ms A's pregnancy was confirmed.
- 5.27 The GP appeared not to have offered Ms A any cessation support with what was a considerable and very recent alcohol issue, nor was there any indication, in this or in any subsequent appointment throughout her pregnancy, that the GP was monitoring Ms A's alcohol consumption.
- 5.28 We would suggest that both Ms A's drug misuse and her very recent and considerable alcohol use should have been considered as significant and ongoing risk factors that should have been communicated by the GP to the midwife service. We would also suggest that this should have been monitored throughout Ms A's pregnancy, as both pose very significant risks to the unborn child and the mother. The National Service Framework for Maternity

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<sup>80</sup> DHR, p30-31

Services identified at the time (2004) that “women who have substance misuse problems are at greater risk of problem pregnancies and their care should be provided by an integrated multidisciplinary and multi-agency team which will include a specialist midwife and/or obstetrician in this area”<sup>81</sup>. All services were relying on information provided by Ms A’s self-reporting, and therefore this issue was not seen as a significant high risk factor in relation to her antenatal care, the wellbeing of her unborn child or her abilities to care for herself and her child.

- 5.29 We would suggest that any pregnant teenager’s psychosocial situation and as well as potential risk behaviours, such as alcohol and drug misuse, should be being regularly reviewed throughout the pregnancy as they are a particularly vulnerable patient group.
- 5.30 If this had occurred in Ms A’s care it would have enabled an up-to-date and comprehensive profile of her support needs and risk factors to have been developed and monitored.
- 5.31 There was a health visitor/midwife referral form completed on 10 July 2006, which Ms A signed, reporting that she was aware that information was being shared by other health professionals. However, due to the poor quality of the copy of this form within Ms A’s pregnancy notes, it has not been possible to identify what information was reported and the reasons why. As Ms A’s child healthcare is outside the scope of this investigation therefore records from the health visitor’s service were not obtained so we are unable to comment further on what engagement Ms A had with the health visitor’s service.
- 5.32 It was reported to us<sup>82</sup> that since 2006 there have been significant changes in the antenatal assessment processes, such as the introduction of the Vulnerable Mothers Care Pathway<sup>83</sup> and Family Nurse Partnerships.<sup>84</sup> However, we were informed that midwives still do not have access to either a patient’s GP patient information records or statutory safeguarding agencies’ records. Therefore they remain solely reliant on information provided by the mother-to-be and their professional observations. We would suggest that this is a significant issue, as there is always the possibility that the mother is an unreliable self-historian, and therefore potential risks to both the mother and the child may be unknown, placing them both at significant risk.
- 5.33 The National Framework (2004) highlighted the need to engage with fathers and partners, particularly young men in their preparation for parenthood.<sup>85</sup> It noted that “young men who become fathers may also come from disadvantaged and vulnerable groups. A positive relationship with the young

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<sup>81</sup> The National Service Framework for Maternity Services (2004), p22 <https://www.gov.uk/.../national-service-framework-children-young-peop...>

<sup>82</sup> Telephone interview with head of midwife service

<sup>83</sup> Pathway enables professionals to identify where women, children or families are at higher risk of poor outcomes and pregnant women with complex social factors may need additional support

<sup>84</sup> Family Nurse Partnerships is a voluntary, preventive programme for vulnerable young first-time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two

<sup>85</sup> The National Service Framework for Maternity Services (2004), p14

woman during pregnancy is a key predictor of the father's involvement with his child in the early years."<sup>86</sup> The Framework also noted that "maternity services can support this relationship through involving and encouraging young fathers but health professionals may know little about teenage fathers and may lack the skills to engage with them"<sup>87</sup>. As far as we are able to ascertain, during Ms A's prenatal care there was no evidence that services made any attempt to ascertain any in-depth information regarding the relationship Ms A had with the father or to actively seek to engage and prepare him for his role both at the birth and as a father.

- 5.34 We had some concern that despite the fact that Ms A was 15 years old at the time of her pregnancy, and therefore under the age for sexual consent, and that a midwife had documented that the father of the baby was significantly older than Ms A, we could find no evidence to indicate if any of the involved practitioners were considering that there may have been safeguarding issues with regard to this relationship that required, at the very least, further enquiry.
- 5.35 Directly after Ms A gave birth to her baby, she was prescribed the contraception Depo-Provera<sup>88</sup> (29 September 2006). However, she repeatedly presented herself to the GP with concerns that she may be pregnant, indicating that she was sexually active. Ms A subsequently reported to her GP that she had stopped this form of contraception and that she had had unprotected sex.
- 5.36 The NICE guidelines introduced in 2007<sup>89</sup> clearly identified that Ms A's known lifestyle – for example, her substance and alcohol misuse, early onset of sexual activity and history of sexual risk behaviour (for instance, unprotected sex) – placed her in what was identified as a particularly high-risk group for unplanned pregnancies and contracting sexually transmitted infections (STIs). The guidelines recommended that healthcare practitioners:
- “identify individuals at high risk of STIs using their sexual history. Opportunities for risk assessment may arise during consultations on contraception, pregnancy or abortion, and when carrying out a cervical smear test, offering an STI test or providing travel immunisation. Risk assessment could also be carried out during routine care or when a new patient registers. Have one to one structured discussions with individuals at high risk of STIs (if trained in sexual health), or arrange for these discussions to take place with a trained practitioner.”<sup>90</sup>
- 5.37 There was no indication that the risk of sexually transmitted infections (STIs) was discussed with Ms A.

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<sup>86</sup> The National Service Framework for Maternity Services (2004), p9

<sup>87</sup> The National Service Framework for Maternity Services (2004), p11

<sup>88</sup> Depo-Provera (Medroxyprogesterone) is an injection used to prevent pregnancy

<sup>89</sup> NICE guidelines [PH3] Published date: February 2007 <https://www.nice.org.uk/guidance/ph3/chapter/1->

<sup>90</sup> <https://www.nice.org.uk/guidance/ph3/chapter/1->

## 6 Custody of Ms A's child (from 2008)

- 6.1 On 1 June 2008, Ms A's mother contacted the local authority emergency duty team (EDT)<sup>91</sup> to report her concerns about her grandson. The case was referred to a social work team, who made several failed attempts to make telephone contact with the grandmother.
- 6.2 Three days later Ms A's mother again contacted the social work team, and she was advised to talk to the child's social worker. As far as we have been able to ascertain, at the time Ms A's son did not have a social worker allocated. Ms A's mother was reportedly angry at the lack of response by social services and said that she was unwilling to provide any further information and no longer wished to make a referral. The case was closed.
- 6.3 On 29 December 2009 Ms A's mother again contacted children's services, asking for advice about how she could obtain a residency order to secure the custody of her grandson. She reported that her daughter and her grandson had moved in with her, as her daughter was having "a problem with alcohol and violence from her ex-partner"<sup>92</sup>.
- 6.4 On 21 January 2010 Ms A's mother informed children's services that her grandson was now living with her permanently and that it was her intention to seek legal advice regarding obtaining a residency order.<sup>93</sup>
- 6.5 This was also the time when Ms A first began to present to her GP with significant mental health issues and numerous referrals began to be made to community mental health services<sup>94</sup> (refer to psychiatric history).
- 6.6 On 6 April 2010 police records indicated that there had been an incident where Ms A had been verbally aggressive towards her mother when she had come to her house to drop off her grandson. It was noted that Ms A's mother was refusing to allow her grandson to stay with her daughter.
- 6.7 During a probation visit on 15 April 2010, Mr O reported that Ms A was involved in a custody case where she was trying to regain custody of her son and that a family court hearing was to take place the following week. She was currently having contact with her son on a daily basis.
- 6.8 A core assessment report that was completed by children's services noted that all Ms A's son's needs were being met by his grandmother. Ms A's mother was granted a full residency order (27 October 2010) and her grandson was in her care until the incident in 2013.

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<sup>91</sup> 1 June 2008

<sup>92</sup> DHR chronology, 29 January 2009, p7

<sup>93</sup> Residency order: court order that agrees to where a child should live and makes access arrangements for the birth parents <https://www.gov.uk/looking-after-children.../types-of-court-order>

<sup>94</sup> 27 January 2010

## 7 Ms A's relationship with Mr O

- 7.1 On 12 July 2008 Ms A attended A&E following an alleged assault in which she sustained lacerations to her eye and bruising to her nose. It was not documented who had assaulted her or if it was a domestic violence incident.
- 7.2 Until 2010 Ms A's relationship history is not known, although her mother reported (29 December 2009) that her daughter and grandson had moved back in with her, as she had been experiencing "problems with violence from her ex-partner"<sup>95</sup>. It was at this stage that Ms A's mother began to make enquiries with social services about obtaining a residency order, and also a health visitor reported her concerns regarding certain individuals whom Ms A was associating with.
- 7.3 On 17 January 2010<sup>96</sup> police received intelligence that Mr O and Ms A had begun a relationship. Mr O and the father of Ms A's child were friends, although it is noted that Ms A had not known Mr O while she had been in a relationship with the father.
- 7.4 Mr O was known to the police and probation services and was also on a methadone reduction programme at the time the relationship began.
- 7.5 The first reported incident of domestic violence between Ms A and Mr O was on 11 February 2010, when Mr O reported to his probation officer that he had sustained a black eye during an argument with Ms A. Probation services contacted the police to ascertain if they had been involved in the incident, which they had not. No further action or assessment was undertaken.<sup>97</sup>
- 7.6 By 3 March 2010 police intelligence documented that Mr O and Ms A and her son were now living together. On 8 March 2010 Ms A called her mother, "begging"<sup>98</sup> that her mother take the child back to live with her. When Ms A's mother arrived to collect her grandson, it was evident that her daughter was drunk, and she passed the child through the window, reporting that Mr O had locked her in the house. It was after this incident that Ms A's mother made the decision to apply for a full residency order.
- 7.7 Less than a month later,<sup>99</sup> during a home visit by Mr O's probation officer, it was noted that Mr O had another black eye; he reported that he had been involved in another altercation but did not disclose any further information regarding who was involved.

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<sup>95</sup> DNR chronology, 29 December 2009

<sup>96</sup> DHR chronology, 17 January 2010, p8

<sup>97</sup> National Standards for the Management of Offenders (2007) require that the "assessment and sentence plan are reviewed and revised immediately if any new information arises which may significantly affect the validity of the existing assessment and/or plan" <https://www.gov.uk/government/publications/national-standards-for-the-management-of-offenders-and-a-competent-workforce-to-transform-rehabilitation>

<sup>98</sup> DHR chronology, 8 March 2010

<sup>99</sup> 10 March 2010

- 7.8 The next day<sup>100</sup> Ms A and Mr O were admitted to hospital having both taken an overdose. Ms A reported that she had impulsively taken the overdose of paracetamol and venlafaxine<sup>101</sup> as she had thought that Mr O was going to leave her. Both the police and the hospital's security officers were involved in managing an incident during their admission.
- 7.9 On 22 March 2010 Mr O sustained an injury to his left hand, which he reported was caused when he was trying to defend himself. He did not identify his assailant or the circumstances of the incident.
- 7.10 During the investigation into the unexplained injury that Ms A's son sustained while in her care,<sup>102</sup> it was noted at a strategy meeting (26 April)<sup>103</sup> that there was a history of domestic violence between Ms A and Mr O and that they both had ongoing issues with drugs and alcohol.
- 7.11 On 14 June 2010 Ms A rang the police to report that Mr O had stolen her purse. She later retracted this allegation. However, later that day she again called the police, reporting that Mr O had stolen £50. Police attended and noted that Ms A was very intoxicated and that she did not wish to report an offence or assault involving Mr O.
- 7.12 On 17 June 2010 Mr O presented himself to the Urgent Care Centre, reporting that his partner had assaulted him while she was intoxicated. He had sustained an injury to his finger and it was documented that he also had bite marks on his neck. He reported that both had occurred during an altercation 10 days earlier with Ms A. On examination Mr O revealed other injuries that he reported had occurred during this incident. These were multiple scars over both hands and on other parts of his body. A letter (25 June 2010) to Mr O's GP detailed both the cause and injuries sustained.
- 7.13 Four days later (21 June 2010) Ms A presented herself to her GP reporting that she was experiencing significant back and chest pain after being attacked. She reported that this attack involved someone pulling her hair. There is no evidence within her primary care notes that Ms A's GP enquired as to who had attacked her. But given the very recent escalation of incidents of violence between Ms A and Mr O, we can probably assume that her injuries may have been sustained in a domestic violence incident.
- 7.14 After this incident, the couple had separated for a short period and Ms A had briefly returned to live with her mother. On 14 July 2010 the police were called to a domestic disturbance. It appears that Ms A had returned to the property to collect her belongings, and an argument developed with Mr O. The police took Mr O to his parents' house in order to defuse the situation. By 19 July Ms A reported that she was again living with Mr O but that they were no longer in

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<sup>100</sup> 11 March 2010

<sup>101</sup> Venlafaxine: antidepressant used to treat major depressive disorder, anxiety and panic disorder

<sup>102</sup> 23 April 2010

<sup>103</sup> Information in DHR chronology

an intimate relationship. A month later Mr O reported to his probation officer that the relationship had resumed.

- 7.15 On 21 September 2010, during Ms A's son's birthday party at his grandmother's house, the police were called to a domestic incident between Ms A and her mother. The police assessed that there was an increased risk to Ms A's mother and referred the incident to a local domestic support agency.
- 7.16 When Ms A was next seen<sup>104</sup> by her support worker at probation, it was noted that they had discussed a referral to a domestic abuse organisation to support Ms A. There is no documented evidence to indicate if a referral was made.
- 7.17 This pattern in their turbulent relationship continued, and on several occasions the police were called. There was one incident when both parties had been drinking, Ms A reportedly told Mr O that she would "grass him up"<sup>105</sup> for a burglary offence. He then head-butted Ms A in the face, causing swelling to her nose, and she had to attend A&E. Mr O was later arrested, but Ms A refused to provide a statement and he was later released without charge. At a subsequent probation meeting which Ms A attended, it was noted that Mr O had scratches to his forehead which he claimed were from brambles, but it was noted that when Mr O reported this, Ms A became upset and left the meeting.
- 7.18 On 12 October 2011 Ms A attended A&E with a facial injury which she reported she had sustained in an assault. There was no evidence to indicate if Ms A disclosed or staff enquired as to the circumstances or identity of the assailant.
- 7.19 On 17 October 2011 it was also documented that they had reported that they were seeking relationship counselling. There is no evidence that this occurred.
- 7.20 Another incident occurred on 20 October 2011 when Ms A locked herself in the bathroom after a verbal argument with Mr O, who had been drinking. When police arrived Mr O left, and they assessed Ms A's risk as standard; however, due to previous incidents she was referred to their domestic violence unit. But she failed to respond to their repeated calls.
- 7.21 On 16 March 2012 both Ms A and Mr O were found guilty of handling stolen goods. Ms A received a 12-month community order. A pre-sentencing report for Mr O documented incidents of domestic abuse and therefore noted that a curfew would not be appropriate for him.<sup>106</sup>
- 7.22 On 16 April 2012 Ms A contacted Mr O's probation officer to report that he would be unable to attend his appointment as he had "accidentally been

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<sup>104</sup> DHR report, 19 July 2011

<sup>105</sup> DHR chronology, 11 October 2011

<sup>106</sup> DHR chronology, 15 March 2010

stabbed in his arm”<sup>107</sup>. Mr O later reported that he had sustained this injury while he had been playing darts with a knife. This incident was highlighted in one of Ms A’s police interviews<sup>108</sup> after the incident in 2013, but she did not confirm or deny that she had inflicted this injury on Mr O.

