NHS England independent investigation into the NHS care and treament of Mother in Essex

To be read as an appendix to the Serious Case Review (Child R)

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Contents

1. NHS England independent investigation

Approach to the investigation

1.1 The independent investigation follows the NHS England Serious Incident Framework (SiF, March 2015)[1] and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[2] The terms of reference for this investigation are given in full in Appendix A.

1.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.3 The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning. This investigation was commissioned to support the work of the independent lead reviewer of the Serious Case Review (SCR) which was commissioned by Essex Safeguarding Board, and the terms of reference were agreed jointly. This investigation should be seen as an addendum/appendix to the SCR.

1.4 Following the homicide of Child R by his Mother in July 2018, NHS England Midlands & East commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user, called Mother for the purpose of this investigation. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.5 The decision to carry out a SCR took place after new statutory guidance came into force in 2018[3] and prior to new partnership arrangements for safeguarding children being in place in Essex and Southend. Arrangements for initiating this review and publishing the report have therefore remained with Essex Safeguarding Children Board but it is important that the final recommendations are considered and responded to by both Essex and Southend Safeguarding Children Boards/Partnerships.

1.6 The focus of the SCR is Child R. Due to the circumstances of his death many of the recommendations of this review relate to the way in which risks to children can be recognised by practitioners working with adults with physical and mental health problems.

1.7 This investigation commissioned by NHS England focusses in more detail on the NHS services provided to Mother, however it should be noted that the two reviewers

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[1] *NHS England Serious Incident Framework (March 2015). https://www.england.nhs.uk/patientsafety/serious-incident/*

[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

[3] *HM Government (2018) Working Together to Safeguard Children.*

have worked closely together in finalising the findings and recommendations of this review. This report and the findings from the NHS England investigation should be considered by Essex and Southend Safeguarding Adult Boards/Partnerships and the expectation is that there will joint planning in response to this report and the NHS England mental health homicide investigation.

1.8 The independent mental health homicide investigation was carried out by Dr Carol Rooney, Associate Director for Niche, with specialist advice from Dr Lucinda Green, consultant psychiatrist. The investigation team will be referred to in the first person plural in the report. The report was peer reviewed by Kate Jury, Partner, Niche.

1.9 The investigation comprised interviews carried out with the SCR lead author, and a review of clinical records and documents.

1.10 We met with Mother in May 2019. Mother's family and Child R's father did not wish to meet us, but the final report was shared with the family.

Structure of the report

1.11 This addendum focusses on an analysis of the care and treatment provided to Mother by NHS services in line with the additional health terms of reference. Mental health services were provided by South Essex Partnership University NHS Foundation Trust (SEPT) until the new Trust was established in April 2017. Mental health services across Essex are now provided by Essex Partnership University NHS Foundation Trust (EPUT). Child mental health services are provided by North East London NHS Foundation Trust (NELFT) and are called the Emotional Wellbeing and Mental Health Service (EWMHS). We have not reviewed the care provided to the children concerned but have included the recommendations made in the SCR as they are recommendations for NHS services. The detailed issues regarding the children's care are discussed in the full SCR.

1.12 Section 2 provides a review of the EPUT internal investigation report and examines the issues arising from the care and treatment provided to Mother against the health terms of reference (see appendix A).

1.13 Section 3 sets out our overall analysis and recommendations. The SCR has made eight recommendations for health services which we endorse (SCR recommendations 3,4,5,7,8,9 and 10) and we have made three individual recommendations.

1.14 Where we have come to a conclusion we have included these in a 'summary statements' box at the end of discussion sections.

2. Arising issues, comment and analysis

2.1 The terms of reference for this investigation are to:

- critically examine and quality assure the NHS contributions to the Children's Serious Case Review;
- examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with Mother;
- review and assess compliance with local policies, national guidance and relevant statutory obligation;
- examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and her family;
- examine the communication with the service user and her family in the lead up to the homicide and the responsiveness of services; and
- review the appropriateness of the treatment of the service user considering any identified health needs/treatment pathway.

Quality assurance of internal investigation report

2.2 The internal investigation was described as a 'Root Cause analysis investigation report' but does not reference the definitions in the NHS England SiF.

2.3 The report is written in a root cause analysis format and lists clear terms of reference. A team was established including a Consultant Psychiatrist, a Non-Executive Director, an external investigator, the Head of Safeguarding Children and the Director of Mental Health Services.

2.4 Mother's previous care in EPUT/SEPT was summarised, and a detailed chronology is provided. Care and service delivery problems were identified against the terms of reference, exploring the care provided in detail.

2.5 The efforts to involve the family are described, and detailed responses to the family's questions are listed. The process of the investigation is clearly described, including those interviewed and materials accessed.

2.6 Contributory factors were identified, which were patient factors, individual factors, task factors and system factors.

2.7 The patient factors identified were:

- the children were identified by Mother as protective factors, although she had '*made some reference to them while sharing psychotic beliefs'*;
- Mother had a long-term diagnosis of fibromyalgia[4] and used cannabis to manage pain;
- her psychotic symptoms had responded well to antipsychotic medication, although this exacerbated her chronic pain;

[4] *Fibromyalgia is a long-term condition that causes pain all over the body.*

- she had a preference for holistic approaches to her health and was reluctant to take antipsychotic medication;
- she went on holiday to Jamaica with her partner and reportedly consumed cannabis, although showed no psychotic symptoms when reviewed after her return, although her mental state deteriorated a week later;
- Mother lived in her parent's house, sharing a room with both children; and
- Grandmother was very supportive.

We consider that there was a missed opportunity to clarify who is caring for the children when there are several adults in the house, as highlighted in previous child serious case reviews.[5]

2.8 The system factors identified were:

- Mother and Grandmother attended A&E on 19 July to obtain antipsychotic medication, but the mental health liaison team do not prescribe out of hours; and
- there was a delay in prescribing antipsychotic medication.

In our view a further system factor was that the mental health liaison service did not have a protocol for informing the GP and the early intervention in psychosis service (ESTEP) of the out of hours consultation, and the advice given.

2.9 Task factors identified were:

- some of the staff involved had not completed mandatory refresher training
- some staff were not compliant with mandatory supervision

The report does not specify whether the mandatory training included child or adult safeguarding, and whether the supervision was safeguarding supervision.

2.10 In the section entitled 'root cause' the report states that 'the incident was not predictable', with 'no past history of aggression towards others or children, and in the absence of overt risk factors for violence'. It does state however that the 'likelihood of the incident could have been significantly reduced'. The factors contributing to the incident include 'Mother's psychotic symptoms, inconsistent engagement with the services, use of cannabis and lack of timely treatment interventions'.

2.11 The omission of previous aggression attributed to Mother is not noted i.e.: there was a history of aggressive behaviour, sibling told a teacher in 2015 that '*Mum hurts Dad'*. Also, in 2016 Mother allegedly grabbed the neighbour and attempted to drag her into the flat. The Trust has clarified that this history was noted in the submission to the SCR, so was not repeated in the internal report.

2.12 The report does not explicitly state whether these was considered to be a root cause or not. In patient safety terms, the root cause of a serious incident is the earliest point at which intervention could have prevented the incident, and in our view this aspect should have been explored further. The terms of reference for the internal

[5] *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final report, Department for Education May 2016.*

investigation did not in fact require a determination about predictability, so it is unclear why this was included.

