



# **Stockport Independent Mental Health Investigation overview report incorporating Domestic Homicide Review themes**

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

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

We would also like to thank the family for their invaluable contribution to our investigation.

This report was commissioned by NHS England and cannot be used or published without their permission.

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# 1 Executive Summary

- 1.1 This Domestic Homicide Review and Independent Mental Health Investigation (joint review) examines the circumstances surrounding the death of Adult S in Bredbury, Stockport, Greater Manchester on 31 December 2014 and the care and treatment of Adult D by health services. The family have requested that Sandra be referred to by her name throughout the report.

## Incident

- 1.2 On the night of 30/31 December 2014, D attacked his mother Sandra in the family home. After Sandra was killed, D remained in the house until family members arrived on the morning of 31 December 2014, and discovered the body of Sandra.
- 1.3 Police and ambulance services went to the home of Sandra and D at approximately 11.00 on 31 December 2014. Sandra's sister L had called emergency services after finding Sandra. Officers entered the address and she was pronounced deceased at 11.13 by paramedics at her home.
- 1.4 D was subsequently arrested on suspicion of murder, and he was taken into custody, prior to being sectioned and transferred to a mental health hospital. In December 2015 D was convicted of the manslaughter of Sandra on the grounds of diminished responsibility and detained under Section 37/41 of the Mental Health Act 1983.<sup>1</sup>
- 1.5 In summing up the case at sentencing in December 2015 the judge said 'this terrible case, this tragic case is based upon a medical problem'. Judge Patrick Field QC, sentencing, said he was satisfied that 'the mental disorder in this case almost entirely overwhelmed D, and that the fatal attack on his mother was almost entirely attributable to it'.
- 1.6 This independent review fulfils the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. The independent investigation follows guidance published by the Department of Health in HSG (94) 27, on the discharge of mentally disordered people, their continuing care in the community and the updated paragraphs 33-36 issued in June 2005.
- 1.7 The main purpose of the joint independent investigation is to identify whether there were any aspects of the care or services that could have altered or prevented the incident. The investigation process will also identify areas where improvements to services might be required which could improve quality and help prevent similar incidents occurring.

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<sup>1</sup> The provisions of Mental Health Act 1983 Act sets out the law with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters. Section 37/41 is a court order, which can only be made by the Crown Court, which imposes a s37 hospital order together with a s41 restriction order. The restriction order is imposed to protect the public from serious harm. The restrictions affect leave of absence, transfer between hospitals, and discharge, all of which require Ministry of Justice permission <http://www.legislation.gov.uk/ukpga/1983/20/section/1>

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

1.9 We would like to express our sincere condolences to the family of Sandra.

**1.10 Statement by Family of Sandra:**

1.11 *'Sandra has been very greatly missed by her family and friends. She is always in our thoughts and prayers. Sandra was completely devoted towards ensuring her families ongoing care and wellbeing. She exhibited unconditional love towards everybody in her family and was also a loyal friend. She was a generous giver of both her time and money. Sandra loved having her family around her at all times. She went out of her way to help people who were less fortunate than herself and this included offering them accommodation until they got back on their feet. She also had a great love of the animal and bird kingdom and, as well as once being a leading Persian Cat Breeder, liked helping injured animals and birds.*

*We have experienced many and varied emotions as a family since Sandra passed away. We have supported one another through the grieving process together, which has helped us enormously. We are all in different places regarding the emotional and mental healing process following the tragic incident.*

*As a family, we have been committed to ensuring that the circumstances surrounding the death of Sandra are fully and effectively investigated. We have actively participated in this investigation and have offered our views and opinions in support of this process. It is our wish that the lessons learned from this tragic incident be clearly identified and disseminated to involved parties'.*

**D's mental health history**

1.12 D was initially referred at age 14 to child and adolescent mental health services (CAMHS) provided by Stockport NHS Trust (now Pennine Care NHS Foundation Trust or PCFT) in June 2000 by the family GP. He was referred because of his parents 'concern that he may have an eating disorder and other behavioural problems'. No diagnosis was suggested but it was noted that D seemed disadvantaged socially, and was refusing to attend school because of bullying. It was planned that activities outside the home would be encouraged, and referral to other groups was explored.

1.13 D was brought to Accident an Emergency Department (AED) at Stepping Hill Hospital (SHH) by his mother in August 2003, with a history of hearing voices for eight or nine months, and responding to voice and visual hallucinations for the previous two days. He said he heard two angels, and had been openly conversing with them. D was assessed by Pennine Care NHS Foundation Trust (now Pennine Care NHS Foundation Trust or PCFT) mental health crisis resolution team (MHCRT) and assessed as an unclear presentation. It was noted that there 'appear no risks', and he was discharged home with a referral made for early review by primary mental health and a consultant psychiatrist.

- 1.14 D remained under the care of the then Pennine Care Mental Health Trust mental health services, having one admission at age 17 to SHH in December 2003 for one month. He was seen by the crisis team initially, the early psychosis service (2004 and 2005), Stockport community mental health team (2005 to April 2014) and the recovery and inclusion team from April to December 2014. He was diagnosed as suffering from paranoid schizophrenia in 2003, and with atypical autism in 2005.

### Internal Investigation

- 1.15 Pennine Care NHS Foundation Trust ('PCFT' hereafter) undertook an internal investigation that has been reviewed by the investigation team.
- 1.16 The internal investigation for PCFT was led by an experienced investigator from within the organisation, with expert input from internal and external consultant psychiatrists and medical and nursing executive directors.

### Independent investigation

- 1.17 This independent investigation has drawn upon the internal process and has studied clinical information, police information, witness statements, interview transcripts and policies. We also interviewed clinical staff who had been in contact with D, and senior staff from PCFT. We reviewed individual management reviews (IMRs) provided by other agencies involved.
- 1.18 D was interviewed to give him an opportunity to contribute to the report.
- 1.19 Members of the family met with the panel chair and lead author to give their experiences and perspective.
- 1.20 The recommendations from our independent investigation focus on the improvements that we consider should be made across the whole system.
- 1.21 We do not consider that on the information available to any individual service or group of people at the time, the incident on the 30 December 2014 was predictable. Predictability is 'the quality of being regarded as likely to happen, as behaviour or an event'.<sup>2</sup> 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.
- 1.22 It is our view that **if all of the information had been available**, it was predictable that there was a potential risk of violence in the context of relapse and thus preventable in terms of a DHR review across services. PCFT did not have all the necessary information and nor did any single organisation including the family to predict and prevent it but across those involved sufficient information was known.

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<sup>2</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

- 1.23 The information shared by Sandra at the critical points of the assault in September 2014 and the Christmas period did not include reference to crucial information that we believe would have altered D's risk assessment, and the level of intervention by PCFT. The incident would have been preventable if all the information available had been shared.
- 1.24 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 be the knowledge, legal means and opportunity to stop the incident from occurring. Information has come to light since the homicide which suggests that D's delusional beliefs had become focussed on the PA and Sandra and he believed that one of them needed to be killed, based on his religious delusions. His psychotic thinking led him to finally identify that it was his mother that needed to die.
- 1.25 We do not consider therefore that the homicide of Sandra was predictable or preventable by PCFT services, but with the caveat that information existed which could have altered this if it had been made available to them. However we consider that good care planning would have hindered this event happening even though the specific event itself was not predicted. The key is preventing relapse as without relapse the event would not have happened.
- 1.26 We consider that the root cause of the homicide was the relapse of D's inadequately treated psychosis, although recognising that multiple contributory factors existed that influenced this. Some of these contributory factors are issues that we have discovered as part of the review, and within these we consider there to be a mixture of influencing and causal factors<sup>3</sup>.
- 1.27 Good Practice

The following areas of good practice are noted:

- Continuity of care by care coordinator and consultant psychiatrist over a number of years.
  - Regular communication from Stepping Hill Hospital to GP.
  - Regular communication from consultant psychiatrist to GP.
  - The PCFT internal investigation report was shared with the family, and later adjusted to include family perspectives on the content.
- 1.28 There were key events which could have altered the course of events if they had been approached differently:
- The move of D to the Recovery and Inclusion team
  - Absence of involvement of the PA in care planning

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<sup>3</sup> NPSA 7Steps: Representing Contributory Factors: Fishbone Diagrams and other formats.  
[https://report.nrls.nhs.uk/.../Tools\\_Representing\\_Contributory\\_Factors](https://report.nrls.nhs.uk/.../Tools_Representing_Contributory_Factors).

- Lack of enquiry into the distress of Sandra in September 2014
- Key aspects of D's presentation not shared with professionals
- Risk assessments and care planning not robust
- Lack of enquiry into Sandra's injury in September 2014
- Sandra's declining physical health and lack of discharge planning from Stepping Hill Hospital in December 2014
- Knowledge of domestic abuse not shared
- The relapse of D in the absence of a robust contingency plan

1.29 We have made 22 recommendations to promote wider systems learning

## Recommendations

### Recommendation 1:

Pennine Care NHS Foundation Trust : should ensure that the quality of care and contingency plans is audited, including the checking of plans against identified needs

### Recommendation 2:

Pennine Care NHS Foundation Trust : should amend the CPA policy to describe the role of the psychiatrist with regard to the CPA policy and care planning

### Recommendation 3:

Pennine Care NHS Foundation Trust : CPA policy should provide guidance on assessment and CPA care planning to clarify responsibilities and requirements where there are carers funded by direct payments

**Recommendation 4:**

Stockport Metropolitan Borough Council should develop a system to follow up on plans and interventions after carers assessments and co-ordinate interventions with Pennine Care NHS Foundation Trust where the carer is caring for a mental health service user

**Recommendation 5:**

Pennine Care NHS Foundation Trust : should ensure that NICE CG178 ( Psychosis and schizophrenia in adults: prevention and management) is implemented and monitored

**Recommendation 6:**

Pennine Care NHS Foundation Trust, Stockport CCG : implement a system for follow up and monitoring of GP physical health checks re psychiatric medication

**Recommendation 7:**

For Pennine Care NHS Foundation Trust, Stockport CCG & Stockport Metropolitan Borough Council : audit of implementation of the autism strategy, and resources to support staff & patients who are diagnosed with Autistic Spectrum Disorder

**Recommendation 8:**

Pennine Care NHS Foundation Trust : Ensure that clinical decisions about changes to pathways or services should include the care team, and there is evidence that the perspectives of patient and carers have been considered, taken into account and documented

**Recommendation 9:**

Pennine Care NHS Foundation Trust : change approach to Risk Assessment training, to focus on formulations; and implement a quality assurance process for Risk Assessments

**Recommendation 10:**

Pennine Care NHS Foundation Trust & Stockport Metropolitan Borough Council : should have triggers for responding to crisis calls and an escalation process in place

**Recommendation 11:**

Stockport NHS Foundation Trust : should set a clear strategy for the recognition of domestic abuse, with up to date policy guidance and a programme of staff training

**Recommendation 12:**

Stockport Community Safety Partnership : should assess the results of the Domestic Abuse strategy thus far, with emphasis on increasing the access to training to frontline healthcare staff, and ensuring that child to parent violence is included

**Recommendation 13:**

Stockport NHS Foundation Trust : should ensure the lessons learned from this incident with specific regard to domestic abuse and violence are conveyed across the Trust, and particularly in the Emergency Department

**Recommendation 14:**

Stockport NHS Foundation Trust : should revise its admission and discharge documentation to include a prompt regarding carers needs and signposting to a plan of care and an assessment before discharge

**Recommendation 15:**

Stockport Metropolitan Borough Council : should assess the efficacy of the current multi-agency approach to carers needs, along with partner organisations, and implement a strategy to ensure the aims of the position statement are carried out

**Recommendation 16:**

Stockport NHS Foundation Trust : should revise the recording systems to ensure a complete and contemporaneous record is maintained of all clinical encounters

**Recommendation 17:**

Stockport CCG : formal processes must be in place so that multiagency risk assessments are carried out for all vulnerable children and their carers on transition from children to adult services

**Recommendation 18:**

Stockport CCG : GP practice staff must undertake adult safeguarding and domestic abuse training.

**Recommendation 19:**

Pennine Care NHS Foundation Trust and Stockport NHS Foundation Trust : Domestic abuse training material should be reviewed to ensure that it includes domestic abuse in both children and adults safeguarding; including that any individual in a domestic arrangement may abuse anyone else in that setting

**Recommendation 20:**

Stockport NHS Foundation Trust : Fully implement NICE guidance 'Domestic violence and abuse: multi-agency working' (PH50) recommendation 5: 'Create an environment for disclosing domestic violence and abuse' with particular emphasis on consistent implementation of policy, and recording of information

**Recommendation 21:**

Pennine Care NHS Foundation Trust : change incident reporting and management policy to implement structures and processes as described in NHS Serious Incident Framework March 2015

**Recommendation 22:**

Stockport Community Safety Partnership : guidance on domestic abuse by children to parents should be included in domestic abuse strategies

## 2 The Review Process

- 2.1 This section outlines the process undertaken by the Joint Domestic Homicide Review and Independent Mental Health Investigation Panel in the care and treatment of D and services involved with Sandra to identify if there were any opportunities to intervene, which may have prevented the death of Sandra, and also to identify if there are any lessons to be learned to improve practice.
- 2.2 The Home Office approved the suggestion by the Safer Stockport Partnership that the Domestic Homicide Review (DHR) themes should be considered within Mental Health Homicide Review (MHHR) which had been commissioned by NHS England. The author has followed the requirements of the Domestic Violence, Crime and Victims Act 2004 and the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013.<sup>4</sup>
- 2.3 The circumstances of the homicide also met the requirements for an independent investigation into mental health homicides as outlined in Health Service Guidance 94(27)<sup>5</sup> and the Serious Incident Framework (2015)<sup>6</sup>. NHS England (North) along with Stockport Community Safety Partnership agreed to hold a joint independent review as it was acknowledged that the aims would be the same, and there did not initially appear to be multi-agency involvement in Adult D's care. The review will be referred to as the 'joint review'.
- 2.4 NHS England North commissioned Niche Patient Safety (Niche) to carry out the independent joint review into both the care and treatment of D by NHS services, and of the domestic homicide of S. Niche is a consultancy company specialising in patient safety investigations and reviews.
- 2.5 The process began on 22 June 2015 with an initiation meeting involving the Trust and other agencies who had the most contact with D and Sandra prior to her death.
- 2.6 Sandra's husband, sister and brother in law were contacted initially by NHS England and later by Niche, and were kept informed throughout by the lead author and by the Chair. The family were supported by an advocate from the charity Advocacy After Fatal Domestic Abuse (AAFDA).<sup>7</sup> Contact was later made with Sandra's other sister.
- 2.7 The agencies participating in this review are:
  - Pennine Care NHS Foundation Trust \*
  - Stockport Metropolitan Borough Council\*
  - Stockport NHS Foundation Trust\*

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<sup>4</sup> <https://www.gov.uk/government/collections/domestic-homicide-review>

<sup>5</sup> *Independent investigation of adverse events in mental health services. DoH 2005*

<sup>6</sup> <https://www.england.nhs.uk/patientsafety/serious-incident/>

<sup>7</sup> *Helping families after domestic homicide through listening and via practical help by informing, advocating and enabling* <http://www.aafda.org.uk/>

- NHS Stockport Clinical Commissioning Group\*
- NHS England Lancashire and Greater Manchester\* (for CCGs)
- Greater Manchester Police (minimal involvement only after the homicide)
- North West Ambulance Service (minimal involvement only after the homicide)
- Stockport Progress and Recovery Centre (minimal involvement only)
- Brothers of Charity (minimal involvement only)

2.8 Her Majesty's Coroner has opened and adjourned an inquest into the death of Sandra, and this joint review report will be provided to the Coroner.

2.9 Agencies were asked to give chronological accounts of their contact with the perpetrator and victim prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the terms of reference, this report has reviewed the care, treatment and services provided by the NHS, the local authority and other relevant agencies from D's first contact with services to the time of the offence.

2.10 The report has also reviewed the care, treatment and services provided by the NHS, the local authority and other relevant agencies to Sandra, both as a patient and in her role as carer of D.

2.11 All have responded with information indicating some level of involvement with the family and have completed either an Individual Management Review (IMR) or a report. The agencies that completed an IMR are identified with an \* in paragraph 2.7 above. It should be noted that the contacts with Greater Manchester Police were minor, other than the contacts after the homicide.

2.12 In December 2015 D was convicted of the manslaughter of Sandra on the grounds of diminished responsibility and detained under Section 37/41 of the Mental Health Act 1983. He remains in a secure hospital.

### **3 Events of 30 December 2014**

3.1 We have pieced together the sequence of events leading up to 22.00 on 30 December 2014 from family accounts and police information.

3.2 Sandra had been admitted to hospital on 28 December 2014; she was very breathless and had not felt better since being discharged on 23 December. She had wanted to come home for Christmas, and it was agreed that D's sister would help Sandra to cook Christmas dinner at their home. Sandra was tired and still felt unwell. Her sister L and her husband were ill with norovirus, and couldn't provide the support that they normally would. Sandra's sister SI was away at the family's holiday home and was unavailable. D's father was at work in Saudi Arabia. D had a Personal Assistant, K, paid for by direct

payments. K was on two weeks leave. Sandra had asked D's sister to look after him while she was in hospital. Family members were in touch with D by phone several times a day to check he had taken his medication and had eaten.

- 3.3 By telephone her sisters persuaded Sandra to call an ambulance, which she did, arriving by ambulance at the AED at Stepping Hill at about 16.40 on 28 December 2014. Sandra was admitted to hospital and treated with antibiotics, steroids, nebulisers and rest. She was discharged on 30 December at 16.45, and her sister L and brother in law were well enough to take her home. On arrival at the home it was apparent that D had not been eating the food that his sister had provided, and did not appear to have washed or generally looked after himself. Sandra told her sister later that D had missed many doses of medication, as these were not signed for in his diary. The remnants of the Christmas meal were still there and family offered to clear up, but Sandra said she was tired and hungry. It was decided she would order a pizza, and then herself and D would eat and go to bed.
- 3.4 Sandra tried to persuade D to take his medication, and he was refusing. She spoke by phone to both sisters, who also tried to persuade D to take his medication. D's father also spoke to him. D said he was afraid that Sandra had contaminated his food, and the family encouraged him to collect it at the door so he would feel better. When the delivery arrived D was not fully dressed and Sandra had to answer the door. D was still suspicious but was encouraged to eat by family members on the phone. Sandra told her family that D would not take his medication, and had missed at least six tablets. They reported they could hear him calling Sandra the devil when she was talking to them on the phone. It was agreed amongst the family that if D refused to take his tablets by 22.00 (when he normally took them) they would call the crisis team. The family explained to us that their understanding was that if the crisis team were called, then D would be taken to hospital. We explained to the family that admission to hospital would be concluded following an assessment of mental state and risk and therefore contact with the Crisis Team would not automatically result in a hospital admission. They maintained that they had never been told this.
- 3.5 Several family members spoke to D on the phone to persuade him to eat and take his medication. It was left that Sandra would not call anyone if D took his medication at 22.00, telling her sisters she was tired and would go to bed. It is believed D stabbed his mother sometime later that night. The following morning, Sandra's sister L noticed that there had been no calls overnight and arranged to go to Sandra's house. When there was no answer she collected keys from D's sister, and entered the house, finding Sandra. D was still in the house, and ran to lock himself in the bathroom.
- 3.6 Emergency services were called at 10.57 on 31 December 2014, and an ambulance attended at 11.00. Staff did not enter because they were told the attacker was still in the property. An armed response vehicle was requested to support entry. This is not unusual where a perpetrator is thought to be present with a weapon. By 11.13 paramedics and police were inside the address and

had certified death. D was arrested and later transferred to a secure hospital under the Mental Health Act.

## 4 Joint review

### Approach to the review

- 4.1 The main purpose of an independent mental health homicide investigation is to discover whether there were any aspects of the care which could have altered or prevented the incident. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

The main purposes of a domestic homicide review are to establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims; identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; apply those lessons to service responses including changes to policies and procedures as appropriate; and prevent domestic violence homicide and improve service responses for all domestic violence victims, their children and/or other relatives through improved intra and inter-agency working.

- 4.2 The overall aim is to identify common risks and opportunities to improve safety, and make recommendations about organisational and system learning.
- 4.3 The joint review panel was chaired by Dr Ian Davidson, consultant psychiatrist, supported by the lead author Carol Rooney, Senior Investigations Manager, Niche.
- 4.4 The remaining panel members are listed below, and the panel will be referred to in the first person plural from here on in.

Carol Dudley, safeguarding consultant;

John Kelly, retired police detective chief superintendent;

Clare Hughes, Criminal Justice Coordinator, National Autistic Society and

Nicole Jacobs, CEO, Standing Together

- 4.5 The report was peer reviewed by Nick Moor, Director, Niche, and quality assured by NHS England. Legal review was carried out by Hill Dickinson LLP for NHS England.
- 4.6 The investigation comprised a comprehensive review of documents and series of interviews, with reference to the National Patient Safety Agency

(NPSA) guidance<sup>8</sup> and DHR report writing guidance.<sup>9</sup> The terms of reference were agreed in October 2014 after family consultation, and are at Appendix A.

