An independent review of the mental health care and treatment of Clive by Norfolk and Suffolk NHS Foundation Trust

March 2024

Report Advisory Notice

This report deals with difficult subjects relating to mental health conditions, care and treatment, and serious incidents. We have made efforts to write our report in a way which is not overly descriptive and limits the use of third-party and non-relevant personal information. However, there are instances where information is necessary, for example, where it is relevant to quote the opinion of a psychiatrist or doctor or where a specific act has been documented. We do advise caution for those who may be triggered by reading information which might be distressing, particularly, and ask that they are helped to read this report in a safe and supported way.

This report contains detailed information on self-harm. Limitations exist on the extent of publication of such information.

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1 Introduction, approach, and scope of this review

1.1 This report was prepared by Niche Health and Social Care Consulting (Niche), who were commissioned by NHS England– Midlands and East of England, to provide independent mental health specialist support to a Domestic Homicide Review (DHR) panel.

1.2 The DHR was itself commissioned by the Norfolk County Community Safety Partnership (NCCSP) in response to the death of 'Elouise' in January 2022. 'Clive' was convicted of the murder of Elouise.

1.3 This report sets out the background history of Clive and his contact with Norfolk and Suffolk NHS Foundation Trust's (NSFT or 'the Trust') services, focusing on events between 1 January 2019 and 23 January 2022. This report also highlights the context of contacts that Clive had with other services.

1.4 Despite multiple service involvement, up to the time of the homicide, the Trust were aware of Clive's contact with other services only as reported by him. This self-reported information was limited and was often mis-represented to Trust staff. This review into the care provided to Clive considers only the information available at the time to Trust services.

1.5 The full terms of reference for the review can be seen in Appendix A.

1.6 A summary of the involved Trust services can be seen at Appendix B.

1.7 The Trust documents reviewed in preparing this report can be seen in Appendix C. The author also spoke to two clinical lead nurses from the Trust and met (virtually) Clive in August 2023. Clive's views on the care he received from the Trust are included in Section 4 of this report. As part of the DHR process, Clive's wife was given the opportunity to take part in this review. The Chair of the DHR confirmed that Clive's wife did not wish to take part in this review, preferring to share her views in the wider DHR review. Clive's wife will be given the opportunity to comment on the final report pre-publication. The author had access to Trust clinical records and the Individual Management Review (IMR) reports submitted to the DHR (by Norfolk and Waveney Mind, (NWM)[1] and the Trust) in preparing the chronology of mental health service contacts.

1.8 The draft report was checked for factual accuracy by the Trust and a legal review was completed by solicitors acting of behalf NHS England.

1.9 Update August 2024. On completion of the final draft report the author wrote to Clive asking if he would like to receive a final copy. The author did not receive a reply.

[1] https://www.norfolkandwaveneymind.org.uk/

2 Executive summary

2.1 Clive is a white British male who was 44 years old at the time of the homicide in January 2022. He was married but living separately from his wife and four children. Clive was living alone at the time of the homicide, although he received some care from Elouise, his eldest daughter, who occasionally stayed with him. Elouise was the homicide victim.

2.2 Clive was known to Trust services from 2019, although his contact that year was only by telephone with the Trust's wellbeing services. The Trust had no contact with Clive during 2020. The Trust's main contact with Clive began in April 2021. Throughout Clive's time with the Trust, he was referred to six Trust services, was assessed on 12 occasions, and referred but not assessed, on two other occasions.

2.3 The assessments completed with Clive were detailed and focused on addressing his presenting mental health needs.

2.4 However, this review has identified some areas of learning for the Trust. Assessments undertaken with Clive did not always consider or take a wider view of the risks associated with:

- Clive's use of substances and alcohol,
- Clive being an alleged perpetrator of domestic abuse,
- the role of child safeguarding and child protection, and
- the role of his children as (young) carers.

2.5 We also identified missed opportunities for services to assess Clive or to follow up when referrals made to other services were not accepted.

2.6 We have summarised our main findings below:

- Lack of professional curiosity in risk assessments. Trust services that assessed Clive identified factors relating to allegations of domestic abuse, substance and alcohol misuse, and child safeguarding risks, alongside reports of poor physical and mental health. In addition, throughout his contacts with the Trust, Clive gave varying and inaccurate accounts of events and his history that were both misleading and appeared to be self-serving. Despite this, assessing services did not explore the impact of risk factors or these inaccuracies further, often just recording Clive's version unverified into electronic records. Services did not check whether other services were involved with Clive and his family, or whether other services were aware of the risks identified, nor clarify whether the events and history recounted by Clive were accurate. We found that, throughout his time with Trust services, professionals were not curious enough about Clive's family circumstances, they did not look beyond Clive's stated needs, and they did not consider risk, or management of risk, from a whole family perspective.
- Lack of awareness of the impact of domestic abuse. We found that services did not specifically consider the impact of Clive as an alleged perpetrator of domestic abuse on his wider family. Clive's role as an alleged perpetrator of domestic abuse was not fully assessed or considered in risk assessments completed by Trust services. When domestic abuse offences were identified, Trust services did not communicate with other statutory partners. Despite procedures and processes in place, information was not shared between services, and information held by other agencies remained unknown to the Trust. In addition, when Clive disclosed that he was still seeing his wife and family in January 2022, despite a restraining order being in place, the Trust did not share this information with the services who are set up to manage such risks.
- Lack of awareness of child safeguarding. We found that services did not specifically consider the impact of Clive's risk-taking behaviours and poor mental health on his children. During 2021, Clive was estranged from his wife, and it was known that he continued to have contact with his

children. On only one occasion did Trust services seek child safeguarding advice, and then after being told not to make a referral, left identified risks unaddressed. In addition, Clive's view on his children and their role in protecting him from suicide was not challenged and the impact of this behaviour on their mental well-being was not considered.

- Time between referral to CMHT and first visit. Clive was referred to a Community Mental Health Team (CMHT) in May 2021. We believe this service initially responded promptly and offered Clive three appointments for assessment during June and July. When Clive did not engage in July, however, the CMHT offered a fourth assessment over 40 days later in September 2021. Clive was seen in September and then put on a waiting list. Clive was not seen for an initial CMHT home visit until January 2022, eight months after referral and four months after being accepted onto the CMHT caseload. We were told by Trust staff that this was not unusual given the service pressures, but it is our view that the service should have prioritised Clive for a service visit after he was seen by the Trust's Crisis resolution and Home Treatment Team (CRHT) in October 2021, given the additional risk factors, and increasing knowledge about Clive's family situation.

- The use of waiting lists. Clive was placed on a CMHT waiting list and graded as Amber[2] and nCPA.[3] CPA or Care Programme Approach has now been replaced with the community mental health framework for mental health community services. Clive was not contacted regularly whilst on this waiting list. The Trust policy identified the frequency of contacts for individuals on this list who were at high risk (graded as Red) but did not provide detail regarding frequency of contact for those waiting but graded at lower risk (amber or green). This lack of guidance and clarity may cause uncertainty for those waiting to be seen and for services managing the waiting list.

- Referrals not acted on. We have identified two occasions when Trust services received referrals for Clive but did not act on them. The first was in April 2021, when Clive refused to engage with the Trust Liaison and Diversion (L&D) service. Whilst Clive did not wish to be seen, we believe the L&D service could have provided more than an assessment. We identify that this was a missed opportunity for the Trust L&D service to gather information and to work with other agencies to assess and manage risk. The second occasion was in September 2021 when the Mental Health Acute Liaison Service's (MHLS) high workload meant he could not be assessed.

- Invisibility of carers and young carers. Throughout his contact with Trust services, Clive identified that his eldest daughter (Elouise) was his main carer, but also that another child, who was 14 years old at the time of the incident, provided a level of support, and that he also had contact with his other children. Despite these references to the care and support being provided by Clive's children, we found no evidence in the records that any of them were considered as carers, or as young carers, or offered support or assessment.

- Lack of follow-up after referrals. There were two occasions when Trust services referred Clive for additional support from a third sector, charity run, mental health support service commissioned by the Trust. These referrals were not accepted, and whilst this information was shared with the referring services, they did not follow this up or consider whether alternative support was required.

- Lack of follow up following the Care Act 2014[4] referrals. Clive was referred to Norfolk County Council (NCC) adult social care services by Trust services (or by Norfolk Waveney Mind (NWM) as part of his care plan under the CMHT) for both Care Act 2014 assessments and consideration

[2] The RAG rating traffic light system (Red, Amber, and Green) is commonly used in mental health settings to indicate levels of risk.

[3] The Trust CMHT operational policy categorises care based on acuity into groups known as 'formerly CPA' or 'non-CPA' (nCPA). CPA refers to the Care programme approach - a system of care management that has now been replaced with the community mental health framework for community mental health services. This change was to enable services to shift away from 'an inequitable, rigid and arbitrary CPA classification' … 'towards a minimum universal standard of high-quality care for everyone in need of community mental healthcare'. For more information see https://www.england.nhs.uk/publication/care-programme-approach-position-statement/

[4] Adults referred for a Care Act (2014) assessment are assessed by the local authority (or someone delegated on their behalf), to determine whether they have social care support needs. See:https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

of self-neglect under adult safeguarding. NCC children's social care were also aware of Clive's family. Given these referrals and this knowledge, we would have expected to find some evidence of communication between NCC and the Trust to establish the nature and severity of any eligible care and support needs. We found no evidence of this, or of any follow up by Trust services to referrals made to NCC.

2.7 We make eight recommendations to support the learning from this incident.

Recommendation 1: Lack of professional curiosity

Throughout his contacts with the Trust, Clive gave varying and inaccurate accounts of events and his history. These inconsistencies were recorded verbatim in Trust records without being verified or challenged. Trust services also identified significant risk factors in their interactions with Clive, risk factors that went beyond his mental health symptoms.

Despite the risks identified and the inconsistencies recorded, Trust services were not curious at all about Clive's living situation. Trust services showed a distinct lack of professional curiosity, and they did not seek to assure themselves that Clive and his family were known to other (perhaps more appropriate) services. Trust services did not seek to assure themselves that the multiple risks identified were being managed appropriately.

This practice fell below the expected standard required in multi-agency safeguarding that the Trust had signed up to. This lack of curiosity was particularly evident in considering the impact of the alleged domestic abuse, Clive's continued substance misuse, and his prolonged contact with his family, including his children.

The Trust must use the learning from this incident to brief all registered and non-registered staff working with service users on the importance of being curious when assessing and managing risk, especially when individuals have contact with children or are suspected to be perpetrators of domestic abuse.

The Trust must ensure all registered and non-registered staff working with service users are aware of the need to share such risk information with other relevant agencies and must demonstrate compliance with the safeguarding policies and procedures in place.

Recommendation 2: Child safeguarding was not always considered.

Child safety and child safeguarding were not always considered when Trust services met Clive, and when concerns were raised, advice was given but the risks remained unaddressed.

The Trust must ensure safeguarding training at Level 3 includes advice for professionals on the importance of escalating safeguarding concerns when they are not addressed by other agencies, but where the risks remain. The Trust must ensure this training captures the role of seeking advice, the importance of information sharing, and the importance of ensuring the advice given by other agencies is received and recorded in the correct format.

Recommendation 3: Review on a Community Mental Health Team (CMHT) waiting list.

Clive was open to CMHT services for eight months without being seen and fully assessed by the service. During this time Clive was contacted as part of the waiting list monitoring on three occasions: in November and December 2021, and January 2022.

The Trust CMHT should ensure individuals on a waiting list for CMHT contact who go into crisis are reviewed after this crisis; they should receive appropriate follow-up care immediately as standard and not simply rejoin a waiting list they're already on.

Recommendation 4: Frequency of contact whilst on a CMHT waiting list.

The Trust policy in use at the time did not formally stipulate frequency of contact for individuals assessed as medium to low risk who were waiting for CMHT assessment.

The Trust should ensure services have clear guidance on the frequency of CMHT contact for all individuals whilst they are on a Trust CMHT waiting list, ensuring this contact frequency takes account of the levels of risk assessment, risk management, safety planning and the views and involvement of carers and families as appropriate. This guidance should include actions to be undertaken when individuals go into crisis or when they disengage from services.

Recommendation 5: Evidence of multi-agency consideration when individuals are assessed by Mental Health Acute Liaison Service (MHLS).

When Clive attended an Accident and Emergency Department (ED) he was referred to MHLS. During these contacts, his wider home and family situation and associated risks were not considered before the referrals were closed.

When individuals who have contact with children and have identified risks relating to both domestic abuse and substance misuse, come to the attention of the Trust MHLS, they must explore these factors with the service user, and seek information from other services regarding risk management, before closing the referral or referring the individual elsewhere.

Recommendation 6: Consideration for follow up when individuals are referred to other agencies.

Following assessments by Trust services, Clive was referred for support to Norfolk Waveney Mind (NWM). NWM did not accept these referrals, and they did inform the Trust referring service of their reasoning. The Trust referring services did not follow up or look at whether Clive required alternative support.

