An independent investigation into the care and treatment of Mr A, a mental health service user in Derby

August 2021

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Our Report has been written in line with the terms as set out in the Terms of Reference on the independent investigation into the care and treatment of Mr A. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Although where there is evidence that the information is not accurate, this has been made clear in the report.

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Contents

1 Executive Summary

1.1 NHS England, Midlands & East commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user, A. Niche is a consultancy company specialising in patient safety investigations and reviews.

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

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

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning.

1.5 This independent investigation has been conducted in co-operation with the Domestic Homicide Review (DHR) into the death of Sobhia, which has been commissioned by Derby City Community Safety Partnership. The family have requested that Sobhia's own name is used in this report.

The homicide

1.6 Sobhia lived in Derby with Amir,[3] whom she had married sometime in April 2017. Sobhia was 37 years old when she died, Amir was 36 years old. He had been married before, he met and married his first wife aged 17 and they had three children.

1.7 Amir contacted his brother in the evening of 27 May 2017, asking him to come to his house because he said there was a problem with Sobhia. His brother was accompanied to the house by Amir's sister. Amir did not call the emergency services until around 2 am on 28 May 2017, after speaking to his solicitor and booking a flight to Pakistan. Sobhia was found deceased in the bath upstairs.

1.8 Sobhia was described in the judge's sentencing remarks as '*savagely beaten*', with 36 fresh injuries, including a severe head injury. Further inquiries showed old

[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*

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

[3] *This is a pseudonym*

injuries to her body also. She was described as having been the victim of a '*violent and sustained assault'*.

1.9 Amir pleaded not guilty to murder, and several psychiatric reports were submitted to the court. It was considered by the court that there was *'no underlying medical condition that comes close to excusing or explaining*' his actions. His plea of manslaughter due to diminished responsibility was not accepted.

1.10 On 3 May 2018 Amir was convicted of murder. The aggravated and sadistic nature of the murder in the context of domestic violence was noted, and he was sentenced to life imprisonment, to serve a minimum of 33 years.

1.11 We would like to express our sincere condolences to the family and friends of Sobhia.

Mental health history

1.12 Mental health care was initially provided to Amir by Nottinghamshire Healthcare NHS Foundation Trust (NHCFT) while he was on remand in HMP Nottingham in 2008. He was arrested and remanded in February 2008 for rape and assault on his first wife. He was transferred to Wathwood Hospital in February 2009 for treatment while on remand, and received a diagnosis of paranoid schizophrenia. He was convicted of two counts of rape, and of causing grievous bodily harm (GBH)[4] with intent. He was made subject to a hospital order under Section 37/41[5] of the Mental Health Act (MHA) 1983. He was also subject to supervision from the Derbyshire Constabulary Dangerous Persons Management Unit (DPMU) and placed on the Sex Offenders Register[6] and dangerous persons database (ViSOR).[7]

1.13 Section 37/41 MHA means that there is a restriction on discharge, which can only be authorised by the Secretary of State or a First Tier Tribunal.[8] In practice the Mental Health Casework Section of the Ministry of Justice (MoJ)[9] oversees the progress of patients under Section 37/41 MHA, and clinical teams are required to send regular updates on progress. The role of the Mental Health Casework

[4] *This offence is committed when a person unlawfully and maliciously, with intent to do some GBH, or with intent to resist or prevent the lawful apprehension or detainer of any other person, either wounds another person or causes GBH to another person. It is an indictable only offence, which carries a maximum penalty of imprisonment for life. The distinction between charges under s18 and s20 is one of intent. The gravity of the injury resulting is not the determining factor, although it may provide some evidence of intent. //www.cps.gov.uk/legal-guidance/offences-against-person-incorporating-charging-standard*

[5] *Section 37/41 Hospital order with restrictions on discharge. https://www.legislation.gov.uk/ukpga/1983/20/section/37 Power of higher courts to restrict discharge from hospital. https://www.legislation.gov.uk/ukpga/1983/20/section/41.*

[6] *The Sexual Offences Act 2003 (like the Sex Offenders Act 1997,which it replaced) provides that persons are required to notify their local police force of their name, address and other details (and any changes to those details) if, in respect of certain sexual offences.*

[7] *Violent and Sex Offender Register (ViSOR) is a database of records of those required to register with the police under the Sexual Offences Act 2003. Increasing the Notification Requirements of Registered Sex Offenders under Part 2 of the Sexual Offences Act 2003. https://www.gov.uk/government/publications/guidance-on-part-2-of-the-sexual-offences-act-2003.*

[8] *First-tier Tribunal (Mental Health) is responsible for handling applications for the discharge of patients detained in psychiatric hospitals. They also handle applications to change community treatment orders and the conditions placed on a 'conditional discharge' from hospital. https://www.gov.uk/courts-tribunals/first-tier-tribunal-mental-health*

[9] *HMPPS Mental Health Casework Section. https://www.gov.uk/guidance/noms-mental-health-casework-section-contact-list*

Section is to oversee progress, with the power to recall patients to be re-detained in hospital if there is an increase in their risks to the public which is directly attributable to a change in the nature or degree of their mental disorder.

1.14 Amir was treated with antipsychotic medication and there were no psychotic symptoms reported after 2010. The approach to his care and treatment changed after contact was made with his first wife, the victim of the first offence. His first wife reported a history of violence and controlling behaviour towards her throughout the first marriage. After this information was shared with him, Amir started to become reticent to allow further exploration of his understanding of his illness, and to show annoyance if he felt reports showed him in a negative light. This information led to a gradual reformulation of his presentation, risk assessment and treatment needs by the Wathwood team.

1.15 When Amir was discharged from Wathwood in July 2013 there was a comprehensive risk formulation that clearly indicated that while he was seen as suffering from a psychotic illness, there were aspects of his personality that indicated a high risk of violence to women, in particular if he was in a relationship.

1.16 He was transferred to Cygnet Health Care, Derby (Cygnet) in 2013. Assessments and reports were completed at Cygnet regarding his presentation and potential future risks. These show a very clear formulation, which was that he was potentially vulnerable to outside stressors especially within the family, and the risk to females in a relationship with him remained. It was stressed that these risks were not necessarily related to mental illness.

1.17 He had a programme of gradually increasing leave from Cygnet, and in May 2014 the MoJ agreed unescorted leave to the local area, for two hours four times a week, with no access to children. He used this to visit his family and the mosque. In October 2014 a health care support worker disclosed that she had developed a sexual relationship with Amir. She was subsequently dismissed. There were no signs of any psychotic symptoms or relapse in mental state around this time.

1.18 At that time the view was taken that Amir was seen as the victim in the situation. This view has later been questioned by the Cygnet internal report, which suggests that his manipulative and intimidating and threatening behaviour in the relationship should have been seen as coercive and controlling. There was an investigation undertaken by the police also, but no formal action was taken by the Crown Prosecution Service regarding the staff member's actions.[10]

1.19 The information conveyed to the MoJ about this relationship emphasised that he was the victim, and made no reference to the staff member's concerns about threats and coercive control.

1.20 The MoJ agreed overnight leave at his parent's house in Derby from January 2015, after assessments were carried out. Amir was conditionally discharged in

[10] *This is a criminal offence: Offences by care workers against those with a mental disorder, Sexual Offences Act 2003 – sections 38–41.*

July 2015 to community mental health services provided by Derbyshire Healthcare NHS Foundation Trust (DHCFT).

1.21 As part of the conditional discharge arrangements he was allocated a Derby Care Programme Approach (CPA) care coordinator,[11] clinical supervisor[12] and social supervisor.[13] On 13 August 2015 the MoJ sent written agreement that permission was granted for Amir to travel to Pakistan to visit his terminally ill father on compassionate grounds, and he was in Pakistan for six weeks, returning in late September 2015. He requested to return in October, and the MoJ agreed a further visit for six weeks. Amir then booked tickets for a four-month trip, and the MoJ advised that they did not have the legal authority to prevent him from travelling, unless there were grounds for recall. He remained in Pakistan from October 2015 to January 2016, after his father's death in late December 2015.

1.22 On his return Amir was seen fortnightly by the care coordinator, sometimes jointly with the social supervisor. Reports on progress to the MoJ were provided at intervals, reflecting visits and meetings between Amir and various professionals. He was seen two days before the murder, with no reported psychotic symptoms or concerns about his mental health.

1.23 He had registered with a new GP whilst at Cygnet, and this GP provided prescriptions for antipsychotic medication. There were no observations of psychotic symptoms while he was being supervised in the community in Derby. A large amount of unused medication was found in the house after the murder, so it appears likely that he had not been taking this medication.

Internal investigation

1.24 DHCFT conducted an internal serious incident investigation which was completed in February 2018. Six recommendations were made, four of these focus on the need for an effective forensic service in DHCFT, and sharing the findings of the investigation with the MoJ. One recommendation concerns the decision-making process about discharge from medium to low security by commissioners, and the other makes a recommendation regarding an individual staff member.

1.25 A review of the internal investigation has been carried out, detailed below at Section 6.

Independent investigation

1.26 This independent investigation has been conducted in co-operation with the Domestic Homicide Review (DHR) into the death of Sobhia, which has been commissioned by Derby City Council Community Safety Partnership. We have reviewed the internal investigation reports and studied clinical information and

[11] *The Care Programme Approach (CPA) is a package of care for people with mental health problems, a care coordinator manages the care plan and reviews it at least once a year.*

[12] *The clinical supervisor is the responsible psychiatrist, Guidance for clinical supervisors, MoJ 2009*

[13] *The social supervisor oversees the boundaries of the conditional discharge. Guidance for social supervisors, MoJ 2009.*

policies. The team has also interviewed staff who had been responsible for Amir's care and treatment.

1.27 The investigation was carried out by Dr Carol Rooney, associate director, Niche, with expert advice provided by Dr Afzal Javed, consultant psychiatrist. The investigation was supervised by Nick Moor, Partner, Niche.

Findings and recommendations

1.28 From our analysis of the issues we have identified eight findings in relation to the issues. We have made 11 recommendations accordingly.

1.29 The Section 37/41 MHA which was applied in 2009 was made following a diagnosis of paranoid schizophrenia, and reports to the court supporting a hospital order. It became clear as further information emerged that there was a history of domestic violence and coercive controlling behaviour in his first marriage. There was also a degree of sadism which was not explained by mental illness alone.

1.30 Further personality testing in Wathwood between 2009 and 2013 showed narcissistic and paranoid tendencies, and there remained a high risk of emotional and physical abuse within the context of an intimate relationship.

1.31 The formulation of his presentation that was handed over from Wathwood to Cygnet contained detailed information about these risks, and the care planning and risk management required. However, he showed a degree of skill in successful subversion of boundaries at Cygnet and under the care of DHCFT, and these were not always addressed effectively, or communicated clearly to the MoJ.

1.32 There was a significant missed opportunity to review risk assessments and communicate effectively with the MoJ following the development of the relationship with the staff member.

1.33 The move to the community care from Cygnet Derby in July 2015 was not managed in a way that provided detailed information and robust care planning.

1.34 DHCFT was not commissioned to provide a community forensic team, and his care was allocated to the caseload of a generic community mental health team which lacked the knowledge and resources to adequately supervise his care and manage risk.

1.35 Consequently, the resulting care plans did not reflect the previous risk assessment and formulation.

Finding 1

Care provided at Wathwood was planned with the involvement of Amir and his family, and was sensitive to his cultural needs, which is good practice.

Risk assessment and management plans were adjusted as new information emerged, and were clearly communicated to all other parties in the discharge decision making in July 2013.

The involvement of victim advocacy service and the gathering of the victim's perspective is an example of good practice.

Finding 2

Care provided at Cygnet Derby was planned in conjunction with partner agencies, and plans for conditional discharge were developed with the awareness of MAPPA, DPMU, DHCFT, Derby City Council and the MoJ as would be expected. There was no communication with the GP practice however.

In our view these plans lacked detail and were not given sufficient preparation time to ensure that detailed plans were in place.

We consider that the information that was provided to the MoJ to support the conditional discharge lacked relevant detail and the nuanced feedback that would be important in managing risk. The involvement of the victim advocacy service and the gathering of the victim's perspective is an example of good practice, as was the involvement of his family in planning.

In our view the subsequent conditional discharge care plan was not sufficiently detailed or robust enough to manage the considerable risk identified, and was prepared without the direct involvement of the DHCFT clinical and social supervisors.

Finding 3

In the absence of a commissioned community forensic team Amir was allocated to the caseload of a generic community mental health team which lacked the knowledge and resources to adequately supervise his care and manage risk.

Finding 4

Changes in structures and systems between DHCFT and Derby City Council limited communication about details of treatment and care.

Finding 5

The GP practice did not have any contextual information about Amir.

Primary care were not seen as partners in the overall plan of multi-agency care.

Finding 6

The input provided by NHS England specialised commissioners was within expected policy and practice.

Finding 7

The MoJ does not appear to have a system to identify when reports are not submitted to the required expectations.

Systems in Cygnet and Derbyshire Healthcare NHS Foundation Trust did not ensure that MOJ reports were submitted to expected standards.

Finding 8

Care planning and communication by the Derby City Recovery Team was not culturally sensitive, and did not foster open communication with his family.

Recommendation 1

Cygnet Health Care must ensure that all risk management information is included in care planning.

Recommendation 2

Cygnet Health Care must ensure that all of the expected standards are met when arranging conditional discharges for patients on Section 37/41 to including communication with the local GP.

Recommendation 3

Because of the lessons learned from this independent investigation the commissioning and development of the Derbyshire Healthcare NHS Foundation Trust Forensic Team should include:

- effective supervision structures
- audit of family contacts
- quality standards for MoJ reporting

Recommendation 4

The operational policy for the Derbyshire Healthcare NHS Foundation Trust Forensic team must include clarity about roles, responsibilities and communication between Derby City Council and Derbyshire Healthcare NHS Foundation Trust when caring for a patient who is conditionally discharged from Section 37/41 MHA.

Recommendation 5

NHS Derby and Derbyshire Clinical Commissioning Group must ensure that there is primary care involvement in the MAPPA process for appropriate individuals.

Recommendation 6

Cygnet Health Care must ensure that standards for reporting to the Ministry of Justice regarding progress of conditional discharged patients are maintained.

Recommendation 7

Derbyshire Healthcare NHS Foundation Trust must ensure that standards for reporting to the Ministry of Justice regarding progress of conditional discharged patients are maintained.

Recommendation 8

Derbyshire Healthcare NHS Foundation Trust should assure itself that race and ethnicity, gender and religious issues are routinely addressed in CPA needs assessments and care planning as per the Trust's policy.

Recommendation 9

Derbyshire Healthcare NHS Foundation Trust should assure itself that the perspective of families, and the provision of collateral information is included in care planning, and appropriate cultural awareness is applied when communicating with families.

Recommendation 10

Cygnet Health Care must ensure that all the available relevant information is reviewed for the production of a report for a formal external review.

Recommendation 11

Derbyshire Healthcare NHS Foundation Trust must ensure that staff involved in the reviews of complex and high-profile serious incidents receive additional support.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework[14] (March 2015) and Department of Health guidance[15] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring. The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

2.3 The timeframe under review is from Amir's first contact with mental health services in February 2008 until the murder in May 2017.

2.4 The independent investigation has been conducted in partnership with the Domestic Homicide Review (DHR) into the death of Sobhia, which has been commissioned by Derby City Council Community Safety Partnership.

2.5 We have reviewed the internal investigation report provided by Derbyshire Healthcare NHS Foundation Trust (DHCFT) and studied clinical information and policies. The team has also interviewed staff who had been responsible for Amir's care and treatment.

2.6 The investigation was led by Dr Carol Rooney, associate director, with expert advice provided by Dr Afzal Javed, consultant psychiatrist. The report was peer reviewed by Nick Moor, Partner, Niche. The investigation team will be referred to in the first-person plural in the report.

2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[16]

2.8 We have reviewed Amir's care provided by:

- Nottinghamshire Healthcare NHS Foundation Trust (NHCFT)
- Cygnet Health Care, Derby (Cygnet)

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[14] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf

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

[16] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

- Derbyshire Healthcare NHS Foundation Trust (DHCFT)
- Derby City Council

2.9 We used documentation[17] from these healthcare providers, and from Derby City Council, to complete this investigation. We had access to the internal management reviews (IMRs) provided to the DHR.

2.10 We also held interviews and group meetings which included:

- NHCFT: group meeting with Wathwood consultant psychiatrists, social worker, psychologist and team manager.
- DHCFT: consultant psychiatrist, care coordinator, internal investigation author
- Derby City Council: social supervisor and team manager;
- Cygnet: Hospital Director, operational manager, consultant psychiatrist, consultant clinical psychologist; and

2.11 Amir's defence solicitor requested to be interviewed as part of the investigation. We had telephone contact with him, but he did not respond to subsequent opportunities to be interviewed by phone and email.

2.12 We had a telephone interview with NHS England (NHSE) specialised commissioners, to discuss access arrangements to low secure from medium secure, and a telephone interview with the Care Quality Commission (CQC) to discuss service user reference panels.

2.13 A full list of all documents we referenced is at Appendix B, and a full chronology is at Appendix C. Appendix D lists questions for the independent investigation provided by Sobhia's family and our responses.

2.14 The draft report was shared with:

- Derbyshire Healthcare Foundation NHS Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Cygnet Health Care;
- the GP surgery;
- NHS Derby and Derbyshire Clinical Commissioning Group;
- Derby City Council
- Ministry of Justice and;
- CQC (relevant excerpt only).

[17] *Complete list is at Appendix B*

2.15 This provided the opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review, make factual corrections and comment upon the content.

The homicide

2.16 Sobhia lived in Derby with Amir, whom it is believed she had married sometime in April 2017. Sobhia was 37 years old when she died, and Amir was 36 years old. Amir contacted his brother on the evening of 27 May 2017, which was the first day of Ramadan, asking him to come to his house because there was a problem with Sobhia. Amir's brother and sister accompanied him to his house. Amir did not call the emergency services until around 2 am on 28 May 2017, after speaking to his solicitor and booking a flight to Pakistan. Sobhia was found deceased in the bath upstairs.

2.17 She was described in the judge's sentencing remarks as '*savagely beaten*', with 36 fresh injuries, including a severe head injury. Further inquiries showed old injuries to her body also. She was described as having been the victim of a '*violent and sustained assault*'.

2.18 Amir pleaded not guilty to murder, and several psychiatric reports were submitted to the court. It was considered by the court that there was '*no underlying medical condition that comes close to excusing or explaining*' his actions. His plea of manslaughter due to diminished responsibility was not accepted.

2.19 On 3 May 2018 Amir was convicted of murder. The aggravating sadistic nature of the murder in the context of domestic violence was noted, and he was sentenced to life imprisonment, to serve a minimum of 33 years.

Contact with Sobhia's family

2.20 Sobhia's family live in Bradford, and until she moved to Derby she lived with her mother and her brother's family. Her father is deceased, and other siblings and nephews and nieces live nearby. We arranged to meet with Sobhia's brother, and the family's advocate in October 2018, with NHS England. We returned for a digitally recorded interview with her brother in December 2018 in order to check facts and timelines.

2.21 The family provided details of their contact with Amir and their awareness of the relationship. They gave us a detailed list of questions they had about Amir's care. We have incorporated these into the report, and also provided specific responses to these at Appendix D.

2.22 We offered the family an opportunity to meet with us prior to publication of the report. They have read the draft report and had no detailed comments to make.

Contact with Amir's family

2.23 Amir's family live in Derby. Amir's father died in late 2015. Amir was then expected to take on the role of head of the family. Amir's mother lives in Derby, and several siblings live nearby with their families.

2.24 In April 2019 we met Amir's family members, and we had meetings with them together at their home.

2.25 They told us that Amir's father had done most of the communication while he was in Wathwood and Cygnet. They knew that he was supposed to take his medication and tell the care team if he got into a relationship. They said they did not know who to talk to about any concerns about him when he was in Derby. His sisters said he was aggressive with them when they asked about the medication that was in the house, that he had not taken, and told them to mind their own business.

2.26 We shared a copy of the draft report with Amir's siblings, and they acknowledged the findings and had no comments to make.

2.27 Because of the level of detail contained in the repot, we have also shared the draft with the victim of his first offence.

Contact with Amir

2.28 Amir is serving a life sentence, and we met with him in prison.

2.29 We had a short meeting with him, where he contradicted information that was available to us as fact, such as that Sobhia was not dead. He gave us an account of the relationship in Cygnet (discussed later at the relevant section) which was difficult to follow but which we have tried to triangulate with the investigation information provided to us by Cygnet.

2.30 We shared the draft report with his solicitor and invited comments but did not receive any feedback.

Structure of the report

2.31 Section 3 provides detail of Amir's background.

2.32 Section 4 sets out the details of the mental health care and treatment provided to Amir.

2.33 Section 5 examines the issues arising from the care and treatment provided to Amir, including comment and analysis.

2.34 Section 6 provides a review of the healthcare contributions to the DHR.

2.35 Section 7 sets out our overall conclusions and recommendations.

2.36 Appendices:

Appendix A – Terms of reference.
Appendix B – Professionals involved.
Appendix C – Documents reviewed.
Appendix D – Sobhia's family questions.
Appendix E - DHCFT SI report analysis

3 Background of Amir

Personal background

3.1 Amir was born and raised in Derby, apart from a period of time when the family lived in Pakistan during his childhood. His family are of Pakistani Muslim origin. He is the third child of eight, and the eldest son, meaning that within the family he undertakes responsibility for his parents and for his siblings.

3.2 Amir's own account is that he experienced a happy childhood, enjoyed school and had a wide circle of friends. He described himself to professionals as a moderately devout Muslim and said that he prayed regularly, tried to attend to religious fasting obligations and valued meetings with the Imam.

3.3 Amir's family told us that he was not particularly religious, and did not always want to follow the rituals. He has stated that he used alcohol on a few occasions in the past, but denied using any illicit substances. Other sources suggest he may have used alcohol and illicit substances throughout his life.

3.4 He has always previously been in employment, and was employed as a manager of a security company up until the time of his arrest for the first offence in 2008. This involved interviewing staff, writing reports, and managing health and safety aspects. He has described this as a stressful job, working long hours.

3.5 He owned a property in Derby, which was gifted by his family as a wedding present at his first marriage. This was where the offence against his first wife was committed, and also where the murder of Sobhia took place.

Relationships

3.6 Amir met and married his first wife at aged 17 and they had three children. She was from a different city in the UK, but the families knew of each other in Pakistan.

3.7 Amir has claimed that there was some 'minor' violence in the marriage, but denied anything more serious leading up to the offences committed in February 2008. Subsequent reports provide details of a history of sustained cruelty and violence towards his first wife. She divorced him after the conviction of grievous bodily harm against her.

3.8 The background to the development of the relationship with Sobhia has been gathered from Sobhia and Amir's families.

3.9 We have included the detail of this because the relationship was conducted while he was under the care of mental health services, and later had formal conditions of supervision that expected him to disclose any relationships. That he was able to develop a relationship, cohabit and marry without the knowledge of any of these services raises questions about the quality of supervision provided, and illustrates the extent to which he was able to conceal his behaviours from services.