- 4.7 We would like to offer our deepest sympathies to the family of Sandra and D, and we thank them for their contributions to this report. It is our sincere wish that this report does not contribute further to their pain and distress.
- 4.8 We have used information from D's clinical records provided by Pennine Care NHS Foundation Trust, Stockport NHS Foundation Trust, the GP practice where the family was registered, and other agencies as listed at 2.7. We have read D's clinical notes at his current hospital placement.
- 4.9 We have read Sandra's clinical records from Stockport NHS Foundation Trust and the GP practice where the family was registered.
- 4.10 We have read the Greater Manchester Police case summary, and reviewed the police information with regards to the emergency response on 31 December 2014.
- 4.11 As part of our investigation we interviewed the following staff:

Pennine Care NHS Foundation Trust

- Consultant psychiatrist who saw D as outpatient;
  - Care coordinator from early psychosis service (CC2);
  - Care coordinator from community mental health team (CMHT) (CC3);
  - Care coordinator from recovery and inclusion team (RIT) (CC4);
  - Stockport recovery and inclusion team (RIT) team manager.
- 4.12 These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature to verify they were an accurate record of the interviews.
- 4.13 Joint meetings were held with Director of Nursing and Allied Health Professionals, Medical Director, Mental Health Governance Lead, Risk Manager and Patient Safety Lead which were not recorded.
- 4.14 The personal assistant K was also interviewed and the recording transcribed and returned for comment.
- 4.15 We wrote to D at the start of the investigation, explained the purpose of the investigation and asked to meet him. D gave written consent for us to access his medical and other records. We met with D in hospital, and offered him the opportunity to meet with us again to discuss the report prior to publication. Advice was sought from his responsible clinician, and it was agreed that the draft was sent to D via his consultant psychiatrist for D to review and comment if he wished.

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<sup>8</sup> National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*. <http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60156>

<sup>9</sup> DHR overview report writing guidance.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/143782/dhr-report-guide.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/143782/dhr-report-guide.pdf)

- 4.16 We made contact with family members at the start of the investigation, explained the purpose of the investigation and offered to meet with them to share the report prior to publication. We remained in contact throughout the investigation to ensure the family was updated on the progress of the investigation and had an opportunity to ask questions. A number of additions to the terms of reference were agreed at the request of the family. Family members requested to be interviewed as a group as part of the investigation, which was done with the support of an advocate. One family member was interviewed separately. The draft report was sent to family members for their comments, and the family met to feedback their comments, which have been incorporated into the report. The family have highlighted that these events have had an effect on the wellbeing of family members, and would have welcomed a direct approach from NHS services to offer support.
- 4.17 The family requested that we consider whether there are similarities between this case and the case of *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2; [2012] WLR (D) 23.<sup>10</sup> Having taken legal advice it is not appropriate for this to be considered in this report as it is not within the terms of reference for the independent investigation, and remains a matter for legal consideration.
- 4.18 A full list of all documents referenced is at Appendix C.
- 4.19 The draft report was shared with PCFT, Stockport NHS Trust, Stockport CCG, Stockport Metropolitan Borough Council and NHS England prior to publication. This provided an opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed to review and comment upon the content. Scott and Salmon<sup>11</sup> principles were adhered to.
- 4.20 A draft was provided to the Coroner for information.

## Structure of the report

- 4.21 We have included in Section 3 a chronology of the likely sequence of events on 30 December 2014, pieced together from family accounts and police information.
- 4.22 Section 4 sets out the details of the background, and care and treatment provided to D and Sandra. In preparation we developed a detailed chronology of D and Sandra's care, but this has not been included in this report to assist with confidentiality. Where questions and issues raised in the terms of reference are addressed these will be indicated throughout the report.

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<sup>10</sup> *Rabone and another (Appellants) v Pennine Care NHS Foundation Trust (Respondent)* <https://www.supremecourt.uk/cases/docs/uksc-2010-0140-judgment.pdf>.

<sup>11</sup> *The Salmon principles: For inquiries conducted under the Inquiries Act 2005, the Salmon letter procedure has been codified in to a process of "warning letters" (see section 13 of the Act). This provides that the chairman may not include any explicit or significant criticism of a person in a report unless he has sent a warning letter to a person who: (a) He considers may be, or who has been, subject to criticism in the inquiry proceedings; or (b) About whom criticism may be inferred from evidence that has been given during the inquiry proceedings; or (c) Who may be subject to criticism in any report or interim report. Rule 13 of The Inquiry Rules 2006.*

- 4.23 Section 5 examines the issues arising from the care and treatment provided to D and Sandra including comment and analysis, with regard to the terms of reference for the investigation.
- 4.24 Section 6 focusses on the key lines of enquiry in the terms of reference specifically related to domestic abuse.
- 4.25 Section 7 provides a review of the PCFT internal investigation, and reports on any progress made in addressing the organisational and operational matters identified.
- 4.26 Section 8 sets out our overall analysis and recommendations, and comments on predictability and preventability.

## 5 The care and treatment of D and Sandra

### Family background

- 5.1 D was born in Stockport after a normal pregnancy and caesarean birth, and has one sister. The family continued to live in Stockport and had many family members living locally. Other family members were known to have autistic spectrum disorder, Crohn's disease, diabetes and arthritis.
- 5.2 D attended school but was reportedly bullied and attendance was irregular. At age 14 he was moved to a 'pupil referral unit' centre which provided full-time placements for secondary age students with a variety of social, emotional and mental health issues, and left with three GCSEs in Maths, English and Human Physiology. He studied plumbing at college initially but did not complete the course, and had one job only after leaving school. He appears to have been socially isolated with few friends.
- 5.3 The family lived in a bungalow in Stockport and D lived with his parents. A close network of family and friends lived nearby, including Sandra's two sisters. The family had an apartment in Barmouth and enjoyed regular holidays there throughout the year. The personal assistant (PA) would accompany the family at times and take care of D's needs. In recent years Sandra provided sole care while D's father worked abroad. His father returned to the home several times a year, and the family often went to the seaside apartment in that time. The intention was that D's father would take over support and care of D when he retired in August 2015.

### Physical health history and treatment – D

- 5.4 D was born in 1985 by emergency caesarean at 40 weeks pregnancy. No complications were noted, although Sandra was unwell during the pregnancy. As a baby he had a febrile illness in 1986 age nine months, and spent some time in isolation with urticaria<sup>12</sup> and left upper lobe pneumonia<sup>13</sup>. He had

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<sup>12</sup>Urticaria – also known as hives, welts or nettle rash – is a raised, itchy rash that appears on the skin. <http://www.nhs.uk/conditions/Nettle-rash/Pages/Introduction.aspx>

<sup>13</sup> Pneumonia is an infection of the lungs that causes persistent coughing, breathing difficulties and– an infection of the blood that causes a fever, rapid heartbeat and rapid breathing. <http://www.nhs.uk/search/?collection=nhs-meta&query=+pneumonia>

some GP attendance for coughs and dry chapped skin. He had a squint operated on at age seven in 1992.

- 5.5 D sustained a nose injury at football in October 1999 for which he was seen at Stepping Hill Accident and Emergency department (AED), and later assessed by an ENT surgeon. He was discharged from ENT in January 2000. The advice was to consider surgery for a lump on his nose after 16 years of age, when facial bones stop growing. D was referred to a dietician in March 1999 and seen for several sessions for advice on maintaining a healthy diet.
- 5.6 In April 2000 at age 14, a GP referral to a paediatrician was made, as D had been having abdominal pain for eight weeks. Colitis was ruled out and he was diagnosed with constipation as a result of poor diet. D was discharged in June 2000 after a follow up visit, when it was decided that no further assessment was needed. At this time S expressed concern that he may have hearing difficulties, and a referral to audiology was made.
- 5.7 In June 2000 his GP referred him to 'Child Guidance' reporting that his parents thought he may have an eating disorder and other behavioural problems.
- 5.8 At aged 16 D was seen by the audiology department at Stepping Hill Hospital, as his mother expressed concerns about his hearing. In July 2000 the results showed normal hearing, although there was 'a possible pattern of deterioration in the high frequencies on both sides'. He was reviewed after twelve months, and again judged to be within normal limits. He was discharged from audiology in March 2003 with no follow up advised.
- 5.9 The GP IMR notes that D was last seen by his GP on 14 July 2014 for an annual review to assess his physical health, which is offered to all patients with a mental health diagnosis. The electronic records provided to the review do not include notes of this consultation. The previous annual health check was carried out in October 2013.
- 5.10 Results of the blood tests carried out in October 2013 were noted to suggest that D was at 'high risk of cardio vascular disease' and advice on a low cholesterol diet was given to him. Although it is noted that these test were made at the request of a psychiatrist, there is no record of results being sent to the mental health services.

### **Contact with criminal justice system or police – D**

- 5.11 D had no contact with the criminal justice system before 31 December 2014. The only police contact had been in relation to Section 136 MHA in December 2003 and there were no records for him on the police national database.

### **Mental health history and care – D**

- 5.12 D's mental health care is reviewed in detail at the time of his referral to adult services in 2003 and again in the final year 2014. The intervening period is summarised through a review of key events such as changes of team, care planning meetings and care programme approach (CPA) reviews.

- 5.13 D was initially referred to child and adolescent mental health services (CAMHS) in Stockport in June 2000 (aged 14) by the family GP. He was referred because of his parents 'concern that he may have an eating disorder and other behavioural problems'. There was some input and advice from a social worker in August 2000, and he was offered an assessment by a psychiatrist in September 2000. A family assessment meeting was held, a high degree of distress in the family was noted, and D was referred to a weekly group session. No diagnosis was suggested but it was noted that D seemed disadvantaged socially, and was refusing to attend school because of bullying. It was planned that activities outside the home would be encouraged, and referral to other groups was explored.
- 5.14 Sandra called CAMHS in February 2001 and was reported to have said 'she's had enough of D and wants him out of the house today'. D was aged 15. This was treated as an urgent referral to social services, and when Sandra was contacted she asked if D could go into a 'safe hostel' as she needed a break. The CAMHS notes do not record any subsequent actions, however the Stockport council family support team was involved and a strategy meeting was suggested to consider any mental health and child protection issues in the family.
- 5.15 On 31 August 2003 D was brought to AED by his mother, with a history of hearing voices for eight or nine months, and responding to voice and visual hallucinations for the previous two days. He said he heard two angels, and had been openly conversing with them. D was assessed by the mental health crisis resolution team (MHCRT) and assessed as an unclear presentation with D being monosyllabic so history was taken from Sandra. It was noted that there 'appear no risks', and he was discharged home with a referral made for early review by primary mental health and a consultant psychiatrist. The referral was received by the community mental health team (CMHT) on 2 September 2003, and it was agreed that the MHCRT would maintain contact until D had been assessed by a psychiatrist. An outpatient psychiatry appointment was arranged for 11 September 2003. He was seen by Dr M, and the opinion was that D had a developmental disorder (described as an Asperger's-like picture) with psychotic features, and he prescribed 5mg Olanzapine<sup>14</sup> twice a day. This had not commenced as the family had not been able to obtain the medication.
- 5.16 D was again brought to AED by his family on 14 September 2003 after seeing the out of hours GP. His family reported that he had become very bizarre for the previous two days, repeating nonsensical words continuously. D did not respond to direct questions, and spoke in nonsensical phrases. It was noted that the psychiatrist was very uncertain about whether D was experiencing psychotic phenomena, though he was regarded as very low risk because there was no history of previous violence or self-harm. He was discharged

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<sup>14</sup> Olanzapine is an antipsychotic medication that affects chemicals in the brain. Olanzapine is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder.  
<http://www.drugs.com/mtm/olanzapine.html>

home to start the Olanzapine 10mg, with an outpatient review planned for two months later, and it was noted his family were happy with this.

- 5.17 A MHCRT initial assessment was completed on 2 October 2003 at AED, where he had been taken by college friends after becoming agitated talking of hearing voices, seeing angels and talking to them. D was seen weekly by Dr M2, a psychiatrist at MHCRT. D continued to say he could communicate with angels and that they can be 'god' at times, and hearing the voice of god. Dr M2 found it difficult to explore D's belief systems as it was difficult to get him to agree to attend and take medication. Dr M2 saw him by himself and with his mother, finding it easier to engage D without mother present.
- 5.18 By 29 October 2003 D was adamant he did not want to continue taking medication, he was persuaded to attend the clinic weekly, but would not agree to take medication, and stopped the Olanzapine. D was seen again on 21 November 2003, and further plans to review CAMHS note and discuss with the consultant were made. He was seen again on 2 December 2003 by Dr M2, and talked of visualising his mother as a tarantula three times, and was very distressed, spoke of 'bad angels' telling him not to look at the TV, or there would be a 'terror image'. At this session D was encouraged to take Risperidone<sup>15</sup> in gradually increasing doses up to 3mg at night by the end of the week. A diagnosis of paranoid schizophrenia was suggested. CPA documentation completed by the MHCRT care coordinator records that D had seen and heard 'angels', had ideas of reference about TV, and did not believe he was mentally ill. The care plan was to: assess and monitor D's mental state, identify needs and address accordingly, assess and monitor D's presentation of risk, identify D's long term needs and refer as necessary, assess for therapeutic intervention. It was discussed by the CC2 at this stage with the team psychiatrist Dr M that Clozapine should be tried. CC2 also expressed concerns about the potential for increased risk if D was unable to live up to the expectations of the bible.
- 5.19 On 4 December 2003 D had become more disturbed at home, was shouting and attempted to jump through a first floor window. He ran away and was found by police, placed on Section 136 MHA<sup>16,17</sup>, then later placed on Section 4 MHA<sup>18</sup> at SHH. D was admitted to SHH under Section 2 MHA<sup>19</sup> on 5 December 2003, and was described as suffering from hallucinations and delusions, and a danger to himself and possibly others. At the point of admission D was discharged from the case load of the MCRHT. D was discharged on 31 December 2003 after a period of home leave with follow up from the CMHT, and a care coordinator (CC1), was allocated.

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<sup>15</sup> Risperidone is an antipsychotic medicine. It works by changing the effects of chemicals in the brain. Risperidone is used to treat schizophrenia and symptoms of bipolar disorder. <http://www.drugs.com/risperidone.html>

<sup>16</sup> The provisions of the Mental Health Act 1983 shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters. <http://www.legislation.gov.uk/ukpga/1983/20/section/1>

<sup>17</sup> Section 136 MHA relates to police powers regarding mentally disordered persons found in public places. <http://www.legislation.gov.uk/ukpga/1983/20/section/136>

<sup>18</sup> Section 4 MHA relates to an application for urgent admission for assessment. <http://www.legislation.gov.uk/ukpga/1983/20/section/4>

<sup>19</sup> Section 2 MHA relates to an application for admission for assessment. <http://www.legislation.gov.uk/ukpga/1983/20/section/2>

- 5.20 During home visits D appeared to be responding to hallucinations, and was unhappy with side effects of Risperidone. At a medication review in January 2004 with the team psychiatrist (at which D, Sandra and CC1 were all present) it was agreed to reduce the Risperidone. By 11 February 2004 D was actively psychotic and talking about not being able to resist the voices and Risperidone was increased. Consideration was given to Clozapine treatment but it was reported that D was not keen to have regular blood tests. Later in February 2004 his medication was changed to Olanzapine 20mg.
- 5.21 A CPA meeting was held on 26 January 2004, and the following plan was agreed: continued assessment of mental state following this first episode psychosis by regular visits from CC1, stabilisation of medication by outpatient appointments with the psychiatrist, assessment of daily living skills and independence, by assessment with the support worker. An assessment of mother and father's support needs was also planned. It was noted that D may present with risks (not specified) when in an acutely psychotic state, and that his mother felt he was at risk if he left the house by himself. The crisis plan was to contact the care coordinator or support worker.
- 5.22 A brain scan was conducted in February 2004, which showed that his left cerebral hemisphere was slightly smaller than the right, but was otherwise normal. An EEG in March 2004 was noted as normal. D was seen regularly by CC1 and a support worker, usually monthly or six weekly throughout 2004. Documentation of breakthrough psychotic symptoms such as clapping and religious ideas were recorded on ten occasions, and regular observations of brief fluctuations in psychotic symptoms, observations of religious preoccupations and occasional agitation. He was taking 20mg Olanzapine at this time.
- 5.23 D was referred to the early psychosis clinic in September 2004, and in an outpatients clinic in October 2004 Dr B stated he was not able to give a definitive diagnosis, but described D as having a 'mixture of paranoid (mainly religious based) psychotic symptoms and autistic spectrum features'. At this time D was experiencing side effects of Olanzapine at 20 mg, so this was reduced to 15 mg per day. A care plan including support worker, occupational therapy and family therapy input was implemented, focussing on developing life skills. In October 2004 S was supported by the team to apply for direct payments for financial support to assist with D's care. A change of care coordinator took place in October 2005 (to CC2), when the care coordination reverted back to the CMHT. CC2 remained D's care coordinator until May 2006.
- 5.24 In July 2005 D was assessed by Dr B of the Sheffield Asperger Syndrome service. Developmental questionnaires had been completed by the family in advance of the appointment, and problems with social and emotional development, social interaction and communication were identified. At this time D said he did not think he had any psychiatric or psychological problems. The formal outcome of this assessment was that D suffered from

Schizophrenia and Pervasive Development disorder<sup>20</sup> which is a 'disorder of psychological development', according to the international classification of mental and behavioural disorders (ICD10). It was explained to the family and D that this was a form of atypical Asperger's Syndrome. D did not agree with this diagnosis. It was suggested that he may benefit from social skills training and assertiveness training. The overall opinion was that antipsychotic medication would remain the mainstay of his treatment, but that professionals could adapt the way that care is organised to take account of his functioning.

- 5.25 In November 2005 D was referred back to the CMHT after input from the early psychosis service, when he was regarded as doing well on 15 mg Olanzapine regularly participating in social activities with support. It was noted that D would not agree to blood tests although the importance of checking was emphasised to him. It was suggested that the team return to this and possibly use local anaesthesia to assist. In November 2005 CC2 completed a risk assessment which detailed historical factors of delusions, command hallucinations, impulsivity, wandering, self-neglect, unplanned disengagement from services, ongoing high levels of stress and concern by others.
- 5.26 CC2 visited regularly until handing over to CC3 in the CMHT for longer term follow up, in May 2006. CC2 saw D initially fortnightly, then monthly following the CPA review in July 2005. Throughout this time D was reported to be generally stable, but with residual symptoms particularly auditory hallucinations. He was preoccupied with the Koran, and other religious texts. In January 2005 D's father went to work in Saudi Arabia, so D and Sandra lived in the house together, with D's sister lived nearby.
- 5.27 Six monthly outpatient appointments were carried out throughout this time, and D was seen by a locum psychiatrist Dr F in April 2006, who reported that D was doing well, with some breakthrough symptoms. It was confirmed to Sandra that blood tests had been carried out by the GP to check D's general health whilst on medication. Olanzapine was at 15 mg at this time, and was adjusted back to 20mg in July 2006 following concerns expressed by Sandra. D had apparently expressed that he had married an angel, and had purchased a doll. D at this time denied any difficulties although he acknowledged hearing 'voices of angels'. In November 2006 there were occasional biblical references noticed, and on one occasion Sandra reported that D did not return home from an errand and was found by Sandra helping a drunk man. Sandra was reported to be concerned at this as she regarded him as vulnerable.
- 5.28 In 2006 and 2007 D continued to be seen by CC3, monthly in 2007. In early 2007 there was some concern about finances in the family due to D's father's circumstances but this was resolved. A CPA review was held in July 2007, with a locum psychiatrist Dr F, CC3, the CMHT Manager, D and Sandra. The review meeting noted that D was stable, and while religious delusions remained, there was no other evidence of psychotic symptoms. He was maintained on 20mg Olanzapine daily. In December 2007 there were reports

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<sup>20</sup> F84.9 Pervasive developmental disorder, unspecified is a 'Disorder of psychological development' according to ICD10. <http://www.who.int/classifications/icd/en/GRNBOOK.pdf>

of D waking himself up at night to read scriptures and becoming dogmatic and argumentative.

- 5.29 A referral to the Recovery & Inclusion team was suggested in November 2008. When this was discussed D was reported to be adamant that he did not want any changes to his care, and his mother also did not want any changes as she was concerned this may destabilise D.
- 5.30 Medication was reduced to 17.5 mg Olanzapine at the CPA review in January 2009 after a review of his mental state, noting that he had been 'stable for a number of years'. A risk assessment was completed in April 2009, noting a history of mental illness, risk of exploitation, impulsive behaviour, wandering and night disturbance. The CPA risk management plan identified these actions to minimise risk: parents to control finances, and D to be escorted in the community. The PA K was employed in 2010, and remained the PA until December 2014.
- 5.31 At the January 2010 review by Dr A, D was reported to have been more irritable, an increase in Olanzapine was suggested but was refused by D. Through March, May and June 2010 D was seen monthly, and CC3 reported a gradual increase in irritability, preoccupation and agitation. In July 2010 he was reported to be loud and hostile. CC3 discussed an increase of Olanzapine with Sandra, who planned to discuss with D's father. CC3 also planned to discuss with Dr A. No changes were made, as D became much more settled when his access to the internet was restricted, sleeping and able to get up better.
- 5.32 A review on 9 November 2010 with Dr A, Sandra, D and CC3 noted that D was 'stable' and functioning well with the support of the personal assistant. It was summarised that D was diagnosed with Asperger's syndrome and Schizophrenia, but had no symptoms, though required constant prompting to complete daily activities, and close monitoring to ensure he slept and was not vulnerable to others. A risk assessment completed as part of the 'Mental Health Review' documentation referred to past history of command hallucinations, visual hallucinations and an attempt climb out of a second floor window in response to 'angel voices'. Stress was identified as a factor increasing risk, while supportive relationships and antipsychotic medication were identified as factors to decrease risk. The next planned review was planned as June 2011.
- 5.33 In the early part of 2011 Sandra and D spent long periods of time in the family's holiday flat in Barmouth, and on return in May 2011 Sandra reported that D had become much less stable, continuously referring to Sandra as satan, had pressure of speech and was sleeping poorly. CC3 advised Sandra to increase his Olanzapine to 20mg and to monitor his mental state & contact CC3 again if needed. D was reported to be 'zoned in red' by the CMHT. This was monitored by the duty team because CC3 was on leave, and Sandra reported that D had settled well, and were back in Barmouth at the beginning of June.

