Independent Mental Health Homicide Investigation into the care and treatment of Mr A Executive Summary

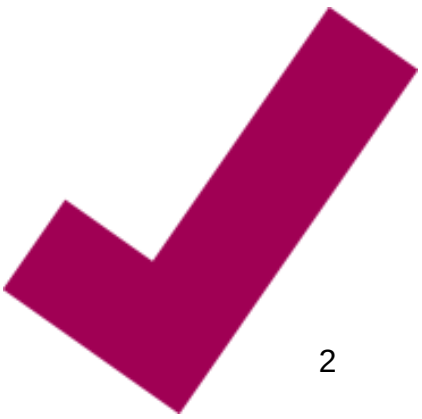
Authors:

Sancus Solutions

Lockside Office Park, 8G, Lockside Rd, Preston. PR2 2YS

Sancus Solutions wish to thank Mr A's family for their ongoing involvement with this investigation. Their contribution has been of great assistance in enabling a deeper understanding of the events that led up to this tragic incident. It is our sincere wish that this report does not contribute further to their pain and distress.

Sancus Solutions' investigation team would also like to acknowledge the contribution and support of staff from South West Yorkshire Partnership NHS Foundation Trust and West Yorkshire Police.



Contents

1 Incident

Mr A attended a Crown Court hearing where he pleaded guilty to the murder of his stepfather.

At the time of the incident, Mr A had recently been discharged under Section 42(2) of the Mental Health Act 1983[1] and was being supported and monitored by South West Yorkshire Partnership NHS Foundation Trust's (hereafter referred to as SWYPFT) forensic community transition service,[2] Regular reports were being submitted to the Ministry of Justice (hereafter referred to as MOJ) by Mr A's Responsible Clinician[3] (hereafter referred to as RC), his care coordinator and his social supervisor.[4] Mr A was living with his parents, who were both elderly with multiple health issues.

Leading up to the incident Mr A's mother was being supported by SWYPFT's community mental health and Kirklees outreach teams. During a visit by a healthcare professional from the Kirklees outreach team, Mr A's mother made a disclosure about historic incidents of domestic violence, as well as making a more detailed disclosure about a more recent incident of alleged sexual abuse. She named the perpetrators, who were both at the time living with her and, on occasions, were providing her with personal care.

2 Background information

Mr A's last recall to hospital was in February 2017, in response to concerns regarding deterioration in his mental health and a suspected increase in his substance misuse. Despite reservations being reported by the involved clinicians, the First-Tier Mental Health Tribunal[5] directed that Mr A should be discharged to reside at his parents' home address until suitable accommodation could be identified. A number of conditions were imposed on Mr A, which included regular supervision by the RC, a social supervisor and his care coordinator; compliance with his medication regime and undergoing random drug screening.

[1] Section 42(2) conditionally discharged patient subject to conditions such as to recall Section 42 (2)
[2] The forensic community transition team provides a community-based service to service users who are still under the care of specialist forensic psychiatry. It monitors health and social welfare as well as monitoring mental health and risk. The service offers practical support with housing, benefits, and activity and employment. The service is staffed by both health and social care staff. Forensic team
[3] The Responsible Clinician has overall responsibility for care and treatment for a patient who is being detained on a section of the Mental Health Act 1983. RC
[4] Social supervisor refers to the professional involved in providing reports to the Ministry of Justice following a restricted service user being discharged from hospital. The person discharged from hospital is subject to Section 37/41 of the Mental Health Act. Following discharge, the service user will be "conditionally discharged". The social supervisor reports to the MOJ and Mental Health Tribunals on a service user's care in the community, their rehabilitation and their risk to the public on a regular basis. A statutory report has to be completed initially within 28 days of the discharge and quarterly thereafter. Mr A's social supervisor was employed by the local authority. Social supervisor
[5] The First-Tier Tribunal is an independent panel that has the authority to discharge a patient from a Mental Health Act 1983 section. First Tier Tribunal

Following his discharge, Mr A's care coordinator and the social supervisor began to receive reports from Mr A's parents and his siblings reporting their increasing concerns about Mr A's ongoing substance misuse, his mental health and the suitability of him living with his elderly parents. During this period one random drug screen tested positive for amphetamine, cannabis and cocaine. During Mr A's care coordinator's last visit before the incident, Mr A reported that he was unable to provide a sample for drug screening. He also disclosed that he had used a small amount of cannabis.

3 Commissioning of the investigation

NHS England and NHS Improvement (North) commissioned Sancus Solutions to undertake a combined independent mental health[6] and domestic homicide[7] investigation. Due to possible safeguarding issues that arose during the initial investigation, NHS England and NHS Improvement (North) revised the initial Terms of Reference (hereafter referred to as ToR) to include the following addition: "Were any issues with respect to safeguarding (adults) adequately assessed and acted upon?"[8]

Due to the delays in publishing this report it was agreed that SWYPFT would provide Sancus Solutions with up to date information[9] about the progress that has been made in implementing the original recommendations and also the developments that have been part of the Trust's on going improvement plans. Where this is the case, an update section will identify the progress made and the evidence provided.

Involvement of Mr A's family

During the course of this investigation, both the lead investigator and the family liaison officer from Sancus Solutions met with Mr A's family on a number of occasions. The family were invited to contribute to the ToR. Members of the family received bimonthly progress reports.

[6] NHS England's criteria for the commissioning of an independent mental health homicide investigation are as follows: "When a homicide has been committed by a person who is, or has been, in receipt of care and has been subject to the regular or enhanced care programme approach or is under the care of specialist mental health services, in the 6 months prior to the event." Serious Incident Framework
[7] Under the Domestic Violence, Crime and Victims Act (2016), the Home Office requires the commissioning of an independent domestic homicide review when "the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself". Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016) states that the purpose of a domestic homicide review is to: "Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims." Home Office Guidance
[8] NHS England ToR p2
[9] Information was provided in May 2021

Care and treatment

4 Risk assessments

4.1 At the time of Mr A's involvement with SWYPFT's services, SWYPFT was directing staff to use the following:

- Sainsbury Centre for Mental Health's clinical risk assessment tool[10] and the Health of the Nation Outcome Scales[11] (hereafter referred to as HoNOS).

In addition, the inpatient forensic services were using Historical Clinical Risk Management-20 (hereafter referred to as HCR-20).[12]

4.2 SWYPFT's Clinical Risk Assessment, Management and Training Policy directs that risk assessments should be reviewed when there are "changes in risk, at point of any CPA review, or at least annually"[13].

4.3 Given Mr A's known and significant historical and current risk factors and the long-term involvement of SWYPFT's forensic services, it was concerning that Sancus Solutions' investigation team were able to locate only seven Sainsbury risk assessments[14] and one crisis plan that were completed from 2009 to 2016.

4.4 There is no evidence that an HCR-20 assessment was completed for Mr A during his inpatient admission. It was reported to Sancus Solutions' investigation team that although it is not prescribed within the trust's policy, the aim is that an HCR-20 is completed by a member of the inpatient clinical team prior to a patient's first inpatient CPA, which usually occurs at the three-month stage of an admission. It should then be reviewed at each subsequent Care Programme Approach[15] (hereafter referred to as CPA) review, either by the inpatient team or by the forensic community transition team.

---

[10] The tool consists of separate checklists that assess the risk of violence, neglect and self-harm or suicide. The Self-Report Risk Scale (SRS) is designed to assess both the risk of violence to others, and the risk for self-harm and suicide.