When a referral, made by a Trust service to another agency, is not accepted, the referring service must consider whether alternative support is required, and pursue that alternative support if it is required

Recommendation 7: Evidence of multi-agency consideration when individuals are assessed by Trust Liaison and Diversion Services (L&D).

Clive was arrested for offences relating to domestic abuse and drug possession and referred to the Trust L&D service. Whilst Clive did not engage, the Trust L&D service did not take this opportunity to ensure other services knew of the identified risks before closing the referral.

When individuals who have contact with children and have identified risks relating to both domestic abuse and substance misuse, refuse to engage with the Trust L&D service, the L&D service must ensure they alert child protection services, and any other relevant agencies, to this risk information before closing the referral. This is to ensure agencies can develop appropriate safety plans and risk management plans.

Recommendation 8: Referring carers, especially young carers.

When Trust services were told that Clive's children were providing an element of care and support, they were not identified as carers and were not referred for assessment.

The Trust must reinforce (through training and policy guidance) the importance of referring carers, particularly young carers, and children, to the appropriate agency for assessment of their needs. Compliance with referrals for carer assessments should be evidenced through regular yearly audit.

Finally, we also recognise, support, and further endorse the recommendation made by the Trust's patient safety incident investigation report (dated 26 August 2022).

- '*The review panel agreed that a missed opportunity to have multi-agency oversight over the patient's family may have occurred but recognised that the impetus for identifying this by any individual agency may have been difficult to determine. Therefore, a recommendation is made that the DHR considers how best to co-ordinate multi-agency involvement in cases such as this and how this can be achieved.'*

We strongly advise that this recommendation be considered and addressed as part of the full DHR review.

3 Background history and narrative chronology

3.1 Clive, a white British male, was 44 years old at the time of the homicide. He was married but living separately from his wife and four children. At the time of the homicide Clive was living alone, although he received some care from his eldest daughter, Elouise, who occasionally stayed with him. Elouise was the homicide victim.

Contact with NHS health services

3.2 Clive had a long history of physical health problems and was in contact with primary care GP services alongside more specialist community health services. The specialist community services were provided by Norfolk Community Health Care (NCHC) and included Speech and Language Therapy, Specialist Palliative Care, and Heart Failure Nursing. Clive was also known to mental health services provided by Norfolk and Suffolk NHS Foundation Trust (the Trust). Clive's first contact with the Trust was in 2019.

3.3 Clive had numerous physical health conditions and received several significant diagnoses in 2021 including heart failure and chronic obstructive lung disease. Clive was on a variety of medication for these diagnoses.

3.4 Clive was diagnosed with depressed mood in May 2021. Clive's prescribed medication, for mental health related symptoms, at the time of the homicide, is listed below.

- Mirtazapine[5] 15 mg [one at night from 30/12/21 until 15/02/22].
- Fluoxetine[6] 20 mg [last issued on 23/12/21].

Contact with NSFT

3.5 Clive was known to Trust services from 2019 until the time of the homicide. Clive's contacts and referrals are detailed below.

2019

3.6 The Trust Wellbeing Service (WBS) made 11 records about Clive in 2019. These relate to three self-referrals made on 30 April, 16 June, and 22 August. The records indicate that the WBS wrote to Clive following each self-referral and, on each occasion, made several attempts to contact and engage him. Of the three self-referrals, the August contact resulted in a telephone assessment on 24 September 2019. During this assessment Clive identified issues with grief related to his father's death some years previously, and following this assessment, Clive was signposted to Cruse[7] and Shelter[8] and then discharged.

2020

3.7 There is no evidence Clive contacted and/or was referred to Trust services during 2020.

2021

3.8 Clive was referred to the Trust L&D service on 7 April 2021, following his arrest for an assault on his wife, resulting in Actual Bodily Harm (ABH),[9] domestic abuse (specifically coercive and controlling

[5] Mirtazapine is an antidepressant medicine. It's used to treat depression and sometimes obsessive-compulsive disorder (OCD) and anxiety. See https://bnf.nice.org.uk/drugs/mirtazapine/

[6] Fluoxetine is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression, and sometimes obsessive-compulsive disorder and bulimia. See https://bnf.nice.org.uk/drugs/fluoxetine/

[7] Cruse is a national bereavement service – see https://www.cruse.org.uk/about/

[8] Shelter is a charity supporting individuals in housing crises – see https://england.shelter.org.uk/.

[9] The offence is committed when a person intentionally or recklessly assaults another, thereby causing Actual Bodily Harm. See Section 47 of the offences against the person Act 1861. https://www.legislation.gov.uk/ukpga/Vict/24-25/100/section/47

behaviour),[10] and drug possession (Class B or C).[11] On arrest, Clive told the custody sergeant that he had Post-Traumatic Stress Disorder (PTSD) and anxiety. The custody sergeant referred him for an assessment to the Trust L&D service. L&D attempted to speak to Clive, but he refused, and the team recorded that Clive '*Did not respond to screening questions. Unable to determine risk. PLAN. No current identified role for services due to refusal to engage'*. Clive was not assessed by the Trust L&D service on that date.

3.9 Clive was seen by Trust services three weeks later, towards the end of April 2021, in the Emergency Department (ED) of the Queen Elizabeth Hospital (QEH[12]) following an overdose of his prescribed medication (pregabalin).[13] There are contraindications for pregabalin related to both Chronic Obstructive Pulmonary Disease (COPD) and substance misuse.[14] Clive, accompanied by Elouise, was referred to, and assessed by, the MHLS.

3.10 During this assessment, Clive described the overdose as '*impulsive'*. The assessor identified that Clive had recently been arrested for ABH, that this related to an offence against his wife (domestic abuse) and noted under risk to others that *'Clive described having anger issues'* and that he was '*angry about the position he finds himself without his wife'.* The assessor noted that Clive's wife had left (April 2021) and that his (19-year-old) daughter - Elouise - was caring for him. The assessment did not cover substance or alcohol use.

3.11 The assessor noted '*no obvious signs / symptoms of mental illness',* that Clive engaged well with the assessment process, and they assessed that he had full capacity to engage with the assessment. The assessment concluded that Clive required support with social issues, bereavement support, and anger management. The assessor referred Clive to NWM psychiatric liaison service for social support, recording that they would send out information to Clive about the recovery college,[15] and later wrote to Clive's GP detailing his attendance and assessment at ED. The assessor then closed the referral to Trust services.

3.12 NWM psychiatric liaison service worked with Clive from 29 April to 14 June 2021. On 14 June Clive was in hospital for physical health issues and, as the length of this admission was not known, NWM closed the case. However, it was agreed he could be re-referred on discharge, and MHLS were notified of this.

3.13 The Trust WBS wrote to Clive on 10 May 2021, offering him an appointment on 19 May 2021. This appears to be following a further self-referral as advised by NWM.

3.14 Clive attended a Trust WBS telephone advice session on 19 May 2021. The WBS worker recorded a summary (on 24 May 2021) of this session noting that Clive described feelings of hopelessness, that he reported hearing voices that were telling him lies, that he had a recent arrest for '*coercive control towards his wife*' and that as a result she had left him and taken the children. The WBS worker also noted Clive reported that a lack of carer support was impacting on his wellbeing (although he also said his daughter was helping when she could). The assessment does not provide the name or age of Clive's daughter.

3.15 The WBS worker recorded current risks as hopelessness, suicidality, harm to self and to others. The WBS worker also noted that Clive told them he had recently stopped using alcohol and so no longer

[10] Section 76 Serious Crime Act 2015 (SCA 2015) created the offence of controlling or coercive behaviour in an intimate or family relationship. https://www.legislation.gov.uk/ukpga/2015/9/section/76/2015-12-29

[11] https://www.gov.uk/penalties-drug-possession-dealing

[12] https://www.qehkl.nhs.uk/

[13] Pregabalin is used to treat epilepsy and anxiety. It is also taken to treat nerve pain. Clive was prescribed pregabalin during 2020 by his GP for pain relief for a sore shoulder. Following this overdose, the prescription was stopped. For more information see https://bnf.nice.org.uk/drugs/pregabalin/

[14] https://cks.nice.org.uk/topics/neuropathic-pain-drug-treatment/prescribing-information/pregabalin/#contraindications-cautions

[15] The recovery college within NSFT offers workshops and self-help interventions to manage common mental health issues such as anxiety and isolation. Reference NSFT IMR see https://www.nsft.nhs.uk/recovery-college/ for more information.

engaged with the substance misuse service Change Grow Live (CGL).[16] The worker recorded concerns that Clive was low in mood, was experiencing delusions and auditory hallucinations (hearing his wife's voice), and that he had unresolved grief following his father's death some years previously.

3.16 The WBS worker recorded a care cluster[17] of 7[18] and recommended a referral to the Trust secondary mental health services '*Due to the complexity of Clive's presentation and risk, the Wellbeing Service is unable to provide the most appropriate care for his needs. A multi- disciplinary approach appears to be the best next step in helping Clive with the different areas of his life'.*

3.17 The referral was sent to the Trust's West Norfolk CMHT.

3.18 The CMHT manager asked the Early Intervention Service (EIS) team on 25 May 2021 to consider the referral. The referral was discussed in the EIS team meeting the next day and the outcome was recorded as '*Not enough information to suggest First Episode Psychosis'*. EIS closed the referral to their service and notified the CMHT manager by email.

3.19 Clive remained open to CMHT from this point.

3.20 Clive attended an 'Appointment Anywhere (AA)'[19] call on 10 June 2021 with a worker from the CMHT. Clive was in hospital at this time with a physical health issue; however, he attended the remote appointment. This initial CMHT assessment noted that Clive was living alone after his wife and children had left due to domestic abuse on his part (assault and coercive control) and he had a court case pending relating to this. Records also noted that Clive had previously experienced auditory hallucinations but that he thought these were due to his prescribed pain medication (pregabalin) and that they had stopped when he stopped taking these tablets.

3.21 Clive told the worker he was hopeful he would reconcile with his wife, with whom he was still in communication, but that he had been asked to attend anger management before this could happen. There is no record that Clive discussed the anger management work further or clarified whether it was a requirement or just advised, and/or by which service. Clive denied risks to himself or others, and the CMHT assessor recorded '*No current suicidal ideation, planning or intent and clear protective factor of wife children and mother.*' Clive told the assessor he was working with NWM, and staff knew he was in hospital. Clive was in hospital at the time for physical health issues, and he requested a further AA appointment with the CMHT. The CMHT worker scheduled an appointment for 14 June 2021.

3.22 The CMHT worker called Clive, who was still in hospital, on 14 June 2021. Clive told the worker he was feeling more positive '*despite his situation and hoping to have further contact with his family'*. Clive denied risks to himself or others and said he felt supported by the hospital staff. As he remained in hospital, Clive asked if this AA appointment could be rearranged. The CMHT worker agreed to discuss this request at the Initial Assessment Meeting (IAT)[20] meeting on 15 June.

3.23 The Adult CMHT IAT meeting (held via Microsoft Teams) on 15 June 2021 discussed the AA initial assessment contact with Clive on 10 June. The agreed outcome was to rebook a face-to-face appointment for Clive at the CMHT office base. This appointment was scheduled for 27 June 2021.

3.24 Clive contacted his previous worker at NWM on 21 June 2021 asking for support with social care

[16] CGL is a voluntary sector organisation specialising in substance misuse and criminal justice intervention projects in England and Wales. For more information see Change Grow Live | Charity | We can help you change your life

[17] Clustering tool used in MH services to categorise patients by symptoms. A cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool (MHCT). see for more information: https://www.england.nhs.uk/wp-content/uploads/2021/03/21-22NT_Annex-DtD-Technical-guidance-for-mental-health-clusters.pdf.

[18] Care Cluster 7 indicates Enduring Non-Psychotic Disorders (High Disability) for more information see: https://www.datadictionary.nhs.uk/data_elements/adult_mental_health_care_cluster_code___initial_.html.

[19] NSFT offer online video calls and appointments as an alternative to face-to-face appointments where this is felt appropriate by the service user. The service is provided in partnership with Attend Anywhere, the video consultation specialists used throughout the NHS. See https://www.nsft.nhs.uk/attend-anywhere/

[20] IAT taken to mean Initial Assessment Team meeting.

and housing. Clive was advised the referral had been closed and a new referral would be needed. The worker made an internal referral to the NWM West Community Crisis Intervention service (WCCI).[21] NWM WCCI worked with Clive from 8 July to 5 October 2021. There is no evidence that the CMHT were updated following this referral.

3.25 Clive did not attend his (third) planned assessment at the CMHT team base on 27 June 2021. This was discussed in a team meeting and a further (fourth) assessment appointment was arranged to take place on 9 September at the team base.