- 5.34 A CPA review with Dr Aon 14 June 2011 noted that D had been on edge and accusing Sandra of being satan on 15mg Olanzapine. He was apparently much improved on an increase to 20mg Olanzapine. Dr A noted no evidence of psychotic symptoms and requested the GP to complete blood monitoring and an ECG.
- 5.35 In July 2011 CC3 completed a trust approved risk assessment (TARA), and risk were noted as before. No risks were identified in the domains of harm to others /violence/self-neglect. It was noted that D had no insight into his diagnosis or recognised any problems, but that the family were aware of steps needed to keep him safe. No significant risks were noted because D's psychosis was considered to be well controlled and carers were able to assist with deficits that were seen as due to Asperger's. The Council funding panel requested information regarding D's payments to be provided in July 2011. A wellbeing plan was written on 12 July 2011, with no changes to the previous plans made.
- 5.36 In February 2012 a possible transfer to the Recovery and inclusion (RIT) team was discussed with Sandra, and she was reported to be unhappy with this suggestion, not wanting changes to his care, and seeing it a 'step down' service. D is reported as being happy with the change. This was revisited by CC3 in July 2012, and a possible change of worker was suggested. Sandra again verbalised her unhappiness, and requested a meeting with the team manager. A meeting took place in August 2012 with the CMHT manager, Sandra, Sandra's sister L, and the PA, K. S was concerned that such a change may cause a crisis and mean that D would need admitting to hospital, she stated that it had taken D years to build up a trusting relationship with CC3, and after the meeting wrote to reiterate her concerns and suggested she may take legal advice. It was agreed that no changes would be made, and a letter was sent to Sandra by the team manager to confirm this.
- 5.37 A CPA review by Dr A on 4 September 2012 records that D is 'stable' on 20 mg Olanzapine, with no evidence of psychosis, no suicidal ideas, no intent to harm others and for review in six months. There was no mention of the potential transfer to the RIT team, or of Sandra's concerns. CPA documentation was completed on 27 September 2012, and within the carers section it stated that Sandra suffered from fibromyalgia, arthritis, ulcerative colitis and asthma, and had regularly disturbed sleep due to D. It was noted that she required respite in order to maintain her caring role. The plan was: continuation of direct payments to enable D to access peer appropriate leisure and social activities, continued funding of the PA, regular monitoring by CC3, and six monthly reviews by the consultant. The risk assessment and care plan were unchanged. CC3 spent time in September and October supporting Sandra with re-applying for D's benefits and sending forms to the funding panel.
- 5.38 In February 2013 CC3 provided information for the funding panel, and D was in receipt of funding for 15 hours a week of the PA's time, and 24 respite nights per year. The care coordinator was requested to attend the next funding panel because concerns were expressed that D was not showing any improvement. Sandra was reported to be very stressed at the potential for any

changes in D's funding. In March 2013 CC3 notes that direct payments were finalised, and made arrangements to see D in March when they returned from Barmouth. In April 2013 Sandra reported D being unwell, and reported he was not happy with the generic Olanzapine formulation, so CC3 arranged for the original formulation to be obtained from GP and pharmacy. D had to fill in an employment and support claim (ESA) which Sandra also found very stressful and remained anxious about funding. It was noted that D was affected by his mother's 'high anxiety'.

- 5.39 D was seen at a CPA review by Dr A on 25 June 2013. Sandra reported D had been unsettled which lasted for a few weeks, and said this usually happened about once a year. During this time he called Sandra a devil and a witch, but was currently back to normal. Sandra related this to stress around financial forms and the ESA process. The Mental Health Review documentation was completed, with no changes to assessment or plans made.
- 5.40 In October 2013 Sandra requested that D's Olanzapine be reduced to 17.5mg, and CC3 clarified that Dr A did not want to make any changes until the CPA review in December 2013. This was agreed at the CPA review on 10 December, as D was noted to be 'stable', and functioning 'a little better'. The Mental Health Review documentation was completed, with no changes to assessment or plans made.
- 5.41 At the CPA review in December 2013 Dr A notes that there are no active psychotic symptoms, no suicidal ideas and no intent to harm anyone. Sandra requested a reduction in Olanzapine to 17.5mg, which was agreed, with a plan to review in six months. CC3 was noted to be present. Dr A's next (and last) entry is 3 June 2014.
- 5.42 At a home visit in January 2014 CC3 noted that D remained stable and the PA K is a calming influence, although Sandra was very stressed and this 'often upsets D.' In March 2014 CC3 notes that she discussed a transfer to the RIT team and 'this was accepted by them'. In March 2014 CC3 completed forms for the Council funding panel confirming that payments should continue to allow funding of a support worker for 15 hours a week to enable D to be supported to address socialisation, health and leisure needs. The application was for 15 hours a week and funding for 24 respite nights a year.
- 5.43 The next home visit in April 2014 is a joint visit with CC4, to introduce her and hand D's care over. D and Sandra were present and D was noted to be stable and 'his usual self.' CC4 visited for the first time four weeks later in May 2014, and met with Sandra, D and briefly K. She noted that Sandra appeared stressed due to workmen being in the house, and Sandra described D's breakdown and how services have been in the past in terms of support. Sandra expressed a fear of change and spoke of the stresses in her relationship with D, regarding 'his religious views and family conflicts'. The internal report notes that the later statement provided by PCFT to the coroner, which was completed after the death of Sandra, records that Sandra explained her difficulties in distinguishing whether D's behaviours were due to

his Asperger's or mental health, clarified that K was present briefly for introductions but then was in a different room.

- 5.44 It is recorded in the clinical notes that the wellbeing care plan and Mental Health Review forms were reviewed and amended. The care plan was recorded as amended. In fact almost exactly the same wording as the previous care plan were used. The well-being plan dated 19 May 2014 is signed by CC4, but not by D. The crisis management plan section states that D does not know when he is unwell, that others may notice that he becomes anxious/on edge, and is thinking a lot and argumentative. The entry in the 'what I can do' section is 'tell Mum'. The contingency plan in the event of the care coordinator being unavailable were: contact the GP or visit A&E; contact duty worker at RIT team, and out of hours the Crisis team. 'Monthly CPN visits to monitor D's mental state and provide support to S' are noted in action planning. This is exactly the same wording as previously, and CC4 is not in fact a CPN.
- 5.45 Those 'involved in the review' on 19 May 2014 are noted as Dr A, CC4, the GP, Sandra, D and K, although the final sections of the plan are noted to have been completed on 11 June 2014. The CPA review meeting with Dr A actually took place on 3 June 2014. CC4 notes that Sandra expressed her anxieties about D's obsessions with reading biblical literature although D is 'progressing well despite having arguments with his mother'. The plan according to CC4 was to arrange a home visit after the family holiday in June, and write to the GP asking for the most recent physical health check. On 3 June 2014 Dr A notes D is 'euthymic', no psychosis, no suicidal ideation, no intent harm others, that mother has no concerns about psychosis, and he is stable on 17.5mg of Olanzapine. The plan was to review him in six months.
- 5.46 CC4 visited as planned on 16 June 2014, and noted that Sandra was tired and 'extremely anxious' due to D's behaviour towards her, being argumentative, calling her a witch. D denied this. Sandra talked of 'family circumstances and events from the past'. CC4 records a discussion about sources of support that could be used such as National Autistic Society, Brothers of Charity social group and Hope 4Disability. Her plan was to refer Sandra to Rethink carers support service, and for Sandra to explore other support for D. Sandra phoned CC4 on 1 July 2014 saying D's behaviour had escalated and he had been upsetting her and 'vice versa'. Sandra reported D undermining her and her feeling constantly upset. She is noted to not want to increase his medication or speak to Dr A. CC4 advised she would chase up the Rethink carers referral, although Sandra said she did not think it would help. She also advised Sandra to follow up on the other referrals, and Sandra phoned later to say she had done this.
- 5.47 The next home visit was made on 14 July 2014, and Sandra reported feeling stressed by D's behaviour. Sandra queried the funding agreed, and CC4 explained that it had been agreed in the previous application, and encouraged her to use the respite care allocation. The notes record that CC4 'explained the dynamics of D's behaviour and the difficulty in assessing causes due to his complex diagnoses. It was planned to visit in two weeks to assess further and offer further support'.

- 5.48 CC4 received a letter from Rethink dated 17 July 2014, with a request to sign and return it. The forms were signed by Sandra, and in the form she confirmed that she provided and needed support in the following areas: emotional care, social care, safety care, practical care, managing care, managing finances, transport, advocacy, accompanying. Her problems were noted as arthritis, fibromyalgia, asthma, ulcerative colitis, and it was noted that she could not go anywhere without D. Sandra was reported to have said she could not plan a respite break at the time, although time out from caring was identified as a need.
- 5.49 The next home visit was in fact a month later, on 13 August 2014, and follows a phone call from Sandra asking CC4 to call back. Sandra stated that D had not been well and has been in bed for the last few days. The family had no access to a shower as work was being done in the house and D sees this as part of his routine. Sandra said he had been talking to himself and she requested an urgent visit to assess D and for his Olanzapine to be increased to 20mg. Dr A was on leave so CC4 called another psychiatrist and asked for medication to be increased, which was agreed. A faxed request was sent to D's GP. On arrival Sandra described D as agitated, calling her a demon, preoccupied with reading the bible, not eating very well and angry with a raised voice. D reportedly had no insight into his presentation and blamed S for a 'number of things' but agreed to the increased medication. CC4 planned to visit again on 15 August 2014.
- 5.50 On 15 August Sandra called to say D had a 'horrendous night' not sleeping, responding to noises, and was too agitated to go out to football. CC4 arranged to visit later that day (although had planned to visit on 15 August anyway) and requested an urgent outpatient's appointment, and made a request for the home treatment team to get involved. At the home visit D appeared calmer, and said he was not going to call his mother a demon any more. Sandra was advised to contact the crisis team or the police if needed. Sandra expressed reluctance to call the crisis team because she was afraid he may be admitted and CC4 offered reassurance that the crisis team would assess and it may not mean admission, but they could offer some extra support. It was left that Sandra would phone on 18 August, and CC4 would visit on 19 August. There are no notes of a visit on 19 August, or of a change to the visit date, and we suggest that this planned visit did not take place.
- 5.51 The next note is 22 August, where Sandra phoned to say that D is continuing to be preoccupied with religious readings and the relationship is still difficult, and if it continues D will have to live somewhere else. Sandra said her husband was due home soon so they would review the situation then. Sandra phoned again several times, and spoke to CC4, telling her that D had been 'kicking off' and had taped this. Sandra said she would not call the crisis team unless she absolutely had to as she feared D would be admitted again. No home visit was planned. A holiday was planned for the following week which Sandra really wanted to go ahead. She was advised to call 999 or take him to the nearest hospital if he relapsed on holiday, and it was suggested she saw the GP before going away. CC 4 noted that she planned to discuss the case with the team manager and plan an urgent review with a consultant

psychiatrist if needed. She made enquiries about potential respite residential care for D.

- 5.52 CC4 spoke to Sandra by phone on 27 August, and Sandra said he was much calmer and able to do tasks at home. CC4 explained that Dr A was back from leave and she was waiting for a call back to update him. Sandra said she did not want any increase in medication, and said she felt misled by the sector 3 CMHT about the change of team and care coordinator. Sandra said she would not discuss D with the RIT duty worker, as they don't know him. CC4 noted that she planned to discuss the case with Dr A and possibly have a team meeting discussion to review the package of care following the family holiday. CC4 made a home visit that day on 27 August, and D appeared much calmer. His father was due home and the holiday was planned to start the following day. Advice on managing in the short term was given while on holiday, and Sandra said that D's uncle and aunt were joining them for part of the time so would make things easier then. CC4 planned to discuss a review of D's personal budget support package and explore specific support for Asperger's support.
- 5.53 CC4 next saw D and Sandra on 17 September, and describes spending the first half of the visit providing emotional support to Sandra, discussing her physical health problems, stress levels and 'undue' anxieties over D. Sandra again referred to her belief that D was in the wrong team because he would never recover. CC4 recorded that she explained that there were changes and cutbacks in secondary mental health and she could write to the team manager or PALS. CC4 noted that she spoke to D on his own after speaking to Sandra and he appeared stable in mood and was able to follow conversation with minimal eye contact, and felt he was 'getting on' with his mother better.
- 5.54 Sandra phoned CC4 on 18 September, stating she wanted him out of the house that day, and he hadn't been taking his medication since the Monday (four days). CC4 advised her to monitor the situation and if she felt at risk to call the police. Sandra was reported in the notes as having said that D would never harm her and she did not feel at risk. She advised of the contacts for respite care she had made but that there is a process to go through to find alternative accommodation, but she would discuss with his consultant and ask for an early review, and encouraged her to call the duty team if needed. There is no record of CC4 asking why Sandra was so distressed. CC4 phoned the following day and was told by Sandra that D had now calmed down and she did not feel the need to action finding D somewhere else to live.
- 5.55 On 25 September Sandra phoned again saying she was stressed over D's behaviour and asking for assistance in finding short term respite accommodation for D. She was advised to contact services as before, and contact Rethink carer's service for emotional and practical support. . CC4 visited at home on 15 October and Sandra again said how D's behaviour distressed her, she had been in hospital recently and D had been looked after by K. Sandra had in fact been in hospital with renal colic from 12 October to 13 October 2014, there is no record that CC4 explored this in more depth.

- 5.56 A meeting was planned with Brothers of Charity on 24 October to assess the home situation, and CC4 planned to attend this with Sandra. It was noted that a CPA review was planned for 21 October 2014.
- 5.57 The CPA review was attended by Sandra, D, CC4 and Dr A, according to Dr A's letter to the GP dated 22 October 2014. D stated things were better 'between them at home', Sandra is noted to ask about the long term effects of Olanzapine and was 'reassured there were other options should the need arise'. D was reported to be still reading scriptures and believing he is a prophet, and though he calls his mother satan he does not believe it really, and would not act on his beliefs. Dr A recorded in his letter that D was 'reasonably stable' had fixed ideas of being 'some manner of religious figure', but he was not acting on these ideas and was not bothered by them, there were no evidence of other psychotic symptoms. He denied any intent to harm himself for others. He was noted to be on 20mg Olanzapine at night, and there were no further concerns raised. Dr A's plan was to remain on 20mg Olanzapine, he requested the GP to do an annual health check of specific blood tests, blood pressure, weight and ECG, and would see him again in six months' time.
- 5.58 The planned meeting on 24 October 2014 was attended by Sandra and CC4, staff from Brothers of Charity and the 'learning disability team' (organisation not specified). Sandra wished to discuss future planning, and expressed concern about D's future care if anything were to happen to her or D's father. The family had seen a solicitor and contacted the Council to discuss assisted accommodation in the future. The plan was for family to get back in touch in the New Year when they have thought through the options. The family planned to be away from three weeks from 11 November, and a visit was arranged for 28 November, which Sandra later phoned to rearrange. The last home visit was on 4 December 2014, and 'family difficulties' were mentioned by Sandra, and said D blamed Sandra for actions. It was noted that Sandra believed this was an Asperger's trait, although 'most of the time things have been settled'. It was left that CC4 would plan an appointment at a later date for 'supportive care'. There are no further clinical entries.

## **Involvement of Stockport Metropolitan Borough Council**

- 5.59 Stockport Metropolitan Borough Council (the Council hereafter) Social Care operational social work teams did not have responsibility for managing D's case. If social services are not involved, the local Trust is expected to assess needs, with reference to personal budgets.
- 5.60 We requested clarification regarding how decisions are made about the allocation of social workers, which is outlined below.
- 5.61 The community mental health service is a fully integrated health and social care service that is hosted by PCFT under a Section 75<sup>21</sup> agreement with the

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<sup>21</sup> Section 75 Arrangements between NHS bodies and local authorities  
<http://www.legislation.gov.uk/ukpga/2006/41/section/75>

(1) The Secretary of State may by regulations make provision for or in connection with enabling prescribed NHS bodies (on the one hand) and prescribed local authorities (on the other) to enter into prescribed arrangements in relation to the exercise of—

Council. The qualified staff within the service are from both health and social care disciplines and undertake the generic role of care coordinators for an allocated caseload of clients. The role of the care coordinator is to assess an individual's health and social needs, develop care and support plans to meet these needs and be responsible for the ongoing review of these plans to ensure that they continue to effectively meet an individual's identified needs regardless of the care coordinators professional qualification (nurse, occupational therapist or social worker). The only exception to this is the administration of medication which is only undertaken by nurses within the team.

- 5.62 All health staff within the service who act as care coordinators should have the required knowledge, skills and experience to undertake a comprehensive assessment of an individual's social needs and if required develop a support plan incorporating local authority funded interventions, either through a commissioned service or self-directed support, in order to meet these needs e.g. through the provision of a personal assistant, residential care placement, day services etc.
- 5.63 All support plans developed by care coordinators that require an element of Local Authority funding are reviewed either by the Team Manager or a funding panel that is chaired by the Social Care Lead for Mental Health for Stockport who is also the Lead Approved Mental Health Practitioner (AMHP) for the council. This function is undertaken on behalf of the council to ensure that support plans are able to effectively meet an individual's eligible social care needs and to ensure that Local Authority funds are spent appropriately.
- 5.64 Within this structure there is no requirement for an individual whose care coordinator is from a non-social care background to be referred to a social worker for any additional assessment or intervention as care coordinators from health backgrounds are able to undertake this role. This reduces duplication and the need for multi professional involvement and enables individuals to build effective therapeutic relationships with their care coordinators. Whilst this individual did not have a Social Worker the professional allocated to coordinate their care clearly had authority, skills and role to act within that capacity that would be required within the social work discipline. However, should they have required additional support from a qualified social worker to manage this case it could have been sought from one of the social work practitioners within the team or from the social work lead within mental health services.
- 5.65 D's needs regarding Direct Payments were originally assessed by a CMHT practitioner. The forms for renewal for these were regularly completed by the care coordinators. Direct Payments are social care payments for people who have been assessed as needing help from services, and who would like to arrange and pay for their own care and support services instead of being commissioned directly from local services. This was initially managed in Stockport by the Shaw Trust, and then transferred into the Council's Choosing

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*(a)prescribed functions of the NHS bodies, and  
(b)prescribed health-related functions of the local authorities,*

and Purchasing Service. The need assessment was reviewed annually by the Council's direct payment funding panel, and the care coordinator provided an annual update. The most recent form was dated 4 March 2014.

- 5.66 D received Adult Social Care 'direct payments' funding which allowed the employment of a personal assistant (PA) for social and leisure care, and respite nights for S. These were used to employ a personal assistant K for three days a week, who would take D out to social and leisure pursuits, with a view to widening his interests and adding to his life skills. Within the accepted structure of this process it is expected that the carer becomes the employer, and support was available from Shaw Trust to set this up. The Council maintains a list of people whom it has screened that can be accessed by the prospective employer, which is how K was approached by Sandra. There is no expectation of quality governance or oversight of the care provided by the Council, although there is a regular audit process in place to review the spending /use of funds.
- 5.67 K took him on a range of activities, from country walks to football, cinema, and occasionally practising cooking. The respite monies were used to fund K to come to the holiday flat with Sandra, or at times take D away for weekends, for instance to Blackpool. We have clarified that K wasn't being given supervision or training, including safeguarding. This is a gap and a potential risk area for those who use direct funding to employ workers.
- 5.68 Stockport Council completed an IMR regarding their involvement in D's case, and have noted that Sandra made regular phone calls to the Council's Choosing & Purchasing team, at times asking for support, and the staff member also noted that at times S would decline suggestions offered.
- 5.69 Sandra called the Council on 18 September 2014 requesting urgent respite for D, and it would seem from the case record entered by the staff member that S had spoken to a number of different people from different teams that day and had not been able to get the support she was looking for. It was discussed in the IMR whether the response on this date was sufficient, or whether more could have been done at that time.

## Physical health history and treatment – Sandra

- 5.70 Sandra was diagnosed as asthmatic<sup>22</sup> in childhood, had ulcerative colitis<sup>23</sup> since at least 1989, and osteoarthritis<sup>24</sup> of both knees.
- 5.71 In Feb 2005 probable fibromyalgia<sup>25</sup> was diagnosed, and 'early generalised osteoarthritis'. These caused swelling and joint pain which came to restrict her mobility. She was later diagnosed as having renal problems, including kidney stones and renal colic.

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<sup>22</sup> Asthma affects the airways – the tubes that carry air in and out of your lungs, causing chest tightness and wheezing and make it harder to breathe. <https://www.blf.org.uk/Page/Causes-of-asthma>

<sup>23</sup> Ulcerative colitis is an idiopathic chronic inflammatory disease of the colon that follows a course of relapse and remission. <http://patient.info/doctor/ulcerative-colitis-pro>

<sup>24</sup> Osteoarthritis (OA) causes pain and stiffness in joints. Symptoms may be helped by exercises, some physical devices and treatments, and losing weight if overweight. <http://patient.info/health/osteoarthritis-leaflet>

<sup>25</sup> Fibromyalgia is a long-term (chronic) condition that causes widespread pain in the muscles, tendons and ligaments. <http://www.arthritisresearchuk.org/arthritis-information/conditions/fibromyalgia/what-is-fibromyalgia.aspx>

- 5.72 Sandra was registered with her current GP in 2008, and was treated by specialist hospital outpatient departments and by the GP for asthma (present since childhood), eczema, osteoarthritis (since 1980s), ulcerative colitis (since 1989), otitis externa<sup>26</sup> (intermittent until July 2013) recurrent anal fissures<sup>27</sup> (up to July 2014), and lichen sclerosus<sup>28</sup> (since November 2012). The GP history refers to a past episode of depression, but there was no evidence of a mental health referral or medication prescribed. Sandra was seen for regular asthma clinic reviews. She was seen frequently by her GP, with the last visit on 22 December 2014.
- 5.73 The GP history refers to a past episode of depression, but there was no evidence of a mental health referral or medication prescribed. S was seen for regular asthma clinic reviews. She was seen frequently by her GP, with the last visit on 22 December 2014.
- 5.74 Sandra attended Stepping Hill AED on 23 September 2014 with a history of facial injury. She told the triage nurse and attending doctor that someone had run into a door five days earlier, pushing a large doorknob into her face. Her face and nose were noted to be swollen and tender, although an x ray ruled out any breakages. She was discharged from AED with pain control advice.
- 5.75 Sandra was admitted to AED with renal colic on 12 October 2014, in severe pain and having blood in her urine. Tests showed a kidney stone, and she was discharged, but represented at AED on 14 October due to worsening pain. Renal colic was confirmed and she was discharged with pain medication in the afternoon of 14 October, and seen by a consultant urological surgeon in November 2014, where kidney stones were confirmed as still present. A procedure was planned, and pain control advice given.
- 5.76 Sandra was again admitted to the AED on 22 December 2014, with high temperature and cough over the preceding seven days. The diagnosis was exacerbation of asthma with infection. Sandra was discharged home on the morning of 23 December.
- 5.77 Sandra was readmitted (by ambulance) just before 16.40 on 28 December 2014 with shortness of breath, having had no improvement since taking antibiotics and an increased dose of prednisolone.<sup>29</sup> It was recorded on admission that fatigue and 'deconditioning'<sup>30</sup> was thought to have contributed. It was noted that there had been no improvement in her cough and shortness of breath since discharge on 23 December. Notes record the 23 December as

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<sup>26</sup> Otitis externa can cause a number of different symptoms affecting the ear and the surrounding area.