3.10 It appears that Sobhia's relationship with Amir may have started as an online dating contact, during 2015. Sobhia's family noticed that she was spending an increasing amount of time on her phone, and received some letters that looked as though they were from a custodial establishment.

3.11 According to Sobhia's family, there was no contact between the two families prior to this. Amir has claimed the families knew each other, but this was shown to be untrue during police enquiries.

3.12 Although it would be traditional for families to get to know each other in this type of situation, Sobhia's family say they decided to wait to see when/if she told them about the relationship. Amir was first introduced to the family in their home as part of a conversation with a social worker, and it appears that Sobhia may have introduced him as another social worker. Amir was introduced to the family using a false name, and the family did not know his real name until after the murder.

3.13 Over the next few weeks it became clear to the family that Sobhia had begun a relationship with Amir, and he began to visit the family in Bradford. Sobhia told the family that Amir had told her that he had been convicted of assaulting his first wife. She said he had told her that he had caught her cheating and was in prison for five years, but he had since changed.

3.14 Amir's family came to Bradford on one occasion in August 2016, bringing sweets, clothes and an engagement ring, and it appears this was to ask for an engagement to marry Sobhia. We were told by Sobhia's family that it would be traditional not to bring anything, in case the proposal was turned down, but in this case it felt to Sobhia's family that the other family came prepared. Sobhia's eldest brother was not present, and he would have been expected to agree to a marriage, however Amir insisted that her mother should agree.

3.15 Amir's family have told us that he told them to come with him at short notice to meet the other family in Bradford because he was getting engaged.

3.16 The wedding was set for November 2016, then postponed to February 2017. This was because Amir had to take his mother abroad for a family ceremony. Sobhia's grandmother passed away in February 2017 so the wedding was postponed again, because Sobhia's mother and brother had to go abroad.

3.17 In April 2017 Amir came to the family home again in Bradford, with his mother and family members. Her mother had asked her to wait to get married until family funeral ceremonies in Pakistan were completed. At this stage Amir said it was "*now or never*" and became very agitated and insisted that Sobhia's mother agree, stating that a nikah[18] had been conducted. It later transpired that Amir arranged for two of his friends to conduct the nikah in his house, although the date is unclear. His brother had been asked to conduct the ceremony and had refused.

[18] *A Muslim wedding is known as a nikah. It is a simple but solemn ceremony, at which the bride does not have to be present so long as she sends two witnesses to the drawn-up agreement. Normally, the ceremony consists of reading from the Qur'an, and the exchange of vows in front of witnesses for both partners.* https://www.learnreligions.com/islamic-marriage-2004443

3.18 There was a further visit in early May 2017 when Amir came to the Bradford house with his family and insisted that Sobhia come with him. She then packed some bags and left with him. Sobhia called to say she had arrived in Derby safely. There were a couple more phone calls from Sobhia, but her own family never saw her again.

3.19 It is clear from the accounts of Amir's family that Sobhia was part of the Derby family's life and took part in family meals and outings. She visited others and had family members visit their house. They expressed surprise when Sobhia began to wear a full niqab[19]after she moved to Derby, saying they had not thought she was very religious.

3.20 Both Amir's sister and her brother saw her on the last day of her life, and both said that she asked them to stay longer at the house. Amir's brother said that he had gone around to cut the grass to be helpful. Amir was out walking the dog. With hindsight he said Sobhia was wearing a headscarf that almost covered her face and he wondered why at the time. Amir's sister said she saw her after the first prayers at the start of Ramadan, and Sobhia wanted her to stay longer, but it was late, and she had to get back to her children.

History of violence

3.21 In February 2008 Amir was arrested after assaulting his first wife, subjecting her to an ordeal between 23 and 26 February 2008. During this four-day period Amir subjected her to a prolonged series of sadistic sexual assaults which caused significant injuries including second and third degree burns to her abdomen and legs.

3.22 He was convicted in September 2009 of two counts of rape, and of causing grievous bodily harm (GBH)[20] with intent. He received a Section 37/41 MHA 1983 Hospital Order, to be detained at Wathwood Hospital. He was placed on the 'Violent and Sex Offender Register' (ViSOR)[21] indefinitely. This meant that he was subject to compulsory mental healthcare and treatment, and to the supervision structures of the police under the Sexual Offences Act 2003.

3.23 He was not allowed to have contact with his first wife or children after this. Information about previous risk of violence was gathered in 2010 and 2011 by the Wathwood clinical team. Information was obtained through an advocacy service as part of risk assessment and showed a history of violence towards his first wife from early in the marriage. He was said to drink heavily and was frequently assaultive both physically and sexually. There is significant information in his

[19] *Niqab is an Islamic religious head wear which covers the face while leaving the eyes uncovered.*

[20] *Section 18 Offences against the Person Act - causing grievous bodily harm with intent.* https://www.sentencingcouncil.org.uk/offences/crown-court/item/causing-grievous-bodily-harm-with-intent-to-do-grievous-bodily-harm-wounding-with-intent-to-do-gbh/

[21] *Violent and Sex Offender Register (ViSOR) is a database of records of those required to register with the police under the Sexual Offences Act 2003. Increasing the Notification Requirements of Registered Sex Offenders under Part 2 of the Sexual Offences Act 2003.* https://www.gov.uk/government/publications/guidance-on-part-2-of-the-sexual-offences-act-2003

clinical records that present a picture of coercion, humiliation and violence towards his first wife.

3.24 For the purpose of this report we will not describe any further detail about these offences, as this is essentially third-party information. This information is however provided in detail in the clinical records, and would have been available to all subsequent clinical teams after transfer from Wathwood.

3.25 Amir's family also describe him as aggressive and unpredictable at times. Although there were no further convictions until the murder of Sobhia, we were given examples of alleged violence by the family such as;

- slapping his sister's face;
- breaking her car windscreen;
- driving very fast in the town with his mother and sisters in the car, then when they said they were frightened, he laughed and drove faster, and;
- kicked the wall panels in his mother's house and broke them, after being challenged.

3.26 There is no evidence that any of this information was ever shared with healthcare staff, or discussed outside of the family.

4 Mental health care and treatment

4.1 We have provided a narrative chronology of Amir's treatment and care by mental health services from 2008 to 2017. Information from Sobhia's family indicates that the family were aware that the relationship had been ongoing for some time before the homicide. We have included the family's experience of contact between Sobhia and Amir from 2015 onwards as part of the narrative.

4.2 Amir had no history of care by secondary mental health services prior to his remand in 2008. After this date he was treated/monitored in the following services:

HMP Nottingham primary and secondary health care, provided by NHCFT. This is an 'in reach' service where prisoners attend clinics and sessions, and/or are seen on the wings. There are no 'inpatient' beds.

NHS England specialised commissioners**.** Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. For mental health, specialised commissioners have responsibility for placing patients who require conditions of high, medium or low security. These are managed regionally, and each patient is allocated a case manager who monitors their progress, until they are discharged from an NHS England commissioned service.

Wathwood Medium Secure Unit (MSU), provided by NHCFT. Wathwood provides medium secure inpatient services to male adult patients with mental disorder, through assessment, treatment and rehabilitation. It is a specialist service for patients requiring conditions of medium security, who are detained under the MHA, and are often offenders. Admission would need to be approved by NHS England as it commissions and funds placements at the MSU, relying on the clinical assessment as to the admission itself.
Cygnet Hospital Derby, provided by Cygnet Health Care. Cygnet Hospital Derby provides low secure and mental health rehabilitation care. There are three wards: Litchurch, a low secure ward, Wyvern, a mental health rehabilitation service, and Alvaston, which is a specialist female personality disorder service. Most patients at Cygnet Hospital Derby would be funded by the NHS. Admissions to the low secure Litchurch ward would need to be approved by NHS England as it commissions and funds placements at a low secure ward, relying on the clinical assessment as to the admission itself.

Derby City Recovery Team (DCRT), provided by DHCFT. The Derby City Recovery Team provides mental health support to adults regardless of age; this support is based on individuals' needs. The team is made up of a range of health professionals including nurses, occupational therapists, psychologists, mental health support workers and consultant psychiatrists.

Prior to 2008

4.3 The GP records note that Amir had approached his GP in March 2006 complaining of anxiety, and he appeared to have a number of anxieties and health phobias. He described being tearful for several months and it was suspected he was suffering from mild depression. He was prescribed citalopram[22]10 mg once a day. He was given health and lifestyle advice.

4.4 In May 2006 he was seen by the practice community psychiatric nurse and was believed to have anxiety and psychosomatic symptoms.[23] His citalopram was increased to 20 mg daily. There have been frequent complaints of foot pain, back pain and chest pain over several years. These had been thought to be musculoskeletal in origin, although the GP later viewed these as being related to anxiety. Amir has said that he took the antidepressants for about a month and declined to attend the counselling offered.

4.5 He was treated for asthma with inhalers. There is no history of secondary mental health service input until after his remand into custody in 2008.

HMP Nottingham 2008 to 2009

4.6 Amir was remanded into custody at HMP Nottingham on 29 February 2008. NHCFT provides the primary and secondary health care at HMP Nottingham. As is routine, Amir was seen by healthcare staff at his reception into prison in February 2008. At this assessment he said he suffered from 'fits' and 'blackouts' and had seen his GP for stress and headaches. It was not deemed necessary to refer him for a mental health assessment.

4.7 He was referred to the prison mental health team in April 2008, after complaining of feeling depressed and stressed, with difficulty coping. At the mental health assessment he described having episodes of 'extreme stress', feeling low and depressed, and was tearful during the interview. He was described as having symptoms of depression to '*level 3 of NICE guidelines'.*[24] There was also a concern noted about his reported 'blackouts'.

4.8 The plan was to

- refer to the prison GP for investigation to establish whether there is a physical cause for his 'blackouts';
- recommend a prescription for antidepressants;
- recommend a short term prescription of night sedation and;

[22] *Citalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI).* https://www.nhs.uk/medicines/citalopram/

[23] *https://www.nhs.uk/conditions/medically-unexplained-symptoms/*

[24] *It is not clear what this means: NICE guidance 'Depression in adults: recognition and management' does not indicate levels of depression. https://www.nice.org.uk/guidance/cg90.*

- mental health nurse follow up to explore anxiety management and coping strategies, to see again within two weeks.

4.9 He was seen by the prison GP who noted that he had *'severe family stress*' following a rape allegation, and had a stressful managerial job for the last three years. Amir reported frequent fainting episodes every two to three weeks, following periods of stress, and that he felt '*confused*' afterwards. He was prescribed mirtazapine,[25] and referred for a neurological assessment to exclude fits. The prison GP's view was that it was likely to be fainting secondary to hyperventilation, and agreed with mental health nurse follow up. A neurological appointment was arranged for June 2008.

4.10 He was seen for an asthma review later in April 2008, and he described waking up with shortness of breath, which was thought to be anxiety related.

4.11 He did not attend the next three mental health nurse appointments, although records suggest he did appear to be taking the mirtazapine. The neurological appointment in June 2008 concluded that he was experiencing simple faints, and there was no evidence of epileptic seizures. The '*pins and needles'* he described prior to collapse was thought to be related anxiety.

4.12 Amir did not attend a further mental health nurse appointment in August or September 2008. He was seen in reception in October 2008 after attending court, and there were no health concerns. Following this the prison GP reduced the dose of mirtazapine.

4.13 He was seen for an assessment interview in October 2008 by a Wathwood consultant forensic psychiatrist Dr N. Amir appeared tearful and experiencing anxiety. He described his cell mate telling him he had been talking to someone at night who was not there. He did not appear objectively depressed but appeared perplexed and described symptoms of anxiety. He also described his father coming into his cell at night and talking to him, and he believed there were ghosts in the prison. He also described a pervasive feeling that he may die or something bad would happen to him, which also made him anxious. It was thought he was describing a '*delusional mood*'.

4.14 Dr N also noted that Amir said he had a sensation of someone holding his head, but could not explain this. He continued to express the belief that his first wife had been having affairs and had made a pornographic video. In addition he was suspicious that the police may have been involved in fabricating evidence against him and of being blackmailed. It was recommended that he be transferred to a mental health hospital for further assessment.

4.15 A probation pre-sentence report prepared in December 2008 noted that a psychiatrist had suggested that Amir suffered from a persistent delusional disorder, relating to his first wife's fidelity. An interim hospital order was recommended, and the probation report also supported this. The probation report advised fuller assessment to consider the reasons why such extreme violence,

[25] *Mirtazapine is an antidepressant medicine. It's used to treat depression and sometimes obsessive compulsive disorder and anxiety disorders. https://www.nhs.uk/medicines/mirtazapine/*

torture and rape were used during the offence, and whether this was indicative of any psychiatric disorder.

4.16 On 6 February 2009 a warrant was issued for his transfer to a mental health hospital. He was transferred to Wathwood Hospital on 17 February 2009 under Section 38[26] MHA. Section 38 MHA allows the court to send a prisoner to hospital for assessment and treatment before they are sentenced. An order under Section 38 of the Mental Health Act is known as an 'interim hospital order', it is short-term while the court decides what sentence to make. An interim hospital order is made when there is a possibility that the outcome at court will be a hospital order under the MHA.

4.17 The outcome could also be that the individual is returned to prison and is sentenced by the court. In Amir's case there remained a question about whether the index offence was influenced by a mental disorder. The interim order was to be used to allow a period of assessment in hospital, which would determine the psychiatrist's recommendations to court.

Wathwood February 2009 to July 2013

4.18 On admission to Wathwood Amir was subdued and appeared anxious, and rocked from side to side. Antidepressant medication was stopped in order to observe him medication free. He presented as pleased to be in hospital and able to converse easily, although at times was tearful when talking about his family. He had episodes where he would stop talking, stare into space and appear to be in a trance-like state that lasted for several minutes.

4.19 He began to verbalise hearing the voice of his first wife, but it was thought that these were not true auditory hallucinations, more an expression of his own emotionality about his actions. He initially complained of not sleeping and was prescribed short-term night sedation medication, but he did not in fact use it, and it was discontinued. He presented with distress about his belief about his first wife having had an affair, and how upset he was about this. At this stage he denied assaulting her, and regarded himself as having been *'set up'*.

4.20 At initial interview with the social worker he denied the allegations of rape, saying no DNA evidence was found. He continued to assert that his first wife had been unfaithful, she said she had then been raped, and he told her to go to the police, which he believed she had now somehow turned against him.

4.21 He presented as severely depressed when measured on the Beck Depression Inventory,[27] although his named nurse did raise questions about the validity of some of his answers. He sought out staff frequently for reassurance and described disturbing nightmares of his first wife trying to attack him.

4.22 He continued to present as anxious and appeared not to understand conversations at times. He complained of poor sleep but appeared asleep on

[26] *Interim hospital order, following conviction.* http://www.legislation.gov.uk/ukpga/1983/20/section/38

[27] *The Beck depression inventory is an evidence based tool used to measure mood levels. https://beckinstitute.org/get-informed/tools-and-resources/professionals/patient-assessment-tools/*

observations. He also complained of tingling in his hands and feet, which were felt to be somatised anxiety symptoms. Over the next few months he complained of having pains which he felt were due to staff secretly injecting him at night, hearing whistling, and appeared convinced that doctors were able to read his mind and the minds of others. At times he would sit rocking, and other times sit with his hands over his ears.

4.23 In April 2009 he developed a belief that he had cancer of the nose, and believed the prison GP was not being honest with him, because his first wife had requested this. In May 2009 he expressed the belief that he had bone cancer, in spite of the prison GP diagnosing a musculoskeletal gym injury.

4.24 During this time several contraband items were found in his room, including a glass bottle, a used battery and some silver paper. He also smuggled some cooked meat into his room. Investigations into these events suggested they were misunderstandings rather than deliberate, apart from the meat incident.

4.25 He claimed to have been hearing voices for some time, believing these voices came from ghosts sent by his first wife. He also claimed to be hearing people laughing outside his room at night. At this time he was not engaging meaningfully in personality testing. In view of these apparent psychotic symptoms he was prescribed risperidone,[28] which was increased to 8 mg daily by May 2009. This increase appeared to have the effect of him becoming less preoccupied with delusional ideation and more relaxed generally. His father became seriously ill in July 2009 and although was not expected to survive, he did return to the family home. Amir expressed appropriate grief and distress at this situation.

4.26 As Amir became more settled he was transferred to the continuing care ward in July 2009, and showed better concentration and cognitive ability.

4.27 Formal personality testing was started using the Millon Clinical Multiaxial Inventory III.[29] The findings of these tests show a complex pattern of personality features, including the presence of schizotypal personality traits.

4.28 Schizotypal personality disorder (STPD) or schizotypal disorder is a mental disorder characterized by severe social anxiety, thought disorder, paranoid ideation, derealisation, transient psychosis, and often unconventional beliefs. People with this disorder feel extreme discomfort with maintaining close relationships with people and avoid forming them, mainly because they think their peers harbour negative thoughts towards them.

4.29 Peculiar speech mannerisms and odd modes of dress are also symptoms of this disorder. Those with STPD may react oddly in conversations, not respond or talk to themselves. They frequently interpret situations as being strange or having unusual meaning for them; paranormal and superstitious beliefs are common.

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[28] *Risperidone is an antipsychotic medication. https://www.nhs.uk/conditions/schizophrenia/*

[29] *The brief Millon Clinical Multiaxial Inventory-III (MCMI-III) instrument provides a measure of 24 personality disorders and clinical syndromes for adults undergoing psychological or psychiatric assessment or treatment https://www.pearsonclinical.co.uk/Psychology/AdultMentalHealth/AdultForensic/MillonClinicalMultiaxialInventory-III(MCMI-III)/MillonClinicalMultiaxialInventory-III(MCMI-III).aspx*

Such people frequently seek medical attention for anxiety or depression instead of their personality disorder. Schizotypal personality disorder occurs in approximately 3% of the general population and is more common in males.

4.30 Testing showed the presence of thought disorder, thinking which was fragmented, confused and bizarre, delusional beliefs and occasional hallucinations. He also showed features of depression and anxiety. His presentation gradually improved; he became less suspicions and more easy-going and able to concentrate. By August 2009 his father's health had improved sufficiently to enable him to visit Amir which helped to reduce Amir's anxieties.

4.31 An addendum to the original probation presentence report was provided in September 2009. This noted that all reports point to [Amir] being a mentally disordered offender, and a hospital order had been recommended by two psychiatrists. It was further noted that he continued to present a serious risk to his first wife, and that according to the Victim's Charter, she should be notified of relevant points in his sentence and her views considered prior to release. In September 2009 he attended Derby Crown Court and was sentenced to a Section 37 MHA hospital order with Section 41 MHA restrictions. He became more accepting of the violence he had committed against his first wife, although he maintained that the Crown Court Judge must have been working for his first wife.

4.32 He started cognitive behaviour therapy (CBT) and appeared keen to work on gaining a better understanding of his mental illness. CBT work focussed on relapse prevention work and helping him to recognise and manage his symptoms.

4.33 He was granted supervised access to the internet in September 2009. Shortly after this he approached a member of staff saying he knew he lived locally and could easily find out where he lived. This was investigated and thought to be an inappropriate joke.

4.34 Shortly after this he tried to give the staff grade psychiatrist £50 as a maternity leave present. He accepted the reasons given as to why this would be inappropriate. It was observed that he went to great lengths to try to please staff; he bought coffee and biscuits, offered hospitality and tried to help with cleaning.

4.35 In February 2010 a personality test was completed, and this indicated a tendency to give an overly positive view of himself. During the test Amir became irritated with the questions and began to answer randomly. In a ward review meeting it was stressed to him that one of his difficulties appeared to be a reluctance to be open in discussing more negative aspects of his personality.

4.36 Following completion of CBT relapse prevention work, Amir was referred for a psychology assessment. By this time he was working in the hospital shop and library. It was considered that once he engaged in psychological work it would be appropriate to apply for escorted leave to the MoJ.[30]

[30] *Working with restricted patients, Ministry of Justice. https://www.gov.uk/government/collections/mentally-disordered-offenders*

4.37 He was transferred to the rehabilitation ward in April 2010. During psychology sessions he denied feelings of anger, but scored highly on the index for controlling his anger. It was noted he continued to have difficulty acknowledging negative emotions such as anger.

4.38 An impression had developed amongst staff and patients that Amir was trying to generate favours by for example cooking for staff. He also developed the view that he did not need to go to a low secure hospital as part of his rehabilitation. In reality it seemed that although he had been cooperative in psychology sessions, he found it extremely difficult to acknowledge negative aspects of himself, including anger.

4.39 A psychology report noted that he had difficulty processing feelings, and it was felt that there remained a risk of catastrophic aggression if his psychological defences became overwhelmed (as could occur if his mental illness were to relapse). It was decided that it was not possible to work with him psychologically on reducing risk at that time, and he was informed of this. It was felt that he responded well to external controls, and could be treated in low secure conditions. However it was made clear to Amir that there was a significant amount of work to do to reduce the risk of reoffending.

4.40 He was granted escorted leave in September 2010 by the MoJ. He found it difficult to accept that this would need to be built up slowly, and did not feel he required further rehabilitation. He had to be reminded again not to buy food for his staff escorts on a community trip.

4.41 He began to work in the horticulture area and applied himself enthusiastically to this. In this month he received a letter from the Independent Safeguarding Authority (ISA),[31] informing him he was placed on a list of individuals who were barred from working with children and vulnerable adults due to the nature of his offence. He became irritated with staff who explained this, saying he had been mentally ill at the time, and this should be taken into consideration. He appealed this decision through his solicitor.

4.42 Reports were prepared in October 2010 for the forthcoming First Tier Tribunal. Amir appeared to be under stress regarding these reports, requesting many changes, and it was clear he wished to present himself in a positive light. He later withdrew his appeal. A pre-MAPPA[32] meeting was held at Wathwood, involving the team psychiatrists, social worker and police from Derby Public Protection Unit. Further information from the advocacy service was obtained, and it was decided to share this new information about his previous violence with the MoJ.

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[31] The Independent Safeguarding Authority's role is to help prevent unsuitable people from working with children and vulnerable adults. Their Board and caseworkers assess whether individuals working or wishing to work in regulated activity pose a possible risk of harm to vulnerable groups. http://www.safeguardingmatters.co.uk/uk-safeguarding-approach/isa-barring/

[32] The Criminal Justice Act 2003 ("CJA 2003") provides for the establishment of Multi-Agency Public Protection Arrangements ("MAPPA") in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. https://mappa.justice.gov.uk/connect.ti/MAPPA/view?objectId=7134100

4.43 In November 2010 there were concerns that Amir was occupying himself solely in horticulture, and neglecting to attend to other aspects of his care plan. He had to be reminded again not to try to pay for staff meals or shopping, and he refused to sign a care plan stating he would not do this.

4.44 Links were made with Derby Dangerous Persons Management Unit[33] (DPMU), and a professionals meeting was planned to share information. The clinical team agreed that new information received about his past risk behaviours indicated that risks are greater than initially formulated. A strategy was planned about how to incorporate these into his clinical care.

4.45 A risperidone serum level blood test was carried out in December 2010, and this indicated compliance with medication.