2.13 We tested the internal report against our standard 'credibility, thoroughness and impact' framework (see appendix A). The score was 21/25, and the areas where the investigation did not meet accepted standards were:

The investigation should have been completed within 60 days.

2.14 The finalised investigation report was supplied to the SCR lead author in September 2019. This is 14 months after the homicide, which is well outside the policy expectations in the SiF. The Trust have commented that the incident was 'stop-clocked' in agreement with the CCG for a significant period of time pending conclusion and outcome of Police investigations. Further time was used to source and appoint an independent investigator. Once underway, the investigation was extended, in agreement with the Commissioner. Further witnesses and lines of enquiry were also requested which it was stated was not unusual for a complex investigation of this nature.

Summary statement 1

The internal report was not completed within expected timeliness standards, and the delay was not explained in the internal report.

There was no discussion regarding root cause.

2.15 In the section entitled 'root cause' the report states that 'the incident was not predictable', with 'no past history of aggression towards others or children, and in the absence of overt risk factors for violence'. It does state however that the 'likelihood of the incident could have been significantly reduced'. The factors contributing to the incident include 'Mother's psychotic symptoms, inconsistent engagement with the services, use of cannabis and lack of timely treatment interventions'.

2.16 The report does not explicitly state whether there was considered to be a root cause or not. The terms of reference for the internal investigation did not in fact require a determination about predictability, so it is unclear why this was included.

Recommendations do not all relate to the findings and lead to a change in practice, are measurable and outcome focused.

2.17 There were three recommendations made. In order for recommendations to be measurable and outcome focussed there should be a clear statement of what the action is intended to achieve (the outcome) and a statement of what would indicate that it had been achieved. All three of the recommendations use aspirational language and encourage an 'exploration' of the issues, rather than actions to address the care and serve delivery problems identified.

2.18 The three actions are for ESTEP to 'consider the RAG rating for patients', 'explore full psychiatric symptomology …in order to fully understand the nature and degree of

illness', and for the psychiatric liaison service to 'explore developing a process of informing ESTEP if one of their patients is assessed at A&E'. These recommendations are not linked directly to the care and service delivery problems identified.

2.19 The first of these recommendations suggests that a system of rating (red/amber/green: RAG) rating be used to monitor patients who are relapsing. It is not clear whether there is already a system/protocol in place for this, and the liaison team did not use it, or whether this would be a new system.

2.20 The clinical risk assessment and safety management procedure[6] already in place does not make any reference to a RAG rating procedure.

Summary statement 2

Recommendations made in the internal serious incident investigation report were not outcome focussed or measurable.

Summary statement 3

The clinical risk assessment and safety management procedure does not include a RAG rating protocol to identify heightened need or risk.

2.21 The second recommendation expects that ESTEP should make a thorough mental state examination and take a detailed history. It is then anticipated that the team could '*better understand the risks and formulate an appropriate risk management plan'*.

2.22 The taking of a detailed history is already a clear requirement of the CPA procedure,[7] with a list of all the areas that should be explored, including psychiatric and psychological functioning, personal circumstances, social functioning and physical health needs. A thorough assessment should include review of previous health records and requesting previous records from the GP, and the taking of collateral history from a family member.

2.23 Under the heading 'personal circumstances', there are prompts related to assessment of family and parenting issues which are 'family including genogram', 'caring responsibilities', 'childcare issues', 'relationship issues'. The internal report does not comment on the lack of assessment of Mother as a parent, or the potential impact of her mental health issues on the children. If the history taking had identified the extent of her previous lack of functioning in 2014 and the need for Father to move back in as she couldn't cope in 2015, the assessing clinician might have wanted to find out more about all this in terms of considering parenting capacity and risk to the children.

[6] *Clinical risk assessment and safety management procedure, CLPG 28, July 2017*

[7] *Care Programme Approach procedure, CLPG30, July 2017*

2.24 The expectation that CPA assessments include reference to children has been in place since 2008.[8] We were informed that the Trust has implemented a 'Think Family'[9] approach which was intended to help services improve their response to parents with mental health problems and their families.

Summary statement 4

The 'Think Family' approach did not influence direct clinical practice in ESTEP in this case. There is no 'child risk screen' included as part of the assessment process.

2.25 The final recommendation was that the psychiatric liaison service should 'explore developing a process of informing ESTEP if one of their patients is assessed at A&E'.

2.26 We suggest that this wording should have a clearer outcome focus, for example setting a standard for communication to a team where the patient is already open to an EPUT service. We would also suggest that this standard should include communication back to the patient's GP.

Summary statement 5

When an existing service user is assessed out of hours, there is no standard for communication back to the relevant clinical team and their GP

Referral, assessment and discharge procedures

2.27 The GP records show that Mother's first prescription for nerve pain was in 2001. Mother has told professionals that she suffered from fibromyalgia since the age of 13, which would have been in 1994. GP records from 1994 do not confirm this. There are records showing that amitriptyline[10] was prescribed in 2001, which is the first prescription for nerve pain in her records. In these historic records there is reference to her experiencing migraines, but no detailed explanation for this prescription, or referral for specialist input. There is no reference to fibromyalgia until 2007.

2.28 She had a history of asthma which was treated with inhalers. There is also a history of gynaecological problems dating back to 1998.

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[8] *Laming (2003) Recommendation 12 in The Victoria Climbie Inquiry; Summary and Recommendations*

http://www.victoria-climbie-inquiry.org.uk/finreports/summary-report.pdf

[9] *SCIE Report 56: Think child, think parent, think family: final evaluation report, March 2012. https://www.scie.org.uk/publications/reports/report56.asp*

[10] *Amitriptyline is an antidepressant medication used in lower doses to treat pain. It is especially good for nerve pain such as back pain and neuralgia. It can also help prevent migraine attacks. https://www.nhs.uk/medicines/amitriptyline-for-pain/*

2.29 Early GP records note her first pregnancy was in 2008. There are no entries which describe her antenatal care, although her older son was born by caesarean on 9 September 2008. The postnatal GP examination was completed without problems.

2.30 In 2007 the GP records state that she was 'adamant' that she had fibromyalgia, and she said she had done a lot of research. Consequently she was referred by her GP to the rheumatology department at Broomfield Hospital. The diagnosis of fibromyalgia was made in 2007, and she was found to have chronic back pain, with limitation of movement in her spine, but with no evidence of rheumatoid arthritis. In 2008 she was treated with depomedrone[11] injections but had no pain relief.

2.31 Between 2000 and 2017 she moved GP surgery three times, as she changed addresses. One of the changes in August 2014 was, according to her, because the previous surgery did not provide the services she expected for her pain. Her GP notes were visible at each new practice and she was referred for physiotherapy, and to rheumatology for back pain and joint pain over many years. She was prescribed pregabalin,[12] duloxetine,[13] tramadol,[14] folic acid and inhalers. She also had a prescription for 'as required' diazepam.[15]

2.32 As well as widespread pain, people with fibromyalgia may also have:

- increased sensitivity to pain
- extreme tiredness (fatigue)
- anxiety and depression
- muscle stiffness
- difficulty sleeping
- problems with mental processes (known as 'fibro-fog'), such as problems with memory and concentration
- headaches
- irritable bowel syndrome (IBS), a digestive condition that causes stomach pain and bloating

2.33 We consider that it is possible that prodromal or negative symptoms of schizophrenia may have been missed because some of the symptoms were attributed to fibromyalgia.

