An independent investigation into the care and treatment of Ben

February 2023

niche
HEALTH & SOCIAL CARE CONSULTING

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Our Executive Summary has been written in line with the Terms of Reference for the investigation into the care and treatment of Ben. This is a limited scope review and has been written 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Events which may occur outside of the timescale of this review will render our report out-of-date.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. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

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Incident

1.1 The names in this report have been changed to protect the privacy of the individuals.

1.2 In the summer of 2018 Ben had been drinking alcohol with his mother, Joan, at her home when there was an altercation between them. During this altercation Ben punched his mother in the face and she sustained a "significant head injury".[1]

1.3 Joan was admitted to hospital by ambulance where her condition deteriorated. Despite emergency surgery, treatment was not successful, and she died in hospital 12 days later.

1.4 In October 2018 Ben was charged with unlawfully killing Joan. In 2019 Ben was sentenced to four and a half years in prison for the manslaughter of his mother.

Investigation

1.5 NHS England and NHS Improvement commissioned Niche Health & Social Care Consulting (Niche) to carry out an independent investigation into Ben's care and treatment. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.6 The investigation follows the NHS England Serious Incident Framework (SIF)[2].

1.7 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.

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

1.9 The investigation was conducted by:

- Naomi Ibbs, Senior Associate, Niche and lead author; and
- Dr Mark Potter, Consultant Psychiatrist, Associate, Niche.

1.10 We would like to express our condolences to all the parties affected by this incident. It is our sincere wish that this report does not add to their pain and distress, and that it goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Ben.

Relevant health history

1.11 Ben had been under the care of mental health services in the north of England since 2007. Although Ben had been allocated to three care coordinators (CCOs) during the period of care that we reviewed (August 2016 to August 2018), he had been seen by the same consultant psychiatrist (CP1) throughout this time.

1.12 Ben lived in supported accommodation and an appointeeship was in place to help him to manage his finances, as there were concerns that he was vulnerable to financial exploitation.

1.13 Ben's diagnoses were:

- complex past trauma/emotionally unstable personality disorder (EUPD) – borderline and impulsive features;

[1] As reported in the Domestic Homicide Review, June 2021.
[2] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

- obsessive compulsive disorder (OCD);
- depressive episodes with anxiety; and
- harmful use of alcohol.

1.14 Ben also had a hearing impairment. There are differing reports about when he first experienced this; some reports say that he was born deaf, others say that the impairment started in his teens.

1.15 Records indicate that Ben was both a victim and perpetrator of assaults, often linked with excessive consumption of alcohol.

1.16 Ben's care and treatment was reviewed regularly, and clinically appropriate changes were made to his medication in accordance with his wishes, e.g., depot (injection) instead of oral medication.

1.17 In May 2018, it was agreed that the appointeeship was no longer required. This followed a number of complaints made by Ben about the restrictions placed on him because of the appointeeship. It is not clear from the records when the appointeeship was lifted; the last reference is in July 2018 when it was documented that the Department for Work and Pensions had been provided with Ben's bank account details to enable his benefits to be paid directly into his account.

1.18 Ben was seen for review on 31 July 2018 when his CCO documented that Ben spoke about becoming a volunteer and seeking to move away from supported living into his own accommodation.

1.19 Ben was last seen two weeks later, on 14 August 2018, when it was documented that he had been offered an interview for a volunteer role in the fire service. Although this was positive, it was also documented that there were "some concerns" about Ben's benefits and how these were being spent. However, the details of the concerns and any action to be taken in response to them were not documented.

Forensic history

1.20 Ben was known to the police prior to the incident that resulted in the death of his mother:

- November 2015: arrested for breach of a court order.
- January 2016: identified by the Criminal Justice Liaison and Diversion Team (CJLDT) as being in custody.
- February 2016: arrested for criminal damage and assessed by the CJLDT.
- September 2016: arrested for "Section 47 domestic violence assault" on his mother.

Internal investigation

1.21 The Trust undertook an internal investigation into Ben's care and treatment. The investigation covered the period from 2006 to August 2018.

1.22 There were four recommendations arising:

1. "All patients with a dual diagnosis including those whose contact with their CMHT is variable should have their alcohol related behaviours explored using motivational interview techniques as advocated in NICE [National Institute for Health and Social Care Excellence] guidance (CG115). Such patients should have a care plan formulated to proactively address their alcohol behaviours.
2. The Trust should raise awareness of the potential for use of extended care plans for those patients on [Care Programme Approach] CPA with EUPD. CMHT's should identify those

patients who would benefit from such an extended care plan, which should as part of any draft address any issues of engagement and motivation.

3. Greater emphasis should be given to psychological formulation training in order that teams can better identify and manage EUPD.

4. The Trust should develop a model of care that will enable and direct staff to encompass in their care planning other conditions/problems that the service user is experiencing including physical health concerns and drugs and alcohol problems. This will enable staff to develop care strategies that consider how different pathologies affect each other and risks can be minimised."