[11] HoNOS (Health of the Nation Outcome Scales) were developed during the early 1990s by the Royal College of Psychiatrists as a measure of the health and social functioning of people with severe mental illness. The scales contain 12 items measuring behaviour, impairment, symptoms and social functioning. HoNOS

[12] The HCR-20 is used to assess both the risk of violence to others, and the risk of self-harm and suicide HCR-20

[13] SWYPFT's Clinical Risk Assessment, Management and Training Policy (2016) p10

[14] Sainsbury's risk assessment consists of separate checklists that assess the risk of violence, neglect and self-harm or suicide. The Self-Report Risk Scale (SRS) is designed to assess both the risk of violence to others, and the risk for self-harm and suicide. The tool was developed to be used in primary care mental health and learning disability services Sainsbury Risk Assessment

[15] The Care Programme Approach is the national framework for mental health services assessment, care planning, review, care coordination, and service user and carer involvement focused on recovery. The Care Programme Approach (CPA) was introduced in 1990 to provide a framework for effective mental health care for people with severe mental health problems. Its four main elements were: systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services; the formation of a care plan which identifies the health and social care required from a variety of providers; the appointment of a key worker (care coordinator) to keep in close touch with the service user, and to monitor and coordinate care; and regular review and, where necessary, agreed changes to the care plan. CPA

4.5 The involved inpatient practitioners reported that as Mr A was unexpectedly discharged by the First-Tier Mental Health Tribunal prior to the first CPA review, this assessment had not occurred. There was no evidence that it was the intention of the community forensic outreach service to complete an HCR-20 once Mr A had been discharged.

4.6 Sancus Solutions' investigation team were of the opinion that the Sainsbury risk assessments that were completed were generally of a poor quality and changes in Mr A's risks were not being documented or assessed using the prescribed assessment tools. This resulted in significant risks not being documented or considered. For example:

- From 2013 there were concerns being documented about Mr A's relationship with a young woman called Jane[16], who was, at the time, on the local authority's Child Protection register.[17] In March 2016, the care coordinator was also made aware by the police that there had been an incident where Mr A had been arrested for a physical assault, with Jane being the victim.

- In 2016 and 2017 there were multiple occasions when both of Mr A's siblings voiced their concerns about Mr A living with their elderly parents, and on one occasion they reported that he had asked their parents for money.

- Mr A's siblings also reported to Mr A's care coordinator on a number of occasions that they either suspected or had seen evidence of Mr A's ongoing substance misuse. This was known to be a significant risk factor for deterioration in Mr A's mental health and an escalation in his risk factors.

Sancus Solutions' investigation team concluded that all of the above should have triggered a review of Mr A's risk assessment and risk management plan.

Involvement of Mr A's family

4.7 There are several references in SWYPFT's Clinical Risk Assessment, Management and Training Policy to the importance of the involvement of patients and their family in risk assessments and management plans.

4.8 All the Sainsbury risk assessments that were completed indicated that Mr A's family were not involved. It was not documented if this lack of involvement was because Mr A had expressed his wish that they were not to be involved. Sancus Solutions' investigation team suggest that if this was the case, then it should have been clearly documented.

[16] Pseudonym
[17] Progress notes 30 July 2013 2.11pm

4.9 Sancus Solutions' investigation team would suggest that the lack of involvement of Mr A's family in the risk assessments was a significant missed opportunity. Clearly, they were in a position to communicate valuable and real-time information about Mr A's risks and behaviours and how these were affecting the whole family. It would also have given the family a regular opportunity to voice their concerns and to have any unmet support needs identified and signposted to the relevant carers' services.

Involvement of Mr A

4.10 In all but one assessment (14 February 2017), it was indicated that Mr A had been involved; however, as there was so little narrative completed it was difficult for Sancus Solutions' investigation team to ascertain what his contribution was or if there was any disagreement with the assessor's conclusion. Such information is always important and must be documented, as it provides an additional level of information that contributes to the overall assessment of the risks and risk management.

Involvement of other agencies

4.11 Sancus Solutions' investigation team noted that there was no evidence that Mr A's GP or any other involved agencies, such as the social housing agency and the police, were asked to contribute to Mr A's risk assessments, care plans or reports to the MOJ and First-Tier Mental Health Tribunals.

4.12 Sancus Solutions' investigation team are aware that information sharing between services now has to comply with the General Data Protection Regulation (GDPR)[18]. However, SWYPFT's practitioners need to be aware that GDPR is not a barrier to justified information sharing, but rather provides the framework to ensure that personal information is shared appropriately.

4.13 Sancus Solutions' investigation team have concluded that based on the evidence available, Mr A's historic and evolving risks were not being adequately or robustly assessed and documented. This resulted in not only deficits in the responses to Mr A's risk factors but also non-compliance with SWYPFT's Clinical Risk Assessment, Management and Training Policy and best practice guidelines. Additionally, it placed others, such as Mr A's vulnerable elderly parents and Jane, at significant risk.

4.14 Sancus Solutions' original report made several recommendations to strengthen risk assessments and care planning in the involved SWYPFT forensic and inpatient services in order to improve practice and compliance with SWYPFT policies and best practice guidelines.

[18] General Data Protection Regulation 2018 GDPR

Psychological interventions

4.15 Given the complexities of Mr A's historical and recent comorbidities and the longevity of services' involvement, Sancus Solutions' investigation team were concerned that it appears that no psychosocial assessments and/or psychological interventions, such as cognitive behavioural therapy[19] or skills training in work rehabilitation, were ever considered or offered to Mr A.

4.16 The ongoing support that was offered by the forensic community transition team and Mr A's social supervisor was mainly a monitoring exercise to ensure Mr A complied with his conditional discharge requirements – for example, administering his depot medication and undertaking random drug screening.

4.17 Sancus Solutions' investigation team would suggest that engaging a patient such as Mr A in recovery-based assertive therapeutic support will always be challenging, especially when there is the overriding legal requirement for close monitoring and the possibility of a recall to hospital. Additionally, it was being documented that Mr A was consistently refusing to either accept his mental health diagnosis or disclose the extent of his substance misuse, all of which would have limited his willingness to engage with therapeutic interventions.

4.18 It was reported to Sancus Solutions' investigation team that although the inpatient psychologists do attend the weekly referral meetings, there has been a historic and ongoing difficulty in recruiting and retaining forensic psychologists. It was also reported that at the time of the investigation the forensic community transition team did not have an allocated psychologist. These issues have resulted in limited psychological assessments and recovery-focused interventions being available.

4.19 Sancus Solutions' investigation team were also informed that the forensic community transition service does not have an allocated forensic psychiatrist. It was reported that 10 per cent of all SWYPFT's forensic inpatient psychiatrists' time is allocated to the service. It was also reported that as the forensic psychiatrists are allocated to particular patients rather than to the service itself, there is not adequate time for them to contribute to either the development of an overarching biopsychosocial[20] or a recovery-oriented outreach rehabilitation practice.

[19] Cognitive behavioural therapy (CBT) is a psychosocial intervention that aims to improve mental health. CBT focuses on challenging and changing unhelpful cognitive distortions and behaviours, improving emotional regulation, and the development of personal coping strategies that target solving current problems. It is a NICE recommended therapy to manage a range of mental health issues. NICE guidelines

[20] The biopsychosocial model is an interdisciplinary model that looks at the interconnection between biology, psychology and socio-environmental factors. Biopsychosocial

4.20 Sancus Solutions' investigation team have suggested that SWYPFT considers allocating a forensic psychiatrist, who has experience of operating within community forensic services, to the community transition service.[21]

4.21 It was reported by both the inpatient clinical team and the community forensic transition service that the level of close supervision and report writing for patients under Section 42(2) of the Mental Health Act 1983 is extremely time consuming. There is no administrative support for either service. It was reported that, at times, this has resulted in missing report submission deadlines and significantly compromising clinical responsibilities, resulting in there being little capacity to undertake any therapeutic interventions with patients. It was also reported that there is no dual diagnosis practitioner allocated to the community transition service and this deficit is a significant issue, as so many of their patients have substance misuse issues that require specialist interventions.

4.22 Sancus Solutions investigation team were informed that although there is currently no time limit for a patient to be allocated to the forensic community transition team. In cases where there is no requirement for ongoing supervision/monitoring a patient is often referred to the adult community mental health service's enhanced care pathway. Sancus Solutions' investigation team were informed that currently there is no direct entry into this service and that a patient has to be referred and then assessed for their suitability for community mental health services.

4.23 It was reported that patients are often not being accepted to SWYPFT's adult community mental health service, mainly due to concerns about their forensic comorbidities[22] and/or their risk history. This can result in patients remaining within the forensic community transition service for long periods of time resulting in additional pressure on the team's capacity/resources. It also results in these patients not having access to the types of support that community mental health services can provide, such as recovery-focused therapeutic and psychological support.