4.46 Community mental health team nursing staff from DHCFT were involved in his Tribunal preparations in early 2011.

4.47 There were concerns expressed by nursing staff that Amir's engagement was superficial and avoidant of any issues in relation to his mental health or offending. In medical reviews he was not amenable to the suggestion that any personality factors had any influence on his offending. He ordered a recordable 'spy' pen to be sent to him at Wathwood. He maintained that it had been ordered as a present for his mother, and was delivered to the hospital by mistake.

4.48 Contact was made by the team social worker with the advocacy service (who were supporting his first wife), and with MAPPA with a view to future planning. His first wife made a victim impact statement to the Tribunal.

4.49 In March 2011 Amir spontaneously developed a left sided facial Bell's palsy,[34] from which he made a full recovery over the next few weeks. In May 2011 it was agreed he could work in the farm shop when it was open to the public.

4.50 Also in May 2011 the clinical team received information from the police and victim liaison. This information suggested there had been a considerable amount of violence and control within his marriage which preceded the index offence, and the onset of any mental illness. It was suggested that he may have used alcohol and drugs and had many extra marital affairs. A suggested motive for the offences was to pressurise his first wife into agreeing a divorce so that second marriage could be allowed. Amir vehemently denied the truthfulness of this information. His escorted leave was temporarily stopped as a precaution. He continued to express incredulity but with no other changes in his demeanour, and his leave was reinstated.

4.51 In August 2011 he refused to sign a copy of his CPA review meeting minutes, becoming visibly angry. He contested the information (about alleged drugs/alcohol

[33] *Dangerous Persons Management Unit, now Management of Sex Offenders & Offenders and Violent Offenders (MOSOVO) team at Derbyshire Constabulary. The management of sexual offenders and violent offenders. The police have a shared responsibility for the management of sexual offenders and violent offenders when they are released from prison into the community, in partnership with probation and prison staff and other agencies.*

[34] *Bell's palsy is temporary weakness or lack of movement affecting 1 side of the face. Most people get better within 9 months.* https://www.nhs.uk/conditions/bells-palsy/

and the question of a second marriage) and complained of feeling intimidated by the clinical team, and threatened to withdraw attendance at a review meetings. During this meeting he tapped angrily on the arms and legs of his named nurse in a controlling manner.

4.52 In September 2011 a domestic violence risk assessment was commenced by the team psychologist. Amir tended to deny feelings and incidents of anger, and remained very defensive in these sessions.

4.53 Risperidone was reduced to 6 mg daily because he had remained mentally well, and it was felt he would not need 8 mg daily for future maintenance. There were further instances of him attempting to purchase items for staff.

4.54 At a CPA review in January 2012, the psychologist reported on the nine sessions that had taken place to assess his future risk of violence within intimate relationships. It was reported that he presented many barriers to future sexual offending work but his need to undertake such work was believed to be high. It was decided to offer Amir sixteen sessions of cognitive analytic therapy (CAT), to address issues he had within interpersonal relationships to prepare him for future psychological work. He remained mentally stable and occupied most of his time with horticulture and the farm shop, although he did attend a problem solving group. As the director of the farm shop he was a granted an email address so that he could receive Trust communications directly, and took part in some Trust promotional activities.

4.55 Escorted leave to visit his family in Derby was agreed in order to observe his presentation within the family setting. A social worker visited his family in order to assess future child contact, although Derby Social Services later decided not to allow any child contact that time.

4.56 By April 2012 Amir started to find the CAT sessions more stressful but his mental state remained stable. He repeatedly requested unescorted leave and a transfer to a low secure unit, but it was explained that this could not be considered until he had completed further psychological work. In June 2012 risperidone was reduced to 4 mg daily. Amir moved to ‘the Lodges’ around this time, which is a rehabilitation ward in Wathwood. There were initial concerns about him pushing boundaries and questioning the need for procedures in this more relaxed environment. He undertook ‘buddy’ training, which was a scheme to help new patients settle in. however given his ISA barring it was felt inappropriate for him to be supporting vulnerable adults.

4.57 In July 2012 team concerns were raised when an Asian lady, along with her young daughters, became regular visitors to the farm shop. It was felt that the lady was visiting Amir rather than attending the shop. Staff intervened and this was discouraged.

4.58 During preparation for a CPA meeting in July 2012 Amir became angry and confrontational with the social worker, saying his history of violence should not be continually repeated in reports. He maintained that any reports of previous violence or controlling behaviour were entirely untrue, and there were no further

treatment needs in these areas. He also challenged the suggestion that he may be overly compliant.

4.59 The feedback from the CAT therapy was that he initially appeared detached and it was exceedingly difficult for him to discuss aspects of his offending. As time progressed he was able to tolerate accounts read to him from witness statements. It was concluded that he was now able to start working psychologically on issues around his relationships, violence and sexual offending. It was recommended that he would benefit greatly from group work, peer influence and the social milieu of an established sex offender service. This CPA meeting was also held as a Section 117 MHA[35] aftercare planning meeting. The care plan developed from this meeting was to:

- further assess behaviour and risks on community escorted leave;
- monitor his mental state and assess his ongoing risks and response to psychological work;
- liaise with commissioners to identify a low secure placement which offers a Sex Offenders Treatment Programme (SOTP);
- continue to liaise with local community services, MAPPA and victim liaison;
- DHCFT staff would continue to attend future CPA meetings to keep abreast of discharge plans.

4.60 In August 2012 Dr N wrote to NHS England specialised commissioners who agreed to fund an appropriate placement.

4.61 DHCFT Criminal Justice Mental Health Team provided a report to the Tribunal in October 2012, to outline contingencies if he was conditionally discharged. The possible options locally for rehabilitation were outlined. These included the DHCFT low secure unit at Kedleston, and independent providers. He expressed a reluctance to move to Kedleston due to the 'stigma' attached to it. This is not explained. It was noted that Amir would need to be referred to a community consultant psychiatrist and community mental health team, and the Local Authority would need to provide community support in the form of social supervision. Amir's family also submitted a letter to the Tribunal asking for him to move to Derby.

4.62 His current RC Dr N recommended that he should not be discharged. The Tribunal in January 2013 did not agree to discharge Amir, and noted that it was being asked to make a recommendation about where Amir should undertake SOTP work. The Tribunal made a statement to the effect that this was wholly

[35] *Section 117 MHA 1983 describes the duty of the clinical commissioning group, local health services and of the local social services authority to provide aftercare, following detention under certain sections of the MHA 1983.* http://www.legislation.gov.uk/ukpga/1983/20/section/117

inappropriate for the Tribunal to comment, and was a matter for the clinical team to decide.

4.63 Kemple View in Lancashire was identified as a suitable placement, but this was rejected by Amir and his solicitor as being too far from Derby. Other low secure units where group SOTP was available in England and Wales were identified, but these were consistently rejected as too far away.

4.64 A safeguarding alert was raised by a member of Wathwood senior nursing staff in February 2013. The allegation was that Dr N and his clinical team were treating Amir unfairly, with punitive behaviour towards him. This included the allegations that expectation were changed slightly over time so that it appeared he was breaching plans.

4.65 This was investigated and Amir alleged that he was not listened to by the clinical team, and whatever he does is not right. He gave the example that he had been delayed from moving to another unit to access SOTP. He had visited two units and did not like them, and in particular did not want to be so far away from his family. A unit in Derby had been identified but they did not have SOTP group work available, although there were plans to provide this in the future.

4.66 Amir also made a complaint about Dr N and his clinical team as part of this safeguarding complaint. The subsequent investigation found that there had been an appropriate change in his risk assessment and treatment plans in 2011 following information from the victim. This had been shared with him, his solicitor and with the Tribunal, and the complaint was not upheld.

4.67 Part of the outcome of this was that in February 2013 RC responsibility was transferred to Dr Y, and the social worker also changed. The plans to locate a suitable low secure placement were to continue, to include group SOTP.

4.68 In April 2013 Amir was referred to Cygnet Derby for assessment and treatment. It was noted that the symptoms of mental illness recovered in the first year of his admission. He had undergone a series of lengthy psychological assessments which shed light onto '*the dysfunctional nature of his relationship and personality functioning*'. The clinical psychologist treating him recommended a group SOTP. At this time the risperidone had been reduced to 2 mg a day.

4.69 Cygnet were requested to confirm whether:

- he could be managed in low security,
- whether there was a group SOTP, and if so the commencement date of the SOTP, the duration and structure of the programme; and
- a care plan for other aspects of his rehabilitation

4.70 Amir arranged for his solicitor to write to Dr Y, challenging the requirement for group SOTP, assuring that he would co-operate with individual SOTP, and reiterating that Amir would benefit from moving to Derby.

4.71 Dr Y responded by reiterating that he agreed with the previous clinical team's approach, which was that Amir should complete a programme of SOTP, delivered in low secure hospital setting. Several options were identified and Dr Y noted the preference for a Derby placement, however at that stage Cygnet Derby had not responded to two separate referrals. Based on this, Dr Y began referrals to other units that could offer a suitable treatment plan, stating that the priority must be the provision of specialist treatment plan, rather than the geographical area.

4.72 The new team social worker wrote to advise DPMU of the team change, and make them aware that plans were in progress for Amir to move to a low secure unit, and that the team were liaising with the advocacy service to canvas the victim's views on where he may be discharged.

4.73 The response from the advocacy service was that his first wife was still very afraid and did not want him to be discharged to Derby because she still had family there. Amir had told staff that she did not have relatives in Derby.

4.74 We have seen no evidence that the victim's view was taken into consideration when the transfer to Cygnet was agreed by the clinical team and the MoJ.

4.75 An assessment was conducted by an independent provider, Kemple View in May 2013. This assessment noted that although Amir had a diagnosis of paranoid schizophrenia, this was stabilised and he was ready to transfer to conditions of low security. At that stage he was not considered to be able to meaningfully engage in treatment to address his sexual offending.

4.76 There were concerns about his insight into his need for treatment and the extent to which he would meaningfully engage with any therapeutic intervention aimed at reducing his sexual offending risks. Kemple View offered a care plan that included two kinds of group treatment for sexual offending and was prepared to offer a place.

4.77 East Midlands Secure Commissioning group[36] were initially supportive of a move to Chadwick Lodge in Milton Keynes, which had a group SOTP programme. Amir refused to consider this as he felt it was too far from his family and used his solicitor to support his position. The commissioners then agreed in principle to a transfer to Cygnet Derby from a funding perspective, with the understanding that a group SOTP would be in place by the time he was transferred. A detailed care plan proposal was requested from Cygnet Derby in order to make a formal decision. It was clear from Cygnet Derby responses that the SOTP was in development, and had been planned to start in March, but was not yet available.

4.78 The Wathwood psychologist had recommended group SOTP treatment because a group programme would been helpful in providing group feedback and challenge, which could reduce Amir's tendency to defensiveness and minimisation. The report notes that;

> 'there is a risk of psychological and emotional abuse within the context of an intimate relationship. This may typically involve, although not restricted to;

[36] *Now replaced by NHS England Specialised Commissioners.*

implicit threats of harm or violence, intimidation, insults, excessive monitoring of behaviour, isolating behaviour or withdrawal from supportive networks, financial abuse and using male privilege, all of which will render his partner's life fearful and miserable. These behaviours are likely to increase when, for example, [A] feels insecure, criticised or jealous. Psychological and emotional abuse will likely start as soon as [A] perceives he 'possesses' his partner, like the very start of a marriage for example'.

4.79 Amir's solicitor had instructed an independent psychologist to review his potential treatment options and risk. This psychology report, which was provided in November 2012, suggested there was no difference in the evidence base for group or individual treatment. The psychologist had been in touch with the lead psychologist who had provided assurances that group treatment for SOTP was due to start in the spring of 2013. It was noted that Cygnet currently offered group work which focused on relationships and sex education, which was considered to be preparatory to offence focussed work. Individual interventions offered at the time were to address offence analysis, perspective-taking and empathy, in addition to emotion-focused work which was aimed to support offence related interventions. This report was used by Amir and his solicitor to apply pressure for him to move to Cygnet Derby.

4.80 A Beck Depression inventory and Beck Anxiety inventory completed with Amir in April 2013 scored 'zero' showing no indicators of depression.

4.81 The most recent Historical and Clinical Risk assessment (HCR 20) v2[37] was completed in January 2013. This is presented as a 'scored' sheet, although there is some narrative in the various domains, which described risks.

4.82 Revised risk assessments were completed in June and July 2013 prior to discharge. A revised risk assessment was carried out using the Short-Term Assessment of treatability and Risk (START). This showed vulnerability to external triggers, described as concerns about previous sexual offending, which are mitigated by supervision structures. His current concerns about group SOTP treatment were also noted.

4.83 A summary 'current risk statement' in June 2013 noted that there had been no incidents of violence in hospital, and no incidents of absconding or escape. There were several incidents of subversive behaviour, including smuggling contraband items into his room. A concern was raised after he appeared to befriend an Asian lady in the hospital shop. He was awaiting specific SOTP, and he still contradicted accounts of the index offence, attributing it to mental illness.

4.84 At this time he had escorted leave only, within the local area and for horticulture, group leave to surrounding towns in Yorkshire, and escorted leave to visit relatives in Derby.

4.85 For his relapse signature it was noted that he presented with symptoms of psychosis between February and October 2009, characterised by paranoid ideas relating to his first wife, the police and the criminal justice system, somatic

[37] *A Historical and Clinical Risk assessment for violence, now replaced by HCR 20 v3, see footnote 26*

hallucinations and ideas of reference and hypochondriacal delusions. He had been symptom free since 2010.

4.86 Dr Y wrote to the Derby DPMU informing them that he had agreed the transfer of Amir to Cygnet Derby, and that he had informed the MoJ of this plan. He noted that he had made the MoJ aware that there might be other representations to them from the DPMU and Victim Liaison Officer. This letter was copied to the relevant Victim Liaison Officer. Dr Y also noted that he had adjusted the leave forms when he became the RC, to specify addresses where Amir could be escorted to in Derby. There had not been any reports of inappropriate behaviour during these escorted visits.

4.87 A pre-discharge (Section 117) meeting was held at Wathwood on 15 July 2013. The discharge summary from Wathwood stated his diagnosis was paranoid schizophrenia, and he was prescribed risperidone 2 mg twice a day.

4.88 It was noted that he had a number of physical health problems; asthma, chronic sinusitis and a previous Bell's palsy. Medication for asthma, sinusitis and occasional dizziness was prescribed.

4.89 The relapse signature and prevention plan was:

Relapse signature and prevention plan
Early warning signs/symptoms Frequently voicing delusional beliefs and preoccupation with delusions, emotionally labile, increasing aggressive and controlling behaviour, and somatisation.
Precipitating/predisposing factors Stress due to family illness, interpersonal issues or employment
Protective factors Response to medication, support from family and staff, religious beliefs
Action to be taken in the event of a crisis/clinical deterioration
Review clinical and risk assessments, medication and placement within the hospital Re-refer to Wathwood for second opinion/gatekeeping assessment

The discharge summary from Wathwood included a list of documents enclosed, including

- four court reports made prior to his sentence in 2008/2009;
- a police case summary and record of police interview in December 2009;
- an interim psychology report in 2010;
- victim perspective notes prepared by the social worker in 2011;
- psychology report on assessment of domestic violence in 2011;
- Dr N's annual report dated November 2012;
- psychology report on domestic and sexual violence, dated May 2013;

- worksheet for the sexual violence assessment;
- relapse prevention report dated 11 July 2013, and
- printouts of medical records from Wathwood.

4.90 A 'third party information' letter was also sent by Dr Y to Dr M, the Cygnet RC. This letter contained information not to be disclosed to Amir regarding victim liaison. It was noted that the DPMU had recently liaised with the social worker at Cygnet and a further handover was expected during an initial meeting after transfer. Amir was noted to be registered for life on the 'sex offender register', and was subject to an ISA barring order for the next six years. He had not been authorised to have contact with children. The letter notes that if he chose to make contact with children within the family in the Derby area, this would need assessing, and escorting staff should be aware of this during home visits.

4.91 Amir was discharged from Wathwood to Cygnet Derby on 18 July 2013. While this was a discharge from one hospital to another, it was actually a transfer in terms of the Mental Health Act. He remained on Section 37/41 MHA, with the restrictions on discharge in place.

Cygnet July 2013 to July 2015

4.92 Multidisciplinary care plans were commenced on admission, covering life skills, medication, relationships, staying healthy and risk. In August 2013 he had two hours escorted ground leave, and a one-off escorted visit to his parents' home for Eid.

4.93 In August 2013 a mobile phone agreement (non-internet, non-camera) was signed as authorised by Dr M, but not dated or signed by Amir. This meant that he could have access to a non-internet, non-camera phone on the ward, Smart phones were not allowed in the ward area or to be used off-ward. It is clear however that he had a smart phone later in his stay, although it is not clear whether this was authorised or not.

4.94 Derby DCRT allocated a Derby care coordinator temporarily, until a community psychiatric nurse (CPN) could be allocated by the DCRT. A permanent care coordinator was allocated in October 2013, and Dr M sent updates by letter accordingly. In October 2013 it was reported that Amir had been attending psychological assessments and had agreed to start SOTP. By this time the MoJ had granted escorted leave to visit his parents fortnightly and he had been using unescorted leave without incident. There were no concerns about his behaviour or mental state.

4.95 An initial psychological assessment was conducted in October 2013. Amir maintained that his mental health was the main thing that caused him to get in trouble with the law. He was able to describe shame and guilt after seeing photographs of his first wife's injuries but stated that during the offence he was "out of his head" and did not remember details.

4.96 A risk assessment was conducted by the Cygnet social worker, following a request by the family that Amir be allowed to have a home visit to his parents house to celebrate Eid, in August 2013. This assessment noted that the DPMU had requested to be informed of any such 'one-off' home visits, so that Victim Liaison could ensure his first wife would not also be visiting the area. Amir told the clinical team that his first wife did not have family in Derby, which appears to be untrue. The family provided assurances that there would be no children present, and the family agreed he would have two escorts at all times.

4.97 In April 2014 his escorted leave was suspended after an incident in which he persuaded a female staff member to accept a lift for them both in his brother's car. He had earlier asked if he could meet his brother when he was at the gym, which had been agreed. During the walk to the gym he kept insisting on buying the staff member some food, which was eventually agreed. After meeting his brother at the gym, Amir told the escort that his brother would give them a lift and said he did this all the time. The staff member objected, but Amir and his brother got into the car. The staff member reported they had to weigh up the possibility of Amir and his brother driving off, and made the decision to get in the car. They were driven to the Normanton area, and Amir ordered food for the staff member, despite her refusal. They were eventually driven back to the unit, after taking her to a car repair shop and telling her he could get her a good deal. Amir also allegedly said there was a kind of club amongst staff that he felt he belonged to.

4.98 His leave was suspended pending investigation and discussion, and he maintained that he had not intended to do anything wrong, but had given the staff member the option of getting into the car or walking. This was contrary to the account of the staff member. He also said that the female staff member said she would not say anything and he should not either. This was denied by the staff member. Amir implied that his brother had recording equipment in the car and he could prove his point if needed.

4.99 Amir was upset and angry about the leave suspension, being concerned about how it would seem to his parents in particular, and then said he worried that staff did not always write the truth. Escorted leave was reinstated after MDT discussion on 16 April 2014. Limits and boundaries were clarified, and a list of addresses he could attend (gym, mosque) were made clear. He was not to visit or meet family whilst on escorted leave, and to have a male escort only.

4.100 In May 2014 this was changed to male or female escort, after several escorted trips with no problems. An MDT meeting on 22 May noted that he was disappointed about the setback with leave, and the effect that it has had on his parents. It was agreed that 'a line be drawn under the investigation'. The next actions were: Dr M to write to the MoJ requesting unescorted leave, leave with his father to the mosque was granted, weekly escorted home leave was agreed with a male or female escort, and escorted day leave was agreed to attend a conference/job fair.

4.101 A further personality assessment was conducted in April 2014, the Millon™ Clinical Multiaxial Inventory-III (MCMI-III™).[38] This suggested that he had a tendency to answer questions to show himself in a positive light, with narcissistic and compulsive tendencies.

4.102 An IQ test (WAIS-IV)[39] was carried out in May 2014. This showed a full-scale IQ of 72, which is in the borderline range of intellectual functioning. The interpretation of this was that Amir may experience difficulty in keeping up with peers in a wide variety of situations that require thinking and reasoning abilities.

4.103 Cygnet have a system of a written 'mini risk assessment', which is for review by the MDT every two weeks, and is signed by the RC and nurse in charge. Between April 2014 and January 2015, Amir scored 'yes' to the following: use of garden tools, mobile phone on the ward, mobile phone on section 17 leave, driver as escort on leave, full sharps access, unsupervised shaving, off ward access, male escort only.

4.104 Between January 2015 and April 2015, sharps access had changed to 'level 3', and all other items above were 'yes' apart from 'male escorts'; this was because he had unescorted leave by then.

4.105 In March 2014 Amir was offered a role on a CQC service user reference panel. He requested permission to take up this offer with the CQC, which was to be discussed with DPMU. Amir told staff he had a 'job' offer from the CQC, which was in fact membership of a service user reference panel.[40]

4.106 It was clarified within the clinical team that he had an ISA barring order which meant he could not work with the CQC where there is a possibility of coming into contact with vulnerable people. Dr M confirmed to the CQC that it would not be appropriate for him to attend any meetings.

4.107 In May 2014 the MoJ agreed unescorted leave to the local area, for two hours four times a week, with no access to children. He used this to visit his family and the mosque. He asked if he would be able to go to Pakistan if his father died, and was advised this was unlikely at present.

4.108 In July 2014 Amir became more challenging about details of his care, questioning why he was not allowed more freedom. He was critical of staff and his care team, particularly in relation to SOTP work. He appeared stressed and also verbalised worries about his father's health. At this time it was planned to start domestic violence and dialectical behaviour therapy DBT[41] work with psychology. He was

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[38] Millon™ Clinical Multiaxial Inventory-III (MCMI-III™) Assessment for personality disorders and clinical syndromes. https://www.pearsonclinical.co.uk/Psychology/AdultMentalHealth/AdultForensic/MillonClinicalMultiaxialInventory-III(MCMI-III)/MillonClinicalMultiaxialInventory-III(MCMI-III).aspx

[39] Wechsler Adult Intelligence Scale. https://wechsleriqtest.com/

[40] Mental Health Service User Reference Panel. https://www.cqc.org.uk/get-involved/how-we-involve-you/panels-advisory-groups.

[41] Dialectical behaviour therapy (DBT) is a type of talking treatment. It's based on cognitive behavioural therapy (CBT), but has been adapted to help people who experience emotions very intensely. https://www.nhs.uk/conditions/borderline-personality-disorder/treatment/

found with a camera phone on him in the ward area, which was removed, and he was reminded about restrictions.

4.109 He requested overnight leave to his parents address in July 2014, and it was agreed that this would be discussed with DPMU prior to making any application. This became an ongoing request.