2.34 Although there is currently no cure for fibromyalgia, there are treatments to help relieve some of the symptoms and make the condition easier to live with.

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[11] Depo-Medrol (methylprednisolone acetate) is an anti-inflammatory glucocorticoid used to treat pain and swelling that occurs with arthritis and other joint disorders. https://bnf.nice.org.uk/drug/methylprednisolone.html

[12] Pregabalin is used to treat epilepsy and anxiety, and is also taken to treat nerve pain. https://www.nhs.uk/medicines/pregabalin/

[13]Duloxetine is an antidepressant medicine. It's used to treat depression and anxiety. It's also used to treat nerve pain, such as fibromyalgia. https://www.nhs.uk/medicines/duloxetine/

[14] Tramadol is a strong painkiller. It's used to treat moderate to severe pain, and is also used to treat long-standing pain when weaker painkillers no longer work https://www.nhs.uk/medicines/tramadol/

[15] Diazepam belongs to a group of medicines called benzodiazepines. It is used to treat anxiety, muscle spasms and fits (seizures). https://www.nhs.uk/medicines/diazepam/

2.35 Treatment tends to be a combination of:

- medicine, such as antidepressants and painkillers.
- talking therapies, such as cognitive behavioural therapy (CBT) and counselling.
- lifestyle changes, such as exercise programmes and relaxation techniques.
- exercise in particular has been found to have a number of important benefits for people with fibromyalgia, including helping to reduce pain.

2.36 On 4 February 2010 the GP records note 'severe depressive episode with no psychosis', and that she was referred to 'improving access to therapies' programme. According to GP records she was seen by a counsellor in March 2010, but there is no detail provided. Child R was born on 30 September 2010. There are no notes of antenatal or postnatal care, and no further reference to mental health until September 2013. At this time Mother attended the GP surgery with Father, saying she was unable to cope, that she had depression since she was a child, postnatal depression after Child R and was again awaiting pain management help.

2.37 Mother was referred by her GP to the pain management clinic at Southend in 2013. On assessment she reported memory and sleep problems, pain, fatigue and irritable bowel symptoms. Mother also said she had suffered from depression since she was eight years old. She reported having benefited from a pain management programme at Broomfield Hospital. Mother admitted to smoking one 'joint' of cannabis every evening and was willing to abstain while undergoing a pain management programme. A referral was then made to the clinical psychologist for chronic pain management. There are no reports back to the GP of what treatment she received.

2.38 She was referred to 'therapy for you'[16] which is an 'improving access to psychological therapy' (IAPT) service in Essex. This was an appropriate referral for exploration of Mothers' mental health issues. The service attempted to contact her by phone on the day she was referred, due to the concerns she expressed. She did not reply, and this was followed up by a letter, as required by the local assessment protocols for IAPT. Mother did not respond to the letter either, and was removed from the waiting list in October 2013. IAPT did not communicate this back to the GP, which would have been in line with expected practice.

2.39 She was allocated to a high intensity IAPT therapist in January 2014, although it is not clear from the records how this referral was followed through.

2.40 Mother was seen in February 2014 ,and as part of the assessment she undertook a Patient Health Questionnaire (PHQ-9).[17] Her score was 27, which is the maximum score, and according to the guidance, indicates *'severe depression, and warrants treatment for depression, using antidepressants, psychotherapy and/or a combination of treatment'*. She also completed a General Anxiety Disorder-7

[16] *https://www.therapyforyou.co.uk/*

[17] *The Patient Health Questionnaire-9 (PHQ-9) is a nine item questionnaire designed to screen for depression in primary care and other medical settings. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med2001;16:606-13.*

questionnaire (GAD-7),[18] and the total score was 21, which again is the maximum and indicates severe anxiety. According to the guidance, this indicates that '*active treatment is probably warranted*'.

2.41 The IAPT notes on 6 February 2014 record that her scores reflect her *'frustration that the extent and impact of her physical health condition is not appreciated by professionals'*. She was reported to be stressed by money and benefits issues, and the focus was on anxiety/panic symptoms, although she was thought to '*need further assessment for pain management and depression'*. It was noted that she did not feel suicidal at that point, nor had any urge to self-harm. There are undated GAD-7 and PHQ-9 score sheets that show some improvement in scores, but it is not clear when they were completed. She did not attend the second planned session, and she made no further contact at that time, so the plan was to discharge her from 'therapy for you'.

2.42 Meanwhile Mother had taken an overdose of her prescribed medication and presented at A&E on 12 February 2014. This was a serious overdose: 34 tramadol, 72 pregabalin and 25 duloxetine. When seen by mental health liaison staff in February 2014 she expressed regret at her actions, and said it was impulsive due to stress and frustration, and there had been a family argument that day. There were no psychotic symptoms observed. No child risk assessment was undertaken, there is no evidence of any attempts to clarify her day to day responsibility for the children and whether they were witnessing regular arguments, or whether this was a one-off.

2.43 She was referred to the Rapid Assessment Interface and Discharge team[19] (RAID) and seen for an assessment by mental health services on 3 March 2014, and told the assessing team that she had recently started at 'therapy for you' and said she felt that would help her. Her GP was written to stating she would not be taken on by secondary mental health services, as she was not actively suicidal and was under the care of IAPT, which seemed the most appropriate service for her. She was also written to advising her of this outcome, and reminding her that it was agreed she would attend her IAPT appointments. It was noted her children were 'protective factors' and she cared too much for them to consider a further overdose. There was no record of attempts to explore whether she was actually attending IAPT appointments.

2.44 She was not seen again, and was in process of being discharged by IAPT when the letter from the RAID service arrived, which recommended that she continue with IAPT.

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[18] Generalised Anxiety Disorder Assessment (GAD-7) is a self-administered patient questionnaire used as a screening tool and severity measure for generalised anxiety disorder. https://patient.info/doctor/generalised-anxiety-disorder-assessment-gad-7

[19] Rapid Assessment Interface and Discharge (RAID) team provided an in-reach psychiatric liaison service to prevent avoidable admissions to inpatient wards and mitigate longer lengths of stay associated with mental illness as a co-morbidity to physical conditions.

Summary statement 6

Mother was referred by the GP to appropriate primary care mental health services.

Summary statement 7

Mother's statement about 'postnatal depression' is not explored by either the GP or IAPT.

Summary statement 8

After the overdose in February 2014 it is not clear whether this information was conveyed directly back to IAPT, and a joint plan agreed.

The outcome of her IAPT contact was not communicated back to the GP.

Summary statement 9

After the overdose there was no reassessment offered by IAPT.

2.45 In March 2016 Mother saw a GP and presented as upset and anxious, talking of problems with her neighbours She attended again three days later, and asked to see a GP who knew her, which was facilitated later that day. Mother asked the GP for a letter of support with regard to housing. She reported being attacked by the house manager and people were 'talking about her'. Neither GP appears to have explored this in any depth, and the outcome was a prescription for diazepam at her request. Father saw Mother's GP in April 2016 to report that she may need counselling for depression and panic attacks. He was given the contact information for 'therapy for you'.

2.46 Mother changed GP surgery again in April 2016, saying someone had recommended a GP there.

2.47 Mother was referred to the Essex Chronic Fatigue Service in May 2016 after a reported 'nervous breakdown' (sic).[20] These were Mother's words, and she was seen with Father and her advocate. She described having depression, anxiety and panic attacks all her life. She was taking diazepam but reported trying to cut this down. She said her neighbours were harassing her and this was now affecting her children. The plan agreed was to support her with a letter to housing, and refer to fibromyalgia clinic, then review.

