An independent investigation into the care and treatment of Mr M

Executive summary

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Sancus Solutions wish to thank Annie's family for their contribution to this investigation. It is hoped that this report does not contribute further to their pain and distress.

Sancus Solutions' investigation team would like to acknowledge the contribution and support of the staff from Tees, Esk and Wear Valleys NHSFoundation Trust.

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Extended executive summary

1 Incident

On the evening of 3 August 2018 Annie[1] was attacked in the street by Mr M.[2]

Mr M subsequently pleaded guilty to killing Annie and was sentenced to life imprisonment and ordered to serve a minimum term of 29 years.

Mr M and Annie had a number of children. At the time of the incident on 3 August 2018 there was on-going police investigation into the incident which had resulted in the children being taken into care.

At the point of Mr M's discharge from Tees, Esk and Wear Valleys NHS Trust's[3] (hereafter referred to as TEWV) affective disorder service[4] (April 2018) his mental health diagnosis was recurrent depressive disorder[5] and his medication regime included the antidepressant venlafaxine.[6]

2 Commissioning of the investigation

In 2019 NHS England (North) commissioned Sancus Solutions[7] to undertake an independent mental health homicide investigation under its Serious Incident Framework.[8]

The homicide of Annie also met the Home Office's criteria[9] for the commissioning of a Domestic Homicide Review (hereafter referred to as DHR). The Safer Hartlepool Partnership[10] commissioned a DHR and agreed with NHS England (North) that the

[1] Annie is a pseudonym used in the DHR
[2] Mr M is a pseudonym
[3] TEWV
[4] The affective disorder service, also known as the community resource team, offers individuals support with a wide range of mental health difficulties, including severe depression, anxiety, personality disorders, OCD, eating disorders and several other non-psychotic conditions. TEWV
[5] A disorder characterised by repeated episodes of depression, the current episode being of moderate severity. International Statistical Classification of Diseases and Related Health Problems (ICD) code F33.1
[6] Venlafaxine is an antidepressant belonging to a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SSNRIs). Venlafaxine
[7] Sancus Solutions is a national training and investigations company and is one of NHS England's selected providers on their serious incident framework. Sancus Solutions
[8] "When a homicide has been committed by a person who is, or has been, in receipt of care and has been subject to the regular or enhanced care programme approach or is under the care of specialist mental health services, in the 6 months prior to the event." NHS Serious Incident Framework
[9] "the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship"
[10] Safer Hartlepool Partnership

role of Sancus Solutions would be to “provide relevant mental health and investigative expertise to assist the Domestic Homicide Review panel.” [11]

During the course of Sancus Solutions’ investigation, the families of both Mr M and Annie were invited to contribute to the Terms of Reference (hereafter referred to as ToR.

In order to avoid duplication of investigations, it was agreed that Sancus Solutions’ investigation would focus on the involvement of TEWV’s mental health services and the specific key lines of inquiry within the ToR.

Involvement of services

3 Tees, Esk and Wear Valleys NHS Foundation Trust

From 2012 Mr M had sporadic contact with TEWV’s community mental health services when he presented to his GP or Accident and Emergency department (hereafter referred to as A&E) with low mood and/or suicidal thoughts.

In 2017 Mr M was reporting to the affective disorder service that his relationship with Annie had ended, his children had been taken into foster care and his ongoing difficulties in his relationship with Annie were all significant contributory factors in his mental health difficulties. It was being documented that Annie or Mr M’s new partner often accompanied him to A&E, and to his scheduled appointments with TEWV’s affective disorder service. On several occasions, it was documented, that Annie made telephone contact with the TEWV’s crisis service requesting support for Mr M.

Due to concerns regarding Mr M making inappropriate comments to female support staff and after consultation with the police it was decided that there would beno lone working with Mr M and wherever possible there would be no home visiting. This decision was communicated to children’s social services (21 August 2017).

At the last appointment with his care coordinator (19 April 2018) Mr M reported that his mood was stable and that his children were his main protective factor and motivator for improving his life. The care coordinator updated Mr M’s safety summary assessment, identifying that there was no current risk of harm to either himself or others. Mr M’s discharge from the affective disorder team was reported to his GP and discussed with children’s social services.

[11] ToR p1

4 Other involved services

Primary care

Mr M's last appointment with his GP was on 11 June 2018 and he collected his repeat prescription on 23 July 2018.

Children's social care services

In May 2017, children's social care services became involved with Mr M's family. They made a referral to Harbour[12] for Mr M to attend a domestic abuse perpetrator programme.