4.110 By August 2014 his unescorted leave was extended, and contact was made with MAPPA regarding whether he could have access to his nieces and nephews when he was at his parent's house. His attendance at DBT had decreased because he was spending more time with his father. He regularly requested more unescorted time, which was refused. At this time he had six hours a day which was felt to be sufficient. He attended the last session of DBT in September 2014, which focussed on distress tolerance, and it is noted that he showed a good understanding and was well engaged.

4.111 A notification was received from Birmingham Children's Services in September 2014, stating that an assessment would be completed to determine whether Amir should have access to his nephews and nieces who lived in the area.

4.112 At this time his application for a driving licence had been refused by the DVLA, and Dr M did not feel it appropriate to support his application. His mental state was noted to be stable, and he was compliant with medication.

4.113 Amir continued to ask for overnight leave, and expressed guilt that he may be in hospital when his father dies. The Cygnet social worker was requested to arrange a meeting with Amir and his family to discuss relationships, and encourage the family not to push him into a new relationship.

4.114 An update was received from Birmingham social services in September 2014, with the outcome that Amir could have contact with children in the family, but must be supervised at all times by other adults. The Section 17 leave form was adjusted to clarify that he should have no contact with children whilst on unescorted leave. However it was noted that his sister collected him by car, with a child in the car. This was noted in the clinical record as a 'significant event' but there was no record of any discussion with him, or care plan review afterwards.

4.115 On 23 September 2014 a card was found in his wallet during a pat-down search. On this was written 'to the man I love', and on questioning he stated that he had found it.

4.116 The MoJ declined the application for overnight leave, and this was discussed at an MDT meeting on 2 October 2014. The refusal was based on the MoJ asking for the outcome of his next CPA review, and to ascertain views of family members. Amir was noted to be more challenging to the clinical team, complaining that his progress was not being supported and that Dr M should have asked for leave earlier. On 10 October it was noted that he had brought his nephew into reception to use the toilet. He was reminded again that he should not be alone with any children. He apologised and said he thought it would not be a problem because his sister was outside in the car.

4.117 On 12 October 2014 Amir requested to make a complaint, and was advised to do this with healthcare assistant (HCA) Y when she returned to the unit. He said that the complaint was about overnight leaves. He told staff that he had received some unsettling family news on 13 October, 'nothing tragic, just upsetting'. The notes record support offered to him, but there is no detail recorded of what the issue was. Around this time his father went to Pakistan for medical treatment. Over the next few weeks he was noted to be more distant, not going out and was described as elusive.

4.118 On 13 October 2014 HCA Y was off duty, and contacted a deputy ward manager (DWM) and asked to speak to her urgently. It was arranged that HCA Y would come to the car park outside the unit. HCA Y disclosed that she had been having a sexual relationship with Amir. Allegedly he grabbed her phone while they were on escorted leave and he took her number, and they texted each other for 'a while' it was not clear when this had started. HCA Y made a number of allegations that Amir had other staffs' phone numbers, that he had 'bugged' her house, and had her watched, and had asked her to provoke other patients, and was convinced that she was having affairs with other patients. HCA Y said she felt threatened by him, he had allegedly smashed her phone when accusing her of seeing other men, and she had seen Asian men in a car outside her house. It was alleged that the relationship had been ongoing for the previous three months.

4.119 At the investigation interview HCA Y made several references to feeling frightened of Amir. She was shown a letter written by Amir which alleged she had forced him into the relationship and he was planning to disclose it to the hospital management. There was no evidence to support any of HCA Y's claims regarding threats or 'bugging' of cars or men outside her house in cars. HCA Y did not inform police or Cygnet of this until Amir allegedly threatened to expose the relationship. At an investigation interview Amir stated that HCA Y started the relationship and pressured him to continue it. HCA Y was suspended from duty and a formal disciplinary investigation followed. HCA Y was dismissed for gross misconduct two weeks later.

4.120 On 31 October 2014 a MAPPA meeting was noted, attended by DPMU, the social supervisor (SW1), Cygnet psychologist and social worker, and Dr M. The notes record that a Cygnet senior manager briefed the meeting on an investigation that had been conducted and concluded. There were no signs of any psychotic symptoms or relapse in mental state around this time. It was recorded that he was now registered as MAPPA category 1, level 2.

4.121 The outcome was that Dr M was to write to the MoJ, unescorted leaves were suspended to become male only escorted, up to three times a week, and to continue psychology work and DBT. Dr M noted in an MDT meeting in December that Amir needed to do 'some work regarding his emotions and around relationships'. We did not find any record of this taking place.

4.122 Amir had an operation to extract wisdom teeth in November 2014. He had been in pain for some time and appeared very stressed in anticipation of the operation.

4.123 The relationship with the HCA was also reported to Leicestershire Police, because care workers who have sexual contact with a person who has a mental disorder

are liable to prosecution under the Sexual Offences Act 2003.[42] The DPMU case worker attend an MDT meeting in December 2014 with the police to inform the team that an investigation was in progress. Amir had refused to give a statement and it was noted that in this situation he should be seen as a vulnerable adult and potential victim.

4.124 A police investigation was conducted, and a file submitted to the Crown Prosecution Service (CPS). We were informed by Leicestershire Police that the CPS declined to pursue the prosecution and the reasons for this were not recorded.

4.125 Potential future discharge addresses were discussed, and concerns were expressed at the idea of him being discharged to his own address. Amir wanted to be discharged to his parents' house so he could support them. It was agreed that his mother's views needed to be gathered, interviewing her separately if needed. Overnight leave would not be applied for until the social worker had carried out an assessment, and this would also need to be discussed at a MAPPA meeting.

4.126 Amir was very unhappy with these limitations, and became verbally frustrated and disgruntled. He expressed the view that he should be discharged within five weeks, he was being punished and no longer trusted staff. He became angry and hostile in an altercation with a female staff nurse about using nicotine replacement and smoking, and demanded to speak to another nurse and the doctor. Both (male) staff members supported the staff nurses' position. He did however approach another doctor the following day, saying his GP had agreed he could have nicotine replacement as well as carrying on smoking. He was advised to use the replacement lozenges 'sensibly'.

4.127 It was decided at a CPA review meeting in December 2014 that a MAPPA meeting on 6 January 2015 would discuss future plans, including the viability of him living with his parents on discharge. It was noted that he appeared angry and considered these to be unnecessary delays.

4.128 An update was sent by Dr M to SW1 in December 2014, advising that that there had been no psychotic symptoms, violence or aggression. The letter noted that his Section 17 leave had been suspended but was reinstated in December 2014. It was further stated 'there have been issues around his relationships and leave which are not mentioned due to confidentiality reasons. As a result MAPPA, DPMU and police have been involved'. It was however clear from correspondence by SW1 that she was involved in meetings about this issue and was aware of the details. It was noted that overnight leave had been applied for but the MoJ had refused, and advised it could be considered again after his next CPA review, and they would like to see a 'robust post discharge package of support' agreed.

[42] *Care workers: sexual activity with a person with a mental disorder, Sexual Offences Act 2003 – section 38. https://consult.justice.gov.uk/sentencing-council/offences-against-those-with-mental-disorder/supporting_documents/sexual%20offences%20consultation_Offences%20against%20those%20with%20a%20mental%20disorder.pdf*

4.129 In January 2015 a full HCR-20 v3[43] was completed. His tendency to present himself in a positive light was noted. A reasonable degree of insight into his mental health was reported, however Amir maintained that his violence occurs in the context of a decline in his mental state. In contrast, information from his first wife reported that he enjoyed violence, and was violent throughout their marriage. She also maintained that he was fully in control of his actions during the index offence. The HCR 20 v3 notes that he will require continued support and monitoring to support insight into mental health and violence.

4.130 The HCR 20 v3 includes comment on any '*supervision failures*' and it was noted that since his admission to Litchurch ward he had displayed difficulty in adhering to hospital rules, and the rules of his Section 17 leave. He had visited areas he was not permitted to, and pushed boundaries with staff. This took the form of buying staff food when they have explicitly stated they do not want it, accepting lifts from his brother when it had not been agreed, and starting work without informing the DPMU.

4.131 A 'formulation of risk' was developed. This is a structured approach to risk, which is intended to provide a depth of understanding of the person's risks. This then leads to a description of factors likely to increase and factors likely to decrease risk behaviours. This looks at:

- what the problem is (presenting factors);
- what internal elements make risk more likely (predisposing);
- what circumstances may trigger risks (precipitating);
- what contributes to continued risks (perpetuating) and;
- what will minimise risk (protective factors).

4.132 The formulation for Amir is detailed in the table below:

[43] *The Historical Clinical Risk Management-20, Version 3 (Douglas, Hart, Webster, & Belfrage, 2013), also known as HCR-20V3, or simply V3, is a comprehensive set of professional guidelines for the assessment and management of violence risk.* http://hcr-20.com/about/

Presenting issues
Violence (sexual and physical) perpetrated against his then wife Anxiety Diagnosis of schizophrenia (with no current evidence of symptoms)
Predisposing factors
Maladaptive schemas (entitlement, enmeshment, subjugation) Perceived cultural norms (consider honour-based violence literature) Attitudes to women Limited experience of establishing/maintaining intimate relationships Over control of emotions Pressure to achieve Sense of responsibility (eldest son, position in family)
Precipitating factors
Stress and difficulty coping Symptoms of mental illness Jealousy Immediate need to meet his own needs without consideration of impact on others
Perpetuating factors
Perceived pressure to meet family expectations Collusive nature of family relationships Narcissist personality features (glib, grandiose, manipulative) Schema activation/modes Minimisation of problems Problems with self-awareness Problems with treatment
Protective factors
Motivation to engage in therapy Easily able to establish social relationships and can be popular with peers Reports being motivated to stay mentally well Reports being motivated to not reoffend

4.133 As part of the HCR-20 v3 assessment, the team then develops a set of 'scenarios' that suggest the types of violence the person is likely to commit, the imminence of this, the degree of likely harm, and the case management plans that are necessary to reduce risk.

4.134 Three scenarios were outlined: emotional abuse against a wife or intimate partner, physical violence against a wife or intimate partner, sexual violence of a partner in the form of rape. There follows a detailed analysis of the potential imminence of risks and what factors are likely to increase and decrease risk.

4.135 It was noted that compliance with his medication and supervision by mental health professionals appears to reduce his risk violence, and a new relationship or voicing of delusional ideas, and changes in his mood, attitudes or behaviour should trigger a reassessment of risk.

4.136 A meeting with Amir's family was arranged with the Cygnet clinical team in January 2015. A member of staff acted as interpreter for his mother, who did not appear to speak English. This meeting was to discuss the family's views regarding overnight leave to his parents' house. The MoJ had specifically asked that their views be sought before a decision could be made. The team specifically wanted to explore whether his mother would be happy for Amir to return to the family home, if she would feel intimidated by him, and what would happen if one of the parents died. The parents were asked if the surviving parent would be able to cope with his care.

4.137 The answers given indicated that the family depended on Amir, particularly now as his father was very ill. They all wanted him to return to the family home, particularly as his father's illness was likely to be terminal. It was suggested to the family that they seemed to be rather dependent on Amir, and it was pointed out that he has not responded well to stress in the past.

4.138 It was said by his mother that if his father died, Amir would look after her. His mother said that he had never hurt or intimidated her in any way in the past. The family said they would like him to have the support of the mental health team, and for him to be admitted to hospital quickly if things go wrong. The family was invited to send a letter with their opinions that could be included in Dr M's response to the MoJ. The family sent a typed letter, signed by two brothers and two sisters, and his father and mother. This letter assures services that the family would monitor his mood, behaviours, medication compliance and direct him to the support of professionals if they are unsure of anything. The letter assures that the family has been very involved in his care and as a result have a good insight overall. It was requested that a date for discharge be provided by the MoJ, along with overnight leave from January 2015, as his father was terminally ill.

4.139 In a START risk assessment in early 2015, self-neglect was noted as a potential risk if there was a deterioration in his mental state. The fact that Amir's father was terminally ill was incorporated in the risk assessment from May 2015. This was causing him stress, and he was tearful at times. Planned strategies were 1:1 time with the named nurse, as required medication, 'stop and think' techniques, attending the mosque, keeping active and going to the gym, and distraction techniques.

4.140 On 2 February 2015 Dr M applied for overnight leave to his parents' address in Derby. On 18 February 2015 the MOJ agreed that Amir should have up to five nights a week at the RC's discretion at his parents address in Derby, with reports back at one, two- and three-monthly intervals. There was a handwritten note (undated) that this had been cancelled; emails from the MoJ indicated that concerns had been raised by MAPPA about the overnight leave to his parent's house. This leave was suspended, pending Dr M identifying a discharge address.

4.141 A START risk assessment was done in April, May, June and July 2015, which stated historical risk of self-neglect and violence, but currently low risk. In the formulation section it was noted that if Amir 'was engaged in a close relationship and there was a deterioration in his mental state, there would be a high probability that he would engage in acts of violence against his partner within a couple of months. This would place his partner at risk of violence and sexual harm'.

4.142 The fact that Amir's father was terminally ill was incorporated in the risk assessment from May 2015. This was causing him stress, and he was tearful at times. Planned strategies were 1:1 time with the named nurse, as required medication, 'stop and think' techniques, attending the mosque, keeping active and going to the gym, and distraction techniques.

4.143 A Spousal Risk Assessment[44] (SARA) was completed in February 2015. It was noted that he initially minimised the index offence, and relied on explaining all violent behaviour as being due to mental illness, but the report noted that this does not explain aspects of sexual deviance in the offence. Sexually sadistic features of the offence had not been explored. It was also stated that perceived cultural beliefs and family pressures may mean that Amir has rigid assumptions about the role of an intimate partner in a relationship, which may give rise to attitudes of male prerogative/misogyny/sexual entitlement.

4.144 He continued to maintain that the trigger for the index offence was his mental illness. The report is quite clear that this was not the only explanation and suggests that if there are concerns about violence in the future, he should be taken down a criminal justice route.

4.145 There is a detailed analysis of potential areas which should be the focus of future risk management. Both this and the HCR 20 V3 scenarios suggest that Amir would not disclose problems and would minimise risk in the future, and that supervision should be weekly, and focus on developing his cooperation with treatment. Amir stated he found this report very negative and had not focussed enough on all the therapy he had completed. He stated that a difference of opinion regarding his risk did not matter to him and he believe that he is at “zero” risk of reoffending.

4.146 In February 2015 he had unescorted leave for up to eight hours a day, six days per week in the Derby area, and that he could go to his parent’s and brother’s addresses (not listed). It was agreed he could have contact with nephews and nieces supervised by adults. The unescorted times had been gradually increased over the previous months.

4.147 In February 2015 a referral was made by the Cygnet Social Worker to Derby City Council, with a view to allocating a Social Supervisor if he was to be conditionally discharged in the future. The referral noted that there had been discussions at a recent MAPPA meeting and it was requested that his care should be managed by a social supervisor, as well as a care coordinator, due to the levels of risk involved. At this time Amir’s father was terminally ill, and it was expected that his death would be stressful for Amir. This was not only due to bereavement, but also the family’s assumption that he would then become the head of the family.

4.148 In March 2015 Section 17 leave was granted for one episode of two consecutive overnight leaves and one episode of three consecutive overnight leaves each week. The address which he was designated to stay overnight was Amir’s own house, where the index offence was carried out. The DPMU was to be informed in advance each week. The Cygnet social worker made telephone contact with MAPPA notifying them of his leave status, and they were to make contact with victim liaison. It was noted in an MDT meeting in April that he was allowed overnight leave for five nights a week, but that this should be two nights out, one

[44] *SARA, the Spousal Assault Risk Assessment Guide (SARA) helps criminal justice professionals predict the likelihood of domestic violence by screening for risk factors in individuals who are suspected of, or who are being treated for spousal abuse. P. Randall Kropp, Ph.D , Stephen D. Hart, Ph.D. , Christopher D. Webster, Ph.D. , Derek Eaves, M.B. https://www.mhs.com/MHS-Assessment?prodname=sara.*

night on the ward, and then three nights out. He had been taking two lots of three nights, which amounted to six nights a week. Staff were reminded of his leave boundaries.

4.149 A Section 117 meeting was held at Cygnet in April 2015 to plan his discharge, which was attended by Cygnet clinical staff, the DPMU case worker, and DHCFT care coordinator (CCO1). A comprehensive list of risk indicators was noted, and a detailed risk management plan was outlined. The conditional discharge conditions were that he reside at an address agreed between him and his CCO1, to keep his appointments with CCO1 and the Social Supervisor (SW1), comply with medication as agreed by Dr R, under no circumstances make contact with his first wife, if he has any concerns about relapse he should immediately contact CCO1 or Dr R, and he should inform Dr R, CCO1 and the DPMU if he and when he starts a new relationship.

4.150 The agreed conditional discharge plan was that:

- CCO1 would visit Amir and his family weekly to monitor his mental state and provide support;
- Cygnet would make one post-discharge visit to ensure he had settled;
- Phone numbers of the out of hours team would be provided;
- Dr R would see him within four weeks of discharge, and at regular intervals thereafter and;
- Amir would try to structure his week so that he is meaningfully occupied.

4.151 It was noted that the following agencies would be involved in his aftercare;

- DCHFT Recovery Team, Derby City DCRT; CCO1 and Dr R,
- Derby City Council: social supervisor (SW1)
- DPMU case worker
- Victim Liaison worker
- MAPPA led by Derbyshire Police

4.152 In June and July 2015 his Section 17 leave conditions were: escorted leave as long as required to visit his terminally ill father. He also had unescorted leave throughout Derbyshire, visit his family in Birmingham and Stoke, with all trips to be discussed with the DPMU. The leave forms stated he could stop between home and the destination, for example to buy petrol; it was not made clear however whether he would be driving himself.

4.153 While on overnight leave he was expected to speak to ward staff once a day, which he complied with. Dr M's junior doctor phoned him whilst he was on leave on 1 June 2015, to gather information for an MoJ update. He told the doctor that

he had been looking after his parents, and had visited family in Derby, Nottingham, Birmingham and Stoke on Trent. He said he always informed DPMU of his whereabouts. He said he had been offered a driving job by a meat firm, and said DPMU had advised he consider part time work initially. The doctor later discovered from the Cygnet social worker that his parents had gone to Pakistan 10 days previously. When Amir was challenged about this misinformation, he said he had told a member of staff the night before. None of the previous leave notes contained this information. The doctor stated this would be conveyed to the MDT and the MoJ. When he returned there was no evidence that this was challenged. In the update letter on 3 June 2015, this anomaly was not conveyed to the MoJ, although they were informed that his parents had gone to Pakistan.

4.154 He was visited at his home address by the Cygnet social worker and DPMU on 6 June 2015. The house had been left in a state of disrepair by the previous occupants, and he was experiencing significant stress trying to sort it out by himself. He expressed anxiety at going out in case he got into trouble, and was spending most of his time at the address on his own. He said he heard his father's voice telling him not to go out, and asked his sister to get him some milk because he thought there were prostitutes in the street. It was recommended that he be seen weekly by the team until discharge.

4.155 At a subsequent meeting he said his father would need to be in Pakistan for another month. At an MDT meeting he attended on 9 June 2015 he presented as tearful and said he felt guilty. He was asked if memories were bothering him, and he said they were not and the layout of the house was very different from when his first wife and children lived there. This information was not conveyed to SW1 in the update report of 23 June 2015.

4.156 The MOJ requested a three-month update report on 30 June 2015. This was provided by Dr M on 6 July 2015,and does not mention that he was using too many night leaves, that he had not told the team his parents had gone to Pakistan, or that he was too anxious to go out at times and had mentioned he heard his father's voice. The report does say that there were concerns about him being overcautious to leave home and limiting his interactions with friends. The report noted he was encouraged to engage more and build a routine for himself. He did say he attended the mosque four times a day.

4.157 The MoJ granted a conditional discharge on 27 July 2015 at the request of the Cygnet RC. The conditions were:

- to reside at (own address) or other such accommodation agreed by the care team;
- to keep appointments as and when necessary with his care coordinator and social supervisor;
- to comply with medication that is agreed between him and his responsible clinician, to inform his responsible clinician, care coordinator and DPMU if and when he starts a new relationship and;

- not to seek to approach or communicate with the victim of the index offence without prior approval, and not to enter the relevant area (exclusion zone map supplied).

4.158 A first progress report was requested from Dr R after one month, with subsequent reports every three months until further notice.

4.159 These conditions were sent by letter to Dr R, Dr M, CCO1 and SW1.

Around this time Sobhia's family started to notice she was constantly on the phone and thought she may have been in a developing relationship. Earlier in the year they noticed she received some letters that looked as though they were from a custodial type environment. The family decided to wait for Sobhia to tell them if she was involved with someone.

Derby City Recovery Team 2015 to May 2017

4.160 DHCFT had maintained contact as Amir progressed through the system, with a view to taking on clinical responsibility when he was discharged.

4.161 The MoJ noted that Dr R was to be the clinical supervisor, a care coordinator was allocated (CCO1), and SW1 was to be the social supervisor, and they wrote separately to each.

4.162 Dr R was requested to provide an update report to the MoJ one month after discharge, and every three months thereafter. SW1 was requested to provide an update report to the MoJ one month after discharge, and every three months thereafter. Both were referred to the guidance notes[45] for what to include in the reports, and requested they copy the updates to each other.

4.163 When his conditional discharge was granted there was some miscommunication about who would provide supervision. SW1 was under the impression that he did not have any social care needs, hence it was suggested the CPN (CCO1) could be the social supervisor. A joint meeting between Amir, SW1 and CCO1 was held at his home address on 3 August 2015, which also served the function of a seven day follow up after discharge. It was agreed that he had few social care needs, and therefore it was thought that SW1's role would be short term, although CCO1 would see him regularly.

4.164 Amir's main concern was that his father had gone to Pakistan to attend a funeral and may be too ill to return, and he was starting to plan how he could travel to Pakistan himself. He had been advised by DPMU that they would need a week's notice if he wished to travel abroad. He was advised to email DPMU to clarify and SW1 agreed to raise this with the MoJ.

[45] *The guidance covers work with restricted patients detained in hospital and those discharged into the community. It also covers transfers from prison to hospital under the Mental Health Act 1983. Gov.uk.* https://www.gov.uk/government/collections/mentally-disordered-offenders

4.165 The MoJ case worker clarified that the MoJ would not generally allow travel outside the UK in the first year. However they would consider this because of the special circumstances, and would want to know where he would be going, who he would be staying with, and when he would return. They would need clarity with regard to medication administration if required and he would also need to see Dr R, who would have to contact MoJ with his view of the situation, prior to approval being given.

4.166 An urgent appointment with another consultant psychiatrist in the team was arranged because Dr R was on leave, and Amir was seen on 7 August with SW1 and CCO1. A detailed assessment of his current mental state and presentation was carried out and documented. The care plan was for him to continue to take medication (risperidone 2mg and various physical health medications),to be reviewed by Dr R in 8 to 12 weeks, CCO1 and SW1 to monitor his mental state and offer psychosocial support, await MoJ decision about travel to Pakistan.

4.167 CCO1 met Amir with his sisters on 10 August 2015.

4.168 He was noted to remain settled and was complying with the conditions he was subject to. The plan was for Amir to be supported by the DCRT, Dr R to offer regular outpatients' appointments, and CCO1 to visit on a two weekly basis for support and monitoring of his mental health.