[20] *This is the phrase used in the GP records, and does not refer to any recognised mental health disorder.*

Summary statement 10

The issues in the GP consultation were seen as her reaction to social stressors and chronic pain and fatigue. While this was a reasonable assessment, there could have been an exploration of any thoughts of self-harm or of harming others, or whether the beliefs about the neighbours were delusional beliefs, and if so whether this meant the children were featured in these delusional beliefs, and whether there were any other psychotic symptoms given what she described. It appears there was diagnostic overshadowing in relation to fibromyalgia.

The statement about the effects on her children should have been explored.

2.48 In July 2016 the GP noted the feedback from the Chronic Fatigue Service, Mother was now off her pain medication and was gradually increasing her activity, and she was encouraged to access the council's 'active women' programme.

2.49 Mother was seen by the GP in July, September and October 2016 for minor physical health issues with no note of any mental health concerns.

2.50 On 6 March 2017 Mother was brought to A&E at Southend University Hospital by Grandmother. Mother was assessed by the rapid assessment interface and discharge (RAID) mental health team. Grandmother stated that Mother had been paranoid, suspicious and hallucinating for the last three years. Mother thought people were after her, and reported a long history of paranoia and visual hallucinations. The overdose in 2014 was noted, and she denied any thoughts, plans or intent to harm herself. She was not asked about potential harm to others.

2.51 The clinical impression was a 35-year-old lady with a three-year history of paranoia and visual hallucinations, with delusions that were not fixed but constantly returning. It was stated she requires further assessment of psychosis and appropriate intervention. The assessment noted that she had two children (ages six and eight) living with her at Grandmother's but made no other observation. The GP should have provided ESTEP with information about previous concerns re children and ESTEP should have asked the GP for information about whether children's services were ever involved and whether there had been any concerns re the children.

2.52 The plan was 'refer to ESTEP ; appropriate intervention/treatment taking her fibromyalgia into account, and discharge from RAID'.

2.53 Mother was assessed by ESTEP on 18 March 2017 and attended with her sister. The assessment was structured to draw out Mother's perceptions and understanding as well as any psychotic symptoms. Mother described constant anxiety for many years with some increase since stopping cannabis recently. When she was asked if she was afraid of people her sister interrupted and encourage her to be honest. Mother said she no longer felt that people were following her or plotting against her and said this must be due to the effects of cannabis wearing off. Her sister clearly disagreed and mentioned the neighbours plotting against her. Her sister later became tearful and pleaded with Mother to be honest and open, saying she was

worried Mother may have paranoid schizophrenia. Mother insisted she was not holding back and felt better than she did when she came to A&E.

2.54 Regarding her children she mentioned and that she had not been involved in their lives due to being bedridden for so long but was determined to change that. There was no attempt to clarify who was the main carer for the children and to assess the impact of their illness on them.

2.55 The plan was to discuss in the ESTEP team meeting and make a decision about treatment.

2.56 Mother's parents phoned the RAID team on 5 April to say she was getting worse and asking for a plan. ESTEP tried to call Mother. She was offered an assessment appointment with an ESTEP practitioner and doctor on 21 April 2017. Mother said things were getting worse but did not elaborate, she did say she hoped to be seen sooner. Emergency and crisis numbers were provided.

2.57 Grandmother called NHS 111 on 5 April because Mother was talking of seeing things, saying everything is bugged. Took her to hospital six weeks ago and saw mental health services, and was now waiting for 'an appointment with a counsellor'. The advice given was to see her GP within 24 hours.

2.58 Grandmother called ESTEP on 7 April 2017 and talked of Mother's paranoia, how she believed the whole family would be killed by carbon monoxide and she would be dead before the appointment on 21 April. She said Mother would only drink bottled water and goes into Grandmother's room at night to try to convince her that her beliefs were real. They planned to go to the GP that day to request sleeping tablets for Mother.

2.59 Mother was seen by her GP on 7 April 2017, and was regarded as suffering from a 'major anxiety disorder' which also interfered with her sleep. Mother said she had been taking drugs (cannabis) although she does try meditation. She was prescribed zolpidem[21] 10mg to aid sleep for two weeks.

[21] *Zolpidem is a nonbenzodiazepine hypnotic prescribed for insomnia.* https://bnf.nice.org.uk/drug/zolpidem-tartrate.html

Summary statement 11

The assessment letter from RAID is stamped as having been received and scanned in by the GP practice on 15 March 2017**.** ESTEP later asked for a summary of this GP consultation. This should have been referenced in the consultation on 7 April, and the GP should have considered further information about the children. The history available at this time includes three years of paranoid thoughts, suspiciousness, visual hallucinations and significant delusional beliefs regarding the likelihood that she and her family would be killed and that she was only drinking bottled water due to her fears. She also believes 'everything is bugged'.

The presentation at this point includes:

- symptoms which strongly suggest a diagnosis of schizophrenia;
- children being involved in delusional beliefs as she believes they will also be killed and poisoned;
- a woman with a psychotic illness who has been bedridden to the extent that she has not been involved in her children's lives.

2.60 This was discussed in the ESTEP team on 10 April 2017 and it was agreed that Mother needed support sooner than the planned appointment. It was agreed that they would ask the crisis team to become involved. The crisis team stated that she would need to have been seen within 24 hours and referred by a GP. ESTEP staff called grandmother back and asked her to ask the GP to make a crisis team referral, which she is noted to have agreed to. There is no mention of this in the GP consultation.

Summary statement 12

Mental health services recognised appropriately that Mother needed help before the planned referral.

Systems were such that the GP needed to make a referral for this to happen, and the expectation was that family would pass this message on.

Both the GP and the Trust missed this opportunity to provide timely mental health assessment and support when the family requested it.

Early intervention in psychosis guidance states that '*if the service cannot provide urgent intervention for people in a crisis, refer the person to a crisis resolution and home treatment team (with support from early intervention in psychosis services). Referral may be from primary or secondary care (including other community services) or a self-or carer-referral*'.[22]

2.61 ESTEP visited Mother at home however on 12 April 2017 to follow up after Grandmother's calls. Grandmother was present, and Mother reported that things have been worse recently. She described that her family dogs are acting strangely, and believes they are being poisoned. She believed her children were being 'spiked' and bullied at school because of her, she had checked their pupils and thought they were 'different'. Mother believed that songs playing on the radio were directed at her and tell her what to do, people are coming into the house, since a 'tin of worms' had been opened, but she would not elaborate on this. She also believed that the sleeping tablets the GP gave her recently had caused lumps on her neck, and her sleep is regularly disturbed anyway because her son has nightmares. She was advised that there would be a discussion in the next team meeting and they would be in touch soon regarding a possible assessment by a psychiatrist.

2.62 Mother was seen at home by the associate specialist psychiatrist and a mental health nurse with grandmother on 19 April 2017. Mother confirmed she was still having unusual experiences but they were no worse. Sleep was still a problem and made worse because her son wets the bed and it wakes her up. The notes do not specify which son or when, although grandmother offered to have him to help out for a few nights. They were informed that a care coordinator was allocated and she would visit on 26 April. Aripiprazole[23] 5 mg was prescribed, to increase to 10 mg after two weeks, and promethazine[24] 25 to 50mg as needed to aid sleep.

