Report to Yorkshire and the Humber Strategic Health Authority

Independent Investigation of the Case of EF (StEIS 2007/12661)

Incident date: 2007

Investigation report date: December 2012

Commissioned by Yorkshire and the Humber Strategic Health Authority

Version 5

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Incident Investigation Title:	Independent Investigation of the Homicides of ML and DB by EF
Incident date:	2007
Incident number:	StEIS 2007/12661
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The independent investigation panel would like to thank all those who helped us to gain a better understanding of the issues in this case. We interviewed members of the Trust who were open and frank in their discussions with us even though still deeply upset by the events of 2007.

We wish to thank our liaison contacts and other staff in the Sheffield Health & Social Care NHS Foundation Trust, for all their work in gathering together the records and papers relating to the case as well as making all the interview arrangements.

Members of the South Yorkshire Police kindly provided information about the current arrangements for improving the safety of victims of domestic abuse and were instrumental in helping us to contact members of the family of one of the victims who knew something of the care and treatment provided for EF. We are grateful to them for agreeing to contribute towards this report.

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EXECUTIVE SUMMARY

Introduction

1. In 2007, EF (at the time an outpatient of Sheffield Health & Social Care NHS Foundation Trust) attacked his former partner (ML) and her male friend (DB) in ML's home in Sheffield. The two victims died at the scene as the result of the injuries received. EF appeared in court in 2008 and was given a life sentence with a minimum term of twenty-eight years.

2. After the incident Sheffield Health & Social Care NHS Foundation Trust (hereafter referred to as "the Trust") set up an internal serious incident investigation team which produced a report of its findings in December 2008. The report generated six recommendations:

- setting up of a city-wide group to look at inter-agency communication where mental health or substance misuse is a factor in domestic abuse;
- updating the Trust's Risk Assessment and Screening Tools in the light of this incident;
- further consideration of the role of carers and relatives in the assessment of service users;
- increasing appointment times to be considered and where appropriate increased to allow for assessment and care planning to be thorough, inclusive and documented contemporaneously;
- streamlining the serious untoward incident procedures and making them less complicated; and,
- improving continuously the implementation of Trust policies so all consistently meet the Trust's *Policy on Policies*.

3. This report sets out the findings of the independent investigation panel. The panel reviewed the Trust's internal serious incident report into the care and treatment of EF. In addition, the independent investigation report was further informed by interviews with key participants and stakeholders, a review of EF's health record (for which consent was refused but the decision taken by the Yorkshire and the Humber Strategic Health Authority (YHSHA) that it was in the public interest to release the papers), and a review of relevant Trust documentation including policies and procedures.

Purpose

4. The independent investigation was commissioned by YHSHA. An independent investigation is required when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the incident. The purpose is to examine all the circumstances surrounding the care and treatment provided, and in each case to identify any errors or shortfalls in the quality of the service, and to make recommendations for improvement as necessary.

5. The independent investigation panel was required to address Terms of Reference agreed by YHSHA in consultation with the NHS organisations involved in the commissioning and delivery of the care and treatment. More specifically the Terms of Reference were:

1. To examine by documentary review:

- The care and treatment the service user was receiving at the time of the incident and the suitability of the care and treatment in view of the service user's history and assessed health and social care needs;

- The extent to which the care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies, including:

i. Safeguarding Children

ii. Domestic Abuse;

- The adequacy of the risk assessment of the service user (perpetrator) including the risk posed to others;

- The involvement of carers and relatives when undertaking risk assessments, the resulting care plan and its use in practice.

2. To investigate:

- The interface, communication and joint working between all the agencies involved in providing care to meet the service user's mental health and social needs and their efforts to manage the needs of both the perpetrator and the victim within the context of their relationship;

- The perceptions of the service user's family of the level and quality of care and treatment provided.

3. To comment upon:

- The quality of the internal investigation, its ability to identify root causes, the clarity in which these are presented in the report and the strength of the recommendations to address these;

- The quality of the internal action plan, the strength of the proposed activities in response to the recommendations;

- The progress made towards the implementation of the action plan and the evidence of the effective audit and review of those actions;

- The impact of the resulting changes to frontline clinical practice and patient outcomes;

- The degree to which mental health was considered a contributory factor by the judiciary.