4.169 On 13 August 2015 the MoJ sent written agreement that permission was granted for Amir to travel to Pakistan to visit his father on compassionate grounds. It was noted that he was currently stable and compliant, and that he would have medication and documents about his condition with him. It was arranged that he would be in Pakistan from 25 August to 26 September 2015. Weekly contact by telephone was to be arranged with CCO1, the DPMU were to establish that his first wife was not in Pakistan at the time, and medication for four weeks would be supplied.

4.170 CCO1 saw him weekly until he travelled to Pakistan in August. The notes of these meetings are superficial and lack any detailed exploration of Amir's mental state, how he had adjusted to being discharged, his living conditions or how he was spending his time. CCO1 and SW1 attended a MAPPA meeting on 18 August 2015, and reported that the meeting requested that if the MoJ gave permission for him to travel to Pakistan, he should phone mental health services weekly. CCO1 recorded on 24 August that Amir was preparing to travel to Pakistan. Amir gave travel and flight details, and said he was travelling from 25 August to 29 September. SW1 noted that at the MAPPA it was recorded he was at 'category 1, level 2 high risk'.

4.171 Amir maintained telephone contact as requested, and it appeared that his father was very ill and could not return to the UK. He returned as planned and was seen by CCO1 on his return, Amir said he was fine and had been taking his medication. He wanted to return to Pakistan in October to spend more time with his father. There was no exploration of his mental state, mood, or experiences whilst away.

4.172 CCO1 and SW1 attended a MAPPA meeting on 13 October 2015, and it was noted that it had been agreed at the meeting that he no longer met the criteria for level 2.

4.173 Dr R saw Amir for the first time on 8 October 2015, along with CCO1 and SW1. There is a documented mental state assessment and discussion about his progress in health services since his index offence. Dr R also asked about whether there had been any discussion about another marriage while he had been in Pakistan, which he denied. Regarding risk assessment, Dr R noted the risk was significantly low because he was now stable, considering that his index offence was influenced by mental illness. Dr R supported his request to the MoJ that he be allowed to return to Pakistan for a further six weeks. A contingency plan was put in place, with six weeks medication, and Dr R stated that there was extra medication available if needed, Amir was aware of signs of relapse, and could see a local psychiatrist if needed.

4.174 The MoJ agreed to the six-week trip, on the basis that this had been discussed in the care team and an adequate contingency plan was in place. CCO1 continued to see him weekly until he returned to Pakistan at the end of October.

4.175 Amir booked tickets for a four-month trip, despite having been given permission for six weeks. When challenged he said that the cost of going backwards and forwards was too great. Dr R discussed this with the MoJ, who stated that they could not actually legally prevent him from travelling. He was booked to travel from the end of October to the beginning of December 2015, and it was agreed he would call CCO1 and/or SW1 every week.

4.176 Amir called every week, contacting SW1 if he could not get in touch with CCO1. He sent an email on 23 December 2015, stating that his father's health had deteriorated and he required breathing equipment that may need to be brought from the UK. He said he thought there were no restrictions on staying longer from DPMU and the MoJ as long as he is taking his medication and was well.

4.177 He then called on 4 January to say his father passed away on 1 January 2016, and he planned to stay in Pakistan until the end of March. He later told the GP surgery that his father passed away on 26 December 2015. The funeral notice was shared by Derby Jamia Mosque on 25 December 2015, stating that he passed away that day.

4.178 Amir did however return unexpectedly in January, saying he planned to travel back again in March. CCO1 saw him on 21 January and noted that he seemed 'reasonably cheerful'. The meetings were two weekly at this point. A joint meeting took place with CCO1, SW1 and Amir. He said he was working voluntarily at a meat delivery place, and was challenged that he had not told the DPMU of this. Amir said he only wanted to be visited monthly, and it should be at that level by now. He was challenged on this, and SW1 stated that as he had been out of the country the team needed to get to know him properly. Amir continued to challenge this, saying he should be treated as an individual. The notes made by SW1 are far more detailed than those made by CCO1. He also stated he was planning to return to Pakistan in March to complete funeral prayers for his father.

4.179 CCO1 continued to see him every two weeks, making very brief notes. A joint visit was made in May with SW1 and CCO1. This focussed on his concerns about selling his car and sorting out his father's car. There was discussion about returning to Pakistan but no firm date.

4.180 Formal updates were sent by SW1 to the MoJ in November 2015, March 2016 and June 2016. These reports give little detail, and the first was completed while Amir was in Pakistan.

4.181 Dr R's first report to the MoJ was sent in April 2016. At this time Amir had not been seen by Dr R since October 2015. The report stated that risks were managed well by the current care plans, his mental state was good and he had a responsible attitude to drugs and alcohol.

In June 2016 Sobhia's family told us that Amir was brought to their house in Bradford by Sobhia and introduced as a social worker. There was another person present who was a social worker who was giving some advice to the family, and Amir was introduced as part of this conversation. He was introduced to the family as 'Amir', which they later found out was not his real name.

Sobhia's brothers and mother both met Amir at that time and they noticed that he did not contribute much to the conversation.

Sobhia later told one of her nieces that Amir was her boyfriend, and she was concerned her eldest brother should not find out. It is not clear why this was, and may reflect a reluctance by Sobhia to introduce him to the family, because she was by then apparently aware that he had spent some time in prison for domestic violence.

After this Sobhia's family say that Amir regularly made visits to Bradford, and would take Sobhia and her nieces out for meals.

4.182 In August 2016 Amir spoke to CCO1 and SW1 about wanting to come off his section completely, and apply to work full time. He was advised the team thought this was too soon, but he had the right to apply for a tribunal. A CPA review meeting was held in August 2016, which was Dr R's second meeting with Amir. It was noted that Dr R would offer regular outpatients' appointments (without stating at what interval) and CCO1 would see him every two weeks, to support and monitor his mental health. Dr R made his clinical supervisor's report to the MoJ in November 2016.

4.183 A Functional Analysis of Care Environments (FACE)[46] risk assessment was completed on 11 August 2016, which appears to be the first FACE completed since his discharge. This notes only two risks, both graded as 'low'. These were:

[46] *Functional Analysis of Care Environments(FACE) is a recognised risk assessment tool. https://imosphere.co.uk/solutions/face-assessments/toolsets-risk*

risk of violence to others, and risk to child/vulnerable other. A high risk of relapse was noted, and in the personal circumstances indicative of risk 'severe stress was noted as 'current'. There was no narrative to support this, and stressors of the past only are noted.

4.184 The main past risks noted were:

- getting into a new relationship;
- family stress or loss;
- lack of compliance with treatment;
- neglecting physical appearance;
- idealising or denigrating individuals; and
- overworking or acting in ways which go against his religion.

4.185 Previous actions taken to reduce risk were 'hospitalisation' and protective factors were identified as support by his siblings, relapse and risk management plan. In the event of relapse urgent medical assessment must be arranged with the consultant, and to involve the crisis team and increase visits by the CCO.

In August 2016 Sobhia's family told us that an engagement meeting was arranged at short notice. We were told that in their tradition if you are asking for a girl's hand in marriage you would come to meet the family 'emptyhanded', in case the proposal was rejected. The fact that Amir came with members of his family with Indian sweets, clothes and a ring was seen as presumptuous. Sobhia's mother wanted them to wait and speak to her eldest son, as the head of the household.

According to Sobhia's mother, Amir and his mother were insistent, with his sisters and brother not saying much.

A provisional date for the wedding was set for October or November 2016.

Amir's family told us that Amir told them (in August 2016) that they had to go to Bradford with him for his engagement. They all went up in one car and while driving up Amir told them that he had told Sobhia all about his previous case, so it was 'all sorted' and they did not need to say anything. The family apparently sat on couches and waited for Amir and their mother to have the conversation. Amir was described as agitated and driving fast up the motorway, becoming very angry if he was overtaken.

Amir apparently asked one of his brothers to perform the nikah, but he refused.

4.186 In October 2016 a safeguarding issue was raised involving a third party. Agency meetings were held to discuss these allegations. Because of the nature of these, they were withheld from Amir and cannot be disclosed in this report, but are discussed in the Domestic Homicide Review. It is not clear from the records whether they were ever discussed directly with him. There were however heightened concerns about his risks to females, and there was a suggestion that he had started a new relationship. The details of these issues were not shared with the MoJ by the care team at the time.

4.187 A change of care coordinator occurred in November 2016. This was an anticipated change due to retirement. SW1 wrote to the DCRT team manager stressing that in her view an experienced senior male care coordinator should be allocated, due to the risks that were highlighted on his file.

Sobhia was visiting Amir in Derby during this time, her family said she would either be collected by Amir or get a lift to Derby. They thought she was helping him to decorate the house because she would come home with paint on her clothes.

The wedding was then moved forward to December 2016, Amir had said a friend of his was renting the house and needed to find somewhere else to live, so they could not move in together yet. Amir then said it would have to be January 2017 because he had to go to Pakistan with his mother to do his father's yearly prayers. Sobhia's family were told that Amir would be going to Pakistan with his mother and returning in mid- January.

Amir's family told us they were surprised that Sobhia began to wear a hijab and a niqab when she came to live in Derby, because she had looked very 'western' before then and did not seem overly religious. The family said that Amir was not very religious himself.

4.188 CCO2 was allocated, who was seen as part of a 'virtual' forensic team, having had previous forensic experience. CCO2 was in fact female, but was a very experienced practitioner. A joint visit with CCO2 and SW1 took place in late November 2016. At this time he was planning to travel to Pakistan again in early December 2016. Two of his sisters were present and a discussion was held about who and how to contact services if help was needed while he was away. The next appointment was planned for mid-January 2017. Amir sent a text message to CCO2 on 14 December 2016 stating that everything was fine.

4.189 Further information was received about the safeguarding allegations in January 2017, and CCO2 met him to discuss how his trip had been and enquired in detail about how he had spent the time in Pakistan. He described various ceremonies and memorials that had to be bought. CCO2 asked about the family's living arrangements and how his mother was being supported. Services were keen to try to establish how exactly/where he lived to inform risk assessment. It seemed

that there were times when nephews and nieces regularly slept at Amir's mother's house, and Amir moved between his own house and his mother's. It was strongly suspected that he was alone at times with his sister's children, in breach of his conditions.

4.190 Amir became very defensive to the point of agitation and kept trying to change the subject. CCO2 also asked him if he was planning any future relationships, which he categorically denied.

4.191 After further multiagency discussion, it was decided that a family tree be compiled using all information gathered. It was noted that Amir was mentally stable and his diagnosis was under question. In order to test this out a medication free trial might be helpful, but it was judged that that it would not be safe to stop his medication in the current circumstances. The plan was for mental health services and DPMU to make a joint visit to view his property and explore any potential marriage.

4.192 He was next seen jointly at the team office by CCO2 and SW1 on 6 February 2017. They explored how he was coping with the stress of being head of the household, given that his index offence was linked to stress. He said he did not find the responsibilities stressful, and enjoyed looking after his family. He did say if he felt he was starting to suffer from stress he would reduce his responsibilities. He talked of the part time voluntary work he was doing and hoping to be paid. It was suggested he make contact with a DHCFT employment adviser, but he was reluctant to do this. Amir made efforts to reassure staff that he tries to avoid any interactions with the police. He was encouraged to lead a normal life without focussing on this, and advised that if he breaks the law and had no psychotic symptoms he would be dealt with by the criminal justice process like anyone else. He was aware that he needed to inform DPMU of his movements.

Sobhia's grandmother passed away in February 2017 so the wedding was postponed again. Sobhia's mother and brother went to Pakistan for the funeral. Sobhia's mother did not return until the middle of April, and she asked Sobhia to wait a few weeks until people had paid their respects.

Sobhia's brother described Amir and Sobhia having a big argument at their house in Bradford on 18 April 2017, he was threatening her to say it was 'now or never' and she was very upset, afraid he was going to call it all off.

Amir apparently turned up at the family house the following day with his mother, saying they had done the nikah. Sobhia's mother apparently asked them to wait until her eldest son was present, Amir began shouting and left to drive away, driving fast.

He returned a short time later and seemed to try to be reasonable with her oldest brother, explaining that they wanted to be together and had done the nikah. Sobhia went upstairs to pack and said she was going to Derby with Amir.

Sobhia rang her mother a few times in early May, and there followed odd phone calls to the Bradford house; from Amir alleging that he had found men in the house with Sobhia; and from Sobhia making allegations to her brother.

4.193 A joint home visit by CCO2 and SW1 was made on 23 February 2017. He denied any symptoms of psychosis or stress, and said he was enjoying his role as 'Bhapa'[47] to the family. It was noted that Amir kept the conversation superficial as usual, talking of his voluntary work and how he is looking after the family.

4.194 In the 24 February 2017 update to the MoJ, Dr R alluded to the safeguarding concern, but without detail. Dr R had not seen him prior to preparing the report, and last saw him in October 2016.

4.195 An unannounced visit by CCO2 and DPMU was carried out on 2 March 2017. When they arrived at his home address he was not there, and his sisters were just leaving. The staff went to his mother's house but he was not there either. They phoned him and he said he was in Sheffield delivering meat, and arranged to meet them at his home address later that morning. When they arrived at the agreed time his sisters were there again. Amir had bought a puppy and the sisters were there to help look after it while he was out.

4.196 Amir spoke of his family, and portrayed himself as the patriarch who looked after others and gave advice. There was no evidence of mental illness or stress. CCO2 had to leave early, so there are no records of whether the rest of the house was visited. It was agreed that a Trust safety plan would be completed.

[47] *Bhapa in Pakistani culture is a child's word for father, or a sibling's word for older brother.*

4.197 A further joint meeting took place at the team base with SW1 and CCO2 on 16 March. They discussed his new puppy and he said he had got a dog so that he could overcome his fear of dogs, and had sought advice from a friend about how to train it. He again refused to make contact with an employment adviser, preferring to wait to see if he might be paid for work he was currently doing . Again he showed no signs of stress or mental illness, and said he was taking his medication. There are no records of any enquiries made by clinical staff about his employment status.

4.198 He was requested to complete part of the DHCFT safety assessment, and this was reviewed with him by CCO2 and SW1 on 3 April 2017. The safety plan required him to list the possible stressors and relapse indicators, and what helped him to stay safe and how to get help if needed. The safety assessment was very detailed, and he was reluctant to include historical risk issues such as the relationship incident at Cygnet.

4.199 This led to discussion about his contact with children, and it appears he was the named contact for schools for his nieces and nephews. It appeared that his sister's children were having some form of input from social services, and she regularly asked him to look after them. The consequences of this were reiterated to him. It was suggested he discuss his restrictions with the family to avoid this kind of situation, but Amir was very resistant to that. He again said he enjoyed his role as head of the family.

4.200 Some of his answers were flippant, but he was able to list the ways in which he could help himself, and seek help if needed. It was clear in the assessment that he should not have unsupervised access to children, and he was obliged to inform his care team of any new relationship, after which disclosure of his index offence would be arranged.

4.201 A multiagency meeting was attended in January 2017 by CCO2 and SW1 to update on the safeguarding issue, but it was noted that the relevant agency did not attend so there was no new information. The question of Amir acting as next of kin for children was conveyed to DPMU.

4.202 A joint meeting on 25 April 2017 was held with SW1 and CCO2. Amir was preoccupied with a dispute over boundaries with his neighbour and focussed the meeting on this. There were no signs of stress or psychosis.

4.203 Records from Derby Royal Infirmary show that Amir attended the hospital on 28 April 2017, after being brought by ambulance in extreme pain. He was seen in A&E then the urology assessment unit. A CT scan showed symptoms of renal colic, and a 2mm stone was observed. He also had a productive cough, for which antibiotics were prescribed.

4.204 Amir was discharged on paracetamol and diclofenac for pain, and it was planned to follow up with a repeat scan in two to three weeks to check the stone had passed.

4.205 On 2 May 2017 SW1 sent a further update to Dr R to complete and forward to the MoJ. There is no record of this report being sent.

4.206 CCO2 saw Amir at the team base on 25 May 2017. Amir was noted to be superficially pleasant, remarked that CCO1 had been much less formal and 'laid back' in his approach, that he doesn't need to be seen so regularly, and there was no need for joint meetings with SW1. It was suggested that he needed to see Dr R before his next MoJ report. He said he did not want or need to see Dr R. Amir showed no symptoms of psychosis, denied any stress or side effects from his medication, or any issues related to his mental health.

4.207 Amir told CCO2 that he had been taken to hospital in April in extreme pain and given morphine. He said he had a CT scan and was diagnosed with kidney stones, and advised they were moving, and to drink plenty of water. He expressed some concern that it was Ramadan soon and he would need to fast. He was aware he could be excused if needed because of his health but apparently planned to wait and see how he feels.

Amir's brother saw Sobhia on her last day. It was a fasting day and he went round to Amir's house to cut the grass. Sobhia brought him out a drink and he reassured her he was happy to help. He said that her headscarf was pulled right down so he could hardly see her face. Amir was out walking the dog, and returned at this point.

Amir's sister also saw her later that night after prayers, and said that Sobhia kept asking her to stay longer, but she had to leave to prepare food for her own family.

5 Arising issues, comment and analysis

5.1 The terms of reference for this element require us to:

- Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user
- Examine the discharge arrangement from the secure services and the follow up arrangements for his continuing care.
- Review and assess compliance with local policies, national guidance and relevant statutory obligation
- Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family
- Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway

5.2 In order to consider the issues in detail we have approached them by using these points to analyse Amir's care from each of the services involved.

5.3 We will include compliance with local policies, national guidance and relevant statutory obligations as part of our analysis.

Nottinghamshire NHS Foundation Trust

5.4 The initial focus of Amir's treatment at Wathwood from 2009 was on the treatment of his psychotic symptoms. While he was at Wathwood he was diagnosed with paranoid schizophrenia, and treated with antipsychotic medication.

5.5 After the court outcome in September 2009 he appeared more settled, and CBT was started to assist him in understanding and coping with symptoms of mental illness. His family were encouraged to attend meetings and be involved in his care. Amir's father attended CPA meetings regularly. This plan of care is in line with the expectations of the NICE guidance.[48]

5.6 Concerns arose about Amir's interactions with staff, he was presenting as though he had information about staff members, and appeared to try to ingratiate himself by buying food and drinks and trying to give away money. There was an impression amongst staff and patients that Amir was trying to generate favours by for example cooking for staff. He developed the view that he did not need to go to a low secure hospital as part of his rehabilitation. In reality it seemed that although he had been cooperative in psychology sessions, he found it extremely difficult to acknowledge negative aspects of himself, including anger.

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

5.7 Personality testing was started, and findings of these tests showed a complex pattern of personality features, including the presence of schizotypal personality traits. Amir was irritated with the questioning involved in these tests. It was made clear to him that there was a significant amount of psychological work to do to reduce the risk of reoffending.

5.8 His rehabilitation was managed appropriately slowly, with a transfer to a rehabilitation ward at Wathwood in April 2010, and escorted leave was applied for in September 2010.

5.9 The focus of treatment started to change after a multi-agency meeting in October 2010, which was planned take place before the First Tier Tribunal. Information was sought from the organisation supporting his first wife, the victim of the index offence. The Wathwood social worker made contact with the advocacy organisation and met his first wife.

5.10 This information was handled sensitively as was appropriate and discussed within the clinical team. It was felt important to share some of the detail provided by his first wife, which clearly indicated that there was violent and controlling behaviour in the marriage well before the index offence. This information led to a gradual reformulation of his presentation, risk assessment and treatment needs.

5.11 Amir denied that any of this was true. Further testing of risk was carried out, using a domestic violence risk assessment. Amir tended to deny feelings and incidents of anger and remained very defensive in these sessions. It was expected that he should work on these issues with psychology, but his level of denial made it impossible at this stage. It was decided instead to work on interpersonal relationships to try to prepare him for sexual offending work.

5.12 A social worker visited the family in Derby prior to escorted leave being arranged, to assess safety and contact with children. Derby Social Services however later decided not to allow any child contact that time.

5.13 Structured risk assessments were carried out using the HCR 20 v2 in January 2010, July 2010, January 2011, July 2011, January 2012, July 2012 and January 2013. The standard expectation of the NHCFT Wathwood procedure for clinical risk assessment[49] at the time was that the HCR 20 v2 should be completed every six months during admission. There is evidence that this was carried out as expected. The assessment of risk changed markedly over this time, noting from 2011 onwards that Amir had negative attitudes to women, there was violence and controlling behaviour from very early in the marriage. The recommendation was that future care could be at a low secure unit where SOTP was available.

5.14 The HCR 20 v2 risk assessments are presented as a numerical score, out of a total score of 38. The original guidance to professionals on assessing risk using the HCR 20 v2 was to encourage assessors to establish summary risk ratings of low, moderate, or high risk. It was not advised that numerical scores by

[49] *NHCFT procedure FO/W/50, assessment and management of clinical risk, January 2013.*

themselves were used as a measure of the likelihood of a risk occurring. This assessment has since been replaced by the revised version, HCR 20 v3.

5.15 The change in approach to his care planning and risk management is evident from 2012 onwards, and Amir became more questioning about plans for his future. It was made clear to him that he would need to move to a low secure environment that would be able to offer SOTP, and that Wathwood would not apply for unescorted leave in the meantime. The RC wrote to NHSE specialised commissioners to request funding for a low secure placement. Funding was agreed. Within the service specification there was no requirement to make an assessment,[50] but commissioners expected to be kept informed of the options and decisions made, and agreed to the final placement.

5.16 Amir became challenging about the details of his previous violence being reiterated at CPA and Tribunal reports. He refused to consider moving to the Kedleston unit in Derby, due to the 'stigma' attached to it, which is not explained. He refused other units which were in Yorkshire, Lancashire and Buckinghamshire on the grounds that they were too far away from his family. Cygnet Derby was identified as a possible placement, but at that time SOTP was only offered at the Derby unit on an individual basis.

5.17 It was considered that a group SOTP programme would be most beneficial because of his tendency to minimise risk and show himself in a positive light. It was arranged through Amir's solicitor that an independent psychology report was provided. This psychology report was used to apply pressure for the move to Derby.

5.18 Discharge to Cygnet Derby was planned with the involvement of the Cygnet unit, DHCFT, MAPPA and DPMU. The discharge summary included a comprehensive list of relevant documents, an up to date risk assessment, and third party information about the victim's perspective.

5.19 Dr Y had written to the MoJ outlining the treatment plan, and the transfer to Cygnet Derby under Section 37/41 MHA was agreed.

5.20 The internal management report (IMR) submitted to the DHR panel by NHCFT made no recommendations, which we accept.

[50] *NHS England service specification: low secure mental health services (Adult).* https://www.england.nhs.uk/publication/service-specification-low-secure-mental-health-services-adult/

Comment 1

The risk assessment and treatment plans at Wathwood were initially based around the premise that Amir had committed the index offence in the context of mental illness. It was noted that Amir was very keen to present himself in a positive light, and made attempts to subvert security, push boundaries and ingratiate himself with staff.