<http://www.nhs.uk/Conditions/Otitis-externa/Pages/Symptoms.aspx>

<sup>27</sup> An anal fissure is a tear or ulcer (open sore) that develops in the lining of the anal canal.

<http://www.nhs.uk/Conditions/anal-fissure/Pages/Introduction.aspx>

<sup>28</sup> Lichen sclerosus is a long-term skin condition that mainly affects the skin of the genitals. It usually causes itching and white patches to appear on the affected skin. <http://www.nhs.uk/conditions/lichen-sclerosus/Pages/Introduction.aspx>

<sup>29</sup> Prednisolone is from a family of medicines known as steroids. It is used to help reduce the symptoms of asthma, such as wheeze. Taking prednisolone regularly may help prevent asthma attacks and control symptoms such as wheezing. Prednisolone is usually used alongside other asthma treatments such as inhalers. <http://www.evidence.nhs.uk/formulary/bnf/current/6-endocrine-system/63-corticosteroids/632-gluocorticoid-therapy/prednisolone>

<sup>30</sup> A decline from a condition of physical fitness, as through a prolonged period of inactivity or absence of exercise. <http://www.thefreedictionary.com/deconditioning>

a 'failed discharge' and a 'self-discharge', and it was also noted that she is the carer for her disabled son. 'Failed discharge' refers to the treatment given not preventing readmission. Sandra was seen initially by a medical team, then by the respiratory in-reach team. She was treated with IV antibiotics, increased steroids, and regular nebulisers. The Nursing Patient Assessment Report notes Sandra was allergic to dust. The respiratory in-reach doctor saw her on 29 December, and adjusted her medication and nebuliser regime, and advised she could be discharged on 30 December 2014, with chest clinic follow up. S left the ward at 16.45 on 30 December 2014 and was taken home by members of her family.

## 6 Arising issues, comment and analysis

### Arising issues, comment and analysis – care of D

- 6.1 We address each element of the terms of reference in separate sections, supporting our analysis with evidence as appropriate. We have included the relevant sections of the terms of reference for ease of reading.
- 6.2 ***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.***

#### Mental Health Care

- 6.3 D had been on CPA since his original admission in 2003, and had an allocated care coordinator. The care programme approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. The Trust's CPA policy dated December 2012 states that 'it is the responsibility of CPA care coordinators and key workers to ensure they undertake assessment and care planning in line with the CPA policy and to ensure that they have attended the approved training to do so'. It would be expected that care coordinators would update wellbeing care plans after each CPA review.
- 6.4 While D has care plans dating back to 2003, we have reviewed care plans in detail dating back to 2009, and find that there are clear documented reviews of the care plans, and a wellbeing care plan is in place in the record, signed by D in some cases. PCFT uses a 'Mental Health Review' document that provides a comprehensive overview of information related to the person, including:
- review of current care plan, social/personal circumstances update, mental health update, physical health, risk assessment including harm to self/suicide, harm to others/violence, exploitation/vulnerability, self-neglect, service users and family perspective, children and safeguarding issues, safeguarding adults, carers - ending with outcome and review agreement;
- 6.5 These sections all contain prompts which encourage a narrative description of the issues - for example in the domain of harm to others/violence, the 'current situation' subheading is 'expression of concern from others about risk of violence, paranoid delusions about others, violent command hallucinations, preoccupations with violent fantasy, current evidence of using weapons, sexually inappropriate behaviours beliefs or thoughts, contact with children or older adults'. This form is an example of good practice in encouraging a comprehensive narrative assessment, as recommended in national guidance.<sup>31</sup> This section however was never filled in in D's case. The entries

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<sup>31</sup> *Best Practice in Managing Risk, Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services. Department of Health 2007.*

in other sections are completed in almost identical wording, over a span of five years, which includes a change of clinical team and care coordinator. An update and review of the risk and care plan information would be expected before transfer.

- 6.6 The care plan reviewed and updated by CC4 in May 2014 has an agreed action of 'Monthly CPN visits to monitor D's mental state and support S'. CC4 is an occupational therapist, not a CPN, and the RIT team (undated) protocol states that 'you can expect to see your worker at least 3 monthly' or more frequently if specific interventions are planned. We suggest that this care plan was not given sufficient attention to detail in review, which was a missed opportunity to reassess the situation. However it is acknowledged that Sandra made it clear she did not want K to be directly involved in D's mental health care planning.
- 6.7 The August 2014 review contains more relevant up to date information, and notes that 'D's psychiatric symptoms are unstable and he cannot separate fantasy from reality with reference to God and religious ideas, He takes no notice of his mother's emotions. He is impaired by the symptoms of Asperger's and cannot pick up verbal and nonverbal cues'.
- 6.8 It is noteworthy that Sandra was always present at CPA reviews and care coordinator meetings. Staff involved were aware that Sandra wanted to be involved in D's care, and could be regarded as protective of him. It was known that there was a tendency for high expressed emotion in the household, with both D and Sandra upsetting each other and arguing about aspects of D's behaviour. There are differing accounts of whether D was always seen separately. We consider that efforts should have been made to interview D by himself to properly assess his mental state, try to engage him in his care planning, and also to explore his relationship with his mother from his own perspective. We also consider that Sandra should have been seen by herself to explore her perspective. We have been told that D and Sandra were seen separately and together. However given that their relationship was known to be of significance in D's care, we would expect there to be more emphasis on this in planning, and recording of interventions.
- 6.9 The wellbeing care plan was updated in August 2014, and included monthly contact with the care coordinator, medication reviews and six monthly consultant reviews. The psychiatrist who carried out the CPA reviews had been D's psychiatrist since 2008. The notes of CPA reviews are repetitive in content and refer regularly to D being 'stable' despite a background of regular fluctuation and breakthrough psychotic symptoms. At the CPA review in June 2014 there is no reference to the transfer to the RIT team in April 2014, or to the change of care coordinator.
- 6.10 The CPA review held on 21 October 2014 makes no reference to the events of September when Sandra was clearly distressed by D's behaviour and his psychotic symptoms had increased to the point where D was focusing verbal

aggression on Sandra. The adopted approach at CMHT and RIT was that Sandra was seen first at reviews and then D, which would have given Sandra an opportunity to talk to the team about any concerns about D, and raise the issue of violence towards her, and her concerns around events in September.

- 6.11 The family have queried whether this review meeting on 21 October 2014 actually took place, considering how unwell Sandra was with renal colic earlier in October, having been in severe pain. We have reviewed all the available notes with this question in mind. There is a clinical entry made by CC4 recording contents of the meeting, an entry on the electronic patient administration record noting D's outpatient attendance ( in sequence after all the other entries noting previous attendances) and a letter from Dr A to the GP summarising the meeting. We have not been able to locate the handwritten notes that Dr A states he made. Given this information we conclude that there is sufficient evidence that the meeting did in fact take place. There is however no record of why it was held early, as the six monthly review was due to be held in January. It has been confirmed that CC4 requested the earlier review by contacting Dr A's secretary in September when concerns were raised.
- 6.12 The crisis and contingency plan dated May 2014 relies on others noticing that D is unwell, 'because he does not know'. It suggests he can tell his Mum if he feels unwell, and the contingency plan if the care coordinator was unavailable was to contact the duty RIT worker, or the crisis team out of hours. We consider that this placed an undue emphasis both on self-reporting by D, but also on the assumption that D's mother would always be present and able to intervene. This does not appear to us to be an adequate contingency plan as his mother was critical to the care plan including sole care for him most of the day and night and getting him to take his medication. Even if their relationship was without issues there needed to be a written contingency plan as to what to do if for any reason she was unavailable.

**Recommendation 1:**

Pennine Care NHS Foundation Trust : should ensure that the quality of care and contingency plans is audited, including the checking of plans against identified needs

**Recommendation 2:**

Pennine Care NHS Foundation Trust : should amend the CPA policy to describe the role of the psychiatrist with regard to the CPA policy and care planning

**Direct Payments**

- 6.13 With regard to the Direct Payments and the provision of the PA, from interviews with PCFT staff and with K, it appears that K was not seen as part of D's mental health care by Sandra, and was asked to wait outside during CPA or outpatient meetings which were attended by Sandra and D. K was given to understand by Sandra that his input was relevant to D's Asperger's

syndrome, and not to his mental health issues. Although K knew D was taking medication and had to prompt if he was with him at medication times, he told us that he believed the medication was to help in keeping D calm, and he was not aware of D's diagnosis of schizophrenia. He reported going along with Sandra's wishes that he was not involved in mental health service meetings. As D had a dual diagnosis we would have expected his care coordinator to have documented attempts to find out from K his role and what he found and did as part of coordinating the care. If K or Sandra refused permission then this would be a heightened risk sign.

- 6.14 The advice about health related Direct Payments on the relevant government website<sup>32</sup> is that social care needs have to be reassessed every year. It is not clear who was responsible for re assessing D's social care needs nor was it clear exactly what needs the direct payment was intended to help with, for instance if it was to help with medication, this could be seen as a carer rather than a personal assistant role.
- 6.15 There is no expectation of monitoring by the Council, apart from monetary audit aspects. We consider that there should be an expectation that significant carers should be involved in CPA care planning and reviews. PCFT has no policy guidance for staff on support for Direct Payments or of the involvement of funded carers in care planning. Stockport Council information<sup>33</sup> states that 'in essence it is a way of arranging social care with the aim of giving people more options about their support services and a greater say in how they arranged'. The benefits of self-directed support are listed, but there is no information about how it will be monitored, and how often needs will be reassessed, and there is no explanation on the website about the person with disability being an employer.
- 6.16 While it is clear that the Direct Payment scheme is intended to promote independence and offer personal choice, in this case we believe that the lack of oversight contributed to a fragmentation of D's care. We have recommended that PCFT address this locally, but there is a wider issue about the quality assurance of funded care for vulnerable people. It seems unfair to place the onus for due diligence on already stressed families struggling with a long term demanding condition.

**Recommendation 3:**

Pennine Care NHS Foundation Trust : CPA policy should provide guidance on assessment and CPA care planning to clarify responsibilities and requirements where there are carers funded by direct payments

- 6.17 ***Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.***

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<sup>32</sup> <http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/direct-payments-personal-budgets.aspx> The Carers (Recognition and Services) Act 1995

<sup>33</sup> <http://www.mycaremychoice.org.uk/self-directed-support.aspx>

- 6.18 Within the December 2012 CPA policy it is stated that both Pennine Care and its Local Authority (LA) partners have responsibilities around carer's assessments - in the case of the latter; the LA has a statutory duty to ensure all carers are offered one. The Carers Recognition Act (1995) placed the responsibility to assess carers needs (when they are the carer of someone assessed under the National Health Service and Community Care Act 1990) upon the local authority when they are asked for an assessment by the carer. The Care Act 2014 now makes the carers assessment a statutory duty placed upon local authorities, and they also now have a duty to provide the care and supported identified in the assessment.
- 6.19 Because the Local Authority responsibility is a statutory one, and because arrangements for carer's assessments vary from borough to borough, PCFT's policy does not require that a standardised form/process be used. Performance and recording requirements around carer's assessments are met through the establishment and maintenance of the core dataset.
- 6.20 In Sandra's case the section of the 'Mental Health Review' document that relates to carers needs had been completed with a list of her physical ailments, and records that carers assessment has 'done previously' with no recorded date (since 2009). In response to Sandra's needs, CC4 did refer her for a carers' assessment in July 2014, and this was carried out by Rethink, who provided the local service at the time. Sandra requested help in many areas and the report was returned to CC4. The CPA policy does not detail what may happen next, and the assessment service from Rethink appeared to offer an assessment and signposting to other services, but no actual resource. Sandra did not apparently have any further contact with Rethink. The service is no longer provided by Rethink in Stockport.
- 6.21 With the benefit of hindsight<sup>34</sup> it is clear that Sandra played a very active part in the treatment of D, to the extent that her voice was heard rather than professionals focussing on what D may want or need. However there is no evidence that Sandra's perspective was explored in any depth. There is no record of any attempt to see her alone, and latterly there was more of a focus on her distress, but critically not upon the impact of the various issues including her pain, and his greater fluctuations, on her ability to continue to deliver his care. A more in depth approach by professionals to Sandra could have discovered that she had a number of firmly held views about D's care, for instance her motivation for asking for reductions in Olanzapine was apparently so that she would be able to increase it again if he relapsed. She told family that she believe this would prevent him relapsing to the point where he may need hospital admission. There is also no evidence of an in depth discussion about Sandra's health and how this might impact on D's future care.

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<sup>34</sup> Hindsight bias occurs when people feel that they "knew it all along," that is, when they believe that an event is more predictable after it becomes known than it was before it became known. Hindsight bias embodies any combination of three aspects: memory distortion, beliefs about events' objective likelihoods, or subjective beliefs about one's own prediction abilities. Roese NJ, and Vohs KD (2012) Hindsight Bias. *Perspectives on Psychological Science* 7(5) 411–426.

- 6.22 With regard to D's involvement in his care planning, it is clear that he did not agree with either diagnosis, and only very reluctantly accepted medication as given to him by his mother. This lack of involvement by D was masked we believe by professional's acceptance of the degree of his mother's involvement.

**Recommendation 4:**

Stockport Metropolitan Borough Council should develop a system to follow up on plans and interventions after carers assessments and co-ordinate interventions with Pennine Care NHS Foundation Trust where the carer is caring for a mental health service user

- 6.23 ***Review if the Trust fully assessed and appreciated the perpetrator's dual diagnosis of schizophrenia and atypical Asperger's and if they provided appropriate support, care and treatment options that met national standards.***
- 6.24 The internal report comments on a 'confusion' when considering D's presentation as being due to atypical Asperger's. We found the clinical team to be clear that they were treating a psychotic illness primarily, but accepting the dual diagnosis and that some of D's behaviours and presentation were due to autism. D was latterly treated with 20mg Olanzapine, taken in divided doses. D took these tablets at 10.00 and 22.00 and was described as obsessional about this routine. The tablets were kept in a kitchen drawer at home, and to keep track Sandra introduced a diary where D would sign that he taken the tablets.
- 6.25 D was first diagnosed with schizophrenia after his admission to SHH in December 2003. He was initially treated with Risperidone and referred to the early psychosis clinic on discharge, where he received a range of psychosocial interventions, and remained with this team until May 2006, when he was referred to the CMHT.
- 6.26 The NICE guideline for psychosis and schizophrenia in adults: prevention and management<sup>35</sup> (updated 2014) provides best practice guidance on the management of subsequent episodes of psychosis or schizophrenia and referral in crisis, and for promoting recovery and possible future care:
- Offer cognitive behaviour therapy (CBT) to all people with psychosis or schizophrenia. This can be started either during the acute phase or later, including in inpatient settings. (2009)
  - Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings. (2009)

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<sup>35</sup>Psychosis and schizophrenia in adults: prevention and management NICE guidelines [CG178] Published date: February 2014. <http://www.nice.org.uk/guidance/cg178/chapter/Key-priorities-for-implementation#promoting-recovery-and-possible-future-care> .

- GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. Include all the checks recommended in 1.3.6.1 and refer to relevant NICE guidance on monitoring for cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the care coordinator and psychiatrist, and put in the secondary care notes. (new 2014)
- Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least 2 different antipsychotic drugs. At least 1 of the drugs should be a non-clozapine second-generation antipsychotic. (2009)
- Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment. (new 2014)

6.27 With regard to CBT and family interventions, there is no evidence in the record that D was offered CBT at any stage in his treatment. Family work was provided in the early stages by the early psychosis service. As mentioned above, it was known that Sandra and D spent a great deal of time together in the family home, and at times there were high expressed emotions. It would have been helpful to have had a considered assessment of this situation, with some targeted interventions to assist them both. We were informed that there was no allocated psychological service for the RIT team.

**Recommendation 5:**

Pennine Care NHS Foundation Trust should ensure that NICE CG178 (psychosis and schizophrenia in adults: prevention and management) is implemented and monitored

6.28 The detailed health check expectation of GPs was introduced in 2014, however the 2009 wording contains the expectation of health checks by GPs, with the results to be sent to the care coordinator for secondary health care notes. The six monthly CPA reviews regularly record requests to D's GP to carry out annual blood tests and/or annual health checks, and the care coordinator notes that the details of the tests to be done were provided to the GP. There are no records of results being conveyed back to the secondary mental health care teams. The 'Mental Health Review' form has a prompt to note whether the GP has been requested to do health checks, and this is ticked, and in 2014 the box that asks 'has the GP been requested to provide results' has been ticked. At interview staff told us they did not routinely get the

results, and assumed the GP would let them know if there was anything to be concerned about. The last blood tests carried out by the GP were in October 2013. In the GP notes there are records of requests by Dr A to have the results sent to PCFT. We did not find any evidence that they arrived, or were reviewed by Dr A.

#### Recommendation 6:

Pennine Care NHS Foundation Trust and Stockport CCG: implement a system for follow up and monitoring of GP physical health checks re psychiatric medication

- 6.29 There are references to potential prescribing of Clozapine in 2004 which noted that D objected to having bloods taken. This was discussed again in 2005, and it was suggested that sedation and behaviour therapy may be useful. There are no further references to supporting D with this, though references are made to D having a 'needle phobia'. The GP was written to by care coordinator asking for specific blood tests, and advising that D was not keen on blood test, so asking for the GPs support. Clearly D had blood taken for testing at the GP surgery, although the last recorded result is in October 2013. We consider that the option of Clozapine was not sufficiently explored. We suggest that there is no evidence that D had a needle phobia and the issue of depot medication should also have been assertively explored.
- 6.30 The family have asked why D was not prescribed a depot injection<sup>36</sup> given their concerns about his compliance. There is no evidence that this was given much discussion as an option, and was discounted as not possible due to D's 'needle phobia'. From discussions with family and with professionals however, it is clear that there were two very different perceptions of D's compliance with medication. There was a complete reliance on Sandra or K to give medication to D. D was acknowledged to have no understanding of his illness, and did not agree with either diagnosis. It appears D took the medication because his mother told him to. There are two issues here, one of concordance<sup>37</sup> and one of compliance.
- 6.31 Given that it was questionable whether concordance was possible, we believe that there should have been a focus by professionals on the process of D taking medication. It is clear with hindsight that his mother had to prompt him daily to take medication, and this was a significant flashpoint in their interactions. It was also known that D relapsed very quickly if he missed small doses of medication, although the breakthrough symptoms which occurred were managed without any extra interventions or hospital admission. It would have been helpful to have had a detailed discussion about the pros and cons

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<sup>36</sup> Depot antipsychotics are administered by deep intramuscular injection at intervals of 1 to 4 weeks. Long-acting depot injections are used for maintenance therapy especially when compliance with oral treatment is unreliable. <https://www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system/42-drugs-used-in-psychoses-and-related-disorders/422-antipsychotic-depot-injections>

<sup>37</sup> A negotiated, shared agreement between clinician and patient concerning treatment regimen(s), outcomes, and behaviours; a more cooperative relationship than those based on issues of compliance and noncompliance. <http://www.drugs.com/dict/concordance.html>

of depot medication, and record made of Sandra and D's perspectives on this. We acknowledge however that Sandra did not convey the level of effort that she had to put into persuade D to take his medication to ensure he didn't relapse. This appears to have been influenced by Sandra's belief that the next possible level of input from services was admission, which she was adamant she wanted to avoid. There does not appear to have been an exploration of what was so negative about the previous admission or what might help to reduce the problem if he ever did need future admission. Accepting that the team had no access to specialist ASD advice, but things like hospital passports/advance directives can be considered in such situations.