[21] Sancus Solutions' investigation team would suggest that there are differences between the functions and roles of inpatient and community forensic services that require different forensic psychiatric skills. The Royal College of Psychiatrists supports this view, as it suggests that "specialists in rehabilitation psychiatry have the core competencies of the general adult psychiatrist with additional expertise to undertake the core tasks".
[22] Comorbidities – presence of one or more additional conditions co-occurring

Pharmaceutical interventions

4.24 Sancus Solutions concluded that the medications that were being prescribed to Mr A were concordant[23] with British National Formulary[24] advisory limits.

Substance misuse

4.25 From Mr A's initial contact with mental health services in 1987, it was being identified, by both his family and the involved SWYPFT practitioners, that his ongoing substance misuse was having a significant detrimental effect on his mental health. Apart from undertaking a drug prevention programme in October 2002, Mr A consistently refused to engage in any further programmes either during his inpatient admissions or in the community.

4.26 During his last inpatient admission, Mr A agreed to meet with the dual diagnosis nurse, and he completed the service user screening tool, which indicated that he felt that he did not have any problems with illicit substances or alcohol. It was decided that due to Mr A's refusal to identify any particular risks associated with his substance misuse, no further involvement by the dual diagnosis nurse was required.

4.27 Members of Mr A's family reported to Sancus Solutions' investigation team that the lack of perceived action being taken when they reported Mr A's non-compliance with his conditions of abstinence resulted in considerable frustration and concern as well as a lack of confidence in a system that they had been led to believe was meant to care for and protect both Mr A and their elderly parents.

4.28 Sancus Solutions' investigation team were informed that the local substance misuse services are provided locally by third-sector agencies and that a patient is required to self-refer. It is likely that a patient would only be motivated to self-refer to such services if they identified that they were experiencing substance misuse difficulties that they wanted to address. As Mr A did not agree that he had a substance misuse issue, it was unlikely that he would ever have voluntarily engaged with such services.

4.29 Sancus Solutions' investigation team concluded that although the MOJ's responses to the reports of Mr A's substance misuse were concordant with their guidelines, the repeated decisions not to recall him meant that this condition on his discharge was unlikely to have acted as much of a deterrent

[23] In agreement/consistent

[24] The British National Formulary is a United Kingdom pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology. It is published jointly by the British Medical Association and the Royal Pharmaceutical Society. BNF

for Mr A. It also undermined the involved practitioners' ability to effectively supervise Mr A in the community.

4.30 Additionally, given Mr A's ongoing failure to comply with this condition and the lack of action taken when he failed to comply, it is unclear why the First-Tier Mental Health Tribunals consistently cited it as one of his conditions for being discharged from the inpatient unit.

Developments within the forensic community transition service

4.31 During the course of their original investigation Sancus Solutions' team were provided with updated reports from the new forensic community transition team manager, who came into post in March 2019. The practice governance coach from the forensic business delivery unit (BDU) also provided updates on the changes and improvements that have been introduced within the forensic community transition team since this incident and in response to the findings of SWYPFT's serious incident report (hereafter referred to as SIR). For example:

- All care coordinators have now undertaken HCR-20 training.

- The new team manager is in the process of restructuring clinical and managerial supervision. However, ongoing sickness absences in the team have made it difficult to complete a full review of the service and implement the required changes.

- Two dip-sample audits of case files have been undertaken. It was reported that the outcome of both audits was that there remain considerable concerns about the quality of the risk assessments and CPA planning – for example, HCR-20 assessments had not been completed for all patients.

- Sancus Solutions' investigation team were provided with evidence of the development of a more robust multidisciplinary team (MDT) and referral meeting structure in both the community and inpatient forensic teams.

4.32 The SIR noted that Mr A's care coordinator only visited Mr A at prearranged dates/times, despite his siblings reporting that their brother was "pulling the wool over everyone's eyes"[25]. The authors of the SIR suggested that Mr A was able to ensure that he was not under the influence of illegal substances at the time of the prearranged visits from his care coordinator and that although there were suspicions and reports from Mr A's family, the true extent of his behaviours and illegal substance misuse were not known. It was reported to Sancus Solutions' investigation team that one of the developments within the forensic community transition team is that there has been a significant change

[25] SWYPFT's SI report p17

in the way care coordinators visit patients, which now includes unannounced visits. This enables a more comprehensive picture to be developed.

5 Updates- June 2021

In May 2021 SWYPFT provided Sancus Solutions with the following information

HCR 20

5.1 Forensic community service

- It was reported that all practitioners in the forensic community service have now completed HCR 20 training. Additionally, there is an on gong HCR-20 training programme for practitioners in all the forensic services.

- SWYPFT's most recent Clinical Record Keeping Re-Audit of Forensic Business Delivery Unit (FBDU) Low Secure Community Team (June 2020) reported

  "Overall compliance level currently :75%

  The audit highlights that 21% of service users do not have a current HCR-20 assessment and that 32% of assessments have not been updated in the last 12 month period.

  Action: The compliance level needs to be that 100% of patients have a current updated HCR-20 and a process needs to be embedded where this is updated at least every year as a minimum as per trust policy.

  Completion levels an update of Sainsbury risk assessment (or the new FIRM at the point this is rolled out) need to achieve 100% compliance.

  Presence of risk management in care planning needs to be reviewed with the MDT colleagues and ensure it is comprehensive and relevent."[26]

- In response to this audit the forensic community service identified the following actions:

  " The compliance level needs to be that 100% of patients have a current updated HCR-20 and a process needs to be embedded where this is updated at least every year."[27] – to be completed by January 2021

[26] Clinical Record Keeping Re-Audit of Forensic Business Delivery Unit (FBDU) Low Secure Community Team June 2020 p6
[27] Forensic community service action plan p2

5.2 Forensic inpatient unit: unlike the forensic community service Sancus Solutions were not provided with a detailed action plan from forensic inpatient unit. However, the following information was verbally provided:

- As part of the commission's requirement that all assessments, including HCR-20, have to be completed within the initial 12 weeks period and reviewed at the 6 months stage of an admission.

- A discharge plan now needs to commence at the point a patient is initially admitted to the unit.

5.3 Sancus Solutions are recommending that at their quality assurance review SWYPFT will be in a position to provide evidence of the progress that has been with regard to the completion of HCR-20 assessments in both the forensic inpatient services.

Risk Assessments

5.4 Since the completion of Sancus Solutions' investigation SWYPFT have introduced a new risk assessment – a formulation-informed risk management (FIRM)-

- Implementation of New Formulation Informed Risk Management (FIRM) Framework, post Covid-19 and post CAMHS implementation reported:

  "The FIRM risk assessment is based on a revision of the Sainsbury's tools and was designed by a group of experienced clinicians from across secure services, working age adults and CAMHS who frequently conduct risk assessments. The purpose was to replace Sainsbury's Level 1 and 2 assessments with a single, more relevant tool that would be used across all services, based on a formulation-informed risk management (FIRM) approach and incorporating a Staying Safe Plan.… The FIRM assessment is designed to enhance current clinical practice. The fundamentals of risk assessment and management will not change as a result of implementing FIRM. Rather it will provide a more robust, evidence-based and up to date framework for staff to use to record clinical judgements about risk and to inform management and care plans. "[28]

- The following update was provided to Sancus Solutions (May 2021.)

  "Due to the ongoing Covid-19 pandemic the planned April 2020 roll-out of the FIRM risk assessment was initially postponed,

[28] Implementation of New Formulation Informed Risk Management (FIRM) Framework, post Covid-19 and post CAMHS implementation reported p1

A pilot of the new assessment took place in a number of Children and Adolescent service. (CAMHS) 6 July 2020.

Feedback from FIRM Champions (including 'no issues raised') has been collected weekly to identify any concerns, suggestions for improvement and to use any learning to guide wider roll-out.

Following agreement at OMG[29] 5th August and on 6th August 2020 a new go-live date of 28th September has been approved (26th October for Forensics and ADHD/ASD services).

Communications and training via MS Teams has recommenced."

