Independent review into treatment and care provided by Oxford Mental Health NHS Foundation Trust

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Report prepared by: Anne Richardson
Anne Richardson Consulting Ltd

Investigators: Dr. Hugh Griffiths MBBS FRCPsych
Prof. Adrian Childs RGN Dip.N (Lond) MSc RMN
Ms. Anne Richardson BSc MPhil FBPsS
Ms. Lisa Haywood

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Commissioner: Mr. Lucien Champion,
Head of Investigations, NHS England South (South Central), Jubilee House, 5510 John Smith Drive, Oxford Business Park South, Oxford, OX4 2LH

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EXPERIENCE, KNOWLEDGE AND EXPERTISE IN MANAGING RISK

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1. Introduction

1.1. This is the report of an investigation commissioned by NHS England into care and treatment provided by Oxford Mental Health NHS Foundation Trust (`the Trust') for `X' who was in contact with community mental health services when, in a severely disturbed psychotic state, she tragically killed her son. We would like to extend our sincere condolences to this young child's extended family for their very sad loss. We would also like to extend our condolences to X herself; she clearly loved her son dearly but was then and is still now, very unwell.

1.2. Details about how the investigation was commissioned; its Terms of Reference; the team, and the methodology we used can be found in the main report attached. We would like to thank all the staff and organisations who agreed to participate in the investigation process. The team is also grateful to the Trust for assisting us to access policy documents, case notes and other material relevant to the care that was provided for X whilst she was under their care.

2. Background

2.1. A full chronology of the care and treatment provided for X may be found in the main report. Briefly, records and information from X and her family describe how she was born in London and first developed mental health problems in her mid to late twenties. X's first admission was at the age of 28 to St Charles' Hospital (part of the St Mary's group of hospitals within Central and North West London) with depression following an overdose. Between then and the point when X moved to Oxfordshire in 2015, X was admitted ten times to psychiatric hospitals. X was given several different diagnoses over this period including depression, paranoid personality disorder, psychotic disorder, emotionally unstable personality disorder, schizophrenia and Bipolar disorder.

2.2. In August 2011, X presented herself to services as she was happily pregnant and concerned in case her tablets which included Olanzapine (an anti-psychotic) might harm her baby. The assessing psychiatrist judged X to have symptoms of recurrent depression with severe depressive episodes with psychotic symptoms and thought she might have experienced at least two hypomanic episodes. She therefore gave a `probable' diagnosis of Bipolar Affective Disorder (BPAD). X's treatment and care appears to have been managed effectively; X's baby was born safely, and mother and baby remained well for the next two years.

2.3. Two years later, in May 2014, X moved to Swindon to find a better life for herself and her son. However, by Christmas 2014, X was beginning to show signs of relapse. In January 2015 X presented in A&E in Swindon with thoughts of suicide. Unwilling to give her previous address or provide information about her family/next of kin, X reported that she had a diagnosis of bipolar disorder; she also expressed paranoid thoughts about her son's safety but, on further questioning, she denied thoughts or plans to kill or otherwise harm him. A decision with X's consent was taken to place her son into foster care and X was admitted (her tenth admission) with acute and florid paranoid delusions, auditory hallucinations and suicidal ideation. X was given a diagnosis of paranoid schizophrenia. X's parents were unaware of any of these events and they remain upset that services complied with X's wish not to inform them of her or their grandson's whereabouts.

2.4. After seven weeks at the end of February, X was discharged, and her son was returned to her care. X then indicated that she would prefer to move way from Swindon because of transport problems and because, in her psychotic state, she was anxious that `her mother would find her if she stayed'. X's medication was increased (Sertraline 100mg and Risperidone 1mg) and she was given a prescription for two weeks. In 2015, X moved to Faringdon and continued to say that she did not want her parents to know where she was. The Oxford GP after consulting with X herself, wrote a letter in June 2015 to the local mental health services to ensure that follow-up and/or continuing care could be provided.

2.5. At this time in Oxford, apparently in the interests of providing services more seamlessly `crisis resolution' and `assertive outreach' functions had recently been

incorporated into single multi-disciplinary Adult Mental Health (AMHT) teams. Whilst it was policy to see routine referrals within 4 weeks, urgent referrals within 7 days and emergency referrals within 4 hours, staff shortages led to a single assessment team based in Wallingford delivering this function for the whole South Oxford service. There were some delays in the initial referral getting through and, owing to difficulties travelling (X reported a longstanding phobia of public transport) and given that she was reportedly feeling quite well, agreement was reached to offer X an appointment for September 7th at an outpatient clinic managed by the Consultant Psychiatrist on site in the GP's surgery which she could easily reach.

2.6. The consultant found X to be very well when he saw her with her son; there were no signs of mental ill health and the he stated this clearly in his letter back to the GP. The consultant stated that X's diagnosis was `probable bi-polar II disorder'. It subsequently became clear that not all the relevant history had been provided to him and that the information provided by X was partial, especially regarding her previous psychiatric treatment. Furthermore, it has become clear that X could present very well (behave in a socially appropriate manner, withhold details about her thoughts) even when quite unwell. After this, for the next few weeks X was seen regularly by the South Oxon Community Adult Mental Health Teams. X was also seen by her social worker and the Health Visitor. X's son attended infants' school locally. However, X's CPN, the care coordinator, was due to move and she saw X only three times before she left due to what were described as very severe work pressures for the South Oxon service.

2.7. No formal Risk Assessment form, nor a formal Care Plan was completed before the Care Coordinator left, although the notes contain a narrative description of the supportive care that was provided. By February 2016, the team was ready to discharge X. The Consultant wrote to the GP to say that X appeared to be managing well, though he commented that her mood remained variable. He affirmed to the GP that X was taking Lithium as well as small doses of antidepressant and antipsychotic medication; he also confirmed that the team would be content to see her again, if necessary.

2.8. By June 2016, X had become anxious about an impending `return to work interview' prompted by the fact that X's benefits were due to be curtailed when her son turned five and, on 21st July, X called an ambulance as she was having suicidal thoughts. The ambulance service (SCAS) referred X to the Multi-Agency-Safeguarding Hub (MASH) and more detail about this period is provided in the report of the Serious Case Review prepared by Oxfordshire's Serious Case Review Board. The GP then referred X for help with her phobia of public transport and referred her back to the AMHT who saw her on 4th August 2016.

2.9. Once again, no formal Risk Assessment was completed and, apart from her travel phobia, staff recorded X as showing no signs of mental illness. The team therefore made a referral to psychology services. Although the psychologist reported some concerns to the team, which was by now, led by a new Consultant Psychiatrist (the earlier incumbent having left in July 2016) regarding X's presentation and history which indicated a more complex picture, it was agreed to continue with the plan to offer treatment for her travel phobia and X was not at this point being seen by anyone else. X reported to the psychologist that her mood was relatively low, but she said that the presence of her son stopped her from taking action to harm herself.

3. The incident

3.1. Notes record that in early March 2017, X became concerned about how her child was being treated at school and she wrote to the Acting Head about the behavior of another child who, she thought, might have been bullying him. The school responded by monitoring the children very carefully (no evidence of bullying was found) and a meeting with X was arranged. The following Monday 13th March, X's child failed to attend school and, as X had not alerted the staff which was unusual, staff visited X at home, but they failed to get a response. The next day, Tuesday 14th March 2017, after X's son was absent from school for a second day, staff visited X's home again; thinking that they saw a curtain move. Aware that X had a history of mental ill health and might be unwell, they called the Police. Police then found X with moderately severe self-inflicted cuts to her arms and throat and they found her son's body upstairs; he had died from multiple stab wounds. X was detained on a Section 2 of the MHA.

3.2. On 20th April 2018 X's plea of manslaughter on the grounds of diminished responsibility due to mental ill health was accepted by Oxford Crown Court, a plea that was recommended as appropriate by both independent specialist forensic psychiatrists, and by the Consultant Forensic Psychiatrist with responsibility for X's care. X was sentenced an `indefinite' Hospital Order (Section 37/41[1] of the Mental Health Act (MHA)) and she remains in secure psychiatric care.

4. Findings and conclusions

4.1. A full chronology of the care provided for X can be found in the main report, along with detailed findings in relation to the items set out in the Investigation Team's Terms of Reference (which can be found in the main report in Appendix 1). Our team was asked to consider if this incident was predictable, preventable or avoidable and comment on relevant issues that may warrant further investigation.

4.2. Our team has concluded that for X's son's death to have been preventable there would have to have been a level of knowledge; an opportunity to intervene, and the legal means to do so. Very sadly, the evidence suggests that information relating to all three of these elements was severely restricted.

4.3. Staff knew that X cared deeply for her son and that she had no intention of hurting him. When she became mentally unwell, for example in Swindon, appropriate action was taken, with her consent, to take her son into care and admit her as a voluntary patient to hospital. However, when X was a patient in Oxford two years later, not only did she seem well, she did not fully disclose her thoughts or her full history, despite having the opportunity.

4.4. It is possible that elements of X's behavior were misinterpreted. For example, X had paranoid thoughts about her mother and she was feeling fearful for her son's

[1] Section 37/41 of the Mental Health Act is used to detain someone in secure mental health care. S. 37 is also known as `a Hospital Order' and S.41 is also known as a `Restriction Order'. These Sections restrict discharge, transfer or leave without agreement from the Secretary of State. Medication can be given without consent (although consent is always sought). All detentions under the MHA are governed by the Mental Health Act Code of Practice.

safety, especially at night. With hindsight, it appears that these were signs of a relapse of her psychotic illness. However, it is not unusual for patients in mental health settings to insist that their families should not be contacted, and therefore mental health staff complied with X's wish.

4.5. Had staff been aware of how ill it subsequently transpired X was, it would potentially have been possible to use the Mental Health Act to detain her against her will. Had staff been able to speak to X's parents, it is possible that they could have stepped in to provide care for their grandson. However, there appeared to be no reason to trigger a Mental Health Act Assessment and X was, due to her paranoid state, strongly of the view that her parents should be kept in the dark. Together, the evidence gathered during our investigation about the quality of care that was provided for X, does not suggest that the tragic death of her son could have been predicted or prevented.

4.6. Whilst the evidence gathered during our investigation about the quality of care that was provided for X, does not suggest that the tragic death of her son could have been predicted or prevented, our team considers that there were still shortcomings in the care that was provided for X. For example, there was no care plan and no risk assessment; a diagnosis was made which relied too much upon X's personal testimony and current presentation than the full history of her contact with mental health services. Furthermore, X's treatment with Lithium, whilst it was consistent with her presentation and self-report of BPAD, also failed to be consistent with historical evidence that subsequently emerged regarding her diagnosis (schizophrenia) which suggests that ongoing anti-psychotic medication (in addition to if not in place of Lithium) would likely have been important to provide.

4.7. The shortcomings that the report of the internal investigation and our own investigation identified cannot be attributed to any one person's failure. A combination of factors together led to the failure to identify, treat and manage X at the time she became acutely unwell with symptoms that, by her own admission, she was reluctant to disclose. Many of these issues have been addressed within the framework provided by an Action Plan prepared by the Trust after the internal investigation was completed.

4.8. It is with an enduring sense of profound loss that everyone associated with this case will consider these circumstances. Our team hopes, by highlighting the following areas to strengthen care, we support a group of caring and ultimately competent staff to deliver the quality of mental health services that we know they are highly motivated to provide.

5. Recommendations

History taking, formulation and diagnosis recorded in case notes

5.1. We note that the Trust Action Plan includes steps to ensure that clinical team leads encourage and require their staff to collect such information, record a summary and a presumed diagnosis in the front of the clinical record and communicate this to partner services, where appropriate. We note that steps have been taken to implement this. In addition, we recommend an audit of care records across the Trust should be undertaken in six months' time to check that the new system is working effectively.

`Think Family' inter-agency communication

5.2. In addition to monitoring carefully the implementation and impact of their revised `Think Family' policy, our team recommends that staff should be prompted to ensure that families (as appropriate) and partners in primary health, social care and education are engaged, informed and heard whenever there is a potentially vulnerable child involved.

Risk assessment, relapse prevention and information sharing

5.3. The Trust's internal investigation made a recommendation relating to training for qualified staff to assess risk. A thorough assessment should include information from the patient, his or her family, carers, primary care and other agencies, as appropriate. When a patient's permission to disclose information is withheld, and whilst it is important to respect patients' rights, we recommend that training should be provided for staff to balance their legal and professional responsibilities to ensure that potentially vital information to assist in case formulation and the assessment and management of risk is collected. We recommend that training content and provision are audited to ensure that this is done.

5.4. NHS England/NHS Digital should consider how to develop current patient information systems to promote timely information sharing across NHS services for example that a chronology of health episodes is visible to all. This would enable practitioners to seek or request further information from other health providers to inform future assessments.

Pre-registration training

5.5. We recommend that NHS England consider with Health Education England the scope to strengthen guidance for those with responsibility for pre-registration training of NHS staff regarding their legal and professional responsibilities in law (MHA, Data Protection, NHS Constitution) to protect patients' privacy and the confidentiality of their medical information which is balanced with the responsibility to provide a safe environment, including for staff, families, children and the public.

Shared care

5.6. We note that steps have been taken by the Trust to review and refresh their shared care protocol for the management of patients taking Lithium and that steps have also been taken to ensure that information about risk is communicated effectively. We recommend that an audit be undertaken of a sample of patients in receipt of shared care to understand whether this is effective or whether there are still concerns.

Care management, care coordination and communication

5.7. Trust policy is already clear in requiring patients in contact with specialised mental health services to have a care plan. We recommend the Trust pay special attention through clinical audit to ensure that care planning, care coordination and communications policies are followed, especially at times when staffing levels, resourcing or organisational change present a challenge.

INDEPENDENT INVESTIGATION INTO CARE AND TREATMENT PROVIDED FOR X BY OXFORD MENTAL HEALTH NHS FOUNDATION TRUST

1. Introduction

1.1. This is the report of an investigation commissioned by NHS England into care and treatment provided by Oxford Mental Health NHS Foundation Trust (`the Trust') for `X' who was in contact with community mental health services when, in a severely disturbed psychotic state, she tragically killed her young son. We would like to extend our sincere condolences to this young child's extended family for their very sad loss. We would also like to extend our condolences to X herself. X clearly loved her son dearly and was then, and is now, very unwell.