- 6.32 Sandra also believed that the 20mg Olanzapine was the maximum dose and only option for D's treatment, and this motivated her to ask for reductions regularly, in the belief that when he had his frequent breakthrough symptoms, there would be 'room' to add more up to 20mg if needed to prevent a full relapse. We consider that the issue of medication should have been explored and explained to both D and Sandra in greater depth, and emerging issues addressed in care planning.
- 6.33 With regard to Autism, D was diagnosed as having a pervasive developmental disorder in 2005 by the Sheffield Asperger's syndrome service, following referral by the early psychosis consultant, which is an example of good practice. D was described as having an atypical Asperger's syndrome, which he disagreed with. There is a family history of autistic spectrum disorder, so there happened to be a high degree of awareness of the kinds of behaviours that D may present. It was suggested that he would benefit from social skills and assertiveness training, and the Sheffield psychiatrist noted that antipsychotic medication would probably be the mainstay of treatment for psychosis. He did suggest a psychometric assessment of his intelligence to identify a picture of strengths and weakness, but there is no evidence that this was followed up at the time.
- 6.34 The direct funding of a support worker and respite care by the Council was supported by care coordinators, and seen as an essential element in his care to assist with D's deficits in social functioning that were largely attributed to Asperger's. This entailed completing forms, signing off funding requests and ensuring the funding panel had sufficient information. PCFT does not have responsibility for the oversight of any service provided by direct funding.
- 6.35 At interview PCFT staff conveyed their concern that there was no service to signpost D and Sandra to, with a view to assisting with Asperger's, nor any local professional Trust resource that they could go to for advice on management.
- 6.36 In the NICE guidelines for Autism in adults: diagnosis and management<sup>38</sup> the following recommendations have been identified as priorities for implementation:

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<sup>38</sup> *Autism in adults: diagnosis and management NICE guidelines [CG142] Published date: June 2012.*  
<https://www.nice.org.uk/guidance/cg142>

- All staff working with adults with autism should work in partnership with adults with autism and, where appropriate, with their families, partners or carers offer support and care respectfully take time to build a trusting, supportive, empathic and non-judgemental relationship as an essential part of care.
- In order to effectively provide care and support for adults with autism, the local autism multi-agency strategy group should include representation from managers, commissioners and clinicians from adult services, including mental health, learning disability, primary healthcare, social care, housing, educational and employment services, the criminal justice system and the third sector. There should be meaningful representation from people with autism and their families, partners and carers.

6.37 There is a clear Stockport CCG Autism strategy<sup>39</sup>, and in ‘transforming care’ guidance to commissioners it is required that resources are available and appropriate for adults with Autism who do not have learning disabilities as well as those who do have learning disabilities.

#### Recommendation 7:

Pennine Care NHS Foundation Trust, Stockport CCG and Stockport Metropolitan Borough Council : audit of implementation of the autism strategy, and resources to support staff & patients who are diagnosed with Autistic Spectrum Disorder

**6.38 *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.***

6.39 An initial suggestion of transferring D to the RIT team was made to Sandra in February 2012. It was noted that Sandra was not happy about any changes. In July 2012 it was again discussed with Sandra by CC3.D is recorded as being happy with this but Sandra was very unhappy, believing that any change would detrimental to D’s wellbeing and may affect his benefits. Sandra was particularly concerned that the name of the team was ‘recovery and inclusion’ and believed that this was the wrong focus for D, and that it may be a way of ultimately discharging him from services. She also maintained that D would never ‘recover’.

6.40 Sandra requested a meeting with the CMHT team manager, which took place on 6 August 2012. After this meeting the CMHT manager wrote to Sandra and confirmed her concerns had been noted and that no action would be taken without a full consultation with her. Sandra’s concerns are noted as how long it has taken to build up trust in CC3, her own ill health and not wanting any upheaval, and that D cannot tolerate change and his behaviour tends to worsen.

<sup>39</sup> Stockport adult autism strategy 2014- 2016 <http://www.stockport.gov.uk/2013/2996/41151/autismstrategy201416>

6.41 A further transfer to the RIT team was proposed in March 2014. CC3 discussed this with D and Sandra and noted that both were accepting of the decision at time. The family have questioned this 'acceptance' and the internal PCT report notes that Sandra had confided to her sister that she had tried to resist the change, but felt she had no option to accept because it was due to cuts to funding. CC4 has made an entry advising Sandra to that effect. The internal report queries D's transfer to the RIT team, with a focus on the promotion of social inclusion and recovery. We have reviewed the (undated) document titled 'Stockport Recovery and Inclusion Team'. In Section 4, 'who is the service for' the list is of people in the following positions:

- a. People who have been receiving a service and reach a point when they and their care team feel they are ready to move on
- b. People will probably have been receiving a low level of support from a community team for some time
- c. People who wish to develop social networks
- d. People who wish to explore options for education, training, voluntary or paid work
- e. People who are ready to develop their own support plans
- f. People who wish to 'build bridges' into mainstream living e.g. if someone's life is lived almost entirely within mental health services and this limits their opportunities and relationships

6.42 We consider that D did not meet the above admission criteria for care by the RIT team, and there is no evidence that Sandra's previously stated concerns were considered when the transfer was planned. There was a suggestion that changes to the configuration of community teams had impacted on decision-making, with the need to maintain smaller caseloads in other parts of the service. It is acknowledged that CC3 and CC4 had a handover and joint visit to Sandra and D in April 2014, and that the degree of input by the care coordinator and consultant did not dramatically change. We do however consider that the remit and functioning of the RIT team had a considerable influence on the approach to problem-solving, assessment and care planning. The outpatient notes in May 2014 do not acknowledge or explore how the change has been received. Care coordinator notes of the four home visits in May and June record in detail Sandra's anxiety and concern about D's behaviours towards her, and the focus of input at this time appears to be to find sources of support for Sandra, rather than consider whether D was adequately treated.

6.43 We consider that from the time of transfer to the date of the incident there were more evident signs of increased concerns by Sandra about D even though they fluctuated. There was a lack of urgent home visits when she contacted them urgently, which would fit with their remit but not with a dual diagnosis complex case with no insight, reluctant compliance with treatment and recurrent breakthrough symptoms including those directed at Sandra.

6.44 We have been informed that there has been a more recent review of community mental health services in Stockport by PCFT, which would mean that patients who require varying degrees of input could still remain on the caseload of CMHT CPNs.

## Recommendation 8:

Pennine Care NHS Foundation Trust : Ensure that clinical decisions about changes to pathways or services should include the care team, and there is evidence that the perspectives of patient and carers have been considered, taken into account and documented

- 6.45 *Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.***
- 6.46 At CPA reviews D was noted to be generally 'stable' in his mental health. There is reference to D frequently referring to his mother as a 'witch' and 'satan' and considerable antagonism towards her is noted. There was no formulation or analysis of D's religious beliefs, delusional beliefs, or of his continued hostility towards his mother. Everyone we saw who was involved clinically and the family noted that high expressed emotion was a well-known reality. The risk assessment did not address this and nor did the care plan, although K's care outings were in fact reducing face to face contact between D and Sandra which is known to be part of protection against psychotic relapse and reduces risk in cases of high expressed emotion. K was in fact contributing to care and treatment of psychotic illness as well as autism but not explicitly recognised. If it had been then periods when he was not around due to leave etc would have been seen as higher risk and included in contingency planning.
- 6.47 The PCFT Clinical Risk Assessment & Management (CRAM) Policy dated November 2013 requires that all patients have a 'Trust Approved Risk Assessment' (TARA) document completed. Subsequent reviews of this risk assessment are then incorporated into the patients overall CPA documents. The TARA for D was completed in December 2010 and repeated in July 2011. The domain 'harm to self/suicide requires a list of issues to be ticked 'yes' or 'no', then any 'yes' notes should be expanded upon in the free text area. In harm to self, yes is ticked for: 'experiencing and responding to command hallucinations, expressing high levels of distress, psychiatric diagnosis, substance misuse, and unemployed (there is in fact no history of substance misuse). Factors increasing risk are noted as 'stress', with factors decreasing risk as 'supportive relationships and antipsychotic therapy. In the domain harm to others/violence, there are no 'yes' ticks. In the 'risk summary and formulation' section, there is the statement 'currently no risk due to psychosis being controlled and carer present to assist with deficits due to Asperger's syndrome'. This sentence is repeated up to and including May 2014.
- 6.48 In the first review under the care of the RIT team, the Mental Health Review document is blank in the domain of 'harm to others'. We consider that this was a missed opportunity to take a fresh look at his current care in a new team, and review his history and care over time.

- 6.49 In the risk summary and formulation section of the review completed on 13 August 2014, there is a prompt to the worker to 'consider the nature and degree of risk, who is at risk, how likely is it, relationship between risk and mental illness, current social circumstances and contextual factors'. The entry is 'increased support and routine, support network, difficult to ascertain symptoms of Asperger's and mental health'. The CRAM policy provides clear guidance on how to assess the risk of harm to self and to others. This does not appear to us to be an adequately formulated risk assessment.
- 6.50 We concur with the comments made regarding the use of the word 'stable' in each outpatient clinical note. In October 2014 D was described as 'reasonably stable' and comment was made about his fixed idea of being a religious figure, but that he is not acting on these ideas and 'not bothered by them'. Note is made of his denial of suicidal thoughts or intent to harm others. There is no recorded exploration of the recent crisis that Sandra had reported, or of D's recent agitation and hostility towards Sandra. D was routinely seen with Sandra which we consider did not allow for a richness of assessment.

**Recommendation 9:**

Pennine Care NHS Foundation Trust : change approach to Risk Assessment training, to focus on formulations; and implement a quality assurance process for Risk Assessments

- 6.51 Sandra had multiple physical health problems, which appear to have been deteriorating during the summer of 2014. Given that the contingency plan in place relied on Sandra noticing that D may be deteriorating, we consider that her health and its potential impact on D's mental health should have been explored more assertively.
- 6.52 There was an obvious increase in D's agitation, religiosity and hostility towards his mother from August 2014 onwards. An increase in care coordinator contact was arranged, and a review by the consultant was requested. At this time Sandra voiced her concern that she did not want to increase D's medication and did not want him to be admitted to hospital.
- 6.53 On 18 September 2014 Sandra phoned the RIT team to say she wanted D out of the house today and that somewhere else be found for him to live. She was advised by CC4 to call the police if she felt at risk, and Sandra was reported to say she didn't feel at risk and that D would never harm her. CC4 called Sandra on 19 September and was advised that D was calmer now and she did not need to action finding him alternative accommodation. She told CC4 she did not need a home visit. However on 25 September Sandra called again asking for respite accommodation for D, and she was given advice on reducing her stress and obtaining other sources of support for D (focusing on Asperger's care and input) and was reported to have said he had made some contacts as agreed. The family were due to go on holiday the following day and were preparing to go away. A visit was booked for 15 October 2014 at

Sandra's request, because the family were due to go on holiday in the meantime.

- 6.54 It seems clear now from family information that D assaulted Sandra on 17 or 18 September 2014 and caused significant bruising and swelling to her face. She was not seen by mental health services until 15 October, by which time her face had recovered. The PA noticed her facial injury and was told by Sandra that D had hit her. It is reported that Sandra told him she had let the mental health services know, and they were dealing with it. There is no evidence that Sandra told mental health services that she had been assaulted by D. However we consider that there was an absence of inquiry into why Sandra was so distressed and asking for D to be removed, especially given the history of her being his sole carer for many years and actively reporting that she didn't want him going into hospital over many years yet was now asking for his immediate removal from the home.
- 6.55 We believe that such a significant change should normally have resulted in a home visit to urgently reassess the situation, but acknowledge that Sandra is reported to have said it was not necessary. It is also reported that at times Sandra presented with a significant degree of high expressed emotion, and it may well have been difficult to make an objective assessment of her degree of concern on this occasion.
- 6.56 The community teams operate a zoning system, as outlined in the draft 'Zoning Protocol' dated 6 November 2011. This document describes a daily zoning meeting, where risk issues are discussed in 'An approach to applied clinical risk management and targeting resources in community and in patient mental health settings'. It is stated 'Service Users who are currently in crisis or thought to be at risk and requiring ACT<sup>40</sup> should be re-zoned to Red Zone and an action plan agreed.
- 6.57 Zones as described:

**Red Zone:** Service Users, who are considered currently to be at the most risk or in crisis, may be disengaging from services, non-compliant or only partially compliant with treatment plans and whose care requires shared case management (Team Approach), assertive outreach, and frequent review. This group will have: multiple interventions; multi-agency input; frequent consultations/review; issues of non-compliance; vulnerability; risk; sensor / physical impairment; isolation; self-harm; dual diagnosis; significant carers' needs.

**Amber Zone:** Service Users, who although have complex need and have significant risk issues, are engaging with their established risk management and care plan. Long term Service Users who are mentally unwell, who have a known risk history and who have intermittent high demand on services. To remain well they require regular support/monitoring; remain vulnerable to relapse; may require inpatient treatment or crisis intervention; need for carer support

**Green Zone:** Service Users who are mentally stable, who have engaged and are compliant with their care plan. These Service Users need to be established on the pathway to Social Inclusion / Recovery and who are being prepared for transfer to a less intensive support part of our service or discharge to primary care

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<sup>40</sup> Assertive Community treatment : Pennine Care Zoning Protocol CMHT (V3) 6.6.11 page 2

- 6.58 While it is clear that PCFT staff did not have knowledge of D's assault on Sandra, we consider that D should have been placed in the Amber or Red Zones and more robust enquiries into the details of the home situation should have been made. We have been told that zoning is done twice a week in the RIT team, and by the next zoning meeting CC4 had been reassured by Sandra that things had resolved. There was no reference to the intervals of zoning meetings in the RIT policy supplied to the investigation. CC4 stated that Sandra provided sufficient reassurance to her that things had settled down at home, so she did not bring D to the zoning meeting the following week.
- 6.59 It appears Sandra also phoned the Council Choosing and Purchasing Service with a similar request, and was advised there was a process to follow for respite care. Notes were made by the Council after Sandra called them, but this did not trigger any other communication or action. Sandra did not tell CC4 that she had made this call.
- 6.60 These two agencies had received calls from a known carer, expressing significant distress, on the same day. We believe it would have been expected that this information would trigger a notification to a senior member of staff to review the situation and consider implementing contingency plans, and an urgent visit to reassess.

**Recommendation 10:**

Pennine Care NHS Foundation Trust & Stockport Metropolitan Borough Council should have triggers for responding to crisis calls and an escalation process in place

## Arising issues, comment and analysis – care of Sandra

- 6.61 ***Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies to the victim, both as a patient and in her role as sole carer of the perpetrator.***
- 6.62 Sandra received medical care from Stockport NHS Foundation Trust at Stepping Hill Hospital (SHH) and primary care GP services from Bredbury Medical Centre, Stockport. Her full medical history is as previously noted in section 4.13.
- 6.63 Stepping Hill Hospital**
- 6.64 The IMR report written on 6 October 2015 reviews the care of Sandra at SHH during 2014, as her previous contact was in November 2012. Sandra was admitted overnight on 11 January 2014, having attended the AED with symptoms of an acute asthma attack. She was discharged home on 12 January 2014.

- 6.65 Sandra attended AED on 13 May 2014, after experiencing severe pains to her chest, nothing abnormal was found and she was discharged home.
- 6.66 On 23 September 2014 Sandra attended AED for an injury to her face. The consulting doctor and triage nurse were interviewed as part of the IMR, and could not remember any details apart from what was noted on the patient attendance form. Sandra presented with a swollen and tender face and told staff 'someone ran into a door 5 days ago, pushing a large door knob into her face'. Sandra did not tell staff that her son had assaulted her 5 days previously. She had attended AED after encouragement from her sister, with whom she discussed what to tell the staff, as she did not wish to tell them that her son had hit her.
- 6.67 The Stockport NHS Foundation Trust Domestic Abuse Policy dated January 2014 has an appendix 'Emergency Department Domestic Abuse policy' dated February 2013 which describes in detail how to approach women and children who may be suspected of being victims of domestic abuse. There is guidance on what signs may be significant in women and children, how to approach routine or selective enquiry, and the policy contains the line: '*Do not be afraid of broaching the subject with the woman because you are afraid of the repercussions she may have to deal with once she has left ED*'. This protocol is based on guidance published by the Department of Health in 2005<sup>41</sup>. While this protocol appears to give guidance about women or girls, the focus is on partners or ex-partners, with no mention of intergenerational violence. There is a notable absence of reference to domestic violence by other family members, or against males or older people.
- 6.68 Training in domestic abuse is not mandatory in Stockport NHS Foundation Trust, although this is included in child safeguarding training. 120 community staff were trained in 2015 in specific domestic abuse awareness. There has not been any training focussed on AED staff, and this is planned in line with policy review (the policy was due to be reviewed in February 2015).
- 6.69 Stockport NHS Foundation Trust is a partner in the Safer Stockport Domestic Abuse Prevention Strategy<sup>42</sup> which gives a comprehensive set of strategic aims and actions. However objective 3 'Workforce Development' contains the aim to (a) *Ensure the workforce are equipped to recognise the indicators of domestic abuse and know where to refer for help*. The objective is that: '*Domestic abuse enquiries become a routine of good practice and professionals know where to refer to*'. The target date is from September 2014 to September 2015. The training of frontline workers has been identified as a priority, and in our view this certainly applies to AED staff.

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<sup>41</sup> *Responding to domestic abuse: a handbook for health professionals*

[http://www.domesticviolencelondon.nhs.uk/uploads/downloads/DH\\_4126619.pdf](http://www.domesticviolencelondon.nhs.uk/uploads/downloads/DH_4126619.pdf)

<sup>42</sup> *Stockport Domestic Abuse Prevention Strategy 2015-16* <http://www.saferstockport.org.uk/wp-content/uploads/2015/11/Stockport-Domestic-Abuse-Prevention-Strategy.pdf>

**Recommendation 11:**

Stockport NHS Foundation Trust should set a clear strategy for the recognition of domestic abuse, with up to date policy guidance and a programme of staff training

**Recommendation 12:**

Stockport Community Safety Partnership : should assess the results of the Domestic Abuse strategy thus far, with emphasis on increasing the access to training to frontline healthcare staff, and ensuring that child to parent violence is included

- 6.70 We have carefully considered the question of whether the AED staff should have asked Sandra in more depth about how her facial injury happened, and specifically whether they should have enquired about domestic abuse. With hindsight a 60 year old woman with a facial injury explained by an unlikely story would seem to be a potential indicator of the need to enquire about abuse. However this needs to be balanced with the presentation of Sandra as settled and calm; it was about five days post assault; she had driven herself and her sister out for the day and drove herself to AED. There was a discussion about what Sandra would tell them, and Sandra decided to tell them she fell onto a doorknob.
- 6.71 Recommendation 6 of NICE guidelines regarding multi agency working <sup>43</sup> is 'Ensure trained staff ask people about domestic violence and abuse (DVA).
- 6.72 It appears that training, information and policy were available for DVA and that the practitioners did not implement their policy on this occasion. Had they, and if Sandra had disclosed abuse from D, they would have been likely to try to access services but they would have struggled to find an appropriate service and one in which Sandra would have felt confident.
- 6.73 We believe it would not be clear to a parent in the situation like Sandra that there would have been support and advice in a case of child to parent violence (CPV) and likely it would be similarly unclear to front line professionals who would be in position to have suggested services. The services which related most closely would be more appropriate with a teenage or adult child who had come to the attention of the Police or the Youth Offending Service. The strategic partnership should consider how to raise awareness and how to further develop the CPV referral pathways and to ensure that it is not focused on a trigger by criminal justice.

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<sup>43</sup> Domestic violence and abuse: multi-agency working NICE guidelines [PH50] 2014  
<https://www.nice.org.uk/guidance/ph50>

- 6.74 We cannot know whether Sandra would have told them that D had assaulted her if staff had asked. We do believe they should have asked for more details about how the door was pushed into her face and by whom, and note the absence of training and focus in AED on domestic abuse which would have supported staff's practice.

**Recommendation 13:**

Stockport NHS Foundation Trust should ensure the lessons learned from this incident with specific regard to domestic abuse and violence are conveyed across the Trust, and particularly in the Emergency Department

- 6.75 Sandra was admitted on 12 October 2014 through AED with back pain. The AED forms note when the last visit was made, and it correctly indicates 23 September 2014. It was assessed that this may be a kidney stone, and Sandra was admitted for an overnight stay. She was diagnosed with renal colic. A 'Nursing Patient Assessment Document' was completed on admission. This document should be completed on admission and contains sixteen page of health related information to be gathered from the patient by nurses: next of kin, care/dependents details, health promotion, infection prevention, belongings checklist, usual abilities, mobility assessment, social history and pre discharge planning information, pressure ulcer monitoring, VTE<sup>44</sup> risk assessment, malnutrition screening, falls risk assessment, hospital transfer checklist and a pre discharge checklist.
- 6.76 The next of kin contact details are Sandra's sister L and Sandra's sister SI, and there is a note that 'husband is in Saudi'. It is noted that Sandra is a carer. There is a guidance note on this part of the form: 'if yes, who for and what provision has been made whilst in hospital? The note reads '29 year old autistic son' but does not note any provision discussed. In the pre discharge planning information it is noted that she has a 29 year old autistic son, and has 'family helps and carers'.
- 6.77 Sandra attended AED again on 14 October 2014 with severe back pain which improved with pain relief. She was discharged home and advised to return if the pain worsened, and was re-referred for a urology outpatient's appointment, as after her attendance the day before.
- 6.78 Sandra's next admission was on 22 December 2014 with shortness of breath, high temperature and cough. She had previously seen her GP and had been prescribed antibiotics and increased steroids. She was admitted overnight to the acute medical assessment ward, diagnosed with infective asthma and treated with steroids and antibiotics, and referred to the respiratory nurse specialist. A plan was formulated by the respiratory nurse specialist which included monitoring peak flow and use of a nebuliser. The entry notes she was 'very eager to get home to her disabled child', this nurse was interviewed

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<sup>44</sup> Venous thromboembolism (VTE) is an international patient safety issue and a clinical priority for the NHS in England. <https://www.england.nhs.uk/patientsafety/venous-thromb/>

as part of the IMR and recalled that Sandra was in the department with her sister, and recalls her saying something like she needed to get home because her son would not cope well without her.