- Forensic community service's action plan states:

"All service users will have a new FIRM risk assessment in 6 months. This work should commence on all caseloads from November 2020.
Progress on this action will be monitored through weekly caseload supervision."[30]

- "Tailored FIRM training to Forensics Services will commence from 6th October ahead of a FIRM go-live of 26th October for these teams.[31]

5.5 Sancus Solutions were provided with the following evidence of:

- FIRM proforma. This now includes an extended section on exploitation, vulnerability and safeguarding concerns – including self-neglect and domestic violence. It directs the assessor to contact the safeguarding team if the risk of abuse impacts directly or indirectly the service user.

- Revised Record Keeping SOP and Risk Assessment and Management Policies.

- FIRM Clinical Training presentations.

5.6 Sancus Solutions concluded that the new FIRM assessment proforma is an improved tool. It is evident that SWYPFT has committed considerable resources in the development and roll out of the new assessment tool across its services. However, as with all risk assessments tools it is reliant on the skills of the assessor to identify, document and accurately assess risks. Sancus Solutions would expect that at their quality assurance review SWYPFT will be in a position to provide evidence from an audit of the use of FIRM in their forensic community and inpatient services.

[29] Operations Management Group
[30] Forensic community service action plan p4
[31] SystmOne Optimisation p5

5.7 Sancus Solutions also noted that as FIRM is a generic assessment tool it does not ask the assessor to detail and assess potential forensic risk factors/assessments- for example outcomes of HCR-20 assessments, potential risks of MOJ restrictions etc. Sancus Solutions would suggest that SWYPFT considers developing a FIRM assessment specially for its forensic services.

5.8 Sancus Solutions were provided with a Clinical Record Keeping Audit for Forensic Business Delivery Unit (FBDU) Low Secure Community Team audit completed in June 2020. The audit measured compliance against the following standards:

- Standard 1: Record Keeping. The activity of making and keeping records is an essential legal and integral part of patient care, which should be performed by all professionals who contribute to service user records- 61% compliance.

- Standard 2[32] Information given to service users. Each area should provide written information about the service, and its aims and objectives, to promote a safe effective admission to the service and a positive experience for the person- 25% compliance.

- Standard 3: Assessments. Each person should have a documented assessment of their health and social care needs – 73 % compliance.

- Standard 4: Risk assessments and risks management. Assessments should include identification of clinical risk and will be documented and evaluated regularly in the care plan- 75% compliance.

- Standard 5: -Plan of care and intervention: Everyone should have a documented comprehensive package of care. Care plans will highlight the proposed actions aimed at helping the person- 55% compliance.

- Standard 6: Inpatient and community discharge. Each area must have identified transfer/discharge procedures/pathways/plans, which clearly state the aims and objectives in facilitating an integrated safe effective transfer/discharge or referral to other services/agencies. - 56% compliance.

- Standard 7: Family carers involvement in care. Family carers and the essential role they play in the person's recovery is acknowledged at first contact with the service or as soon as possible thereafter. 41% compliance.

[32] Note this standard was identified a 3 in the audit report

5.9 Sancus Solutions were provided with an action plan for the community forensic service that was developed in response to this finding of the audit. For example:

Standard 2 "The team to develop a format to share broad information about the team."[33]. Completed by December 2021.

Standard 6 – "Review all service users subject to conditional discharge and ensure that required care plans are linked with their discharge arrangements."[34] Aim to be completed date May 2021.

There were also a number of other actions identifed that included:

"All team members will have individual management supervision to review ongoing practice and development needs.
Training needs to be identified and relevant training offered.
A review of cases presented will be undertaken as an assurance check of processes being robust and contributing to enhanced quality and safe management of service users."[35]

5.10 Sancus Solutions were informed that SWYPFT is currently looking at introducing a significant number of changes within the forensic community mental health services which include:

- A forensic outreach team that provides episodic care

- Developing a pathway between forensic community services and the CMHT services.

5.11 Sancus Solutions were assured that a number of their original findings relating to the forensic community service have begun to be addressed. It is expected that at their quality assurance review SWYPFT will have completed a further audit and will be in the position to provide a further update on the development of the service.

6 Multi-agency public protection arrangements (MAPPA) and Potentially Dangerous Person (PDP)

6.1 In 2007 and 2009, MAPPA[36] meetings were convened at which a risk management plan was agreed to manage Mr A in the community. Mr A was

[33] Action Plan p2
[34] Action Plan p5
[35] Action Plan p 5
[36] MAPPA level 1: Effective risk management is the core function of MAPPA, and achieving it requires all agencies to share relevant information. All agencies should look to do all they can within their powers to contribute to risk management. Risk management is the construction and implementation of a plan which

made subject to risk management level 1, with SWYPFT being the lead agency.

6.2 Sancus Solutions' investigation team were of the opinion that once the decision had been made by the First Tier Mental Health Tribunal to discharge Mr A, a referral should have been made to MAPPA – particularly given the concerns about Mr A's risks to others, especially Jane and his elderly parents.

6.3 Additionally, if it was felt that he would not meet the MAPPA criteria, then consideration should have been given to reporting him to the police in order to assess if he met the referral criteria for a Potentially Dangerous Person (PDP)[37].

6.4 Both would have provided the opportunity for both information sharing and an up-to-date multi-agency risk assessment to have been undertaken.

6.5 During the course of Sancus Solutions' investigation, it was apparent that certain members of the involved teams appeared to be unaware of the purpose and benefits of PDP. Sancus Solutions' investigation team would suggest that this is a deficit in knowledge that needs to be addressed so that, in future, this option is utilised in the management of high-risk patients.

Update- June 2021

6.1 It was reported to Sancus Solutions that the recommendation to update SWYPFT's forensic services on the role of PDP is still outstanding, therefore this recommendation remains. Sancus Solutions would expect to see implementation at their quality assurance review.

7 Capacity

7.1 With regard to the specific ToR "Were there issues in relation to capacity or resources in any agency that impacted the ability to provide services to the victim and to work effectively with other agencies?", Sancus Solutions' investigation team have highlighted several resource issues that although did

addresses the identified risk and protective factors. In effect, it is what staff do with an offender that is crucial. Risk management is not an exact science as it is not possible to eliminate risk entirely. It is therefore critical that the decisions made are defensible, the Risk Management Plan (RMP) is implemented and monitored through regular reviews, and adjustments to the RMP are made as necessary. RMPs should be shared with all relevant agencies following a review, including reviews for level 1 cases. When an offender is identified as a MAPPA offender, the lead agency has a duty to ensure that any identified risks are managed robustly at the appropriate level of MAPPA management. The RMP must include actions to monitor and where possible change the behaviour and attitudes of the offender in order to minimise the risk of serious harm. RMPs should relate to current and expected future risks and should draw upon information from all relevant agencies within MAPPA. All MAPPA offenders must have an RMP completed by the lead agency to its own required standards. Information from DTC or any other agencies involved, and other Responsible Authority agencies, should inform the RMP. MAPPA

[37] PDP is a person who is not currently managed by one of the three multi-agency public protection arrangements (MAPPA) categories, but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm. PDP

not directly impact on the management of Mr A but which, in their opinion, were affecting the community transition services. These included:

- lack of administrative support

- no dedicated forensic psychiatrist, psychologist**,** dual diagnosis practitioner situated within the forensic community transition service.

Update- June 2021

- Sancus Solutions were not provided with any evidence that the above issues had been addressed therefore their original recommendation remains. Sancus Solutions would expect to see evidence of implementation at their quality assurance review.

8 Ministry of Justice

8.1 Mr A's positive drug screens, incidents when he refused to comply with drug screening and concerns regarding his substance misuse were all reported by his RC in the three-monthly reports to the MOJ. There were also occasions when the RC and the care coordinator documented that they had warned Mr A that his failed drug screening and his refusal to agree to drug screening would have to be reported to the MOJ and might result in a recall to hospital.