3.26 Clive attended the local hospital ED on 2 September 2021. A nurse from the MHLS spoke to a senior member of staff who advised '*Clive is low in mood due to an impending court case… denied any suicidal thoughts or DSH[22] he reported he is under the care for [sic][23] CGL*'. MHLS recorded that they were unable to assess Clive that day due to high workload and advised Clive to '*engage with mental health services*.' MHLS did not specify which mental health service Clive should engage with and he was discharged home the same day.

3.27 Clive was seen and assessed by the CMHT at the team base on 9 September 2021. He attended with Elouise, and his support worker from NWM WCCI. The assessment recorded that Elouise was living with Clive following the breakdown of her relationship and she was identified as Clive's main carer / supporter. During the assessment, Clive reported he had numerous physical health conditions. The assessor also recorded that Clive experienced '*hallucinations hears voice inside head critical and lies about wife… sees people in house'*. Clive's mental health medication was listed as citalopram[24] 20 mg.

3.28 Clive was assessed as having full capacity to take part in the assessment, and his current risks were recorded in the areas of suicidality, harm to self and others, driving ('*had a car but not working has been advised not to drive until concentration improves'*), hallucinations, delusions, and vulnerability. The assessment recorded past risks in the areas of harm to others (namely his wife, whom he had reportedly punched and kicked), alcohol and substance misuse, and abuse from others. Clive denied current alcohol or substance misuse.

3.29 The assessment concluded that Clive's physical health was impacting on his functioning in activities of daily living, and that he required both a referral to social care and a medication review. It was agreed that the NWM WCCI worker would refer Clive to adult social care for an assessment of need. The plan was recorded as *'allocate to team nCPA Amber, medication review, seek meaningful activity and monitor mental state'.* The NWM WCCI worker referred Clive to NCC adult social care who provided a support service through Norfolk First Response service (NFR)[25]. Clive refused this service after one visit.

3.30 The assessment was discussed at the CMHT multi-disciplinary team meeting (MDT) on 14 September 2021. The discussion records indicate '*risks to self, moderate, risk to others moderate. Has Court case 16th September for coercive control and assault to wife*'. The outcome of the discussion reflected the above assessment plan: a referral to adult social care for assessment (by NWM), allocation to the team for nCPA (Amber) support, for the team to complete a medication review, for the team to offer support for Clive to seek meaningful activity and for ongoing monitoring of Clive's mental state. Following this meeting, Clive was placed on the waiting list to be allocated a

[21] The NWM Crisis Community Support is known as West Community Crisis Intervention service (WCCI) - an admission prevention service, supporting individuals and NSFT teams to keep people well in their own homes and the community rather than admission to hospital. The service is commissioned by Norfolk and Suffolk Foundation Trust (NSFT).

[22] DSH taken to mean deliberate self-harm.

[23] sic is the abbreviation of 'sic erat scriptum', from the Latin meaning 'thus it had been written'; sic is used in this context to identify that the text is quoted verbatim, including any spelling mistakes, non-standard spelling, or grammatical errors.

[24] Citalopram is a selective serotonin reuptake inhibitor (SSRI) antidepressant, often used to treat low mood (depression) and panic attacks. It helps many people recover from depression and has fewer side effects than older antidepressants. https://bnf.nice.org.uk/drugs/citalopram/

[25] Norfolk County Council service providing reablement support to adults in their own homes for up to 6 weeks with planned visits. https://www.norfolk.gov.uk/care-support-and-health/start-with-social-care/types-of-care/leaving-hospital/norfolk-first-support-reablement-support-at-home

CMHT worker. Clive and his GP were informed of the meeting outcome by letter.

3.31 The next recorded contact with Trust services was on 15 October 2021 when Clive was referred to MHLS. The referral was made by a physical health nurse; the reason for the referral recorded as '*noted to have self-harmed when admitted for chest pain at A&E.*' Clive was seen and assessed on the ward by the MHLS. The assessment summary recorded '*Treated for depressive illness with citalopram which seems to be successful. Currently showing poor reaction to personal circumstances which is causing emotional dysregulation and use of cutting as a coping strategy. We believe there is a risk of more serious harm to self as misadventure'*.

3.32 The outcome of this assessment was a referral to NWM for support whilst awaiting allocation of a CMHT worker, for Clive to discuss medication with his GP, and to provide Clive with crisis information including the phone number for the Trust's crisis line, FRS[26]. Clive was discharged home the same day.

3.33 NWM did not accept the referral and sent an email to MHLS on 18 October 2021 stating *'Unfortunately we are unable to accept this referral due to the fact this person is already under Secondary Mental Health Services. However, I did call the team and update them that we are unable to take this on and hopefully this will prompt them to look into this case and take this as a change of circumstance. If they see the need is higher they may be able to allocate this person sooner.'*

3.34 The next Trust contact was on 24 October 2021 when Clive called the FRS, stating he felt '*… very down, depressed, suicidal and [was] "struggling really bad"'.* Clive talked about his social situation including the breakdown of marriage, debt, poor physical health, loss of his father, recent changes in medication from citalopram to fluoxetine[27] and suicidal thoughts and self-harm. Clive told the assessor he had self-harmed in the past to "*drain pressure"* and "*take the pain away*' and although he '*still has suicidal thoughts but will "not bother" due to the protective factor of his children'*. Clive told the assessor he believed his wife had been cheating on him, he did not mention his arrest for domestic abuse, but he did tell the assessor he was seeing his two children at the weekend. Clive denied any psychotic symptoms, denied current drug use, said he had not worked in over ten years and was struggling with sleep. Clive told staff he had been discharged from hospital a few days previously for heart failure and that he had a maximum of five years to live. Clive told the FRS that he was being supported by the CMHT.

3.35 The FRS worker completed a risk assessment identifying Clive's risks in suicidal intent or plans and self-harming behaviours. No other risks were noted, and the assessor identified Clive's children and family as protective factors. The assessment recorded summary of risks as '*Risk of decline in mental health. Risk of isolation. Risk of suicide by drug overdose due to historical attempts of this'.* FRS agreed a safety plan with Clive, including to refer Clive for a Care Act (2014) needs assessment, that they would complete a vulnerable adult safeguarding referral, and inform secondary mental health services. As part of the safety plan, Clive agreed to request a food parcel from the local foodbank, to rest, and to contact services again if in crisis. Clive was rated as F on the 'Mental Health Triage scale (A-G). F on this scale indicates *'referral not requiring face-to-face response from mental health"*.[28] It is unclear why Clive was given this rating as it appears to contradict the assessment summary of risks.

3.36 Following the FRS assessment, the CMHT recorded *'On basis of clinical evidence immediate upgrade to RAG RED. To be followed up today. Discussed briefly in CRHT MDT - they will accept referral if it is impossible to establish patient safety by the end of this working day'*. The CMHT attempted to contact Clive four times by telephone on 25 October. Clive did not respond; Clive was

[26] Within Norfolk, the NHS 111 telephone line operates a helpline for people of all ages who need urgent mental health support. The helpline is available 24 hours a day, every day of the year and forms part of the Trust's crisis response service. https://www.nsft.nhs.uk/first-response

[27] This change appears to have occurred in October 2021. The exact date is not recorded. Clive advised he was on citalopram at the MHLS assessment on 15 October 2021, and then said this had switched to fluoxetine during his call with FRS on 24 October 2021.

[28] https://ukmentalhealthtriagescale.org/uk-mental-health-triage-scale/

moved to red on RAG rating and an urgent request for a 'cold call' was made to the CRHT.

3.37 The CRHT attempted a home visit later that day but were unable to get an answer at Clive's home address. The practitioners contacted Elouise, who informed them that she had spoken to Clive that morning. Elouise agreed to contact her father and ask him whether he would speak to the crisis worker. Elouise agreed to let the team know the outcome.

3.38 The following day, the CRHT spoke to Elouise again, who told them that she had spoken to Clive, who said he had been asleep the day before, that he knew he had over 100 missed calls but would not confirm whether he would engage with the CRHT. The CRHT attempted to call Clive directly but had no response.

3.39 The CRHT spoke to Clive by telephone on 27 October 2021. He agreed a time for a home visit, but Clive was not in when CRHT attended as scheduled. The CRHT left a note and attempted a second visit later in the day, but there was no response at Clive's address when the team visited.

3.40 The CRHT MDT on 28 October 2021 reviewed the referral and attempts to contact Clive. A plan was agreed to make a further attempt to contact Clive that day and visit, but if this failed, to inform the CMHT. The record is not clear what the plan beyond contacting CMHT would have been. Clive remained RAG rated red. The CRHT managed to speak to Clive by phone, and he stated he had been asleep when CRHT had visited the previous day. When reminded he had previously told staff that he had been shopping, Clive reported he struggled with his memory due to having ME.[29]

3.41 The CRHT made a home visit on the evening of 28 October 2021. At the time of the visit, Clive was home with two of his children, identified as being 4 years and 14 years of age. The CRHT completed an assessment. The home environment was noted to be 'untidy, dirty and cold'. Clive told the assessors he had limited access to money for food and needed a food parcel. Clive talked about sensitive issues including poor physical and mental health, drug use, suicidal thoughts and acts of deliberate self-harm. The records noted that *'[14-year-old child] did distract the 4-year-old child given the conversation's explicit content',* but that Clive *'spoke about his self-harm and past cocaine use in front of his 4-year-old [child*]'. Clive told staff he had '*been cutting himself for the past four weeks that has put pressure on his relationship with his 4-year-old [child] who refused to see him for four weeks as [they] was scared. Clive also reported that he shoved a pin in himself [to] let 2 litres of blood out of his body. The 14-year-old confirmed this*.'

3.42 Clive denied any recent drug or alcohol use, but he admitted hitting his wife, and said he had not left the house for several months. The CRHT worker asked Clive what he was '*shopping for when he was out with his friend. Clive admitted that was the first time he has left the house. Clive avoided the question regarding what he purchased… explaining that his friend bought him bread, butter, and milk… Clive reported that he was due to pick up his new car on 29/10/2021'*.

3.43 Overall, the assessment concluded *'No evidence of acute mental distress… Risk of suicide: LOW: Chronic suicidal thoughts reported but has not identified any means…. Risk of self-harm: MODERATE: Chronic self-harm. [Child] aware of appropriate contacts should Clive require immediate physical health assistance…. Risk of self-neglect: MODERATE: Lack of food and reported difficulty with utility bills due to social restraints and lack of funds. Reports that he is purchasing a car tomorrow. No evidence of psychosis… Orientated to time and place…. Good insight into his mental state…. Clive was able to demonstrate that he could retain, understand, and weigh up the information given to him and were able to communicate his decision (Mental Capacity Act 2005)*'.

3.44 The CRHT agreed to transfer Clive's care back to the CMHT, to arrange a food parcel and to make a referral for additional support from NWM.

3.45 The CRHT worker contacted Children's Social Care (CSC) on 29 October 2021 to discuss '*possible children safeguarding concerns'* following their assessment the day before. CSC took the details

[29] Myalgic encephalomyelitis, also called chronic fatigue syndrome or ME/CFS, is a long-term condition with a wide range of symptoms. The most common symptom is extreme tiredness. https://www.nhs.uk/conditions/chronic-fatigue-syndrome-cfs/

and agreed to call CRHT back. The CRHT then contacted the CMHT to discuss the referral and follow up actions taken. The CRHT informed the CMHT that Clive's '*mental health difficulties are chronic but there is [sic] no current acute risks'* The CRHT informed the CMHT of the children safeguarding concerns, that they had made a call to CSC for advice. The teams agreed a plan for the CRHT to deliver a food parcel to Clive and inform him that he was to be discharged to the CMHT waiting list.

3.46 Just over an hour later, the CRHT spoke to a Family Support Practitioner (FSP) from CSC regarding the safeguarding concerns identified during their home visit the evening before. The records indicate that the FSP told staff that '*the situation and the family dynamics were known to Family Services and were not unusual*.' How this advice was determined, or what records the FSP reviewed to inform them of this, is not expanded on within the records. The CRHT record concludes *'with that in mind, consideration for safeguarding was not necessary at this stage*'. Again, how this conclusion was reached is not expanded on in the records. Our reading of this advice indicates that the FSP identified that in their view, this situation was usual for this family, that these concerns (of neglect and abuse) were commonplace, and that a safeguarding response was not therefore necessary. We are not clear how this advice was reached, and we are not clear why the advice was accepted by CRHT. We discuss the Trust management of child safeguarding concerns in our analysis section below (section 5.18 onwards).

3.47 Following the visit by CRHT and advice provided by FSP, a safeguarding referral was not taken forward.

3.48 The CRHT completed a final home visit later that day (29 October 2021), to deliver the food parcel and to '*assess mental state and review for discharge and transfer care back to CMHT waiting list'*. The CRHT worker noted that '*Clive reported the incident when he self-harmed and lost a significant amount of blood happened on 18/09/2021, Clive said he didn't think he wanted to die but wanted to get help. Clive said he didn't self-harm in front of children but said two of the children came in unexpectedly. Clive had no intention to self-harm in front of his children. Clive says he saw 2 of his [children] for the 1st time yesterday and his [youngest child] is staying with him and [Elouise] 19 yrs whom [sic] lives with him he reported this will be the first time [he sees the younger children] in 4 weeks''.*

3.49 The CRHT:

- made a record of Clive's children's names and ages,
- noted the domestic abuse court case had been deferred until May 2022,
- confirmed that Clive denied any substance misuse, and
- noted Clive agreed both to a referral to NWM, and to be placed back on CMHT waiting list with weekly phone contact.