1.2. Oxford Crown Court ruled on 20th April 2018 found X to be guilty of manslaughter on the grounds of diminished responsibility due to mental ill health; she was sentenced to an indefinite hospital order (Section 37/41[2]) under the Mental Health Act (MHA) and she currently remains in secure psychiatric care at Littlemore Hospital in Oxford where she is receiving treatment.

1.3. This investigation, commissioned by NHS England, was established under the Department of Health Article 2 of the European Convention on Human Rights and guidance published by NHS England[3] for investigating serious incidents in mental health services.

1.4. Specific Terms of Reference (TOR) were developed for the work (see Appendix 1) that required the investigation team to focus on present day services and current processes, as well as look back over events prior to the incident. The TOR were designed to focus the investigation upon the quality of care provided; to help X, X's family and the staff to understand what happened; whether there were failures of care and identify any necessary learning to strengthen and improve services. The TOR also specified that investigators should review procedures used in an initial independent report commissioned by the Trust that was submitted in October 2017; establish whether its recommendations were

[2] Section 37/41 of the Mental Health Act is used to detain someone in mental health care. S. 37 is also known as `a Hospital Order' and S.41 is also known as a `Restriction Order'. These Sections restrict discharge, transfer or leave without agreement from the Secretary of State. Medication can be given without consent (although consent is always sought). All detentions under the MHA are governed by the Mental Health Act Code of Practice.

[3] NHS England Patient Safety Domain (2015) `Revised Serious Incident Framework: Supporting learning to prevent recurrence.' www.england.nhs.uk/patientsafety/

sound and assess any remedial actions taken since then. The four recommendations that were made in this report can be found in Appendix 2.

1.5. Appendix 3 contains details about the investigation team (our team) that was appointed by NHS England in February 2018. The team included individuals with a wide range of relevant skills and training including Psychiatry, Nursing, Clinical Psychology and lay representation.

2. Methodology

2.1. An initial `scoping' meeting was held on 8th March 2018 with the commissioner of the investigation (NHS England); representatives from the Trust in Oxford and their local commissioners and two other trusts (Avon and Wiltshire Partnership and South London and Maudsley) with whom X had had contact in the past. Agreement was reached about the methods our team would use to examine the facts of the case, identify ways in which care might have been altered or improved, and to understand how systems for delivering care and managing risk are currently working.

2.2. Arrangements were agreed to conduct personal interviews with staff and undertake a desktop review of policies and clinical case notes. Meetings were held with X and with X's parents to outline the aims of the investigation and gather information. Consultation was also undertaken with those involved in the Serious Case Review for Oxfordshire Safeguarding Children Board and with local Police.

2.3. We would like to thank all those who were involved, including X who gave her permission to access her medical records and speak to those involved in her care. Appendix 4 contains a list of Trust staff with whom the investigation team spoke about the care and treatment provided for X around the time of this tragic incident and/or afterwards.

2.4. Adapted Salmon Principles[4] were used for this non-judicial investigation meaning that all those interviewed personally were contacted in writing with information about the investigation and its Terms of Reference. They were

[4]The Salmon Principles are six requirements set out under the Tribunals and Inquiries Act 1921 designed to ensure fair and appropriate procedures are used in the conduct of investigations. This investigation was not judicial, and solicitors were not involved in the investigation process.

offered the opportunity to be accompanied to the interviews, if they wished and at least two interviewers were always present. All the meetings, with the exception of those with X and her family, were recorded. Written accounts of the interviews were then verified for accuracy by each witness before being `signed off.' All witnesses were assured that their testimony would be confidential and that no personally identifying information would be included in the report (although it remains true that a Court may subpoena witness statements in certain circumstances).

2.5. Appendix 5 contains a list of the Trust policies, case notes, records and correspondence reviewed by the team over the course of this investigation.

3. Background

3.1. A detailed chronology of care provided for X over the course of her adult life is provided in Appendix 6. A narrative summary of the facts of the case, information about X's personal and psychiatric history, the incident, its antecedents and consequences is provided below.

3.2. The records show that X was born in London, the oldest of four children with three younger brothers. During subsequent interviews with professionals providing care, X and her parents indicated that there was a family history of severe mental ill health. X herself first appears to have developed mental health problems in her mid to late twenties. In 2004 at the age of 28 she was admitted briefly to St Charles' Hospital (part of the St Mary's group of hospitals within Central and North West London) with depression following an overdose. A presumptive diagnosis of personality disorder was made. X subsequently fell out of contact with services and was lost to follow up.

3.3. Two years later, by which time X had left home, she contacted the South London and Maudsley Hospital (SLAM) Out of Hours service. The assessing doctor reported X to have said that she had begun to hear a controlling and domineering male voice that introduced himself as `John' over a period of 6-9 years. X's mother had also contacted services because of concern about X who had lost weight and was standing still staring for long periods. X and her mother came together to St

Mary's in north London and in February 2006 X was admitted for the second time to St Charles'.

3.4. The notes indicate that two months later in April 2006 X took an overdose whilst she was on trial leave from St Charles'. It appears that she was offered a local (to her flat) appointment at the SLAM emergency clinic which she missed. However, X was then followed up by the St Charles' Early Intervention Team - a community team with expertise in working with people showing the first signs of psychosis and she was given a diagnosis of schizophrenia.

3.5. In July 2006, X's third admission was to Ruskin Ward within Guy's Hospital after she presented to the SLAM Emergency Clinic. At this time, X is reported to have described paranoid thoughts relating to her employers who she said had previously been investigated for fraud. X was not given a formal diagnosis. However, the records showed that X had previously been prescribed Amisulpride and Risperidone (anti-psychotics) and it was noted that she had some rent arrears and other debts.

3.6. X's fourth admission came late that same year in September, but this time to St Mary's Paddington as X had left her flat and gone back to live with her parents in West London. A diagnosis was made of paranoid personality disorder. Two further brief admissions to St Charles' followed in October (6 days and 14 days) after X took a further overdose and presented to A&E with thoughts of suicide.

3.7. A seventh admission to St Charles' in February 2007 was for a much longer period of five months. X had been neglecting her personal hygiene, failing to eat, had lost weight, and had been hiding a knife. However, clear signs of psychosis only emerged towards the end of the first month of X's inpatient stay when her diagnosis was given as Psychotic Disorder[5]. The psychiatric staff did not consider that X's symptoms met the criteria for a diagnosis of schizophrenia at this time.

[5] This diagnosis is described in ICD-10-CM, the WHO International Classification of Diseases, as `Code F28' or `Other psychotic disorder not due to a substance or known physiological condition.' As such, it is distinguished from schizophrenia which requires so-called `first rank' symptoms such as delusions or hallucinations to be present for a month or more.

3.8. X's eighth admission was to the Maudsley Hospital in March 2009 after she was detained on Section 136 of the Mental Health Act (MHA) by the Police after threatening suicide. This was a serious plan on X's part to end her life: she had reportedly ceased taking her medication two months previously and had told her Care Coordinator earlier that month that she thought people could read her thoughts. X went to the balcony of her 19th floor block with a clear plan to jump. Fortunately, she telephoned her mother for help and her mother called the police. On this occasion, X was given a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and she was started on Lamotrigine (a mood stabilizer).

3.9. X's ninth admission came a year later in November 2010 when she was admitted to the Patterson Centre (part of St Mary's, Paddington) after presenting in A&E with suicidal thoughts. This was a brief admission during which X showed no clear signs of psychosis.

3.10. The following year, in August 2011, X presented herself to services as, by now, she was happily pregnant and concerned lest the medication she was taking which included Olanzapine (an anti-psychotic) might harm her baby. X's midwife referred X to the peri-natal mental health team at St Thomas' Hospital. X reported experiencing periods of elated mood, had spent money on her credit cards, and accumulated a significant level of debt. The assessing psychiatrist judged X to have symptoms of recurrent depression with severe depressive episodes with psychotic symptoms and thought she might have experienced at least two hypomanic[6] episodes. The psychiatrist therefore thought it appropriate to give a `probable' diagnosis of Bipolar Affective Disorder (BPAD). X's parents did not then, and do not now, agree with this diagnosis. However, it is important to note that it is not uncommon in the early stages of the development of a severe mental illness for several diagnoses to be considered, and it is not uncommon for a patient's presentation to be unclear.

3.11. Owing to the risk of post-partum psychosis (which is a risk for anyone with a psychosis), the team provided full support and monitoring for X, and provided information regarding her drug treatment. A pre-birth Child Protection Conference

[6] The term hypomanic is used to describe elevated or `high' mood that does not interfere too severely with social functioning and does not meet criteria for use of the term `mania'.

was held at St Thomas' Hospital with X's partner, the father of her unborn child, and her parents. A thorough peri-natal care plan was developed. X then received a significant level of support; a care plan, a risk assessment and drug treatment regime were in place. In March 2012, baby T was born and both he and X maintained a healthy and allegedly very happy first couple of years.

3.12. Two years later, in May 2014, X (now age 38) decided to move to Swindon to find a better life for herself and her son. X's mother helped her look for a property and helped X with the move. X reported that her partner, T's father, did not want to go with them to Swindon and they effectively separated after this. By Christmas 2014, X was beginning to show signs of relapsing. X's parents who visited at Christmas said that she was thin, the house was cold, and that X was behaving oddly: switching the heating boiler on and off; walking about at night fearing that she could hear someone. They brought X back with them briefly to London. Baby T was well at this point and was described as a very happy little boy.

3.13. In January of the following year (2015) X, presented in A&E at the Great Western Hospital in Swindon saying she felt low in mood and was having thoughts of suicide. She was unwilling to give her previous address or provide information about her family/next of kin. However, she did tell staff she had a diagnosis of bipolar disorder. X said she had stopped taking her Lithium four weeks earlier; she expressed paranoid thoughts about her son's safety but, on further questioning, denied thoughts or plans to kill or harm him.

3.14. After assessment, a decision with X's consent, was taken to place her son into foster care and X was admitted (her tenth admission) in January to Applewood Ward in Swindon with acute and florid paranoid delusions, auditory hallucinations and suicidal ideation. Her personal hygiene was also poor. X was given a diagnosis of paranoid schizophrenia and prescribed oral Aripiprazole to which she apparently responded well, and she was discharged after a few days with support from the Home Treatment Team. At this time, she had supervised visits with her son and after his death X reported she thought he had been bullied whilst he was in foster care. X's parents were unaware of any of these events and they remain upset that services complied with X's wish not to inform them of her or their

grandson's whereabouts as they would happily have cared for X's son rather than have him go into care.

3.15. After seven weeks at the end of February, X's son was returned to her care, albeit less quickly than X would have liked, and she was supported by the Swindon Intensive Service, by social work staff and her Health Visitor. X's risk summary was updated appropriately in the notes and her mental health remained stable. X was seen in outpatients by the consultant psychiatrist and, in his summary letter, he described X as `somewhat wary and anxious and I think with a paranoid tinge.' He referred to X's view that she would prefer to move away from Swindon because of transport problems and because `her mother would find her if she stayed'. X's medication was increased (Sertraline 100mg and Risperidone 1mg) and she was given a prescription for two weeks.

3.16. In June 2015, X moved to Faringdon as part of a Council house swap scheme which she arranged herself. Her Swindon Health Visitor (HV) alerted the community based (in primary care) Oxford Health Visiting services, partly because of X's mental health needs and partly because her son had been recorded only as a `Child in Need' in Swindon (it was not thought appropriate to list him on the Child Protection register). X was allocated a Health Visitor (HV) who then saw X every 6-8 weeks with her son until February 2017 when he turned five.

3.17. X registered with a local GP to whom she indicated that she was content for information to be shared with local mental health services about her care. However, she continued to say that she did not want her parents to know where she was. A fax was sent to the GP on June 17th2015 from Swindon. This contained the letter dated 21st April from the Swindon Consultant Psychiatrist to X's Swindon GP containing partial information about her clinical history; the fax outlined that X had had `three previous admissions' (sic) and that her diagnosis had varied. The fax contained a summary of the initial assessment by the A&E Department to which X had initially presented herself; a summary of care provided by the Swindon Intensive Service that supported X after her admission, and a discharge letter.

3.18. The Oxford GP after consulting with X herself, wrote a letter dated 29th June 2015 to the local specialised mental health services to ensure that follow-up and/or continuing care could be provided. She marked the letter `Urgent Referral' and summarized what she knew: that X had been `told that she has bipolar disorder and maybe schizophrenia'; that she had an admission eight weeks previously, and that her son had been taken into foster care.

3.19. At this time in Oxford, in the interests of apparently providing services more seamlessly, `crisis resolution' and `assertive outreach' functions had recently been incorporated into single multi-disciplinary Adult Mental Health (AMHT) teams. Adult Mental Health Teams were subdivided into `assessment' and `treatment' functions. Whilst staff shortages had led to a single assessment team based in Wallingford delivering this function for the whole South Oxford service, it was policy to see routine referrals within 4 weeks, urgent referrals within 7 days and emergency referrals within 4 hours.

3.20. Unfortunately, it appears that the GP's referral letter was not initially received by the South Oxford community adult mental health assessment team. However, it was faxed across on 8th July after X's GP chased it. The mental health team tried to contact X but were unable to do so immediately as the mobile number given in the referral letter was out of date. In the event, contact was made with X on 16th July when she had an appointment anyway with the GP, and discussion was initiated about an assessment appointment. Owing to difficulties travelling (X reported a longstanding phobia of public transport) and given that she was reportedly feeling quite well, agreement was reached to offer X an appointment for September 7th at an outpatient clinic managed by the Consultant Psychiatrist on site in the GP's surgery which she could easily reach.

3.21. A telephone call between the Swindon and the South Oxford service in early July to solicit further information about her history resulted in a 10-page fax being sent to the AMHT on July 15th 2015 which was scanned in to the correspondence (other) section of the notes and, seemingly as a result, its importance was not subsequently recognised. This contained a copy of the referral letter to the Oxfordshire GP; information about X's admission; a summary from the Swindon

Intensive Service outlining X's paranoid thoughts about her son, and details of her treatment including that her son had been fostered.