8.2 MOJ's guidance for the recall of conditionally discharged restricted patients states that:

"Substance (or alcohol) misuse cannot, of itself, lead to recall, even if it is in breach of the patient's conditions of discharge. Substance (and alcohol) misuse will lead to consideration of recall if there is evidence that these are risk behaviours and/or such misuse is known to have had a detrimental effect on the patient's mental state. It is not necessary to wait for the patient's mental state to deteriorate if there is evidence of a pattern of behaviour likely to lead to such deterioration. What constitutes such a pattern will, of course, depend upon the circumstances of the case."[38]

8.3 The fact that Mr A's substance misuse did not automatically trigger an MOJ decision to recall him to hospital caused his family considerable concerns. The MOJ authorised Mr A's recall only when his RC and social supervisor reported evidence of a significant decline in Mr A's mental health and a potential escalation of his risk factors, which were often being exacerbated by substance misuse.

[38] The Recall of Conditionally Discharged Patients 2009 pp6-7 MOJ

9 First Tier Mental Health Tribunal[39]

9.1 The chair of the First Tier Mental Health Tribunal noted the concerns being expressed by the involved clinicians regarding Mr A's risks, but the panel concluded that they were:

"Not satisfied that the patient is suffering from a mental disorder or from mental disorder of a nature or degree which makes it appropriate for the patient to be liable to be detained in a hospital for medical treatment. The tribunal … [was] not satisfied that it [was] necessary for the health and safety of the patient or the protection of other persons that the patient should receive such inpatient treatment."[40]

9.2 With regard to the First Tier Tribunal panel's decision, unfortunately Sancus Solutions' investigation team have been unable to interview the judge and therefore do not feel they are in a position to directly comment on this decision. However, they would make the following comments:

- A lack of suitable accommodation is not in itself a justifiable reason for not discharging a patient.
- It was extensively reported that Mr A had previously failed to comply with conditions in relation to his substance misuse and drug screening, and there was no evidence presented to the panel that indicated that this behaviour would not be repeated.

9.3 Clearly, the First Tier Tribunal panel's decision to conditionally discharge Mr A had been unexpected and was opposed by some of the involved clinicians. In the email correspondence between the chair and the author of SWYPFT's SIR, it was suggested that the trust had an option to appeal this decision[41]. There was no evidence that this was considered.

10 Safeguarding and domestic violence

Mr A's mother

10.1 Mr A's mother made a number of concerning disclosures and allegations to her care coordinators and visiting clinicians about historical abuse, as well as a disclosure of more recent abuse. She also reported that her son was on a

[39] Unfortunately, despite considerable efforts, Sancus Solutions' investigation team were unable to make direct contact with the chair of the most recent First-Tier Mental Health Tribunal (27 March 2017). Rather than face a further delay to the completion of their investigation, Sancus Solutions' investigation team decided that they would base their analysis on the reports submitted to the First-Tier Mental Health Tribunal and documents completed by the chair. They were also provided with email correspondence between the chair and the author of SWYPFT's SIR.

[40] First-Tier Mental Health Tribunal 27 March 2017 p2

[41] There are two formal means of challenging a Tribunal's decision: an appeal to the Upper Tribunal, and a judicial review. Mental Health Act

mental health section and that she suspected that he was using illegal substances when he was living with her.

10.2 In response to one disclosure, the practitioner reported it to her team manager. It was documented in Mr A's mother's progress notes that "it was agreed that this can be broached at a time when [Mr A's mother's] mental health state is more stable"[42].

10.3 No further action was taken regarding the alleged abuse disclosures until after the death of Mr A's stepfather. Sancus Solutions' investigation team would question the timing of the decision to discuss the disclosures with Mr A's mother, as it had not been a year since she had lost her husband in such traumatic circumstances.

10.4 Additionally, members of Mr A's family expressed their concerns to Sancus Solutions' investigation team about the timing and manner in which their mother was asked about this allegation. They reported that they had been unaware that this was to be discussed, and so they were not prepared for how distressed their mother was after the visit.

10.5 Sancus Solutions' investigation team would suggest that the delay in revisiting the allegation of abuse with Mr A's mother may have been due to the fact that the original disclosure was only documented within Mr A's mother's patient records and was not identified in successive risk assessments and care plans or discussed at MDT meetings. This resulted in it being overlooked until it was raised during SWYPFT's SIR investigation process.

Mr A's stepfather

10.6 The evidence reviewed by Sancus Solutions' investigation team clearly indicated that Mr A's stepfather was also a frail and vulnerable elderly adult who had complex health issues. There were several disclosures made by both Mr A's brother and his stepfather that Mr A had made threats of physical violence towards this elderly gentleman.

10.7 There was no evidence that the involved agencies were identifying Mr A's stepfather in respect to his needs or that consideration was being given to potential safeguarding concerns that needed to be addressed.

10.8 Sancus Solutions' investigation team concluded that the lack of responses both to disclosures made by Mr A's mother and to the information that Mr A had made threats of violence towards his stepfather contravened SWYPFT's Safeguarding Adults at Risk Policy, which states that all employees have a

[42] Progress notes 10 June 2016 4.40pm

statutory duty to take action when there is a concern that a vulnerable person might be:

"Experiencing, or at risk of, abuse or neglect; and [who] as a result of those care and support needs [is] unable to protect themselves from either the risk of, or the experience of abuse or neglect"[43].

10.9 The policy also states that SWYPFT's practitioners' role is to:

"Provide a first level of advice where they feel able, referring onto the Safeguarding Team depending on the presenting issue or complexity of the case"[44].

10.10 Clearly, the evidence available to the involved practitioners was indicating that this was a very complex family situation that should have prompted a multi-agency approach. Such were the known and unknown risks that the following actions should have been taken:

- obtaining advice from SWYPFT's safeguarding team, who would have considered whether the allegations and possible risk factors met the criteria for a referral to the local authority for a possible Section 42 enquiry[45]

- ongoing information sharing between the services involved with Mr A and his mother

- reporting the allegations to the police, who would have decided whether a criminal investigation was required.

10.11 Sancus Solutions' investigation team concluded that regardless of the rationale for the lack of response to the allegations and known vulnerabilities, the lack of safeguarding responses/considerations and failure to liaise with Mr A's community forensic team was unacceptable and contrary to SWYPFT's safeguarding policies.

10.12 In response to the findings of the SIR, SWYPFT commissioned an internal safeguarding report, which made a number of recommendations that aimed to increase the involved practitioners' knowledge and understanding of domestic violence. This included a number of domestic violence training and learning events. Clearly, such training can only benefit and increase practitioners' knowledge of this issue, but it was unclear to Sancus Solutions' investigation team how focused this training was on domestic violence involving the elderly

[43] SWYPFT's Safeguarding Adults at Risk of Abuse or Neglect Policy p6
[44] SWYPFT's Safeguarding Adults at Risk of Abuse or Neglect Policy p13
[45] The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. When an allegation about abuse or neglect has been made, an enquiry is undertaken. Care Act

and how it is now informing practice. Sancus Solutions' investigation team have therefore recommended that until there is assurance that this knowledge is fully embedded in the practices of the community and inpatient elderly mental health teams, SWYPFT's safeguarding team should regularly attend the inpatient and community elderly care mental health services multidisciplinary team meetings.

10.13 In March 2019 SWYPFT introduced a revised Safeguarding Adults at Risk of Abuse or Neglect Policy. It was, however, noted that the policy does not make any specific reference to the particular challenges of identifying and assessing the risk of domestic violence in the elderly patient group. Sancus Solutions' investigation team would suggest that this is a deficit within the policy that needs to be addressed.

10.14 It was reported to Sancus Solutions' investigation team that the elderly mental health service's practitioners, who had been involved in supporting Mr A's mother, did not have a comprehensive understanding of the particular Mental Health Act 1983 sections or the role of the conditional discharge restrictions. Sancus Solutions' investigation team would suggest that this is a deficit in their knowledge that needs to be addressed through ongoing training.

10.15 Sancus Solutions' investigation team concluded that the responses by the involved staff to the disclosures made by Mr A's mother and by other members of the family were not adequately assessed or acted upon.

Jane

10.16 Sancus Solutions were unable to contact Jane to invite her to contribute to their investigation.

10.17 Mr A's relationship with Jane first came to the attention of SWYPFT's practitioners in 2013, when Mr A disclosed during an outpatient appointment that he had a female friend (Jane) whose mother was a family friend. He also reported that Jane was 22 years old and that their relationship was platonic. The consultant locum forensic psychiatrist, who was, at the time, acting as Mr A's RC, documented his concerns about this relationship and questioned Mr A about his sex offence history. At the next CPA review, Mr A contradicted his previous account, reporting that he was in an "intimate relationship"[46] with Jane and that he had only known her for a year.