3.50 The CRHT made a referral to NWM and discharged Clive back to the CMHT waiting list.

3.51 The NWM emailed the CRHT on 2 November 2021 *'Good Afternoon, this gentleman has recently had two referrals under Psych Liaison and our community team which is 24 weeks of support. Unfortunately, we cannot accept another referral at this time as support only finished 2 weeks ago.'* The referral was rejected, and the email was put on the clinical records. There is no evidence that this referral outcome was discussed in the CMHT.

3.52 The CMHT next made a waiting list call to Clive on 8 November 2021. Clive described issues with his mood, *'great deal of the time he is very down and hopeless. The stressors remain the same, his overall health prognosis weighs very heavily on him and he finds the whole realisation that his life may end prematurely very depressing indeed'*. Clive also described issues with rent arrears and overall money concerns. No new risks were identified or noted, Clive *'seemed genuinely thankful that he was receiving some kind of input albeit not quite at the level that was desired at this time'*. The call did not record Clive's overall risk rating, and the plan continued for Clive to receive 'regular'

waiting list calls.

3.53 The next CMHT waiting list call to Clive was on 2 December 2021, when they completed a *'my recovery'*[30] plan with him. Clive told the assessor he was struggling to cope at home after his wife had left, that he had multiple health concerns, and that he had also recently been diagnosed with cystic fibrosis.[31] Clive described difficulties with his home environment, and with cooking and caring for himself. Clive said he '*feels that his wife encourages and [sic] parental alienation between himself and his children; he hasn't seen some of them in a couple of months*'. Clive also told the assessor he had recently had a house break in, and the children's Christmas gifts and his medication had been stolen. There is no evidence that the impact of the missing medication was discussed or that a replacement was offered by CMHT. In addition, Clive told the worker '*He was unsure who to speak to but that he needed to talk to someone'*.

3.54 During this call, the CMHT worker provided Clive with details of charities and support groups, gave details of Trust services (CRHT and FRS), and told Clive he would continue to be called until he was allocated a CMHT worker. Risks were recorded as moderate to self and others and the worker again noted the pending court case for '*coercive control and assault to wife*'. Clive denied alcohol use '*despite attendances in A&E under the influence*' and the assessment concluded '*CPA review: it appears that as no one else is currently working with Clive that he can be reviewed as non-CPA. He remains an amber RAG rating, no thoughts of suicide mentioned with no plans or intentions, no evidence of self-harm discussed, and no evidence of harm to others.'*

3.55 Clive contacted the FRS call line on 21 December 2021, asking to talk as he felt a '*bit low'*. Clive talked about his current living situation and difficulties with his relationships. He denied any thoughts or plans to harm himself, and when discussing an alleged planned bowel operation, said he intended to refuse this as he did not wish to die. The worker did not note any new concerns or risks and completed both a mental state and risk assessment. Areas not covered or no risk identified, included harm to others; harm to children; disclosure of physical, sexual, emotional, and financial abuse. The FRS noted Clive was on the CMHT waiting list and agreed to update both the CMHT and Clive's GP about the call. Clive agreed to contact the WBS, and to contact services if he reached a crisis.

3.56 Clive contacted the FRS again on 30 December 2021, stating that he was alone at home and low in mood. However, the worker noted *'[Clive] is safe, no thought plan or intent to harm himself or others.'*

3.57 The CMHT attempted to contact Clive by telephone on 9 January 2022, but had no response.

3.58 Clive was allocated to a lead practitioner in CMHT on 11 January 2022.

3.59 Clive's GP wrote to the FRS on 14 January 2022 informing them that the Community Heart Failure Specialist Nurse had visited Clive on 6 January 2022. The GP wrote *'[the nurse] had noted that [Clive] was taking more of his Mirtazapine than was prescribed, when contacted today, he said that he was becoming increasingly depressed. He complained of ongoing low mood. He said that he was not sleeping well in spite of being on Zopiclone*[32] *7.5 mg daily. He said that he was feeling as if no one wanted him anymore…. In view of ongoing symptoms of depression which appear to be deteriorating, could you kindly review and advise on further management'*. This contact was passed on to the CMHT.

3.60 The CMHT also contacted Clive on 14 January 2022 to arrange an initial assessment visit. Clive described struggling with low mood, poor mental health, social isolation, issues with finances and issues with housing. Clive and the CMHT agreed a first visit for 20 January 2022. The CMHT

[30] Part of the care planning process. The Trust CMHT policy states individuals under the team should have a 'Recovery Plan' completed within 15 weeks and updated yearly or when clinical needs change.

[31] This is extremely unusual as in the UK, most cases of cystic fibrosis are picked up at birth. For more information see https://www.nhs.uk/conditions/cystic-fibrosis/

[32] A type of sleeping pill that can be taken for short-term treatment of severe insomnia. https://bnf.nice.org.uk/drugs/zopiclone/

agreed to take a food parcel.

3.61 The CMHT completed their initial assessment at Clive's home on 20 January 2022. Clive described struggling with low mood, poor sleep, memory loss and '*feeling numb*' emotionally. The assessment noted several social issues, recording that they '*seem to be the root cause of his low mood'* including the breakdown of his relationship with his wife in April 2021. Clive said this was due to '*a fight and she hit him, so he hit her back*.' Clive also told the CMHT staff that he was the subject of a restraining order towards his family and the local area including the shop where his wife worked, although Clive reported he was still seeing his wife and that she was '*bringing him meals because she is worried about him. He believes that they would be back together if it wasn't for the police and her family who dislike him'*. Clive also told the CMHT '*3 out of his 4 children have mental health issues which he worries about'*.

3.62 Other social stressors identified at this assessment included housing, benefit arrears (due to not be truthful about his living situation), issues with paying bills, loss of contact with his children, although he said, '*his daughter* [not identified] *has still been seeing him at times because [sic] she is worried about him*.' Clive talked about issues with seeing his children, and he described a recent incident when he had been subject to an *'unprovoked attack whilst out with his daughter* [not identified]', although he also said he had been drinking and could not remember the details and did not wish to report this to the police. Clive told CMHT that he used to have a carer, but they only provided microwave meals and he could not eat them. During the assessment, the police called to discuss the recent alleged break in at Clive's home. The CMHT worker reported the conversation became '*quite heated'*.

3.63 The agreed plan following the assessment:

- *Refer to [NICHS][33] for support with housing and social issues.*
- *Medication review with [consultant] - Email sent.*
- *Contact NCC to see if Clive can have another carer.*
- *Possible referral to MIND for support.*
- *Discuss whether need for CMHT in MDT - Complete above actions and discharge.*

3.64 Clive fatally assaulted his daughter, Elouise, on 23 January 2022. He was arrested on suspicion of murder, causing death by dangerous driving, and drink driving.

3.65 Clive was subsequently found guilty of murder and sentenced to a minimum term of 18 years.

Contact with other services

Norfolk Waveney Mind (NWM)

3.66 NWM is an independent charity which is part of the National Mind Federation. The Trust commissions NWM to provide support services following presentations at the local hospital ED and for people in mental health crisis. Clive was supported by two NWM services in 2021; the NWM psychiatric liaison support service, and the NWM community service (known as West Community Crisis Intervention service (WCCI)), as shown below.

[33] Norfolk Integrated Housing and Community Support Service supports adults (aged over 18) with severe and enduring mental health needs, including individuals with complex needs. The service supports people across the whole of Norfolk in supported living and within the community. https://www.together-uk.org/projects/norfolk-integrated-housing-and-community-support-service/

Table 1: Contact with NWM

NWM Psychiatric liaison support service 29 April – 14 June 2021	
Face to face meeting	1
Telephone call (answered)	7
Did not respond [to NWM phone contact]	10
Text contact	1
Total	**19**
NWM Community Crisis service 8 July – 5 October 2021	
Face to face meeting	7 (5 of these to support attending appointments)
Telephone call (answered)	3
Did not respond	9 (2 were cancelled home visits, 7 were phone contacts)
Total	**19**

Adult Social Care

3.67 NWM WCCI referred Clive to Norfolk County Council (NCC) Adult Social Care (ASC) Services in September 2021 for an assessment of his social care needs. A further referral was made by the FRS on 24 October 2021 for consideration of adult safeguarding concerns related to possible self-neglect, and for an assessment of social care needs under the Care Act 2014.[34]

3.68 Within the IMR report provided to the DHR, NCC Adult Social Care identified 17 referrals made for Clive during the time under review. The two requests for Safeguarding and Care Act 2014 Assessments made by NWM and FRS were amongst the health referrals. We have summarised these referrals below.

Table 2: Summary of adult social care referrals made to NCC.

No.	Source	Reason and outcome
7	Norfolk Constabulary	Notification to NCC of MARAC meetings not requiring any input from NCC. NCC were unable to contact Clive.
5	Health 111 service Mind Hospice Care	Requesting Safeguarding and Care Act 2014 Assessments for Clive Offered care service for meals, but this was declined.
5	Self-referrals	Requesting support with care and support food and housing and electricity. NCC made numerous attempts to contact Clive, but only information and advice relating to NCC support services, housing and finance could be shared in leaflet form.

Criminal Justice System.

3.69 Between 1 January 2019 to 23 January 2022, Clive had extensive contact with criminal justice systems including reports and investigations for domestic abuse offences, assaultive behaviour, and one firearm incident. There is no evidence that Clive's contact with the criminal justice system was shared with the Trust by other agencies beyond one police referral in April 2021 to the Trust L&D service.

[34] See Section 9 'Assessment of an adult's needs for care and support' https://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted

Children Social Care Services

3.70 In addition, and often because of his contact with the criminal justice system and police, Children's Social Care (CSC) provided by Norfolk County Council (NCC) confirmed in their IMR that Clive and his family had been known to their services since 2014. During September 2021, the Trust contacted NCC CSC to discuss '*possible safeguarding concerns*.' The Trust were told that '*the situation and the family dynamics were known to Family Services and were not unusual*'. There is no evidence that details of this knowledge of the family was discussed or shared further. The records do indicate that the Trust shared the details of the CRHT home visit with CSC. The CSC IMR indicates that the case was closed to CSC social work team in September 2021.

Other services

3.71 The family were known to various local education providers, and child health visiting services. There is no evidence that the Trust were aware of any of these contacts.

4 Clive's views on his care from the Trust

4.1 The author met with Clive as part of this review on 31 August 2023. The meeting was held virtually. Clive was asked if he wished to comment on the care he had received from the Trust, or services commissioned by the Trust, prior to the homicide. The author did not seek or record Clive's views on any other aspect of the case.

4.2 Clive told us that he had struggled with his mental health since the death of his father in 1995, but that this got worse in 2021. Clive said his main issues related to depression and negative thoughts. Clive told us he used overdosing, self-harm, and substance and alcohol misuse to cope.

4.3 Clive told us that he had contacted the Trust WBS in 2019 but as he was not suicidal. He said they were unable to help him. Clive remembered being referred by the WBS to the Trust (CMHT) in 2021.

4.4 Clive told us that he made no contact with mental health services during 2020 because of the restrictions imposed by the pandemic caused by the Coronavirus (COVID-19).[35]

4.5 Clive recalled working with NWM from April 2021. Clive said that he had found the help provided by NWM useful. Clive told us that he was also referred to the Trust mental health services (CMHT) early in 2021 and that there was a delay from the initial referral to being seen by them in December 2021. Clive said help was '*slow to get going'*, that he '*sought help from the Trust in January 2021, but didn't get any help until December that year'*. We found no evidence that Clive sought help in January 2021; the first recorded referral in 2021 was made by the police to the Trust L&D service on 7 April.

4.6 Clive told us he knew he was on a CMHT waiting list and was told he would be called. Clive told us the CMHT did call him, but that it was not weekly, but he could not recall how often they made contact. Clive told us that following the breakup of his marriage in April 2021, he '*took an overdose, then things got worse with drinking and taking drugs*'. Clive told us his '*physical health had affected his ability to help himself and his mood was low*', he also told us he spent weeks in bed.

4.7 Clive also told us he found the help provided by the Trust CRHT later in 2021 to be useful.

4.8 Clive said he remembered that the CMHT saw him in January 2022 but told us he struggled to recall the details other than they discussed medication. When asked about the care received overall, Clive said '*it was a long time to wait when you were low'*.

[35] https://www.who.int/health-topics/coronavirus#tab=tab_1

5 Analysis of care and treatment provided to Clive.

5.1 During the time under review Clive contacted or was referred to six Trust services. The months, contacts or referral and their outcomes are shown below.