3.22. On 8th September 2015, the consultant psychiatrist saw X with a social work member of the assessment team and he wrote back to the GP. The consultant described that he had found X to be very well when he saw her with her son; he had found no signs of mental ill health and he stated this clearly. He commented that X appeared to be getting on very well with her son, who seemed happy and bright. He indicated that preparations would be made to start the Lithium which X had expressed interest in re-starting and he said that the team would continue to see X to assess her further and optimize her treatment. He indicated his view that X's diagnosis was `probable bi-polar II disorder'. He referred to X's (at least) two previous overdoses and to information provided by X about her reasons for leaving London, including what she described as a breakdown in her relationship with her mother. It is now clear that the information provided by X was partial, especially regarding her previous psychiatric treatment.

3.23. For the next few weeks X was seen regularly by members of, first the South Oxon Community Adult Mental Health Assessment Team and then by the Treatment team. She was also seen by her social worker, and every six weeks or so by the Health Visitor. X's son attended infants' school locally. Work was started to support X to manage her debts and help her to negotiate her benefits. However, X's CPN was due to move and she saw X only three times before she left due to what were described as very severe work pressures for the South Oxon service. No formal Risk Assessment form, nor a formal Care Plan[7] was completed before the Care Coordinator left, although the notes contain a narrative description of the supportive care that was provided. Final supervision notes between the care coordinator and supervisor before show that, based on X's needs, no new care coordinator would be allocated, but X would be followed up by the consultant psychiatrist in out-patients.

[7] At the South Oxon AMHT Away Day in January 2016 a decision was taken to review the operation of the community mental health service to lessen the chance that the most complex patients would see staff with whom they were unfamiliar. This policy also strengthens guidance on CPA and sets out the need for formal CPA reviews at least every six months.

3.24. By February 2016, the team was ready to discharge X. The Consultant wrote to the GP to say that X appeared to be managing well, although he commented that her mood remained variable. He affirmed to the GP that X was taking Lithium as well as small doses of antidepressant and antipsychotic medication; he also confirmed that the team would be content to see her again, if necessary.

3.25. By June 2016, X had become anxious about an impending `return to work (benefits) interview' prompted by the fact that X's benefits were due to be curtailed when her son turned five. A decision was taken to refer her to a service called `Talking Space' for help with her phobia of public transport, which was an impediment to travelling to any job. On 21st July X called an ambulance as she was having suicidal thoughts. The ambulance service (SCAS) noted X's concern about her level of debt and her fear that her son might be taken away again. SCAS referred X to the Multi-Agency-Safeguarding Hub (MASH). The MASH team then telephoned X and, after telephoning the Adult Mental Health team and the Health Visitor about X's mental state, the local authority MASH team decided that it was safe not to pursue the referral. More detail about this period is provided in the Serious Case Review report prepared by Oxfordshire's Safeguarding Children Board.

3.26. On 22nd July, X referred herself to `Talking Space.' However, policy dictates (as is consistent with national guidance) that the Talking Space team, part of the Improving Access to Psychological Therapy (IAPT) service in Oxfordshire located in Primary Care, cannot take patients with a diagnosis of severe mental illness (including bipolar disorder). The GP therefore referred X back to the AMHT who saw her on 4th August 2016. Once again, no formal Risk Assessment was completed (although an electronic risk assessment form was opened) which simply states: `no risk identified unless relapses in Bipolar. Managing an awful situation very well'. This refers to information provided to the team by X that she had been the victim of a home-working scam advertised on EBay and was now in greater debt than before. Apart from her travel phobia, staff recorded X as showing no signs of mental illness. The team made a referral to psychology services where waiting times were normally (and are currently) around three months.

3.27. X and her GP chased up the Psychology referral in November and in December and the referral was discussed with the team psychologist in a meeting on December 19th2016. Unfortunately, no formal referral had ever been received by them. The psychology department tried to help X find an early slot with someone else, but the first appointment that X could travel to was 1st February 2017. X was then assessed by the psychologist who found her to be suffering from more than a travel phobia and she discussed her findings and concerns with the team.

3.28. The assessment was thorough; it shows that X was judged to be well oriented, appropriate in her manner, and clear about the difficulties she was experiencing with travelling. Although X reported her mood to be relatively low, she said that the presence of her son stopped her from taking any action and she said she had no plans to harm herself. The notes also record that X may also have recently ended a relationship with a boyfriend she met on Facebook just before Christmas. She reported pressure to return to work at the end of the month when her son would be five years old, and pressure due to certain other benefits and support (e.g., from the Health Visitor) would cease.

3.29. The psychologist offered some advice about managing anxiety and a second appointment was planned for 14th March to leave enough time for X to practice the self-help strategies they discussed. The psychologist fed back her findings to the team which was, by now, led by a new Consultant Psychiatrist (the earlier incumbent having left in July 2016).

3.30. On the 24th February 2017 (incidentally, also the date of X's son's birthday), primary care records contain blood test results showing X's blood Lithium levels to have been very low, indicating that X had stopped taking her medication. Although the GP saw the blood test result, she had recently seen X who appeared to be functioning very well, and she knew X was seeing the psychologist, so she saw no reason to alert the AMHT.

4. The incident and the immediate consequences

4.1. Notes record that in early March 2017, X became concerned about how her child was being treated at school and she wrote to the Acting Head about the behavior

of another child who, she thought, might have been bullying him. The school responded by monitoring the children very carefully (no evidence of bullying was found) and a meeting with X was arranged to discuss it. With hindsight, it appears that X's concerns about her son may have been symptoms of a relapsing or untreated ongoing psychosis. It is also possible as X left Swindon for Oxfordshire that her wish to exclude her mother (with whom she formerly had a good relationship) was part of this.

4.2. The following Monday 13th March, X's child failed to attend school and, as X had not alerted the staff which was unusual, staff visited X at home, but they failed to get a response when they knocked at the door. The next day (Tuesday 14th March 2017), after X's son was absent from school for a second day, staff visited X's home again; thinking that they saw a curtain move and, aware that X had a history of mental ill health and might be unwell, they called the Police. Police then found X with moderately severe self-inflicted cuts to her arms and throat and they found her son's body upstairs; he had died from multiple stab wounds. It is not clear exactly when this happened. X was arrested and taken to the John Radcliffe Hospital for treatment. X initially appeared to be very confused about what had happened. She was detained on a Section 2 of the MHA and transferred to a forensic secure ward in Oxford to receive treatment and to await a Court date.

4.3. The next steps taken by the Trust, police and other services included:

4.3.1. A meeting between the Trust clinical team and X's family;

4.3.2. Independent reports on X's mental state were commissioned from forensic psychiatrists by the Court;

4.3.3. Oxford Health NHS Trust initiated an internal independent investigation into the care they had provided;

4.3.4. Oxfordshire Safeguarding Children Board (LSCB) initiated a Serious Case Review into the care provided by Local Authority social services in Swindon between 2014 and 2015 and in Oxfordshire between June 2015 and March 2017;

4.3.5. NHS England commissioned independent work to investigate the Trust's internal investigation into care provided by and communications about X across the span of NHS care since 2012.

4.3.6. Police commissioned an investigation into the death of X's son.

4.3.7. An Inquest was opened at Oxford Coroner's Court on 6th April 2017 and adjourned whilst other `more substantive' inquiries were completed. Now that the Court case is complete, it is possible that an Inquest will not be held.

4.4. On 20th April 2018 X's plea of manslaughter on the grounds of diminished responsibility due to mental ill health was accepted by Oxford Crown Court, a plea that was recommended as appropriate by both independent specialist forensic psychiatrists, and by the Consultant Forensic Psychiatrist with responsibility for X's care. X was sentenced an `indefinite' Hospital Order (Section 37/41[8] of the Mental Health Act (MHA) and she remains in secure psychiatric care.

5. Findings

5.1. In this section, for ease of reference, our findings are presented in the order that the Terms of Reference (Appendix 1) sets them out. Appendix 2 contains a list of recommendations made in the internal NHS report; these are addressed alongside the TOR items to which they most closely refer.

- **Provide a full chronology of X's contact with mental health services from her first known contact with the South London and Maudsley NHS Trust in 2012**

5.2. A full chronology of NHS care provided for X is provided in Appendix 6. This shows that X had a much longer history of contact with mental health services than either Oxford or AWP knew. X is recorded to have had eleven admissions to psychiatric hospital, including to hospitals in the Central and North West London (CNWL) Mental Health NHS Foundation Trust, South London and Maudsley (SLAM) NHS Foundation Trust, Avon and Wiltshire Partnership NHS Trust and Oxford Mental Health NHS Foundation Trust. It is clear from the records of accounts given by X when in Swindon and Oxford that she restricted the information she provided

[8] Section 37/41 of the Mental Health Act is used to detain someone in secure mental health care. S. 37 is also known as `a Hospital Order' and S.41 is also known as a `Restriction Order'. These Sections restrict discharge, transfer or leave without agreement from the Secretary of State. Medication can be given without consent (although consent is always sought). All detentions under the MHA are governed by the Mental Health Act Code of Practice.

about her psychiatric history and that this is one reason why the records in the clinical notes are patchy.

- **Review the communication and liaison at transition points between South London and Maudsley Trust, Avon and Wiltshire Partnership Trust and Oxford Health NHS Foundation Trust and whether that met policy requirements.**

5.3. The investigation team were able to examine summaries written at points of transition in X's care. These contained information about her diagnosis, care and treatment whilst in contact with SLAM, AWP and Oxford services. There is no reason to think that these documents failed to summarise adequately the information that their authors had. For example, there is a thorough and clear formulation and summary provided about the contact between X and St Thomas' perinatal mental health team at the time of X's pregnancy in 2011 and after the birth of her son in 2012 which was forwarded to AWP when they requested it.

5.4. When X moved from London to Swindon, with help from her mother, she registered with a GP to whom she gave information about her most recent diagnosis (BPAD) and her drugs, which the GP continued to prescribe. After becoming unwell just after Christmas 2014 and after stopping Lithium, X went to A&E and was assessed afresh. The treating psychiatrist said in the correspondence that he was aware of `two or three' previous admissions but was not aware of all the detail. AWP records show that information solicited by AWP from SLAM containing details about X's contact with SLAM was faxed on 8th January 2015 to the Swindon mental health team.

5.5. Appropriate information was also sent from AWP Swindon mental health services to X's Swindon GP and to X's GP in Oxfordshire when X moved to Faringdon. It contained such information as AWP knew about X's history, her diagnoses, her admission, her unwillingness to disclose, her tendency to re-locate, and the fact that she had been so unwell that her child was taken into care. X's psychotic symptoms were described, including her thoughts relating to harm, and it contained information about X's drug treatment regime.

5.6. A 10-page fax containing this information was also sent on 15th July 2015 to the mental health team when they asked for it. It contained narrative details about X's admission and the care and follow-up provided. It also contained information about the risks to X herself and potentially to her child. However, once the fax was received, it was scanned into the electronic file and stored in the `correspondence' section. It was labelled `Image-Other: [X]' where it was not reportedly extracted or seen by any of the staff who subsequently became involved in providing care for X. The information was also not seen by the Health Visitor (HV). HVs do not have access to the secondary mental health care records and the AMHT team did not contact the HV to provide any. However, there was an exchange of verbal information between the Swindon and Oxford HVs, and the Oxford HV met regularly with X's GP.

5.7. Our team judges that communications and liaison at transition points were restricted and/or faulty and our team believes that there are five main reasons:

5.7.1. X's atypical symptoms challenged professionals at many points in her history to make an unequivocal diagnosis because they did not fit a classical pattern. Notes record, and current information reinforces this point, that X could present very well (behave in a socially appropriate manner, withhold details about her thoughts) even when she was mentally very unwell.

5.7.2. X was, by her own admission, reluctant to disclose details about her history. It is possible that she feared that her son might be removed from her care (as she told SCAS) if she described her mental state accurately. Lastly, BPAD, the diagnosis X was provisionally given before the birth of her son, is regarded by some as a less stigmatizing diagnosis than schizophrenia and this may also have been a factor in X's reluctance to discuss it.

5.7.3. Full information about X's history was not solicited by Oxford or AWP from all the NHS trusts from whom X previously received treatment because they were unaware of the extent of X's psychiatric history. This meant that they did not have a complete picture of the severity or longevity of X's symptoms; nor did they have a clear picture of her relapse profile.

5.7.4. Information sharing between all parts of the service in Oxford involved in X's care (Mental health team/GP/Health Visitor) was restricted partly by a lack of access by all parties to the same set of electronic notes and partly because pressure of work restricted the time available to teams to speak to one another.

5.7.5. Such information as Oxford did receive from AWP about X's history and likely diagnosis (paranoid schizophrenia) was filed in a place where it was unlikely to be found. Coupled with the failure to complete formal risk assessments (see below) or a care plan, no information about X's risk or a relapse profile[9] was available.

- **Review the quality of the longitudinal risk assessments, contingency and crisis plan in place for X at the time of the incident**.
- **Identify whether any further risk assessments should have been completed during X's admission to hospital, in particular with relation to her risk of harm to others.**
- **Identify any factors that hindered the risk assessment and management processes.**

5.8. Narrative notes in the electronic case record completed about X by the South Oxon community mental health service staff who had contact with her in the period leading up to the incident are thorough. Dates and reasons for staff contact with X are clear and prompt communications were sent back to the GP. However, there was no formal Risk Assessment in place for X either at the point when she was initially referred to South Oxon in 2015, or at the time of the incident when X was referred to the Psychologist in 2017. An electronic Risk Assessment form had been opened in the file towards the end of 2016, but it had not been completed. It states only that `no risk identified unless relapses in Bipolar. Managing an awful situation very well' (this refers to information provided to the team by X that she had been the victim of a home-working scam advertised on EBay and was now in greater debt than previously).

[9] A relapse profile is the pattern of behaviour that for any individual over time tends to be indicative of a recurrence of their mental illness.

5.9. The failure to complete a risk assessment for a patient with X's history is a serious omission and runs counter to Trust policy in Oxford[10]. By contrast, AWP notes about X's care in Swindon contain Care Plans and Risk Assessments which were updated regularly; X's thoughts about suicide and her thoughts regarding risk to her son were included, there was information about X becoming more irritable and anxious about her son's care. The AWP notes also contain information about risk solicited by AWP from SLAM. These show that the SLAM (MAPPIM) team also completed a thorough risk assessment, including a relapse profile which highlights X's tendency when relapsing to sleep more; to experience a reduction of appetite; to neglect her appearance; to withdraw from her mother, and to experience her voice changing (sic).