2.63 The GP was written to, and a diagnosis of unspecified non-organic psychosis ICD10 F29[25] was made. The risk assessment stated there was a previous history of

[22] *Psychosis and schizophrenia in adults: prevention and management, Clinical guideline [CG178] NICE 2014. https://www.nice.org.uk/guidance/cg178*

[23] *Aripiprazole is an antipsychotic medication. https://patient.info/medicine/aripiprazole-abilify*

[24] *Promethazine is an antihistamine medicine that relieves the symptoms of allergies, and can be used as a short term aid to sleep. https://www.nhs.uk/medicines/promethazine/*

[25] *Unspecified psychosis not due to a substance or known physiological condition. https://www.icd10data.com/ICD10CM/Codes/F01-F99/F20-F29/F29-/F29*

substance misuse, but no self-harm or suicidal ideation at that time. The risk to others was 'low'; it was noted she had two young children who were not present, but 'she receives support to look after them from her mother. There is no clarification of what 'support' meant, nor mention of children being 'spiked' or their pupils being different.

2.64 In our opinion, at this stage the nature and duration of symptoms would meet the diagnostic criteria for schizophrenia. Had this diagnosis been considered, and if staff had appropriate training in child risk, this should have prompted some serious thinking about a woman with significant psychotic symptoms and negative symptoms having caring responsibilities for her children. Whist the diagnosis in itself cannot be used to determine risk, there is a lot of evidence in terms of the potential harms to children when there is parental schizophrenia. Even without this, the impact of the specific symptoms of a parent with a chronic psychotic illness should be considered and so the combination of symptoms described should have raised serious concerns and warranted a referral to Children's Social Care.

Summary statement 13

ESTEP responded quickly after family concerns increased, saw her at home and developed a care plan.

Summary statement 14

There is no further exploration of the visual hallucinations that Mother first described.[26] The presence of visual hallucinations in psychosis has often been linked to a more severe psychopathological profile and to a less favourable prognosis, and is more usually linked to an organic cause.[27] Mother had previously said she had been experiencing these for three years.

The children were clearly involved in delusional beliefs and this is an indicator of high risk[28] and should have triggered an immediate reassessment, including the exploration of collateral information about childcare with other family members. There should have been an assessment of whether the children were safe in her care.

Summary statement 15

The NICE quality statement on early intervention in psychosis[29] states that treatment should be started within two weeks of referral, which was achieved.

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[26] *Visual Hallucinations in the Psychosis Spectrum and Comparative Information From Neurodegenerative Disorders and Eye Disease. Waters et al 2014. https://academic.oup.com/schizophreniabulletin/article/40/Suppl_4/S233/1875426*

[27] *The effect of delusion and hallucination types on treatment response in schizophrenia and schizoaffective disorder. Kilicaslan E, et al. The Journal of Psychiatry and Neurological Sciences, (3) 2016.*

[28] *Filicide-Suicide: Common Factors in Parents Who Kill Their Children and Themselves, Friedman S et al. J Am Acad Psychiatry Law 33:496 –504, 2005.*

[29] *Psychosis and schizophrenia in adults. Quality standard [QS80] NICE 2015. https://www.nice.org.uk/guidance/qs80/chapter/Quality-statement-1-Referral-to-early-intervention-in-psychosis-services*

Care planning and risk assessment

2.65 The allocated care coordinator saw Mother at home a week later with Grandmother. Information about the ESTEP treatment programme and about carer support was shared. Mother stated that the hallucinations she had been experiencing had stopped since taking aripiprazole, and that she had been fearful of people harming her, but they have 'not done anything' since she started the medication. She said her pain had increased since taking it, but Grandmother said she had been complaining of increased pain before this. It was noted that Mother was physically sensitive to medication, but was also at risk of stopping it due to her own thoughts about the effects on her fibromyalgia. She said she had stopped using cannabis in March because she could not afford it.

Summary statement 16

The recommended therapeutic dose of aripiprazole for adults is between 10 and 30 mg, increasing gradually from 5 mg.[30] Mother had taken a sub therapeutic dose for one week when she said her symptoms had gone. There are findings that indicate some people respond more quickly, and early response is a good predictor.[31] There is also some evidence that there are gender differences in response to antipsychotics so that sometimes women respond to lower doses.[32]

This does seem a quick response however, and we consider that professionals should have had more curiosity about this sudden recovery.

2.66 A risk assessment was completed on 26 April 2017. The format of this is a 'tick-box' list of possible risk. The risks 'ticked' as 'yes' were 'risk related to health/ mental health conditions', 'likelihood of disengagement /nonadherence', 'risk to self through the use of alcohol/drugs'. The risk of Mother refusing to take antipsychotic medication because of her concerns about side effects was noted, as was the potential use of cannabis. She was frightened to go out because of fear of harm, feeling someone might make her disappear. She was thought to feel safe at home, but there was no discussion about her care of the children. 'Risk to children' was ticked as 'no' but without exploration. This is difficult to understand in the context of the extent of her psychotic symptoms and her previous poor functioning.

2.67 The plan was for the care coordinator to see her 'every one to four weeks' to monitor risk, mental health and medication. Medical reviews would be required at least six monthly, to monitor for use of cannabis and offer support with abstinence, to liaise with social worker if required, and support with healthy eating and debt (by signposting as needed). The contingency plans for her current risk which was listed as '*my mental health is at risk if I take cannabis*. *Medication causes me pains and I have stopped taking medication in the past'*. Various contingencies were listed,

[30] *https://bnf.nice.org.uk/drug/aripiprazole.html*

[31] *Agid O, Kapur S, Arenovich T, Zipursky RB. Delayed-onset hypothesis of antipsychotic action: a hypothesis tested and rejected. Arch Gen Psychiatry. 2003;60(12):1228.*

[32] *Seeman MV1. Men and women respond differently to antipsychotic drugs. Neuropharmacology. 2019 May 8:107631.*

relapse signs were identified as '*increased pain, hallucinations and paranoia*'. Plans to reduce risks were '*tell my Mum'*, '*call the ESTEP team'.* It was noted that her parents needed to be aware of this risk also. Grandmother was offered carer support.

2.68 A formal care plan was written on 26 April, Mother identified being free of pain, hallucinations and paranoia as goals, and also wanting to be able to sleep and go out alone, and cope without taking medication. She agreed to contact the team if her symptoms increased, or if she wanted to stop medication because it caused her pain. She also agreed to accept help with her use of cannabis is she was unable to abstain.

2.69 In early May Mother was seen by the care coordinator with Grandmother. She reported her physical symptoms had increased and she believed this was due to the aripiprazole. She asked if smoking a small amount of cannabis would be helpful and was strongly advised against this. Both Mother and Grandmother reported that Mother had seemed stressed and irritable about debts, housing and impending divorce. There were no psychotic symptoms evident.

2.70 She said promethazine did not help her sleeping, and requested zolpidem, which was later prescribed. She talked of not driving at present but would like to, and was advised that she needed to inform the DVLA of the medication she was taking if she did plan to drive. The children were described by her as alright, and various problems with money, housing and physical heath were discussed. She was apparently spending most of the time at home, with visits to her boyfriend in Chelmsford at the weekends. After some cancelled appointments Mother reported she had been away for a few days in Norfolk with her children and boyfriend which they had all enjoyed. She was tired but denied any psychotic symptoms, and had been able to concentrate on sorting out housing applications. There do not appear to have been questions asked by the team about her boyfriend, in terms of risk to children, given the history of domestic violence and that she was clearly a vulnerable woman.