- 6.79 The family have told us that Sandra remained unwell over the Christmas period, and it was agreed that D's sister would cook Christmas dinner at the family home. D had a heavy cold, and the PA K was on leave. Over the next few days Sandra's family encouraged her to return to SHH because she was unwell and very breathless. After initially refusing, Sandra called an ambulance at 16.30 on 28 December, and was admitted to SHH via AED at about 21.30.
- 6.80 In the 'Nursing Patient Assessment Document' it is noted that her husband is her next of kin. In the carers section it is recorded that she has an autistic child, and that her husband is at home. The pre discharge checklist is not completed, and does not in fact include a section referring to the need to consider carer responsibilities. The nurse who completed the forms was interviewed as part of the IMR, and could not recall anything further, or any concerns expressed by Sandra about her home situation. The family question that Sandra would have told them that her husband was at home, and describe her calling him on Skype regularly from her hospital bed. There is clearly a discrepancy here which this report cannot investigate further. However this should be fed back to management at Stepping Hill Hospital to address.
- 6.81 Sandra was discharged at around 16.45 on 30 December 2014. Her sister and brother in law were with her and stated that Sandra was asking to go home partly because she was allergic to dust, although there is no note of this in the clinical record. She was taken home by her family.
- 6.82 The family have raised a particular concern about the noting of Sandra's role as carer, and an expectation that there should be an assessment made and a package of care agreed before discharge.
- 6.83 It has been established that SHH works to the Stockport Multi-agency 'Joint Carers Strategy' for Health<sup>45</sup>. There is no internal carer's assessment process, but there is a carer's information point in the hospital which was set up in 2014. The current documentation asks if provision has been made for dependents and asks if the carer has support and asks if the carer has been referred to 'Signpost'<sup>46</sup> which is a service that acts as a 'one stop shop' and will guide carers to the appropriate service. The IMR recommends that a change to the 'Nursing Patient Assessment Document' be made to prompt nursing staff to consider a referral to adult social care for a carer's assessment when it is identified that a person has caring responsibilities and consents to this. We agree with this recommendation, and have included it in this report, however we have extend this to include an evaluation of work thus

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<sup>45</sup> Carers Support Position Statement NHS Stockport – September 2012. [stockportccg.org/wp-content/.../Carers-Position-Statement-Sept-2012.doc](http://stockportccg.org/wp-content/.../Carers-Position-Statement-Sept-2012.doc)

<sup>46</sup> Signpost Stockport for Carers is an independent charity, established in 1986, which provides free, confidential information to unpaid carers of all ages and ethnicity, and professionals who work with carers, in the Stockport area. <http://www.signpostforcarers.org.uk/>

far and an update of the current multi agency strategy for carers. We could not locate an updated recent carer's strategy document (the cited one is from September 2012) on either Stockport CCG or Stockport Council websites.

- 6.84 We acknowledge that these recommendations are addressing potential gaps in services for carers that we have noted as part of the review. We do not consider that these issues had a direct influence on the service provided to Sandra on 30 December 2014. Sandra is noted to have told SHH staff that she had a disabled child but that her husband was at home, although the family still question this. She was noted to be collected by family members to go home. We consider it was reasonable for SHH staff to have gained the impression that her son was cared for while she was in hospital and afterwards.
- 6.85 The information about Sandra's visit to SHH AED on 23 September 2014 was not initially available. It appears the recording systems are separate, that is if a patient visits AED, the record is kept separately unless they are admitted. If not admitted, the AED visit does not become part of the clinical record. This presents risks in not having a complete clinical record available to clinicians.

**Recommendation 14:**

Stockport NHS Foundation Trust should revise its admission and discharge documentation to include a prompt regarding carers needs and signposting to a plan of care and an assessment before discharge

**Recommendation 15:**

Stockport Metropolitan Borough Council should assess the efficacy of the current multi-agency approach to carers needs, along with partner organisations, and implement a strategy to ensure the aims of the position statement are carried out

**Recommendation 16:**

Stockport NHS Foundation Trust should revise the recording systems to ensure a complete and contemporaneous record is maintained of all clinical encounters

**6.86 GP service**

- 6.87 Sandra was a regular attender at her GP surgery, as she had a number of medical issues, previously detailed. Hospital records of attendance were regularly sent to the GP, and the AED note of 23 September was received by the surgery. Her last consultation was on 22 December 2014 for breathlessness.

- 6.88 The IMR conducted for the GP surgery notes effective liaison between mental health services and the GP about D's care, and between SHH and the GP surgery about Sandra's care. Sandra did not request any additional support in her role as carer. There has been no training in adult safeguarding or domestic abuse in the local practice.
- 6.89 While there was no concerns about risk raised, it was evident to the GP that S was the sole carer for D. Sandra had a number of physical problems, and while it was not raised by Sandra, there is no evidence that her ability to carry out her role as carer was assessed.
- 6.90 A lack of assessment of D's care needs when the transition from being a child to becoming a vulnerable adult was also noted. The IMR makes two recommendations, which we agree with and have incorporated here:

**Recommendation 17:**

Stockport CCG : formal processes must be in place so that multiagency risk assessments are carried out for all vulnerable children and their carers on transition from children to adult services

**Recommendation 18:**

Stockport CCG: GP practice staff must undertake adult safeguarding and domestic abuse training

## 7 Key lines of enquiry related to the terms of reference

- 7.1 The wider key lines of enquiry were incorporated into the terms of reference following consultation with the family. We have addressed these in turn, giving evidence for our conclusions under the headings of training in domestic abuse, knowledge of domestic abuse, resources and communication.

### Training in domestic abuse

- 7.2 **Key questions:** How are professionals training needs in domestic abuse identified? What training in domestic abuse was available to professionals at the time of the homicide? What was the take up of domestic abuse training at the time of the incident? What training in domestic abuse is currently available to professionals? What is the current take up of training by professionals in domestic abuse and how is this being measured? Identify any gaps in training for professionals in domestic abuse? Review the processes currently in place to identify the training requirements for professionals in domestic abuse.
- 7.3 Training in domestic abuse is not routinely provided as a separate entity in either Trust. There has been some specialist training in domestic abuse across both Trusts; Stockport NHS Foundation Trust has had access to some

stand-alone training for 120 community staff, and Pennine Care has had access to some MARAC<sup>47</sup> training across the Trust.

- 7.4 Both Trusts include reference to domestic abuse in their mandatory safeguarding training, and uptake of this is monitored centrally through the Trust's training departments.
- 7.5 Stockport NHS Foundation Trust mandatory training figures are monitored at Board level, and the figures for November 2015<sup>48</sup> are at 87% compliance, across the Trust and it has noted that none of the business units achieved the target of 95% compliance. The meeting reports describe measures to improve this across the Trust.
- 7.6 In Stockport NHS Foundation Trust domestic abuse is included in the children's safeguarding training Level 2, which is mandatory at 85%. Adult safeguarding training is also mandatory. Key performance indicators for adult and children's safeguarding is set at 85%. These are monitored monthly and currently stand at 88% for both in December 2015.
- 7.7 In PCFT domestic abuse is included in the safeguarding training. Current compliance against the expected target for safeguarding training is shown: SG Adults L1 = 95% - Stockport currently at 86.23%, SG Children L1 = 95% - Stockport currently at 89.76%, SG Children L2 = 75% - Stockport currently at 63.23%, SG Children L3 = 83.5% - Stockport currently at 100%. Levels of safeguarding training for PCFT as a whole is at SG Adults L1 = 95% - 90.83%, SG Children L1 = 95% - 93.92%, SG Children L2 = 75% - 72.86%, SG Children L3 = 95% - 83.09%.
- 7.8 Local Trust training needs analysis identifies training needs, and priority is given to identifying that which is mandatory or to meet regulations.
- 7.9 There is no training provision for a personal assistant funded through Direct Payments, as the carer or service user is the employer.

#### **Recommendation 19:**

Pennine Care NHS Foundation Trust and Stockport NHS Foundation Trust : Domestic abuse training material should be reviewed to ensure that it includes domestic abuse in both children and adults safeguarding; including that any individual in a domestic arrangement may abuse anyone else in that setting

## **Knowledge of domestic abuse**

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<sup>47</sup> A Multi Agency Risk Assessment Conference (MARAC) is a local, multi-agency victim-focussed meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies. <http://www.standingtogether.org.uk/standingtogetherlocal/standingtogethermarac/>

<sup>48</sup> <https://www.stockport.nhs.uk/webdocs/BoardMeetings/BoD%20-%20Public%20Meeting%20-%2026%20Nov%202015%20-%20agenda%20pack%20inc%20cover.pdf>

- 7.10 **Key questions:** Did organisations have knowledge of domestic abuse in this family? If so, how was this knowledge acted upon? What knowledge did the victim's family and friends have about domestic abuse within the family composition and what did they do with it? Were there any barriers to family and friends raising concerns about domestic abuse? How did agencies, family members and friends deal with any confidentiality issues the victim might have requested of them? Were there any specific diversity issues relating to the subject/family? Were issues with respect to safeguarding (adults) adequately assessed and acted upon?
- 7.11 None of the organisations involved had knowledge of domestic abuse within the family. The PA K became aware that D had assaulted Sandra through his regular contact with the family, and was told that Sandra had disclosed it to D's care team. While this does not appear to be true in hindsight, it is accepted that K did not have any reason for doubting what his employer Sandra had told him and therefore no reason for further checking her account to him.
- 7.12 The significant missed opportunity to ask the question about domestic abuse by Stepping Hill AED staff has been discussed at 6.70 to 6.74 above.
- 7.13 From our meetings with family it is clear that there was awareness of the assault on Sandra by D in September, and that D had previously pushed her against a wall. The high expressed emotion between Sandra and D was well known, as was the degree to which D was hostile and challenging to Sandra about medication in particular. The family describe being challenging to Sandra about her responses to D's assault, saying 'he's crossed a line'. They told us that D was very emotional in his apologies to Sandra, and within this both Sandra and D were afraid the he would be taken to hospital because of this, if services knew about the assault.
- 7.14 The family described respecting Sandra's wishes not to disclose these incidents. We are satisfied that if this assault had been disclosed to PCFT, there would have been a very different risk assessment and response in September 2014.
- 7.15 From the information we have gathered we can only conjecture that part of Sandra's motivation was her fear of D being hospitalised. To some extent this may have been influenced by her understanding of what mental health services response may be to a disclosure, and certainly her desire to protect her son.
- 7.16 However no-one in the family could have predicted that D's hostility would escalate to the degree of homicide.
- 7.17 No specific diversity issues were identified. Within the GP service IMR it is noted that a safeguarding assessment should have been carried out when D became an adult.

## Recommendation 20:

Stockport NHS Foundation Trust : Implementation of NICE guidance 'Domestic violence and abuse: multi-agency working' (PH50) recommendation 5: 'Create an environment for disclosing domestic violence and abuse' with particular emphasis on consistent implementation of policy, and recording of information

## Resources and communication

- 7.18 **Key questions:** Were there issues in relation to capacity or resources in your agency that impacted the ability to provide services to the victim and to work effectively with other agencies? Was information sharing within and between agencies appropriate, timely and effective? Were there effective and appropriate arrangements in place for risk assessment and escalation of concerns?
- 7.19 We have not found new resource issues that directly impacted on the provision of services other than those already mentioned, regarding an absence of local resources for Autism support for adults without learning disability support and the changing configurations of community services in PCFT. The family were told and it is recorded in PCFT records that the move to RIT was specifically due to resource reduction issues. We have found that there was no clinical justification for the move and it was against policy.
- 7.20 We have highlighted where there are specific areas where information sharing could be improved upon earlier; such as the sharing of physical health information between the GP and mental health services.
- 7.21 We suggest that a more assertive enquiry by a range of professionals into events could have led to more information relevant to domestic abuse.
- 7.22 With regard to risk assessment and structures for escalation, we have discussed these earlier at 6.60.
- 7.23 We have to conclude that the level of domestic abuse was only known to the direct family. We believe they acted at all times in what they perceived as the best interests of D and Sandra including respecting the wishes of Sandra not to tell others about the abuse but in hindsight this was clearly a missed opportunity in the lead up to the death of Sandra.

## 8 Internal Pennine Care investigation and action plan

- 8.1 The terms of reference for this element of the investigation require that we review:
- the (Pennine Care) Trust's internal investigation and assess the

adequacy of its findings, recommendations and action plan.

- if the internal investigation satisfied its own Terms of Reference.
- if all key issues and lessons have been identified and shared.
- the progress that the Trust has made in implementing the action plan.
- processes in place to embed any lessons learnt.

***Review the (Pennine Care) Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.***

- 8.2 The Trust conducted what was described as a '*provider focussed internal investigation in accordance with NHS England standard operating model requirements*', which is the terminology used in the NHS England SI Framework March 2015<sup>49</sup> This phrase does not appear in the PCFT Incident Reporting, Management & Investigation Policy dated September 2014, and it would be expected that a Level 2 Root Cause Analysis<sup>50</sup> (RCA) investigation would be carried out. The investigation does appear to have been at this level, but not described as such. This terminology has since been replaced by that in the NHS serious incident framework in March 2015<sup>51</sup>, which was published subsequent to this incident
- 8.3 The investigation was carried out by a team of nine; six internal senior staff, and three external professionals, with the Trust Investigation Coordinator as lead author. PCFT's Incident Reporting, Management & Investigation Policy dated September 2014 'RCA investigation protocol' states that the decision to commission a Trust internal investigation will be made by the Trust Patient Safety Improvement Group (PSIG). The decision making regarding the extensive team was described to us, with the rationale being that PCFT wanted to carry out an in-depth internal investigation of good quality, recognising the catastrophic effects on the family. It was decided that there would be executive medical and nursing representation both internally and externally. The intention of the external element was to provide a degree of objective 'check and challenge' to the process.
- 8.4 The terms of reference for the internal investigation were as follows:

**1. To examine:**

1.1. *The care and treatment provided to D at the time of the incident (Including that from non NHS providers e.g. social care, voluntary/private sector, if appropriate);*

1.2. *The suitability of that care and treatment in view of D's history and assessed health and social care needs;*

1.3. *The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;*

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<sup>49</sup> NHS Serious Incident Framework. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

<sup>50</sup> Root Cause Analysis investigations in the nhs identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for patients.

<http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/>

<sup>51</sup> Serious Incident Framework - Supporting learning to prevent recurrence. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

- 1.4. *The adequacy of risk assessments to support care planning.*
- 1.5. *The use of the care programme approach and the interventions of the Review & Recovery Team;*
- 1.6. *The exercise of professional judgement and clinical decision making;*
- 1.7. *The interface, communication, information sharing and joint working between all those involved in providing care to meet the service user's mental, social and physical health care needs.*
- 1.8. *The extent of the services engagement with carers; use of carer's assessments and the impact of this upon the incident in question;*
- 1.9. *The consideration of safeguarding requirements given the information known at the time.*
- 1.10. *The appropriateness and quality of the Trust's initial response to the incident;*
- 1.11. *The level of support to staff after the incident.*

**2. To identify:**

- 2.1. *Learning points for improving systems and services;*
- 2.2. *Development in services since the user's engagement with mental health services and any action taken by services since the incident occurred; positive features of the service.*

**3. To make realistic recommendations for action to address the learning points to improve systems and services.**

**4. To report findings and recommendations to the Trust Board, local Commissioners, and NHS England.**

- 8.5 The report is constructed as an RCA, with contributory factors listed. These are listed in a descriptive narrative format, rather than in a root cause analysis format, with the detailed findings under each heading. The headings of the NPSA contributory factors framework were not used. It is stated under 'investigation type, process and methods used' that this was a Single investigation using a Root Cause Analysis approach. The standard NPSA investigation template has been used which presents the finding under the standard RCA headings. We have listed PCFT findings in italics, and added our views in bold where relevant.

**PCFT findings**

***Diagnoses:***

***Schizophrenia***

*D was diagnosed with schizophrenia in 2003 when he was 16 years old. He was subsequently maintained on antipsychotic medication. Episodes of increased psychosis were in the context of the Bible and made reference to angels, demons and Satan. These were managed by increased olanzapine medication. The diagnosis and aggressive treatment of schizophrenia did not seem to be at the forefront of the management strategy. **We concur with this finding.***

***Atypical Asperger's diagnosis***

*A number of mental health reviews list the psychological impairments attributed to D as a result of the atypical Asperger's. It is stated that D was unwilling to accept either diagnosis, either at the time of diagnosis, or throughout his contact with mental health services.*

### **Forensic and clinical history**

*In considering information produced by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report (July 2014), it is apparent that D did not have a previous history that would indicate the risk of an offence of this nature. The majority of mental health patients who are convicted of homicide have a history of violence with: 78% of patients convicted of homicide having been previously convicted of an offence 53% having been previously convicted of committing a violent offence, 47% having been in prison before the offence. **We consider that the inclusion of this information limits the view, and suggests that the only consideration of future risk was previous offending. This is not in line with modern concepts of risk assessment which are person centred rather than based on population statistics. In this case he had barely controlled active symptoms, no insight, persistent delusional beliefs including that Sandra was satan. Advice was given to her to call the police if she got more concerned. All of these are indicative of increased risk which needs managing and all of which can indicate a risk of an offence of this type.***

### **Lack of diagnostic clarity**

*The dual diagnosis of psychotic illness and atypical Asperger's was not fully understood. It was unclear as to which attributes / presentations were of psychosis and which were of atypical Asperger's. There was an acceptance of the opinion from the tertiary care centre of the atypical Asperger's diagnosis. There was no evidence of questioning of that diagnosis post the atypical Asperger's diagnosis. It would appear that professionals seemed reluctant to question colleagues from the same team or different teams, or even in this case outside of the organisation. The review team felt that the diagnosis did cause confusion in the mental health team's management of D's case. **We cannot concur with this finding. It was apparent that the team were well aware that they were treating D as someone with a long term psychotic illness. It was documented that D's atypical Asperger's diagnosis contributed to many of his presentations. The diagnosis is interesting as D's family did not notice any specific communication or autism traits until D was aged 7 – 12 years old. This would be expected to be noted much earlier. In our view, although PCFT did have external clinicians on the panel, this demonstrates that the review team did not have access to expert knowledge in ASD. It is stated in the case notes that 'D blaming (his mother) is an Asperger's trait'. However this diagnosis may have overshadowed D's psychotic presentation and symptoms.***

*Within the Trust there is no routine Asperger's / high functioning autism training for mental health staff. Recently learning disability awareness sessions have been available to staff which have used a case study of*

someone with high functioning autism. However this is not a mandatory course. D's atypical Asperger's diagnosis was not confirmed until the age of 20. To make a diagnosis of a development disorder such as Asperger's a sufficiently detailed history of infancy, childhood, milestones and adolescence is required. The later a diagnosis is made the less certain one can be about the information a diagnosis is based on. **We consider this to be a truism but irrelevant. He was only 20 so just out of adolescence but even if he had been 50 or older this is irrelevant. He had a confirmed diagnosis and no grounds to disagree with it were given and family and clinical teams were fully aware and accepted it – again more a reflection on lack of expertise in review team than the diagnosis or PCFT clinical service.**

It is not apparent if any post diagnostic support was available to D to explore what this diagnosis meant to him, how the diagnosis contribute to his quality of life, and what he understood in terms of managing his symptoms. If D was only being treated for a psychotic illness then more proactive medical treatment may have been pursued. However D's dose of antipsychotic was repeatedly reduced, then increased if there was deterioration. There was confusion when considering the presentation as being due to atypical Asperger's which limited the options in terms of medical intervention. **This does not fit with accounts to us. His last care coordinator did note her uncertainty about some of his symptoms but this had not previously been an issue and no one suggested that it was a reason for not altering his treatment for schizophrenia.** This contributed to the perception of a therapeutic plateau having been reached. This in itself feeds into the perception that D was 'stable' within the recovery pathway. **There is clear detail in the notes about lack of specific autism informed post diagnostic support available after diagnosis. We make the point earlier about a lack of resource locally to support staffs knowledge in Asperger's.**

### **Assessment and management of risk**

The review team have questioned the robustness and adequacy of the ongoing risk assessment in regards to risk to other people and vulnerability. **We consider that the risk assessment was definitely lacking in robustness and adequacy.**

### **Absence of information**

The mental health team considered D to generally be 'stable' in his mental health. He was maintained in the community living at home with his mother with support via a personalised budget, and it was felt that his needs were essentially met. There are occasions when his symptoms worried his mother but he remained at home, and he had a social life supported by his P.A. However it is acknowledged that in hindsight there was information that services did not know. Although there was no documented evidence of D harming anyone in the past, there is reference to D being at times antagonistic towards his mother and frequently referring to her as 'Satan' or 'a witch'. We are now aware from the DHR investigation that evidence available

following Sandra's death suggests that Sandra attended A&E in September 2014 as a result of a facial injury caused by D. This was not reported to the mental health team. Mental health services were not aware of Sandra's admission to hospital immediately prior to the incident. However this could be seen as a key event as there is a potential that D may have not taken his medication during this time. In addition mental health services were not contacted during the evening of 30<sup>th</sup> December 2014 when information now available to the review team suggests that D was agitated, uncooperative, and accusing his mother of trying to poison him. **We agree with this finding.**

### **Consideration of information available**

When D first presented to adult mental health services he had quite a significant CAMHS history. However there did not seem to be an opportunity to review all of the information to inform future management of the case. It is felt that some of the historical information the review team have now had the opportunity to review may not have been comprehensively reviewed by the mental health team. This may have informed the mental health team in regards to the risks and dynamic between D and his mother. **We agree with this finding.** The point of handover between teams was an opportunity to review D's case in depth and determine the treatment pathway. This was not done in a systemised way. It is acknowledged that this may not have changed the outcome. At times D voiced his belief that his mother was 'a witch', or 'Satan', however he always denied that he would act on this belief. D and his mother had a complex relationship. There was evidence that the relationship between D and his mother was at times strained. Attempts were made to provide additional support via direct payments which funded the PA, and attempts were more recently made to provide Sandra with support via a carer's assessment, and sourcing support from other organisations but this did not significantly impact on the domestic situation.

There was evidence that Sandra had multiple physical health problems but there is no details in regards to the health provision she required or any specific detail about how her health affected her on a day to day basis. Sandra spoke to mental health staff on 15<sup>th</sup> October 2014 and discussed a recent hospital admission, but this does not suggest that this prompted any specific discussion about her current health status, whether the admission was planned or an emergency, or if further follow up treatment or monitoring was required.