Table 3 Referrals to Trust services

Date	Service	Outcome
August 2019	WBS	Signposted to CRUSE and SHELTER
April 2021	L&D	Seen but not assessed (did not engage)
April 2021	MHLS	Referred to NWM
May 2021	WBS	Referred to CMHT (remained an open referral to CMHT from this point)
June 2021	CMHT	Offered and completed appointment anywhere (AA)
June 2021	CMHT	Offered AA and rearranged
September 2021	MHLS	Not seen or assessed (due to high workload)
September 2021	CMHT	Face to face initial assessment, accepted and placed on waiting list as non-CPA
October 2021	MHLS	Referred to NWM whilst on CMHT waiting list
October 2021	FRS	Advice plus updated CMHT
October 2021	CRHT	Assessment at home, seen next day and closed back to CMHT waiting list
December 2021	FRS	Advice plus updated CMHT
December 2021	FRS	Advice plus updated CMHT
January 2022	CMHT	Face to face initial appointment with care coordinator/lead practitioner.

Assessment and management of risk

5.2 The Trust clinical risk assessment and management policy (page 2 summary of key points) highlights:

- *'All service users accepted for an assessment of their mental health needs should have an assessment for the current episode of care. Substantive changes in risks or needs must always be reflected in appropriate documentation….*
- *Risk assessment must take into account the whole picture and recognise how each risk factor impacts as a whole…*
- *It is essential that information is recorded accurately and comprehensively and communicated to all those who need to have access to it in order to care for the service user.'*

5.3 The Trust's safeguarding adult policy and safeguarding children policy confirm that the Trust is a member of the Norfolk and Suffolk Safeguarding Children's Boards and follows the procedures produced by these Boards. Both policies indicate that these procedures are available to Trust staff via the intranet.

5.4 The Trust safeguarding children policy (page 6) also states *'Good practice also advises that referrals should be made where mental health issues, domestic violence and/or drug or alcohol abuse may put a child at risk of abuse or neglect.'*

5.5 Finally, the Norfolk Safeguarding Adult Board website notes *'Professional curiosity is about having the capacity and communication skills to explore and understand what is happening with an individual or family. It is about asking more, and using proactive questioning and challenge. It is about understanding your own responsibility and knowing when to act, rather than making assumptions. It is about being interested in the person and the situation; not taking things at face value - asking 'why'?'*[36]

5.6 Between 2019 and 2022, Clive was assessed on at least ten occasions by Trust services. In 2019, he was assessed by the WBS and, given his presenting need at the time, was appropriately referred for support to third sector providers. Clive was not seen or assessed in 2020.

5.7 During April 2021, Clive was referred to and assessed by the Trust MHLS. This referral was made three weeks after Clive had been arrested for ABH and followed an overdose of prescribed medication. This assessment identified risk to self (impulsive overdose), risks to others (domestic abuse), anger issues, ongoing grief, chronic physical health, and social care issues. The assessment also noted Elouise was now his main carer, and that he had other children in the family who were living with his wife. The assessment did not consider alcohol or substance misuse, although the available records indicated that Clive had been arrested for drug offences just a few days previously. The outcome of this assessment was a referral to the Trust commissioned support service provided by NWM.

5.8 Whilst a referral to support provided by NWM appears to be an appropriate outcome for Clive at that time, we believe the MHLS could have done more with the information provided and the risks identified. We believe the MHLS could have considered sharing this information with other statutory agencies such as the police and children social care. The MHLS could also have considered whether the risks warranted a child safeguarding referral, whether Clive's wife was known to adult social care, and/or she had care and support needs[37] and so required an adult safeguarding referral in her own right.

5.9 In addition, MHLS could have considered whether Elouise (as a young adult) was known to health or care services, and whether she needed or was being offered appropriate support. That this information (and the detail from the earlier contact with L&D) was not shared suggests a lack of awareness about the impact of domestic abuse and comorbid mental health issues on child welfare and demonstrates a lack of professional curiosity and a lack of proper consideration of Clive's family situation.

5.10 Clive was next assessed in May 2021 by the Trust WBS. This was a detailed assessment that identified risks and recommended that Clive required secondary mental health services. The CMHT accepted this referral and attempted to assess Clive during June 2021. Clive initially engaged but, as he was in hospital, the CMHT rearranged his assessment to 27 July 2021. Clive did not attend in July and the assessor did attempt to call him but could not leave a message. The assessor also informed Clive's GP of the failure to attend. The CMHT arranged a third assessment date over forty days later in September.

5.11 The CMHT saw Clive and completed their initial assessment at the CMHT team base on 9 September 2021. This assessment resulted in a referral to adult social care and for allocation of non-CPA care and support under CMHT. This assessment also identified risk to others (domestic abuse), that Elouise was his young carer, and risks relating to substance and alcohol misuse. Following this assessment Clive was placed on the CMHT waiting list. Whilst a waiting list appeared to have been necessary given the workload of the CMHT at this time, we note that Clive had been waiting for support since April (see further discussion in 'wait for support' section below).

5.12 Reviewing this assessment and the Trust's growing knowledge about Clive and his family situation, we believe the CMHT also showed a lack of proper consideration of Clive and his family

[36] https://www.norfolksafeguardingadultsboard.info/protecting-adults/working-with-adults-at-risk/professional-curiosity/

[37] For criteria for adult safeguarding see Section 42 of the Care Act 2014. https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

circumstances. Given the risks identified and the growing picture surrounding Clive and his family, we believe the CMHT could have explored whether there was a need to share information with other relevant services, considered if there was a need for adult (not just for Clive but for his wife) and children safeguarding referrals, and considered whether this family were known and being supported appropriately.

5.13 Following the CMHT assessment in September, Clive came to the attention of, and was assessed by the MHLS and the FRS in October 2021. The assessments completed by MHLS and FRS were detailed and covered risks and mental state, and were shared with the CMHT, who referred Clive to the CRHT for urgent follow up. The CRHT accepted the referral and completed an assessment in October 2021. This assessment identified Clive was at low risk of suicide, moderate risk of self-harm and self-neglect, and found '*no evidence of acute mental distress'*. This assessment, however, also identified several child safeguarding concerns. After discussion and following advice (discussed below) these risks were not addressed, and Clive was placed back on to the waiting list for CMHT.

5.14 We found no evidence that following disclosure of the safeguarding concerns, the CRHT or CMHT believed any further action was necessary. We found no consideration of the impact of leaving Clive unsupported, or any consideration of how a lack of support might impact on Clive, his wider family and in particular his young children.

5.15 Finally, Clive was seen by CMHT in January 2022. This assessment identified inconsistencies in Clive's account of alcohol use, and domestic abuse, that his family life was impacting on his mental health, and that he was in breach of a restraining order. This assessment added more information to the Trust's knowledge of Clive's home life and risk profile, yet we found no evidence that the team considered whether this information should be shared (as per Trust risk policy or safeguarding policies), or that consideration was given to how Clive's behaviour and actions were impacting on his children.

5.16 In addition, throughout his contacts with the Trust Clive gave varying and inaccurate accounts of events and his history that were both misleading and appeared to be self-serving. These inconsistencies related to his use of alcohol and substances, his account of his relationship with his wife, and reports of his financial situation and housing. Clive also told Trust services he had been victim of an assault whilst out (and drinking) with his daughter but told staff he didn't want police involved, he gave a confused account of a burglary, and he gave two different accounts of why he didn't attend an urgent CRHT appointment. Clive also gave varying reports about physical health conditions including an adult diagnosis of cystic fibrosis and the prognosis of death due to various cancers. It appears that none of these inconsistencies were challenged by Trust staff, and none were verified through contact with other services before being recorded in Trust records and risk assessments.

5.17 In summary, Trust services that assessed Clive identified factors relating to domestic abuse, substance and alcohol misuse, and child safeguarding risks, alongside reports of poor mental and physical health. Clive also provided Trust services with varying and inconsistent accounts of both his health and family living situation. Despite identifying significant risk factors, the assessing services did not explore these factors further. Services did not seek to understand whether other services were involved with Clive and his family or check whether other services were aware of the risks identified. Services did not verify whether Clive was accurately reporting his situation. We found that, throughout his time with Trust services, professionals paid insufficient attention to Clive's family circumstances, they did not look beyond Clive's needs or his statements, and they did not consider risk or management of risk from a whole family perspective.

Child safeguarding concerns

5.18 The Trust child safeguarding policy states, *'The Trust recognises that the welfare of children and young people are paramount and that at all times a child or young person, in all situations, has a right to feel safe and protected from any situation or practice that result in them being harmed or at risk of harm. Trust staff will recognise and take appropriate action when there is a concern or*

allegation of significant harm, within a multi-agency framework that promotes the welfare of children'.

5.19 We also note that the Trust are partners in, and have access to, advice and guidance provided by a local Multi-Agency Safeguarding Hub (MASH).[38] The Trust safeguarding children policy states '*The MASH brings together key professionals from the police, children's and adult Social Care, health and domestic abuse services. The MASH aims to facilitate early and effective information sharing, analysis and decision making to protect the most vulnerable children from harm, neglect and abuse.'*

5.20 The Trust were aware that Clive was an alleged perpetrator of domestic abuse, that he was known to use substances and alcohol, that he was not always truthful about the frequency or nature of this use, and that he was at risk of self-neglect. In addition, throughout Clive's contact with Trust services, it was known that he had contact with four children and that his eldest daughter, Elouise, was his carer. Despite these multiple contacts and assessments with Trust services, we found only one reference to a child safeguarding referral.

5.21 CRHT saw Clive at home on 28 October 2021. Two of Clive's children, identified as being 4 years and 14 years of age, were present during the visit. CRHT completed an assessment, identifying several child safeguarding concerns, alongside a poor living environment.

5.22 The records indicate that the worker was concerned about the children and possible safeguarding concerns during their visit, and they discussed this visit and their assessment with the local authority CSC within the MASH and the Trust safeguarding team. The CMHT were also updated. This was good practice. However, despite the risks identified, the CRHT were advised by NCC children's social care (CSC) that the family were known to them, and they believed that the matter was not a safeguarding one. Consequently, after completing a follow up visit the next day, CRHT referred Clive for additional support by NWM and discharged him back to the CMHT waiting list.

5.23 The CRHT home visit identified significant child safeguarding risks. Once identified, the assessor correctly sought advice from safeguarding colleagues. The number called was the one detailed in the Trust policy, '*All referrals to the Norfolk Multi-Agency Safeguarding Hub (MASH) must now be submitted via the professional consultation line*'. The advice given indicated that, as the family were known, the concerns did not warrant a safeguarding response. We found no evidence of the rationale for this decision. We also found no evidence that the Trust were given (or sought) detail of how the family were known to CSC, what the concerns or risks were, or what plans were in place to support this family.

5.24 The Trust policy also states, *'Discussions which do not result in a referral will not be recorded on the Children's Services recording system, but an email of the contents and decision should be sent by MASH to the practitioner in all scenarios.'*

5.25 We found no evidence of email correspondence from MASH to the CRHT.

5.26 We are unclear why discussions about such concerns are not recorded in the child safeguarding records. There was clear evidence of neglect and concerns that Clive was talking and behaving inappropriately in front of his children about self-harm and drug use. We believe this was important information to inform partner agencies when planning child safety.

5.27 Despite the concerns raised, there is no evidence in the records that CRHT disagreed with the advice provided, or that the matter was taken any further, and the referral was passed back to CMHT.

5.28 However, given the concerns raised, we believe a child safeguarding response was warranted. The records indicate there was evidence of neglect (lack of food, dirty cold home), inappropriate behaviour from Clive towards his two children (expectation that the 14-year-old shield the 4-year-

[38] Multi-Agency Safeguarding Hubs (MASH) aim to improve the safeguarding response for children and vulnerable adults through better information sharing and safeguarding responses. See https://www.norfolk.gov.uk/what-we-do-and-how-we-work/policy-performance-and-partnerships/partnerships/mash

old from conversations about drug use and self-harm) and domestic abuse towards his wife (with whom he still had contact).

5.29 We are unclear why the worker did not challenge the advice given. Had they disagreed with, and challenged this advice, the policy is clear that they should '*Document concerns, decision making process and outcome (who, where, when). Record all discussions about the situation. If required, seek advice…*'

5.30 However, we do recognise that the CRHT assessment identified child safeguarding risks. Why the outcome did not result in a referral or action, is a matter for other agencies to consider.

5.31 Finally, we identified that, throughout Clive's contact with Trust services, he routinely identified that he had contact with his children. Clive was also clear that he was attempting to have contact with his wife even when an order was in place restricting this contact. During several assessments staff identified that Clive's children were '*protective factors*' against his risk of suicide yet we found no evidence that assessing services considered the appropriateness of this, or considered whether Clive's children should have been placed in that position. Similarly, there is no evidence assessing services considered whether the children required referral for support, or indeed whether any other services were aware of the information gathered during the multiple Trust contacts.

5.32 Except for the contact with the CRHT in October 2021, we found no evidence of any awareness of child safeguarding throughout Clive's contacts with the Trust.