- 7.23 Ms A reported to her probation officer on 21 May 2012 that she had an injury to her finger which had resulted in exposure of the bone. She explained that she had been drinking with Mr O and had fallen and cut her finger on some glass.
- 7.24 On 30 July 2012, Mr O presented himself to an Urgent Care Centre with a further hand injury, reporting that he had ‘stubbed’ his finger. Four months later (20 November 2012), he again attended the same Urgent Care Centre with a further injury to his left hand, reporting that he had sustained it while cleaning out a kitchen cupboard.
- 7.25 There were no further recorded incidents of domestic violence or police involvement until the incident itself, although both Ms A and Mr O disclosed to their probation officers that alcohol was a significant factor in the difficulties in their relationship.

### **Arising issues, comment and analysis**

- 7.26 In a core assessment report (21 October 2010) that was prepared by children’s services for the residency order, it was documented that Ms A had a history of domestic violence with her previous partners and that in Ms A’s current relationship with Mr O it was known that domestic violence was an issue, although the report failed to identify who was the perpetrator and/or the victim.
- 7.27 Ms A’s mother reported to us that two weeks before the incident she had seen her daughter, who had a black eye, which she reported, had been caused by Mr O. There is no documented evidence to support this therefore we have to view this information as anecdotal.
- 7.28 The DHR stated that Mr O and Ms A were particularly chaotic individuals who were difficult to engage with, that their relationship was volatile and that they were in many respects co-dependent. Specific references were made to their ongoing self-destructive behaviours, criminality and avoidance in engaging with services.
- 7.29 There were records of eight incidents of violent assault involving Ms A and Mr O and also a number of recorded injuries that were noted where violence between them may or may not have been the cause.
- 7.30 There was an occasion when Mr O self-reported an incident of domestic abuse within the relationship (11 February 2010) in which he had sustained

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<sup>107</sup> DHR chronology, 16 April 2012, and also police interview

<sup>108</sup> Police interview with Ms A, 24 February 2013, 18:44, p3

physical injuries. However, despite this disclosure and observation of further injuries, there was no further exploration. He was given information about a local charitable organisation that offered support for males and females experiencing domestic abuse, but he dismissed this as an option for him.

- 7.31 There were several occasions when police undertook a number of domestic abuse assessments where Ms A was consistently viewed as the victim. These were assessed and followed up with offers of support, but either they were unable to make contact or she did not take up the offer of support.
- 7.32 The emergency duty team always passed on information to the locality team when the police were called to assist the family. Assessments were completed identifying domestic abuse as an issue of concern, and appropriate steps were taken to safeguard Ms A's son by supporting the grandmother and submitting a section 7 report to court that identified domestic abuse as a risk to the child if he were to reside with Mr O and Ms A. The locality team also viewed Ms A as the victim and Mr O as the perpetrator.
- 7.33 In the numerous assessments undertaken by the various community mental health teams (CMHT) with Ms A, it was noted that no issues of domestic violence were identified. She may have purposely denied this was occurring, or alternatively it may be that her perception of domestic violence and relationships differs to that of professionals and that she did not see her relationship with Mr O as being abusive.
- 7.34 Retrospective analysis identifies that domestic violence was a palpable and ongoing component of Ms A and Mr O's relationship. There is ample evidence to indicate that both Mr O and Ms A were the perpetrators of domestic abuse as well as the victims.
- 7.35 In our interview with Ms A, she clearly saw the violence as an integral and acceptable part of her relationship with Mr O. She reported to us that they would occasionally identify the link between their alcohol consumption and violence and agreed that they wanted to improve their relationship. However, she reported that following such discussions they would always continue to drink. There is considerable evidence<sup>109</sup> to suggest that there are significant links between domestic violence and substance misuse (both alcohol and drugs), both of which were significant factors that were prevalent in Mr O and Ms A's relationship.
- 7.36 The DHR suggested that the fact that Ms A was 10 years younger than Mr O was perhaps a significant factor, but it was difficult to determine from the level of information available to the authors how significant Mr O's influence may have been on Ms A's behaviours. It goes on to suggest that although a large age gap in itself is not necessarily a risk factor or concern, it can be indicative of issues around power and control that are often evident within relationships that involve domestic abuse.

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<sup>109</sup> <https://www.gov.uk/.../guidance-for-health-professionals-on-domestic-vi>.

7.37 The DHR considered Ms A and Mr O's relationship in light of research<sup>110</sup> into intimate partner violence (Coercive Controlling Violence, Violent Resistance, Situational Couple Violence and Separation-Instigated Violence).<sup>111</sup>

7.38 The DHR considered the question of whether Ms A and Mr O's ongoing domestic violence could be viewed in the light of Situational Couple Violence. Such a dynamic

“is the most common type of physical aggression in the general population of married spouses and cohabiting partners, and is perpetrated by both men and women ... Violence and jealousy may also exist as a recurrent theme in Situational Couple Violence, with accusations of infidelity expressed in conflicts.”<sup>112</sup>

7.39 The DHR authors went on to consider the issue of violence and gender in intimate relationships, suggesting that:

“Based on hundreds of studies, it is quite apparent that both men and women are violent in intimate partner relationships ... violence is not based on a relationship dynamic of coercion and control, is less severe, and mostly arises from conflicts and arguments between the partners (Johnson, 2006) ... female violence is common, occurs at about the same rate as male violence and is generated independently of the actions of the 'current boyfriend' or husband. Perhaps most importantly, the violence that is identified in these studies has a long developmental history, preceding the current adult relationship, so it cannot be dismissed as self-defence. ... Furthermore, female domestic violence offenders share many of the same characteristics as male offenders, including similar motives and psycho-social characteristics (prior aggression, substance use, personality disturbance etc.).”<sup>113</sup>

7.40 The DHR authors make a recommendation that “further work is undertaken to understand and assess situational couple violence and what interventions are the most effective in situations such as these”<sup>114</sup>. In addition, “links should be made with services working with child sexual exploitation to ensure issues of domestic abuse in relation to 16 to 18 year olds are assessed and addressed creatively as part of the child sexual exploitation action plan”<sup>115</sup>. When we interviewed TEWV's practitioners, they reported that they had not received any domestic violence training. In light of our findings that all agencies failed

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<sup>110</sup> Differentiation among types of intimate partner violence: research update and implication for interactions (2008) Kelly, B and Johnson, P in Family Court Review Vol 46 No 3 476-499

<sup>111</sup> Coercive controlling violence is a pattern of emotionally abusive intimidation, coercion and control coupled with physical violence against partners. Violent resistance (to a violent coercively controlling partner) is seen as a violent reaction in an attempt to stop or to stand up to coercive controlling violence. Situational couple violence is used to identify the type of partner violence that does not have its basis in the dynamic of power and control. Separation-instigated violence describes the violence which first occurs on separation

<sup>112</sup> DHR, pp94/95

<sup>113</sup> DHR, p96

<sup>114</sup> DHR, p101

<sup>115</sup> DHR, p101

to identify the complex relationship between Ms A and Mr O, which involved numerous incidents of domestic violence, we would like to reiterate the DHR recommendation that domestic violence training must be a core training component of TEWV's managers and practitioners. We would also recommend that primary care services also undertake such training.

**Recommendation 1:** Tees, Esk and Wear Valleys NHS Foundation Trust's community mental health services should undertake domestic violence training in order to improve both their understanding of and their responsibilities for reporting and taking the appropriate action in relation to suspected and known incidents of domestic violence.

**Recommendation 2:** The involved primary care services should undertake domestic violence training in order to improve both their understanding of and their responsibilities for reporting and taking the appropriate action in relation to suspected and known incidents of domestic violence.

## 8 Ms A's substance misuse

- 8.1 Ms A disclosed on several occasions that from the age of 13 years she had been a regular user of cannabis and also that she had taken amphetamines and was sniffing glue. However, she maintained that when she became pregnant she stopped drinking alcohol and taking illegal drugs.
- 8.2 Ms A's mother reported her concerns (1 June 2008) to children's services that her daughter was taking amphetamines when she was caring for her young son.
- 8.3 On 25 November 2010 Ms A disclosed to her probation officer that she occasionally used cannabis, but she consistently maintained until the incident in 2013 that she was not taking any other drugs.
- 8.4 However, when Ms A was arrested on New Year's Eve 2012, she disclosed that she was addicted to subutex.<sup>116</sup> She reported that she was using it on a daily basis and was buying it on the streets.<sup>117</sup> She also reported that when she was not using it she experienced significant physical withdrawal symptoms. She did not disclose this to her probation officer or to CMHT, and therefore it was not identified as a risk factor.

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<sup>116</sup> Subutex is the trade name for buprenorphine, which is a man-made (synthetic) drug licensed for the treatment of opioid (heroin, morphine) addiction

<sup>117</sup> Information obtained from DHR chronology, 1 January 2013

## 9 Ms A's psychiatric history

2009-2010

- 9.1 It was well documented within Ms A's primary care and CMHT notes that she had reported that from the age of 15 years she had been experiencing an eating disorder which was presenting itself as binge eating and self-induced vomiting with periods of extremely limited diet.<sup>118</sup> This was confirmed in our interview with Mr O's parents, who reported that while Ms A was living with them she would only eat limited types of food and at particular times.
- 9.2 Ms A first presented herself to her GP on 15 July 2009 with mental health issues. She reported that she was feeling "low"<sup>119</sup> and that she had, in the past, been binge drinking and taking cocaine. Her son was three years old at the time and she reported that she was feeling "very lonely" and isolated. She was initially prescribed escitalopram.<sup>120</sup>
- 9.3 On 1 September 2009 Ms A again presented herself to the GP reporting that she had recently ended a relationship, that she and her son had moved in with her mother and that she was feeling depressed. She also reported that she was feeling like she may take an overdose. The GP changed her antidepressant to venlafaxine (37.5mg).
- 9.4 At her next appointment<sup>121</sup> the GP undertook a PHQ-9 test<sup>122</sup> with Ms A and issued another prescription for venlafaxine. A second PHQ-9 was undertaken on 1 November 2009.
- 9.5 Ms A presented again on 29 November 2009 reporting that the prescribed antidepressant was having little effect and that she was experiencing rapid mood changes. The GP referred her to a local NHS counselling service; it is not evident if she engaged with this service.
- 9.6 At the next appointment Ms A reported that since the age of 14 she had been experiencing extreme fluctuation of moods, describing herself currently as feeling "all over the place"<sup>123</sup>. She reported that she would experience sudden "highs", when she would become very chaotic and unable to control herself, and that this was often connected to her alcohol consumption. She also reported that when she had been drinking excessively she would often not remember what she had done. The GP concluded that Ms A was

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<sup>118</sup> Letter from consultant psychiatrist to GP, 27 September 2011

<sup>119</sup> GP notes, 15 July 2009

<sup>120</sup> Escitalopram is used to treat depression and generalised anxiety disorder (GAD). It is an antidepressant that belongs to a group of medicines known as selective serotonin reuptake inhibitors (SSRIs)

<sup>121</sup> 1 October 2009

<sup>122</sup> PHQ-9 screening tool used to monitor the severity of depression and response to treatment <http://patient.info/doctor/patient-health-questionnaire-phq-9>

<sup>123</sup> GP notes, 27 January 2010

experiencing “rapid cycling mood disorder”<sup>124</sup>. As Ms A had recently moved, the GP advised her that she needed to register with her local GP and ask to be referred to the local mental health service.

- 9.7 By March 2010 Ms A had registered with the GP practice. She was seen on 11 March 2010 and the GP made a referral to the community mental health team (CMHT). It was documented that Ms A was presenting with some pressure of speech<sup>125</sup> and had disclosed some suicidal thoughts, although she did not have a specific plan and cited that her son was a strong protective factor.
- 9.8 On the same day Ms A took an overdose (16 paracetamol and 12 venlafaxine). The discharge summary reported that Ms A had disclosed that the reason for the overdose was that she had had an argument with her boyfriend and that she was afraid that he would leave her. She also reported that she had felt unable to cope with looking after her son and that her mother was looking after him until she had “sorted herself out”<sup>126</sup>.
- 9.9 Prior to her discharge a FACE risk assessment<sup>127</sup> was undertaken, and it was identified that Ms A had both historical and current drug and alcohol use. It concluded that Ms A was presenting with an enduring non-psychotic disorder, that her risk of suicide was low and that this was an impulsive overdose. She was subsequently discharged.
- 9.10 The Consultant Liaison Psychiatrist recommended<sup>128</sup> to the GP that in view of Ms A’s personality traits and dysthymia,<sup>129</sup> she should be prescribed prozac.<sup>130</sup>
- 9.11 At the next GP appointment<sup>131</sup> Ms A reported that she had been diagnosed with a bipolar disorder. We were unable to locate any evidence that indicated that Ms A had been given this diagnosis.
- 9.12 In a referral letter to the CMHT, the GP suggested that it was her opinion that Ms A was presenting with features of a personality disorder. It was noted that

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<sup>124</sup> GP notes, 27 January 2010

<sup>125</sup> Pressure of speech is a tendency to speak rapidly and frenziedly

<sup>126</sup> Liaison psychiatric assessment, 11 March 2010

<sup>127</sup> The FACE risk profile is part of the toolkits for calculating risks for young and older people with mental health problems, learning disabilities and substance misuse problems <https://www.evidence.nhs.uk/Search?q=face+risk+profile>

<sup>128</sup> Discharge summary, 12 March 2010

<sup>129</sup> Dysthymia persistent depressive disorder is a chronic (ongoing) type of depression in which a person’s moods are regularly low, but symptoms are not as severe as with major depression. <https://www.nlm.nih.gov/medlineplus/ency/article/000918.htm>

<sup>130</sup> Prozac (fluoxetine) is a selective serotonin reuptake inhibitors (SSRI) antidepressant

<sup>131</sup> 19 April 2010

Ms A was now being prescribed citalopram 20mg.<sup>132</sup> However, the referral letter did not report Ms A's recent overdose.

- 9.13 As Ms A failed to respond to two 'opt in' letters from the CMHT, her GP was informed<sup>133</sup> that she had been discharged from the service.
- 9.14 On 22 June 2010 Ms A attended her GP, asking to be referred to the CMHT again. The referral letter noted that Ms A's medication had been changed back to venlafaxine (75mg) and that she was also being prescribed temazepam<sup>134</sup> (10mg nocte) and diazepam.<sup>135</sup>
- 9.15 An initial assessment was completed by the CMHT on 15 July 2010. The FACE assessment documented that Ms A was at potential risk of deliberate self-harm and had a history of drug and alcohol use and of poor compliance with medication. It also noted that she had no forensic history and was not at current risk of victimisation from others. During this assessment Ms A disclosed that she had been unable to maintain relationships for a long time and that she had recently begun having a relationship with Mr O. It was documented that Ms A had "never experienced physical, sexual or emotional abuse"<sup>136</sup>.
- 9.16 Ms A also reported that from the age of 14 she had been experiencing ongoing issues with her moods. She disclosed that when she was in a low mood she would experience anxiety, poor concentration and a lack of self-confidence. At such times she would binge on food and spend excessive amounts of money. She also revealed that she'd had problems with alcohol in the past but denied any current substance or alcohol misuse.
- 9.17 It was noted that Ms A disclosed during the assessment that she had been misusing temazepam and diazepam but that she was now taking it as prescribed.
- 9.18 Ms A was discharged from the service. The discharge letter to the GP advised that Ms A had been diagnosed with dysthymia<sup>137</sup> and emotionally unstable personality traits. It also documented that Ms A had reported that the GP had been prescribing haloperidol<sup>138</sup> (500mcg) and that she had reported that it had helped with her levels of anxiety. The discharge summary advised the GP that the use of haloperidol should be reviewed after Ms A had been stabilised on antidepressants; it also suggested that Ms A should be prescribed

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<sup>132</sup> Citalopram is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Citalopram is used to treat depression

<sup>133</sup> 14 May 2010

<sup>134</sup> Temazepam: used to treat insomnia; intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class of psychoactive

<sup>135</sup> Diazepam is used to treat anxiety disorders, alcohol withdrawal symptoms or muscle spasms

<sup>136</sup> Care Coordinators Assistant & CP, 15 July 2010

<sup>137</sup> Persistent depressive disorder

<sup>138</sup> Haloperidol: antipsychotic medication

mirtazapine.<sup>139</sup> It was advised that a temazepam reduction programme should commence and that it had been suggested to Ms A that she self-refer herself to the local Improving Access to Psychological Therapies (IAPT) service.<sup>140</sup>

- 9.19 It appears that Ms A failed to make contact with the IAPT service.
- 9.20 Ms A's GP referred her again to the CMHT service on 13 September 2010, noting that she was experiencing ongoing anxiety and mood instability. After Ms A failed to respond to a number of 'opt in' letters sent by the CMHT, she was discharged back to the GP (11 November 2010).
- 9.21 A month later (3 December 2010) the GP again referred Ms A to the CMHT due to her ongoing low mood. In the referral letter the GP noted that "I am not sure what else I can offer her. I have given her a trial of duloxetine but I don't expect this to be really much more effective than venlafaxine and mirtazapine. I wonder if she does have a bi polar disorder which has never manifested itself with the manic state."<sup>141</sup>
- 9.22 Ms A was reviewed on 23 December 2010 by the CMHT GP registrar. A full assessment was completed. The FACE risk assessment noted that Ms A "wants medication for her depression. She is not convinced that any other approach will work."<sup>142</sup> It was documented that Ms A reported that she was experiencing severe problems with her relationships and was socially isolated, only having contact with her mother and boyfriend. It was also noted that Ms A's mental health problems were further exacerbated by some of her avoidance behaviour, that her function was severely impaired and that "she has lost her role as a mother and is concerned that her relationship will fail"<sup>143</sup>.
- 9.23 It assessed that Ms A's current risk was low, concluding that she was currently experiencing moderate depression with a "background of dysthymia"<sup>144</sup>, and confirmed the previous diagnosis of emotionally unstable personality disorder. It was also noted that "under considerable pressure from [Ms A] and based also on her previous response to haloperidol I have commenced an antipsychotic medication, quetiapine<sup>145</sup> (150 nocte)". The plan was to refer Ms A for an occupational functional assessment and then undertake a further review.