4. To identify:

- Any further learning points for improving systems and services;

- Aspects of the services user's treatment and management which was of good quality or commendable practice.

5. To produce:

- Realistic recommendations for action in conjunction with NHS Sheffield and Sheffield Health & Social Care NHS Foundation Trust and to address any learning points to improve systems and services;

- A final report that complies with all relevant legislation to enable the publication of the report by YHSHA through the Independent Investigations Committee.

Methodology

6. The independent investigation was informed by:

- Interviews with key staff;
- A review and analysis of EF's heath record including records from primary care and from the specialist mental health trust which cared for him as an outpatient;
- A review and analysis of the Trust's key policies and procedures in place at the time of the homicides and currently;
- An audit and analysis of the Trust's internal serious untoward incident report completed in December 2008;
- A review and analysis of ML's medical records;
- Interviews with ML's parents and her sister;
- A review of (relevant) national policy guidance, for example, safeguarding children and domestic abuse.

7. ML's medical records were analysed as they referred to a number of the issues the independent inquiry panel had been asked to investigate in respect of EF, for example, child safeguarding and domestic abuse issues. The Trust agreed to release these records following dialogue with the Strategic Health Authority on the following grounds:

- As the individual concerned is deceased the request falls outside the Data Protection Act but within the purview of the Access to Medical Records Act;
- It is in the public interest to release the records so that they can be reviewed in relation to this case as safeguarding issues have been discussed in relation to both the child and the deceased ex-partner and there may be some information in relation to this area in the records held;
- The records are considered the property of the Secretary of State and as this review is being carried out on behalf of the Secretary of State, it would be appropriate to release them for this purpose;
- The Trust can confirm that in past cases where records have been required in relation to deceased persons they have only sought permission from the next of kin on one occasion and that was due to the sensitivities of that particular case;
- The Trust notes the sensitivities around any contact with the next of kin in this case and agrees that it would be inappropriate to approach them for this reason.

Summary of main conclusions

8. The independent investigation panel has concluded that the Trust could not have prevented the murders of ML and DB by EF in 2007. Although EF had suffered from a recurrent depressive disorder, during the time he was under the care and treatment of the Trust, he was not mentally ill within the meaning of the Mental Health Act 1983 so could not be detained or have his liberty restricted in any way that might have physically prevented the murders. EF was seen by Trust staff on seven occasions and was scheduled to begin Cognitive Analytical Therapy (CAT) two weeks after the murders.

9. The independent investigation panel has considered many factors that might have contributed to the tragedy and have concluded that EF himself was the main cause. EF was a difficult individual to engage with mental health services. ML, EF's partner, was an important factor in getting him into contact with mental health services and once their relationship broke down completely an important motivator was lost. EF was given open access to any further appointments he cared to make.

10. EF's motivation to engage with mental health services was difficult to assess for two reasons: first, his engagement was to some degree based on ML's interest and concern about his mental health as she clearly retained some responsibility for the father of her child; and, second, ML's interest and concern decreased as their relationship deteriorated.

11. The independent investigation panel identified several service delivery issues which might have influenced the outcome. Delays occurred in making arrangements for EF to see mental health professionals. However, earlier appointments might not have made any difference to the outcome as he might not have engaged with CAT, it might not have been effective, and also ML was no longer there to encourage him to engage.

12. Communication problems may have affected the care and treatment EF received. At the time EF was in contact with Trust staff there were no established means of sharing information the police had with the health services or vice versa. But even if EF's behaviour towards ML in 2007 had been more widely known about, it was not of a kind that could have led to restrictions on EF's liberty under mental health legislation.

13. The panel concluded that the suitability of the care and treatment EF received from the Trust was compromised by the long delay between his first assessment and his being seen by the Community Mental Health Team (CMHT) assessor. The views of his partner, ML, were not fully considered for an even longer time.

14. The independent investigation panel has concluded that there were several failures concerning the creation and implementation of policies within the Trust. The mechanisms for creating and embedding new national policies on safeguarding children and domestic abuse at Trust level were both slow and inadequate. The Trust versions of these policies were pale imitations of the national policies. The Trust had many policies in place prescribing how service users should be treated, but there were failures to adhere to these policies in this case. For example, notes made by Psychological Services Sheffield and the special psychotherapeutic service were not contemporaneous with interviews, nor were they integrated with the medical and electronic note systems and, consequently, information was not available to colleagues.