5.33 In summary, we found that services did not specifically consider the impact of Clive's risk-taking behaviours and poor mental health on his children. During 2021, Clive was estranged from his wife, and it was known that he continued to have contact with his children. On only one occasion did Trust services seek child safeguarding advice, and then after being told not to make a referral, left identified risks unaddressed. In addition, Clive's view on his children and their role in 'protecting him' from suicide was not challenged, and the impact of this behaviour on their mental wellbeing was not considered.

CMHT referral and follow up (including use of a waiting list)

5.34 The Trust WBS referred Clive to the CMHT for assessment and follow up in May 2021. We discuss the CMHT response and the use of a waiting list below.

5.35 Clive was referred to the CMHT in May 2021 by the WBS and contacted by the CMHT via AA telephone contacts in June 2021. These contacts were timely, the records made were detailed; given Clive was in hospital at the time, and the outcome appears to have been appropriate. Following these two contacts, Clive was offered a face-to-face appointment in July at the CMHT office base. The timings of the appointments offered met the 28-day timescale as stated in the Trust CMHT operational policy for initial assessments.

5.36 Clive did not attend the (third) planned assessment at the CMHT team base in July 2021. Clive's non-attendance was discussed in a team meeting and a further (fourth) assessment appointment was arranged for September. The CMHT wrote to Clive on 28 July offering an appointment for 9 September 2021 at the team base.

5.37 Whilst a further appointment appears to have been an appropriate response, we do not believe a further wait of over four weeks was a timely response. Clive had been referred by the WBS who noted risks due to domestic abuse, hopelessness, suicidality, and harm to self and to others. These risks remained unassessed, and whilst Clive had initially been supported by NWM, they had closed his case after his admission to hospital in June. The records are not clear as to whether the CMHT were aware of this.

5.38 Whilst waiting to be seen, Clive attended ED in September 2021 but was not assessed or seen by the MHLS who referred him back to mental health services. The records were not clear about which service Clive was supposed to engage with as he was still on a waiting list to be seen at that time.

5.39 We discussed this delay with the service lead who confirmed that, due to the high volume of work, 40 days was not an unusual gap between an initial AA and the face-to-face appointment. Regardless of service pressures, we believe Clive's wait for initial CMHT assessment was too long and that he tried to access help via ED whilst waiting, but this only resulted in him being sent back to the waiting list.

5.40 Clive attended an assessment at the CMHT team base on 9 September 2021 with Elouise and his support worker from NWM WCCI. The assessment noted that Elouise was now his main carer, and that Clive continued to experience hallucinations and delusions. During this assessment, Clive denied current alcohol or substance misuse. The outcome of this assessment was for Clive to be offered non-CPA (nCPA) care and for the NWM worker to refer him for an adult social care assessment of need. Following discussion at the CMHT MDT meeting on 14 September 2021, Clive was placed on the waiting list for the CMHT.

5.41 Whilst Clive was to be offered CMHT support, this did not happen immediately. The CMHT were operating a waiting list due to capacity issues.

5.42 The waiting list system for CMHT was guided at the time by the Trust Clinical Harm Review Standard Operating Procedure. We have been told that a new version of this policy is now in operation. This procedure indicates for people identified as red (on the risk rating scale) '*[they] will be contacted weekly initially'.* For those identified as amber or green (on the risk rating scale) the procedure states, *'Best practice would be to ensure a named clinically appropriate practitioner contacts the service user consistently and future contacts are purposeful and planned'.* Whilst contact frequency is not noted for individuals rated amber or green, we were told that in this instance, the CMHT would aim for contact to be fortnightly, or as agreed with the service user.

5.43 Clive was rated as amber throughout most of his time on the waiting list (except when referred to CRHT in October 2021 when he moved to red – he reverted to amber after the assessment). Clive was told that he would have *'regular'* waiting list calls, and following the assessment by CRHT that these contacts would be weekly. We found no evidence that Clive was contacted regularly, or that he was contacted weekly after the CRHT assessment in October.

5.44 In addition, and whilst on the CMHT waiting list, Clive attended ED for a physical health issue and was assessed by the MHLS on 15 October 2021. The MHLS completed a risk and mental state assessment, noting a low risk of suicide, that Clive used self-harm at times of stress, that he was struggling with the loss of his family and breakup of his marriage and under safeguarding recorded that Clive told staff that he was the victim of abuse and that he was going to 'win' his court case. The outcome of this assessment was a referral to NWM for support whilst awaiting allocation of a CMHT worker. The CMHT were informed of Clive's attendance to ED but did not contact him.

5.45 Clive also contacted FRS on 24 October 2021. The FRS worker competed a comprehensive assessment and the contact was appropriately shared with the CMHT who subsequently attempted to speak to Clive. The CMHT were unable to contact Clive and so made an urgent referral to the CRHT. This was an appropriate response in line with Trust CMHT and CRHT policies.

5.46 The CRHT saw Clive on 28 October 2021 and later shared the assessment details and child safeguarding concerns with the CMHT. As noted above, no further action was undertaken in relation to the child safeguarding concerns, and Clive returned to the CMHT waiting list on 29 October 2021.

5.47 Clive was next contacted by the CMHT for a waiting list call on 8 November 2021. This was ten days after the CRHT discharge visit. The Trust CMHT policy does not indicate frequency of contact for individuals on a waiting list who have gone into crisis, but the Trust Clinical Harm Review policy indicates that when risks change or individuals deteriorate '*risk needs to be minimised through regular clinical review and assessment of each case to identify any potential harm due to the length of wait'*. (Page 7 Referral to Treatment (RTT) Pathway Delays). We found no evidence that, following the CRHT assessment and intervention, the CMHT considered or reviewed Clive's risk whilst he was waiting for support. This was despite the contacts by MHLS, FRS and CRHT.

5.48 The next CMHT waiting list call to Clive was on 2 December 2021, when they completed a *'my recovery'* plan. Risks were again noted in several areas, and the assessment noted that as Clive was not working with anyone (presumably because he was on the CMHT waiting list) he was felt to be appropriate for non-CPA and continued to be rated at amber risk. Following this assessment Clive remained on the CMHT waiting list. Clive had now been on the CMHT waiting list for three months, and despite seeking support through ED and the FRS he remained unsupported.

5.49 Clive contacted the crisis FRS twice in December, on 21 and 30 December 2021, asking to talk because he was low in mood. On both occasions the FRS noted Clive was under the CMHT waiting list and agreed to update the CMHT about the call. Both contacts indicated appropriate responses for this service, who completed both a mental state and risk assessment and shared the assessments by email with the CMHT.

5.50 The CMHT did not contact Clive following either of the FRS calls and there is no evidence that they reviewed or considered the information provided in the FRS risk and mental state assessments.

5.51 Clive was allocated to a CMHT lead practitioner on 11 January 2022 and this practitioner contacted Clive on 14 January 2022 to arrange a home visit.

5.52 Also on 14 January 2022, Clive's GP made a referral to the FRS. During the contact with the FRS, Clive described struggling with low mood, poor mental health, social isolation, issues with finances and issues with housing.

5.53 The CMHT completed their first home visit on 20 January 2022. This visit was eight months after the initial referral and four months after an initial assessment placed him on the CMHT waiting list. Whilst waiting to be seen by CMHT, Clive attended ED in September, and was referred to but not seen by MHLS. Following an initial assessment and whilst on the CMHT waiting list, Clive had one contact assessment with the MHLS, three FRS contacts, one referral by his GP and one episode of care under CRHT. We found no evidence that the CMHT considered these numerous contacts when planning their response to Clive for support.

5.54 This assessment on 20 January 2022 identified social issues including domestic abuse and that Clive was subject to a restraining order although he also told the CMHT that he was breaking this and still having contact with his family. The assessment identified that Clive experienced low mood and numbness and had multiple social stressors. The outcome of this appointment was to refer Clive for support with housing and social issues, to complete a medication review, to contact the adult social care provider to see if Clive could have another carer, and to re-refer to NWM for support. The assessor also planned to discuss the assessment in the team MDT to decide whether Clive required ongoing CMHT support.

5.55 The Trust (and subsequently the CMHT) are partners in the Norfolk Children Safeguarding partnership and are signed up to the shared policies and procedures detailed on their website. These are clear that, in certain situations, sharing of information is vital and that the information shared should be necessary and proportionate, adequate, accurate, timely and secure. We found no evidence that the CMHT considered sharing any risk information throughout their contacts with Clive. Further, we found no evidence that the CMHT considered the growing picture relating to Clive's family life, or that he was now breaching a restraining order, before planning any future service.

5.56 Whilst it is possible that Clive may have had limited need for ongoing secondary mental health service support, we believe that the risks and information identified through Clive's time under the Trust, should have been considered, discussed, and shared before any decision was made about the level of support offered. We also believe that Clive's breach of a restraining order indicated a growing level of risk. We found no evidence that this was considered or that the CMHT shared this information or sought to understand from either Clive or other agencies, whether this information needed to be shared.

5.57 Clive remained open and on the CMHT waiting list for approximately four months, from 14

September 2021, until he was seen and assessed in January 2022, two days before the homicide. As noted above this demonstrates a significant delay outside of Trust policy. In addition, whilst on the waiting list, Clive had limited contact with the CMHT, who only contacted him on three occasions: on 8 November 2021, on 2 December 2021 (where a 'my recovery plan' was also completed) and 14 January 2022. The CMHT attempted to call Clive on 9 January 2022 but there was no response. This is again outside of Trust policy and did not meet the agreed contact frequencies for someone waiting for CMHT service.

5.58 Finally, we have identified that the CMHT did not contact Clive to follow up any concerns or risks after he was seen by other services and on the waiting list. This again was not in line with Trust policy.

5.59 We believe the time Clive waited for a full CMHT assessment was too long, and that despite the difficulties with service provision, the risks highlighted, and the additional contacts made by Clive and others, should have resulted in a faster response. In addition, it is our view that other Trust services should also have been more active in their approach to the CMHT, ensuring that when risks were identified these were reviewed by CMHT, particularly around contact with his children.

Referred but not assessed.

5.60 Clive was referred, but not assessed, on two occasions. Once to the Trust L&D service in April 2021, and once to MHLS in September 2021.

5.61 The role and aims of the L&D service are listed on the Trust and local area directory websites. They include.

- *'To improve health and justice outcomes for adults and children who come into contact with the youth and criminal justice systems where a range of complex needs are identified as factors in their offending behaviour…*
- *Liaison and Diversion (L&D) services operate by referring people suspected of crime who are identified with having mental health, learning disabilities, substance misuse or other vulnerabilities to an appropriate treatment or support service.*'[39]

5.62 Clive was referred to the L&D service on 7 April 2021, following arrest for an assault on his wife. L&D attempted to speak to Clive, but he refused, and so was not assessed.

5.63 The above indicates, however, that the role of the L&D service is more than assessing an individual's need for access to secondary mental health care. Their role, as described, is about prevention; working proactively to ensure appropriate services are involved to support and prevent further crimes and to protect vulnerable or at-risk individuals.

5.64 We acknowledge that Clive did not engage with the assessment process. However, we do not believe his engagement was required for the L&D service to consider if more action was needed. Similarly, we believe there was reasonable scope for the L&D service to initiate a professionals' discussion, and to establish what, if any, services might be appropriate to manage the risks identified. We found no evidence that these discussions took place.

5.65 When Clive was in custody in April 2021, we consider this presented the first opportunity for the Trust L&D services to explore Clive's situation further with the police and other health and social care services. We believe this was an opportunity to ensure that those who needed to know, were in full possession of facts relating to Clive's home life, to be aware of and consider the serious risks identified to his wife, to '*think family*',[40] to consider any children involved, and to consider whether the identified risk to others was being appropriately assessed and managed in the community by the

[39] For more information see https://communitydirectory.norfolk.gov.uk/Services/6388 and https://www.nsft.nhs.uk/service-details/service/liaison- and-diversion-service-ld-68/

[40] The Think Family agenda recognises and promotes the importance of a whole-family approach which is built on the principles of 'Reaching out – think family'. https://nhssafeguarding.app/context-of-NHS-safeguarding/

services involved. We found no evidence of such L&D engagement with other services / agencies.

5.66 Clive was also referred for an assessment by the MHLS on 2 September 2021 when he attended ED.

5.67 The Trust website states that the Trust Mental Health Acute Liaison Service (MHLS*) 'offers mental health assessments, interventions, and treatment… for people who are under the care of an acute hospital in Suffolk or Norfolk… the team will provide a mental health assessment and a plan of care or treatment as appropriate'*.

5.68 The reason given for the referral in September was '*low mood secondary to alcohol use'*. On this date, Clive was waiting to be seen by CMHT for completion of an initial assessment. The MHLS recorded that they were unable to assess that day due to high workload. The MHLS spoke to the ward matron and made the decision that Clive did not require an urgent assessment and so advised Clive to engage with mental health services, [the exact service was not specified, although the paper record indicated he should engage with CGL – a non mental health service].