Third sector services

Harbour: Between 2017 and 2018, Mr M attended Harbour's domestic abuse perpetrator programme (DAPP). A Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment[13] was completed which identified a number of risks factors with regard to Mr M's mental health and his on-going risks to both Annie and his children.

In October 2017, a member of the Harbour staff contacted Mr M's care coordinator to report that Mr M had displayed 'concerning behaviour' and inappropriate responses to images shown during a perpetrators' group meeting. It was reported that a referral had been submitted for Mr M to be considered as a Potentially Dangerous Person.[14]

Hartlepool and East Durham Mind[15] and Hartlepool Borough Council's alcohol service[16]:
Although Mr M was reporting that he was receiving ongoing support from these services he either failed to attend the initial assessment or quickly disengaged with their programs.

Police

Between June 2017 and September 2017, the police received a number of reports of alleged harassment and criminal damage citing Mr M as the offender.

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[12] Harbour is a specialist charity that works with families and individuals who are affected by abuse from a partner, ex-partner or other family member. They also work with perpetrators of domestic violence. Harbour
[13] The DASH risk checklist is a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk. DASH
[14] A potentially dangerous person is a person who has not been convicted of, or cautioned for, any offence that places them into one of the three MAPPA categories but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence that will cause serious harm. PDP
[15] MIND
[16] Hartlepool Borough Council Drug and Alcohol Service

In October 2017, the police analytical team reviewed the PDP referral and determined that Mr M did pose a high risk. At a subsequent meeting in February 2018, it was agreed that as there had been no further intelligence, Mr M would be discharged from the PDP unit but that the Child Abuse Investigation Unit would continue to manage the case.

The following section briefly documents Sancus Solutions' investigation team's responses to particular ToR.

5 Risk

"Review the adequacy of risk assessments and risk management, including specifically the risk posed to others."[17]

- During Mr M's involvement with TEWV's mental health services from 2017 to 2018, nine safety summaries were either completed or partially completed[18]. The safety summaries were being completed by practitioners from the affective disorder service and members of the liaison psychiatry service who assessed Mr M during his various admissions to Accident and Emergency Department.

- There was no evidence that the practitioners, who were completing the safety summaries, consulted with other agencies who were involved in Mr M or his family's care. The investigation team concluded that this was a significant error, as it was known that there was a complex family dynamic with considerable concerns about the safety and wellbeing of Mr M's children. It was also known that Mr M was engaging with a perpetrators-of-domestic-violence group, which should have alerted practitioners that there were concerns regarding domestic violence within his relationship with Annie. This should have been documented and risk assessed within his safety summaries.

- An Attention Deficit Hyperactivity Disorder (ADHD) assessment was undertaken by a clinical nurse specialist from ADHD team. The assessment recommended that a forensic assessment be undertaken. This referral was not made, and it wasnot documented why this did not occur. It was, however, reported to both the author of TEWV's Serious Incident Report (hereafter referred to as SIR) and the investigation team that as Mr M's presentation became more stable it was decided that there was no indication that a forensic assessment was necessary. Given the information that was known to the affective disorder service, the investigation team concluded that this was a proportionate decision.

[17] NHS England ToR pp1-2
[18] 7, 14 and 31 July 2017; 15, 28 and 31 August 2017; 7 September and 4 October 2017; and on his discharge from the affective disorder service on 19 April 2018
[19] 25 August 2017

- The investigation team concurred with the SIR authors' conclusion that Mr M's safety summaries were "incomplete and poorly updated"[20]. That there were some significant and concerning deficits in the documentation and assessment of Mr M's risk factors, particularly in relation to documenting and assessing his known historic and more recent risks, in particular his risks to others including Annie.

- There was no evidence that the practitioners who were completing the safety summaries invited the other agencies who were involved in Mr M's care – such as Harbour, his GP and children's social care services- to contribute to the assessments.

- The investigation team have concluded that the SIR's recommendations sufficiently addressed the deficits within the assessments and documentation of Mr M's risks, practitioners' non-compliance with TEWV's policies and best practice guidelines. The investigation team are recommending that to obtain assurance that the improvements are now fully embedded within the affective disorder service that a quality assurance audit of safety summaries is completed (recommendation1).

6 Care planning

"Examine the effectiveness of the service user's care plan including the involvement of the service user and the family."[21]

- Although, as the author of the SIR noted, there was evidence within Mr M's patient records of discussions with Mr M regarding his care plan and support needs, there was no evidence of a care plan being completed during Mr M's time with the affective disorder service. No satisfactory answer was provided to the investigation team as to why care plans were not being completed.