15. Opportunities to initiate referral under the Safeguarding Children policy were missed at least twice.

16. National policies on safeguarding children and domestic abuse were being developed in the early 2000s leading to the introduction of significant legislation such as the Children Act 2004 and the Domestic Violence, Crime and Victims Act 2004. The Inter-Ministerial Group was an important driving force behind the changing policy landscape. Public bodies such as police forces and health services were expected to implement the new policies but it is quite clear that working practices within these organisations did not change as quickly as policymakers hoped.

17. Similarly, issues concerning Safeguarding Children were not picked up. The policies existed at national level and were in effect as the commencement date for the Children Act 2004 was 1st October 2005. It is unclear what frontline staff would have known about their legal obligations in the months leading up to the publication of local policy documents and the accompanying training.

18. Information sharing and confidentiality issues have been identified as having a bearing on this case, but it has to be acknowledged that the need for agencies to share information was then only just being recognised. The opportunities for sharing information with other agencies in the form of domestic abuse partnerships had been around in Sheffield since the mid 1990s but the more formal Multi Agency Risk Assessment Conference (MARAC) was not set up until July 2007. The level of abuse in the EF/ML relationship might not have been of sufficiently high risk to be MARAC eligible, so the MARAC system should not be relied upon to pick up a case like this. Lower-level information sharing remains important.

19. Trust staff came across evidence of domestic abuse with implications for the welfare of FL (their child) where no action was taken. Traditional approaches to clients as individuals rather than as partners and parents may have been part of the explanation.

20. The pace of introducing new Trust policy documents and consequent staff training on new approaches and new expectations is of concern to the independent investigation panel. The new expectations on staff are to be much more active in how they think about what they come across in their professional work and to be prepared to break the traditional rules of client confidentiality to protect the safety or development of third parties.

21. There is also the quality of the Trust policy documents which do not convey the importance of these policy and practice changes in the vivid way found in the original central government documents. The evidence bases found in the original documents contain some important, if not startling, information on the outcomes of abuse. They also set out the risk factors, generated by research, which might help staff make connections between what they see in clients' behaviour and Trust policies. The recognition factor, the first step in a process, helps determine the outcome.

22. The Trust's adult mental health services did not know about the increasing number and frequency of ML's calls to the police during 2007. The Sheffield Multi Agency Risk Assessment Conference (MARAC) was in its early days and this means of communicating information between the South Yorkshire Police and the Trust was not functioning as it does now in 2012. The independent investigation panel has been assured that EF's behaviour would now come to the attention of MARAC and in those circumstances EF would have been offered further appointments by the Trust.

23. ML reported to her health visitor in September 2006 that she had experienced both physical and emotional abuse from EF. Their child, FL, had witnessed some of these incidents. The child protection issues were relayed to both the Community Mental Health Directorate of the Trust and to Social Services. No information was available to the independent investigation panel about any action taken by Social Services. In later encounters with Adult Mental Health Services ML repeated these statements but the interest and activity was always on EF, his mental state, and his risk of self-harm. The Trust's policies on domestic abuse and safeguarding children do not seem to have been applied in this case.

24. Both primary and secondary health services knew that ML was the victim of domestic abuse at EF's hands but their knowledge of its nature and extent was limited to what she told them. ML seemed never to have felt seriously threatened by EF, regarding his behaviour towards her as a nuisance rather than as a threat to her life. ML did, however, worry that EF might try to abduct and smuggle their child out of the country.

25. The City of Sheffield as a whole seems to have been out of step with the development of interagency arrangements to tackle domestic abuse. Multi Agency Risk Assessment Conferences (MARACs) were established elsewhere as early as 2006, the Sheffield MARAC was set up in July 2007.

26. The independent investigation panel concluded that there is very little documentary evidence about the interface, communication and joint working between the agencies engaged in providing care for EF and ML's mental health and social needs.

27. The independent investigation panel found that four separate organisations (General Practice, the South Yorkshire Police, the South Yorkshire Probation Service and the Trust in the guise of its Adult Mental Health Services, Maternal Mental Health Services, Social Services, Psychological Services Sheffield and health visitors) were all involved in the lives of EF, his onetime partner ML and their child FL over the period between 2004 and 2007, though not all of them were involved simultaneously.