5.69 In this instance, a discussion over the telephone may have been an adequate response, but we also believe the MHLS should have followed this up with a call to the CMHT to ensure they highlighted Clive's change in presentation including use of alcohol, and that they should have been clear which service Clive was engaged with (incorrectly identified by Clive as CGL). We found no evidence of any contact by MHLS to CMHT. Clive was discharged home.

Domestic abuse

5.70 The Trust safeguarding children policy states:

'A child protection referral must be made where a risk assessment identifies that:
- *the service user is expressing delusional beliefs involving a child and/or;*
- *the service user might harm a child as part of a suicide plan.*

Good practice also advises that referrals should be made where mental health issues, domestic violence and/or drug or alcohol abuse may put a child a risk of abuse or neglect.'

5.71 The Trust is a strategic partner member of the Norfolk Safeguarding Adults Board, and the Norfolk Safeguarding Children Partnership. These bodies provide leadership, guidance, and procedural advice for organisations responsible for safeguarding adults and children at risk of abuse. Throughout the guidance, the presence of domestic abuse is highlighted as a key factor when assessing risk in safeguarding situations. In addition, the guidance provided highlights the importance of assessing and managing this risk when families separate due to domestic abuse.[41]

5.72 Throughout Clive's contact with the Trust in 2021 it was known that he was an alleged perpetrator of domestic abuse, and that the allegations included physical abuse (ABH) and coercion and control. It was known that Clive often claimed to be the victim of domestic abuse, appearing to minimise his involvement and responsibility, yet the Trust were also aware of his pending court case and requirement for anger management. It was also known that Clive's wife had left, taking the younger children to live elsewhere, but that he still had contact at least with his eldest daughter (Elouise) and that he continued to seek contact with his other children and wife. The Trust became aware that in January 2022 that Clive was openly telling staff that he was seeing his wife and breaching a restraining order.

5.73 This, and growing knowledge of the risks around Clive and his contact with his family, should have changed the way Trust services thought about and managed risk.

[41] https://norfolklscp.org.uk/about/policies-procedures/complex-families-and-working-with-parentscarers/74-domestic-violence-and-abuse

5.74 The services who spoke to, or assessed Clive were aware that his alleged victim, his wife, was not using mental health services, but they did not establish whether she had any other care and support needs. They were also aware that Clive had children, and that he was still having contact with them. In addition, Clive told services:

- he was angry about the situation with his wife (on 21 April 2021),
- he hoped to be reconciled with his wife and was still in communication with her but that he needed anger management sessions first (on 10 June 2021),
- he hoped to have more contact with his family (on 14 June 2021), and
- he was still seeing his wife / family despite there being a restraining order in place (on 20 January 2022).

5.75 Despite this knowledge, we found no evidence that any of the services involved with Clive considered whether contact with other statutory services, such as the police, NHS or local authority services might be appropriate to manage identified risk. We also found no evidence that Trust services considered whether Clive's wife required an adult safeguarding response in her own right.

5.76 Throughout Clive's contact with the Trust, his mental health was rightly their focus. Yet we believe the Trust services who met and assessed Clive should also have considered the identified risk factors more broadly. Using their growing knowledge of Clive's family situation, his misleading stories about his substance and alcohol misuse, the records concerning domestic abuse, his reported poor mental health, his overdosing and self-harming behaviours, and his identified attempts to stay in contact with his family despite orders to the contrary, services should have considered whether this information met the threshold for sharing with other health and social care providers. We found no evidence that this was considered.

Recognition of the role of young carer(s)

5.77 Trust policies, including CMHT, Child Safeguarding, CRHT and Risk Management, all highlight the importance of recognising the role carers play in an individual's support, and the importance of ensuring carers' needs are met. This includes the recognition of the role of young carers and the need to refer for young carer assessment. In addition, the Trust website indicates the Trust has signed up to the Triangle of Care,[42] described as '*an alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing'.*

5.78 Throughout his contact with services, Clive identified that his eldest daughter, Elouise, was his main carer, but also that another child, who was 14 years old at the time, provided a level of support, and that he had contact with his other children (all of whom, apart from Elouise, were under 18 years of age).

5.79 In Clive told Trust staff that his child(ren) were caring for him on at least six occasions in 2021 detailed below.

Table 4 Dates when Clive's daughter(s) was identified as a carer.

Date	Service	Detail
21/04/21	MHLS	Told staff his 19-year-old daughter (Elouise) provided care.
24/05/21	WBS	The assessor noted a lack of carer support but noted that his young child was helping where they could.
09/09/21	CMHT	Identified Elouise as his carer at the assessment.

[42] https://www.nsft.nhs.uk/triangle-of-care

Date	Service	Detail
28/10/21	CRHT	Identified that Clive's 14-year-old child *'was aware of appropriate contacts should Clive require immediate physical health assistance'.*
29/10/21	CRHT	Noted that Clive has contact with three of his children and that his 19-year-old daughter (Elouise) was living with him.
20/01/21	CMHT	The assessment identified '*his daughter* [not identified] *has still been seeing him at times because [sic] she is worried about him.'*

5.80 Despite these references to the care and support provided by young children, we found no evidence in the records that any of the children were considered as young carers or offered support or assessment. We also found no evidence that Elouise was referred for an adult carer assessment.

5.81 This was a significant missed opportunity and was against Trust policy.

Follow up not taken forward.

5.82 During the Trust contacts with Clive, there were two occasions when he was referred for additional support to a third sector mental health service commissioned by the Trust. These referrals were not accepted, and whilst this information was shared with the services who made the referrals, they did not follow this up or consider whether alternative support was required for Clive. We did not identify any Trust guidance for services in this situation, but we would have expected the two services involved (MHLS and CRHT) to follow up on their referrals to NWM and, when these had been rejected, to ensure that the CMHT were fully aware that Clive was not being supported whilst on their waiting list.

5.83 The first referral was made on 15 October 2021. Clive was on the waiting list for CMHT support and attended ED for a physical health issue. MHLS assessed Clive due to concern about self- harming behaviours. The outcome of this assessment was a referral to NWM for support whilst awaiting allocation of a CMHT worker. Three days later, on 18 October 2021, however, NWM informed the MHLS that they would not accept the referral stating '*Unfortunately we are unable to accept this referral due to the fact this person is already under Secondary Mental Health Services. However, I did call the team and update them that we are unable to take this on and hopefully this will prompt them to look into this case and take this as a change of circumstance. If they see the need is higher they may be able to allocate this person sooner*.'

5.84 This discussion was not in the Trust records provided to us, and the referral was not detailed in the chronology information provided by the Trust as part of the DHR or referenced in the serious incident report. This referral was referenced in the chronology provided by NWM. We also found no evidence in the Trust records of the call from NWM to CMHT as mentioned in this email.

5.85 We also note that, once closed, the information from NWM that Clive was not to be accepted did not generate further correspondence or discussion between the MHLS and the CMHT. Clive remained at home unsupported, and the family situation and associated risks remained unassessed.

5.86 In addition, following an assessment in October 2021, the CRHT made a further referral to NWM. NWM again wrote to the CRHT on 2 November 2021 stating the referral had not been accepted. We found no evidence that this was followed up, or that the CRHT considered whether Clive had enough support, or that this was discussed or shared with the CMHT.

5.87 Whilst we would have expected both the MHLS and CRHT to update the CMHT about their assessment and failed referrals to NWM, the responsibility for managing Clive remained with the CMHT whilst he was on their waiting list.

5.88 We found no evidence that the increased risks noted by MHLS or CRHT or the changes in

circumstance identified led to any change in the management of Clive's care on the CMHT waiting list.

Consideration of adult social care needs and adult safeguarding referral

5.89 The terms of reference for this review included: Using the Trust IMR and access to clinical records, review and assess the extent to which care, and treatment corresponded with statutory obligations, best practice, relevant guidance, and local operational policies particularly focusing on social care. (See Appendix A)

5.90 In completing this review, we sought to focus as requested on social care. We have addressed issues relating to child safeguarding (see 5.18 above) and have considered the impact of domestic abuse (see 5.70 above). We consider adult safeguarding and assessment of social care needs here. This focus is limited however, and we acknowledge this. In seeking to review social care activity, we were informed that the Trust do not complete social care activity (delegated by the local authority), as a section 75[43] agreement was ended some years previously. Under Section 75 of the NHS Act 2006, local authorities and NHS bodies can decide and make agreements for pooling resources and delegating certain NHS and local authority health-related functions to the other partners. In addition, the Trust records do not contain social care referrals or outcomes, and we identified just three referrals for social care assessment during the time under review.

5.91 We are confident that the review of social care practice, with any associated recommendations, will form part of the wider domestic homicide review.

5.92 Section 9 of the Care Act 2014 provides:

(1) Where it appears to a local authority that an adult may have needs for care and support, the authority must assess—

(a) whether the adult does have needs for care and support, and

(b) if the adult does, what those needs are.

5.93 Clive was referred twice for consideration and assessment of his care needs under the Care Act 2014 (September and October 2021).

5.94 Following the referral in September, NCC agreed to provide care twice daily to Clive through the NFR service. NFR service completed one evening visit. This service was turned away by his daughter Elouise, as Clive said it was not the service he required. Further phone contact was made with Clive a few days later advising of the support NFR could provide to him. NFR agreed to contact him later for a decision. Contact was attempted and messages left, but Clive did not engage, and the referral was closed three days later.

5.95 Throughout the time under review, we understand (from the IMR provided by NCC) that NCC attempted unsuccessfully to contact Clive, but no Care Act (2014) Assessment was completed. NCC confirmed information and advice was posted to Clive. We are unable to comment on the process of attempting to assess Clive or how robust these attempts were (as we have not seen the NCC records), but, given NCC's knowledge of Clive's family, we would have expected to find some evidence that NCC communicated their efforts back to the referring agencies or sought clarification on whether the assessments were urgent or still required. We also found no evidence that Trust services, aware of the referrals, followed up on whether Clive had been assessed by NCC or what the outcome of the referrals had been.

5.96 Section 42 of the Care Act 2014 provides:

'Where a local authority has reasonable cause to suspect that an adult in its area (whether or not

[43] Section 75 of the NHS Act 2006 allows local authorities and NHS bodies to enter into partnership arrangements and allows delegation of certain functions. See https://www.legislation.gov.uk/ukpga/2006/41/section/75

ordinarily resident there)

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

5.97 Clive was referred to NCC for consideration of adult safeguarding concerns related to possible self-neglect in October 2021. We are unable to determine whether or how this referral was followed up, but NCC confirmed that no Safeguarding Enquiry was raised following the referral, '*as the threshold for a Section 42 Enquiry under the Care Act 2014 was not met'.*

5.98 As with the previous comments about the Care Act 2014 social care needs referrals, we know that NCC were aware of Clive's family. Given this knowledge we would have expected to find some evidence of communication between NCC and the Trust to establish the nature and severity of the adult safeguarding concerns raised by the Trust service (FRS). We found no evidence that NCC contacted the Trust to discuss whether adult safeguarding needs were being adequately addressed. We also found no evidence that the Trust, aware of the referral, followed up on the safeguarding referral.

5.99 Finally, given the reported risks identified in September when CRHT visited Clive we suspect that Clive had both eligible care and support needs, and that a consideration of safeguarding around self-neglect would have been appropriate. We found no evidence that CRHT or CMHT considered making such a referral.

6 Conclusions and recommendations

6.1 Clive was known to the Trust since 2019, but most contacts, and all face-to-face assessments were completed in 2021 and in January 2022. Clive was seen and assessed on several occasions by different Trust services and these assessments focused on addressing his presenting mental health needs. However, we identified that the assessments completed did not always consider or take a wider view of the risks associated with:

- Clive's use of substances and alcohol,
- Clive being an alleged perpetrator of domestic abuse,
- the role of child safeguarding and child protection, and
- the role of his children as (young) carers.

6.2 Clive was referred to the Trust secondary mental health service provided by the CMHT in May 2021, but he was not seen until September 2021. When he was seen, he was placed on a waiting list. Clive's first home visit with CMHT was in January 2022, two days before the homicide.

6.3 Whilst waiting for CMHT assessment and support Clive sought support through other agencies including via ED. Whilst on the waiting list Clive should have been contacted 'frequently' by the CMHT. We found that the CMHT waiting list calls were not frequent, and, that when Clive did present to other services in crisis he was not always routinely followed up and risks were not reviewed.

6.4 On the one occasion Clive was referred by CMHT to CRHT in October 2021, child safeguarding concerns were identified and raised. However, on receipt of advice not to make a safeguarding referral, these concerns did not prompt further assessment or action, and Clive remained unassessed for a further three months.

6.5 We believe the time Clive waited for a full CMHT assessment was too long, and that despite the difficulties with service provision, the risks highlighted, and the additional contacts made by Clive and others should have resulted in a faster and more assertive response. In addition, we believe that other Trust services should have been more proactive in their approach to the CMHT, ensuring that when risks were identified these were reviewed by CMHT, particularly around contact with his children.