- As there was no specific recommendation within TEWV's SIR to address this deficit, the investigation team have recommended that an audit of the affective disorder service is undertaken to review compliance with its Care Programme Approach and Standard Care Policy (recommendation 2).

7 Interagency communication

Review any gaps in inter-agency working and identify opportunities for improvement for inter-agency cooperation and joint working."[22]

[20] SIR p38
[21] NHS England ToR p2
[22] NHS England ToR p1

- It was evident from Mr M's TEWV patient records that the involved community mental health services were in regular written contact with Mr M's GP reporting details of assessments undertaken, reviews and discharge summaries.

- There was evidence of one telephone contact between Harbour and the affective disorder service (11 October 2017). During this contact Harbour reported that Mr M had displayed 'concerning behaviour' at one of their perpetrators' group meetings.

- There was no evidence of any communication or information being passed between Mind and the affective disorder service.

- The investigation team concluded that based on the evidence available therewas no consistent ongoing interagency communication or multi-agency meeting convened, this resulted in no one agency having a comprehensive profile of Mr M's risks. As it was, the involved agencies only had partial information on which to base their own service's assessments of Mr M's support needs and potential risk factors. Services had to rely on information reported by Mr M, who was likely to have been, at times at least, an unreliable self-historian.

- The investigation team also concluded that there were several significant missed opportunities when interagency cooperation and joint working could have improved and informed assessments of both Mr M's support needs and the risks to others, including Annie and his family. The investigation team would suggest that all the involved professionals had a responsibility to instigate and maintain contact with other agencies in order to share and obtain information.

- The investigation team agreed with the SIR's authors' conclusion that this was:

  "a missed opportunity for all agencies involved in the patient's case to meet to discuss and share information in order to assess and manage any potential risks posed by the patient either to himself or others"[23].

- The investigation team are satisfied that TEWV's DHR and SIR action plans focus on improving the affective disorder service's interagency information sharing. To ensure that this has now been fully embedded the investigation team have recommended that TEWV undertake a quality assurance audit of patients at this service for whom there is multi-agency involvement (recommendation 3).

8 Record keeping

"Review the standard of record keeping, identifying any opportunities for improvement."[24]

[23] SIR p28
[24] NHS England ToR p2

- The investigation team reviewed TEWV's patient records and concluded that in the main they were well documented. The one concern that the investigation team had was that Mr M's historic and emerging risks and management plans were being documented in his patient records and not in the safety assessment forms. This resulted in significant risk information not being readily accessible to practitioners.

- As the investigation team have highlighted some issues with regard to the use of patient records to document risk information at the affective disorder service, they have recommended that the audit review of the service should include a review of the standard of the patient records (recommendation 3).

9 Capacity

"Consider if there were any issues in relation to capacity or resources that impacted the ability to provide services and to work effectively with other agencies."[25]

- It was reported by all of the TEWV practitioners and operational managers who were interviewed as part of this investigation that there were no specific capacity or resource issues that affected the service provided to Mr M. Neither TEWV's SIR nor its IMR identified any capacity issues within the involved services.

- The investigation team concluded that there were no capacity or resource issues that impacted on TEWV's service delivery to Mr M or were a contributory factor to the incident on 3 August 2018.

- There was a reference in the DHR regarding the police's capacity in their Protecting Vulnerability People Unit. The DHR concluded that capacity issues may have affected the processing of the initial PDP referral.

10 Safeguarding

"Identify whether any issues with respect to safeguarding were adequately assessed and acted upon."[26]

- There were multiple entries within Mr M's patient records that documented the events that led to his children being taken into care and also some disclosures of domestic violence with Annie being the victim. It was also documented that Mr Mwas attending Harbour which was known to be a service for perpetrators of domestic violence. Despite this knowledge, Mr M's TEWV safety summaries were not consistency identifying domestic violence or child protection issues as being historic or current or potential future risk factors. Additionally, Annie and

[25] NHS England ToR p2
[26] NHS England Tor p2

the children were being documented as protective factors rather than possible victims.

- The DHR made the following three recommendations to address TEWV's deficits in their practitioners' responses and to improve safeguarding issues. These are:

  "TEWV to ensure all frontline staff attend Domestic Abuse training focus on staff always considering potential vulnerabilities of other members of the household when undertaking assessments of a patient's mental health and associated risks encouraging the adoption of a think family approach.

  When there is multi-agency involvement in a patient's case, TEWV to ensure open channels of communication should be maintained with all agencies involved.