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<sup>139</sup> Mirtazapine: antidepressant used to treat major depressive disorder

<sup>140</sup> IAPT: Improving Access to Psychological Therapies. IAPT services are for people with mild, moderate and moderate to severe symptoms of anxiety or depression. <http://www.iapt.nhs.uk/services/>

<sup>141</sup> Referral letter from GP to CMHT, 3 December 2010

<sup>142</sup> FACE risk assessment, 23 December 2010

<sup>143</sup> Care Coordinator & CP, 23 December 2010

<sup>144</sup> Letter to GP, 23 December 2010

<sup>145</sup> Quetiapine is an atypical antipsychotic approved for the treatment of schizophrenia and bipolar disorder

2011

- 9.24 Ms A failed to respond to several 'opt in' letters inviting her for an occupational functional assessment and also failed to turn up to her subsequent appointment to see the CMHT's senior registrar. She was discharged back to the GP (15 March 2011).
- 9.25 It was documented that the CMHT Occupational Therapist (OT) made several attempts to contact Ms A but that she had not responded. Ms A's GP informed the OT that Ms A had moved and that there was no forwarding address.
- 9.26 On 12 May 2011 Ms A was again referred to the CMHT by a new GP, who reported that Ms A realised that she had missed several appointments but was requesting to be referred again.
- 9.27 The referral letter also noted that Ms A had disclosed that she had an eating disorder and that she had become "obsessed"<sup>146</sup> by her body image. The GP noted that she had recommenced prescribing antidepressants (venlafaxine).
- 9.28 Ms A was assessed by the CMHT on 8 June 2011 and another set of assessments was completed. FACE documented that Ms A had a diagnosis of "borderline personality traits with dysthymia"<sup>147</sup>.
- 9.29 It was assessed that Ms A was at low risk of suicide and self-harm, that it was 'not known' if Ms A had either a historical or a current risk of 'failure to attend appointments' and that Ms A did not have a current risk relating to alcohol or drug misuse. These issues had been previously noted within assessments as being historical and current risk factors. This indicates that the assessor failed to review Ms A's past assessments and PARIS<sup>148</sup> notes.
- 9.30 It was documented that Ms A had a son and that it was "unknown"<sup>149</sup> if there were any child protection issues. It failed to document where Ms A's son was living or ascertain information relating to Ms A's mother obtaining a residency order, what possible effects this may have had on Ms A's mental health or if it had contributed to her recent stress factors.
- 9.31 The FACE assessment also documented that Ms A was not at risk of "abuse and victimisation by others"<sup>150</sup>.
- 9.32 The assessment also noted that Ms A was keen to restart haloperidol, reporting that previously when she had been on this medication she had felt significant improvement.

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<sup>146</sup> Referral letter from GP to CMHT, 12 May 2011

<sup>147</sup> FACE, 8 June 2011, p6

<sup>148</sup> PARIS: clinical information system used by the Trust

<sup>149</sup> FACE, 8 June 2011, p4

<sup>150</sup> FACE, 8 June 2011, p7

- 9.33 The outcome of this assessment was that Ms A was referred for cognitive behavioural therapy (CBT). However, after further discussions at the CMHT's Access Meeting (14 June 2011), it was deemed that she should be referred to the IAPT service. She was discharged from the CMHT service back to her GP.
- 9.34 Ms A was accepted by the IAPT service, but she was informed that she would have to wait five weeks for an appointment to become available.
- 9.35 During this time the GP referred her to the CMHT crisis service (19 July 2011). The referral letter noted that Ms A had recently separated from her partner (Mr O) and was experiencing increasing mood swings and disordered thought processes. It also noted that although Ms A denied any drug misuse, it was known that she had a close association with known drug users, and therefore the GP suggested that it was a possibility that she was using illegal drugs.
- 9.36 The GP documented in Ms A's notes that when she had been seen by CMHT services when she was in a high mood, it was unlikely that she would have disclosed her issues. Therefore, the GP suggested that services might not have the accurate information to base their assessments on. The GP reported that in order for the CMHT assessor to base their assessment on a comprehensive profile of Ms A's complex presentation, he had asked her to write down her feelings and symptoms and that he was enclosing this with his referral letter.
- 9.37 We were able to access this account from Ms A, in which she eloquently explained her mood swings and the effects that they were having on her daily life. She also noted that she felt "misunderstood by medical teams all the time". She went on to say that "nobody is helping me properly please give me some proper medication so that I can live my life ... please help me before it's too late. I can't live with this forever I would rather not be here."<sup>151</sup>
- 9.38 The main concern for the GP and the reason for the referral to the crisis service was that Ms A was presenting as extremely anorexic. He also noted that Ms A was being prescribed duloxetine<sup>152</sup> (60mg), temazepam (10mg) and haloperidol (1.5mg when required). In order to ensure that she was being regularly reviewed by the GP, none of Ms A's medications were on repeat prescriptions.
- 9.39 On 28 July 2011 Ms A was assessed by a psychologist from the IAPT service, who reported that "currently I do not consider the patient suitable for brief CBT interventions as her presentation is too complex"<sup>153</sup>. The psychologist telephoned the affective disorder team to discuss the case with their psychologist. She was informed that their psychologist was leaving and was not accepting new patients.

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<sup>151</sup> Handwritten letter from Ms A to the crisis team (not dated)

<sup>152</sup> Duloxetine is a selective serotonin and norepinephrine reuptake inhibitor antidepressant (SSNRI)

<sup>153</sup> Letter to GP, 28 July 2011

- 9.40 Ms A was next seen by the CMHT GP on 8 July 2011, when again a full set of assessments was undertaken. It was assessed that one of Ms A's protective factors was that she was "in a supportive relationship though he can be erratic"<sup>154</sup>. It was also noted that Ms A was currently on probation for fraud.
- 9.41 The assessment concluded that Ms A was to be referred to the affective disorder team for further assessments with regard to her mental health and eating disorders, as well as to establish a diagnosis. She was to be allocated a care coordinator who would undertake a risk management and contingency plan.
- 9.42 Throughout this and in subsequent assessments, it is documented that Ms A denied any historical or current alcohol use. It was also noted that she had not experienced any physical, sexual or emotional abuse.
- 9.43 Ms A was accepted by the affective disorder team but did not attend her appointment with the care coordinator. Her care coordinator contacted Ms A by phone: she reported that she had only received the letter that day. Another appointment was given to her, which she attended. A FACE risk assessment was completed which documented that Ms A had disclosed that she had experienced fleeting thoughts of suicide on Sunday following an argument with her mother. She had planned to end her life on the following Tuesday, giving her time to see everyone. However, later that day she reported that her mood level became high and she denied any further suicidal ideation. She reported that she was increasingly unable to manage the extreme fluctuations in her moods.
- 9.44 She also reported that she was continuing to take her antidepressant medication duloxetine (60mg) but had recently stopped taking haloperidol due to side effects after she increased the dose of her own accord to 10mg. She stated that she intended to make an appointment with her GP to discuss recommencing haloperidol at a reduced dose of 5mg until she was seen by CMHT.
- 9.45 A further appointment with the care coordinator was made for 18 August 2011, which Ms A did not attend. Due to her care coordinator's annual leave, Ms A was offered another appointment on 8 September 2011 and was also provided with the contact details of the crisis service.
- 9.46 On 26 August 2011 a community psychiatric nurse made telephone contact with Ms A to monitor her wellbeing and to assess her current risk factors. It was documented that Ms A had outlined a detailed plan of her activities for that day, and she was given two telephone numbers to contact if she felt she needed further support while her care coordinator was away.
- 9.47 Ms A did not attend the outpatients appointment with her care coordinator (8 September 2011), but she did attend the CMHT offices on the following day, where she was seen briefly by the consultant psychiatrist. Her GP was subsequently advised to stop all her current medication and to issue a

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<sup>154</sup> FACE risk assessment, 8 July 2011, p6

prescription for quetiapine (50mg bd).<sup>155</sup> It was reported to the GP that Ms A was to be reviewed again by the CMHT in three weeks.

- 9.48 On 15 September 2011 Ms A telephoned the affective disorder team; she was very upset, and when she became too distressed she gave the phone to Mr O, who reported that she was upset as her mother was not allowing her to see her son. He also reported that he felt that Ms A would be alright and that he had the contact numbers for the team and crisis service if he felt that she needed further support.
- 9.49 Ms A's care coordinator wrote to Ms A and also left a voicemail message on her mobile (16 September) offering her an appointment on 23 September 2011. Ms A did not attend this appointment.
- 9.50 On 27 September 2011 Ms A attended a CMHT outpatient appointment with the consultant psychiatrist and her care coordinator. At this meeting a full assessment was undertaken and a care plan developed.
- 9.51 At this appointment Ms A reported that she felt that since commencing quetiapine there had been a positive improvement in her emotional stability. She also disclosed that since the age of 15 she had been experiencing ongoing eating problems. She described a repeated cycle of restricted dieting followed by bingeing and over exercising and that at its lowest her weight had been 7st 9lbs and at its highest 9st 12lbs. The psychiatrist assured Ms A that her weight and BMI – 8st 9lbs with a BMI of 19.5 – was currently within normal range.
- 9.52 It was agreed that the care coordinator would refer Ms A to a dietician and provide her with information regarding healthy eating. She would also provide Ms A with the opportunity to discuss her feelings and to provide her with “psycho education around depression”<sup>156</sup> to assist her in developing more positive coping strategies. Ms A was discharged from the consultant psychiatrist and it was agreed that the care coordinator would monitor her and that if there was any increase in Ms A's risks the care coordinator would liaise with the CMHT medics. Ms A's diagnosis was now changed to bulimia nervosa.<sup>157</sup>
- 9.53 Ms A was placed on a standard Care Programme Approach (CPA), and her care plan was to be reviewed in 12 months.
- 9.54 Ms A did not attend a subsequent appointment with her care coordinator (10 October 2011) or a subsequent appointment (17 October 2011) with her care coordinator and dietician.
- 9.55 The dietician gave the care coordinator a form to fill out with Ms A regarding her diet. It was recorded in Ms A's PARIS notes that the care coordinator was

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<sup>155</sup> Bd: twice daily

<sup>156</sup> Care plan review, 27 September 2011, p2

<sup>157</sup> Letter from consultant psychiatrist to GP, 27 September 2011

“reluctant to make another appointment at this stage as there is a risk that [Ms A] may become reliant on services. Also keen not to make the eating a focus as she is currently doing very well on her medication.”<sup>158</sup>

- 9.56 A further letter was sent to Ms A asking her to contact the service within 10 days. She failed to respond, and after another FACE review<sup>159</sup> was undertaken she was discharged back to her GP (4 November 2011).

2012

- 9.57 On 14 February 2012 Ms A's GP sent another referral to the CMHT. He reported that Ms A had disclosed that she was now living with her mother on a temporary basis, as her relationship had ended, and that she was experiencing ongoing emotional difficulties. It was also documented that she was continuing binge eating and was obsessively exercising.
- 9.58 The GP advised that she had not been issued with any prescription since 7 November 2011, so it was likely that she had run out of medication some time ago (quetiapine 50mg twice daily).
- 9.59 Ms A attended an appointment with a senior practitioner at the CMHT (28 February 2012) and a further set of assessments was completed.
- 9.60 During the assessment Ms A cited that her main problem was that she had been very agitated and emotional, with consistent low moods over the last few months, and that she was having difficulty concentrating. She also reported that she had stopped taking quetiapine two months ago, as she felt that it had not been effective.<sup>160</sup>
- 9.61 It was documented that Ms A reported that her previous contact with secondary mental health services had not helped, and it was noted that she “minimised her non engagement”<sup>161</sup>. Ms A was unable to identify exactly what would help her, but she wanted further medication to be prescribed.
- 9.62 Ms A disclosed that one of her current and significant factor at that moment was that her boyfriend was due to be released from prison imminently, and she was having difficulties with her mother whom she was temporarily living with. Based on the PARIS notes, it appears that neither of these issues was discussed in any further detail.
- 9.63 The FACE risk assessment noted that Ms A did not have a history of failure to attend appointments or disengagement with services.

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<sup>158</sup> PARIS entry, 17 October 2011, 13:15

<sup>159</sup> 3 November 2011

<sup>160</sup> Comprehensive assessment, 28 February 2012, p2

<sup>161</sup> Comprehensive assessment, 28 February 2012, p2

- 9.64 After discussions with the consultant psychiatrist, it was agreed that Ms A would resume being prescribed quetiapine (50mg), and she was discharged from the service.
- 9.65 The GP was not informed until 11 April 2012 of this change of medication and that Ms A had been discharged from the CMHT services.
- 9.66 On 11 April 2012 Ms A's probation officer contacted the senior practitioner of the CMHT reporting that Ms A was under the impression that she was scheduled for another appointment at the CMHT. As this was not the case, a letter was sent to Ms A advising her that she needed to contact her GP if she wanted to be referred. This letter was copied to the GP.
- 9.67 On 22 May 2012 the GP wrote to the CMHT again, asking them to see Ms A, as she was not responding to the medication and was continuing to feel very depressed.
- 9.68 Ms A did not attend her CMHT appointment (19 June 2012), and when she failed to respond to the follow-up letter she was discharged back to her GP.
- 9.69 On July 2012 Ms A registered with a new GP practice. At the initial consultation she reported that her previous GP had made a referral to the CMHT and that she was waiting for an appointment. She also asked for a prescription of sedatives. The GP wrote to the CMHT enquiring about the referral and also stated that as he did not yet have access to Ms A's previous GP records, he was reluctant to prescribe sedatives.
- 9.70 The CMHT sent out a letter to Ms A's new address asking her to contact them to arrange an appointment. Ms A made contact with the service and an appointment was arranged for 25 July 2012. Ms A did not attend this appointment and she was discharged back to the GP.
- 9.71 Ms A attended the GP surgery on several more occasions (3 July, 9 July, 17 July, 7 August, 28 August 2012) requesting sedatives. It was also noted that she had been removed from her previous GP list for not attending appointments (3 July 2012).
- 9.72 A GP entry on 9 July 2012 noted that she "needs to stick with one GP for continuity"<sup>162</sup>.
- 9.73 On 9 July the GP changed her medication to sertraline<sup>163</sup> (100mg), as Ms A reported that she thought that it had previously helped her.
- 9.74 Ms A reported to the GP that she had missed her appointment at the CMHT as she did not have the money to get there, but that she had arranged a further appointment the following week. We were unable to find evidence of this appointment.