2.71 In July 2017 Mother called ESTEP, angry and upset, saying the DVLA had suspended her licence for six months, because she had indicated she takes aripiprazole and had taken cannabis. She was angry that she would not be able to drive her children over the holidays, but also said she was being punished. Mother went on to describe her belief that she was being watched inside and outside the house, being followed and being punished, by the "*illuminati who run mental hospitals and control everyone's life".* She said she had stopped taking the aripiprazole the previous week because she was taking antibiotics and felt unwell. She believed the aripiprazole had caused her infection and did not want to restart it. It was agreed she would meet the care coordinator later in July.

2.72 This was discussed with the psychiatrist, it was suggested that Grandmother could be relied upon to call if Mother deteriorated, and a mental health act assessment could be considered. Mother reported starting the aripiprazole again, and when the information from the DVLA was reviewed, it appeared her licence was suspended after she informed them she last used cannabis in March 2017. She was tearful at times but said that restarting the aripiprazole was helping her paranoia. There was

no exploration of her statement about being watched, or the 'illuminati'. There was no consideration of the risk to her children or plan to ensure their wellbeing in the context of a deteriorating mental state.

2.73 In July 2017 there was some discussion about the children; she was sharing a bed with her older (eight year old) son, and her younger son (Child R) slept in a bed above. Mother said it was stressful keeping the children quiet during the day because her father had to get up very early for work, and the house was overcrowded. She said the stress was affecting the children's behaviour which then affects her physical and mental health. This is not explored further. She spoke of being videoed by strangers while out with her children in Chelmsford, the post man tried to enter the house to steal bikes, and her drink had been spiked. When attempts were made to explore these further, Mother appeared unable to differentiate whether they had happened recently or in the past, becoming vague in her answers.

2.74 The risk assessment and care plans were unchanged. At an MDT review in July 2017 it was noted that her paranoid ideas were '*very fixed with high conviction', and it was 'too soon to commence relapse prevention work'*. She had been given information about family work, so it was planned to discuss this again. It was felt that she would benefit from an increase in aripiprazole, but it was uncertain whether she would agree. It was agreed to plan a further MDT review in nine months.

2.75 These symptoms were not evident at the next contact in August, which was by phone. A psychology assessment was arranged for later in August, in line with early intervention standards. In August Mother was agitated about what she said were chemicals in her bedroom, *'coming through the walls'*. She said she has always been sensitive to smells and could now smell that her bedroom smelt *'dusty'*. Mother suggested calling the police and fire brigade as a solution. It appeared there was an increase in family stress, following Child R wetting the bed and her experiencing increased pain. Mother refused to consider an increase in aripiprazole due to side effects.

2.76 This was later discussed with Grandmother by phone; Mother apparently believed the *'chemicals'* were causing Child R to wet the bed, and they had bought a carbon monoxide monitor. Grandmother clarified that some batteries had been stolen, but there was no concern about bikes or cars. She conveyed that Mother had not said strange things for a while, and it was her belief that Child R wet the bed because he was on a top bunk and couldn't get to the toilet in time. Grandmother was asked about family therapy but said she was very busy, and was not sure Grandfather would attend.

2.77 In October 2017 Mother spoke of worrying that Child R may have ADHD and being aggressive to his brother. The GP had apparently referred him to Essex Emotional Wellbeing and Mental Health service (EWMHS) 'and this had helped her'. Her mother and sister were also helping out so that the children did not spend so much time together. There was no communication between the ESTEP team and EWMHS.

Summary statement 17

The planned medical review in nine months recognises that she has a chronic psychotic illness but does not consider any risk to the children. A review should also have recognised that the children have been involved in her delusional beliefs. The current Trust risk assessment does not include a framework for assessing risk to children.

There was no attempt to offer an OT assessment to clarify her level of functioning - it is clear that she had caring responsibilities for her children and that at times she has not been able to function well enough to care for them.

There was no communication from EPUT to the GP about a potential mental health referral for Child R.

2.78 A CPA review was planned for 27 October 2017, in line with policy expectations. Mother was seen for a psychological assessment on 24 October 2017. She still maintained that her physical health had worsened on aripiprazole, including causing lumps in her neck. She apparently had no paranoid beliefs at that time, but acknowledged that had previously believed in her thoughts completely. She believed that her psychotic experiences were caused by cannabis. Mother was able to discuss coping strategies, including diet, exercise and meditation that had been suggested by the Chrysalis Effect[33] members. She was encouraged to develop a relapse plan with her care coordinator, and not to decrease medication without discussing with her psychiatrist. Because she appeared to have good coping mechanism it was not felt there was a role for psychology at this time, which Mother agreed with and was noted to feel positive about.

2.79 Mother cancelled the CPA review, and the next contact after that was by phone with the care coordinator in early November. Mother reported being physically unwell due to fibromyalgia, and hyperthyroidism. She said the hyperthyroidism caused her difficulty in swallowing.[34] They were awaiting counselling for Child (R) who was said to still 'take things out' on his brother but things were 'alright'.

2.80 The CPA meeting took place on 15 November 2017. She reported an increase in her fibromyalgia symptoms which she attributed to aripiprazole, these symptoms were memory loss, trouble thinking, constipation, cold extremities, weight gain and hair loss. It was noted that she said she suffers from hyperthyroidism which "*can cause difficulty swallowing and talking"*. The symptoms described in fact sound similar to hypothyroidism. She said she did not want to discuss her physical health with her GP, preferring natural methods.

[33] *The Chrysalis Effect is a support organisation for people suffering the symptoms of ME, CFS and Fibromyalgia. https://thechrysaliseffect.co.uk/*

[34] *Mother had not been diagnosed with either hyper or hypothyroidism according to GP notes.*

Summary statement 18

Thyroid disorders commonly cause significant psychiatric symptoms and it is important to ensure thyroid function is assessed and any thyroid disorder adequately treated. ESTEP should have contacted the GP for further information and to ensure appropriate investigations and treatment had been initiated.

There was a lack of curiosity regarding this new physical ailment presented by Mother, and how it might affect her mental health, and ESTEP should have explored this with the GP.

She had not in fact been diagnosed with either hyper or hypothyroidism by the GP.

2.81 At the CPA review Mother mentioned that she was still looking after her sons, Child R was still aggressive towards his brother, and she was also looking after her nephew. There was in our view a lack of professional curiosity re potential link with her mental illness, in terms of both her mental illness contributing to behavioural problems in the children, and also that her having to cope with this behaviour was an additional stress which may contribute to relapse. She was noted to be mentally well, but at risk of deterioration if she stopped her medication. A 'process of recovery' user reported measure was completed by Mother, which showed she was feeling much more positive and engaged with her life.

2.82 The care plan was updated: to see her every two to four weeks to monitor mental health and medication, to check physical observations and take a drugs test (for DVLA), start relapse prevention work, reduce and possibly stop aripiprazole. The two children were noted to be a '*protective factor'.* There was no further exploration of her care of her nephew. A medical review was planned at six months.

Summary statement 19

She was noted to be at risk of relapsing if she stopped her medication, yet there was a plan to reduce and possibly stop. The team could have helped her to manage any physical symptoms, and consider the risks and benefits of reducing and stopping medication.

Summary statement 20

Outcome measures were used at the CPA meeting, to provide an objective measure of mental health. There was no objective measure of psychosis symptom reduction completed.