Given the vulnerability of D if not supervised it would have been good practice to consider the need to agree contingency arrangements should Sandra require a further admission. **We agree with this finding**

It is acknowledged that the CMHT believed that Sandra would contact services should she require support. However there were occasions when Sandra acknowledged to mental health services that she would potentially not seek support in a crisis due to concerns D would be admitted to hospital.

*There was no formulation or analysis in regards to a risk assessment of D's religious reading, religious beliefs, or delusional beliefs. There were times whereby the religious content is associated with higher levels of risk and /or adverse behaviour, whilst the case notes would suggest there was some degree of D's presentation moving towards passivity (not being 100% responsible for his actions). Continued hostility towards his mother would prompt questioning around how to manage this more assertively, and these should have been asked. **We agree with this finding.***

### **Assessment of risk in the period prior to the incident**

*From July 2014 onwards where there is evidence that D's mother was significantly stressed, and that she was the object of D's aggression. She was a part of the dynamic affecting the delivery of optimal treatment as she was concerned about D being given the maximum dose of antipsychotic and expressed her wish for D not to be admitted to hospital. Religious preoccupations, poor insight, and poor nutrition were noted. In recognition of the risks the treating team did arrange for an increase in antipsychotic dose, plan for increased frequency of home visits and home treatment resolution team involvement, document the execution of a risk management plan, and sought to expedite psychiatry review. It is not clear that the use of the Mental Health Act was considered. While all of the management plans are understandable, they may have lacked the decisiveness required to manage D's deterioration effectively. In September 2014 the CMHT clinician recognised the apparent risks. The advice given to D's mother that she may need to call the police is acknowledgement of this. Discussion with the family as part of the investigation process has indicated that Sandra would not have disclosed any information to Health Services likely to have resulted in D being admitted to hospital as it was her priority was to protect him, and she was even less likely to have contacted the Police as advised by mental health services. During this month it was apparent that the home situation had broken down by virtue of Sandra requesting alternative accommodation and respite care for D. Though there is no evidence of discussion of D at the RIT zoning meeting and no documentation of consideration for the use of the Mental Health Act, or discussions in regards to safeguarding concerns.*

*There was some improvement to the presentation as the evidence would suggest that at outpatient clinic with the psychiatrist in October 2014, the situation had stabilised. The next medical review was planned for six months. While this may be understandable, as D was not presenting as acutely unwell at the time, the decision may be inconsistent with the changeable clinical situation of the previous weeks. The review team have therefore questioned whether this timeframe was inconsistent given the preceding clinical situation, and if the fluctuations in D's presentation up to this point were minor enough not to warrant further review.*

*Mental health difficulties should be expected to be fluid and at times rapidly changing, as will the risk assessments. As such clinicians should be alive to this, have ready access to senior review, and be able to declare confidently when they feel it is beyond their ability to manage. **We agree with this finding.***

## **Contingency planning**

*D was sensitive to changes in routine and structure and attention needed to be paid to this. Christmas was an identified time for this as the holiday period resulted in the football group and his regular support from the PA ceasing from 18<sup>th</sup> December 2014. This was not documented in the contingency plan. The team review identifies that D appears to relapse quickly when he stopped taking his medication. This was not documented in the contingency plan. Sandra disclosed details of her physical health issues with mental health services, and services were aware of at least one hospital admission. However contingency plans were not developed to address any potential situation which could have affected Sandra's ability to continue to care for D.*

**We agree with this finding.**

*It is now apparent that unknown to mental health services, Sandra was admitted to hospital as an emergency during the period prior to the incident. The family have confirmed that D remained at home alone, in the absence of his mother and the PA who was on annual leave over the Christmas and new year period, Contingency plans appear to be based on Sandra's interpretation of D's symptoms and presentation e.g. 'tweaking' medication doses over the telephone.*

## **Absence of discussion at zoning**

*The Recovery and Inclusion Team utilise a risk management strategy called Zoning. Service users are assessed as being in one of 4 risk zones*

*There is no record of D's presentation and risk being discussed at the team zoning meeting after 4<sup>th</sup> September 2014. This suggests that there were no concerns in regards to risk as it would be usual practice within the RIT to only discuss service users when there is a change (usually those in Red or Amber). Therefore the majority of the caseload who remain in the green zone are not routinely discussed.*

*It is difficult to reconcile a green status from September 2014 onwards with what was documented, as the CMHT clinician recognised the apparent risks with advice given to D's mother that she may need to call the police. During this month it was apparent that the home situation had broken down by virtue of D's mother requesting alternative accommodation and respite care. This is further evidence of there being significant risks associated with the presence of a mental illness. This raises the issue of risk in a situation which is dynamic and changing. **We agree with this finding, but are more definitive in our view that D should have been discussed at the zoning meetings and should have been rezoned.***

## **Medication**

### **Review of medication**

*D's dose of antipsychotic was repeatedly reduced, then increased if there was deterioration. However this was largely led by Sandra's interpretation of D's symptoms and presentation with requests for medication changes being progressed over the telephone in the absence of a formal medication review. It is however noted that medication always remained within a therapeutic range, the dosage was reviewed in response to D's presenting symptoms, and there was evidence of efficacy. **We agree with this finding, but would add that there was insufficient exploration of the reasons behind Sandra's requests and a lack of documentation of discussion of other treatment options.***

### **Dual diagnosis**

*If D was only being treated for a psychotic illness then more proactive medical treatment may have been pursued. There was confusion when considering the presentation as being due to atypical Asperger's which limited the options in terms of medical intervention. **We disagree with this statement, it would have required an autism aware and possibly autism informed approach to medical treatment (used in the MHA sense ie pharmacological and non-pharmacological interventions of any type). While all co-morbidities increase the complexity of interventions it does not preclude any form of therapy so no limits on options.** This contributed to the perception of a therapeutic plateau having been reached. This in itself feeds into the perception that D was 'stable' within the recovery pathway.*

### **Potential of non-concordance with medication**

*D refused to accept the diagnosis of atypical Asperger's Syndrome and Schizophrenia, and as he did not consider himself to be unwell he sometimes did not consider that he needed to take medication. The team review identifies that D appears to relapse quickly when he stopped taking his medication. The relapse window for D was noted as being 2 - 3 weeks, however it appears that on at least one occasion this occurred 3 days following D stopping his medication. This was not documented in the contingency plans within the well-being care plan. **We agree with this finding, but would add that at no time did D consider that he needed to take medication, therefore concordance was not possible.***

*It is unclear if D was taking regular medication prior to the incident. It is now known that D's PA was on holiday from 18<sup>th</sup> December 2014 and that Sandra had an inpatient admission during the days preceding the incident. Mental health services were not aware of the absence of input from the PA over the holiday period, or the admission. It is unclear what plans were put in place to support D whilst his mother was in hospital. **We know now that D was not taking medication regularly at this time and that mental health services were not made aware or involved in any plans for this period.***

### **Consideration of depot injection**

*The panel questioned why depot injections were not actively considered. It appears that decision making in relation to not doing this was based on*

documentation that D was 'needle phobic'. However there is no evidence from case notes that this was discussed and challenged and a desensitisation process explored. **We agree with this finding, and would extend this to a lack of attention to the blood tests at health checks.** The review panel have been made aware that D is now having a regular depot injection whilst detained at his current hospital.

## **CPA review**

### **Effectiveness of outpatient appointment review**

Although occurring on a regular basis the effectiveness of the outpatient appointments is unclear, as is the accuracy of the representation of D's mental health. Letters appear to have been very repetitive in content and contain limited information in regards to D's presentation and if treatment is effective or changes are required in the treatment plan. The approach taken appears to be one of maintenance / continuation rather than challenge. **We agree with this finding.**

### **Information available at the CPA review in October 2014**

The review team were unable to conclude if the Consultant Psychiatrist had all the information on D's presentation during the previous four weeks that may have better alerted him to the dynamic nature of the presentation.

### **Information gathering**

It is evident that the PA did not attend CPA reviews or contribute to information gathering prior to meeting, however there were occasions when he provided transport to D and his mother and sat outside. The review team felt that the PA could have been a further source of information in regards to D. **We agree with this finding.**

### **Record keeping**

The review team found a lack of 'richness' in the detail in the clinical record detailing D's support. This appears to not be person centred; for example there is mention of a regular 'blip' but no detail to evidence further exploration of this. In addition the RIT notes appear to have limited detail and are very similar in the content of entries. **We agree with this finding.**

### **Liaison with family and carer**

#### **The role of D's mother in supporting D's care**

The initial report completed by the team manager confirms that during July and August 2014 a carer assessment was completed for Sandra by the Rethink Carer Support Service Lead. A copy of the assessment was provided to the care coordinator. The documentation shows that Sandra voiced concerns regarding her caring role and the difficulties she had in understanding D's religious beliefs and obsession with religions. Sandra also reported how important her own faith was to her and that she was a practicing

Christian. Although Sandra reported being happy to continue in the caring role, she also commented that there was a plan for D's father to retire from work in 2015, and to take over the caring responsibilities. Sandra reported being happy with the service D was receiving from mental health services.

Following the incident it was confirmed by the Rethink Carer Support Service Lead that Sandra had not made contact with the carer service since August 2014 other than to return a satisfaction survey. All interviewees expressed recognition of the importance of the role of D's mother. They readily acknowledged her role as carer and her focus on what she believed was best for D. They acknowledged that some of her preferences were not entirely in keeping with what the treating team would advise but they did not see this negatively. There was a sense of the team feeling it was their role to positively engage and affirm her wishes in order to provide care for D. It was felt that D would be vulnerable without his mother. **We agree with this finding.** Of note was the approach to Sandra between the care coordinator in CMHT and care coordinator in the RIT team. Whilst the CMHT care coordinator recognised she needed to go through Sandra to focus her treatment approach to D, the contact with the RIT seems to show a focus appeared on addressing Sandra's needs. **We agree with this finding.** The review team thought that the interaction between professionals and Sandra was not as in-depth and thought through as it maybe could have been. It appears to the review team that Sandra controlled many aspects of D's care and interaction with services. **We agree with this finding.** Although it is apparent that CC4 was attempting to support D's future care planning, there is no evidence to suggest that an attempt was made to discuss S's ongoing physical health issues and how this impacted on her caring role. **We agree with this finding.**

#### **Engagement of care coordinator with personal assistant (PA)**

The interview with D's privately employed PA (by Sandra via direct payments funding) highlighted that he was not aware that D had any significant mental health difficulties; he thought his reason for involvement was due to D's Asperger's diagnosis. It was apparent that the PA had a very positive relationship with D and was probably the person who knew him the best; however despite the input from the PA featuring within the care plan he was not involved in any CPA / outpatients review and did not feature in any discussions around treatment plans and support. The lack of involvement was at the request of D's mother. It did not appear that this was challenged by the professionals involved. We were enlightened that the PA had some knowledge that may have changed the view of the risks involved particularly as he was aware that D had assaulted his mother. However the PA was working in isolation, he did not appear to see the wider ramifications in terms of safety and a duty to act in relation to Sandra, and he did not have an opportunity to share this knowledge with the mental health team. It is also apparent that the PA was unaware of D's diagnosis and that he did not have any clear information about D's medication requirements. **We agree with this finding to some extent, but we cannot concur with the suggestion that the PA had a duty to act in relation to Sandra.**

#### **Direct payment**

*D's direct payment was mainly spent on leisure and community activities. This is obviously important but this plan appears to lack any discussion or challenge around possible meaningful daytime occupation/finding employment and working towards independence and D possibly having his own home. **We agree with this to some extent, but refer back to the recognition that the PA was working in isolation from mental health services, so the funds were used for activities that Sandra requested, rather than as part of a comprehensive care plan.***

*An element of the direct payment was identified for funding of respite care (24 respite nights per year (£2174.40), due to Sandra regularly having disturbed nights and her own ongoing health needs). However this option does not appear to have been utilised by the family. **This is inaccurate, the funds were used to take D away overnight, rather than Sandra.***

#### ***Wider issue of governance/training of the Personal Assistant (PA).***

*The PA was working in isolation. The review panel accepted that the issues of governance and training for PA's is one that was outside of the scope and control of Pennine Care NHS Foundation Trust services, and one that is a national issue. It is the employer's (in this case D's mother as the broker) responsibility to ensure that all aspects of risk associated with caring for the service user are known to the PA, and that the PA is able to manage these. The review team consider that when a PA is involved with secondary mental health service users every effort must be made to involve them in governance arrangements by supporting the carer and involving the PA. **We agree with this finding, however suggest this would need to be handled sensitively with families.***

#### ***The use of the term 'stable' in a clinical setting.***

*The review team have noted the use of the term 'stable' within D's clinical record but felt that this was an ambiguous clinical term given that it was used in a situation when presentation was not indeed 'stable'. It is felt that the term was therefore not sufficient to describe a complex situation, and reflects that services did not sufficiently recognise the longer term turbulence. **We agree with this finding.***

#### ***Appropriateness of treatment team***

#### ***Placement in the Review and Inclusion Team***

*The review team has considered the remit of the Review and Inclusion Team noting that the Trust has developed this type of team to help people to move on with their lives and overcome the stigma and consequences of having mental health problems. Referrals to the Recovery and Inclusion Team would be received from within secondary care mental health teams, whilst people with the following characteristics would be considered for transfer **(listed in the report but excluded here for brevity)***

*Although the review team acknowledged that plan of care for D did not dramatically change on his transfer from the CMHT to RIT, and the mental health team members felt that D was appropriately placed in the RIT, the review team questioned D's placement in less intensive care team with the focus on the promotion of social inclusion and recovery, rather than the possibility of serious risk given his profile and history, and whether this team was resource to respond to a serious risk if it occurred. **We broadly agree with this finding, but are more definitive in our view that D did not meet the criteria for transfer to this team based on the PCFT policy***

*It is recognised that there is a temporal association between D's transfer to the RIT and evidence of deterioration of the situation. However, it cannot be said with any certainty that the transfer resulted in the deterioration, or that non-transfer would have averted the tragic death of Sandra.*

*It is acknowledged that the family have challenged the perception that there was an acceptance by Sandra of the transfer to the RIT, noting that S had resisted the change but felt that ultimately she had no option other than to accept the decision.*

### **Clinical leadership**

*The review team acknowledged the difficulty for Borough wide services such as RIT in dealing with different consultants as the team is geographically isolated from the main CMHT and the main hospital site, and does not have a designated consultant psychiatrist. However the team members expressed that they felt there was effective liaison between consultants and both the RIT and CMHT. They described regular contact between the CMHT and designated consultants, and less regular contact between RIT and a nominated consultant (link psychiatrist) that would not necessarily have any clinical knowledge of the patients being discussed. In this instance there is no evidence of meaningful input from the link psychiatrist, nor evidence that any concerns were shared. The team acknowledged that a consultant within the RIT would support better clinical care. **We broadly agree with this finding, but the point is somewhat undermined by the fact that D had continuity of consultant care, and there were no issues identified with access.***

### **Response to safeguarding concerns**

*The review team found little evidence of consideration of the vulnerability of Sandra in relation to domestic abuse including verbal, emotional as well as physical abuse. A number of contacts with Sandra provided information, which in the review panel's opinion were missed opportunities for further discussion with Sandra and enquiry by mental health services. Whilst Sandra was requested to self-report D to the Police if necessary rather than practitioners exploring the safeguard processes in place. **We agree with this finding.***

*The difficulties suggested by Sandra in September 2014 prompting her to request D was rehoused and leading to Sandra being advised to contact the Police as a contingency, did not prompt any increase in monitoring, an MDT*

*review, a discussion with local safeguarding leads, or any increased rigor in review or planning which could have led to a more accurate risk assessment. **We agree with this finding.** Importantly mental health services were not alerted to any safeguarding concerns following Sandra's attendance at Accident & Emergency in September 2014 with a facial injury. **We agree with this finding.***

*Sandra was not identified as a carer during her admission to Stepping Hill Hospital in the immediate period before the incident. **This is inaccurate.***

- 8.6 With regard to root cause the report states: '*The review team does not believe that the incident was predictable, and have been unable to identify a single cause or any direct causes of the incident. No root cause was identified from the Trust perspective*'.
- 8.7 We do not agree with this assertion, and the report is weakened by a lack of evidence of rigorous analysis and no use of formal contributory factors tools such as Fishbone analysis.

### **Lessons learnt and action planning**

- 8.8 The internal report identified eight lessons learned, and made eight recommendations:

#### **Lessons learned:**

- 1. The dual diagnosis of psychotic illness and atypical Asperger's was not fully understood. It was unclear as to which attributes / presentations were of psychosis and which were of atypical Asperger's.*
- 2. The ongoing assessment of risk and vulnerability was insufficient and there was a lack of recognition of safeguarding concerns.*
- 3. Information which may have helped in the assessment of risk and in the formulation of risk management and contingency plans was not shared with mental health services.*
- 4. There was no challenge to the approach of maintenance / continuation taken to management D's care.*
- 5. The interaction between professionals and Sandra was not as in-depth and thought through as it maybe could have been.*
- 6. The PA was working in isolation and did not have an opportunity to share his knowledge of the interactions between D and D's mother with the mental health team*
- 7. Given his profile and history, the review team questioned D's placement in the RIT, a less intensive care team which focusses on the promotion of social inclusion and recovery, rather than on the possibility of risk, and whether this team was adequately resource to respond to a serious risk if it occurred.*
- 8. S was not identified as a carer during her admission to Stepping Hill Hospital in the immediate period before the incident.*

#### **Recommendations:**

1. *There should be a review of care pathways to ensure that there is a clearer understanding of the boundaries between CMHT and RIT, and how patients progress through the pathway with more or less intensive support (Lessons Learned 7).*
  2. *Training ensures that the voice of the patient is at the focus of care planning whilst also recognising contribution of family, relatives and carers (Lessons Learned 3, 5 & 6).*
  3. *Training options are considered to develop the knowledge base of autistic spectrum disorder within the Trust (Lessons Learned 1).*
  4. *There is a proactive approach to identifying cases that require detailed longitudinal review rather than a reactive activity. A clinical team could ideally have access to a third party clinical resource to enable the review to happen without impacting on routine care. Although the next 'incident' might not be selected and prevented, the Trust can be reassured of the standard of practice being promoted throughout the organisation and a general reduction of unidentified risk, in keeping with incident prevention theory (Lessons Learned 4).*
  5. *The potential of a dedicated consultant psychiatrist within the RIT is considered (Lessons Learned 7).*
  6. *When a PA is involved with secondary mental health service users every effort must be made to involve them in governance arrangements by supporting the carer and involving the PA (Lessons Learned 3 & 6).*
  7. *Ongoing assessment will not only focus on the service user, but should also address the impact of the service user's mental health on their immediate / extended family (Lessons Learned 2).*
  8. *S was not identified as a carer during her admission to Stepping Hill Hospital in the immediate period before the incident. This finding will be shared with Stockport NHS Foundation Trust and the external investigation team (Lessons Learned 8).*
- 8.9 We have identified above where we agree with or would extend the findings, and we have similar conclusions about the recommendations.
- 8.10 *Review if the internal investigation satisfied its own Terms of Reference.***
- Review if all key issues and lessons have been identified and shared.***
- Review the progress that the Trust has made in implementing the action plan.***
- Review processes in place to embed any lessons learnt.***
- 8.11 We consider that the internal investigation did satisfy its own Terms of Reference, and has provided a comprehensive narrative analysis of D's care.
- 8.12 PCFT's mechanisms for tracking the completion of serious incident action plans, and their actions taken to embed any lessons learnt were explained, and this is clearly described in the Incident Reporting, Management & Investigation Policy.

- 8.13 *'Following scrutiny, the report will be forwarded to the relevant Service Director. The Locality Manager and Service lead (most relevant to the nature of the Investigation), should devise an action plan to address the recommendations. Where a need for change is identified which cannot be authorised by the Service Director, this should be identified in the action plan for further consideration by the relevant Trust forums. The report and action plan should be forwarded to the Medical Director and an Executive Director for formal Trust approval, dissemination and implementation. The finished report should also be shared with relevant borough's Local Authority partners via the Service Director.*
- 8.14 *Following final approval of the completed report a summary of the key issues and recommendations will be included in the Integrated Governance Report.*
- 8.15 *The progress of all grade 4 and 5 incidents will be tracked by the Head of Patient Safety; from the request of the IRR to approval of completed RCA investigation (if commissioned) by the Executive Directors, and successful implementation of recommendations. The Trust Investigation Coordinator will also ensure that relevant people are kept informed of the commissioning, progress and outcome of internal investigations which includes the Service Director and Borough/ Borough/Divisional Governance Manager.*
- 8.16 *Pennine Care has the following provisions to ensure communication, recommendations and for shared learning across the Trust: A quarterly Integrated Governance report, is produced which includes recommendations on incidents, serious case reviews and RCA investigations. These are discussed at Borough/Divisional Governance meetings and disseminated into borough services. In addition, reports will be shared with the various work programme groups such as Suicide Prevention Group, Safeguarding Adults Group. Borough and Divisional action plans will be reviewed at a Borough/Divisional level'.*
- 8.17 While progress on actions following the homicide were described to us in some detail, the final report was provided to us on 28 October 2015, so it is not possible to conduct a detailed review of the embeddedness of actions at this stage. We suggest that this be conducted six months after the completion of the report.
- 8.18 Our overall view is that the report did answer its own on terms of reference, and PCFT has produced a lengthy and detailed report. Good practice in family engagement was evidenced by early contact being made with family members, and meetings and consultation on the report took place. The family's perspective was acknowledged in relevant parts of the report.
- 8.19 The report is also in our view repetitive and overly narrative in style, which contributes to its excessive length. However we acknowledge that the NHS England investigation template does lead to repetition. It was not produced in time, as the expected time frame for this level of report would be 60 working days. The draft was shared with the family on 15 June 2015, but was not finalised until the end of October 2015. The report took ten months to finalise,

and while we accept that some of this time involved consultation with family, this does appear excessive.