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<sup>162</sup> GP notes, 9 July 2012

<sup>163</sup> Sertraline is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs)

- 9.75 At this appointment Ms A again asked the GP for sedatives. The GP noted that he felt that this was not appropriate, as she was “likely to fall into addiction”<sup>164</sup>. He therefore prescribed the beta blocker propranolol hydrochloride<sup>165</sup> (40mg).
- 9.76 There was no further contact with Ms A until 17 October, when she informed her GP that she had moved and was advised that she needed to register with a local practice.
- 9.77 On 31 October 2012 Ms A registered with a new GP practice. She attended an appointment where she reported that she was experiencing increased symptoms of depression and anxiety. She asked to be prescribed sertraline, but the GP noted that he was unwilling to issue a prescription until he had received her previous GP notes.
- 9.78 Ms A presented herself to the GP on 7 November 2012, again reporting that she was experiencing low moods and was having difficulty sleeping. Notes from the previous GP had been received and reviewed, so the GP was now willing to issue a prescription for sertraline (50mg). He also made a referral to the CMHT (9 November 2012).
- 9.79 On 21 November 2012 Ms A presented herself to the GP surgery reporting that she had taken an unknown quantity of her prescribed medication sertraline and subutex.<sup>166</sup> She was presenting with tachycardia,<sup>167</sup> with a pulse of 160 beats a minute.<sup>168</sup> The surgery called the emergency services and she was admitted to hospital.
- 9.80 On admission Ms A disclosed that she had taken sertraline x 10 (50mg) and zopiclone<sup>169</sup> x 12 (7.5mg) two days ago, and that morning she had also taken subutex (2mg and 0.4mg) x 1.
- 9.81 She reported that she had bought the subutex and zopiclone from a friend. She also reported that she had not intended to kill herself and that it was an accidental overdose.
- 9.82 A Scarborough alcohol test (2012) was completed: it documented that Ms A disclosed that she was drinking half a bottle of wine on a daily basis.
- 9.83 A SAD<sup>170</sup> assessment was completed by the crisis service. Ms A was assessed as low suicide risk, and as she reported that a referral had been made with the CMHT, she was discharged.

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<sup>164</sup> GP entry, 17 July 2012

<sup>165</sup> The beta blocker propranolol blocks the effects of the chemicals noradrenaline and adrenaline and therefore makes the heart slow down and reduces shaking. Can be prescribed in the treatment of the physical symptoms of anxiety

<sup>166</sup> Subutex is used in treating opioid dependence

<sup>167</sup> Tachycardia is a faster than normal heart rate at rest

<sup>168</sup> A normal resting heart rate for adults ranges from 60 to 100 beats a minute

<sup>169</sup> Zopiclone is a non-benzodiazepine hypnotic agent used in the treatment of insomnia

- 9.84 At Ms A's next appointment with the GP it was agreed that she should restart sertraline after she had assured the GP that she would only take the prescribed dose.
- 9.85 Ms A did not attend her appointment with the CMHT (6 December 2012). She then presented herself to her GP surgery reporting that she had mislaid her appointment card. Another appointment was arranged for 28 December. She also did not attend this appointment.

January 2013 leading up to the incident (22 February 2013)

- 9.86 On 11 January 2013 Ms A presented herself to her GP. She disclosed that she had been arrested for ABH<sup>171</sup> following an incident on New Year's Eve but that she had no recollection of the incident. She reported that she was feeling very depressed and anxious and that she was also feeling paranoid. The GP made another referral<sup>172</sup> to the CMHT and prescribed flupenthixol (1mg).<sup>173</sup>
- 9.87 Ms A was seen by the CMHT's OT for an initial assessment on 23 January 2013. A full set of assessments was undertaken.
- 9.88 In the mental health clustering tool assessment, it was assessed that Ms A had significant "craving and dependency" issues in relation to drinking and drug taking, with minor issues in relation to depressive moods and aggressive and disruptive or agitated behaviour.
- 9.89 The FACE risk assessment assessed that Ms A was at low risk of violence to others despite it being noted that she was "due in court to answer charges under Section 18 wounding with intent – incident occurred on the 31/12/2012 – while under the influence of alcohol Ms A was involved in a fight and allegedly bit a male's ear off."<sup>174</sup> The assessment goes on to document that Ms A had no historical or current ideas of harming others but that she had current risks of physical harm to others.
- 9.90 Ms A's overdoses in 2010 and 2012 were both noted within the FACE assessment and were assessed as impulsive incidents while she was under the influence of alcohol. It documented that Ms A did not identify her alcohol use as a "problem or as a negative coping strategy"<sup>175</sup>.

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<sup>170</sup> SAD: clinical assessment tool used to determine suicide risk

<sup>171</sup> ABH: assault causing actual bodily harm

<sup>172</sup> 14 January 2013

<sup>173</sup> Flupenthixol belongs to the family of medications known as thioxanthenes. This medication is used in the treatment of nervous, mental and emotional conditions

<sup>174</sup> FACE risk assessment, 23 January 2013, p1

<sup>175</sup> FACE risk assessment, 23 January 2013, p4

- 9.91 The assessment also noted that Ms A had a history of non-concordance with medication, non-attendance and poor engagement with services, but it assessed that these were not current risk issues.
- 9.92 It was also assessed that she was experiencing “definite problems with relationships”<sup>176</sup>, although there was no explanation as to what exactly Ms A had disclosed about her relationship difficulties. The FACE assessment also documented that Ms A “denied any form of abuse”<sup>177</sup>.
- 9.93 Ms A’s protective factors were identified as being her mother, her partner and her son.
- 9.94 The assessor concluded that Ms A’s risk of violence to others was “low”, as were her risks relating to impulsivity, but that there needed to be further assessments and formulation<sup>178</sup> of her mental health needs. The assessment was to be discussed at the MDT<sup>179</sup> in order to identify the most appropriate course of treatment.
- 9.95 Ms A disclosed that she was currently binge drinking three nights a week. It was noted that she did not view her drinking as a problem and had limited insight into the negative impact on her physical and mental health of her drinking. The assessor noted that when under the influence of alcohol Ms A could be impulsive and was recently involved in a fight where she was alleged to have bitten a man’s ear off.
- 9.96 A further appointment was arranged for 20 February 2013; however, this appointment had to be rescheduled due to medical sickness. One of the CMHT secretaries tried to phone Ms A in order to reschedule but was unable to make contact with her.
- 9.97 Ms A arrived at the CMHT offices the following day (21 February 2013) and was seen by a medical secretary. She was requesting that a medical report be completed for her impending court case. Her presentation was described as being “settled; clean and kempt in appearance”<sup>180</sup>. The secretary explained that staff had been trying to contact her in order to rearrange her appointment. Ms A was advised that a further appointment was in the process of being arranged. It was reported that Ms A stated that she was “fine”<sup>181</sup> with this, and she was also advised that she could contact them if she needed any support before her next appointment.

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<sup>176</sup> MH clustering tool, p2

<sup>177</sup> FACE risk assessment, 23 January 2013, p6

<sup>178</sup> Formulation brings together all the relevant information (historical and current, familial and psych social history) about a patient and will inform risk assessments, diagnosis and treatment plans

<sup>179</sup> MDT: multidisciplinary team meeting

<sup>180</sup> Case notes entry, 21 February 2013 , p8

<sup>181</sup> SIR, p24

9.98 This was the last time Ms A was seen by mental health services; the incident occurred the following day (22 February 2013).

### Arising issues, comment and analysis

9.99 As an adolescent Ms A was presenting with behavioural and drug and alcohol misuse issues. She was excluded from school at the age of 14. At the age of 15 she received a criminal charge for vandalism and was referred to the local drug treatment agency. During the period of their initial assessment Ms A became pregnant and was discharged from the service. It was noted that during this time she was socialising with known criminals and heroin users and was described as having a very poor attitude and being difficult to engage with.

9.100 After Ms A's child was born, it appears that her mother was providing extensive support to both her daughter and her grandson. During 2008-9 she began to report to children's services her increasing concerns the wellbeing of her grandson. As we have been unable to access the health visitor's notes, we are unable to comment if there were any concerns being documented about Ms A's mental health in the period after she gave birth until 2009.

9.101 Ms A had a number of known risk factors that research indicates are likely to have significant effects on a teenage mother's mental health and her ability to parent. It is also identified that they will be at significant risk of developing abusive interpersonal relationships and social isolation. Research<sup>182</sup> and governmental strategies<sup>183</sup> at the time identified that teenage mothers were:

“three times more likely than older mothers to develop postnatal depression, with around 40 per cent of young mothers affected. This not only impacts on the young woman, but can also impair her ability to form a close attachment to her baby ... be an attentive and nurturing parent ... to have mental health problems ... to have experienced domestic abuse ... Teenagers who become parents are also more likely than other teenagers to lack the strong social and emotional skills.”<sup>184</sup>

9.102 From 2009 Ms A was presenting herself initially to her GP reporting that she was experiencing fluctuating moods and depression as well as being socially isolated. Based on the evidence that we have been able to obtain, it appears that consideration was not given to the fact that Ms A's presenting symptoms may have been related to the fact that she was a teenage mother and therefore vulnerable and at risk.

9.103 It was noticeable to us that neither the DHR nor TEWV's serious incident report made any comment on or correlation between Ms A's mental health

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<sup>182</sup> Department of Health & Department for Education and Skills (2004). National Service Framework for Children, Young People and Maternity Services. Sure Start Children's Centers Practice Guidance.

<sup>183</sup> Department of Health, Every Child Matters: Change for Children (2004) <http://www.everychildmatters.gov.uk>. Department of Health (July 2008), *Teenage Parents: who cares? A guide to commissioning and delivering maternity services for young parents* Second edition

<sup>184</sup> Martins C & Gaffen EA (2002). Effects of early maternal depression on patterns of infant-mother attachment: a meta-analytic investigation.

and the fact that she was a teenage mother and that her son had been removed from her care.

- 9.104 It was also noticeable to us that her attendance at the GP increased around the time that her mother was taking over the care of her son and applying for the residency order. It was also the time that her relationship began with Mr O.
- 9.105 On occasions Ms A was disclosing, both to her GP and during a CMHT assessment that she wanted to regain custody of him. Despite such disclosures no agency documented if they were considering that this situation may, at least in part, have had some effect on Ms A's mental health presentation.
- 9.106 Additionally, in our review of the numerous risk assessments and support plans that were undertaken by CMHT, we noted that no consideration was being given to what support Ms A, as a young single parent, may have needed in terms of risk factors, therapeutic intervention and practical assistance in accessing her son. There appears to have been no attempt by the CMHT services to liaise with children's services in order to ascertain information or to verify the circumstances of the situation. Such information would have informed Ms A's support needs and their FACE assessments regarding both Ms A's potential risk to children and also her own risk factors.
- 9.107 Despite the difficulty and volatility of Ms A's relationship with her mother and her intermittent contact with her son, both were identified within the CMHT assessments as protective factors.
- 9.108 Without exception all the CMHT assessments were based on information self-reported by Ms A, who was, it is now apparent, an unreliable self-historian who provided partial and at times false information, particularly in relation to her mental health symptoms, her alcohol use, her efforts to regain custody of her son and the fact that she was in an abusive relationship. For example, it was not until 2013, after she was arrested for biting the ear off an individual, that she admitted to CMHT that she was binge drinking. Yet probation had identified her alcohol use as an ongoing risk factor in her criminality and a significant factor in Ms A and Mr O's relationship.
- 9.109 During our interviews with Ms A she reported that she had not disclosed the extent of her alcohol use to CMHT and her GP because she thought that they would not prescribe her the psychiatric medication she wanted if they knew the extent of her alcohol consumption.
- 9.110 There is no evidence to indicate if the CMHT services attempted to seek to obtain Ms A's consent to involve her mother or Mr O in her assessments or to gain her permission to liaise with probation services. Probation was the only agency that had a consistent relationship with Ms A and therefore could have provided some valuable information about Ms A's risks, their concerns about her alcohol consumption and their suspicion that there were issues of domestic abuse within Ms A and Mr O's relationship.

9.111 TEWV's clinical risk assessment and management policy at the time stated:

“Clinical risk assessment must be based on thorough collection of information from all available sources and cover all aspects of the service user's early life experiences, cognitive, emotional, psychological, physical, behavioural and social factors. If the service user is likely to have or resume contact with children the risk assessment must include assessment of the potential risks to children.”<sup>185</sup>

9.112 Additionally, TEWV's CPA policy identified the importance of information sharing as a key to effective care planning.<sup>186</sup> It also stated that the service user should expect “a comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks ... Information should be gathered from as many relevant sources as possible.”<sup>187</sup>

9.113 One of the main difficulties that faced both the primary and community mental health services was that from when Ms A first began to present herself, there was a repeated pattern occurring. She would present herself to her GP, reporting that she was experiencing various mental health issues, and at times she would request specific psychiatric medications. She would agree to be referred to community mental health services but would fail to attend the initial assessment and/or subsequent follow-up appointments. Despite repeated written 'opt in' letters and telephone reminders, the usual outcome was that she failed to respond and would be discharged back to her primary care service, only to present herself once more, often within a relatively short period of time, asking to be referred again.

9.114 Between 2010 and 2013 her GPs made 15 referrals to local CMHT services, requesting assessments and definitive diagnoses to be made, and at times asking for a review of Ms A's medication. During this period Ms A was given various diagnoses (persistent dysthymia, borderline personality disorder, anxiety and mood disorders, and bipolar and eating disorders). The most consistent diagnosis was a borderline personality disorder, although at times other problems became the primary concern, especially to the GPs, for example significant weight loss, which she was reporting was due to her ongoing eating disorder.<sup>188</sup>

9.115 NICE's key recommendations and guidelines for the care and treatment of patients with borderline personality disorders<sup>189</sup> state that mental health trusts should develop multidisciplinary specialist teams or services for people with personality disorders and that these teams should have specific expertise in the diagnosis and management of borderline personality disorder. At no time

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<sup>185</sup> TEWV's clinical risk assessment and management policy, 2013, p5

<sup>186</sup> TEWV's CPA policy, 2013, p4

<sup>187</sup> TEWV's CPA policy, p6, p11

<sup>188</sup> July 2011

<sup>189</sup> NICE clinical guideline 78 (2009) <https://www.nice.org.uk/guidance>

was Ms A referred to such a team; instead, she was managed within generic CMHT.