His family were invited to be part of CPA reviews and future planning, and his father regularly attended care planning meetings. Amir was encouraged to practice his faith as appropriate, and he was escorted to attend a local mosque

When information also emerged from the victim's perspective, further risk assessment and personality testing was completed and his treatment plans were revised accordingly.

When Amir was discharged from Wathwood there was a comprehensive risk formulation that clearly indicated that while he was seen as suffering from a psychotic illness, there were aspects of his personality that indicated a high risk of violence to women, in particular if he was in a relationship.

A Section 117 meeting was held at Wathwood in July 2013, involving all relevant parties. Discharge was planned in a structured way, with extensive information sharing and joint planning.

Finding 1

Care provided at Wathwood was planned with the involvement of Amir and his family, and was sensitive to his cultural needs, which is good practice.

Risk assessment and management plans were adjusted as new information emerged, and were clearly communicated to all other parties in the discharge decision making in July 2013.

The involvement of victim advocacy service and the gathering of the victim's perspective is an example of good practice.

Cygnet Health Care, Derby (Cygnet)

5.21 Amir was discharged from Wathwood, but his Section 37/41 was transferred to Cygnet Derby, who then had sole responsibility for his treatment and risk management. The expectation was that future care would be planned in conjunction with the MoJ, DHCFT and the DPMU. Good practice also suggested that Amir's family should be part of future plans.

5.22 At this time Amir was authorised to have escorted leave only, at the RC's discretion. The MoJ would have to formally authorise any increase in leave or relaxing of conditions in advance. The RC would be expected to send regular reports, and apply in writing for any change to conditions.

5.23 The placement at Cygnet Derby was agreed by clinicians and commissioners on the premise that SOTP would be part of the treatment programme. Psychological testing showed he continued to try to portray himself in a positive light, and he took part in psychological therapy programmes aimed at regulating emotions and managing stress. His primary diagnosis remained as paranoid schizophrenia.

5.24 A risk assessment for domestic violence showed some reduction in risk, but the HCR 20 V3 which was completed in August 2013 showed that he did not have a good understanding of the risk factors that led to the violence towards his first wife. It was recommended that risk assessment should be reviewed if he were to decrease compliance with medication and treatment, his mental health deteriorated, or if he formed a new relationship.

5.25 A 'FACE' risk assessment was completed in January 2014, with 'risk of violence to others' rated as 'low risk'. In this assessment children were not identified as at risk. He was not at the time allowed access to children, including his own children. In our view this risk was rated as too low, given the identified risk to women if he were to develop a new relationship. There had been no assessment of his risk to children at this stage, and in our view this should not have been downgraded without further assessment.

5.26 In March 2014 he told the care team that he was offered a 'job' with the CQC. The clinical notes suggest that the care team discouraged him from partaking in this 'job' but there are no records of this being discussed with the CQC. However we have clarified with the CQC that Amir did express an interest in joining a service user reference panel, for which he would have received some payment.[51] The CQC have informed us that a request was made by them to Dr M, which asked if it would be appropriate for Amir to attend meetings. The CQC have records of Dr M's response, which advised that he would not be granted leave to attend any CQC meetings. This seems to us the appropriate response, but it should have been documented in his clinical records.

5.27 A pattern of pushing boundaries began to emerge, with a notable example being manipulating a situation to persuade an experienced female staff member to get into his brother's car whilst on escorted leave, which was not authorised. Amir was angry about the subsequent suspending of his leave, suggesting that other staff had done similar things and had kept this quiet. He implied his brother could prove his version of events because he had recording equipment in the care.

5.28 He also maintained that it was not necessary to inform victim liaison if he was to be in the Derby area, because his first wife did not have relatives in Derby. It appears this was not checked but was later found not to be true.

5.29 The escorted leave was reinstated in May 2014, after successful leaves with a male escort initially, then a male or female escort. There is a note that 'a line be drawn under the investigation' and it was agreed that Dr M would then write to the MoJ to request unescorted leave locally. In our view there should have been more in-depth discussion about the breach of his leave conditions, the manipulation of

[51] *CQC January 2014 'Putting people first' Payments and reimbursement policy for people who are involved in the work of the Care Quality Commission.*

the staff member, and the involvement of his family in this situation. We believe this should have been incorporated into a revised risk assessment at this stage.

5.30 It is also our view that it was premature to apply to the MoJ for unescorted leave until this issue was explored in more depth. Dr M applied to the MoJ for unescorted day leave in May 2014. Within this application it is stated that there was '*a misunderstanding regarding him meeting his brother on leave'*. It was stated that this had been clarified with Amir and he agreed that this can only be done through agreement with the MDT in future. The request was for 30 minutes three time a week initially, gradually increasing up to six hours four to five times daily.[52]

5.31 We are concerned that the characterisation of a *'misunderstanding'* does not adequately represent the perspective of the staff member in the situation with Amir and his brother, and her concerns about their successful breaching of boundaries and conditions. There is also no mention of Amir's angry response to being challenged about the situation, and his allegations that other staff have done similar things and said nothing.

5.32 In our view applying to the MoJ to relax conditions, and increasing reliance on trusting Amir to keep to boundaries when he had more freedom, was misguided at this stage.

5.33 The MoJ agreed to the unescorted leave at the RC's discretion on 27 May 2014 with the proviso that 'the granting of this leave involves no undue risk to the patient or to others'. While this is within the bounds of what the MoJ can agree, we consider that there could have been a defined number of leaves granted, with the expectation of feeding back, if the Cygnet information had been more descriptive.

5.34 Appropriate assessments were carried out to assess whether Amir could have access to children at the family house, in conjunction with social services. It was agreed he could have supervised access only to the children of family members whilst visiting family. Family meetings were arranged to gather his parents' perspective, which was good practice. At this time Amir's father's health deteriorated, and Amir showed some signs of stress and worry about this.

5.35 Further examples of boundary breaches were recorded in the clinical notes. In July 2014 he was found with a smartphone on the ward, which was prohibited by unit policy. In August 2014 Dr M requested overnight unescorted leave to Amir's parents' address, stating that he was appropriate in his interactions with staff and peers, and was compliant with his treatment plan. There is no mention of the smart phone.

5.36 In September 2014 a card with the writing *'to the man I love'* was found during a 'pat down' search. There is no record that either of these events were investigated in any detail, or discussed by the MDT. This card could be seen as emerging evidence that Amir was starting, or already involved in, a relationship. The risk

[52] *We have assumed that this was intended to read 'four to five times weekly' rather than 'daily'. The MoJ response appears to treat it as such.*

assessments up to this stage are very clear that his risks should be reassessed if he starts a relationship, and that he is likely to present a high risk of harm to a woman in a new relationship.

5.37 We consider that there should have been a detailed review of this issue, and that the lack of examination of this was a missed opportunity to investigate a possible relationship. A further breach of conditions occurred when his sister arrived to collect him from Cygnet, and he brought his nephew into the unit reception to use the toilet, while his sister waited in the car. He was reminded again that he should not be alone with any children, his excuse was that his sister was outside in the car.

5.38 The disclosure that Amir was having a sexual relationship with the Cygnet staff member HCA Y was made by her in October 2014. The subsequent investigation ended in a disciplinary hearing where HCA Y was dismissed. There was limited information shared with the wider clinical team, and little evidence of any MDT discussion about this relationship. The disciplinary investigation noted that there was abusive, controlling and violent behaviour alleged by the staff member. This included installing tracker software on her phone, smashing her phone, threatening to have her followed and watched, and pushing her head against a table in a café. It was evident that HCA Y was frightened of Amir, and she said this was her reason for the disclosure. Of note was that it was documented that Amir's mental state had not deteriorated, and he was deemed to have capacity to discuss the allegations.

5.39 Clinical records show that information about the relationship was shared with partners and the MoJ, but there is no evidence that the allegations of abusive and controlling behaviour were shared, or that his risk assessment was updated to include these recent elements.

5.40 The Cygnet internal IMR noted that at the time of the disclosure in October 2014, Cygnet Health Care did not have a formal policy in place regarding the management of allegations against professionals (AAP). One of the consequences of this was that the investigation was managed locally, without oversight by Cygnet senior management or safety committee. This is something that given the same set of circumstances, would now be managed differently as there is a corporate AAP policy which was introduced in October 2017.

5.41 The relationship was appropriately reported as a safeguarding issue to the local authority, and there was a subsequent police investigation. His Section 17 leave was suspended, and it was noted that the '*issues were reported to the MoJ*'.

5.42 We have seen the letter sent on 10 November 2014 to the MoJ, summarising the issues and the subsequent actions taken. This report places all responsibility on HCA Y, and emphasises the view that he was vulnerable and had been manipulated. There is no mention of her allegations that he was threatening, controlling and aggressive to her. In our view this issue was not reported to the MoJ in sufficient detail.

5.43 The MoJ responded in November 2014, stating that the clinical team appear to have dealt with the situation, and it could be seen as '*an extreme form of*

boundary pushing'. It was noted that there appeared to be no deterioration of his mental state, and '*revocation of his leave may seem punitive'*.

5.44 There is mention of concerns raised by MAPPA in February 2015 about the address at which he would be spending overnight leaves, because it was believed that his sister and her children were living with his parents at the time. It was felt he would be better to spend time at his own house, since that was where he would be living in the future.

5.45 It is not clear from the clinical records whether the MoJ or Cygnet had considered that the proposed discharge address was the site of his index offence. This information would have been known through MAPPA meetings, and we would have expected this to be discussed as having a potential impact on his mental state. Discharge plans were made along with the Derby City social supervisor SW1, and the DHCFT care coordinator, CCO1.

5.46 Overnight leaves were agreed in March 2015 for two nights, to then return to the ward, and then a further three nights. Amir breached the conditions by taking two lots of three nights, making it six nights consecutively off the ward. We could not find any evidence that this breach was conveyed to the MoJ.

5.47 He also neglected to tell the clinical team that his parents had travelled to Pakistan in June 2015, meaning he was alone in the house for the previous 10 days. In the three-month update report to the MoJ which was requested on 30 June, it was not mentioned that he had been using too many night leaves, that he had not told the team his parents had gone to Pakistan, or that he was too anxious to go out at times and had mentioned he heard his father's voice. The report does say that there were concerns about him being overcautious to leave home and limiting his interactions with friends.

5.48 The report does not say that the potential discharge address was known to be in a state of disrepair, needing a complete redecoration. In our view these are omissions of information that the MoJ should have been provided with, and may have impacted on decisions to discharge him.

5.49 The guidance for completion of leave application documents in place at the time[53] required the RC to indicate compliance with treatment, attendance at therapeutic activities, assessment of risk to victims and others, and risk of absconding. The assessment of risk to the victim was described, along with contingency plans and work with MAPPA on plans for possible conditional discharge. In our view there was insufficient detail provided to the MoJ in the period prior to his conditional discharge.

5.50 The most recent risk assessment in January 2015 present an in-depth analysis of his risk, and clear mitigation plans are proposed.

5.51 The family were seen as part of risk assessment and discharge planning in January 2015. The MoJ had particularly requested that Amir's mother be seen separately to ascertain her views, particularly about how she would cope with

[53] *Leave applications for restricted patients (04.09) Ministry of Justice*

Amir if his father passed away. Amir's mother's native language is Urdu, and she did not speak much English. These were carried out with the aid of an interpreter, and clearly documented.

5.52 Plans were made along with the DHCFT care coordinator, CCO1. The social worker who was later identified as the Derby City social supervisor (SW1) was contacted by Cygnet to inform her of the conditional discharge, and that she had been identified as the social supervisor. The MoJ guidance requires the social supervisor and the clinical supervisor to attend the hospital in advance of discharge, and to attend the discharge planning meeting.

5.53 These arrangements should have been established by Cygnet well in advance of the discharge meeting.

Comment 2

Information was clearly conveyed from Wathwood about Amir's risk issues and the high potential for him to be a risk to females in a relationship.

We were concerned to hear him described to us at interview by Cygnet senior clinicians as a "*perfect patient"* who "*had not put a foot wrong*", apart from the relationship with the HCA. This perspective is not supported by the clinical records, which as described above contain many instances of boundary pushing and breaches of conditions.

When the relationship was disclosed by the HCA, she was seen as the instigator, and the presenting behaviours described by her were not incorporated into Amir's risk assessment. The fact that this controlling behaviour was present without a deterioration in his mental state was not given sufficient recognition.

The assessments and reports completed by psychology regarding his presentation and potential future risk show a very clear formulation, which was that he was potentially vulnerable to outside stressors especially within the family, and the risk to females in a relationship remained. It was stressed that these risks were not necessarily related to mental illness. This perspective does not appear to have been applied to day to day clinical practice.

Finding 2

Care provided at Cygnet Derby was planned in conjunction with partner agencies and plans for conditional discharge were developed with the awareness of MAPPA, DPMU, DHCFT, Derby City Council and the MoJ as would be expected. There was no communication with the GP practice, however.

In our view these plans lacked detail and were not given sufficient preparation time to ensure that detailed plans were in place.

We consider that the information that was provided to the MoJ to support the conditional discharge lacked relevant detail and the nuanced feedback that would be important in managing risk. The involvement of the victim advocacy service and the gathering of the victim's perspective is an example of good practice, as was the involvement of his family in planning.

In our view the subsequent conditional discharge care plan was not sufficiently detailed or robust enough to manage the considerable risk identified and was prepared without the direct involvement of the DHCFT clinical and social supervisors.

Recommendation 1

Cygnet Health Care must ensure that all risk management information is included in care planning.

Recommendation 2

Cygnet Health Care must ensure that all of the expected standards are met when arranging conditional discharges for patients on Section 37/41 to include communication with the local GP.

Derbyshire Healthcare NHS Foundation Trust

5.54 DHCFT staff had been involved in Amir's care since 2011, as the health service who had ultimate responsibility for his care. DHCFT has no medium secure beds within their services, and the usual arrangements are to access a bed provided by one of the NHCFT units, in this case Wathwood.

5.55 Attendance at CPA reviews was initially by the criminal justice liaison team, and latterly a care coordinator was allocated in the Derby recovery team. DHCFT was not commissioned to provide a community forensic mental health team. Patients who were moving on from low secure conditions were at that time referred directly to generic DCRTs. A 'virtual forensic team' had evolved, made up of a part time forensic psychiatrist, part time forensic psychologist, and two CPNs who had a specific interest in working with forensic patients. These two CPNs tended to take patients onto their caseload, and the responsible clinician would therefore be the community consultant psychiatrist.

5.56 The consultant forensic psychiatrist assessed patients referred for forensic care, and the forensic psychologist attended MAPPA meetings, and provided short term focussed work. Given his risk profile and history, it would have been helpful to have a forensic opinion, but Amir was not referred to either of the forensic clinicians.

5.57 In order to agree a conditional discharge, the MOJ requires a social supervisor (SS) and a clinical supervisor (CS) to be appointed. The community consultant psychiatrist Dr R was identified as the CS, who did not have capacity to attend the Section 117 discharge meeting at Cygnet. MoJ guidance[54] requires that the SS and CS should attend the pre-discharge meeting[55] and also meet with each other.

[54] *Guidance for social supervisors, MoJ 2009.*

[55] *Guidance for clinical supervisors, MoJ 2009.*

The meeting was in fact attended only by CCO1 for DHCFT, and the SS had not met the CS, which does not comply with MoJ guidance.

5.58 We are concerned that the care plan placed an over-reliance on self-disclosure, with the expectation that Amir would volunteer any issues of concern. There was a disproportionate emphasis on the presence or absence of mental illness symptoms, and in our view insufficient regard given to the risk entailed in potential controlling or coercive behaviour. It was known that he was to be discharged to his own address, which not only was the site of his index offence but required completely redecorating.

5.59 The practical issues involved in redecorating a property are, in our view, beyond what should be expected when Amir was moving into the community and living independently for the first time since 2008.

5.60 CPA reviews were planned at the 'usual' intervals for the DCRT, which was annually. In this case good practice would suggest that there should have been reviews at least six monthly, and potentially an initial review after three months.

5.61 The CPA policy in effect at the time[56] states that 'it is particularly important to review the implementation of the care plan within the first month of discharge from hospital', and that the care team should agree which issues will trigger an emergency review. The threshold for recall does not appear to have been discussed at the discharge planning meeting, and there was no contingency plan to be used in the event of a relapse.

5.62 At a MAPPA meeting in October 2015 his level was reduced from level 2 to level 1, after 'a lengthy debate'. This was attended by CCO1 for DHCFT and SW1 for Derby City Council. The rationale was that there was good communication between police and mental health services, and is open communication between Derbyshire Police and the Police Domestic Violence Unit in the relevant area . The meeting noted that *'if [Amir] fails to engage with his medication and mental health team he will be recalled'*. In fact the guidance just asks that the social supervisor and clinical supervisor review the care and placement, to come to a decision. It is the MoJ only who make the decision to recall.

5.63 This is not an accurate statement. Amir had conditions of discharge, but these were not necessarily the basis for recall. The MoJ guidance for social supervisors states that:

> *'Supervisors must understand that conditions are designed to operate for the protection of the discharged patient and others and to enable the patient's safe management in the community. They are not measures for social control, or even for crime prevention. Breach of conditions does not, in itself, justify recall to hospital, but it should act as a trigger for considering what action is necessary in response'.*

[56] *DHCFT Care Programme Approach and Care Standards Policy and procedures, October 2009.*

5.64 The MoJ guidance (2009)[57] on the recall of conditionally discharged patients states that:

> *'Mental Health Casework Section's policy is that patients will be recalled where it is necessary to protect the public from the actual or potential risk posed by that patient and that risk is linked to the patient's mental disorder. It is not possible to specify all the circumstances when recall will be appropriate but public safety will always be the most important factor'. 'Non-compliance with medication will lead to consideration of recall. Whether recall is indicated will, of course, turn on the circumstances of the particular case'.*

5.65 The guidance was revised in 2017,[58] and states that:

> *'These patients can be recalled to hospital by the Secretary of State if they need to be detained for treatment (including where the patient is thought to pose a risk to themselves or others as a result of their mental disorder). A conditionally discharged patient cannot be recalled simply for breaching their conditions, unless the breach enables the Secretary of State to form a proper judgment that the statutory criteria for detention are established or where there is evidence to indicate that an urgent recall for assessment is required'.*

5.66 It is clear from this guidance that recall to hospital is made after a considered decision made by the MoJ, ideally in conjunction with clinical and social supervisor and other clinicians. It is not an automatic consequence of not cooperating, as is suggested by the statement above at paragraph 5.62.

5.67 The internal DHCFT report questions whether reducing to level 1 so soon after discharge was reasonable, because '*risks had not yet been tested within the community, and the transition from hospital to community appears to have been underestimated*'. We concur with this concern and agree with this formulation, and also that it would have been prudent to test out some of the protective structures around Amir's care, such as working relationships between DPMU, CCO1, SW1 and Dr R. Furthermore, Amir had been in Pakistan for a month of this period of time, from 25 August to 29 September, with only weekly telephone contact with CCO1.

5.68 When Amir returned from Pakistan, there was no detailed exploration of his mental state, mood, or experiences whilst away. We would have expected to see an in-depth review of his mental state, an exploration of how he felt having spent that much time with his family, especially around his father who was apparently very ill. We found a lack of appreciation around how different his experiences would be of staying with family in a rural village in Pakistan, compared to living in either a hospital or family home. Amir had only left hospital in mid-July 2015 and this should have been seen as significant event that would test his coping mechanisms.

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[57] *The recall of conditionally discharged restricted patients, MoJ 2009.*

[58] *Mentally disordered offenders – the restricted patient system MoJ/HMPPS 2017.*

5.69 Dr R met Amir for the first time in October 2015, and he noted that '*the risk was significantly low because he was now stable, considering that his index offence was influenced by mental illness*.' This was not an accurate representation of the history, where it is clearly indicated that the risk of harm to women in particular was not directly related to a decline in his mental state.

5.70 The internal report also noted that that the transition from inpatient to community, and low secure forensic service to a generic mental health community service happened simultaneously. Amir should have ideally been transferred to a community forensic team initially, in order to provide more focussed risk management. However, DHCFT did not have a commissioned forensic team at that time, and it was not unusual for patients who would be expected to receive the more intense oversight of a forensic team to be allocated to generic team. Furthermore the generic teams were not able to exercise a choice over whether he was discharged to their care.

5.71 Dr R told us that he did not have any extra resources to attend the relevant meetings, review records in-depth, and provide increased outpatient and CPA reviews. The majority of patients on the generic caseload would have yearly CPA reviews, with outpatient appointments only arranged if the care coordinator requested them. In the absence of a commissioned forensic service there was no operational guidance that the DCRT clinicians could reference to inform their practice.

5.72 Equally there was no opportunity to review the MoJ guidance for clinical[59] and supervisors for conditionally discharged patients, or to access clinical supervision in relation to working with risk. The guidance '*strongly recommends that the supervision of restricted patients in the community should be undertaken by professionals who are of consultant grade or equivalent and who have experience of the care and treatment of forensic patients'*. This guidance sets out the role and responsibilities of the clinical supervisor, and is clear in that 'the clinical supervisor is responsible for all matters relating to the mental health of the patient, including regular assessment of the patient's condition, monitoring any necessary medication and its effects and consideration of action in the event of deterioration in the patient's mental state'.

5.73 These expectations were not met by the clinical supervisor, and the internal report highlights that there was an over-reliance on monitoring mental illness with the expectations that Amir would disclose changes in his mental health, and any development in relationships.

5.74 The plans to return to Pakistan in October 2015 can be seen as a further pushing of boundaries. It was agreed with the MoJ that he would go for six weeks, on compassionate grounds. Amir booked a four-month trip without any discussion with clinicians, and the MoJ when asked clarified that they did not in fact have legal powers to prevent him from leaving the country. Amir did call every week as arranged, and informed the clinical team that his father passed away on 1 January 2016. Although the team had no way of knowing this, it appears that his father

[59] *Guidance for clinical supervisors, MoJ 2009.*

passed away on 26 December 2015, and Amir told his GP the date was 26 December 2015.

5.75 On his return to the UK in January 2016 there was again no detailed discussion of his experiences and mental state. It is clear from the risk assessment that family stress was known to be a factor that could increase risk, but this was not explored. He stated that he planned to return to Pakistan in March for funeral prayers, but this was not explored with him. CCO 2 saw him every two weeks, at times jointly with SW1. The notes made by CCO1 continued to be minimal brief notes of contact, with no exploration of mental state or risk indicators.

5.76 Amir went to Pakistan again in December 2016, and on his return in January 2017 he was asked about his experiences and mental state in detail. CCO2 tried to explore the family's current living arrangements, including which family members lived at his mother's address. This was good practice, attempting to explore the situation with regard to the family safeguarding issue, as well as Amir's own mental state. It was noted that he was very avoidant of discussing any detail. He was asked outright if he was planning a relationship, which he denied.

5.77 The unannounced visit to his home on 2 March 2017 was an attempt to explore any evidence of a woman living in his house. Unfortunately he was not there, and arranged for staff to return a while later. CCO2 and the DPMU staff member spent time in the house with Amir and his sisters, and the bathroom was viewed. There was no evidence, and in fact it is now known that Sobhia was not living there at that time.