[46] Mental Health Tribunal report p10

10.18 Later that year, the Child Exploitation Unit contacted Mr A's social supervisor to "report concerns about a 16 year old girl who [appeared] to be on the Child Protection register as she was a vulnerable person"[47].

10.19 Mr A's patient records indicated that children's services contacted Mr A's care coordinators to ascertain information about Mr A. It was documented in that they had also reported that Jane was 16 years old and was on their At Risk Register.[48]

10.20 It is important to note that the involvement and actions taken by children's services in respect of Jane was outside the scope of the investigation. Therefore, Sancus Solutions did not seek to either verify information with children's services regarding their involvement or identify any potential leaning opportunities.

10.21 In a subsequent report by Mr A's RC to the First-Tier Mental Health Tribunal, it was documented that Mr A was:

"An unreliable historian and he [was] limited with his openness … recently this had borne out in his reluctance to discuss a relationship with a 16 year old female who is on the at Risk Register … He previously told professionals that she was in her 20s and that it was a platonic relationship … He later disclosed that it was an intimate relationship."[49]

This information and comments concerning Mr A's relationship with Jane were being repeatedly documented in successive reports to the MOJ and First Tier Mental Health Tribunal reports. However, no further action was taken by any of the involved practitioner either to ascertain more information about the relationship or to share any safeguarding concerns with other involved agencies.

10.22 Sancus Solutions' investigation team have concluded that the lack of action, including information sharing, by SWYPFT's practitioners at a time when it was known that Jane was a vulnerable child and that Mr A was an unreliable historian was a failure to respond to a potential safeguarding issue.

Update – June 2021

10.23 Sancus Solutions were provided with the following evidence:

- Safeguarding Adults at Risk of Abuse or Neglect Policy – issued June 2019.

[47] Progress notes
[48] The Child Protection Register. Each Health and Social Care Trust (HSC Trust) is required to keep a register of every child/young person in its area who is considered to be suffering from, or is likely to suffer, significant harm and for whom there is a Child Protection Plan
[49] First-Tier Mental Health Tribunal report p4

- Policy for Dealing with Domestic Violence and Abuse – issued October 2020.
- Safeguarding and Domestic Abuse training modules – 21 May 2021.
- Audit of electronic records to identify Safeguarding incidents and the quality of recording and actions taken – author Safeguarding Adults Advisor. [50]

10.24 The findings of the audit were as follows:

"The audit findings revealed that all of the identified safeguarding concerns with a DATIX being completed (Sample Group 1) had an appropriate safeguarding referral made to the Local Authority. In the majority of these cases, police were informed appropriately however in three of the twenty one cases (14%) reviewed there were no entries regarding police notification or involvement, as well as no rationale as to why they had not been contacted."[51]

Additionally:

"A key point highlighted by the audit was the infrequent use of the safeguarding risk assessment on SystmOne, which again is a recommended area for improvement, although it was noted that the safeguarding risk assessment on SystmOne was not easily accessible."[52]

10.25 It was also reported to Sancus Solutions that there had been a significant increase in the number of inquiries the safeguarding team have received. There is also ongoing monitoring by the safeguarding team of the Safeguarding incidents reported on Datixweb. Additionally, Practice Governance Coaches "enable staff to deliver on the care agenda which supports safeguarding. They will do this by supporting staff to proactively assess and plan for care, ensuring risk management is intrinsic to the process. … Practice Governance Coaches will advise staff on raising concerns into safeguarding, and support person centred approaches by coaching people through the decision making process. Practice Governance Coaches will advise staff to contact the Safeguarding Team when they feel that they cannot advise appropriately due to the presenting issue or complexity of the case."[53]

10.26 Based on the evidence provided Sancus Solutions were satisfied that since the incident and their initial investigation SWYPFT have made significant effort to improve both the reporting and practitioners' understanding of safeguarding issues. However, as two of the original recommendations

[50] Audit was not dated
[51] Audit of electronic records to identify Safeguarding incidents and the quality of recording and actions taken p2
[52] Audit of electronic records to identify Safeguarding incidents and the quality of recording and actions taken p3
[53] Safeguarding Adults at Risk of Abuse or Neglect Policy p13

remain outstanding Sancus Solutions would expect to see evidence of their implementation at their quality assurance review.

11 West Yorkshire Police

11.1 As part of Sancus Solutions' investigation, West Yorkshire Police completed an Individual Management Report[54] (hereafter referred to as IMR). This report was completed by two serious case review officers and reviewed the 10 incidents where police had contact with Mr A and Jane.

11.2 Their involvement began in 2014 when Jane was 17, and their last contact was in 2016. There were several incidents when Jane was assessed as being the protagonist and was arrested for Breach of the Peace.

11.3 Prior to Jane's 18th birthday, the police were aware that she was a looked-after child[55] and the IMR concluded that "there was no evidence that the attending officer considered completing a Child Protection referral to children's social care"[56].

11.4 The IMR noted that although it was known by the police that Jane and Mr A were in a relationship, at no point was a Domestic Abuse, Stalking and Harassment, and Honour Based Violence risk assessment [57] completed. The IMR concluded that many of the incidents were not "dealt with as a domestic incident, and the subsequent action taken was not compliant with the Force Domestic Abuse Policy"[58].

MAPPA

11.5 The authors of the IMR noted that in 2009 Mr A had been subject to a Multi-Agency Public Protection arrangement[59] (hereafter referred to as MAPPA

[54] An IMR is a report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation. IMR
[55] The definition of a looked-after child is one that has been in the care of their local authority for more than 24 hours. Jane had been placed on the Child Protection Register under the category of neglect. Looked-after child
[56] A child protection referral should be made when there is a concern about the safety and wellbeing of a child
[57] The authors of the police's IMR referred to West Yorkshire Police Force policy, which defines a domestic incident as: "Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality." West Yorkshire Police IMR p14.
[58] West Yorkshire Police IMR p16
[59] MAPPA Level 1: Effective risk management is the core function of MAPPA, and achieving it requires all agencies to share relevant information. All agencies should look to do all they can within their powers to contribute to risk management. Risk management is the construction and implementation of a plan which addresses the identified risk and protective factors. In effect, it is what staff do with an offender that is crucial. Risk management is not an exact science as it is not possible to eliminate risk entirely. It is therefore critical that the decisions made are defensible, the Risk Management Plan (RMP) is implemented and monitored through regular reviews, and adjustments to the RMP are made as necessary. RMPs should be shared with all relevant agencies following a review, including reviews for Level 1 cases. When an offender is identified as a MAPPA offender, the lead agency has a duty to ensure that any identified risks are managed robustly at the appropriate level of MAPPA management. The RMP must include actions to monitor and where possible change the behaviour and attitudes of the offender in order to minimise the risk of serious harm. RMPs should relate to current and expected future risks and should draw upon information from all relevant agencies within MAPPA. All

level 2 meeting where a number of actions were agreed. However, there was no evidence that these actions were ever monitored.

11.6 The authors of the IMR also concluded that there appeared to be a "lack of understanding [by the police] of the serious implications of [the] breaches of [Mr A's] hospital order. This was a missed opportunity to refer him back to the MAPPA Level 2 management."[60]

11.7 One of the concerns identified within the IMR was that there was no evidence that the MAPPA meeting discussed the action(s) that needed to be taken if there was deterioration in Mr A's mental health or substance misuse. It also noted that following the meeting, Mr A's ViSOR[61] record was closed and archived and therefore there was "no accountability mechanism in place to review whether the agreed actions had been completed"[62].

11.8 With regard to the NHS England ToR "Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others"[63], The authors of the IMR noted that only one risk assessment and risk management plan was completed as part of the MAPPA level 2 meeting on 27 August 2009.

11.9 In relation to the NHS England ToR asking "Whether the service user had any previous history of abusive behaviour towards the victim and whether this was known to any agencies"[64], the IMR documented that as there were no recorded incidents involving Mr A and his stepfather, there were no safeguarding markers or concerns documented within the police records.