- 9.116 The NICE national guidance<sup>190</sup> also outlines that long-term psychotherapy is currently the recommended treatment for borderline personality disorders. Ms A was referred to the IAPT, which assessed that her needs were too complex to be managed by the service. The IAPT psychologist did try to refer Ms A to the affective disorder service, but due to staff changes the referral was not accepted. No further specialised psychological therapy was offered to Ms A.
- 9.117 It was reported to us<sup>191</sup> that such a specialised service (for example intensive psychotherapy) is available, but that to obtain a placement requires specific funding approval by CCG. Such services are provided in the more urban areas of the Trust, and given Ms A's extensive history of disengagement from services and the fact that such services were a considerable distance from where Ms A lived, it is probably unlikely that she would have engaged with such a service.
- 9.118 We were informed that the CMHT services provided dialectical behaviour therapy (DBT)<sup>192</sup>, which may have been helpful to Ms A, but again her repeated disengagement meant that they never arrived at the stage where this was offered to her.
- 9.119 Both the CMHT and Ms A's various GPs prescribed a number of antipsychotic and antidepressant medications. This was in line with the NICE guidance regarding psychiatric medications, which may impact isolated symptoms and co-morbid conditions associated with borderline personality disorders. The only group of drugs which were not prescribed to Ms A were mood stabilisers, such as valproate semi-sodium, which are known to have some success in ameliorating<sup>193</sup> depression, interpersonal problems and anger.
- 9.120 It was not clear how compliant Ms A was with various medications. In August 2011 she reported to a CMHT community psychiatric nurse (CPN) that she had been increasing the dosage of her medication (haloperidol), and when she was admitted to hospital in 2012 she disclosed that she had taken excessive amounts of her prescribed medication alongside other drugs (subutex) that she had bought from friends.
- 9.121 At times Ms A would report that the previous medication had not significantly improved her symptoms and therefore she had stopped taking it. She would often request certain medication, reporting either that she had taken it previously and that it had had some good effect (haloperidol), or that she believed that it would help her with particular symptoms that she was experiencing, for example insomnia and anxiety. However, as Ms A did not

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<sup>190</sup> NICE clinical guideline 78 (2009) <https://www.nice.org.uk/guidance>

<sup>191</sup> Interview with TEVV's Director of Operations

<sup>192</sup> Dialectical behaviour therapy (DBT) is a therapy designed to help people change patterns of behaviour that are not helpful, such as self-harm, suicidal thinking and substance abuse

<sup>193</sup> Ameliorate: to make or become better, more bearable, or more satisfactory; improve

engage with either primary care or mental health agencies, they were unable to monitor the effects of such medications over a period of time.

- 9.122 During our interviews with Ms A, we asked her why she had so consistently failed to attend appointments with the CMHT. She reported to us that it was never her intention to attend these appointments or take up offers of therapeutic help. She disclosed that she only attended such appointments in order to obtain certain prescription drugs and that she would not take the prescribed dosage but rather use them for recreational purposes. She also reported that she never disclosed the amount of alcohol she was drinking, as she knew that she would not be prescribed medication. Although this does provide important insight into Ms A and her lifestyle, we would suggest that it does not negate the difficulties that she was experiencing in terms of both her mental health and the various issues that she was managing in her life.
- 9.123 We also noticed that the information provided by the GPs to CMHT was quite variable in content. We were informed by some members of the CMHT that at the time and currently there is no standardised pro forma for such referrals, and that at times they did not receive adequate information about patients from the referring GP, which created some delays in them being able to complete their assessment process. We would suggest that such a standardised process would be advantageous for both parties, as it would ensure that adequate information about a patient is communicated and would expedite the process.
- 9.124 Every time Ms A was referred to the CMHT a complete and comprehensive assessment process was undertaken, which included a FACE risk assessment and the beginnings of a care plan. This was in line with TEWV's clinical risk assessment and management policy (2012).
- 9.125 In our review of these numerous assessments, we did question the value and purpose of so many assessments. We were informed that to review a patient's previous assessments, which in Ms A's case was extensive, and to complete the assessment process could take a significant amount of time, not only because of the size of the assessments, but also because previous information has to be manually transferred onto the latest assessment forms. We were informed that this process can take up the initial appointment and at times subsequent appointments with a patient.
- 9.126 For a patient such as Ms A, who had a history of repeated disengagement after the initial appointment, and due to the time it takes CMHT practitioners to complete the required assessment process, we would like to suggest that the Trust convenes a working party that includes both medics and practitioner, for example CMHT consultant psychiatrist and service manager, to consider piloting an alternative type of assessment and service model. We looked at models used in other clinical disciplines where they use a more direct access approach, in which the patient undertakes a full assessment process on entry to the service. For the following 12 months they are able to contact the service directly when they are experiencing difficulties, and they will be seen within a short time frame, where only a brief assessment review is undertaken. A full assessment is undertaken for all patients every 12 months. When we

discussed this type of service with the CMHT's practitioners whom we interviewed, some expressed some concern, but generally it received a very positive response. It was identified that it would enable a more responsive service to be offered that met the immediate needs of patients but also would possibly reduce the amount of non-attendance of routine clinic appointments. We would like to suggest that TEWV considers piloting such a scheme and evaluates its effectiveness and usage after 12 months.

9.127 It was also suggested that it would be helpful if the PARIS system was able to self-populate historical information, especially risk information, from previous assessments onto any subsequent assessments. It was agreed that this would greatly reduce the amount of time that it takes CMHT practitioners to review prior assessments and also ensure that important historical information is being consistently considered.

9.128 During Ms A's involvement, TEWV's Did Not Attend policy was updated on two occasions (September 2010 and February 2011). Both required that after a DNA, three attempts should be made to contact the patient by telephone within the first 24 hours. There is no evidence that this occurred when Ms A did not attend her appointments.

9.129 The revised Did Not Attend Policy (2011) required that "the referral will be taken to the team's allocations meeting/duty supervisor to discuss further actions needed"<sup>194</sup>. As this is not recorded within Ms A's PARIS notes, we are unable to ascertain if this occurred.

9.130 Since this incident TEWV have introduced a further revised Did Not Attend policy (June 2013), which among other action areas states that:

"If the service user fails to respond to a second letter, the referral should be discussed with the referrer (if this is the GP) and further actions agreed. If discharge is agreed with the GP, a discharge letter will be sent to both the service user and the original referrer ... If the service user fails to respond to the second letter, the referral should be discussed within the team and further actions agreed."

9.131 We reviewed the decision to manage Ms A's risk and support needs under a standard CPA<sup>195</sup> with regard to the Department of Health's guidance CPA policy and practice (March 2008)<sup>196</sup> and TEWV's Care Programme Approach policy (2012). The principles for use of standard care are:

"More straightforward needs. One agency or no problems with accessing other agencies/support. Low risk to self or others. More able to self-

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<sup>194</sup> TEWV's Did Not Attend policy

<sup>195</sup> The system of provision of mental health/learning disability services to those service users not receiving care delivered within the CPA framework. For the purposes of this policy all the principles and values outlined for CPA above also apply to standard care

<sup>196</sup> [webarchive.nationalarchives.gov.uk/.../http://.../dh\\_083649.pdf](http://webarchive.nationalarchives.gov.uk/.../http://.../dh_083649.pdf)

manage mental health needs. Easy/likely to maintain contact with services.”<sup>197</sup>

9.132 Given Ms A’s limited insight into her mental health, ongoing poor compliance with medication and lack of engagement with mental health services, and that it was known that Ms A was under a probation order and that there had been some children’s services’ involvement with regard to her child, we would suggest that she should have been placed on what was at the time called an enhanced CPA.

9.133 This policy also identified what support carers should expect from services. It states: “Carers identified and informed of their right to an assessment of their needs”<sup>198</sup>. Despite it being documented that both Mr O and Ms A’s mother were providing ongoing support to Ms A, there is no documentation indicating that either were offered a carer’s assessment.

**Recommendation 3:** For patients who have had a teenage pregnancy or who have been involved in custody issues, Tees, Esk and Wear Valleys NHS Foundation Trust’s practitioners should take this into consideration when assessing their risk and support plans.

**Recommendation 4:** Tees, Esk and Wear Valleys NHS Foundation Trust, local primary care services and their commissioner (CCGs) should agree a referral form to be used when primary care referring a patient to Tees, Esk and Wear Valleys NHS Foundation Trust’s community and inpatient mental health services.

**Recommendation 5:** Tees, Esk and Wear Valleys NHS Foundation Trust should consider undertaking a pilot project in one of their community mental health services that offers an alternative support pathway for patients who are difficult to engage with and who only require support at points of crisis or when there are any changes in their risk factors.

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<sup>197</sup> TEWV’s Care Programme Approach policy (2012), p16

<sup>198</sup> TEWV’s Care Programme Approach policy (2012), p30

**Recommendation 6:** Tees, Esk and Wear Valleys NHS Foundation Trust should consider if it is possible for their patient electronic system PARIS to self-populate historical risk information automatically into any subsequent assessment forms.

## 10 Ms A's contact with the criminal justice system

- 10.1 Ms A first came into contact with the judicial system when she was 14<sup>199</sup> (2004), when she received a warning for harassment relating to an incident that occurred in school. The following year she was convicted in a Juvenile Court<sup>200</sup> for criminal damage. She received a four-month referral order to a youth offending team.
- 10.2 Ms A next came to the attention of the courts in November 2010, when she and Mr O were arrested and charged with theft from a motor vehicle and fraud. This involved stealing a credit card from an unlocked car and spending £990.20.
- 10.3 It was reported that both Ms A and Mr O were under the influence of alcohol and were misusing antidepressants at the time of committing the offence.
- 10.4 Ms A pleaded guilty. She received a community order and was ordered to pay £445 in compensation and £50.00 court costs.
- 10.5 It was also assessed that Ms A posed a medium risk to her son, but that the mitigating factor was that he was in the care of his grandmother and that Ms A only had supervised access.
- 10.6 During her assessment Ms A disclosed that she was aware that she became aggressive while under the influence of alcohol.
- 10.7 The OASys<sup>201</sup> assessment documented that Ms A was a risk to herself and at emotional and physical risk from her partner (Mr O). It was also assessed that she was at increased risk when under the influence of alcohol. The plan was to support Ms A by addressing her relationship issues and helping her to reduce her alcohol consumption.
- 10.8 On one occasion Ms A attended an appointment with her probation officer (10 February 2011) with her son. The probation officer informed Ms A that she would have to contact children's services regarding having unsupervised

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<sup>199</sup> 23 May 2004

<sup>200</sup> 25 November 2005

<sup>201</sup> OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the National Probation Service from 2002 to measure the risks and needs of criminal offenders under their supervision

contact with her son. Ms A reported to her probation officer that it was her intention to regain custody of her son in the next 12 months.<sup>202</sup>

- 10.9 Up until March 2011 Ms A was attending all her appointments with her probation officer. On 3 March 2011 Ms A's support was transferred to the Community Supervision Service (CSS), who were to provide general support and signposting to community resources. At this appointment it was noted that Ms A's relationship with Mr O had "improved due to the couple refraining from alcohol use"<sup>203</sup>.
- 10.10 On 26 May 2011 Ms A's mother asked to see her daughter's support worker at CSS and reported that her daughter was unwell. She referred to the fact that her daughter had an eating disorder and was currently extremely weak and in bed. The support worker visited Ms A at home and noted that she had lost a considerable amount of weight since she was last seen.
- 10.11 Ms A contacted<sup>204</sup> her support worker to inform her that she had left Mr O and had moved in with her mother. Six days later she contacted her support worker again to report that she had moved back in with Mr O. It was noted that she was very upset.
- 10.12 Ms A failed to attend her last appointment with her support worker on 4 September 2011.
- 10.13 On 2 December 2011 Ms A was arrested for the offence of handling stolen goods. The incident involved Ms A selling some items of stolen jewellery. She pleaded guilty to handling stolen goods and was sentenced to a community order of 12 months (16 March 2012).
- 10.14 At the initial OASys assessment, details of Ms A's mental health history were documented, indicating that there had been some liaison between probation and mental health services. The assessment noted that Ms A had been diagnosed with "mild depression and emotionally unstable personality disorder"<sup>205</sup>. On 25 June 2012 Ms A's probation officer offered to text her to remind of her next CMHT appointment in order to support her to attend.
- 10.15 Again the OASys assessment concluded that Ms A remained at medium risk to children due to her "inability to properly care for her son and domestic abuse perpetrated by her partners"<sup>206</sup>.
- 10.16 There were several occasions when Ms A did not attend her probation appointments, and several times she was issued with warning-of-breach letters. In the main Ms A did engage with her probation officer and

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<sup>202</sup> 17 February 2011

<sup>203</sup> Assessment, 3 March 2011

<sup>204</sup> 7 July 2011

<sup>205</sup> OASys assessment, 5 April 2012

<sup>206</sup> OASys assessment, 5 April 2012

subsequently her CSS support worker, who was supporting her to develop a CV.

- 10.17 Ms A was referred to a mental health counsellor by her probation officer (29 November 2012). As part of the referral the probation officer discussed areas of concern with regard to Ms A's mental health and safeguarding concerns, but not the known concerns regarding domestic violence. Ms A failed to attend her first appointment with the counsellor, reporting that she had forgotten that she had an appointment but said she wanted help.<sup>207</sup> There is no indication that Ms A attended any further appointment with the counsellor.
- 10.18 Due to ongoing issues regarding Ms A repeatedly missing her probation appointments, a home visit was arranged, but Ms A was not at home. Her mother contacted her daughter's probation officer to explain that she had missed her appointment as she had become unwell and was staying with her. This explanation was accepted and no breach letter was issued.
- 10.19 Ms A was not seen again until after the incident at New Year, when she was accused of biting the ear off a male during a street fight. Ms A reported that she had no recollection of the incident.
- 10.20 At the next and at subsequent appointments, Ms A's probation officer<sup>208</sup> used the alcohol audit scoring tool to evaluate Ms A's current drinking patterns and also gave her a drinks diary to complete.
- 10.21 Ms A last saw her probation officer at a home visit on 7 February 2013, when she reported that she had been keeping her drink diary and that she was reducing her alcohol consumption.
- 10.22 Ms A failed to attend a scheduled appointment with probation on 21 February 2013. Mr O reported that she was unwell and would not be attending her appointment with her probation officer. This was the last contact the probation service had with either Ms A or Mr O.

### **Arising issues, comment and analysis**

- 10.23 On no occasion did the CMHT seek to gain Ms A's permission to liaise with her probation officers. If this had occurred, both services would have been able to obtain a more comprehensive profile that would have deepened their knowledge of Ms A and her difficulties.
- 10.24 Such inter-agency sharing of information would have enhanced the identification of Ms A's risks and also her support needs. As it was, agencies were operating in isolation, and assessments by all agencies were being made based on partial and at times inaccurate information.
- 10.25 We were informed that since this incident, a multi-agency information sharing protocol has been developed which includes probation services. If this

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<sup>207</sup> 7 December 2012

<sup>208</sup> 3 January 2013

protocol is effective, then we would hope that many of the issues that have been identified in this case will not occur again.

**Recommendation 7:** A review should be undertaken of the current Multi-Agency Information Sharing Protocol that is in place within Tees, Esk and Wear Valleys NHS Foundation Trust's area to ensure that all services are operating within the protocol.

## 11 Ms A's housing

- 11.1 By 2008 Ms A and her young son, who was two years old, were living alone in a general needs social housing property. There was no evidence that she was receiving any housing support.
- 11.2 By 29 December 2009 Ms A and her son had moved back in with her mother, where she remained until she and Mr O moved into their first private rented accommodation.<sup>209</sup>
- 11.3 From this point on Ms A and Mr O moved into a succession of private rented properties. On 18 October 2010 it was documented<sup>210</sup> that they had been evicted and were now living with Mr O's family.
- 11.4 On 4 March 2011 Ms A reported to her probation officer that there were increasing tensions in Mr O's family home due to overcrowding.
- 11.5 By 24 March 2011 Ms A and Mr O had moved, but on 5 September 2011 they reported that they were facing eviction, as they were unable to afford the rent.
- 11.6 By 11 October 2011 they had moved into another rental accommodation, and they moved again on 16 March 2012.
- 11.7 Two further moves occurred in 2012 (8 May and 18 June 2012); these properties were located near to Ms A's mother.

### Arising issues, comment and analysis

- 11.8 In total Ms A moved accommodation on eight occasions, and apart from one social housing tenancy, she lived in a succession of private sector housing. On at least one occasion she and Mr O were evicted due to non-payment of rent, and on another occasion they had to move into Mr O's family home. It was noted that overcrowding was an issue and contributed to Ms A's mental health issues.
- 11.9 The consequence of these multiple moves was that she often had to change her GP and probation services. This clearly contributed to the fact that no one

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<sup>209</sup> 5 February 2010

<sup>210</sup> Information taken from DHR chronology, 18 October 2010

agency was able to develop an enduring relationship with Ms A or to maintain an overview of her care and psychosocial situation.