5.10. There was no single obvious cause for the failure to follow Trust policy. Instead, according to witnesses, a combination of factors together made failures more likely to occur despite their knowing that X had been admitted to psychiatric hospital in Swindon and her child taken into care. These include that they saw no signs of psychosis; X did not disclose any thoughts to concern them; pressures on staffing levels and workloads against a background of significant service re-organisation meant that staff turnover was very high; X's care coordinator left shortly after X was initially referred (the point when a risk assessment and care plan would normally be prepared), and there were changes in the mental health leadership which restricted the frequency of checks on whether care plans, risk assessments and reviews had been undertaken. Lastly, the mental health team knew that X was in contact with her GP and her Health Visitor who also thought she was safe. Whilst these factors may, to some degree explain the failure to follow policy, they do not excuse the fact that Trust policy was not followed.

5.11. The first recommendation in the report of the internal investigation (see Appendix 2) reinforced Trust policy and said: `*Formal risk assessments are required following a patient's initial contact with an AMHT. This risk assessment is to be documented within both the outpatient clinic letter (in the proforma box at the beginning of the letter) and within the general risk assessment section of*

[10] Clinical Risk Assessment and Management policy (last reviewed 19/06/14)

clinical records. Comprehensive risk assessment requires review of historical and collateral information'. This report also made a recommendation relating to Care Planning: '*During a period of care coordinator transition, communication with the patient must occur to ensure they are fully aware of the transition plan and how their plan of care will be delivered during this period. Team discussions and discussions with the patient must be documented within the patient's clinical record'*. These recommendations are consistent with the evidence and are appropriate.

5.12. Since the tragic death of X's son, the Trust has taken steps to strengthen policy and practice in relation to risk assessment and care planning. Guidance for staff has been re-written; reviews must now to be done within six months of an initial referral and at least annually (or more frequently if clinical need dictates) thereafter. The risk assessment proforma has been changed and simplified, and attention to the needs of potentially vulnerable children (or other dependents) is re-focused both in the proforma and in other guidance developed following a thematic review of incidents, highlighting concerns about safeguarding.

5.13. Importantly, new guidance on CPA reviews includes a requirement to write a clear formulation based upon a patient's history and presenting problems and a new `Red, Amber Green' (RAG) rating system has been developed so that consultants are able to see at a glance which patients have a care plan, a risk assessment, a care coordinator or a review that is due. Called `Patient Safety at a Glance' (PSAG), the new system has been rolled out on seven wards and will be piloted in community services shortly.

5.14. Pressures on staff time and challenges that arise due to problems of recruitment and retention of staff have been discussed at the Trust Board and although there is no quick or easy solution to a problem evident in many NHS mental health services, steps are being taken to manage demand upon services by identifying clearer referral criteria; by testing telephone triage for new cases; and by monitoring and managing caseloads more closely. However, it remains challenging for the trust to deliver mental health services and we urge commissioners and providers of mental health services in Oxfordshire to

continue with their constructive dialogue to better understand the need, demand and capacity of and for local services and seek to ensure that resources are targeted appropriately.

5.15. It is essential that relevant information about a patient's history (previous diagnoses, pattern of illness, treatment and response) is summarised and stored in a location and manner that is accessible to a busy, potentially overworked team. The use of a clearly labeled Risk proforma saved under the relevant tab in the electronic notes might have aided capture of relevant information about X, her relapse profile and her thoughts when she was unwell. This would have likely helped staff to find relevant information and/or find it more quickly. Our team also believes that inclusion of a standardized measure using a tool such as the HCR20 might have been helpful. Whilst there is a debate in the clinical and academic literature about the usefulness of structured tools as against narrative clinical reports to assess risk and opinion varies, DH guidance makes it clear that actuarial tools can be helpful as an adjunct to a thorough clinical and behavioural assessment.

- **Review the discharge planning process following the most recent episode of inpatient care in Oxford**.
- **Reviewthe quality of discharge planning and communication with the GP February 2016 and following the reassessment by the AMHT in August 2016**

5.16. X was not an inpatient in Oxford at any point. However, when X was discharged from contact with community mental health services in February 2016, appropriate information about her care and treatment was passed to her GP. The consultant psychiatrist made it clear that X seemed very well and that he would be happy to see her again at any point. However, owing to a clerical error (failure to remove a tick in a box relating to care planning on the standard template used for written summaries) the GP, who remains dissatisfied about the mistake, erroneously believed the mental health team would maintain contact with X. This was unfortunate, but our team does not believe that the error was material.

5.17. Communication between the AMHT (from the consultant psychiatrist) to the GP at important points in X's care such as her discharge from community services in February and her re-assessment on 4th August 2016 seem appropriate (notwithstanding the clerical error described above). When X was re-referred to the AMHT at the end of July 2016, she was seen by two CPNs from the South Oxon Adult Mental Health team who communicated promptly with the GP. In fact, X had also been seen recently (on 21st July) by South Central Ambulance (SCAS) who referred her to Oxfordshire Safeguarding Children Board the following day after responding to a 111 call from X who was expressing suicidal thoughts. But whilst information about this was faxed to the AMHT on 22nd July, there is no reference to it in the summary prepared by the two CPNs who saw X on August 4th. We cannot therefore be sure that they saw it, and it does not appear that X told them. Instead, the CPNs describe X as having no abnormality of thought content or form; as well oriented, and with capacity. They described X's phobia of public transport; her reports of falling victim to an on-line scam, and her problem with financial debt. X's medication was indicated to be Sertraline (an anti-depressant) and Lithium (a mood stabilizer) and as X's GP indicated that X's last prescription for Aripiprazole was issued in December 2015 it does not appear that X was taking an anti-psychotic at this time.

5.18. It is clear from witness statements that mental health service re-organisation in South Oxon coupled with staff shortages was leading to problems of caseloads and workload management, long waiting times, and problems of communication and liaison. Whilst improvements have been made since then, and staff morale is now much better, there are still, according to witnesses, difficulties in communication between mental health, primary care and Health Visiting services. When asked about this, witnesses from the South Oxon mental health team indicated that they would only make contact with Health Visitors if they were aware that a HV had been allocated, or if they had special concerns. Our team believes it would strengthen care and help to reduce risk where there may be a safeguarding concern if information sharing were formally part of policy, particularly where a child or vulnerable adult has been identified and we understand that work is ongoing to implement this.

- **Review the quality of the mental health treatment/care plans in place for X at the time of the incident, with particular reference to the range of diagnoses described in the level 2 report.**

5.19. Over time, X was given diagnoses of Paranoid Psychosis, Paranoid Schizophrenia, Emotionally Unstable Personality Disorder (EUPD) (which may involve psychotic symptoms), Bi-Polar Affective Disorder (although evidence of manic episodes appears to have been inferred from X's personal account rather than witness testimony), Depression and Anxiety. It seems clear from the records that AWP, Oxford, SLAM and CNWL were all challenged to some degree to identify an appropriate diagnostic label, although the South Oxford clinical team currently caring for X is clear that a diagnosis of paranoid schizophrenia is now appropriate.

5.20. There may be several reasons for the diagnostic challenge that X presented. Whilst X experienced psychotic symptoms and paranoid thoughts from time to time, she seldom appeared, at least in the early days, to exhibit the range or severity of social and psychological impairment typically associated with paranoid schizophrenia. Psychotic symptoms (although quite rare) may occur in someone without schizophrenia; they may be drug-induced, or they can occur in a patient with severe depression, BPAD or personality disorder. The consultant psychiatrist responsible for X's care whilst she was in contact with community services in South Oxon tentatively favoured a diagnosis of BPAD, but by his own admission, he did not have the full history. He therefore concurred with X's stated wish to go back on Lithium and this was arranged in consultation with the GP. His assessment in September 2015 completed with a social worker appears to have been thorough and, as he left the service shortly afterwards, he did not see X over a long enough period to assess her.

5.21. There is no reason to suppose that the broadly supportive treatment, and the drug treatment (Aripiprazole, Lithium and Sertraline) that X received between September and December 2015 was inappropriate. However, during 2016 after she was re-referred, it does appear that there were shortcomings in the assessment that was undertaken. For example, as there is no reference in the

letter to the GP about the SCAS safeguarding referral it does not appear that X disclosed her suicidality the week before, and no care plan or formal risk assessment was completed (although a risk proforma was opened). On the other hand, the narrative notes do contain a clear account of what was being provided in the form of help for X to prioritise her needs; start to address challenges associate with debt and benefits payments and manage her travel phobia. Perhaps importantly (with the benefit of hindsight) it does not appear that X was taking any anti-psychotic medication at this time. Whilst this was consistent with her presumed diagnosis (Bipolar Disorder and Depression) such drugs as Lithium and Sertraline would be unlikely to have a significant impact upon any re-emergence of a psychotic illness such as schizophrenia, which with hindsight seems likely to have been happening.

- **Review the enactment of the Shared Care Policy following discharge in August 2016.**

5.22. The Shared Care Policy in Oxford concerns management of drugs for patients who are in contact with specialized mental health services but living in the community with GP support. Our team learned that the GP had concerns about the management of the shared care of patients taking Lithium having initially received only a handwritten note from the junior doctor with responsibility for checking X's blood prior to making his request that the GP should prescribe it. However, whilst communication could have been strengthened in relation to the case in general, our team does not consider that this was inappropriate, in principle. Furthermore, we note that the Trust has taken action to review and refresh its shared care policy for Lithium, which now appears to be working well in practice. In addition, the Trust has taken action to ensure that information relating to a patient's risk is clearly formulated within the GP letter and that this is consistent with information documented within the risk assessment.

5.23. We understand that X's GP noted X's very low blood Lithium level in February 2017 but, aware that X appeared to be doing very well and that she was due to see the psychologist, she did not feel worried enough to alert the mental health team from which she had technically been discharged. X had also seen her HV on 24th

February 2017 who reported to the GP that X was coping very well, despite anxieties about the fact that some sources of financial as well as HV support would cease as her son turned five.

5.24. It is a difficult fact for the GP to contemplate in the light of what subsequently occurred that perhaps if she had alerted the mental health team to X's low Lithium level (which hindsight suggests was indicative of a relapse) then a further assessment might have been possible to provide. However, our team does not believe that any blame should be ascribed to the GP. The care she provided was of a high quality, an opinion with which X herself concurs and, by all accounts, whilst routine contact between mental health and primary care might have facilitated more detailed communication about shared cases, this was restricted owing to staff shortages and a number of significant changes in mental health leadership in community mental health services.

5.25. The internal report of the investigation commissioned directly by the Trust made reference to concerns about the Shared Care protocol and outlined steps being taken to strengthen the policy and improve information about its implementation. We understand that the protocol has now been updated and that the Trust has taken steps to ensure that it and its associated division of responsibilities are communicated effectively.

- **Determine whether there were any missed opportunities to engage other services and/or agencies to support X and her child.**

5.26. The internal independent commissioned by the Trust report concludes that ` There is little evidence within X's adult mental health clinical records that [her] ability to care for Child B were explicitly and/or routinely considered.' Our team concurs that the clinical notes do not contain an explicit proforma-based formulation of the risk that X may have presented to her child. However, in the narrative (so-called `progress') notes there is frequent reference to the good quality of the relationship X and her son appeared to have. Furthermore, this is the subject of comment by the psychiatrist in his letters to the GP, which suggests that the team were mindful of the issues even though the record is patchy.

5.27. X's GP has criticisms of the delays involved on two occasions before X could access mental health services. For example, the GP initially referred X urgently in July 2015 to the mental health team, but X was not seen by a consultant until September owing to her difficulty travelling to an appointment, although efforts to find an appointment closer to her home were made. There were delays in re-routing X when she was referred (inappropriately as it subsequently transpired) to `Talking Space', the primary care-based IAPT service which Trust policy (appropriately) precludes people with a severe mental illness from being seen. Then, there was an almost three-month delay (although this is not unusual in South Oxon or elsewhere) before X could be seen on 1st February for an assessment for specialist (`Tier 4') psychological services for anxiety management related to her phobia of travelling.

5.28. Whether these delays had a material impact upon the risk that X presented to her son is not easy to determine. The notes show that appropriate steps on both occasions were taken to assess the likely impact upon X and avoid delay if possible; so, whilst it would be desirable to shorten waiting times, our team does not believe that delays in X's case were causally related to the tragic death of her son. However, we do believe that work is needed in the Trust to make sure that all partners and stakeholders are aware of referral criteria and waiting times, particularly for the increasingly in-demand `talking treatments' (see 10.34 below).

5.29. We believe that there would be value in strengthening the teaching and training for staff to probe sensitively but more thoroughly in regard to family connections and other sources of potential support for patients who are parents (see below). This is because other sources (social care, education) report that X retained a degree of suspiciousness about her son's treatment at school during February 2017 and that she continued to express a level of concern that her mother should not find out where she was. With hindsight it is possible to argue that this was symptomatic of X relapsing and yet its significance was missed not only in Oxfordshire but also in Swindon when X's son was fostered and the care system made no contact with his grandparents.

5.30. It is possible to argue, if X's history and relapse profile had been fully understood, that closer routine contact between the mental health team and staff in education and/or social care and/or Health Visiting and Primary Care would have been maintained. However, although staff at the school which X's son attended, and the HV, were aware that X had a history of mental ill-health, the former had no details and did not know who to contact in the event of a crisis. In addition, the record of communications from the consultant back to the GP suggest that X's relationship with her son had been assessed as very positive. Witnesses reported clearly to our team that they had observed a good level of appropriate engagement between X and her son; facts which are noted clearly in the record. They had no reason to be suspicious.

5.31. After the tragic death of X's son, the Trust identified six key incident reports highlighting concerns about joint working between Universal Children's Services and Adult Mental Health Services. The Trust reviewed these during the early part of 2018 and identified three areas that required attention:

5.31.1. Lack of communication about the care being provided to a parent and their risks;

5.31.2. Poor awareness of roles in different services and a lack of understanding of the range of services available, and

5.31.3. A need for assessments to include details about dependent children and to involve other services in care planning and reviews.