5.78 Amir was seen by CCO2 at the team base in the week before the murder, and is clear that in her opinion, there were no changes in his mental state, and no signs of psychosis.

Comment 3

The care plan on conditional discharge was not sufficiently detailed or robust to safely and effectively manage the risks identified.

The standards of contact and reporting by the clinical supervisor were not met, and the records of contact by the care coordinator up to November 2016 were brief and superficial.

There was a lack of curiosity about Amir's living arrangements, mental state and occupation up until November 2016. We found an over-reliance on historical information that the family would keep the clinical team informed of any concerns.

Good communication was evident between the partner agencies, however key information about potential risk was not conveyed in appropriate detail to the MoJ in early 2017.

We have been provided with draft documents proposing a community forensic team in Derby, but have not seen the final service specification or start date.

Finding 3

Amir was allocated to the caseload of a generic community mental health team which lacked the knowledge and resources to adequately supervise his care and manage risk.

Recommendation 3

Because of the lessons learned from this independent investigation the commissioning and development of the Derbyshire Healthcare NHS Foundation Trust Forensic Team should include:

- effective supervision structures
- audit of family contacts
- quality standards for MoJ reporting

Derby City Council

5.79 SW1 had been allocated as his social worker in 2014, and was expected to asses his social care needs on return to Derby. As discussed above the planning for conditional discharge at Cygnet did not formally identify the social supervisor prior to discharge. The communication from Cygnet to SW1 implied that it had been formally agreed, when it had not in fact been finalised.

5.80 SW1 was at the time based in the same team base as CCO1 (and later CCO2) and Dr R, therefore contact and regular communication was easily facilitated.

5.81 SW1 maintained contact and made regular joint visits to Amir with both CCO1 and CCO2. When CCO1 was due to retire, SW1 asked if an experienced male CCO could be allocated, but this was not achieved. Visits to Amir by SW1 increased in frequency to monthly to allow CCO2 to be accompanied at all times.

5.82 The Trust and Local Authority provided an integrated mental health service until 2016, meaning that systems such as electronic notes, electronic reporting systems and emails were no longer shared. An effect of this change meant that SW1 was not automatically informed of meetings that were arranged, such as outpatient appointments with Dr R. The electronic records also became separate, so practitioners from DHCFT could not see the notes made by the SS, and vice versa.

5.83 Regular meetings with the DCRT to discuss patient care and concerns were no longer possible, due to the structure of the DCRTs. DCRTs were structured around GP practice areas, where the City Council team were geographically based across electoral awards.

5.84 The duty of a social supervisor was to provide three monthly reports to the MoJ, which was done in a timely way. After his conditional discharge separate reports were sent by the SS and CS individually. In 2016 the MoJ changed the structure of these reports to a combined SS and CS report. SW1 then began the practice of completing their part of the report, then sending on to Dr R for it to be completed and sent to the MoJ.

5.85 SW1 did not always receive confirmation that they had been sent on, nor did they receive a copy of the completed report. This system meant that there was no opportunity for discussion or a shared view on the final report. The MoJ guidance is clear that each should provide a copy to the other.

5.86 Following the family safeguarding issue SW1 attended the meetings alongside CCO2 and other partner agencies. At the follow up meeting in early April 2017, mental health information was fed back. Actions from this meeting were to develop a family tree and complete a further risk assessment, these were done with CCO2. No further actions were expected from the joint agency meeting.

Comment 4

The role of social supervisor was carried out appropriately and information was conveyed to the MoJ via regular timely reporting.

Communications between health and local authority teams became challenging when the integrated service ended.

Finding 4

Changes in structures and systems between DHCFT and Derby City Council limited communication about details of treatment and care.

Recommendation 4

The operational policy for the Derbyshire Healthcare NHS Foundation Trust Forensic team must include clarity about roles, responsibilities and communication between Derby City Council and Derbyshire Healthcare NHS Foundation Trust when caring for a patient who is conditionally discharged from Section 37/41 MHA.

Derby Family Medical Centre

5.87 Amir had brief contact with the GP practice in Derby, where he registered in November 2014.

5.88 The GP Adult Safeguarding Lead for the practice has asked if there is sufficient information sharing around MAPPA. They were not aware of the index offence for which the perpetrator had been detained on Section 37/41. As this had been for a violent offence they question whether they should have been informed. Amir attended the GP practice in March 2015 and gave a highly sanitised version of his history.

5.89 There are no letters from Cygnet in the GP records advising of clinical information and impending discharge. An administration letter was sent by Cygnet to the GP on 29 July 2015 (after his conditional discharge) to inform them of his medication prescriptions.

5.90 DHCFT sent regular letters to the GP practice about progress, however these were progress letters and did not contain any history, or copies of risk assessments.

5.91 After the discharge the prescriptions for risperidone were provided by the practice and collected regularly by Amir.

Comment 5

It was known by mental health services that Amir had a number of physical health issues and was prone to somatisation when under stress. Cygnet did not communicate with the GP practice about progress, and this limited the practices ability to consider risk and safeguarding issues.

Finding 5

The GP practice did not have any contextual information about Amir.

Primary care were not seen as partners in the overall plan of multi-agency care.

Recommendation 5

NHS Derby and Derbyshire Clinical Commissioning Group must ensure that there is primary care involvement in the MAPPA process for appropriate individuals.

NHS England specialised commissioners

5.92 We have reviewed the service specification for the stepping down of patients from conditions of medium to low secure.

5.93 Within the service specification there was no requirement to make an assessment, but commissioners are expected to be kept informed of the options and decisions made, and agreed to the final placement.

5.94 We have discussed this case with NHS England and it was clarified that there would always be a gate keeping assessment if a patient required a higher level of security. Each patient has a case manager from NHS England who attends meetings, receives reports and meets the patient during their treatment. There had been communication and reports sent regularly by the respective clinical teams, and commissioners were aware of plans for Amir and comfortable with them.

5.95 The case manager was invited to an MDT meeting at Cygnet after the relationship with the HCA was disclosed, and was part of discussion about future plans and risk management.

Comment 6

NHS England specialised commissioners were kept informed at all stages of Amir's progress through treatment and levels of security, and provided opinions on appropriate low secure environments. They were appropriately informed and involved in discussions regarding the safeguarding incident at Cygnet.

Finding 6

The input provided by NHE England specialised commissioners was within expected policy and practice.

Ministry of Justice

5.96 There is extensive guidance for clinicians about the responsibilities and expectations of clinical teams when treating a patient on Section 37/41 MHA.[60] The MoJ relies on information conveyed by clinical teams about the progress of each patient. During Amir's time at Wathwood and Cygnet, the responsibility for reporting to the MoJ was held by the consultant psychiatrists (responsible clinician or RC) in charge of his care. RC's must provide the Secretary of State with an annual report detailing the patient's progress. The requirement for an annual report applies to detained patients only. For discharged patients in the community, care teams are asked for a quarterly report. At the time, separate reports were required from the RC and Social Supervisor but this changed shortly before the offence to a combined report.

5.97 Applications for leave outside of the hospital can only be granted by the MoJ. Escorted leave was applied for and agreed in September 2010, in the general area around Wathwood, this was extended to include escorted visits to family in Derby in 2012. These decisions were appropriately based on reports from the Wathwood RC.

5.98 Plans for discharge were proposed to the MoJ, with the support of NHS England specialised commissioners. The MoJ agreed to the discharge from Wathwood, which involved transferring his Section 37/41 to Cygnet. On admission to Cygnet, Amir had escorted leave only, and used this with staff in the Derby area.

5.99 Escorted leave was agreed by the MoJ, but given at the discretion of the RC Dr M, and there was an example of this being suspended in May 2014 when he got into his brother's car after using coercion. This was reported to the MoJ, but in our view the report lacked detail about the degree of boundary pushing. The MoJ accepted Dr M's report and did not formally rescind escorted leave. We have

[60] *Mentally disordered offenders – the restricted patient system Background Briefing. Dec 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/670671/RP_Background_Brief_v1_Dec_2017.pdf*

discussed the degree of detail lacking in the reports to the MoJ in paragraphs 5.29 to 5.53 and finding 2.

5.100 The conditional discharge was planned to take place in July 2013. A Section 37/41 MHA conditional discharge means that the restrictions continue to apply, including monitoring by the MoJ which includes the power to recall the patient to hospital if his or her mental health requires the patient to be detained for treatment including where the patient is thought to present an increased risk to the public, or a risk to themselves.

5.101 The Mental Health Casework Section's policy on recall[61] is that

'patients will be recalled where it is necessary to protect the public from the actual or potential risk posed by that patient and that risk is linked to the patient's mental disorder. It is not possible to specify all the circumstances when recall will be appropriate but public safety will always be the most important factor. The community team should have agreed and recorded a threshold for recall of the patient to hospital'.

5.102 A conditionally discharged patient cannot be recalled simply for breaching their conditions, unless the breach enables the Secretary of State to form a proper judgment that the statutory criteria for detention are established or where there is evidence to indicate that an urgent recall for assessment is required. According to the guidance: 'It is not possible to specify all the circumstances in which the Secretary of State may decide to exercise his power under section 42(3) of the Mental Health Act to recall to hospital a conditionally discharged patient, but in considering the recall of a patient he will always have regard to the safety of the public. An immediate report to the Ministry of Justice must always be made in a case in which:

- there appears to be an actual or potential risk to the public;
- contact with the patient is lost or the patient is unwilling to co-operate with supervision;
- the patient is admitted to hospital for any reason;
- the patient's behaviour or condition suggest a need for further in-patient treatment in hospital;
- the patient is accused of, charged with, or convicted of a serious offence or an offence similar to the index offence; and/or
- the patient's relatives or carers have expressed concern about the patient's behaviour or condition.

[61] *The recall of conditionally discharged restricted patients. MoJ 2009*

5.103 After a conditional discharge, there is clear guidance for the clinical supervisor[62] and social supervisor[63] regarding the responsibilities for supervision and reporting.

5.104 The information reviewed as part of this independent investigation has identified areas where the information provided to the MoJ lacked detail, or was not based on the appropriate standards of supervision.

5.105 Clearly the MoJ can only act on information that is provided, and it is expected that clinical teams would provide timely accurate information.

5.106 After the conditional discharge however, the reports were not always timely, or reflective of the expected standards of supervision. It appears that the MoJ does not have systems that can scrutinise the reports to ensure they have met the expected standards. All reports are scrutinised by officials for points of concern (rather than accuracy) focussing on any changes to the patient's mental disorder which may require MoJ intervention. The only powers under the MHA 1983 retained by the Secretary of State, are to amend the (non-statutory) conditions of discharge or to recall the patient back to hospital under S42(3).[64]

5.107 The MoJ relies wholly upon the information provided and generally does not seek to verify it for accuracy. We were informed by the MoJ that if they receive a report which seems lacking in detail (or simply repeats information given in previous reports) they would raise this with the originator.

5.108 Similarly, if information was received from another source, if required they would draw this to the attention of the RC and/or Social Supervisor; unless it was of a nature where we would alert other criminal justice agencies directly as well. The MoJ informed us that although this is not a formal 'system' as such, officials are advised to raise any concerns as above.

[62] *Guidance for clinical supervisors. MoJ 2009*

[63] *Guidance for social supervisors. MoJ 2009*

[64] *Section 42(3) Powers of Secretary of State in respect of patients subject to restriction orders. The Secretary of State may at any time during the continuance in force of a restriction order in respect of a patient who has been conditionally discharged under subsection (2) above by warrant recall the patient to such hospital as may be specified in the warrant. http://www.legislation.gov.uk/ukpga/1983/20/section/42*

Comment 7

The MoJ was involved in decision making about placements and apprised of progress. The MoJ received requests for leave and transfer. These accurately reflect available information in the clinical records while in Wathwood appropriately up to 2013.

However, information about his progress through increased freedom at Cygnet in 2014 and 2015 was not conveyed in appropriate detail.

The information regarding the relationship with the staff member was not balanced, and contained no information about his coercive and controlling behaviour.

The information conveyed by Cygnet to the MoJ did not always reflect sufficient clinical detail.

Reports made during 2015 and 2017 did not always meet the expected standards.

Finding 7

The MoJ does not appear to have a system to identify when reports are not submitted to the required expectations.

Systems in Cygnet and DHCFT did not ensure that MOJ reports were submitted to expected standards.

Recommendation 6

Cygnet Health Care must ensure that standards for reporting to the Ministry of Justice regarding progress of conditional discharged patients are maintained.

Recommendation 7

Derbyshire Healthcare NHS Foundation Trust must ensure that standards for reporting to the Ministry of Justice regarding progress of conditional discharged patients are maintained.

Cultural issues

5.109 The family are of Pakistani Muslim heritage. The family's heritage does not feature in needs assessments and care plans. Neither is it addressed in the Trust's internal investigation.

5.110 There is a wealth of research going back a number of years that addresses the issue of cultural sensitivity in healthcare. Personalisation in health and social care also puts race and ethnicity as a key issue to be addressed.

5.111 According to NICE Guidance: *'personalisation potentially offers people from black and minority ethnic groups the opportunity to arrange services that fit better with their ethnic, cultural, religious values and preferences'.* [65]

5.112 NHS Choices provides a link to a CPA Factsheet, which states:

'Your age, disability, gender, sexual orientation, race and ethnicity and religious beliefs should be thought about as part of your assessment, care plan and review'.

5.113 The Trust's own Core Care Standards and Care Programme Approach Policy and Procedure (July 2015) states that the care plan must include:

'Any needs relating to REGARDS (race and culture, economic disadvantage, gender, age, religion/spirituality, disability or sexuality)'(p10)

and that lead professionals and care coordinators should:

'*Make sure that their needs in respect of gender, age, ethnicity, sexuality, culture, language, and religion taken into account in the provision of services'*.(p21)

5.114 Amir's family have asked us whether the DCRT should have approached them directly to ask about his presentation and progress. We consider that there should have been a regular approach to the family to obtain collateral information. There were previous approaches to the family by Wathwood and Cygnet, and family were invited to CPA reviews.

5.115 While he was at Cygnet an assessment of his mother's potential vulnerability was carried out at the request of the MoJ, before he could stay at his parents' house overnight. His mother and sisters met with the Cygnet clinical team, and a member of staff acted as interpreter because his mother was not confident communicating in English.

5.116 The DCRT made contact with family members and tried to engage his sisters. However shortly after his conditional discharge, Amir spent long periods in Pakistan and was not engaged with the team.

5.117 It appears that there was a definite change in family dynamics after Amir's father died, and he became the head of the family. We consider that there was a lack of understanding of how this may affect family relationships and Amir's perception of his role.

5.118 The DCRT were aware that family members had made verbal and written commitments to let the team know if he was not taking his medication, or was developing a relationship. In our view there was an unrealistic expectation that the

[65] *National Institute for Clinical Excellence 2014.Personalisation for People from Black and Minority Ethnic Groups. Better Health Briefing (number 34)*

family would tell the clinical team about his developing a relationship or not taking medication. His sisters and brother told us that they asked him about both of these issues, and were told aggressively that they should mind their own business, and he had told people what they needed to know.

5.119 In this context the expectation that family would tell professionals was unrealistic, and did not give adequate consideration to the perspective of family members. His sisters and mother told us that while he took on the role of head of family and provided money and arranged things, he could also be volatile and physically violent. They said that they cared about him but were also afraid of him.

5.120 They described various times when he was unpredictable and aggressive. They told us that they had little understanding of the nature of his mental disorder, how medication was supposed to help, what early warning signs there might be, and who to approach for help. There is however a record of a home visit in November 2016 where Amir and two of his sisters were present. Both SW1 and CCO2 were present, and it was noted that the sisters were asked if they knew who to contact if they had concerns about his mental state. On hearing that the sisters thought they should contact Cygnet, they were given the names and contact details for CCO2 and SW1.

5.121 Dr R asked him about his reactions to his father's death, and his experiences of living in Pakistan. He told us he was concerned about whether Amir might get married in Pakistan, and asked him about this whenever he saw him. After the family safeguarding issue in early 2017 there was an attempt to develop a family tree and establish which family members lived in which house. Amir was very resistive to this and tried to diminish its importance. This was a positive intervention, but in our view should have taken place prior to his discharge from Cygnet, to assist in understanding the family situation.

5.122 We would expect that a community forensic team should pick up on these individual nuances, whatever the cultural background. In our view the issue is not about special consideration for each individual culture or background, more about the team making the effort to understand that there would be specific dynamics to consider.

5.123 As acknowledged in the internal investigation, the DCRT was not resourced to provide a safe and effective service for patients who required the intensive support that would have been available from a community forensic team. However the aspect of cultural context should have been included in care planning by the recovery team.

Comment 8

The cultural and religious context was a considerable influence in how Amir and his family interacted with each other and with services, and should have been taken into consideration when planning his care and in assessing risk.

Finding 8

Care planning and communication by the DCRT was not culturally sensitive, and did not foster open communication with his family.

Recommendation 8

Derbyshire Healthcare NHS Foundation Trust should assure itself that race and ethnicity, gender and religious issues are routinely addressed in CPA needs assessments and care planning as per the Trust's policy.

Recommendation 9

Derbyshire Healthcare NHS Foundation Trust should assure itself that the perspective of families, and the provision of collateral information is included in care planning, and appropriate cultural awareness is applied when communicating with families.

6 Internal investigation

6.1 This element of the terms of reference requires us to critically examine and quality assure the NHS contributions to the Domestic Homicide Review.

6.2 In order to do this we have reviewed the internal investigation reports and IMRs provided by the healthcare providers.

Critically examine and quality assure the NHS contributions to the Domestic Homicide Review (DHR)

6.3 Four healthcare services contributed to the DHR. Three of these are NHS services i.e. NHCFT, DHCFT, NHS Derby and Derbyshire CCG, and one is an independent provider of health services: Cygnet Health Care.

6.4 All four services provided an Individual Management Review (IMR) as requested as part of the Domestic Homicide Review commissioned by Derby City and Neighbourhood Partnerships (incorporating Derby Community Safety Partnership).

6.5 DHCFT also carried out an internal serious incident investigation, described as *'a comprehensive scoping or fact-finding investigation into the circumstances surrounding the incident and the care and treatment of the service user'*.

6.6 We have reviewed each of the reports provided to the DHR against our analysis of the evidence, and we have reviewed the DHCFT serious incident internal investigation report using our structured framework for review.

NHCFT IMR

6.7 The NHFCT IMR provided a chronology of Amir's care and treatment from 2009 to his discharge to Cygnet in 2013. It was noted that his stay at Wathwood Hospital was considerably longer than the average stay at the hospital and *'the appropriate discharge process was followed, with consideration of a number of units and detailed handover of information'*. No recommendations were made.

6.8 We support the analysis made in the IMR, and refer to our Comment 1 and Finding 1 above. We have made no recommendations for NHCFT.

NHS Derby & Derbyshire CCG IMR

6.9 The CCG IMR provides information about both Amir and Sobhia, who were registered with different GP practices. We have not commented on the care provided to Sobhia because this is not within our terms of reference.

6.10 Amir changed GP practices during the time he was at Cygnet, the reasons for this are not known. The adult safeguarding lead for Amir's GP practice considered that there was insufficient information sharing around MAPPA issues. They were not aware of the index offence for which Amir had been detained under the MHA at Wathwood and Cygnet. As this had been for a violent sexual offence they question whether they should have been informed.

6.11 The IMR also makes the point that there was no communication from Cygnet prior to his discharge, and the practice had no information about him until they were contacted by Dr R from DHCFT.

6.12 Clinical Commissioning Groups are one of the agencies who have a duty to cooperate with MAPPA. Information sharing with the GP about Amir through MAPPA does not appear to have been effective in this case. We support the conclusions of this IMR; see finding 5, comment 5 and recommendation 5.

Cygnet Health Care IMR

6.13 The Cygnet Health Care IMR provided a detailed analysis of clinical decision making and communication leading up to the admission from Wathwood in 2013, and his discharge in 2015.

6.14 The report provides an analysis of the service responses to the disclosure of the sexual relationship with the member of staff. It concludes that there was insufficient sharing of this information across the clinical team. The allegations made by the member of staff about threats, intimidation and physical aggression were not shared, and did not appear to form part of an updated risk assessment.

6.15 We concur with this assessment and have commented above at finding 2 and comment 2 (and recommendation 6).

6.16 However the report does not identify the history of boundary pushing and breaches of conditions that were a feature of Amir's care, and that we have noted were not conveyed to the MoJ.

6.17 The report states that the MoJ were '*kept fully appraised of his progress at the hospital and were involved in his discharge planning and setting the conditions prior to his discharge'*. The report then contradicts this by stating that '*it is not clear how much of this detail* [regarding the relationship] *was shared with the Ministry of Justice, and so their decision to grant [Amir] leave to visit Pakistan may have been different'*.

6.18 It appears that the letter describing the relationship to the MoJ was not shared with the team who wrote the internal IMR. As part of this independent investigation we have obtained the letter in question directly from the MoJ. See paragraph 5.42 above). There is no mention of any of the allegations made by the HCW and she is described as '*using a high degree of planning, coercion, manipulation, fear, guilt and threats to ensure [Amir] did not disclose the secret relationship'*.

6.19 We were surprised that the information provided to the MoJ did not feature in the IMR. The report does however make four recommendations:

- *to develop a policy to support staff or patients in their care who may be in abusive relationships. Cygnet Health Care to recognise that staff may be vulnerable to exploitation and coercion and provide support, guidance and advice as appropriate.*

- *to ensure risk assessments are fully complete and accurate, and reflect any significant incidents or risks identified within the daily progress notes.*
- *details of disclosures to be shared internally so that all staff are aware of the severity of risks presented by patients on the ward.*
- *staff to understand the importance of the visitor log and the requirement for this to be completed legibly and fully.*

6.20 Although we concur with some of the findings of this IMR, in our view it is limited by the lack of focus on the information that was conveyed to the MoJ about the sexual relationship.

Recommendation 10

Cygnet Health Care must ensure that all the available relevant information is reviewed for the production of a report for a formal external review.

DHCFT IMR and internal investigation report

6.21 The DHCFT IMR summarises the findings of the internal investigation report. The analysis and recommendations made are taken from the internal report, therefore we will review the internal report in more depth, rather than focus on the detail of the IMR itself. We have applied our Niche Investigation and Assurance Framework (NIAF) to the internal report.

6.22 We have developed a robust framework for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency,[66] NHS England Serious Incident Framework (SIF) and the National Quality Board Guidance on Learning from Deaths.[67] We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

6.23 In developing our framework we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA^2 (or Root Cause Analysis and Action, hence 'RCA Squared')[68] which discusses how to get the best out of root cause analysis investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

[66] *National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

[67] *National Quality Board: National Guidance on Learning from Deaths. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf*

[68] *National Patient Safety Foundation (2016) - RCA2- Improving Root Cause Analyses and Actions to Prevent Harm –published by Institute of Healthcare Improvement, USA.*

6.24 The warning signs of an ineffective RCA investigation include:

- There are no contributing factors identified, or the contributing factors lack supporting data or information.
- One or more individuals are identified as causing the event; causal factors point to human error or blame.
- No stronger or intermediate strength actions are identified.
- Causal statements do not comply with the 'Five Rules of Causation'
- No corrective actions are identified, or the corrective actions do not appear to address the system vulnerabilities identified by the contributing factors.
- Action follow-up is assigned to a group or committee and not to an individual.
- Actions do not have completion dates or meaningful process and outcome measures.
- The event review took longer than 45 days to complete.