11.10 Ms A's housing difficulties were never highlighted or identified as significant needs or risks within the successive FACE or care plans.

11.11 In our opinion, Ms A's ongoing difficulties in obtaining appropriate, affordable and secure housing left her vulnerable in terms of her housing needs and would have also exacerbated her instability and social isolation.

11.12 The correlation between inadequate housing, unstable tenancies, homelessness and mental health is well recognised. It is reported that people who are homeless have 40-50 times higher rates of mental health problems than the general population and that they are one of the most disadvantaged and excluded groups in our society.<sup>211</sup> Securing and maintaining appropriate housing has been identified that inadequate housing and homelessness is a particular issue for people with mental ill-health as "poor housing conditions and unstable tenancies can exacerbate mental health problems while periods of illness can in turn lead to tenancy breakdown"<sup>212</sup>. Research<sup>213</sup> also indicates that individuals who have inadequate housing or experience homelessness often fail to receive the appropriate care and treatment for their mental health conditions for a number of reasons:

- "poor collaboration and gaps in provision between housing and health services;
- failure to join up health, social care and housing support services, and disagreements between agencies over financial and clinical responsibility; and
- failure to recognise behavioural and conduct problems such as self-harm, self-neglect, tenancy issues such as substance misuse and anti-social behaviour."<sup>214</sup>

11.13 In the case of Ms A, it is evident that her poor housing and homeless status was not being identified or given adequate consideration within successive assessments by clinicians; nor was she being provided with adequate support to obtain affordable and secure accommodation.

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<sup>211</sup> Department of Health. No health without mental health: a cross-government mental health outcomes strategy for people of all ages. February 2011 <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

<sup>212</sup> National Housing Federation <http://www.housing.org.uk/policy/health-care-and-housing/mental-health>

<sup>213</sup> St Mungo's, Down and Out? Mental health and street homelessness, 2009 [www.mungos.org/homelessness/.../1251\\_down-and-out-the-final-report-](http://www.mungos.org/homelessness/.../1251_down-and-out-the-final-report-)

<sup>214</sup> St Mungo's, Down and Out? Mental health and street homelessness, 2009

**Recommendation 8:** Tees, Esk and Wear Valleys NHS Foundation Trust's risk assessments and recovery support plans should always identify and consider a patient's housing situation. Where a patient is experiencing housing issues, this should be identified and considered as a significant risk factor and one that requires multi-agency intervention and support.

## 12 Tees, Esk and Wear Valleys NHS Foundation Trust

### Profile of Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

- 12.1 TEWV provides a range of mental health, learning disability and eating disorder services for the 1.6 million people living in County Durham, the Tees Valley, Scarborough, Whitby, Ryedale, Harrogate, Hambleton and Richmondshire. TEWV currently employs over 6,000 staff over c. 180 sites. The services are spread over a wide geographical area of around 3,600 square miles, which includes coastal, rural and industrial areas.<sup>215</sup>
- 12.2 We were informed that TEWV has a Clinical Assurance Framework in place. This consists of the Quality and Assurance Committee (QuAC), which is a subcommittee of the Board of Directors, who oversee the clinical governance systems and processes and the Trust-wide governance infrastructure. The QuAC reports to the Board of Directors monthly and provides assurance on the quality of services by monitoring regulatory compliance, services and clinical outcomes. Within each of the Trust's four localities there is a Locality Management and Governance Board (LMGB), which receives monthly assurance on the quality of services from the Directorate Quality Assurance Groups (QuAGs). QuAGs are in place for each of the localities' functional service directorates.
- 12.3 The directorate QuAGs receive monthly information reports on a range of quality metrics and indicators, including patient safety, safeguarding and patients' experience. The monthly reports include trend analysis of incidents and complaints and the progress of action plans that have arisen from serious incident reports.
- 12.4 TEWV convenes rapid process improvement workshops. These are frequent events facilitated by trained teams who work with the operational and clinical team from each service. Prior to the workshop the team scrutinise all aspects of the service, including reviewing of any serious incidents and complaints, in order to develop a comprehensive understanding of the issues that a particular team may be facing.

<sup>215</sup> Information taken from TEWV website. <http://www.tewv.nhs.uk/About-the-Trust/>

- 12.5 In addition, every month the Trust has “report-out” of quality improvement events. We were informed that currently all Heads of Service and Band 7 levels are in the process of being trained to be workshop leads.

### **TEWV’s serious incident report (SIR)**

- 12.6 We have benchmarked TEWV’s Level 2 serious incident report (SIR), utilising the National Patient Safety Agency’s RCA investigation evaluation checklist.<sup>216</sup>
- 12.7 Following the incident, TEWV commissioned a root cause analysis (RCA) investigation “into the incident to identify any systems, procedures or operational matters arising from the investigation into the serious untoward incident, which are required to be brought to the attention of the chief executive of the trust to establish the full facts and sequence of events and identify the contributory factors and to identify and share learning points in order to reduce the risk of similar future adverse events”<sup>217</sup>.
- 12.8 TEWV commissioned an external investigator to chair the SIR panel. The other panel members included a non-executive director, clinical director and clinical governance lead.
- 12.9 We undertook a telephone interview with the chair of the SIR panel.
- 12.10 The SIR noted that “the panel used the root cause analysis (RCA) framework to review and analyse the information collected”<sup>218</sup>. The SIR identified a significant number of patient, communication, risk, policy, procedural, and environmental factors, but concluded “that there were no fundamental root causes or causal factors for this incident”<sup>219</sup>.

### **Arising issues, comment and analysis**

- 12.11 We concluded that the SIR provided an extensive chronology and in-depth details and analysis of Ms A’s involvement with primary and secondary community mental health services. There was also extensive reference to local and national policies and guidelines in relation to personality disorders.
- 12.12 The author of the SIR reported to us that he had not been aware that a DHR was being undertaken at the same time as his investigations. He also reported to us that the SIR panel had interviewed staff in a group setting and suggested that perhaps such a setting was not the most facilitative environment for staff to feel able to disclose sensitive information.
- 12.13 The SIR panel did not access primary care notes, but they did request and receive a summary from the GP which detailed their involvement with Ms A.

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<sup>216</sup> National Patient Safety Agency (2008), RCA Investigation: Evaluation, checklist, tracking and learning log

<sup>217</sup> SIR, p60

<sup>218</sup> SIR, p6

<sup>219</sup> SIR, p39

- 12.14 Ms A's last primary care service reported to us that they had not received any feedback from the Trust's SI report, nor were they invited to attend a post-incident feedback event.
- 12.15 Ms A's mother and Mr O's family were unclear as to whether they had received feedback from either the SIR and/or the DHR, as they were occurring at the same time.
- 12.16 We made numerous requests to TEWV to obtain the notes from the SIR, however, they were unable to locate them. The National Patient Safety Agency's RCA investigation guidance<sup>220</sup> recommends that evidence from SIR, which includes interview transcripts, is safely and securely stored. In future we would recommend that TEWV follows this guidance in relation to the storing of SIRI interview transcripts to ensure that they are able to access, when required, this information.
- 12.17 The methodology utilised by the author of the SIR was described as root cause analysis. However, we saw no evidence of this methodology within the report, for example a fishbone diagram.<sup>221</sup> Inclusion of such an investigative aid would have assisted the reader to focus on the causal factors.

**Recommendation 9:** Staff who are interviewed as part of a Trust's serious incident investigation should be offered the opportunity to have a one-to-one meeting with the investigative panel.

**Recommendation 10:** We would recommend that Tees, Esk and Wear Valleys NHS Foundation Trust follows the National Patient Safety Agency's RCA investigation guidance with regards to the collection and storage of interview notes.

**Recommendation 11:** Authors of serious incident reports should include evidence within their reports of the methodology that is being utilised; for example when utilising root cause analysis methodology a fishbone (Ishikawa) diagram and/or 5 Whys should be included within the report.

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<sup>220</sup> <http://www.nrls.npsa.nhs.uk>

<sup>221</sup> A fishbone diagram is a visual way to look at cause and effect. Can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories

## **Tees, Esk and Wear Valleys NHS Foundation Trust's progress on the implementation of the SIR action plan**

- 12.18 The two Locality managers, who we interviewed, informed us that they had developed a combined action plan for the areas within the SIR that related to their services and that a specific event was held with representation across the two localities to discuss the implementation of the Action Plan.
- 12.19 With regard to monitoring the progress of action plans relating to Ms A's SIR, we saw evidence that this action plan was audited by TEWV's clinical audit and effectiveness team in July 2015.
- 12.20 In addition, we were provided with a tracking tool which was being used by Redcar and Cleveland locality to ensure evidence was collected in relation to the combined action plan for Redcar and Cleveland and Scarborough, Whitby and Ryedale CITs. The tracking tool identified the progress of all teams within the Redcar and Cleveland locality in implementing the action plan as well as the points that were outstanding.
- 12.21 Out of the 19 actions, all but one area has been implemented. The outstanding issue is the introduction of a supervision template.
- 12.22 The tracking tool for Redcar and Cleveland also noted where developments within the Trust have superseded the particular recommendations of the SIR. Particularly in relation to introduction of the Trust's Structured Clinical Management (SCM) procedure, the provision of personality disorder care pathway and related policies.

## **Arising issues, comment and analysis**

- 12.23 We were satisfied that all the action plans relating directly to the CMHT services were either implemented or were in the process of being implemented and that the respective CMHTs were able to locate and provide evidence of the completed action plans.
- 12.24 We were informed that it is the responsibility of TEWV's Patient Safety Team to coordinate SIRs and to monitor the subsequent action plans. We were also informed that both historic and current recommendations from SIR action plans are entered into a database. This enables the identification of who has responsibility for the implementation of each action and identifies themes and root causes which inform future policy and operational developments within the Trust. It was also reported to us that since this case, there have been significant changes of personnel and processes within TEWV's Patient Safety Team. Despite these developments, there was a considerable delay in TEWV's Patient Safety Team providing us with the updated SIR action plan for this case.
- 12.25 We were informed that SIR's action plans can involve many different directorates and that it can be challenging for the Patient Safety Team to monitor the progress of individual action plans. It was reported to us that there have been some significant developments in the commissioning of SIR and

the monitoring of action plans. It was also reported to us that it is hoped that such processes will now enable more effective, reliable up-to-date data being maintained on a central database which will be monitored by the Patient Safety team. However given the difficulties that the Patient Safety Team had in providing us with up-to-date information on this particular action plans, we would suggest that a review is undertaken in order to identify what exactly were the issues and to ensure that they have been fully resolved.

**Recommendation 12:** Tees, Esk and Wear Valleys NHS Foundation Trust should undertake a review of the difficulties the Patient Safety Team had in providing the investigation team with an up to date action plan on this case. To ensure that the issues that have been highlighted within this report have now been fully resolved.

## 13 Domestic homicide report

- 13.1 The domestic homicide report (DHR) was commissioned by York and North Yorkshire Safer Communities Board. The particular area of focus of the DHR was “the relationship and interactions between Primary Care, Mental Health and Substance Misuse Services in relation to the identification and progression of concerns in relation to Domestic Abuse in general and in relation to Mr O and Ms A”<sup>222</sup>.
- 13.2 We have been asked to “cross reference and compare”<sup>223</sup> the DHR findings with our findings and conclusions.
- 13.3 We agreed with the DHR’s conclusion that on the occasions when agencies did become aware of incidents of domestic violence between Ms A and Mr O, they were managed in isolation. Additionally, the involved agencies did not identify the complex issues within Ms A and Mr O’s relationship where situational couple violence was a key dynamic. Despite it being known that both Mr O and Ms A had substance misuse issues, there was no referral made to specialised services.
- 13.4 DHR also identified that the communication between community mental health services, primary care services and probation services was particularly inconsistent and was of concern to the authors of the DHR in relation to information sharing and the management of risk.
- 13.5 The authors of the DHR concluded that the “challenge of working effectively in a multi-agency way with other agencies and families experiencing domestic abuse where the situation is volatile and chaotic is challenging. This is

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<sup>222</sup> DHR, p10

<sup>223</sup> NHS England (North) TOR

particularly the case where there are pre-existing concerns in relation to mental health, substance misuse and offending. It remains a challenge in the current context of policy change, budget reductions and new commissioning arrangements to be clear about how to effectively work together. Finding a way of the agencies working far more routinely together around this cohort of people may be a way of helpfully building on some of the good individual examples in this case in relation to communication between GP's, Mental Health, Probation and Specialist Substance Misuse Services. The concept of multi-agency co-ordination meetings for such a cohort should be considered."<sup>224</sup>

## Arising issues, comment and analysis

- 13.6 The DHR provided an extensive chronology relating to Ms A and her son and Mr O. It also provided an in-depth analysis of and commentary on all the agencies who had been involved in Ms A and her son as well as Mr O.
- 13.7 Both the families contributed to the DHR and provided considerable insight into the complexities of Ms A and Mr O's relationship.
- 13.8 We agreed with all the findings and conclusions of the DHR. However, there were several issues that were either unknown at the time of the DHR or that the authors did not highlight as significant issues. These were:
- During our interview with Ms A, she provided us with information that she did not appear to have disclosed during her interview with the authors of the DHR. This was in relation to the fact that she had never intended to engage with CMHT services and that she only attended appointments in order to obtain certain prescription drugs. Also, she had used the prescribed medication for recreational purposes and she never disclosed the amount of alcohol she was drinking, as she knew that she would not be prescribed medication. This disclosure provided us with significant additional information and has enabled us to gain a more in-depth profile of Ms A's mental health and lifestyle and provided us with a different perspective on her failure to engage with services. It is unclear why she had not disclosed this to the DHR authors.
  - We would suggest that the DHR failed to identify as a significant issue Ms A and Mr O's lack of secure and affordable accommodation, which we have suggested left them vulnerable in terms of their housing needs and would have also exacerbated Ms A's instability and social isolation.
  - The DHR also did not highlight the fact that Ms A began to present herself to primary care and CMHT after she lost custody of her son; nor did they consider the effects that this may have had on her ongoing mental health and support needs.

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<sup>224</sup> DHR, p94

## Tees, Esk and Wear Valleys NHS Foundation Trust's progress on the implementation of DHR's action plan

- 13.9 As part of NHS England's Terms of Reference for this case, we were asked to support and review TEWV's progress on implementing the recommendations that arose from the domestic homicide report.
- 13.10 Again we had considerable difficulty in obtaining an up-to-date action plan, and there was considerable confusion within TEWV as to which directorate was responsible for overseeing domestic homicide reports' action plans. We were eventually provided with an updated action plan.
- 13.11 Of the three recommendations made by the authors of the domestic homicide report in relation to TEWV, it was reported to us that two recommendations have been fully implemented. These are:
- "All teams will maintain accurate records.
  - Following discharge from services the GP should be notified."
- 13.12 We were informed that since this incident there has been considerable progress in improving communication and discharge processes between TEWV's mental health and primary care services. TEWV now employs a GP Strategic Advisor whose role is to engage with primary care teams.
- 13.13 We saw evidence of TEWV's new discharge template that was rolled out in February 2014. We were informed that this was developed in collaboration with service users, carers and GP leads.
- 13.14 We were advised by the Director of Quality Governance that TEWV had been acting, in an advisory capacity, to the Royal College of Physicians Workshop on Discharge. Additionally TEWV has also recently been approached by Health and Social Care Information Centre (HSCIC) to be a national case study with regards to their approach to discharge planning.
- 13.15 With regards to the DHR's recommendation regarding the standard of TEWV's clinical record keeping and the monitoring of compliance by the use of an annual audit of record keeping. We were provided with evidence of TEWV's Clinical Audit of Clinical Record Keeping that was completed in February 2016. A total of 527 records, both paper and electronic records, were assessed for the purpose of this audit which included both inpatient and community services. The audit focused on clinical records compliance with both national and local guidelines. Of the three issues identified as outstanding none of them were directly related to the issues that we identified within this investigation.
- 13.16 We did have concerns that despite the fact that the domestic homicide report was published on 25 August 2014, one action is still outstanding. This is: "there should be mechanisms within the Trust to identify people who have multiple referrals but fail to engage with services." The action plan states that "the development work this refers to sits within the review as part of the

Clinical Risk and Harm Minimisation project. The draft policy will be due for completion June 2016.” We were informed that TEWV’s Associate Director of Nursing, Quality and Risk has the responsibility for monitoring this project.