5.32. To address these issues, the Trust is in the process of taking action and has appointed a specialist Health Visitor perinatal mental health worker; established regular meetings between mental health and the universal children's service; established a `Think Family' lead in each mental health team; improve access to electronic records for relevant professionals from children's services, and introduced prompts in the electronic records system to trigger an assessment when a dependent child is identified. The Trust's `Think Family' policy, which is designed to highlighted for staff the importance of assessing a patient's ability to care for a child and identify any support needs that they may have, has been reviewed. In addition to monitoring carefully the implementation and impact of this, our team would urge that staff be prompted to ensure that partners in primary

health, social care and education are engaged, informed and heard whenever there is a potentially vulnerable child involved.

- **Comment on the clinical pathways between Oxford Health's AMHT, IAPT and Psychological services identifying any unintended barriers to accessing appropriate and timely services.**

5.33. The psychologist completechrid a thorough assessment in early February 2017. Our team believes that X s mental state was assessed appropriately, and that the facts were communicated promptly to colleagues.

5.34. We examined policy associated with referrals to `Talking Space' the service established in primary care to improve access to psychological therapies. We are confident that the arrangements accord with national policy guidelines; for example, to ensure that people with severe mental ill health (e.g., BPAD, schizophrenia) as opposed to `common mental disorders' (anxiety, moderate depression) are seen in specialised services by senior professionals with an appropriate training. However, we believe that there would be value in ensuring that other professionals across primary health and social care are aware of the policy and always know how to refer, to whom, and for what. Whilst Talkingspace and the AMHTs routinely liaise with GP to ensure that all are aware of pathways to treatment, witnesses reported that there were still some problems. Our team understands that steps have now been taken to improve levels of knowledge and ensure that referrals for talking treatments are appropriate and delays are minimised.

- **Review the Trust's internal investigation reports (Both Lv1 and 2) and assess the adequacy of their findings, recommendations and implementation of the action plans**

5.35. Our team reviewed the reports prepared by the Trust and the team leading the Trust's internal independent investigation. The authors of the latter, by their own admission, were limited by the fact that at the time of writing X's case had not been heard by the Court and criminal proceedings had not been concluded. Furthermore, the authors did not have access to the detailed records that were

subsequently made available to our team from AWP and SLAM and nor did they have the benefit of information about X's clearly very complex mental condition that our team has been able to gather from her current treatment team, as well as conversations with X herself. There are therefore some gaps in the internal report and it is necessarily slim. However, our team believes that the investigation broadly satisfied its terms of reference; it highlights the important issues; the recommendations flow from evidence and the Action Plan is appropriate.

- **Having assessed the above, to consider if this incident was predictable, preventable or avoidable and comment on relevant issues that may warrant further investigation.**

5.36. Prevention means to `stop or hinder something from happening, especially by advance planning or action' and it implies `anticipatory counteraction'. For X's son's death to have been preventable there would have to have been a level of knowledge; an opportunity to intervene, and the legal means to do so. Very sadly, the evidence suggests that information relating to all three of these elements was severely restricted.

5.37. **Knowledge:** Staff knew that X had cared effectively and well for her son until she became mentally ill. They knew that X cared deeply for her son and, when well, she had no intention of harming him. When she became mentally unwell, for example in Swindon, appropriate action was taken, with her consent, to take her son into care and admit her as a voluntary patient to hospital. However, when a similar episode of mental ill health emerged in Oxford two years later, X did not present herself to services or warn any member of staff that help was needed. Although staff should have found information in the notes describing X's likely diagnosis – and a clear diagnosis of schizophrenia might have prompted staff to explore different hypotheses about her risk profile – X had seemed well.

5.38. It is also possible that elements of X's behavior may have been misinterpreted. For example, it is not unusual for council residents to request (as X did) installation of CCTV as a means to monitor noisy neighbours or to reduce the risk of burglary; it is also not unusual for parents to be concerned about

school bullying (as X was). Furthermore, it is not unusual for patients in mental health settings to insist that their families should not be contacted. In addition to what we now know were probably signs of relapse, X had failed to take her medication; she had paranoid thoughts about her mother and she was feeling fearful for her son's safety, especially at night. We cannot know if X was unaware of the signs of her own deterioration or that she simply hid the signs for fear of once again `losing' her son. Either way, staff were unaware of what was happening.

5.39. **Opportunity:** On all previous occasions bar the last one, X presented herself to services, or she was persuaded and helped by her mother to contact services when signs emerged that her mental health was deteriorating. Indeed, SLAM services commented upon how positively X had engaged with the St Thomas' team after feeling concerned about taking medication whilst pregnant. Social care services in AWP were also able to engage in a cooperative and constructive relationship with X regarding care of X's child (one reason X was registered as a child in need rather than as needing child protection). However, on the most recent occasion in Oxford, X did not fully disclose her thoughts, despite having the opportunity in the context of a good relationship with her HV and GP and despite the psychologist having completed a thorough assessment.

5.40. **Legal means:** Had staff been aware of how ill it subsequently transpired X was, it would potentially have been possible to use the Mental Health Act to detain her against her will. In this way, her son could have been protected. However, there appeared to be no reason to trigger a Mental Health Act Assessment at the time when X was seen because she seemed well.

5.41. The evidence gathered during our investigation about the quality of care that was provided for X, does not therefore suggest that the tragic death of her son could have been predicted or prevented.

- **To review and comment on Oxford Health NHS Foundation Trust and the CCGs enactment of the Duty of Candour.**

- **To assess and review any contact made with the victim and perpetrator families involved in this incident, measured against best practice and national standards**
- **To review the Trust's family engagement policy for homicide and serious patient incidents, measured against best practice and national standards.**
- **Assist the family in the production of an impact statement for inclusion in the final published report, if appropriate**

5.42. We are aware that the authors of the report of the internal investigation did not meet with Ms. S and Mr. B, but we understand that this was on the advice of the Police who were, at the time, conducting their own investigation. Our team believes that the Trust has made appropriate contact with X's family since then.

5.43. Our team met X's parents (Ms. S and Mr. B) and we were able to discuss with them the tragic circumstances of the death of their much-loved grandchild. We are very grateful to them for speaking with us despite their profound grief at this sad loss. Ms S had been present at her grandson's birth; she and X's father had supported X when she left her South London flat during a period of ill health and Ms. S had supported X and had helped her get to hospital on more than one occasion so they had formerly been close and are now, once again, in communication with their daughter.

5.44. The meeting was extremely helpful in elucidating the history of contact between X and mental health services in London, Swindon and Oxford. For example, we learned that X had exhibited a level of disturbed behavior from a fairly young age (e.g., when she came back to live with her parents at one point, X had covered the tv; she believed she was being followed which Mr. B helped her to overcome by going out and walking behind her; she would sometimes sit for long periods without moving and, over time, she had taken several overdoses).

5.45. Ms. S and Mr. B last had contact with X before the tragic incident which led to the death of their grandson in 2015. X had telephoned her parents in the Autumn of 2014 to say that her son had been swearing at her and Ms. S could hear him

crying in the background. Ms. S and Mr. B went to Swindon to visit and found X having lost quite a lot of weight (they described how X, when unwell, would tend to neglect her personal hygiene; lose weight; neglect household chores and bills). They stayed with X for a few days, becoming concerned when they arrived that the house was very cold. X was apparently getting up in the night, worried about odd sounds possibly made by `a strange man' and one night, Mr. B got up to find X turning the boiler on and off. Ms. S and Mr. B therefore brought X briefly back to London to look after them.

5.46. The information provided helped the team to understand why X's parents were so upset and angry at being excluded from matters relating to the care of their daughter and their grandson – particularly at the point when their grandson was taken `into the care of strangers' in 2015; they could have looked after him themselves. They felt that `a wall had been put up' when X left Swindon; they were unable to find out any information, including about where their daughter was living. They commented that X, however misplaced her sentiments at this time (because their relationship had formerly been good) was so plausible that the doctors did not see how unwell she was.

5.47. Ms. S and Mr. B reported a good level of contact provided by the Trust in Oxford; for example, from the clinical director and the psychiatrist currently looking after X, as well as from the Serious Case Review team. However, they were doubtful about the diagnosis of BPAD that was tentatively ascribed because they had never known X to have a manic episode. They also still have questions about the treatment that X received and wondered why X was never given a depot (an intramuscular anti-psychotic injection) given her tendency to stop her medication when relapsing. Our team believes that this is likely due to uncertainty relating to X's diagnosis (see Paras 10.19 -10.21) as well as the absence of a clearly defined risk and relapse profile (see Paras 10.9 and 10.10) within which, had the information been known, it could have been recorded.

5.48. Appendix 7 contains a statement made by Ms. S and Mr. B about the appalling impact upon their lives that these events had had. Ms. S and Mr. B would like to see the law changed with respect to the rights of grandparents. They would like staff to be required to probe more deeply into the reasons why a patient does not

want their family to be contacted, especially when there is a potentially vulnerable child involved, and our team agrees with Ms. S and Mr. B in this regard (see Para. 10.29). We note that work has already started in the Trust to strengthen their `Think Family' policy and practice (see Paras 10.31 and 10.32).

- **To review and test the Trust and Clinical Commissioning Group's governance, assurance and oversight of serious incidents with particular reference to this incident.**

5.49. Our team spoke with representatives from the Oxfordshire Clinical Commissioning Group (CCG) and were assured that appropriate attention is being given to monitoring progress with the Action Plan developed following the report of the internal investigation. A joint safeguarding forum has now been established to oversee cases where potentially vulnerable dependent adults and children may be at risk. This helps to ensure that issues that cross Directorates are raised and can be addressed. Other actions, listed in the (updated) Action Plan, such as steps to embed learning from serious incidents, identifying points of contact across services to aid communication, `Think Family' thematic review, `Think Family' forums and team leads, and steps to strengthen history-taking and handovers seem appropriate and have been implemented.

5.50. Like the Trust, the CCG is aware that levels of staffing and resources are problematic for the Trust and that staff turnover is very high. This is particularly challenging in South Oxford which is a rural area with poor transport links, patchy services and high housing costs; staff tend to come to the area to train and then leave because they cannot afford to buy homes. Various strategies to incentivise staff retention are in place but are, inevitably, this is a long-term challenge. Whilst several steps are being taken, as described above, to manage demand upon services, establishing clearer referral criteria; triaging new cases by telephone; and by monitoring and managing caseloads, it is also true that investment in core services should be monitored closely. Commissioners and providers of mental health services in Oxfordshire should continue with their constructive dialogue to better understand the need, demand and capacity of and for local services and seek to ensure that resources are targeted appropriately.

5.51. Organisational change to strengthen access and communications across the age-range have now been implemented. For example, mental health services are now managed in one Directorate across the age range to reduce the potential for barriers to access by young people `graduating' into adult services. Access to mental health services has also been centralized so that triage can be managed more effectively. Separate geographically-located teams still exist to link with local services and steps are being taken to manage workloads and supervise staff to ensure that case formulation, care plans, risk assessments and record-keeping are strengthened.

5.52. The CCG is aware and (there is a designated Safeguarding Lead) engaged with development and implementation of the `Think Family' policy. However, the wider challenges relating to this case (and to others, not only in this Trust) of information-sharing between and across services remain a barrier to the provision of best quality care. Separate electronic records systems impede access by, for example, Health Visitors to mental health records even though the staff teams are managed within the same Directorate. Cultural differences, pressure of work and changes in team leadership further contribute to this.

6. Conclusion

6.1. The evidence gathered during our investigation about the quality of care that was provided for X, does not suggest that the tragic death of her son could have been predicted or prevented. However, consistent with the conclusions of the report of the internal investigation and the Serious Case Review undertaken by Oxfordshire Safeguarding Children Board, our team considers that there were still shortcomings in the care that was provided for X. Many of these have now been addressed in the comprehensive Action Plan developed by the Trust after completion of the internal investigation.

6.2. There was no care plan and no risk assessment; a diagnosis was made which relied too much upon X's personal testimony and current presentation than the full history of her contact with mental health services. Furthermore, X's treatment with Lithium, whilst consistent with her presentation and self-report, also failed to be consistent with historical evidence that subsequently emerged regarding her

diagnosis (which was schizophrenia rather than Bipolar Disorder) and this suggests that ongoing anti-psychotic medication (in addition if not in place of Lithium) would likely have been important to provide.

6.3. The shortcomings that the report of the internal investigation and our own investigation identified cannot be attributed to any one person's failure. A combination of factors together led to the failure to identify, treat and manage X at the time she became acutely unwell with symptoms that, by her own admission, she was reluctant to disclose. It is with an enduring sense of profound loss that everyone associated with this case will consider these circumstances. Our team hopes, by highlighting the following areas to strengthen care, we support a group of caring and ultimately competent staff to deliver the quality of mental health services that we know they are highly motivated to provide.

7. Recommendations

History taking, formulation and diagnosis recorded in case notes

7.1. We note that the Trust Action Plan includes steps to ensure that clinical team leads encourage and require their staff to collect such information, record a summary and a presumed diagnosis in the front of the clinical record and communicate this to partner services, where appropriate. We note that steps have been taken to implement this. In addition, we recommend an audit of care records across the Trust should be undertaken in six months' time to check that the new system is working effectively.

`Think Family' inter-agency communication

7.2. In addition to monitoring carefully the implementation and impact of their revised `Think Family' policy, our team recommends that staff should be prompted to ensure that families (as appropriate) and partners in primary health, social care and education are engaged, informed and heard whenever there is a potentially vulnerable child involved.

Risk assessment, relapse prevention and information sharing

7.3. The Trust's internal investigation made a recommendation relating to training for staff to assess risk. A thorough assessment should include information from the

patient, his or her family, carers, primary care and other agencies, as appropriate. When a patient's permission to disclose information is withheld, and whilst it is important to respect patients' rights, we recommend that training should be provided for staff to balance their legal and professional responsibilities to ensure that potentially vital information for case formulation and the assessment and management of risk is collected. We recommend that training content and provision are audited to ensure that this is done.

Pre-registration training

7.4. We recommend that NHS England consider with Health Education England the scope to strengthen guidance for those with responsibility for pre-registration training of NHS staff regarding their legal and professional responsibilities in law (MHA, Data Protection, NHS Constitution) to protect patients' privacy and the confidentiality of their medical information which is balanced with the responsibility to provide a safe environment, including for staff, families, children and the public**.**

Shared care

7.5. We note that steps have been taken by the Trust to review and refresh their shared care protocol for the management of patients taking Lithium and that steps have also been taken to ensure that information about risk is communicated effectively. We recommend that an audit be undertaken of a sample of patients in receipt of shared care to understand whether this is effective or whether there are still concerns.