6.25 We also considered proposals for the new NHS Improvement Patient Safety Incident Response Framework on how to improve learning from investigations which has identified five key problems with the current application of the process:

- defensive culture/lack of trust e.g. lack of patient/staff involvement;
- inappropriate use of serious incident process e.g. doing too many, overly superficial investigations;
- misaligned oversight/assurance process e.g. too much focus on process related statistics rather than quality;
- lack of time/expertise e.g. clinicians with little training in investigations trying to do them in spare time;
- inconsistent use of evidence-based investigation methodology e.g. too much focus on fact finding, but not enough on analysing why it happened.

6.26 We evaluated the guidance available and constructed 25 standards for the assessing the quality of serious incident reports based around the three key themes of credibility, thoroughness and whether the report was likely to lead to change in practice. We have developed these into our own '**credibility, thoroughness and impact'** framework.

6.27 Our assessment of the internal investigation against these standards is described in detail in appendix E. Six recommendations were made, four of these focus on the need for an effective forensic service in DHCFT, and sharing the findings of the investigation with the MoJ.

6.28 We agree with this as the main finding and recommendation of the investigation. However the conclusions of the report also include criticisms of the practice of both practitioners involved. We have discussed this directly with senior DHCFT staff and they have shared the actions taken after the report was completed. We are satisfied that these issues were subsequently managed appropriately.

6.29 In our view there are several omissions in the report:

- there was no recorded approach to Amir. It may have been that there were criminal justice issues, but it is not explained. There is no reference to contact with his family, although we were subsequently informed that his mother was contacted.
- the report notes that there should be a recognition of the context wider than the Trust, however the social supervisor was not interviewed as part of the internal investigation.
- there is no discussion about the cultural context for care in which the recovery team was working.
- there was no recognition that the DHCFT recovery consultant was not part of the decision-making in the conditional discharge from Cygnet.
- the conclusions of the report include criticisms of the practice of both practitioners involved.
- support for staff after the homicide is not described.

6.30 The final report is a frank exploration of the system factors however, and the final conclusion includes that '*the absence of an adequately commissioned community forensic service, and associated organisational infrastructure, to include operational and clinical policies and procedures, governance mechanisms, access to related education and training and a robust supervision structure, meant that staff had little clarity, direction, support or supervision in terms of their roles, responsibilities and accountability in [Amir's] care'*.

6.31 We concur with this conclusion and support the recommendations regarding the need for a forensic service. We note however that there was no recognition of the cultural context in which the recovery team were working, both in relation to care planning, communication and risk assessment (see recommendation 8).

Recommendation 11

Derbyshire Healthcare NHS Foundation Trust must ensure that staff involved in the reviews of complex and high-profile serious incidents receive additional support.

7 Findings and recommendations

7.1 From our analysis of the issues we have identified eight findings in relation to the issues. We have made 11 recommendations accordingly.

7.2 The Section 37/41 MHA which was applied in 2009 was made following a diagnosis of paranoid schizophrenia, and reports to the court supporting a hospital order. It became clear as further information emerged that there was a history domestic violence and coercive controlling behaviour in his first marriage, and the degree of sadism was not explained by mental illness alone.

7.3 Further personality testing showed narcissistic and paranoid tendencies, and there remained a high risk of emotional and physical abuse within the context of an intimate relationship.

7.4 The formulation of his presentation that was handed over from Wathwood to Cygnet contained detailed information about these risks, and the care planning and risk management required. He showed a degree of skill in successful subversion of boundaries at Cygnet, and in the community under the care of DHCFT, and these were not always communicated or addressed effectively.

7.5 There was a significant missed opportunity to review risk assessments and communicate effectively with the MoJ following the development of the relationship with the staff member.

7.6 There move to the community in July 2015 was not managed in a way that provided detailed information and robust care planning.

7.7 Derbyshire Healthcare NHS Foundation Trust did not have a community forensic team, and his care was allocated to the caseload of a generic community mental health team which lacked the knowledge and resources to adequately supervise his care and manage risk.

7.8 This meant that care plans did not reflect the previous risk assessment and formulation.

Finding 1

Care provided at Wathwood was planned with the involvement of Amir and his family, and was sensitive to his cultural needs, which is good practice.

Risk assessment and management plans were adjusted as new information emerged, and were clearly communicated to all other parties in the discharge decision making in July 2013.

The involvement of victim advocacy service and the gathering of the victim's perspective is an example of good practice.

Finding 2

Care provided at Cygnet Derby was planned in conjunction with partner agencies, and plans for conditional discharge were developed with the awareness of MAPPA, DPMU, DHCFT, Derby City Council and the MoJ as would be expected. There was no communication with the GP practice however.

In our view these plans lacked detail and were not given sufficient preparation time to ensure that detailed plans were in place.

We consider that the information that was provided to the MoJ to support the conditional discharge lacked relevant detail and the nuanced feedback that would be important in managing risk. The involvement of the victim advocacy service and the gathering of the victim's perspective is an example of good practice, as was the involvement of his family in planning.

In our view the subsequent conditional discharge care plan was not sufficiently detailed or robust enough to manage the considerable risk identified and was prepared without the direct involvement of the DHCFT clinical and social supervisors.

Finding 3

Amir was allocated to the caseload of a generic community mental health team which lacked the knowledge and resources to adequately supervise his care and manage risk.

Finding 4

Changes in structures and systems between DHCFT and Derby City Council limited communication about details of treatment and care.

Finding 5

The GP practice did not have any contextual information about Amir.

Primary care were not seen as partners in the overall plan of multi-agency care.

Finding 6

The input provided by NHE England specialised commissioners was within expected policy and practice.

Finding 7

The MoJ does not appear to have a system to identify when reports are not submitted to the required expectations.

Systems in Cygnet and DHCFT did not ensure that MOJ reports were submitted to expected standards.

Finding 8

Care planning and communication by the DCRT was not culturally sensitive, and did not foster open communication with his family.

Recommendation 1

Cygnet Health Care must ensure that all risk management information is included in care planning

Recommendation 2

Cygnet Health Care must ensure that all of the expected standards are met when arranging conditional discharges for patients on Section 37/41 to including communication with the local GP.

Recommendation 3

Because of the lessons learned from this independent investigation the commissioning and development of the Derbyshire Healthcare NHS Foundation Trust Forensic Team should include:

- effective supervision structures
- audit of family contacts
- quality standards for MoJ reporting

Recommendation 4

The operational policy for the Derbyshire Healthcare NHS Foundation Trust Forensic team must include clarity about roles, responsibilities and communication between Derby City Council and Derbyshire Healthcare NHS Foundation Trust when caring for a patient who is conditionally discharged from Section 37/41 MHA.

Recommendation 5

NHS Derby and Derbyshire Clinical Commissioning Group must ensure that there is primary care involvement in the MAPPA process for appropriate individuals.

Recommendation 6

Cygnet Health Care must ensure that standards for reporting to the Ministry of Justice regarding progress of conditional discharged patients are maintained.

Recommendation 7

Derbyshire Healthcare NHS Foundation Trust must ensure that standards for reporting to the Ministry of Justice regarding progress of conditional discharged patients are maintained.

Recommendation 8

Derbyshire Healthcare NHS Foundation Trust should assure itself that race and ethnicity, gender and religious issues are routinely addressed in CPA needs assessments and care planning as per the Trust's policy.

Recommendation 9

Derbyshire Healthcare NHS Foundation Trust should assure itself that the perspective of families, and the provision of collateral information is included in care planning, and appropriate cultural awareness is applied when communicating with families.

Recommendation 10

Cygnet Health Care must ensure that all the available relevant information is reviewed for the production of a report for a formal external review.

Recommendation 11

Derbyshire Healthcare NHS Foundation Trust must ensure that staff involved in the reviews of complex and high-profile serious incidents receive additional support.

Appendix A – Terms of reference for the independent investigation

The investigation is to be conducted in partnership with the Domestic Homicide Review into the death of [S]

Terms of Reference

The investigation is to be conducted in partnership with the Domestic Homicide Review into the death of [S] Terms of Reference.
The investigation will examine the NHS contribution into the care and treatment of [Amir] from his first contact with specialist mental health services up until the date of the incident.

- Critically examine and quality assure the NHS contributions to the Domestic Homicide Review
- Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user
- Examine the discharge arrangement from the secure services and the follow up arrangements for his continuing care.
- Review and assess compliance with local policies, national guidance and relevant statutory obligation
- Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family
- Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway
- To work alongside the Domestic Homicide Review panel and Chair to complete the review and liaise with affected families
- To provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or standalone

Appendix B – Professionals involved

Pseudonym	Role and organisation
Dr N	Consultant forensic psychiatrist Wathwood – RC until 2013
Dr Y	Consultant forensic psychiatrist Wathwood – RC from 2013
Dr M	Consultant psychiatrist Cygnet
HCA Y	Healthcare Assistant Cygnet with whom Amir had a relationship
Dr R	Derby City Recovery Team consultant psychiatrist DHCFT
CCO1	Care coordinator from 2015 DHCFT
CCO2	Care coordinator from November 2016 DHCFT
SW1	Social supervisor Derby City Council

Appendix C – Documents reviewed

NHFCT/Forensic services/Wathwood documents

- Restricted items management July 2012 and December 2018
- Patient access to the internet September 2012 and September 2018
- Post and telephone calls July 2012 and April 2019
- CPA November 2012 and September 2018
- Leave of absence for detained patients February 2013 and January 2019
- Visiting clinical areas (non-professional visits) May 2012

DHCFT documents

- A new model of a Community Forensic Team - Derbyshire Integrated Community Enterprise paper 2018
- Assessment and Management of Risk in Mental Health and Learning Disability Practice Protocol: use of the FACE Risk Profile (Archive Jan 2015)
- Assessment and Management of Clinical Risk Policy and Procedure (Archive Jan 2015)
- Assessment and Management of Risk in Mental Health and Learning Disability Practice Protocol: Use of the FACE Risk Profile (Archive Jan 2015)
- Assessment and Management of Safety Needs Policy May 2018
- Care Programme Approach and Care Standards Policy & procedures October 2009
- Clinical and Operational Policy for the Community Forensic Team, draft April 2019
- Clinical Risk Management Standards Policy and Procedures (Archive Jan 2015)
- Core Care Standard and Care Programme Approach Policy and Procedure [Phase 1] October 2017
- Core Care Standards and Care Programme Approach Policy and Procedure July 2015
- Derbyshire and Derby Safeguarding Adults Policies and Procedures May 2015
- Derbyshire and Derby Safeguarding Adults Policy and Procedure May 2018
- Joint Policy Aftercare for Detained Patients under Section 117 Mental Health Act 1983 Policy and Procedures August 2014
- Joint Policy for Aftercare for Detained Patients under section 117 Mental Health Act 1983 Policy and Procedures December 2018

- Operating Policy for Neighbourhood Teams March- May 2016
- Supervision Policy and Procedure March 2016
- Untoward Incident Reporting and Investigation Policy and Procedure July 2014
- Untoward Incident Reporting and Investigation Policy and Procedure Sept 2015
- Untoward Incident Reporting and Investigation Policy and Procedure October 2017

Cygnet Health Care documents

- Clinical Risk Assessment 2018
- Conducting an investigation 2014
- CPA 2014
- CPA 2017
- Disciplinary Flowchart 2018
- Disciplinary Managers Guide 2018
- Disciplinary Procedure 2018
- Discipline & Dismissal Procedure 2014
- Guidelines for Section 17 2013
- Guidelines for Section 17 2017
- ICT Acceptable use 2013
- ICT Acceptable use 2018
- Local Contraband Policy
- Local Litchurch Admission & Discharge Criteria
- Local Visitors policy
- Managing Discipline 2014
- Professional Boundaries 2014
- Professional Boundaries 2018
- Risk Management Policy 2016
- Risk Management Strategy 2014
- Searching Policy 2014
- Searching Policy 2019
- Service user access to Wifi 2012
- Service user Mobile Phone Access 2012
- Service user Telephone Access 2016

Staff use of Mobile phones 2013

Other documents

- Adult Low Secure Services including Access Assessment Service and Forensic Outreach and Liaison Services (FOLS). Service specification 2018
- Adult Medium Secure Services including Access Assessment Service and Forensic Outreach and Liaison Services (FOLS). Service specification 2018
- Asian in-patient and carer views of mental health care, Asian views of mental health care, Greenwood et al. 2000, Journal of Mental Health (9,4)
- Community conversation: addressing mental health stigma with ethnic minority communities, Knifton et al. Social Psychiatry and Psychiatric Epidemiology, 2010 (45,4)
- Cultural Barriers to Health Care for Southeast Asian Refugees, Public Health Reports, Uba,L 1992, 107(5)
- Derbyshire Multi Agency Public Protection Arrangements 2009-2010
- Derbyshire Multi Agency Public Protection Arrangements 2015 - 2016
- Developing the 'Forensic Mental Health Community Service Model' Background Information Resource (4 of 5):Core components of the model and the Specialist Community Forensic Team. NHS England Mental Health Secure Care Programme 2017
- Guidance for clinical supervisors MoJ, March 2009
- Guidance for social supervisors MoJ, March 2009
- Joint targeted area inspection of the multi-agency response to abuse and neglect in Derby City May 2019 Mentally disordered offenders - the restricted patient system- Background Briefing December 2017
- Muslim patients and health disparities in the UK and the US, Archives of Disease in Childhood, Laird et al, (92) 2007
- The Need for Change in UK Mental Health Services: South Asian Service Users' Views. 2007, Bowl, R, Ethnicity and Health2007, Vol 12 (1).
- The recall of conditionally discharged restricted patients, MoJ February 2009.

Appendix D – Sobhia's family questions

Family questions are in normal text, Niche responses are in italics

While he was in Wathwood he was not taking his medication, he was making curries for staff and management, how can someone be sentenced after such a horrible attack be allowed so much freedom. How was he allowed to play professionals? Surely his play acting of the mental health should have picked up and monitored.

It is not unusual for staff and patients in this kind of small unit to cook together. However the tendency to try to show himself in a positive light and ingratiate himself was well established and managed. There were times when the staff group was split over positive and negative views of his presentation, this was also investigated and managed appropriately, in our view.

Again he was perfect to carry out his torture for 9 years on [first wife] but then as he goes through the legal process everyone believes him and not her as he plays on the mental health due to her not dropping the charges. Easy way out of prison.

Assessments were made at the time and the court made the decision to detain under the MHA. It became clear at Wathwood that it was not as simple as that, and while there may have been some mental illness, it did not explain the first offence.

Family of A need to be looked into as throughout her ordeal and my sisters ordeal no one can pin any blame on them.

We have approached the family of A as part of this investigation but can focus only on his care and treatment.

Same doctor gave evidence in my sister's trial who's wife is a manager at Wathwood (Dr H) Conflict of interest?

We have discussed this with Dr H. His wife was indeed a manager at Wathwood. He himself was the executive director of the forensic service in Nottinghamshire when A was a patient there. He had no clinical involvement in his care and is obliged to maintain professional standards in providing information to the Court, and would have had to declare any conflict of interest.

How was he allowed so much freedom in there after what he had done?
Sounds like it's a Butlins holiday camp not a secure institution.

The focus of mental health secure units is on both safety and recovery. It would be expected that boundaries should be maintained, but that gradual testing of the patient's response to less restriction would be carefully managed. We found that A certainly tried to push boundaries at Wathwood, but that these were addressed.

Then at the Derby hospital he has an affair with a member of staff. Attacks her and she is the perp and he is the victim.
Be interesting to get her story of actual events if possible.

We have tried to make contact with the individual concerned several times without success. The reports to the MoJ did present him as the victim.

Surely after he has this affair staff should be concerned and raise alarms and to extend his stay and not just to release.

The clinical team did not review the risk assessment after this and presented him as the victim. Her allegations were not incorporated into care plans and shared in detail with the MoJ. We believe this was an omission.

Was he allowed Internet access in there? As I believe that's how he made contact with my sister.

Internet access was supervised, and mobile phones were restricted to the kind that can do calls and texts only. He was found with a smart phone on at least one occasion and this was removed. However he had unescorted leave from May 2014 and could access the internet independently.

Appendix E - DHCFT SI report NIAF

Standard		Niche commentary
Theme 1: Credibility		
1.1	The level of investigation is appropriate to the incident:	The Trust's Untoward Incident Reporting and Investigation Policy and Procedure (2015) requires a homicide to have a 'type 1' level 2 investigation, managed by a three person team led by an operational lead, with professional representation at senior level, and senior medical representation. (this reflects SiF guidance). One of these must be external to the Trust. The policy also states that a serious incident will be reviewed by a trained investigator using root cause analysis methodology, with enhanced investigation skills. Terms of reference for the internal investigation indicate that this was assigned as a Level 2 comprehensive RCA Panel Review. This was appropriate at that time, and the way the investigation was conducted reflects the level required. The internal investigation team consisted of a lead investigator (Consultant Nurse), consultant forensic psychiatrist (DHCFT) and an external honorary consultant forensic psychiatrist. Support was also provided by the Head of Equality, Diversity and inclusion. There is clear evidence of staff interviews being undertaken in order to support the investigation findings. There is reference to interviews, policies, procedures and other documents.
		Standard met
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	The terms of reference for this investigation are generic for a Trust Level 2 (SI) Review Report (RCA) with reference to detailed policy, procedures and systems to be reviewed.
		Standard partially met
1.3	The person leading the investigation has skills and training in investigations	The SI Policy that was current at the time of this event states that a level 2 full RCA will be '*conducted by a RCA trained investigator who has Trust Root Cause Analysis and report writing training, enhanced investigation skills and proven competency in undertaking investigations at this level*. The lead investigator was a consultant nurse. She was a Registered Mental Health Nurse (RMN) with experience of working in forensic services, and had the clinical skills necessary to undertake the investigation.

		Standard met
1.4	Investigations are completed within 60 working days	The investigation was commissioned by the Medical Director in December 2017, with the expectation that the report would be completed and submitted to the Trust by 15 February 2018. This internal date appears to have been met, however this is nine months after the homicide. The report notes that the investigation was significantly delayed because the community consult had a long period of absence from work. It is not clear whether there were any other reasons for the delay however.
		Standard not met
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The investigation is written in clear English and the narrative is easy to understand.
		Standard met
1.6	Staff have been supported following the incident	The report states that CCO2 felt supported by colleagues after the homicide. There was no reference to support for any other members of staff.
		Standard not met
Theme 2: Thoroughness		
2.1	A summary of the incident is included, that details the outcome and severity of the incident	A brief description of the incident and the outcome are included in the report.
		Standard partially met
2.2	The terms of reference for the investigation should be included	Terms of reference are included in the report.
		Standard met
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people	There is no description of the methodology. The report is described as a '*comprehensive scoping or fact-finding investigation into the circumstances surrounding the incident and the care and treatment of the service user'.* A chronology is provided, and there is evidence of root cause methodology and other analysis to support the findings. The analysis was conducted using the contributory factors structure. It is stated that the factors are presented in the 'fishbone' framework. The fishbone diagram however contains the generic references rather than any detail which applies to this case.
		Standard partially met
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	The report states that a meeting was held with Sobhia's family in November 2017, by the DHCFT medical director, along with the Trust family liaison and investigation facilitator, and the internal lead investigator.

		There is no mention of meeting with Amir's family, and no explanation about why this was not offered. Were subsequently informed that his mother was contacted, but this is not noted in the report.
		Standard partially met
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	As above, Sobhia's family asked a number of questions that were incorporated into to the terms of reference. There was no opportunity offered to Amir's family to contribute or raise concerns.
		Standard partially met
2.6	A summary of the patient's relevant history and the process of care should be included	A summary of Amir's history and care was provided.
		Standard met
2.7	A chronology or tabular timeline of the event is included	A chronology is embedded within the report.
		Standard met
2.8	The report describes how RCA tools have been used to arrive at the findings	The report describes how root cause analysis or other tools have been used.
		Standard met
2.9	Care and Service Delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	Care or service delivery problems are not listed as identified by the authors, however the list of 'contributory factors' is in fact a list of care and service delivery problems.
		Standard not met
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	Contributory factors are discussed in detail in the body of the report under the accepted headings (team factors etc). The list of 'contributory factors' is in fact a list of care and service delivery problems.
		Standard met
2.11	Root cause or root causes are described	The root cause should be identified as the earliest issue that, had it been different, would have resulted in a different outcome. The investigation identified no root cause for the homicide. Recognising that there may be occasions when this is the case, we can see evidence of RCA methodology being utilised in this investigation.
		Standard not met
2.12	Lessons learned are described	Lessons learned were identified from the contributory factors- which are in fact care and service delivery problems.
		Standard met
2.13	There should be no obvious areas of incongruence	In our view there were several areas of incongruence within the report:

		- There was no approach to Amir himself; given that the report is about Amir's care and treatment. It may have been that there were criminal justice issues, but it is not explained. There is no reference to contact with his family, although we were subsequently told his mother was contacted. - The report notes that there should be a recognition of the context wider than the Trust. The social supervisor was not interviewed as part of the internal investigation. - There is no discussion about the cultural context for care in which the recovery team was working. - there is no recognition that the recovery consultant was not part of the decision-making about conditional discharge. - the conclusions of the report include criticisms of the practice of both practitioners involved.
		Standard not met
2.14	The way the terms of reference have been met is described, including any areas that have not been explored	It is clear how some elements of the terms of reference have been met. However, there is less clarity for other elements including: – perpetrator family contact during the investigation, and sharing of the findings; – communication with the service user – liaison with the GP
		Standard partially met
Theme 3: Lead to a change in practice – impact		
3.1	The terms of reference covered the right issues	The terms of reference were aimed at ensuring a comprehensive investigation proportionate to the severity and complexity of the incident.
		Standard met
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	The report includes a chronology of events with supporting analysis and evidence of root cause methodology. There is a description of what happened and analysis to support the prevention of a recurrence. There are however two conclusions which can be seen as apportioning blame and singling out the practice of individuals. These two criticisms are situated in a summary discussion of the systems issues. There are clear systems issues identified, notably the need for a forensic service and an

		acknowledgement that the service provided was not designed to meet the needs of a service user with Amir's presentation.
		Standard met
3.3	Recommendations relate to the findings and that lead to a change in practice are set out	There were six recommendations made. Four of these focus on the requirement for an effective forensic service in Derby, and sharing the learning from this investigation with the MoJ. One recommendation concerns the statement that '*patients stepping down from medium secure to low secure do not routinely require a gatekeeping assessment should be reviewed and the position clarified'*. In our view this could have been clarified as part of the investigation, as it is a statement of fact.
		Standard met
3.4	Recommendations are written in full, so they can be read alone	The recommendations are detailed and written in full.
		Standard met
3.5	Recommendations are measurable and outcome focused	The recommendations were outcome focussed and measurable
		Standard met