6.6 We do acknowledge that Clive may have only had limited need for ongoing secondary mental health service support. However, it is our view that the risks and information identified throughout his time under the Trust, should have been considered, discussed, and appropriately shared with other agencies before any decision was made about the level of support offered. We found no evidence that this was the plan. We also believe that Clive's breach of a restraining order indicated a growing level of risk. We found no evidence that this was considered or that the CMHT shared this information or sought to understand from either Clive or other agencies, whether this information needed to be shared.

6.7 Finally, it is our view that throughout his time with Trust services, professionals were not curious enough about Clive's family circumstances, they did not look beyond Clive's stated needs, they did not challenge his inconsistent reports and they did not see the wider family situation nor consider risk or management of risk from a whole family perspective. Alongside this lack of professional curiosity, we identified a lack of child and adult safeguarding awareness and practice, a lack of knowledge about the impact of domestic abuse on children, and a lack of awareness and follow up for young children and adults in caring roles. We also found that referrals made by the Trust to other agencies were not followed up.

6.8 This independent investigation has made eight recommendations to be addressed to improve learning from this event.

Recommendations

Recommendation 1: Lack of professional curiosity

Throughout his contacts with the Trust, Clive gave varying and inaccurate accounts of events and his history. These inconsistencies were recorded verbatim in Trust records without being verified or challenged. Trust services also identified significant risk factors in their interactions with Clive, risk factors that went beyond his mental health symptoms.

Despite the risks identified and the inconsistencies recorded, Trust services were not curious at all about Clive's living situation. Trust services showed a distinct lack of professional curiosity, and they did not seek to assure themselves that Clive and his family were known to other (perhaps more appropriate) services. Trust services did not seek to assure themselves that the multiple risks identified were being managed appropriately.

This practice fell below the expected standard required in multi-agency safeguarding that the Trust had signed up to. This lack of curiosity was particularly evident in considering the impact of the alleged domestic abuse, Clive's continued substance misuse, and his prolonged contact with his family, including his children.

The Trust must use the learning from this incident to brief all registered and non-registered staff working with service users on the importance of being curious when assessing and managing risk, especially when individuals have contact with children or are suspected to be perpetrators of domestic abuse.

The Trust must ensure all registered and non-registered staff working with service users are aware of the need to share such risk information with other relevant agencies and must demonstrate compliance with the safeguarding policies and procedures in place.

Recommendation 2: Child safeguarding was not always considered.

Child safety and child safeguarding were not always considered when Trust services met Clive, and when concerns were raised, advice was given but the risks remained unaddressed.

The Trust must ensure safeguarding training at Level 3 includes advice for professionals on the importance of escalating safeguarding concerns when they are not addressed by other agencies, but where the risks remain. The Trust must ensure this training captures the role of seeking advice, the importance of information sharing, and the importance of ensuring the advice given by other agencies is received and recorded in the correct format.

Recommendation 3: Review on a Community Mental Health Team (CMHT) waiting list.

Clive was open to CMHT services for eight months without being seen and fully assessed by the service. During this time Clive was contacted as part of the waiting list monitoring on three occasions: in November and December 2021, and January 2022.

The Trust CMHT should ensure individuals on a waiting list for CMHT contact who go into crisis are reviewed after this crisis they should receive appropriate follow-up care immediately as standard and not simply rejoin a waiting list they're already on.

Recommendation 4: Frequency of contact whilst on a CMHT waiting list.

The Trust policy in use at the time did not formally stipulate frequency of contact for individuals assessed as medium to low risk who were waiting for CMHT assessment.

The Trust should ensure services have clear guidance on the frequency of CMHT contact for all individuals whilst they are on a Trust CMHT waiting list, ensuring this contact frequency takes account of the levels of risk assessment, risk management, safety planning and the views and involvement of carers and families as appropriate. This guidance should include actions to be undertaken when individuals go into crisis or when they disengage from

services.

Recommendation 5: Evidence of multi-agency consideration when individuals are assessed by Mental Health Acute Liaison Service (MHLS).

When Clive attended an Accident and Emergency Department (ED) he was referred to MHLS. During these contacts, his wider home and family situation and associated risks were not considered before the referrals were closed.

When individuals who have contact with children and have identified risks relating to both domestic abuse and substance misuse, come to the attention of the Trust MHLS, they must explore these factors with the service user, and seek information from other services regarding risk management, before closing the referral or referring the individual elsewhere.

Recommendation 6: Consideration for follow up when individuals are referred to other agencies.

Following assessments by Trust services, Clive was referred for support to Norfolk Waveney Mind (NWM). NWM did not accept these referrals, and they did inform the Trust referring service of their reasoning. The Trust referring services did not follow up or look at whether Clive required alternative support.

When a referral, made by a Trust service to another agency, is not accepted, the referring service must consider whether alternative support is required, and pursue that alternative support if it is required

Recommendation 7: Evidence of multi-agency consideration when individuals are assessed by Trust Liaison and Diversion services (L&D).

Clive was arrested for offences relating to domestic abuse and drug possession and referred to the Trust L&D service. Whilst Clive did not engage, the Trust L&D service did not take this opportunity to ensure other services knew of the identified risks before closing the referral.

When individuals who have contact with children and have identified risks relating to both domestic abuse and substance misuse, refuse to engage with the Trust L&D service, the L&D service must ensure they alert child protection services, and any other relevant agencies, to this risk information before closing the referral. This is to ensure agencies can develop appropriate safety plans and risk management plans.

Recommendation 8: Referring carers, especially young carers.

When Trust services were told that Clive's children were providing an element of care and support, they were not identified as carers and were not referred for assessment.

The Trust must reinforce (through training and policy guidance) the importance of referring carers, particularly young carers, and children, to the appropriate agency for assessment of their needs. Compliance with referrals for carer assessments should be evidenced through regular yearly audit.

Finally, we also recognise, support, and further endorse the recommendation made by the Trust's patient safety incident investigation report (dated 26 August 2022).

- '*The review panel agreed that a missed opportunity to have multi-agency oversight over the patient's family may have occurred but recognised that the impetus for identifying this by any individual agency may have been difficult to determine. Therefore, a recommendation is made that the DHR considers how best to co-ordinate multi-agency involvement in cases such as this and how this can be achieved.'*

We strongly advise that this recommendation be considered and addressed as part of the full DHR review.

Appendix A – Terms of Reference

NHS England will commission an Independent Mental Health specialist to review the mental health care and treatment that Clive received prior to the death of Elouise. The Independent Mental Health specialist will work closely with the Domestic Homicide Review (DHR) panel and will provide an addendum to the DHR report.

Project Scope

- Review the mental health care and treatment that Clive received prior to the death of Elouise, working closely with the Domestic Homicide Review (DHR) panel.
- Using the Trust IMR and access to clinical records, review and assess the extent to which care, and treatment corresponded with statutory obligations, best practice, relevant guidance, and local operational policies particularly focusing on social care.
- Provide an addendum to the DHR report, and a short learning lessons bulletin for sharing key learning points within mental health services.

Approach

To work with the DHR Chair to:

- Arrange access to information.
- Establish what information can be shared, and what review of the mental health information has already taken place, if any.
- Attend meetings as required to ensure we are briefed on the panel's progress, timelines, and key lines of enquiry.
- Review of the Trust IMR/internal serious incident report, and other health and social care IMR's and relevant reports.
- Establish communication with a Trust single point of contact and request access to their internal investigation/IMR material, including access to the report author, any interviews, statements, policies, or other material. We will critically analyse the IMR based on policy and best practice guidance.
- Review the treatment, risk assessment and care planning provided to the perpetrator by the Trust up to the time of the homicide, referencing policies and best practice guidance.
- Develop a mental health chronology and possibly conduct interviews where required (limited to a very few key professionals).
- Meet the affected families and alleged perpetrator as required with the DHR Chair.
- Work in collaboration with the DHR Chair and Lead Partner for Niche to develop a written report that can be appended or included (as appropriate) in the final DHR report and will answer your specific terms of reference to review and examine:
  - the care and treatment provided to the perpetrator by specialist mental health services prior to the homicide.
  - the referral arrangements, communication, and discharge procedures of the different parts of the NHS that had contact with the perpetrator.
  - compliance with local policies, national guidance, and relevant statutory obligations; and, the effectiveness and appropriateness of the perpetrator care plan and risk assessment, especially in relation to risk to self and others.
- Upon completion of this report, we will develop a short (2-3 pages) 'Learning Lessons bulletin' so that key messages and points to consider for practitioners and wider mental health services are extracted from the DHR and shared with services around the country.

Appendix B – Trust services

Trust Wellbeing services (WBS)
The Wellbeing Norfolk & Waveney service provides psychological interventions to people aged 16 and over. It follows the National Institute for Health and Care Excellence (NICE) Stepped Care model. The service covers Norwich, South Norfolk, West Norfolk, Great Yarmouth and Waveney and North Norfolk. https://www.nsft.nhs.uk/wellbeing/service/wellbeing-norfolk-waveney-37/

Mental Health Liaison and Diversion team (L&D)
Liaison and Diversion services assess people suspected of a crime before any sentence. They help people to find support from a treatment or support service to improve health and criminal justice outcomes. https://www.nsft.nhs.uk/service-details/service/liaison-and-diversion-service-ld-68/

Mental Health Acute Liaison Service (MHLS)
Our Mental Health Acute Liaison Service offers mental health assessments, interventions and treatment. This is for people who are under the care of an acute hospital in Suffolk or Norfolk. https://www.nsft.nhs.uk/hospital-liaison/service/mental-health-acute-liaison-service-79/

Community Mental Health Team (CMHT)
The Trust Adult Community Mental Health Service delivers secondary care mental health service for adults (aged 25 to 75 years) with severe and enduring mental health problems. The service offers a range of specialist, evidence-based treatments, and interventions. https://www.nsft.nhs.uk/community-services/service/adult-community-mental-health-service-north-norfolk-and-norwich-105/

Crisis Resolution and Home Treatment team (CRHT).
The Trust Crisis Resolution and Home Treatment (CRHT) service provides 'assessment and short-term, intensive community support … work with people to prevent hospital admission' https://www.nsft.nhs.uk/adults/service/crisis-resolution-and-home-treatment-team-central-norfolk-15/

First Response Service (FRS)
Within Norfolk, the Trust and NHS (via the 111-telephone line) operates a helpline for people of all ages who need urgent mental health support. The helpline is available 24 hours a day, every day of the year and forms part of the Trust's crisis response service. https://www.nsft.nhs.uk/first-response

Appendix C – Documents reviewed.

- Chronology of the care provided by the Trust to Clive.
- The Patient Safety Incident 3 Day Pre Investigation / Early Learning Report (ELR) dated 7 February 2022.
- The Patient Safety Incident Investigation (PSII) Report compiled by the Trust. Final version 26 August 2022.
- The clinical records for Clive held by the Trust, 1 January 2019 to 23 January 2022.
- Trust IMR report prepared for the DHR.
- NWM IMR and chronology report prepared for the DHR.
- Policies and operating procedures for Trust services involved.
- C89 Safeguarding Children Version 09.2. Dated 2018
- Clinical Harm Review Version 01.2. Dated 15 August 2019
- Clinical Risk Assessment and Management. C82 Version 09.3. Dated 2021
- CMHT Operational Policy (Trust-wide) – Interim version.
- CRHT Standard Operating Procedure. Approved Version November 2019
- Safeguarding Adults at Risk of Abuse (C90). Dated 17 March 2021.

Appendix D – Glossary

Acronym	Meaning
AA	Appointment anywhere
ABH	Actual Bodily Harm
ASC	Adult Social Care
CBT	Cognitive Behavioural Therapy
CGL	Change Grow Live
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution Home Treatment Team
CSC	Children Social Care
DA	Domestic Abuse
DSH	Deliberate self-harm
ED	Emergency Department
EIS	Early Intervention Service
FRS	First Response Service
FSP	Family Support Practitioner
HQIP	Healthcare Quality Improvement Partnership
IAT	Initial assessment team meeting
IMHT	Integrated Mental Health Team
IMR	Individual Management Review
L&D	Liaison and Diversion Service
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multidisciplinary team
MHA	Mental Health Act
MHLS	Mental health acute liaison service
NCC	Norfolk County Council
NCCSP	Norfolk County Community Safety Partnership
NCHC	Norfolk Community Health Care
nCPA	Non-Care Programme Approach
NFR	Norfolk First Response Service

NICHS	Norfolk Integrated Housing and Community Support Service
NWM	Norfolk Waveney Mind
PIP	Personal Independence Payment
PTSD	Post traumatic stress disorder
SAR	Safeguarding Adult Review
WBS	Wellbeing Service
WCCI	West Community Crisis Intervention Service

Niche Health & Social Care Consulting
4th Floor Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Tel: 0161 785 1000

Read more about us at: **www.nicheconsult.co.uk.**

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