Care management, care coordination and communication

7.6. Trust policy is already clear in requiring patients in contact with specialised mental health services to have a care plan. We recommend the Trust pay special attention through clinical audit to ensure that care planning, care coordination and communications policies are followed, especially at times when staffing levels, resourcing or organisational change present a challenge.

7.7. NHS England/NHS Digital should consider how to develop current patient information systems to promote timely information sharing across NHS services for example that a chronology of health episodes is visible to all. This would enable practitioners to seek or request further information from other health providers to inform future assessments.

APPENDIX 1

Terms of Reference for the investigation (ref: 2017/7489)

Independent investigation into the care and treatment of X by South London and Maudsley Trust, Avon and Wiltshire Partnership Trust and Oxford Health NHS Foundation Trust

Purpose of the investigation

To identify whether there were any gaps, deficiencies or omissions in the care and treatment that X received, which, had they been in place, could have predicted or prevented the incident. The investigation should identify opportunities for learning and areas where improvements to local, regional and national services are required that could prevent similar incidents from occurring.

The outcome of this investigation will be managed through corporate governance structures within NHS England, Clinical Commissioning Groups and the Providers

1. Terms of Reference

NB: The following Terms of Reference remain in draft formal until they have been reviewed at the formal initiation meeting and agreed with the families concerned.

Oxford Health NHS Foundation Trust has commissioned an independent, level 2 investigation following the incident on 14th March 2017.

Oxfordshire LSCB commissioned a Children's Serious Case Review in July 2017 to review the Safeguarding Children practices and processes in place for X's child at the time of the incident.

This investigation will build on that review in the following areas:

1.1 Provide a full chronology of X's contact with mental health services form her first known contact with the South London and Maudsley NHS Trust in 2012

1.2 Review the communication and liaison at transition points between South London and Maudsley Trust, Avon and Wiltshire Partnership Trust and Oxford Health NHS Foundation Trust and whether that met policy requirements.

1.3 Review the quality of the longitudinal risk assessments, contingency and crisis plan in place for X at the time of the incident.

1.4 Identify whether any further risk assessments should have been completed during X's admission to hospital, in particular with relation to her risk of harm to others.

1.5 Identify any factors that hindered the risk assessment and management processes.

1.6 Review the discharge planning process following the most recent episode of inpatient care in Oxford.

1.7 Review the quality of the mental health treatment/care plans in place for X at the time of the incident, with particular reference to the range of diagnoses described in the level 2 report.

1.8 Review the quality of discharge planning and communication with the GP February 2016 and following the reassessment by the AMHT in August 2016

1.9 Review the enactment of the Shared Care Policy following discharge in August 2016.

1.10 Determine whether there were any missed opportunities to engage other services and/or agencies to support X and her child.

1.11 Comment on the clinical pathways between Oxford Health's AMHT, IAPT and Psychological services identifying any unintended barriers to accessing appropriate and timely services.

1.12 Review the Trust's internal investigation reports (Both Lv1 and 2) and assess the adequacy of their findings, recommendations and implementation of the action plans and identify:

i. If the investigations satisfied their own terms of reference.

ii. If all key issues and lessons have been identified and shared.

iii. Whether recommendations are appropriate, comprehensive and flow from the lessons learnt

iv. Review progress made against the action plans

v. Review processes in place to embed any lessons learnt and any evidence to support positive changes in practice

vi. Review the CCGs oversight of the resulting action plan.

1.13 Having assessed the above, to consider if this incident was predictable, preventable or avoidable and comment on relevant issues that may warrant further investigation.

1.14 To review and comment on Oxford Health NHS Foundation Trust and the CCGs enactment of the Duty of Candour.

1.15 To assess and review any contact made with the victim and perpetrator families involved in this incident, measured against best practice and national standards

1.16 To review and test the Trust and Clinical Commissioning Group's governance, assurance and oversight of serious incidents with particular reference to this incident.

1.17 To review the Trust's family engagement policy for homicide and serious patient incidents, measured against best practice and national standards.

1.18 Assist the family in the production of an impact statement for inclusion in the final published report, if appropriate

2. Timescale

The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter

3. Initial steps and stages

NHS England will:

i. Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved including influencing the terms of reference

ii. Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this investigation

iii. Seek full disclosure of the perpetrator's clinical records to the investigation team

4. Outputs

4.1 We will require monthly updates and where required, these to be shared with families

4.2 A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care

4.3 A chronology of X's mental health and forensic history.

4.4 A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome

4.5 A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed)

4.6 Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference, to answer any questions relevant to the investigation process and scope.

4.7 At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to discuss the findings of the investigation and engage the Clinical Commissioning Group with these meetings where appropriate.

4.8 A concise and easy to follow presentation for families

4.9 A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required

4.10 We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS

England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public

4.11 The investigator will deliver learning events/workshops for the Trust, staff and commissioners as appropriate.

5. Other

5.1 We expect the investigators to include a lay person on their investigation panel to play a meaningful role and to bring an independent voice and challenge to the investigation and its processes.

5.2 Should the family formally identify any further areas of concern or complaint, about the care received or the final report, the investigation team should highlight this to NHS England for escalation and resolution at the earliest opportunity.

APPENDIX 2

Recommendations made in the Trust independent report

Recommendation 1

Risk assessment and relapse prevention.

Formal risk assessments are required following a patient's initial contact with an AMHT. This risk assessment is to be documented within both the outpatient clinic letter (in the proforma box at the beginning of the letter) and within the general risk assessment section of clinical records. Comprehensive risk assessment requires review of historical and collateral information.

Recommendation 2

Care Coordination.

During a period of care coordinator transition, communication with the patient must occur to ensure they are fully aware of the transition plan and how their plan of care will be delivered during this period. Team discussions and discussions with the patient must be documented within the patient's clinical records.

Recommendation 3

Parenting capacity.

All AMHT staff across the Trust must be aware of parental responsibilities of all patients and to always keep in mind the impact of mental illness on ability to parent safely. Details of a child's demographic information are to be included within the patient's clinical records when the patient (mother/father) is known the AMHT.

A thematic review focusing on services working together to meet the needs of families when a parent is known to mental health services is currently underway within the Trust. The purpose of this thematic review is to establish whether there are service related themes/wider issues or links recurring across previous serious incidents.

Recommendation 4

Communication between agencies.

To ensure all medical staff within mental health services are aware of shared care responsibilities for Lithium prescribing.

APPENDIX 3

Investigation team

Anne Richardson, Director of ARC, is a clinical psychologist by training; she specialised
in work with adults with severe mental ill health and long-term needs and is an experienced trainer having jointly directed the DClinPsy programme at University College London. As Head of Mental Health Policy at the Department of Health she was instrumental in the development of the National Service Framework for Mental Health and for the development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008). Anne has worked on many investigations into the quality of NHS care and treatment provided for people who lost their lives unexpectedly, or for those who were themselves responsible for a death whilst in contact with services.

Hugh Griffiths is a former consultant psychiatrist in the North-East of England where he carried responsibility for in-patient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, as well as liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as Deputy and then as National Clinical Director for Mental Health (England) at the Department of Health he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework.

Adrian Childs trained both as a general and mental health nurse. He worked as Director of nursing at Newcastle, Northumberland and North Tyneside Mental Health Trust and earned a distinction in his MSc at the University of East London in the mid-1990s. Adrian also holds a diploma in leadership, mentoring and executive coaching. He has contributed to several national working parties including the development and appointment of Consultant Nurses and development packages for nurses working with severe personality disorders. His previous experience includes serving as Deputy Chief Executive and Director of Nursing at Devon Partnership NHS Trust and Newcastle, Northumberland and North Tyneside Mental Health Trust. Adrian is

currently working as Director of Nursing at Leicestershire Partnership Trust. In 2014 he was made Honorary Professor for the Faculty of Health and Life Sciences at De Montfort University, Leicester.

Lisa Haywood (a lay member of the team) has worked as a Mental Health Act Tribunal Member since 2006. She also has a formal role as an appraiser within the tribunal service. Lisa has lived experience of mental health services and extensive experience in the field of service user and carer involvement and services. She has worked on a number of serious incident inquiries and for the Health and Social Care Advisory Service. Lisa was Vice Chair of national MIND for 12 years and has held roles with several local Service User Networks. Lisa supported the team to bring an independent voice and challenge to the investigation methodology and findings.

APPENDIX 4

Witnesses and consultees

Consultant Forensic Psychiatrist, Oxford Mental Health NHSFT.

Health Visitor, Oxford Health.

Clinical Director, Oxford Health

Head of Safeguarding, Oxfordshire CCG

Representative from the CCG (tbc)

Consultant Psychiatrist, Community Services, Oxford Health.

Consultant Clinical Psychologists (D and C) Oxford Health.

Clinical Psychologist, (S) Oxford health.

X – the patient.

X's parents.

Community Psychiatric Nurses (C and A)

Support Worker (1).

GP (D).

Police

Members of the Oxfordshire Safeguarding Children Board

APPENDIX 5

Trust policies and other documents reviewed

Comprehensive Root Cause Analysis Investigation Report (October 2017) STEIS 2017/7489 SI 11 Ulysses number 66396

Adult Directorate Clinical Model and Operational Policy for Community Mental Health Care, and South Oxon Implementation Plan and Operational Guidance (developed Aug 2016, reviewed Jan 2017)

Policy on Non-Attendance for Appointments (last reviewed 20/08/15)

Discharge Policy (last reviewed 13/06/16)

Shared care protocol – responsibilities (March 2015)

Clinical Risk Assessment and Management policy (last reviewed 19/06/14)

Care Programme Approach Policy (including non-CPA) (last reviewed 20/08/15)

Patient, Service User and Carer Information Policy (last reviewed 02/09/15)

Policy on Safeguarding Adults (last reviewed 25/0615)

Policy on practice to improve patient and carer experience: `the Triangle of Care'. A Guide to Best Practice in Acute Mental Health Care, Oxford Health http://static.carers.org/files/caretriangle-web-5250.pdf

Service User and Carer information policy (last reviewed Sep 2015 and next due for review March 2018).

Clinical notes for X for the period between June 2015 and the present when X was under the care of Oxford Mental Health NHS FT

A sample of case notes (summaries) from Avon and Wiltshire Partnership NHS FT about X for the period January – June 2015 when she was in their care.

Summary notes from South London and Maudsley Hospital about X for the period between August 2011 and June 2012 when X was supported by the MAPPIM team.

`A thematic review focusing on working together to meet the needs of families when a parent is known to mental health services' (March 2018)

Findings from a thematic review on joint working between children services and adult mental health services (August 2018) Oxford Mental Health NHS FT.

Action plan Steis 2015/37663 SI 2015/104 – Final (V4) February 2018

APPENDIX 6

Chronology of X's contact with mental health services

DATE	EVENT The following information was obtained from case notes, personal testimony, and specialised independent forensic reports prepared for the Court.
1976	
	X was born in London, the oldest of four, with three younger brothers. X reported a family history of paranoid schizophrenia (two paternal aunts and a maternal uncle). X subsequently reported feeling that her relationship with her mother was poor and that her mother favoured her brothers although it is clear from the history that the relationship was a supportive one for many years.
1982	X reported that she was bullied at primary school, and that at age 7, a neighbour had behaved in an inappropriate way towards her by a neighbour who embarrassed her; allegedly to her mother's amusement.
1993	X also reported some bullying in secondary school. She left school at age 16 with good exam results 9 GCSEs (4 Bs, 2 Cs, one D and 2 Es).
1996	X reported a history of experimenting with drugs in her early twenties but not since, and she denied any history of heavy drinking.
1998	X completed Level 2 & 3 NVQs in beauty therapy and she worked at a trichology clinic until 2001. However, she again reported being bullied and said that someone at the clinic pushed her down some stairs. However, she left the clinic without mentioning this.
2000	X reported first experiencing paranoid thoughts (that people were following her, shadows in her peripheral vision, a feeling of fear) in 2000 which she discussed with her father who affirmed that there was no-one there. She subsequently took an overdose of paracetamol; called an ambulance and was taken to A&E. However, the medical records suggest that this happened in 2004 so the dates are not completely clear.
2001-3	X (now age 25) worked at a private foetal medicine clinic. She reported that her mental health deteriorated whilst working here; she began to feel confused and could not concentrate. She thought that staff were against her. A series of relatively short-term temporary jobs followed (receptionist, office admin, retail, beauty therapist) and X accrued some credit card debt.
2003	
10.4.03	GP records show that X (age 26) took an overdose (O/D) of Paracetamol.
August 03	Records show X was diagnosed with depression.
2004	**ST CHARLES' HOSPITAL (CNWL MH Trust)**
1st admission	X (age 28) took an overdose of Paracetamol which may have followed the breakdown of a relationship with a boyfriend. She later said that it was an impulsive act and that her family had not realised how unwell she was. X was admitted briefly to St Charles' Hospital with depression and was discharged to the crisis team. X had had problems with her employers at this time and she left; she was allegedly also being pursued for benefit fraud (December 04). At this point, records report that X had debts of around £8k. A presumptive diagnosis of Personality Disorder was made. X was referred to Mind counselling services but decided in December that she did not want

	to continue. X's parents report that she was behaving strangely at home – for example, she had covered the television.
2005	South Paddington CMHT notes show that X failed to respond to appointment letters and she was lost to follow-up, possibly due in part to moving from her parents' home to a flat in The Old Kent Road.
2006	**ST MARY'S (CNWL) AND SLAM**
06.01.2006	The assessing doctor at St Mary's to which X referred herself having gone with her mother reported X to have said that she had begun to hear a male voice that introduced himself as `John' over a period of 6-9 years; X apparently initially thought of him as a guardian angel but then he became controlling and domineering.
19.01.2006	X was referred urgently to the Out of Hours (OOH) service complaining of auditory hallucinations. However, she was deemed not to need admission.
29.01.06	X's mother contacted services expressing concern that X had lost a lot of weight, was neglecting her self-care and standing still staring for long periods; she seemed to be experiencing psychotic symptoms. A referral was made to the Crisis Resolution Team (CRT).
02.02.2006	The CRT made a home visit and requested a MHA assessment.
10.02.2006	X called the OOH service again; she said she had a knife and had tried but failed to hurt herself with it. X's parents called the service an hour later to express their grave concern. X decided to go back to her own flat in South London but the following day, she and her mother came to St Mary's together.
11.02.2006 2nd admission	X reported hearing whispers in her ears and had self-inflicted lacerations on her abdomen. She was admitted to Amazon ward at St Charles's; she was recorded as depressed and paranoid.
28.03.06	X presented to the SLAM Emergency Clinic feeling suicidal, but she missed a series of follow up appointments.
10.04.2006	Whilst on trial leave from St Charles's X took an O/D of paracetamol, Ibuprofen and alcohol. She was offered appointments at the SLAM Emergency Clinic.
19.05.06	X was discharged to the Early Intervention Service (EIS) from St Charles; she was given a diagnosis of schizophrenia
23.05.2006	X failed to keep her appointments at the SLAM clinic and was discharged. St Charles' was also trying to follow her up at this time.
2006	**RUSKIN WARD GUY'S HOSPITAL (SLAM)**
July 06 3rd admission	After presenting at the Maudsley Emergency Clinic X was admitted for three days to Ruskin ward, Guy's Hospital (age 29) with paranoid thoughts concerning her employers who had been investigated for fraud two years previously; X thought she was being watched by the Police and members of the public. No formal diagnosis was made. No formal signs of psychosis were observed. However, it was noted that X had previously been prescribed Amisulperide and Risperidone (these are anti-psychotics). The notes record difficulties in X's relationship with her family, and debts.
2006	**CNWL**