  All safeguarding concerns should be recorded in line with TEWV processes, policies and procedures."[27]

- The investigation team have concluded that the deficits highlighted by both the SIR and their investigation with regard to TEWV's practitioners' responses to known or suspected safeguarding concerns have been fully addressed within the DHR's recommendations and action plan. The investigation team would, however, recommend that TEWV report the progress they have made in implementing their DHR recommendations at Sancus Solution's quality assurance review (recommendation 4).

11 Predictability and preventability

"Determine through reasoned argument the extent to which this incident was either predictable[28] or preventable[29], providing detailed rationale for the judgement."[30]

In concluding whether this incident was predictable or preventable, the investigation team have utilised the civil standard of the balance of probabilities.[31]

[27] DHR p 34-35

[28] 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. Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. 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. Predictability

[29] Preventability – to prevent means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring. Preventability

[30] NHS England ToR p1

[31] Balance of probabilities – the probability that some event happens is more than 50%. Balance of probabilities

Predictability: The investigation team have concluded that based on Mr M's support needs, risks and his more recent engagement with TEWV's affective disorder service, the decision to discharge him from the service in April 2018 was proportionate. Additionally, based on Mr M's presentation prior to his discharge, there was not sufficient evidence to indicate that his risk of future violence was sufficient to warrant further action by the involved services. Therefore, the investigation team agree with the authors of the DHR that given the information that was known at the time, the death of Annie was not predictable.

Preventability: As has already been identified, although the investigation team had concerns about the deficits in the assessment of Mr M's risk factors and the lack of formal care planning, they concluded that the decision to discharge Mr M from TEWV's affective disorder service was proportionate. Therefore, they have concluded that TEWV's services did not have the knowledge, legal means or opportunity to prevent the death of Annie.

12 TEWV's Serious Incident Report

"Review the Trust post incident internal investigations and assess the adequacy of their findings, recommendations and action plans."[32]

Following the incident, TEWV commissioned a Level 2 Root Cause Analysis[33] serious incident investigation. The SIR did not identify a root cause or contributory factors, however, it did identify one "care and service delivery problem relating to multi-agency joint working"[34]. Four additional areas of learning were also identified with associated recommendations. The investigation team were provided with TEWV's most recent action plan, which highlights that all actions have now been completed.

The investigation team concluded that the SIR was well written, thorough and addressed all the key lines of enquiry.

There was clear evidence that efforts were made to engage with Mr M, his and Annie's families in the SIR. However, it was unclear if the findings of the report have been presented to Mr M and the families. If this has not occurred, then the investigation team would suggest that they are asked if they would like to receive feedback from both the SIR and the trust's IMR.

The involved TEWV practitioners and managers who were interviewed as part of this investigation reported that although they had received feedback from the SIR, they

[32] NHS England ToR p2
[33] Root cause analysis (RCA) is a systematic process for identifying "root causes" of problems or events and an approach for responding to them. RCA
[34] SIR p1

had not had any feedback from the trust's IMR or the DHR. The investigation team would suggest that although the DHR has yet to receive Home Office approval, it would be a valuable learning opportunity for the involved practitioners if TEWV convened a learning event where the findings of the IMR and the DHR could be discussed (recommendation 5).

13 Concluding comments

This is clearly a very tragic event which continues to deeply affect the lives of all those involved, and Sancus Solutions' investigation team would like to express their condolences to Annie's family.

Although this investigation report has clearly highlighted some deficits in the care and treatment of Mr M, the investigation team is not suggesting that any one individual practitioner was directly responsible for this tragic event. The aim of these independent investigations is to identify where there have been particular practice concerns and to highlight when policies are not adequate. Additionally, these investigations aim to ensure that lessons are learnt and action is taken to improve future delivery of services to vulnerable patients and their families.

14 Recommendations

Recommendation 1: In order to obtain assurance that the improvements in risk assessments are fully embedded within the affective disorder service that a quality assurances audit is undertaken.

TEWV should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.

Recommendation 2: TEWV needs to undertake an audit of the affective disorder service to review compliance with its Care Programme Approach and Standard Care Policy.

TEWV should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.

Recommendation 3: An audit of the affective disorder service's patient records should be undertaken to ascertain if there have been improvements in multi-agency communication, information sharing and record keeping.

TEWV should provide evidence at Sancus Solutions' quality assurance review

that this recommendation has been implemented.

Recommendation 4: TEWV should report the progress they have made on implementing their Domestic Homicide Review's recommendations at Sancus Solutions' quality assurance review.

Recommendation 5: TEWV should hold a learning event for the involved practitioners and operational managers to discuss the findings of the trust's submitted individual management review and the Domestic Homicide Review.