11.10 The IMR's authors concluded:

- "There were no clear pathways/policies/procedures for the risks management of patients who are subject to Hospital Orders and subject to conditional discharge from such Orders currently in West Yorkshire Police local policies."[65]

- "There were missed opportunities for West Yorkshire Police to make referrals to Health Agencies and Adult Social Care when Police Officers attended incidents involving [Mr A]. Such referrals would have informed Health Agencies of any

MAPPA offenders must have an RMP completed by the lead agency to its own required standards. Information from DTC or any other agencies involved and other Responsible Authority agencies should inform the RMP. MAPPA

[60] West Yorkshire Police IMR p25
[61] ViSOR is the Dangerous Persons Database VISOR
[62] West Yorkshire Police IMR pp27-28
[63] NHS England ToR p2
[64] NHS England ToR p2
[65] West Yorkshire Police IMR p25

deterioration in [Mr A's] behaviour and enabled assessments of his health, wellbeing and management of his risk in the community."[66]

11.11 The IMR made the following recommendation:

"West Yorkshire police to review the policies procedures and guidance in place relating to the management of Patients who are subject to Hospital Orders and have been conditionally discharged from hospital."[67]

11.12 During the course of Sancus Solutions' lead investigator's discussion with one of the IMR authors, it became apparent that there was a lack of knowledge within the force with regard to Section 37/41 of the Mental Health Act 1983. It was agreed that it would be helpful for this deficit to be addressed so that it could inform the force's policies and guidance as well as individual officers' skill base.

Update – June 2021

11.13 It was reported to Sancus Solutions that there had not, as yet, been a meeting between SWYPFT's forensic services and West Yorkshire Police to discuss the management of individual patients with forensic histories who reside in the locality. Therefore, the original recommendation remains. Sancus Solutions would expect to see evidence of implementation at their quality assurance review.

12 Predictability and preventability

With regard to the NHS England ToR "Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement"[68], Sancus Solutions' investigation team have utilised the civil standard of the balance of probabilities.

Predictability

Sancus Solutions' investigation team would suggest that it was highly predictable that there would be further acts of violence. Based on Mr A's more recent risk history, his victims were likely to have been either a member of his family or Jane, with whom he was in close contact.

Sancus Solutions' investigation team have, however, concluded that what was less predictable was the ferocity of the attack that led to the death of his stepfather, as the previous incidents involved either verbal threats or more minor physical assaults.

[66] West Yorkshire Police IMR p31
[67] West Yorkshire Police IMR p35
[68] ToR p3

Preventability
Sancus Solutions' investigation team have identified a number of areas of concern and significant deficits in the care and treatment of Mr A and his elderly parents which resulted in the potential risks to Mr A's mother and stepfather not being adequately assessed or addressed.

Using the civil standard of the balance of probabilities, Sancus Solutions' investigation team have concluded that if the identified deficits had not occurred, then it is likely that the incident which resulted in the death of Mr A's stepfather could have been prevented.

Section 3: Serious incident report and Duty of Candour

13 SWYPFT's serious incident report

This part relates to the following NHS England ToR:

> "Review the progress made by the Trust in implementing the action plan associated with the incident."[69]

13.1 SWYPFT's serious incident report (hereafter referred to as SIR) was completed in March 2018. The report made 10 recommendations to improve and develop practice. As part of the action planning process, the recommendations were allocated into six cluster groups. At the time of writing this report, two of the cluster groups were assessed as being amber (active, but some concerns and needs to be monitored closely to monitor progress).

13.2 It was reported to Sancus Solutions' investigation team by both practitioners and managers of the forensic and elderly mental health services, who were interviewed as part of this investigation, that since this incident, they have attended several briefings to discuss the learning from the SIR and also some additional training events. They all reported that they had found these events helpful in developing their skill set and improving their practice.

13.3 Sancus Solutions' investigation team were provided with copies of action plans and noted that all actions were assessed as green – completed – in the RAG rating.

13.4 It was, however, reported that despite significant efforts being made by the forensic community transition service's new team manager and the forensic practice governance coach, successive audits of the service's patient records are still indicating significant issues and non-compliance with SWYPFT's policies. In addition, progress has been greatly hampered by staffing issues

[69] ToR p3

within the service, which has prevented progress being made to further develop the service model and provision.

14 Duty of Candour

This part relates to the following NHS England ToR:

"Review the Trust's application of Duty of Candour principles"[70].

14.1 Immediately after the incident, Mr A's care coordinator contacted the family to offer support.

14.2 It was documented that "the offer of support was also communicated to the family via the Police Family Liaison Officer"[71].

14.3 Mr A's mother received ongoing support from her care coordinator from the elderly mental health service.

14.4 The lead SIR investigator and a member of the investigation panel met with members of Mr A's family, and it was documented that "the family raised questions that they requested the investigators to consider in relation to [Mr A's] care with the Trust and these have been incorporated into the terms of reference for the investigation"[72]. It was also documented that it was agreed that "updates regarding the progress of the investigation would be conveyed to [the nominated member of the family by the lead investigator] via telephone approximately every four weeks"[73].

14.5 Sancus Solutions' investigation team were informed that due to a breakdown in the relationship between SWYPFT and a member of Mr A's family, there was a significant delay in the family receiving feedback from the SIR. Following some interventions by Sancus Solutions' investigation team, the family met with SWYPFT's deputy director of nursing, quality and professions; the associate director of nursing; and the general manager of the forensic service. At this meeting, the SIR report's findings and recommendations were discussed.

14.6 Sancus Solutions' investigation team concluded that in the main, SWYPFT met its Duty of Candour. Clearly, the breakdown in communication that

[70] CQC Regulation 20 providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. Regulation 20 also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support and providing truthful information and an apology when things go wrong. Duty of Candour
[71] SIR p4
[72] SIR p4
[73] SIR report

occurred with a member of Mr A's family was very unfortunate and resulted in a significant delay in the family receiving feedback from the SIR.

14.7 Sancus Solutions' investigation team would suggest that clearly one of the main difficulties with this type of investigation is that families are being asked to be involved in investigations when they are understandably in the midst of their own personal deep bereavement and trauma. This clearly was the case for Mr A's family, who were not only having to come to terms with the loss of a husband, parent and grandfather while supporting Mr A's mother, who was in poor health, but were also having to come to terms with the fact that the perpetrator was a member of the immediate family.

14.8 Sancus Solutions' investigation team would suggest that rather than expecting SIR authors to carry out the challenging role of supporting families alongside undertaking an internal investigation, SWYPFT should consider the viability of recruiting a family liaison officer.

Update – June 2020

14.9 Sancus Solutions were informed that since this incident SWYPFT uses a "buddy system"- another investigator from the SI team supports a family through the SIR process and is the main point of contact.

14.10 Sancus Solutions were satisfied that this process will ensure that families receive adequate support through what is often a very difficult process.

15 Concluding comments

This was clearly a very tragic event which continues to deeply affect the lives of all those involved, and Sancus Solutions' investigation team would like to express their condolences to Mr A's family. They would also like to acknowledge the family's continued understanding during the unavoidable delays over the course of this investigation.

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

It is also the hope of Sancus Solutions' investigation team that the findings and recommendations within this report will provide members of Mr A's family with at least some resolution to their questions and concerns.

16 Recommendations

Recommendation 1: At Sancus Solutions' quality assurance review SWYPFT should provide an updated report on the implementation of HCR-20 assessments in both the forensic inpatient unit and forensic community service.

Recommendation 2: SWYPFT to provide evidence at Sancus Solution's quality assurance review from an audit of the use of FIRM in their forensic community and inpatient services.

Recommendation 3: SWYPFT to consider developing a version of FIRM assessment for its forensic services**.**

SWYPFT to provide evidence at Sancus Solution's quality assurance review.

Recommendation 4: At Sancus Solution's quality assurance review SWYPFT should have completed a further audit of the forensic community service and be able to evidence that they have considered the following Sancus Solutions' recommendations:

- the introduction of rehabilitation outreach forensic psychologist and psychiatrist posts
- the allocation of administrative and dual diagnosis practitioner support.