2.83 In November 2017 Mother requested to stop taking aripiprazole. The consultant psychiatrist advised against it but suggested she reduce to 5 mg every second day. Contingency plans were agreed, early warning signs were identified as believing people are looking at her, and coming into the house. It was agreed she would start relapse prevention work, and either she or Grandmother would call the team if they

have any concerns about her mental health. There was no review of possible effects in the children.

2.84 On 1 Dec 2017 seen at home, was looking after her three-year-old nephew who was asleep. There was no discussion about this. Mother said she had a urinary tract infection, which she maintained had also happened when she stopped medication earlier.[35]

2.85 Mother's initial diagnosis in 2017 was 'non-organic psychotic disorder', and there was no differential diagnosis developed as the team became more familiar with her. There is no evidence that this was discussed with Mother or her parents in any depth, to help them understand the diagnosis. The reason why this is so relevant and important in this case is that there is evidence in terms of the implications of a diagnosis of schizophrenia for parenting. If this diagnosis had been made, and if staff had appropriate training in child risk and safeguarding, the diagnosis itself should prompt a thorough assessment of potential risk to children. Also we consider that if she had the diagnosis the family may have been able to give more thought to the impact on the children, and professionals could have considered the emotional impact of the children of living with a parent with a diagnosis of schizophrenia.

2.86 The NICE guidance (2014)[36] for the management of psychosis and schizophrenia now focusses on each stage of the person's psychotic illness:

- Preventing psychosis
- First episode psychosis
- Subsequent acute episodes of psychosis or schizophrenia and referral in crisis
- Promoting recovery and possible future care

2.87 The referral to ESTEP provided the opportunity for treatment within national guidance; the NICE guidance for the management of psychosis and schizophrenia recommended these standards for psychological interventions:

2.88 'Psychological interventions: CBT should be delivered on a one-to-one basis over at least 16 planned sessions and: follow a treatment manual so that:

- people can establish links between their thoughts, feelings or actions; and their current or past symptoms, and/or functioning;
- the re-evaluation of people's perceptions, beliefs or reasoning relates to the target symptoms;

also include at least one of the following components:

- people monitoring their own thoughts, feelings or behaviours with respect to their symptoms or recurrence of symptoms;
- promoting alternative ways of coping with the target symptom;
- reducing distress; and

[35] *Mother has a twenty year history of recurrent UTIs.*

[36] *Psychosis and schizophrenia in adults: prevention and management. https://www.nice.org.uk/guidance/cg178*

- improving functioning.

2.89 Family intervention should:

- include the person with psychosis or schizophrenia if practical
- be carried out for between 3 months and 1 year
- include at least 10 planned sessions
- take account of the whole family's preference for either single-family intervention or multi-family group intervention
- take account of the relationship between the main carer and the person with psychosis or schizophrenia
- have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work'.

2.90 Mother had regular input from the care coordinator, described as '*supportive monitoring of her mental health and response to medication'*. The interventions documented are of a generally supportive nature, and are not linked to the evidence based interventions as described. Family therapy was offered and refused, and carers assessments were offered and refused.

2.91 The guidance on medication in the 2014 NICE guideline was:

*'*The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees. Provide information and discuss the likely benefits and possible side effects of each drug, including:

- metabolic (including weight gain and diabetes)
- extrapyramidal (including akathisia, dyskinesia and dystonia)
- cardiovascular (including prolonging the QT interval)
- hormonal (including increasing plasma prolactin)
- other (including unpleasant subjective experiences)'

2.92 There is clear evidence that medication and its effects and side effects were discussed many times with Mother. The GP was not involved however in these discussions. Her physical observations were recorded in May 2017 and again in December 2017. As discussed earlier, her assertions that aripiprazole caused her to have infections and hyperthyroidism were not challenged.

Summary statement 21

There was a lack of a structured evidence-based approach that would be expected from an EIP service, which should also consider differential diagnoses.

2.93 It was noted at a review in November 2017 that Mother had stopped taking aripiprazole, and had no psychotic symptoms. A medical review in May 2018 noted that she had remained medication free and had no psychotic symptoms. Her risk to

other and to herself was regarded as low, and the contingency plans relied on her telling Grandmother that she was unwell, or either herself or Grandmother calling ESTEP.

2.94 This review stated that she had been 'symptom free' since June 2017. We question the accuracy of this: she talked of *"illuminati who run mental hospitals and control everyone's life"* in July 2017; in August 2017 *she* believed chemicals were coming through her bedroom walls which caused Child R to wet the bed and were poisoning the family; and in November 2017 she maintained that her physical health had worsened on aripiprazole, including causing lumps in her neck, and that this had caused difficulty in swallowing and hyperthyroidism.

2.95 It was clear that Mother still believed that her psychotic symptoms were caused by her stopping cannabis abruptly. Part of her relapse prevention plan was to ensure she sought help if she was having difficulty abstaining from cannabis use.

Family communication/responsiveness of services

2.96 The family did not agree to meet us as part of this review, therefore our observations are limited to information contained in the clinical records or through interviews with staff and Mother.

2.97 The ESTEP MDT review in May 2018 noted that family therapy was offered and refused, and carers assessments were offered and refused. The care coordinator had contact with Grandmother when she made contact to express concerns about Mother. The coordinator called Grandmother on at least one occasion to ask for more information about Mother's presentation when there was a concern.

2.98 It is evident from the records that Mothers sister was very concerned about her at the ESTEP initial assessment in March 2017. There is a record of the staff member offering the sister an opportunity to talk more about this, but there is no further reference to gathering collateral information from family members.

2.99 Grandfather does not appear to have been present at any point when staff met Mother. It appears that an assumption was made that Grandmother was seen as a protective factor, however Mother clearly had primary responsibility for the children. Grandmother worked full time so was not at home with the children for much of the time. Grandmother was invited to a carers' information evening in July 2017, a response was not recorded.

2.100 The coordinator never met either Child R or his brother, apparently at the request of Mother. There does not appear to have been any challenge or curiosity about this.[37] Clinicians have documented that there is nothing evident to trigger concern about parenting There were no comments on when concerns might arise e.g. when her functioning deteriorates or when her psychotic symptoms become more florid.

2.101 A 10 day holiday to Jamaica with her partner was planned in June/July 2018. Mother called ESTEP in early July and was then not contactable when staff called her back,

[37] *Serious case reviews highlight the importance of professionals being able to see the children.*

Grandmother called a few days later to say she was concerned that Mother's paranoid beliefs about conspiracy theories were still there, and now thought she was unwell but putting on a front.

2.102 Attempts were made to contact Mother which were unsuccessful. Grandmother called back and asked for her to be seen. Accounts of the details of the communication over the next few days differ: Grandmother has stated that asked for Mother to be seen, but it was recorded that Grandmother said it could wait until her care coordinator was available.

2.103 On 20 July 2018 Grandmother took Mother to A&E at Southend Hospital as she was experiencing a relapse of psychosis with similar symptoms as previously. She was seen by the Mental Health Liaison Team and following the contact it was advised that they request that the GP restarted the antipsychotic medication.

2.104 It is acknowledged in the internal investigation report that the Mental Health Liaison Team missed an opportunity to treat Mother who was clearly showing signs of a relapse of her psychotic illness. The report also states that the Mental Health Liaison Team should have considered admission to a psychiatric unit or requested an assessment under the Mental Health Act 1983 in order to prevent further deterioration of her mental illness. There is no comment on the assessment of risk to children, considering she was presenting with psychotic symptoms, and was the main carer to her children.