- 13.17 As a result of our enquiries, TEWV has recognised that they do not have a robust and coordinated approach to the monitoring of action plans resulting from domestic homicide reports. It was reported to us that the responsibility for monitoring domestic homicide report’s action plans will now be within TEWV’s Patient Safety Department.

**Recommendation 13:** Tees, Esk and Wear Valleys NHS Foundation Trust should provide NHS England (North) with evidence of the completion of the outstanding recommendation from the domestic homicide report.

## 14 Predictability and preventability

- 14.1 Throughout the course of this investigation, we have remained mindful of one of the requirements of NHS England’s Terms of Reference, which was that we should consider if the incident which resulted in the death of Mr O was either predictable<sup>225</sup> or preventable<sup>226</sup>.
- 14.2 While analysing the evidence we obtained, we have borne in mind the following definition of a homicide that is judged to have been predictable, which is one where “the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it”<sup>227</sup>.
- 14.3 A significant amount of information regarding Ms A’s historical and recent psychosocial background has only come to light during the course of this investigative process. We were able to access Ms A’s primary care notes and probation records as well as the DHR’s report and chronology. None of these sources of information were available to the primary care service, the community mental health services who were assessing and supporting Ms A, or the author of the SIR report. This benefit of hindsight<sup>228</sup> has been extremely

<sup>225</sup> Predictability is “the quality of being regarded as likely to happen, as behaviour or an event”. We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. <http://dictionary.reference.com/browse/predictability>

<sup>226</sup> Prevention means to “stop or hinder something from happening, especially by advance planning or action” and implies “anticipatory counteraction”; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring. [http://dictionary.reference.com/browse/predictability\\_wrong\\_reference](http://dictionary.reference.com/browse/predictability_wrong_reference)

<sup>227</sup> Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000), 176: 116-120

<sup>228</sup> Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the

useful to us, as it has assisted us in developing a comprehensive profile of both Ms A and the events that led up to the incident itself which resulted in the death of Mr O.

## Predictability

- 14.4 There are a number of significant issues that have come to our attention during the course of our investigations which had direct relevance to an assessment of the predictability of the incident that led to the death of Mr O.
- 14.5 Although it was well documented that Ms A had a significant history of impulsive behaviours, neither primary healthcare nor community mental health services were able to sufficiently engage with her in order to develop a profile of either her mental health needs or her risk and protective factors. Also, the extent of Ms A's alcohol consumption and abuse of prescription medication were significant issues in both her relationship with Mr O and her lack of engagement with services.
- 14.6 It is evident that in the month before the incident, there was a significant escalation in the level of Ms A's violence. She had been arrested for a significant violent attack and was reporting that she was unable to recall the incident, due to her level of intoxication. This indicates that there was a significant increase in Ms A's disinhibited and antisocial behaviours.
- 14.7 We are now aware that Ms A's relationship with Mr O was complex and had many elements of situational couple violence, and there were many documented incidents where both were either the perpetrators or the victims of domestic violence.
- 14.8 Often alcohol was a key factor in such incidents, and although, at the time, they both expressed some remorse, neither engaged nor disclosed the true extent of their difficulties to their respective support services. Based on Ms A's disclosure to us, she and Mr O had some insight into the role that alcohol played in the volatility of their relationship, but they continued with this pattern of behaviour.
- 14.9 We have concluded that the death of Mr O on 22 February 2013 was not predictable by TEWV mental health services. However, from the evidence that we have, it was clear that as the events of that night unfolded, there were several significant key triggers and risks present. Both Ms A and Mr O were drinking alcohol extensively and over a considerable period of time, which had previously led to impulsive behaviours and Ms A reported that she had a significant addiction to subutex. At some point an argument developed between Ms A and Mr O and escalated to such an extent that Ms A's brother removed himself from the room. We now know that previously such a combination of events had often led to incidents of violence in which either Ms A or Mr O sustained physical injuries.

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same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)

14.10 Given such a history, and the fact that such volatile combinations of risk factors were present, we would suggest that it was predictable, or at least a real possibility that at some point the violence was likely to increase to such a level that significant injuries would occur to either of them.

## **Preventability**

14.11 In our consideration of the preventability of this incident, we have asked ourselves the following two questions. Based on the information that was known, were Ms A's risk factors and support needs being adequately identified and assessed? Additionally, was it reasonable to have expected individual practitioners to have taken more proactive steps to have obtained information from either Ms A or the significant people in her life, that is her mother and Mr O?

14.12 What was clearly apparent to us was that Ms A was repeatedly presenting herself to both primary healthcare and community mental health services in crisis. However, no service was able to engage with her or assess her needs and risks, as she would disengage with services after the initial assessment appointment. The probation service was the only service that had developed a significant ongoing relationship with Ms A and was also obtaining some intelligence from the police, and therefore had some knowledge of her risks and difficulties. However, there was no evidence of information sharing, and it is clear that both primary healthcare and community mental health services were basing their assessments solely on Ms A's self-reporting and did not seek to obtain Ms A's permission to talk to probation services, her mother or Mr O. It is now evident that Ms A was clearly an unreliable self-historian and that there were many risk issues that she failed to disclose.

14.13 We have concluded that based on what was known at the time by services, the incident itself was not preventable. However, had a more inter-agency approach been adopted, then information could have been shared and a more comprehensive profile of Ms A's presenting issues, risks and support needs could have been identified. Additionally, we would suggest that community mental health practitioners should have more proactively considered how they could have addressed Ms A's repeated pattern of presenting in crisis and then disengagement.

## **15 Overall analysis and recommendations**

15.1 What was clearly evident to us was that Ms A was a very vulnerable young woman, who had complex needs and, due to her lifestyle, was at high risk to herself and within her relationships. She began to present herself to primary and community mental health services at a time when she had lost custody of her son, and this continued to be a theme through her sporadic contact with services. We felt that the full impact of this loss was not considered to any great extent by services or seen as a contributory factor to her issues and behaviours.

15.2 Despite Ms A's self-disclosure to us that she was consistently misusing prescribed medication and that she never intended to engage with community

mental health services, it was clearly evident that she was experiencing ongoing mental health difficulties and needed the support of services. The difficulties that practitioners were facing were how to engage such a vulnerable young adult within the restraints of the CMHT's service model, where a full and time-consuming assessment process has to take place at every new referral. Often such assessments were taking place within only a few weeks of a previous set of assessments. Not only were such assessments time-consuming, but they resulted in missed opportunities where a deeper understanding of Ms A's needs and risks could have been obtained and she could have been engaged in a therapeutic relationship.

## **16 Recommendations**

**Recommendation 1:** Tees, Esk and Wear Valleys NHS Foundation Trust's community mental health services should undertake domestic violence training in order to improve both their understanding of and their responsibilities for reporting and taking the appropriate action in relation to suspected and known incidents of domestic violence.

**Recommendation 2:** The involved primary care services should undertake domestic violence training in order to improve both their understanding of and their responsibilities for reporting and taking the appropriate action in relation to suspected and known incidents of domestic violence.

**Recommendation 3:** For patients who have had a teenage pregnancy or who have been involved in custody issues, Tees, Esk and Wear Valleys NHS Foundation Trust's practitioners should take this into consideration when assessing their risk and support plans.

**Recommendation 4:** Tees, Esk and Wear Valleys NHS Foundation Trust, local primary care services and their commissioner (CCGs) should agree a referral form to be used when primary care referring a patient to Tees, Esk and Wear Valleys NHS Foundation Trust's community and inpatient mental health services.

**Recommendation 5:** Tees, Esk and Wear Valleys NHS Foundation Trust should consider undertaking a pilot project in one of their community mental health services that offers an alternative support pathway for patients who are difficult to engage with and who only require support at points of crisis or when there are any changes in their risk factors.

**Recommendation 6:** Tees, Esk and Wear Valleys NHS Foundation Trust should consider if it is possible for their patient electronic system PARIS to self-populate historical risk information automatically into any subsequent assessment forms.

**Recommendation 7:** A review should be undertaken of the current Multi-Agency Information Sharing Protocol that is in place within Tees, Esk and Wear Valleys NHS Foundation Trust's area to ensure that all services are operating within the protocol.

**Recommendation 8:** Tees, Esk and Wear Valleys NHS Foundation Trust's risk assessments and recovery support plans should always identify and consider a patient's housing situation. Where a patient is experiencing housing issues, this should be identified and considered as a significant risk factor and one that requires multi-agency intervention and support.

**Recommendation 9:** Staff who are interviewed as part of a Trust's serious incident investigation should be offered the opportunity to have a one-to-one meeting with the investigative panel.

**Recommendation 10:** We would recommend that Tees, Esk and Wear Valleys NHS Foundation Trust follows the National Patient Safety Agency's RCA investigation guidance with regards to the collection and storage of interview notes.

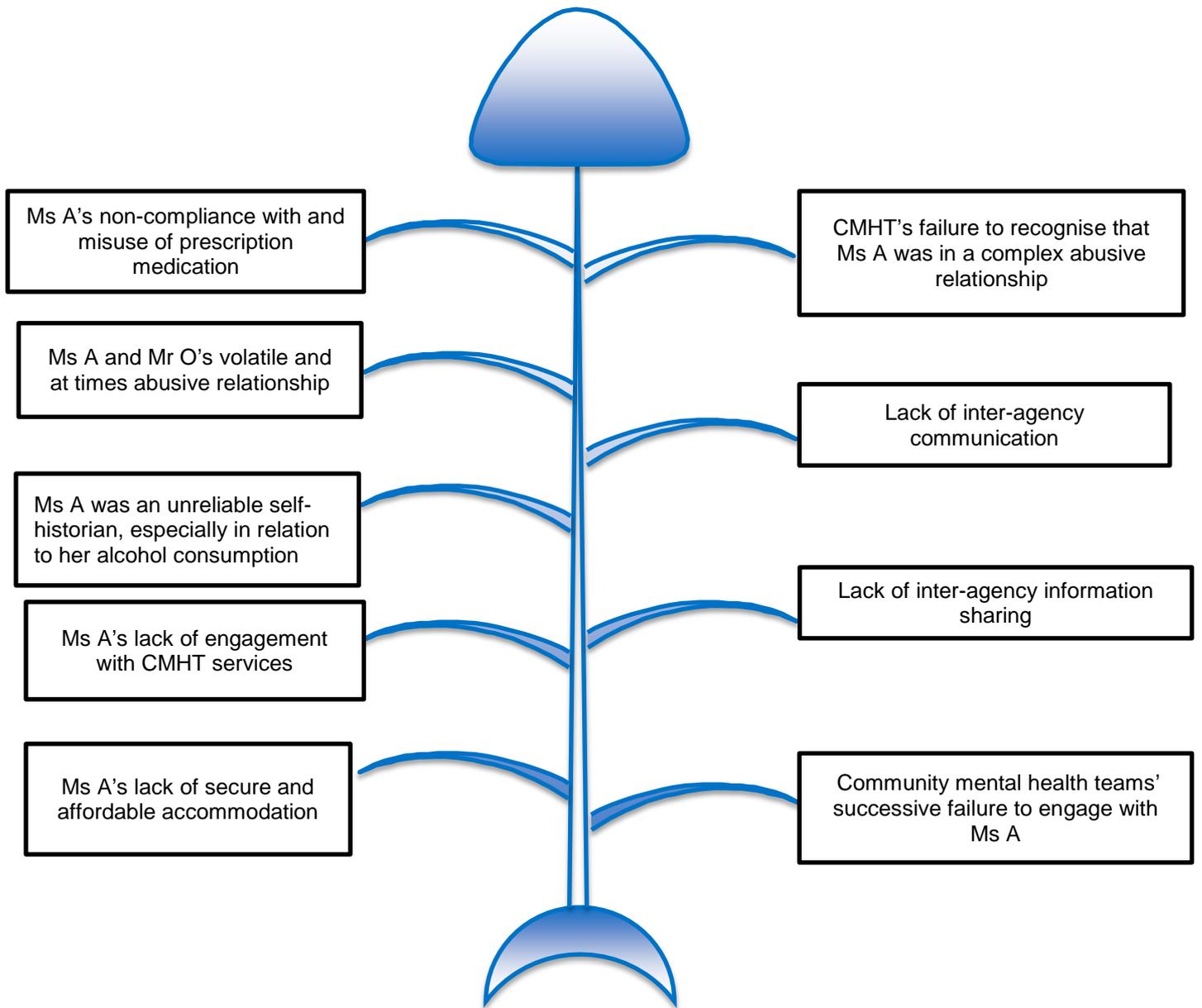
**Recommendation 11:** Authors of serious incident reports should include evidence within their reports of the methodology that is being utilised; for example when utilising root cause analysis methodology a fishbone (Ishikawa) diagram and/or 5 Whys should be included within the report.

**Recommendation 12:** Tees, Esk and Wear Valleys NHS Foundation Trust should undertake a review of the difficulties the Patient Safety Team had in providing the investigation team with an up to date action plan on this case. To ensure that the issues that have been highlighted within this report have now been fully resolved.

**Recommendation 13:** Tees, Esk and Wear Valleys NHS Foundation Trust should provide NHS England (North) with evidence of the completion of the outstanding recommendation from the domestic homicide report.

# Appendix 1

The fishbone diagram



## Appendix 2 – Terms of reference

- Review the Trust's internal investigation and assess the adequacy and robustness of its findings, recommendations and resultant action plan.
- Review the progress that the Trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence.
- Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement.
- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation.

### **Supplemental to the core terms of reference:**

- Review the full maternity pathway to seek assurance in the following areas:
  - That the appropriate level of support was provided during the antenatal and postnatal period.
  - The handover of information from maternity services to the health visiting service was robust.
  - Was there any involvement of mental health services?

**In relation to the preceding domestic homicide report:**

- Review the content and findings of the 2013/4 DHR report, identify any additional key lines of enquiry required for this investigation.
- Cross reference and compare DHR findings with investigation findings and conclusions, where appropriate concur with DHR commentary and findings.
- Support Tees, Esk and Wear Valleys Trust to develop a comprehensive outcome focused action plan which also takes into account DHR findings and recommendations.

## Appendix 3 – Chronology from 2010 to 2013

Date	Source	Event	Age	Comments
17/01/2010	DHR	Police received intelligence that Ms A had begun a relationship with Mr O.	19	Mr O was known to police
21/01/2010	DHR	Referral received by children's services regarding Ms A's son.		
25/01/2010	DHR	Ms A's mother contacted children's services to inform them that her daughter's son was staying with her.		
05/02/2010	GP notes	Ms A requested antidepressants: prescribed venlafaxine 37.5mg.		Venlafaxine: to treat major depressive disorder, anxiety and panic disorders
08/03/2010	DHR	Ms A's mother contacted social workers to report incident in which her daughter had phoned her asking her to take her son. Grandmother reported that it was her intention to apply for a residency order.		Interim residency order granted. Residency order: court order regarding whom a child is to live with
10/03/2010	GP notes	GP appointment: Ms A reported that she was low in mood with periods where she felt high. Wanted to end her life but not specific thoughts, and her son was a protective factor.		
11/03/2010	Hospital 1 and PARIS notes	Ms A was admitted to A&E following an overdose (O/D). Admitted that she had not intended to kill herself but had a fight with Mr O. Beck's suicide scale low risk. Ms A assessed by A&E liaison psychiatrist, who suggested a possible diagnosis of borderline personality traits. Advised GP to prescribe fluoxetine. Ms A was discharged. Mr O was also admitted as he had O/D.		Paracetamol 16 tabs and venlafaxine 12 tabs. The Beck Scale for Suicide Ideation (BSS): assessment to help identify individuals at risk for suicide. Fluoxetine: antidepressant of the selective serotonin reuptake inhibitor (SSRI) class.