Recommendation 5: Potentially Dangerous Person awareness training should be a core requirement for all practitioners in SWYPFT's forensic low secure unit and the Forensic Community Transition team

.

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

Recommendation 6: SWYPFT should provide guidance in their Safeguarding Adults at Risk Policy on the identification and assessment of domestic violence in the elderly patient group.

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

Recommendation 7: A member of SWYPFT's safeguarding team should regularly attend the inpatient and community elderly care mental health services multidisciplinary team meetings.

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

Recommendation 8: SWYPFT's elderly community and inpatient mental health services should be provided with training on the Mental Health Act 1983. SWYPFT should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.

Recommendation 9: SWYPFT's forensic services and West Yorkshire Police Authority should agree a protocol in relation to the management of patients in the locality who are under Section 37/41 of the Mental Health Act 1983. SWYPFT should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.

Appendix 1: Terms of Reference

Terms of Reference for Independent Investigations in accordance with Appendix 1 of NHS England's Serious Incident Framework 2015

These individual Terms of Reference for Independent Investigation 2017/16452 have been drafted by NHS England North in consultation and with the agreement of Kirklees Domestic Homicide Review Standing Panel.

These Terms of Reference will be developed further in collaboration with the offeror and affected family members. However, requirements under Appendix 1 above and Domestic Homicides Reviews under the Domestic Violence, Crime and Victims Act published by the Home Office in 2016, are expected to be met for this case.

Terms of Reference

Mr A

- In the absence of the internal investigation report, compile a detailed chronology of contacts and service access.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence.
- Were there effective and appropriate arrangements in place for risk assessment and escalation of concerns?
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family, specifically in relation to risk assessment/risk of violence and effectiveness of CPA review.
- When the perpetrator failed drug tests, review the response and identify the implications for discharge planning and whether these were fully taken in account.
- Was information sharing within and between agencies appropriate, timely and effective?
- Review the appropriateness of the treatment of the service user and the victim in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement.
- Were there issues in relation to capacity or resources in any agency that impacted the ability to provide services to the victim and to work effectively with other agencies?
- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement.

Safeguarding – Mother, stepfather and Jane

The following additional key lines of enquiry have been submitted for inclusion by Kirklees Safeguarding Adults Review Subgroup as a result of emerging issues identified during the investigative process.

- Were any issues with respect to safeguarding (adults) adequately assessed and acted upon?
- Did the victim's family and friends have any knowledge of domestic abuse by the service user in this family? If so, how was this knowledge acted upon?
- Review the Trust's assessment of vulnerable carers, that includes age and disabilities, who are known to be caring for adults with mental health issues.
- When the organisation undertook an internal investigation into the actions of their clinical staff following receipt of the information being alleged by the mother, did they consider raising this as a safeguarding concern with the Local authority so that a section 42 enquiry could be considered?
- When discharge planning from the hospital services was commenced for the mother making the allegations, what risk assessments were completed given the allegations that was detailed by the individual about those at her home?
- How were the personal wishes of [Mr A's] mother considered as part of discharge planning (considering the importance of Making Safeguarding Personal and of the requirements of the Mental Capacity Act 2005)?
- Was any consideration given by the organisation staff supporting discharge planning to the impact on her family of the allegations that had been made by the mother when she was 'unwell'?

Domestic Homicides

- Identify from both the circumstances of the case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in the future and make this available to the Home Office.
- Whether the service user had any previous history of abusive behaviour towards the victim and whether this was known to any agencies.
- Establish what lessons are to be learned from the domestic death regarding the way in which professionals and organisations work individually and together to safeguard future victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Consider what learning has the Trust identified from their internal investigation into the information that should have been taken by the team involved when the allegations were made by the mother; including consideration of contacting the Police as serious crime was being alleged

by the individual. What actions have now been put in to place to address this?

Trust's serious incident report and Duty of Candour

- Review the progress made by the Trust in implementing the action plan associated with the incident.
- Review the Trust's application of Duty of Candour principles.

Post report

- Provide a written report to NHS England North which can be shared with the NHS Improvement and the Home Office that includes measurable and sustainable outcome focused recommendations.
- Involve the family as fully as is considered appropriate, in liaison with Victim Support, Police and other support organisations.
- Support relevant Stakeholders to develop an outcome-based action plan based on the recommendations.
- Deliver an action planning/ learning event for the Trust and other key stakeholders to share the report's findings and to provide an opportunity to explore and fully understand the intention behind all recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation.
- Support the Commissioners (where required) in developing a structured plan for review of implementation of recommendations. This should be a proposal for measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.
- Within 6-12 months of the report's publication conduct an assessment on the implementation of the reports associated action plan, in conjunction with the CCG and Trust, providing a short written report, that may be made public.

Appendix 2: Sancus Solutions' investigation team

- Grania Jenkins was the lead investigator and author of the report. Grania has a background as a mental health practitioner and a senior manager for adult and children's and young people's mental health services. She has also worked in senior management positions in performance and quality within the health and social care sectors. Grania has extensive experience of undertaking high-profile and complex homicide investigations, under NHS England's Serious Incident Framework, in which the victim and/or perpetrator was a child/young person. Grania holds a police qualification for investigating complex and serious crimes (PiP 2) and has undertaken training in family liaison support.
- Dr Jenny Shaw, a consultant forensic psychiatrist, provided the investigation panel with forensic psychiatry expertise. Jenny has been a forensic consultant psychiatrist and clinical director in both secure and community services. Currently, she is Professor of Forensic Psychiatry and Head of Centre for Mental Health and Risk at the University of Manchester's Institute of Brain, Behaviour and Mental Health. She is the consultant psychiatrist at Greater Manchester Police's Prevent Mental Health Pilot and the Assistant Director on the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
- Ray Galloway assumed the role of family liaison officer. Prior to retirement, Ray was a detective superintendent in the police force. He was then appointed as one of the independent investigators into the activities of Jimmy Savile. In this investigation, Ray has acted as the critical friend, providing a level of independent scrutiny to the investigation, and was also the independent point of contact for both families.
- Tony Hester provided the quality control and governance oversight of the investigation process. Tony is one of the directors of Sancus Solutions. Tony has over 30 years' Metropolitan Police experience in specialist crime investigation. Since 2009, Tony has coordinated and managed numerous domestic homicide reviews for Sancus Solutions where the mental health of the perpetrator and/or victim has been a significant and contributory factor.

Appendix 3: References and bibliography

- Bradley Report, 30 April 2009 Bradley Report
- Care Services Partnership (CSIP). Dual Diagnosis is Everyone's Business (2008) Everyone's Business
- Department of Health. Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach (2000) Effective care coordination
- Department of Health. Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services (2007) Best Practice in Managing Risk
- Femicide Census Report (December 2018) Femicide Census
- HCR-20 Version 3: A Case Study in Risk Formulation. Caroline Logan. International Journal of Forensic Mental Health 13 2014 HoNOS case study
- Independent Mental Health Task Force to NHS England. The Five Year Forward View for Mental Health (February 2016) Five Years Forward
- MOJ and HM Prison and Probation Service. Guidance for Social Supervisors (5 July 2019) MOJ Guidance for Social Supervisors
- Mueser, K. T., Noordy, D. L., Drake, R. E. and Fos, L. Integrated Treatment for Dual Disorders: A Guide to Effective Practice. The Guildford Press (2003) Integrated treatment
- NHS England and NHS Improvement. Technical guidance for mental health clusters (2019) MHCT
- Review of the impact of domestic abuse for older women. Health and Social Care in the Community in 2011 A Review of the impact
- Royal College of Psychiatrists. Enabling recovery for people with complex mental health needs (November 2009) Enabling Recovery
- Royal College of Psychiatrists. Rethinking risk to others in mental health services (August 2016) Rethinking Risk
- Themed Review Report 2006/2007 Regional Reports East of England (2006/2007) National Institute for Mental Health; Dual Diagnosis, Themed Review Report
- Weaver, T., Charles, V., Madden, P. and Renton, A. Co-morbidity of Substance Misuse Collaborative Study. A study of the prevalence and

management of co-morbidity amongst adult substance misuse and mental health treatment (2002) Co-morbidity