2.105 There was no handover to the GP or ESTEP in the morning. We consider that the team should have asked for a clinical review the next morning rather than relying on GP to prescribe antipsychotic medication. As Mother had relapsed, we believe ESTEP should have made arrangements to assess her the next day. This was another missed opportunity to initiate treatment for the psychotic episode. Grandmother contacted the ESTEP team to make them aware of the presentation and that Mother was back on medication. It was documented that Grandmother agreed for the care coordinator to make an appointment the following week, when the care coordinator returned from holiday. We have been informed that Grandmother has told the SCR lead author that she had a different recollection of this conversation.

2.106 ESTEP missed a further opportunity to reassess Mother after being informed that she had restarted medication. Mother told us that she had been smoking cannabis in Jamaica, and described continuing to use cannabis after her return from holiday a few weeks earlier.

Summary statement 22

The views of family and carers should have been sought to ensure there was an opportunity for the family to be listened to, and a more holistic assessment made that incorporated their perspectives**.** Liaison services should routinely ask about caring responsibilities for children and ensure there is a safe plan for the care of the children if sending a parent with a psychotic illness home.

3. Overall analysis and recommendations

Findings and recommendations

3.1 Mother had been under the care of secondary mental health services since March 2017, after an initial short contact in 2014.

3.2 Her diagnosis in 2017 was ‘non-organic psychotic disorder’, and she was treated by the ESTEP team. There was no differential diagnosis developed as the team became more familiar with her, despite symptoms from 2017 warranting a diagnosis of paranoid schizophrenia. There is no evidence that this was discussed with Mother or her parents in any depth, to help them understand the diagnosis and consider contingency plans if she was in need of urgent support.

3.3 Mother had a diagnosis of fibromyalgia, and was reluctant to take conventional medicines to treat this. This reluctance also applied to taking psychiatric medication, and she continued to use cannabis which she believed helped with pain control. She attributed an increase in physical symptoms to her psychiatric medication, and this was accepted at face value by the ESTEP team, without exploration with either Mother, the family or the GP. This contributed to some diagnostic overshadowing, and a lack of consideration that an assessment of negative symptoms of schizophrenia was needed as well as the impact of these on her daily functioning and ability to meet the needs of her children.

The assessment of risk did not include any exploration of the makeup of the household, or potential risks to her children. Her children are noted to be ‘protective factors’ without any depth of assessment, and in our view there was a complete lack of consideration of the children’s need and their safety. The extent to which they were involved in her delusional and paranoid ideas was not explored.

3.4 There are many factors in this case which raise significant concerns that the children were at risk and that a referral to Children’s Social Care should have been made including:

(a) The children clearly featured in Mother’s delusional belief system at various times and this alone should have prompted an urgent referral to Children’s Social Care, and a safeguarding alert raised.
(b) Mother’s poor level of functioning should have been more thoroughly assessed given her history of being bedridden. Even with the information available this indicated a potential risk to the children of physical and emotional neglect.
(c) Her history of aggressive behaviour indicates a potential risk of physical harm which warranted further assessment.
(d) The emotional harm caused by living with a parent with significant paranoid and suspicious thoughts needed further assessment.
(e) The combination of serious mental illness, substance misuse and a history of domestic abuse in this family should also have raised concerns. This ‘toxic trio’ is commonly a feature of child serious case reviews.

(f) assumptions should not be made about other potential carers being protective factors without an assessment of their availability and suitability to meet the needs of the children.
(g) the importance of being able to see the children has been highlighted in serious case reviews.
(h) the new partner was not assessed which is important when there is a history of domestic abuse in previous relationships.
(i) children presenting with aggressive behaviour and bedwetting and reporting concerns to adults suggest the possibility that they are being affected by the situation at home.

3.5 Mother was known to be at risk of relapsing if she stopped her medication, yet there was a plan to reduce and possibly stop this, based on her dislike of taking antipsychotics. The team did not explore her reluctance in any depth, nor try to introduce other medication with a different side effect profile.

3.6 When Mother was reported by family to be showing signs of relapse, there was no structured team approach, such as a traffic light system. In our view the care and risk management plans were not effective in treating her condition or mitigating risk.

3.7 The views of family members were not routinely sought, and actions were not taken on family views where they were provided.

3.8 EPUT has clear policies that include the expectation of a holistic assessment of mental state and risk, a ‘Think Family’ approach, and guidance which encourages staff to consider risk where children are involved in parental delusional systems.

3.9 The internal report into this tragic event was completed in September 2019, 14 months after the death of Child R. The recommendations were not outcome focussed.

3.10 The SCR has made eight recommendations for health services which we endorse (SCR recommendations 3,4,5,7,8,9 and 10) and we have made three individual recommendations.

Recommendation 1

EPUT must ensure that Early Intervention Services meet the expectations of best practice guidance and standards.

Recommendation 2

EPUT must ensure the community mental health teams have a structure and systems for responding to relapse or increase in risks, such as a clinical ‘traffic light’ rating tool.

Recommendation 3

EPUT must ensure that internal investigation reports meet the timeliness standards expected by the NHS England Serious Incident Framework, and that recommendations are outcome focused.

Appendix A – Terms of reference

This investigation was to be conducted in partnership with the Serious Case Review Terms of Reference.
The investigation will examine the NHS contribution into the care and treatment of Mother from her first contact with specialist mental health services following the birth of child up until the date of the incident.

Additional health related Terms of Reference:

- Critically examine and quality assure the NHS contributions to the Children's Serious Case Review
- Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with Mother
- Review and assess compliance with local policies, national guidance and relevant statutory obligation
- Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and her family
- Examine the communication with the service user and her family in the lead up to the homicide and the responsiveness of services
- Review the appropriateness of the treatment of the service user considering any identified health needs/treatment pathway
- To work alongside the Children's Serious Case Review and Chair to complete the review and liaise with affected families
- To provide a written report jointly with the Serious Case Review report to the Safeguarding Board and NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or standalone

Appendix B – Internal report analysis

Standard		Present
Theme 1: Credibility		
1.1	The level of investigation is appropriate to the incident	Yes
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	Yes
1.3	The person leading the investigation has skills and training in investigations	Yes
1.4	Investigations are completed within 60 working days	No
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	Yes
1.6	Staff have been supported following the incident	Yes
Theme 2: Thoroughness		
2.1	A summary of the incident is included, that details the outcome and severity of the incident	Yes
2.2	The terms of reference for the investigation should be included	Yes
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people	Yes
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	Yes
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	Yes
2.6	A summary of the patient's relevant history and the process of care should be included	Yes
2.7	A chronology or tabular timeline of the event is included	Yes
2.8	The report describes how RCA tools have been used to arrive at the findings	Yes
2.9	Care and Service Delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	Yes
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	Yes
2.11	Root cause or root causes are described	No
2.12	Lessons learned are described	Yes
2.13	There should be no obvious areas of incongruence	Yes
2.14	The way the terms of reference have been met is described, including any areas that have not been explored	Yes
Theme 3: Lead to a change in practice - impact Yes		
3.1	The terms of reference covered the right issues	Yes
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	Yes
3.3	Recommendations relate to the findings and that led to a change in practice are set out	No
3.4	Recommendations are written in full, so they can be read alone	Yes
3.5	Recommendations are measurable and outcome focused	No