28.09.06 4th admission	X was admitted to CNWL St Mary's (age 30) having presented to her GP with suicidal thoughts. She reported feeling depressed for two weeks and `paranoid' for 6 years. Two weeks prior to this admission X lost her tenancy due to rent arrears. She is documented to have reported multiple somatic symptoms. She said `I came in initially because I was having suicidal ideas but found the waiting room too much…but now I seem to think everything has a double meaning….I had a terrible feeling that something was going to happen to my baby brother, so I called the Police…this has been going on for years. `Sometimes I know things…I hear whispers. I don't think I have telepathy; it's more like a radio station…it doesn't happen all the time….I know it's racial…people wandering round with bananas outside the Patterson Centre.' A diagnosis of paranoid personality disorder was made.
Oct 06 5th and 6th admissions	X was admitted for 6 days to St Charles Hospital (CNWL) in early October after taking an overdose and admitted again for 14 days at the end of the month when she presented at A & E threatening suicide.
2007	**ST CHARLES CNWL**
11.02.07 7th admission	X was admitted informally (age 30) for five months to 23.05.07 from her mother's address (W2) having presented in A&E and out of hours service. X had been neglecting her personal hygiene, failing to eat and was hiding a knife. However, there were initially no very clear signs of psychosis; these emerged only towards the end of the month when her diagnosis was given as Psychotic Disorder (F28). X was started on Risperidone 2mg at night which was later increased, and she was referred to the Early Intervention Team (EIT).
March 07	X's more florid psychotic symptoms started to decline by April. However, she took an overdose on 10th April and was transferred back to the ward.
12.04.07	X had improved by end of May and was discharged 23.05.07 back to the EIT.
21.11.08	X was discharged from the service due her move back to Southwark.
2009	**MAUDSLEY (SLAM)**
30 March 2009 8th admission	X was admitted informally (now aged 32) to the Maudsley after being detained on S.136 after threatening suicide. This was a serious plan by X to end her life; a note had been written, money taken out for her funeral, and X went to the balcony on the 19th floor of her block of flats with a plan to jump which she decided after several hours not to do. X called her mother for help and her mother called the Police. X had reportedly stopped taking her medication two months previously. X had also reported to her Care Coordinator early in March that people could read her thoughts. X was given a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and given Olanzapine 7.5 (an anti-psychotic) and Venlafaxine 150mg (anti-depressant); she was referred to the `STEP' psychology services but she did not keep the appointments after the initial assessment. Support via X's CPN was provided in the community.
2010	**ST MARY'S (CNWL)**

May 2010	X was started on Lamotrigine 50mg daily (a mood stabiliser) in addition to Olanzepine 7.5mg daily (an anti-psychotic) and Venlafaxine 75mg twice daily. It was suggested, that a diagnosis of Emotionally Unstable Personality Disorder (EUPD) was appropriate.
21.11.2010 9th admission	X was admitted informally on 8th Nov to the Patterson Centre (part of St Mary's Hospital) after presenting to A&E with suicidal intent. However, it is reported that there were no signs of mental ill health during this admission even though X's mother said X had been paranoid and anxious beforehand.
2011	**SLAM**
12.08.2011	After consulting with her midwife to ask about the safety of the medicines she was taking, X was referred to the peri-natal mental health (MAPPIM) team at St Thomas'. X was pregnant and had expressed concerns about whether Olanzapine (anti-psychotic) might harm her baby.
14.09.2011	X was well when she was assessed. She seemed to be very happy about her pregnancy and in close contact with her mother. X reported that she had experienced periods lasting a couple of months of elated mood with increased energy and racing thoughts when she spent money on her credit cards and had accumulated debts as a result. Her debts were allegedly as high as £30k at this point. However, X said she had experienced none of these symptoms since taking Olanzapine. The assessing psychiatrist judged X to have episodes of recurrent depression with severe depressive episodes with psychotic symptoms. She also judged X likely to have had at least two hypomanic episodes and she thought, therefore, that Bipolar Affective Disorder (BPAD) might be an appropriate diagnosis. She gave X information about BPAD and about Emotionally Unstable Personality Disorder (EUPD), and the effects of Olanzapine. As there was a possibility that the risk of post-partum psychosis could be raised, the MAPPIM team provided full support and monitoring.
26.10.11	The MAPPIM team wrote to X's GP to confirm their belief that X's diagnosis was BPAD. X's medication was Sertraline (antidepressant) 100mg nocte and Olanzapine (antipsychotic) 7.5mg nocte.
November 2011	X (at age 35) was referred to the Southwark pre-birth Assessment Team. She agreed to be admitted to the mother and baby unit in the event that she relapsed post-natally X was prescribed Olanzapine and Sertraline (an anti-depressant) but gained weight and the former was changed to Risperidone. Eventually, these drugs were replaced with Lithium.
2012	
11.01.12	A pre-birth Child Protection Conference was held at St Thomas' Hospital with X, X's partner (the baby's father) X's mother, the Health Visitor, Care Coordinator and the Practice Manager. X's history was discussed. X's mother, with X's consent, signed an agreement that she would look after the baby in the event that X experienced a post-natal psychotic episode.
06.03.12	The Peri-natal Mental Health Care Plan was updated. X was in receipt of a significant level of support from social services and NHS. X's mother was involved in providing support for X and their relationship seemed very good.
March 2012	X's baby was born. X's mother was present at the birth of X's baby and cut the umbilical cord X's perinatal mental health care plan was maintained. X's diagnosis was, by now, accepted as BPAD although X's mother has

	subsequently reported that she never saw X manic – only depressed. Her drugs were Sertraline 200mg daily and Olanzapine 7.5mg at night. She still had the same Care Coordinator. There was a clear crisis plan in place. X's partner was intermittently present at this time.
22. 6. 2012	X was discharged to community mental health services from MAPPIM and continued to be supported by them. She proved to be a very good and loving mother and seemed very happy to be with her son.
2014	
May 14	X moved from London to Swindon with her son who was by now two years old `to make a new start' and to find a good school for him. X's partner was reportedly not interested in moving with them. X's mother was involved in helping her move and had gone with X when she viewed the house. X's mother reported that the early months in Swindon went well.
Dec 14	By Christmas X's mother and father report that X was starting to appear very unwell; she let the house become very cold; seemed withdrawn and distant; and was up in the night having thought she'd heard someone and she had become very thin. X's mother said she always knew when X stopped her medication as she lost weight.
2015	**AWP (SWINDON)**
05.01.2015	X (now age 38) presented to A&E in AWP at the Great Western Hospital (GWH) saying she felt low in mood and was having thoughts of suicide. However, she was unwilling to give her previous address. She told staff she had been given a diagnosis of bipolar disorder but would not say by whom. She had apparently stopped taking her Lithium (800 mg daily) four weeks earlier and she expressed paranoid thoughts about her son's safety. She said she had heard someone (foreign men) going into his room at night but when she checks, there's no-one there. X said that `funny things' kept happening at his nursery as well. She said she could hear music during the assessment and was worried that someone was having a party. She reported that she had seen a psychiatrist kidnapped 10 years ago and was fearful for her son's safety because of this. She found it difficult to maintain eye contact and was anxious and suspicious. There is a note in the CPS Case Summary and also in the Swindon notes NHS stating that X said she did have thoughts of killing her son to protect him from the man whose voice she heard at night. However, X also said she would not hurt herself because of her son and would not hurt him either. She would not give any details of her family history, or her previous admissions and treatment and did not want her family contacted, a request with which services complied. A referral was made to social services.
06.01.15	X was seen at home by the mental health team the next day and a full assessment was completed. She was started on Aripiprazole (used in schizophrenia and bipolar disorder) 10 mg and Zopiclone at night to help her sleep. From this point X received twice daily visits from services. Her son attended nursery and was described as healthy and happy. X did not want his father involved. She said he had a prison record and that she left him because of his cannabis use. X also did not want her mother involved and said their relationship was poor.

07.01.15	X's son went into voluntary foster care with experienced foster parents, a plan to which X agreed only reluctantly, even though she had presented herself to services because she was aware she needed help.
23.01.2015 10th admission	X was admitted to Applewood Ward in Swindon via the Crisis Resolution Team with acute and florid paranoid delusions, auditory hallucinations and suicidal ideation. Her personal hygiene was poor. The notes record how, about five weeks earlier, X had stopped her Lithium, believing that the content of the tablets had been altered. She was given a diagnosis of paranoid schizophrenia and she responded well to oral Aripiprazole. X explained she had had 3 previous admissions in London: first time more than 10 years ago and the last time 5 or 6 years ago. She said she had been diagnosed with schizophrenia, then psychotic depression and then BPAD. She was treated with Olanzapine which made her drowsy and gain weight. She described how a perinatal psychiatrist had kept her on Olanzapine 7.5mg and Sertraline 100mg. She described having been tried, briefly, on Risperidone and then starting Lithium (400 mg at night) for the past 2-3 years. X was discharged after a few days with support from the Home Treatment Team until March and she had supervised visits with her son. X's mother remains upset that she and X's father were completely unaware of X's admission, or the fact that X's son had been fostered; they would have been very happy to look after him. X told her parents subsequently that she purposely withheld the information because she was aware that they might intervene; she was subsequently told by X that she had withheld information from services and `hadn't told them everything'. However, notes record that X said about her son: "I would kill rather than let anyone else harm him"
26.02.15	After 7 weeks (later than x would ideally have wished) X's son was returned to her care and the Care Plan was updated; this included a description of her history of support from the Swindon Intensive Service, medication, and Care coordination by the Swindon recovery Team. The aim was to help X to discuss and manage her symptoms. She was seen regularly through Jan, Feb and March. X said she was no longer having thoughts to kill herself or her son.
02. 03.15	X's care was transferred to the Swindon Recovery Team from the Swindon Intensive Services; she was seen by a CPN and a Social Worker twice a week from Swindon local authority children's social care services. Her Risk Summary was updated appropriately. Her medication was Aripiprazole 20mg and her mental health was described as stable.
17.04.15	X was seen in outpatients by her consultant psychiatrist for a follow up. In his letter to X's Swindon GP (which was faxed in July 2105 to the Oxford mental health team) the consultant summarised his knowledge of X, including that her history was `quite vague'. He mentioned four previous admissions and said her diagnosis varied from BPAD to paranoid schizophrenia. He described X as `somewhat wary and anxious and I think with a paranoid tinge'. He described how X had wanted to move from Swindon because of transport problems and because her `mother would find her' if she stayed. X's medication was increased to Sertraline 100mg and she started Risperidone 1mg at night. She was given a prescription for 2 weeks.

2015	OXFORD HEALTH NHS FT
June 15	X moved to Faringdon as part of a council house swap scheme which she arranged herself. She also found appropriate nursery care for her son. Swindon Health Visitors telephoned the Oxford Health Visitors to alert them to the need for a follow-up because X's son was recorded as a `Child in Need' (N.B. he was not on the Child Protection Register).
29 June	X's new (Faringdon) GP wrote to the South Oxford MH team with a referral marked `urgent'. She described X as presenting with a history of bipolar disorder and maybe schizophrenia which had started when she was pregnant. The letter also said that X had had an admission in January to Swindon services when her son was fostered.
9.7.15	The Oxford Adult Mental Health team (AMHT) contacted the GP but were unable to get in touch with X (they only had an old inoperable mobile number). As they did not have information from Swindon with details about X and because X was due to visit the GP on the 16th they decided to wait until then.
15.7.15	A telephone call between the Swindon and the Oxford service resulted in a faxed referral consisting of 10 pages containing: (a) the letter to the GP stating the difficulty of diagnosis; X's frequent relocation, her reluctance to discuss past events and to gloss over how she is feeling. It said that X needed further assessment, mentioned the various diagnoses and it stated that X previously stopped some of her medication against advice. (b) a letter dated 21 April from the consultant which described a psychotic relapse; (c) a summary from Swindon Intensive Service outlining X's paranoid thoughts in relation to her son, the referral to social services, and other supports including fostering for X's son and her admission. The risk of stopping medication was clearly stated. (d) a discharge summary after the AWP admission which refers to several previous admissions. This information was scanned and stored in the `correspondence' section of the electronic case file and labelled 'Images-Other: Jackson E.' It was reportedly not seen by any of the adult mental health staff.
16.7.15	X called the Oxford MH admin team herself; she asked for MH contact and gave them her new mobile number. She asked Oxford not to divulge the number to the Swindon team with whom she seemed to have fallen out. However, X saw her GP and agreed that the Oxford team could access her records. The first available appointment with the Oxford consultant was for September – an earlier appointment had been offered but X said she had difficulty travelling to it. The Health Visitor was seeing X every 6-8 weeks at this point; she and the GP thought X was doing very well and X's son seemed very happy.
07.09.15	X was assessed by the Consultant Psychiatrist and a member of the adult mental health assessment team. In the letter back to the GP, the Consultant described X 's history. He related X's wish to go back on Lithium as well as an anti-depressant, a wish with which he was inclined to concur. X did not say that she was worried about care for her son and the consultant judged X to be well and showing no signs of psychosis; he said that her likely diagnosis was bipolar II. The consultant indicated in his letter back to the GP that he had been unable to access the records in full. It was agreed to provide community support.