28. Communications between some health agencies were good when the GPs were involved, they copied their correspondence to other agencies and Adult Mental Health Services responded. Whether there was any information feedback from Social Services to the GP and the Health Visitor, then to Adult Mental Health Services concerning FL's development in a household with domestic abuse is unclear as there is nothing in the records. No evidence is available of any direct communication between Adult Mental Health Services and the South Yorkshire Police, though Trust staff had evidence of a relationship characterised by domestic abuse.

29. The independent investigation panel found it difficult to establish the perceptions of EF's family of the level and quality of the care and treatment provided as EF's father had died and an older sibling has lived abroad for some years. EF had two half siblings but apparently had little contact with them.

30. The independent investigation panel was able to meet ML's parents and a sibling. The rationale is that ML had been EF's principal carer for several years, even when their relationship had broken down. ML was protective of her parents and they had limited knowledge of EF's care and treatment.

31. The independent investigation panel looked at the quality of the internal investigation report to assess the quality of the action plan. The panel used an audit tool which allowed the assessment of the internal investigation report against a common standard. The common standard is the 'good practice' set out by the National Patient Safety Agency in 2008.

32. The report of the internal investigation on EF was of good quality and the panel went beyond their terms of reference when they discovered failures to comply with Trust policies, for example, record making, or when they found Trust policies 'not fit for purpose' as in the Serious Incident policy. The internal investigation panel took the decision not to interview any Trust staff who provided EF's care and treatment, choosing to rely on documentary materials some of which they knew to be deficient. The panel drew sound conclusions from the material they saw and their recommendations were wide enough to cover their extended remit. Three aspects of the internal process are open to criticism: first, the Trust's failure to interview the staff involved in EF's care; second, the Trust's failure to provide support for staff who worked with EF; and third, the failure to show those staff the report and its action plan.

33. The internal investigation report meets all the criteria suggested by the NPSA; it does not have any areas that are deficient. The report is a clear and careful exposition of the issues central to the EF case. The panel provided a clear and logical account of what happened and the positives and the negatives of the Trust's involvement with EF. The panel were even-handed in their approach as they identified and explained problems with the records kept by Psychology Services Sheffield. They identified the various contributory factors which led to the homicides and drew clear lessons from what they found. The recommendations produced are consistent with and clearly linked to the findings.

34. The independent investigation panel believes that it is not good practice for the staff who worked directly with EF not to have been made aware of either the internal investigation report or the action plan. The action plan was supposed to affect their daily working practices, and in one case the practices they were managing.

35. The independent investigation panel has been provided with a considerable amount of evidence by the Trust to show that it has implemented six recommendations in the (undated) action plan. The Trust is now engaged with the city-wide MARAC that brings together all the agencies working with domestic abuse. An Assistant Director or a nominated deputy attends all the MARAC meetings and practices relating to MARAC and safeguarding children are described as being much more robust than previously. Risk assessment policies, procedures and screening tools all now include reference to domestic abuse and a new risk-assessment tool has been developed. This tool is structured so comparable information is collected systematically on each service user. Carers and relatives are involved whenever possible in risk assessments and management plans. They can attend multi-disciplinary team meetings when consent is given. Work has been done to make initial assessments more effective so service users are not asked to repeat their history every time they meet a new member of Trust staff. Staff are being encouraged to trust their colleagues' judgements and skills when recording information and making assessments. Serious incident management procedures are streamlined and made less complicated. In-house capacity to conduct investigations has been established. A Policy Governance Group has been established to ensure a consistent approach to the development and production of all policies. All Trust policies are now available on the Internet and the Trust's Intranet.

36. The Trust's response to the action plan is silent on issues such as the involvement of staff in the investigation process, the support of staff whose clients have been involved in serious incidents such as this, and the exposure of staff to action plans, especially when they directly affect their daily work. No reference is made to any processes of monitoring the keeping of records, or to the more significant problem of how to embed new policies into staff's daily thinking and routines. The independent investigation panel has been informed that the Trust has a new policy on note taking and record keeping but is not clear how well the new policy meets its concerns about the robustness of monitoring.