- 8.20 We discussed this with members of PCFT executive team and they accepted that the size of the team and the time taken for consultation and sign-off did contribute to this. The motivation was certainly to produce a report of good quality, but they have since reflected and decided that a smaller internal team would be more effective in future. It is clear from reading the report that the review team lacked access to expertise in ASD, specifically in adults with ASD without learning disabilities, It appears unusual in a case where dual diagnosis was such a key element that they did not at least seek an input from a relevant expert - this could have been as an adviser if not wishing to include in panel team.

#### **Recommendation 21:**

Pennine Care NHS Foundation Trust :change incident reporting and management policy to implement structures and processes as described in NHS Serious Incident Framework March 2015

## **9 Overall analysis and recommendations**

- 9.1 The internal investigation by PCFT has identified many areas of learning, which we support and have expanded upon.
- 9.2 As required in the DHR process we have made recommendations for wider systems learning, including for PCFT, Stockport NHS Foundation Trust, Stockport Council, Stockport Community Safety Partnership and Stockport CCG.

### **Contributory factors and root cause**

- 9.3 The Fishbone Analysis in Figure 1 below sets out the key contributory factors we have identified. We have not identified which services or individuals that these contributory factors are attributable to, as it is intended to represent a distillation of the previous analysis.
- 9.4 We consider that the root cause of the homicide was the relapse of D's inadequately treated psychosis, although recognising that multiple contributory factors existed that influenced this. Some of these contributory factors are issues that we have discovered as part of the review, and within these we consider there to be a mixture of influencing and causal factors.<sup>52</sup>
- 9.5 An influencing factor is something that influenced the occurrence of, or outcome of an incident. Generally speaking the incident may have occurred in any event, and the removal of the influence may not prevent incident recurrence but will generally improve the safety of the care system.

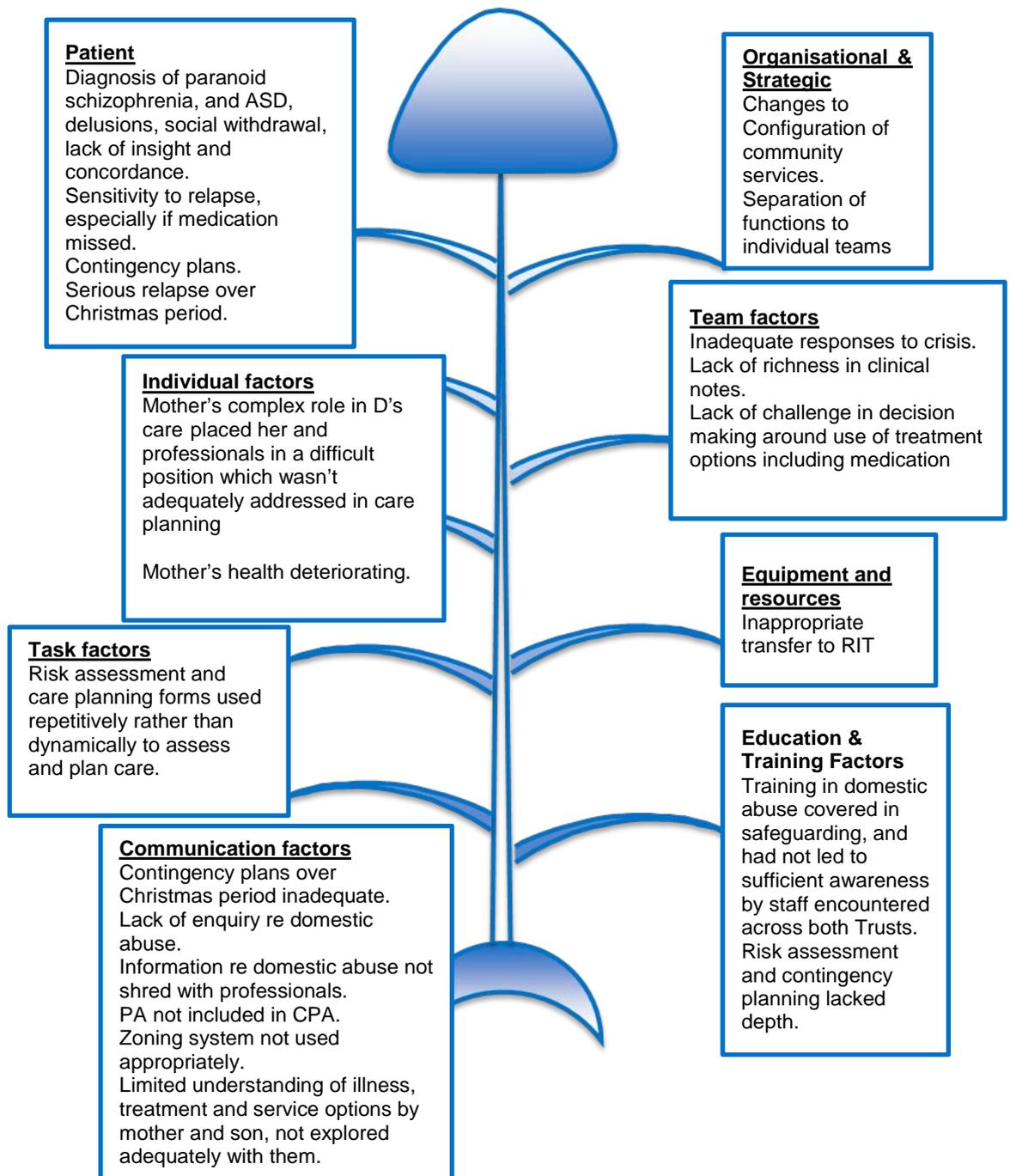
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<sup>52</sup> NPSA 7Steps: Representing Contributory Factors: Fishbone Diagrams and other formats. [https://report.nrls.nhs.uk/.../Tools\\_Representing\\_Contributory\\_Factors](https://report.nrls.nhs.uk/.../Tools_Representing_Contributory_Factors) .

9.6 A causal factor is something that led directly to an incident. Removal of these factors will either prevent, or reduce the chances of a similar type of incident from happening in similar circumstances in the future. Causative factors tend to be more closely related to the incident being analysed.

In our opinion there are two key causal factors in the homicide: the inadequate contingency planning for the Christmas period, and the lack of information regarding the assault on Sandra.

*Figure 1 - Fishbone Analysis*



- 9.7 We will address the other elements of the Terms of reference as follows:
- 9.8 **Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement**

### **Predictability and preventability**

- 9.9 We do not consider that on the information available to any individual service or group of people at the time, the incident on the 30 December 2014 was predictable. Predictability is '*the quality of being regarded as likely to happen, as behaviour or an event*'.<sup>53</sup> 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.<sup>54</sup>
- 9.10 The information shared by Sandra at the critical points of the assault and the Christmas period did not include reference to crucial information that would have altered D's risk assessment, and we believe the level of intervention by PCFT. The incident would have been preventable if all the information available had been shared.
- 9.11 Prevention<sup>55</sup> means to '*stop or hinder something from happening, especially by advance planning or action*' and implies '*anticipatory counteraction*'; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring. Information has come to light since the homicide which suggests that D's delusional beliefs had become focussed on the PA and Sandra and he believed that one of them needed to be killed, based on his religious delusions. His psychotic thinking led him to finally identify that it was his mother that needed to die.
- 9.12 We do not consider therefore that the homicide of Sandra was preventable by PCFT services, but with the caveat that information existed which could have altered this if it had been made available to them. However we consider that good care planning would have hindered this event happening even though the specific event itself was not predicted. The key is preventing relapse as without relapse the event would not have happened.
- 9.13 **Identify from both the circumstances of the case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in the future and make this available to the Home Office.**
- 9.14 This has been an independent review which combined the processes of both DHR and mental health homicide investigation approaches. Within this joint

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<sup>53</sup> <http://dictionary.reference.com/browse/predictability>

<sup>54</sup> Munro E, Rungay J, Role of risk assessment in reducing homicides by people with mental illness. *The British Journal of Psychiatry* (2000)176: 116-120

<sup>55</sup> <http://www.thefreedictionary.com/prevent>

process it has been possible to review the mental health care of the perpetrator in depth, and triangulate this information with other service providers. We have been able to consider the care offered to the victim Sandra in tandem, and develop a timeline informed by all the available information. The richness of the information we believe has enabled us to develop a much more in-depth understanding of the issues, than would have been possible if the two processes had been conducted separately,

- 9.15 We suggest that there is a formal review by NHS England and Niche of the joint process, with feedback through NHSE & the CSP, which should include the family's perspective.
- ***Establish what lessons are to be learned from the domestic death regarding the way in which professionals and organisations work individually and together to safeguard future victims.***
  - ***Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.***
  - ***Apply these lessons to service responses including changes to policies and procedures as appropriate.***
  - ***Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement***
- 9.16 We have set out our views on individual organisations earlier in the report.
- 9.17 There were key events which could have altered the course of events if they had been approached differently:
- The move of D to the RIT team
  - Absence of involvement of the PA in care planning
  - Lack of enquiry into the distress of Sandra in September 2014
  - Key aspects of D's presentation not shared with professionals
  - Risk assessments and care planning not robust
  - Lack of enquiry into Sandra's injury in September 2014
  - Sandra's declining physical health
  - Knowledge of domestic abuse not shared
  - The relapse of D in the absence of a robust contingency plan
- 9.18 We would like to comment however on guidance available on the phenomenon of child to parent violence.
- 9.19 A BBC report<sup>56</sup> in January 2014 suggested that teenagers abusing their parents is a 'serious and often hidden issue'. Within this press coverage the NGO Family Lives (formerly Parentline Plus) says that over a two year period, 31% of over 85,000 calls to its helpline 'concerned physical aggression' by

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<sup>56</sup> <http://www.bbc.co.uk/newsbeat/article/25850554/teens-abusing-parents-serious-and-often-hidden-issue>

children. In England research on patients reporting domestic violence in an emergency department at a local hospital reported that 6% of the cases were cases of young people's violence against their parents (Smith et al., 1992).

- 9.20 A report by Hunter et al., (2010<sup>57</sup>) in family intervention projects found that 11% of 256 families experience this phenomenon. Condry and Miles (2013)<sup>58</sup> found that of all cases reported to Metropolitan Police over one year (April 2009 - March 2010) 1,892 were cases of violence from adolescents (aged 13 -19 years) to a parent and most involved violence against the person or criminal damage in the home.
- 9.21 When CPV cases are reported to the police; and a decision is made whether to charge or not. In Stockport if a young person is charged the local YOS would be alerted automatically. The Stockport YOS may work with the young person and the family in a voluntary capacity, and receive referrals to this effect. According to the research, police very often advise parents to contact social services and family support (Nixon and Hunter, 2012)<sup>59</sup>. In Stockport, referrals for CPV come to the YOS, which runs the Respect<sup>60</sup> programme, which is a family based programme for young people who exhibit CPV. Respect takes referrals from all agencies, including the police.
- 9.22 We suggest that guidance on the possibility of child to parent violence is included in safeguarding and domestic abuse strategies.

#### **Recommendation 22:**

Stockport Community Safety Partnership : guidance on domestic abuse by children to parents should be included in domestic abuse strategies

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<sup>57</sup> *Mother Abuse: A Matter of Youth Justice, Child Welfare or Domestic Violence? Journal of Law and Society* Volume 37, Issue 2, pages 264–284, June 2010

<sup>58</sup> *Adolescent to parent violence: Framing and mapping a hidden problem. Criminology and Criminal Justice* September 3, 2013

<sup>59</sup> *Introduction: Exploring Parent Abuse – Building Knowledge across Disciplines. Social Policy and Society / Volume 11 / Issue 02 / April 2012, pp 211-215* Copyright © Cambridge University Press 2012

<sup>60</sup> *Respect Young People's Programme: <https://www.justice.gov.uk/youth-justice/effective-practice-library/respect-young-peoples-programme>*



## Recommendations by agency

Pennine Care NHS Foundation Trust	1	should ensure that the quality of care and contingency plans is audited, including the checking of plans against identified needs
	2	should amend the CPA policy to describe the role of the psychiatrist with regard to the CPA policy and care planning
	3	CPA policy should provide guidance on assessment and CPA care planning to clarify responsibilities and requirements where there are carers funded by direct payments (with Stockport Metropolitan Borough Council)
	4	should develop a system to follow up on plans and interventions after carers assessments and co-ordinate interventions with Pennine Care NHS Foundation Trust where the carer is caring for a mental health service user
	5	should ensure that NICE CG178 ( Psychosis and schizophrenia in adults: prevention and management) is implemented and monitored
	6	implement a system for follow up and monitoring of GP physical health checks re psychiatric medication ( with Stockport CCG)
	7	For, Stockport CCG & Stockport Metropolitan Borough Council : audit of implementation of the autism strategy, and resources to support staff & patients who are diagnosed with Autistic Spectrum Disorder
	8	Ensure that clinical decisions about changes to pathways or services should include the care team, and there is evidence that the perspectives of patient and carers have been considered, taken into account and documented
	9	change approach to Risk Assessment training, to focus on formulations; and implement a quality assurance process for Risk Assessments
	10	should have triggers for responding to crisis calls and an escalation process in place
	19	domestic abuse training material should be reviewed to ensure that it includes domestic abuse in both children and adults safeguarding; including that any individual in a domestic arrangement may abuse anyone else in that setting

	21	change incident reporting and management policy to implement structures and processes as described in NHS Serious Incident Framework March 2015
Stockport Metropolitan Borough Council	4	should develop a system to follow up on plans and interventions after carers assessments and co-ordinate interventions with Pennine Care NHS Foundation Trust where the carer is caring for a mental health service user
	7	audit of implementation of the autism strategy, and resources to support staff & patients who are diagnosed with Autistic Spectrum Disorder ( with Pennine Care NHS Foundation Trust and Stockport CCG)
	10	should have triggers for responding to crisis calls and an escalation process in place
	15	should assess the efficacy of the current multi-agency approach to carers needs, along with partner organisations, and implement a strategy to ensure the aims of the position statement are carried out.
Stockport CCG	6	implement a system for follow up and monitoring of GP physical health checks re psychiatric medication (with Pennine Care NHS Foundation Trust)
	7	audit of implementation of the autism strategy, and resources to support staff & patients who are diagnosed with Autistic Spectrum Disorder (with Pennine Care NHS Foundation Trust and Stockport Metropolitan Borough Council)
	17	formal processes must be in place so that multiagency risk assessments are carried out for all vulnerable children and their carers on transition from children to adult services.
	18	GP practice staff must undertake adult safeguarding and domestic abuse training.
Stockport NHS Foundation Trust	11	should set a clear strategy for the recognition of domestic abuse, with up to date policy guidance and a programme of staff training
	13	should ensure the lessons learned from this incident with specific regard to domestic abuse and violence are conveyed across the Trust, and particularly in the Emergency Department
	14	should revise its admission and discharge documentation to include a prompt regarding carers needs and signposting to a plan of care and an assessment

		before discharge
	16	should revise the recording systems to ensure a complete and contemporaneous record is maintained of all clinical encounters
	19	domestic abuse training material should be reviewed to ensure that it includes domestic abuse in both children and adults safeguarding; including that any individual in a domestic arrangement may abuse anyone else in that setting
	20	fully implement NICE guidance 'Domestic violence and abuse: multi-agency working' (PH50) recommendation 5: 'Create an environment for disclosing domestic violence and abuse' with particular emphasis on consistent implementation of policy, and recording of information
Stockport Community Safety Partnership	12	should assess the results of the Domestic Abuse strategy thus far, with emphasis on increasing the access to training to frontline healthcare staff, and ensuring that child to parent violence is included
	23	guidance on domestic abuse by children to parents should be included in domestic abuse strategies

## Appendix A – Terms of reference

### **Terms of Reference for Independent Investigations under HSG (94) 27/NHS England's Serious Incident Framework 2015 and Domestic Homicide Review under the Domestic Violence, Crime and Victims Act, 2004.**

NHS England has recently published a revised Serious Incident Framework. The framework details the principles, guidance and criteria for the commissioning of an Independent Investigation following a Mental Healthcare related homicide and which now supersedes the HSG (94)27. The application of this revised guidance will apply to serious incidents occurring from 1<sup>st</sup> April 2015 onwards which require an independent investigation.

Individual Terms of Reference will be developed in collaboration with the successful offeror, however, the following terms of reference under HSG 94 (27) and Domestic Homicides Reviews under the Domestic Violence, Crime and Victims Act published by the Home Office in 2004, are expected to be met for this case (2015/131)

#### Scope of the Panel Review

- 9.23 The scope of the review is to focus on both S (the victim) and D (the perpetrator). The panel will combine the two independent review processes to provide one report that satisfies the requirements of both HSG (94) 27/ NHS England's Serious Incident Framework 2015 and those of a Domestic Homicide Review under the Domestic Violence, Crime and Victims Act, 2004.

#### Purpose of the Panel

The purpose of the panel is through the combined independent review processes to establish the facts that led to the incident and to identify all the lessons to be learned from this domestic homicide. The panel will consider the way in which local professionals and organisations worked both individually and jointly to provide care and treatment to D and how they sought to safeguard S and to determine whether this provision was appropriate.

The Panel will work with all organisations to ensure that both individual and multi-agency implementation plans are developed from the identified lessons; including detailing within the plan what timescales they will be acted on, and what is expected to change as a result.

This investigation should follow and satisfy the key processes that are outlined in the above sets of guidance and include the following actions, to:

- Establish which agencies had contact with the perpetrator and the victim
- Produce a chronology of events and actions in relation to the care of the perpetrator and in the care of the victim

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review if the internal investigation satisfied its own Terms of Reference.
- Review if all key issues and lessons have been identified and shared.
- Review the progress that the Trust has made in implementing the action plan.
- Review processes in place to embed any lessons learnt.
- Review if the Trust fully assessed and appreciated the perpetrator's dual diagnosis of schizophrenia and atypical Asperger's and if they provided appropriate support, care and treatment options that met national standards.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- 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 care, treatment and services provided by the NHS, the local authority and other relevant agencies to the victim, both as a patient and in her role as sole carer of the perpetrator.
- 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.
- Involve the families as fully as is considered appropriate, in liaison with Victim Support, Police and other support organisations.
- Identify from both the circumstances of the case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in the future and make this available to the Home Office.

- Establish what lessons are to be learned from the domestic death regarding the way in which professionals and organisations work individually and together to safeguard future victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement
- 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 Home Office and NHS England North that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation.

## **Supplemental**

### **Key Lines of Enquiry**

- How are professionals training needs in domestic abuse identified?
- What training in domestic abuse was available to professionals at the time of the homicide?
- What was the take up of domestic abuse training at the time of the incident?
- What training in domestic abuse is currently available to professionals?
- What is the current take up of training by professionals in domestic abuse and how is this being measured?
- Identify any gaps in training for professionals in domestic abuse?
- Review the processes currently in place to identify the training requirements for professionals in domestic abuse?
- Did organisations have knowledge of domestic abuse in this family? If so, how was this knowledge acted upon?

- What knowledge did the victim's family and friends have about domestic abuse within the family composition and what did they do with it?
- Were there any barriers to family and friends raising concerns about domestic abuse?
- How did agencies, family members and friends deal with any confidentiality issues the victim might have requested of them?
- Were there any specific diversity issues relating to the subject/family?
- Were issues with respect to safeguarding (adults) adequately assessed and acted upon?
- Were there issues in relation to capacity or resources in your agency that impacted the ability to provide services to the victim and to work effectively with other agencies?
- Was information sharing within and between agencies appropriate, timely and effective?
- Were there effective and appropriate arrangements in place for risk assessment and escalation of concerns?
- Invite the family to be involved with the review of the implementation plans developed from the report's recommendations

## Appendix B – Profile of PCFT and services

Pennine Care NHS Foundation Trust provides community and mental health services to around 1.1 million people within the Greater Manchester area.

This includes:

- Community and mental health services in Bury, Oldham and Rochdale
- Mental health services in Stockport and Stockport and Glossop
- Health improvement services in Bury, Oldham, Tameside and Glossop
- Specialist services in Bury, Rochdale, Oldham, Tameside and Glossop
- Community services and Child and Adolescent Mental Health Services in Trafford

The Stockport Adult Mental Health services are comprised of:

- Stockport Access and Crisis Team
- Stockport Healthy Minds
- Norbury Ward
- Stockport Criminal Justice Mental Health Service
- Arden Ward
- Home Treatment Team
- Recovery and Inclusion Team
- Supported Living Team/Redcroft
- Adult's RAID A&E
- Sector 2 Community Mental Health Team/ Councillor Lane Resource Centre
- Pathfinder Stockport (Stockport Alcohol RAID)
- Community Mental Health Team York House
- Community Mental Health Team Torkington
- Stockport Secondary Care Psychological Therapies

## Appendix C – Documents reviewed

- Case notes for D & S from PCFT, Stockport NHS Foundation Trust, and Bredbury Medical centre
- Case notes for D at current hospital

### PCFT documents

Stockport Adult Community Mental Health Service – Reporting Structure

Fast Track Protocol – April 2011

Incident Reporting, Management & Investigation Policy October 2014

Stockport Recovery and Inclusion Team

Adult Community reconfiguration project 2010

Risk Assessment Policy December 2014

RIT Current staffing arrangements – March 2015

Safeguarding Adults Policy August 2015

Zoning Community Mental Health Team (Final Draft)

Care Programme Approach Policy December 2012

Clinical Risk Assessment & Management Policy October 2013

Community Mental Health Teams Tier 4, secondary care services  
OPERATIONAL POLICY

Community Mental Health Services Pathway 2011 onward

### Other documents

Stockport Adult Autism Strategy 2014-2016

Carers Support Position Statement NHS Stockport – September 2012 –  
Stockport Clinical Commissioning group

Safeguarding Adults Standard Operating Procedure July 2010 Stockport NHS  
Foundation Trust

Greater Manchester Police case summary