30.09.15	The CPN and support worker visited X at home. They reported in the notes that X had stopped seeing her social worker but was now seeing a family support worker every two weeks – this worker had apparently referred X to a Family Links group. They did not see the history from AWP. They agreed that X might apply for a Personal Independence Payment (PIP) and they referred her to `Connections'. X was taking Aripiprazole 10mg daily and Sertraline 100 mg daily. A plan was put in place to re-start Lithium and blood tests were instigated, consistent with good practice and the shared care protocol.
16.10.15	The support worker made a home visit X with a colleague (a `Connections Support Worker') to apply for a PIP. No formal Risk Assessment forms were completed, and no formal Risk Assessment was written up. This was apparently due to the CPN leaving.
27.10.15	X saw her GP and a Lithium prescription was discussed. At this point, X was in receipt of income support, DLA, Child Tax credits and Child benefit although her DLA was due to stop shortly, and the Health Visitor was about to disengage when X's son turned five.
4.11.15	It was reported in the GP notes that X had a phobia of travelling on the tube after fainting in 2003. She described low level paranoia when in crowds and public situations.
19.10.15	In her PIP personal statement, X reported having poor concentration. She said: `I get preoccupied thinking about different things' and that she has burned food due to `losing track of time'. She reported forgetting sometimes to take her medication.
2.11.15	This date was the last time X's GP prescribed (for a month) the anti-psychotic Aripiprazole
2016	
04.01.2016	X missed her appt with the CPN and consultant. A letter to the GP indicates that X's CPN would change shortly.
01.02.2016	The Consultant Psychiatrist met with X and her son. His letter back to the GP dated the following day reports X to be managing very well though her mood remained variable. X's medication was recorded as Sertraline 100mg per day, Aripiprazole 10mg per day, Lithium 400 mg. Her diagnosis was given as `probable Bipolar 11 Disorder'. He wrote: X `related warmly and well today with excellent insight into her situation.' She was discharged back to the care of her GP who was encouraged to get in touch at any point if there were concerns. The standard box at the top of the letter indicates (apparently in error) that a Care Plan and Risk Assessment had yet to be/would be undertaken.
18.01.16	The DVLA wrote to the consultant about X's medication in relation to driving.
19.02.16	General medical update – no abnormalities of thought or behaviour noted.
29.06.16	Notes record that X was anxious about a `return to work' (benefits) interview which forced a confrontation of her fears of using public transport. A decision was taken by the team to refer her to community psychological therapy services `Talking Space' for help. However, this service is unable to take on patients with a diagnosis of severe mental ill health (this includes bipolar disorder) and they wrote back to the Duty Worker in the AMHT to indicate this.
21.07.2016	X called an ambulance after having suicidal thoughts. The Ambulance Service (SCAS) record mentions concern about debts (which X had also contacted the Police about) and stated that X is currently taking lithium and

	Sertraline which had recently been increased. The note mentions X's fear that her son would be taken away again but it also states that X had no clear plan to act on her thoughts. SCAS referred X to the Multi-Agency Safeguarding Hub (MASH) service. The MASH assessment team undertook a telephone triage, checked with the AMHT, and the HV about X's mental health status.
22.07.16	X self-referred to `Talking Space' on the basis of her GP's advice.
23.07.16	The GP referred X again to the CMHT.. X's HV was also concerned at this time about X expressing suicidal thoughts, and about X's son turning five when HV support and family support services would cease.
25.07.16	X was discussed at the adult mental health team meeting and an appointment for a home visit offered for 4th August 2016.
2.8.16	The NHS Children and Families Team (safeguarding) called the adult mental health team to say that although X's son had originally been referred to them by South Central Ambulance Service they were about to close the case and they were not concerned about him any longer.
4.8.16	X was seen by two CPNs from the AMHT who wrote back to the GP to say that X was reporting she had been victim to a financial scam (an EBay Ad for home working) which had added to her level of stress and debt which was already over £20k; she was angry about being defrauded but, apart from her travel phobia, the nurses report no signs of mental ill health. A Risk Assessment form was opened on the file, but not completed. It simply states: `no risk identified unless relapses in Bipolar. Managing an awful situation very well.' They suggested a referral to psychology for treatment of her travel phobia. The plan is outlined as `continue with medication as per prescription: Sertraline 150mg (an anti-depressant) and Lithium; refer to psychology and discharge to care of GP.'
24.11.16	The GP called the AMHT to chase the referral to psychology which the psychology department had no record of having received in August. Psychology staff were informed of the missing referral on the Monday before Christmas (19.12.16) at the AMHT meeting; they therefore endeavoured to find an appointment quickly and the case was discussed at the team meeting. X's lithium level (according to the GP record) was tested as very low this month.
2017	
1.2.17	A report in the case notes from the psychologist shows `CORE' scores in the moderate to severe range. It records X as having said she had no plans to harm herself: even though she thought she would be better off dead, she told the psychologist that the presence of her son stopped her. X reported that she was under pressure to return to work at the end of the month when her son turned five, when her benefits and certain other supports (e.g., from the Health Visitor) would stop. The psychologist discussed the case at the team meeting on 6.2.17 (by now the new consultant psychiatrist was in post) and expressed concern about X's mistrust of others, poor employment history, past suicide attempts and her diagnosis of Bipolar Disorder. The team felt it appropriate to proceed with an offer of CBT. A gap between the first psychology appointment and the next (15th March) was arranged so X could practice implementing strategies for managing her anxiety.
08.03.2017	Notes record that X suddenly ended a relationship with a boyfriend she met just before Christmas on Facebook. She thought he had become more domineering (like her mother, she said). She also reported that she thought

	someone was coming into the house and stealing things. X's medication at this point was 600mg Lithium (but it subsequently became clear that she had probably not been taking it as the blood chart held by the GP showed a very low level in February) and Sertraline (an anti-depressant) 150mg per day.
13.3.17	X's son failed to attend his infants' school on Monday morning and as X had failed to contact them in line with policy to alert them to his absence, which was unusual, the staff were concerned. X had previously told them she thought her son was being bullied. School staff visited X's home but failed to get a response when they knocked at the door.
14.3.17	The next day, X's son was still absent; staff made another home visit but as they thought they saw the curtain move they called the Police. Police went to X's house. They found X with self-inflicted cuts to her arms and throat and they found her son's body upstairs. X was arrested and taken to the JR for treatment of her own wounds.
15.03.17	X had had a second assessment appointment in psychology for this day. Following the incident Oxfordshire Safeguarding Children Board (OSCB) commissioned a Serious Case Review.
2017	**Post Incident Treatment**
15.3.17 11th admission	X was admitted to an Enhanced Low Secure Unit on Section 2 of the Mental Health Act. X's insight was limited, her manner guarded, and she seemed to know little about the circumstances of her son's death. Her blood Lithium levels showed that she had not been taking her medication. It is not clear whether she had also failed to take her other drugs, but this seems likely. X admitted having kept a knife in her room at home for protection and expressed paranoid thoughts about her mother whom she believed had wanted to take her son away, along with others who wanted to harm him.
15.03.17	X was admitted to Kestrel ward for assessment on police bail. Level 3 (maximum) observation was maintained. The aims of X's stay were described as: orientation, monitoring, support to establish contact with solicitor and relationship-building through 1:1 with staff, attendance at OT. A risk of harm to X from others was identified. A brief history of X's past diagnoses and the incident were given in the notes and a preliminary diagnosis (`schizophreniform illness/psychotic depression') was identified. The notes record that X did not want her family involved or provided with any information at this time. The team thought X lacked insight and they observed that X would get annoyed at the suggestion that she might be mentally unwell. She was therefore also confused about the purpose of therapeutic activities and she was suspicious of staff.
25.03.17	X was taken discretely to see her son's body at the JR. She was initially suspicious and puzzled. She repeatedly said `I didn't do this' and was very upset. After seeing him there was a change in her presentation: she became restless and tearful and walked around with a picture of her son, describing how she had been so worried that her mother was trying to take him away. Ongoing other signs of paranoia were also evident around this time in relation to staff. There were clear signs of formal thought disorder with tangentiality and over-inclusiveness, evidence of delusional perception and persecutory thoughts. The assessing team diagnosed paranoid schizophrenia with comorbid depression. X's Mental Health Act (MHA) Section was converted to Section 3 in April.

22.05.17	A note from the chaplain says that X was upset because her son's funeral had gone ahead without her knowledge.
24.05.17	X spoke about having premonition-like experiences and of being able to see what people were doing without having to look at them.
22.06.17	The Consult Psychologist entered a report in the notes of his four months of weekly individual sessions. An assessment HCR-20 assessment and formal memory assessment showed no memory problem nor any dysfunction of global cognition. Shortly after this, X said she felt she could no longer trust him and abrupt changes in trust for other staff followed.
26.06.17	The formal Risk Assessment identified a risk of harm to X's mother as X had deludedly thought she might kidnap her grandson and had previously been trying to get X admitted. The notes refer to other stressors (financial problems) present at the time for X and her very low level of insight.
18.07.17	The consultant who saw X whilst she was under his care in the community completed his statement for the Court. It describes his assessment that X had been suffering from a mood disorder when she saw him and that she had responded well to treatment.
09.10.17	The Care Plan was reviewed and includes new focus to include encouragement for X to mix more. X's medication: Lorazepam oral and IM, codeine, Cyclizine. REGULAR meds: Apixaben (a blood thinner owing to varicose vein and DVT risk), Aripiprazole 10mg OD (Atypical anti-psychotic), Sertraline 100mg OD (an SSRI).
13.10.17	X's MHA Section converted to Section 48/49 - a hospital treatment and detention order under the Mental Health Act given by the Court. An opinion by a specialised forensic consultant psychiatrist was submitted.
14.10.17	X's Care Plan was amended. Her drugs are recorded as Sertraline 200mg and Aripiprazole 20mg once daily. X then ended a relationship she had been having with another patient.
4.11.17	X began to speak to staff about having tried to get help from services before her son's death; she said she felt had been `fobbed off'. However, she admitted that she had been reluctant to talk about her mental health for fear that her son would be taken into care again – something she was keen to avoid after the last time.
29.12.17	At a medical review, the consultant concurred with the view of the independent forensic psychiatrist's opinion that X suffers with paranoid schizophrenia with overlaid major depression. The report noted that X herself favoured a diagnosis of bipolar disorder, but as there was no clear evidence of significant manic or hypomanic episodes the consultant felt unable to concur.
2018	
5.02.2018	A second forensic specialist assessment was prepared and submitted to the Court on 22nd February 2018.
09.03.18	X's plea of manslaughter on the grounds of diminished responsibility was submitted to the Court, a plea that was accepted as appropriate by both independent specialists.
10.4.18	A physical/medical review showed X to be in the pre-diabetic range following significant weight gain; X was also noted to have a small lipoma in her thigh and she was given a blood thinning drug.
11.04.18	A general update from the Social Worker is provided in the notes following a home visit with Police to X's family. The family reported they felt unsupported in the past when they'd raised concerns about X. The team

	spoke about X's diagnosis, treatment and potential management in the future, and of the past and potential for future risks to X's mother.
20.4.18	Oxford Crown Court found X to be guilty of manslaughter on the grounds of diminished responsibility due to mental ill health; she was sentenced to an indefinite hospital order (Section 37/41) under the Mental Health Act (MHA) and she currently remains in secure psychiatric care at Littlemore Hospital in Oxford where she is receiving treatment.
3.5.18	The Consultant Psychologist's note of his sessions with X notes her memory of the incident to be very poor. X knew she had thought people might hurt her son and that she had thought it better for him to be killed by her, rather than tortured by others. She also thought he'd been bullied when he was in care and had endeavoured to avoid a repeat.
Currently	X remains for the foreseeable future in secure psychiatric care where work continues to treat her and help her to gain insight. Care is being taken to manage what is clearly a high level of risk of suicide.

APPENDIX 7

IMPACT STATEMENT BY X's PARENTS

"When we lost our grandson we also lost our daughter. We even had to identify him in a morgue. How are you meant to cope with such horrendous news? I had a nervous breakdown. X's dad tried to keep himself together so he could help me. But how we felt and still feel, doesn't matter. What happened to our grandson mustn't happen to any other family, but it will. So many chances to help our grandson and X were missed. So yes, we do blame numerous health professionals who misdiagnosed her on more than one occasion. Saying that X was a complicated case or that she hid her symptoms isn't good enough. These people were professionals. X can't have been the only person they came across with the same symptoms. We, her parents, knew she wasn't bi-polar. Which is how she was diagnosed more than once. We do believe this horrendous nightmare could have been avoided if X had been diagnosed properly. Reading that I was a bad person hurt so much. I used to stay with X and our grandson often and they would often stay here with us and her 2 brothers who still lived at home. Then suddenly she phoned me to say our grandson was in care. We never saw him alive again. X cut all contact with us and moved house. Through social services (after a lot of searching) We were told both were ok. Why weren't we offered kinship care? We couldn't be told where they were living. X was very ill and thought I was trying to take our grandson from her. She seemed to focus on me wanting to get him. I was later told that people with her illness often focus on the one person they are closest to. I could carry on for pages about how it's affected us. When that little boy was born he bought so much joy and happiness to us all, X included. She loved him so much. I can't pass Peppa Pig items, toddler boys clothes, or hear certain nursery rhymes without thinking of him, and it hurts so much. X's dad's main thought is what our grandson went through during the last few minutes of his life. Yes, life is so hard for us most of the time but at least we're in touch with X again. I can't begin to understand how she must feel even though she is still very unwell. The law must change regarding the rights of grandparents. It has to. How many more 'grandsons' and X's have to go through hell like this, and how many more families have to be torn apart? We don't blame X and she knows that. We blame the people who should have helped her when she needed it the most. We blame the social services for not letting us have kinship care of our grandson. We blame an NHS who can't cope with huge cases of mentally ill

people and children in need or at risk. For a long time after our grandson's death, I wished every day that X had taken me and not him. Nearly every day I still do."