37. The independent investigation panel concluded that the Trust's response does not mention any systematic auditing of practices to check that these good intentions are grounded in everyday activities. For example, checks should be made at regular reviews of contemporaneous record making and recording. The Trust now has regular audits which include checks made on the integration of specialist services' notes and records into the medical records and the electronic record system. If the Trust is serious in its efforts to share information with other agencies, it must ensure that the information shared with colleagues is recorded as soon as possible before recollections fade or are altered in the light of other events.

38. The independent investigation panel found that while many changes have resulted from the action plan it is difficult to assess the impact of these changes on either frontline clinical practice or patient outcomes. Other changes seem to have had a greater impact, for example, the establishment of regular team governance meetings that work with waiting list issues. Work has been done on single data capture of service users' histories. The organisation of the psychotherapy service (which includes CAT) was not mentioned in the action plan but waiting times have been reduced in this area. Information sharing within teams has been improved and there are now clearer routes for discussing issues relating to confidentiality. Service users can now expect to be the subject of an initial risk assessment and they are assessed again when their care plan has its annual review. Changes to the care pathways have had a greater impact than the changes set out in the action plan.

39. Also outside the action plan, the psychotherapy service has been reorganised which means there is now a more integrated psychotherapy service. Some psychotherapy expertise is now to be found within sector teams. This means that for some, at least, waiting times for CAT have been reduced. The quickest route to access CAT, either through the specialist service or through the CMHT, is not clear. The waiting time could still be six to twelve months unless an urgent need is apparent after initial assessment that occurs four to six weeks after referral. A lack of clarity in how CAT is managed across the Trust still persists; a centralised waiting list has only recently been organised as psychologist trainees, trainee and junior doctors have been doing some of this kind of work on an *ad hoc* basis. When the psychologist providing CAT in the South-West Sector Team was on maternity leave during 2011 she was not replaced.

40. The independent investigation panel noted that EF's mental health did not play a part in his trial but his mental state was part of the prosecution case. The Judge did not find mental health a contributory factor in this case and the defence did not employ a mental health defence. The prosecution argued that EF's offences were the result of his extreme feelings of jealousy when ML ended their relationship and started to look for relationships with other men.

41. The Judge did, however, mention EF's recurrent depressive disorder as a mitigating factor when it came to setting the tariff for the life sentence. The Judge gave as much weight to his depression as to EF's previously good character when setting the minimum time EF should serve in custody before being considered for possible release on licence.

Recommendations

42. The following recommendations derive from the independent investigation panel's review of the documentary materials provided by the Trust and the information acquired in interviews and correspondence with members of the Trust and other organisations.

Recommendation 1 - The Trust should ensure that when urgent requests are made for initial appointments these are dealt with in line with the acute care pathway and this should be the subject of audit on a regular basis.

Recommendation 2 - Staff should develop a more co-ordinated approach to avoid multiple versions of basic case history information being taken.

Recommendation 3 - Risk assessments should be improved by seeing service users in as many contexts as possible, and include inputs from carers and others in close contact with the service user whenever this is possible.

Recommendation 4 - The Trust should develop robust methods of reviewing its information sharing policies (both internal and external) to assess their effectiveness and to implement changes as required. Reviews should include investigations of the timeliness of responses from other agencies.

Recommendation 5 - The Trust should carry out regular audits of activities such as record creation ensuring that Trust policies are being carried out in a timely manner and staff supervision should be used to check that notes are made contemporaneously with appointments (i.e. within 24 hours) and that any subsequent formal record accurately reflects the nature of the discussion to ensure their trustworthiness.

Recommendation 6 - When new relevant policy initiatives are announced they should be discussed at the next Trust Board meeting and a process should be put in place to ensure that the Board is kept informed of developments through to implementation including ensuring a review of the internal policy. The Board should consider obtaining external assurances on the quality of major new policies**.**

Recommendation 7 - The Trust should produce a policy on the provision of Cognitive Analytical Therapy (CAT) within the Trust and the policy should include clear criteria as to who is qualified to provide CAT and how staff providing CAT are to be trained and supervised. A centralised waiting list should also be organised. The Trust should aim to make the provision of CAT more systematic and prevent localised fragmented provision**.**