16/03/2010	GP notes	Consultation: Ms A denied taking illegal drugs. Prescribed temazepam 10mg, venlafaxine 150mg and citalopram.		Citalopram: antidepressant
19/04/2010	Agency 1 and GP notes	Referred to agency 1 by GP. Suggested diagnosis bipolar disorder. GP noted that he disagreed as felt that Ms A had a personality disorder.		Agency 1: community assessment and access team
04/05/2010	PARIS notes	Ms A sent a reminder 'opt in' letter from agency 2.		
14/05/2010	PARIS notes	Agency 2 closed referral as no contact from Ms A.		
14/06/2010	DV report	Police reported that there had been two incidents of DV.	20	
15/06/2010	Agency 1 and GP notes	Reviewed by senior registrar: suggested self-referral to IAPT.		IAPT: Improving Access to Psychological Therapies
17/06/2010	DHR	Mr O reported to GP and then hospital that he had been assaulted by Ms A.		First reported injury from a DV incident. Noted in GP and hospital notes.
21/06/2010	GP notes	Ms A went to GP reporting that she had back and chest pain after being attacked and that someone had pulled her hair.		
22/06/2010	Agency 1 and GP notes	Assessment and medication review by primary care mental health worker. Recommendation to GP that Ms A's medication be changed.		Unclear if medication was changed
15/07/2010	PARIS and GP notes	Ms A assessed by senior registrar Ms A to self-refer to IAPT. Antidepressant changed to mirtazapine 30mg. Prescription given on 16/7/2010 by GP.		IAPT: Improving Access to Psychological Therapies
22/07/2010	GP notes	GP dispensed Ms A with temazepam 10mg (10 tabs) and haloperidol 500mcg (56 tabs).		
02/08/2010	DHR	DV incident reported by Ms A:		
13/09/2010	Agency 2 and GP notes	Referred by GP to agency 2. Referral letter identified that Ms A was suffering mood instability and anxiety. Ms A failed to respond to 'opt in' letter		Agency 2: primary care team

		and was discharged back to GP on 11/11/2010.		
19/09/2010	PARIS notes	GP referred Ms A to agency 2.		
21/09/2010	DHR	Domestic incident. Police attended.		No arrests and NFA
18/10/2010	DHR	Ms A and Mr O evicted from their accommodation.		
27/10/2010	DHR	Ms A's mother granted full residency order.		
09/11/2010	OASys report	Ms A attended magistrates' court and found guilty of stealing a credit card and spending £990.20. She was sentenced to a supervised community order.		OASys: Offender Assessment System. Mr O co-accused of same offence.
11/11/2010	PARIS notes	Ms A DNA appointment with mental health service.		DNA: did not attend
18/11/2010	OASys report	Ms A and Mr O had given up their tenancy and moved in with Mr O's parents.		Occasional cannabis use disclosed
25/11/2010	DNR	Initial assessment probation: Ms A disclosed that she got aggressive when she had been drinking. She was drinking alcohol daily and occasionally using cannabis.		
03/12/2010	Agency 1 and GP notes	Referred by GP to agency 1. Ms A failed to respond to 'opt in' letter. Discharged to GP on 24/12/2010.		
24/01/2010	Agency 3 and GP notes	Referred to agency 3 by GP. Assessment completed and a further appointment given to Ms A. She failed to attend appointment and was referred back to GP on 17/3/2011.		Agency 3: assertive outreach
01/02/2011	PARIS notes	Referral for OT assessment sent to Ms A.		
07/04/2011	GP notes	Noted that Ms A had lost more weight (bingeing and starving herself) and that she had missed all of her appointments with CMHT. Ms A asked to be re-referred to CMHT.		

13/04/2011	GP notes	Ms A did not respond to 'opt in' letter with mental health services.		
10/05/2011	GP notes	BMI 17.6, weight 49.442kg; re-referred her to mental health services.		
12/05/2011	Agency 2 and GP notes	Referred by GP to agency 2. Noted that Ms A was presenting with possible eating disorder, low mood and poor self-esteem.		
03/06/2011	Agency 2 and GP notes	Seen by psychiatrist – "no evidence of thought disorder". Referred Ms A to IAPT.	21	Time to Talk (IAPT service) provided by TEWV NHS Foundation Trust
29/06/2011	GP notes	Ms A's weight loss continued. GP prescribed trifluoperazine		Trifluoperazine is an antipsychotic medicine in a group of drugs called phenothiazines
14/07/2011	DHR	Police called to a verbal argument between Mr O and Ms A. Noted that Ms A and Mr O had separated and Ms A was living with her mother and son.		
18/07/2011	GP notes	Ms A reported that she felt suicidal, presenting with bipolar symptoms (extreme highs and lows). Increased trifluoperazine to 5mg (30 days).		
19/07/2011	DHR	Ms A reported to probation officer that she had returned to live with Mr O		
27/07/2011	GP notes	GP prescribed haloperidol 500mcg (28 tbs) and temazepam 10mg (20 days).		Haloperidol: antipsychotic medication
28/07/2011	Time to Talk assessment	Assessed that Ms A was unsuitable for CBT. Referred her to agency 1 with recommendation that she required in-depth psychotherapy and a definitive diagnosis. Case transferred to agency 3.		
01/08/2011	GP notes	GP increased haloperidol as Ms A reported that it had initially helped but the effects had worn off.		
08/08/2011	PARIS notes	Ms A assessed by agency 3.		

26/08/2011	PARIS notes	Ms A called agency 4 to report that she was experiencing fluctuating moods.		Affective disorder team
30/08/2011	GP notes	Ms A requested increase in dose of haloperidol.		Dose increased to 500mcg
09/09/2011	PARIS notes	Seen by agency 6. Plan to stop all medication and be prescribed quetiapine (letter received by GP on 15/9/2011).		Quetiapine: atypical antipsychotic. No evidence that this was being prescribed.
15/09/2011	PARIS notes	Mr O called agency 6 requesting support, as Ms A was distressed.		
23/09/2011	DHR	DV report by police: argument between Ms A and Mr O. Ms A DNA appointment with agency 6.		
27/09/2011	PARIS notes	Ms A was seen at agency 3 by consultant psychiatrist. Ms A reported that previously quetiapine had settled her emotional instability to a significant degree. BMI 19.5 and weight within normal range.		
30/09/2011	PARIS notes	Agency 3 referred Ms A to dietician due to concerns about her weight loss. Plan agreed to monitor mood and emotional stability.		
10/10/2011	PARIS notes	Ms A DNA appointment with agency 4.		
11/10/2011	DHR	DV report by police: Mr O had head-butted Ms A in the face. Assessed Ms A as medium risk. Ms A would not provide a statement and Mr O was released.		
17/10/2011	DHR and PARIS notes	Meeting with Mr O's probation worker noted that Mr O had scratches on his arm. Advised Mr S and Mr O to seek relationship counselling. Ms A DNA appointment with agency 6; letter written to Ms A asking her to contact service within 10 days or be discharged. Noted that workers felt that "there was a risk of Ms A becoming		Not evident if they were given any contact details of relationship counselling. Not clear why worker felt that there was a risk of Ms A becoming reliant on services.

		reliant on services”.		
20/10/2011	DHR	DV incident. Mr O left before the police arrived. Risk to Ms A was assessed as standard. However, due to the number of incidents, specialist DV police tried to contact Ms A via her mobile. Information reported to social services.		
25/10/2011	DHR	Police attended: verbal altercation between Ms A and Mr O. Police assessed risk as standard. Specialist police officer tried to contact Ms A. She did not respond.		
29/10/2011	DHR	Ms A called the police to ask for Mr O to be removed from house. Both under influence of alcohol. Police attended and Mr O eventually agreed to go to his parents' house.		
02/11/2011	OASys	Ms A and Mr O went to a jeweller to try to sell a number of stolen rings. Both were arrested and charged with handling stolen goods.		
04/11/2011	PARIS notes	Ms A discharged from agency 4 due to DNAs.		
07/11/2011	GP notes	Ms A reported that she had stopped using illegal drugs two days earlier and was experiencing withdrawal symptoms. Prescribed zopiclone (7 tabs), sertraline 50mg, and quetiapine 50mg (60 tabs).		Sertraline is an antidepressant used to treat depression, obsessive-compulsive disorder, panic disorder and anxiety. New medication. Zopiclone: sleeping pills.
08/11/2011	DHR	Reviewed by probation: noted no indicators of DV.		

		No current issues around emotional wellbeing or alcohol.		
22/11/2011	PARIS notes	Ms A DNA her appointment with dietician and was discharged from the service after DNA two appointments.		
02/12/2011	OASys	Ms A and Mr O arrested for fraud.		
28/12/2011	GP notes	Telephone call (T/C) with Ms A. She reported that she was staying with her mother. She disclosed that she had not been taking her medication properly. Wanted to start taking medication. Prescription issued: quetiapine 50mg (60 tabs).		
14/02/2012	GP notes	Ms A was referred to agency 1 by GP.		
22/02/2012	OASys	Ms A sentenced for an offence of handling stolen goods. Received 12-month supervision order and compensation attached to her benefits.		
27/02/2012	GP notes	Ms A reported that she was not taking any medication and was feeling anxious. Prescribed trifluoperazine syrup 1mg/500mls.		
28/02/2012	GP and PARIS notes	Assessment by agency 1. Ms A described her mother, son and boyfriend as protective factors. Advised GP to recommence quetiapine.		
07/03/2012	GP notes	T/C consultation: issued prescription of quetiapine 50mg (30 days).		
05/04/2012	DHR	Initial assessment: noted that Ms A had various mental health diagnoses. Probation officer liaised with community mental health services to obtain Ms A's history and their current involvement.		
10/04/2012	GP notes	Ms A presented with agitation and was tearful, asking for medication. GP		

		increased quetiapine to 2x50mg twice a day. Amitriptyline 25mg (14 tabs).		
16/04/2012	DHR	T/C by Ms A advising probation that Mr O would not be attending his appointment as he had accidentally been stabbed in arm. Mr O reported to his probation officer that he had thrown a knife at a dartboard. Later reported that he had been stabbed (02/05/2012).		
08/05/2012	DHR	Ms A reported that she and Mr O had moved.		
21/05/2012	GP notes and DHR	GP referred Ms A to agency 1. Low mood and asking for medication.		
23/05/2012	DHR	Seen in A&E: Ms A reported that she and Mr O had been drinking and that she had fallen and cut her finger on some glass. Significant injury: bone exposed.		
07/06/2012	GP notes	Ms A removed from GP list due to number of DNAs.		
18/06/2012	DHR	Ms A and Mr O moved.	22	
25/06/2012	DHR	Probation officer agreed to send Ms A text reminders for her appointments with mental health services.		
02/07/2012	GP notes	Registered with new GP. Ms S asked for sedatives; GP declined. GP contacted previous mental health services.		
03/07/2012	GP notes	GP appointment – Ms A asked for sedatives.		
05/07/2012	GP notes	T/C from Ms A – requested medication as she was feeling “overwhelmed”. GP refused.		
09/07/2012	GP notes	GP appointment: GP took brief history from Ms A. Prescribed sertraline 100mg. GP noted: “need to stick to one GP for continuity”.		
17/07/2012	GP notes	T/C: Ms A reported that she had not attended her		

		appointment with agency 1 as she did not have the money to get there. She requested sedatives. GP noted that sedatives not appropriate as Ms A was "likely to fall into addiction". Decided to prescribe beta blockers: propranolol hydrochloride 40mg.		
07/08/2012	GP notes	Appointment: Ms A requested sedatives; GP declined. GP prescribed sertraline 100mg.		
15/08/2012	Agency 1 notes	Ms A was discharged from agency 1 as she failed to attend three appointments.		
17/10/2012	GP notes	Ms A informed GP that she had been living in Whitby for some time. GP advised her to register with a local GP.		
31/10/2012	GP notes	First seen by Whitby GP. Ms A reported that she had been feeling low and requested a prescription of sertraline. GP informed her that he wanted to get background information before prescribing her antidepressants.		
07/11/2012	GP notes	Ms A seen by GP: previous medical notes received. Prescribed sertraline 50mg. Referral made to CMHT and GP advised Ms A about crisis service.		
08/11/2012	DHR	Ms A reported to her probation officer that her son was staying with her and Mr O regularly.		
09/11/2012	GP notes	GP referred to agency 6.		Agency 6: CMHT
21/11/2012	GP and agency 4 notes	Ms A presented herself at GP reporting that she had taken an unknown quantity of sertraline (x10) the previous day and also subutex (x10) that day. Surgery called ambulance and Ms A was taken to A&E (hospital 2). She disclosed that she had also taken zopiclone (x12). Ms A reported that she had		Subutex buprenorphine: opioid pain medication used in the treatment and management of opiate reduction programmes. Mr O on this programme.

		bought subutex and zopiclone from a friend. Scarborough alcohol test 2012 completed. Noted that Ms A was drinking half a bottle of wine a day. Beck depression scale completed: scored 0-5 (low risk). Assessed as low risk to self and others. Discharged.		
06/12/2012	PARIS and GP notes	Appointment with GP reported that she had an appointment with agency 6. Agreed to restart Sertraline. Appointment with agency 6 was scheduled for this day and she DNA appointment. GP rang agency 6 and requested that another appointment be sent to Ms A.		
13/12/2012	DHR	Ms A DNA probation appointment. Decided to undertake a home visit.		
20/12/2012	DHR	Home visit by probation to see Ms A. No answer.		
28/12/2012	PARIS notes	Ms A DNA appointment with agency 6.		
31/12/2012	Agency 4 notes	Ms A was discharged from agency 6.		
01/01/2013	DHR	Police received call that approximately 19 people fighting in the street. Allegedly one male had half his ear bitten off. Ms A and Mr O arrested and charged with Section 18 GBH. Police received intelligence that Ms A was addicted to subutex and was using it on a daily basis and was buying it off the streets.		Court case 21 March 2013
10/01/2013	DHR	Ms A attended appointment with probation.		
11/01/2013	GP notes	GP appointment: referred to agency 6. Prescribed flupenthixol 1mg one to two daily (28 tabs).		Flupenthixol: antipsychotic drug
17/01/2013	DHR	Ms A attended appointment		

		with probation.		
23/01/2013	PARIS notes	Ms A attended appointment with agency 6. Initial assessment by OT.		Medic appointment arranged for 20/2/2013
24/01/2013	DHR	Ms A attended appointment with probation.		
31/01/2013	PARIS notes and DHR	GP appointment: Ms A reported that she was feeling anxious. Prescribed diazepam 2mg (21 tabs) 1 x 3 times daily. Ms A attended her probation meeting.		
05/02/2013	GP notes	T/C with GP. Ms A requested more diazepam.		
06/02/2013	GP notes	Seen by GP: asked for diazepam.		
07/02/2013	DHR	Home visit by probation to see both Ms A and Mr O.		
08/02/2013	GP notes	Ms A DNA appointment.		
11/02/2013	DNH	Ms A presented in minor injuries unit with anxiety. Brief history taken and seen by nurse and clinical practitioners. Noted that she had appointment with agency 6 on 20/02/2013.		Last face-to-face contact with Ms A
13/02/2013	GP notes	T/C: GP prescribed further course of diazepam 2mg (21 tabs).		
21/02/2013	PARIS and GP notes DHR	Appointment cancelled at agency 6 due to staff sickness. Ms A telephoned GP to inform them regarding cancelled appointment. Mr O telephoned probation to report that Ms A was unwell but was due to see psychiatrist, GP and her probation officer.		
22/02/2013	DHR	Mr O was last seen at clinic: reported that he had no issues with his treatment or home life.		Last sighting of Mr O by agencies

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