1.23 The report was thorough and met 21 of our 25 quality assessment standards.

1.24 We agreed with the findings of the internal investigation. However, we have identified one aspect of Ben's care and treatment that was not identified by the internal investigation. This related to the quality and frequency of risk assessments.

Action plan

1.25 The Trust developed an action plan in response to the recommendations made in the internal investigation report. We were asked to assess the Trust's progress with the action plan.

1.26 Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a numerical grading system to support the representation of progress data.

1.27 Our measurement criteria are set out in Figure 1.

Figure 1: Niche Investigation Assurance Framework (NIAF) action plan assessment criteria

Score and assessment category	
0	Insufficient evidence to support action progress /action incomplete/not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement

1.28 The Trust provided evidence of action implementation for each recommendation. Table 1 provides an overview of our assessment.

Table 1: Trust action plan progress

Recommendation	Score	Assessment category
1 (part 1)	2	Action significantly progressed
1 (part 2)	3	Action completed but not yet tested
2 (part 1)	2	Action significantly progressed
2 (part 2)	2	Action significantly progressed
3	4	Action complete, tested and embedded

4	0	Insufficient evidence to support action progress/action incomplete/not yet commenced

1.29 Although the evidence provided to us showed that significant work had been undertaken, it was insufficient to demonstrate the sustained implementation of learning specifically related to the recommendations in the internal investigation report.

Domestic Homicide Review (DHR)

1.30 A Domestic Homicide Review (DHR) was separately commissioned by NHS England to examine the responses from agencies and the support given to Ben's mother, Joan. Our report uses the same anonymised names as the DHR.

1.31 We have used selective information from the DHR because our terms of reference required us to consider inputs into Ben's care and treatment from non-NHS agencies. NHS England advised that they wished us to use the information available from the DHR, rather than seek source material from the relevant agencies.

1.32 The period covered by the DHR was 1 July 2014 to the date of the incident. Organisations that had significant contacts and involvement with Ben and Joan contributed to the DHR. These included:

- the local authority;
- the NHS mental health services provider;
- the independent domestic violence advisors (IDVA) service;
- supported housing services for Ben;
- the police;
- the National Probation Service and a local provider of rehabilitation support; and
- NHS commissioners.

1.33 The key conclusions from the DHR relating to health and social care agencies were:

- "The absence of any active responses under Safeguarding Adults procedures, was a major missed opportunity for developing a cohesive multi-agency risk management strategy. This missed opportunity was one of many examples where agencies were working [in] silos.
- Supported housing staff reportedly had no knowledge of the [Multi-Agency Risk Assessment Conference] MARAC process, indicating a serious deficit in training on domestic abuse. Given that they were working with residents who were likely to be domestic [abuse] victims and/or perpetrators, this is a matter of serious concern.
- The DHR has highlighted numerous examples of agencies working in "silos", resulting in a lack of effective multi-agency working. Perhaps the starkest illustration of this is that the supported housing provider's focus on [Ben] in relation to domestic abuse was in managing the risks to him as a victim, when all of the evidence held by partner agencies was that the risks he posed as perpetrator of violence against [Ben's mother] were far greater than any risks in the opposite direction. A result of this silo working was that the service which had intensive daily contact with [Ben], did no work with him to try and address his abusive behaviours.
- The DHR has highlighted a lack of clarity in respect of the MARAC process, including a need for clear operational guidance and procedures which recognise thresholds for instigating multi-agency strategy meetings and action plans.

- The use and meaning of terminologies such as referral, notification, vulnerable person notification, safeguarding referral, safeguarding alert continues to be a source of confusion between agencies in [the locality]. As a result, different agencies have different understandings and expectations of what actions (if any) will result from these types of inter-agency communications."

1.34 Table 2 provides a summary of the recommendations arising from the DHR for NHS organisations:

Table 2: Summary of recommendations for individual healthcare organisations from the Domestic Homicide Review

Organisation	Recommendations
NHS Mental Health Services provider	• Clinical records to be reviewed regarding domestic violence alerts and a system to be introduced to trigger further action in domestic abuse cases. • Review organisational training needs to identify targeted training on domestic abuse where required.
GP practice	• Highlighting of known domestic abuse within GP records. • Emphasising the importance of professional curiosity. • Record keeping.

1.35 The DHR also made four overview recommendations that cut across all agencies.

Table 3: Overview recommendations from the DHR

Overview recommendations
Overview recommendation 1 Commissioners of housing support services should ensure that all service contracts include a requirement for staff and managers to receive regularly updated training on domestic abuse. This training should include work on risk assessment and risk management approaches with perpetrators and with victims of abuse. It should also include raising awareness and understanding of local multi-agency policy and procedure and the role and function of MARAC. This recommendation should be particularly highlighted and followed up for action, with the specific supported housing provider, which featured in [the] DHR.
Overview recommendation 2 The local safety partnership Board should arrange a review of MARAC processes, and related multi-agency procedures and guidance on domestic abuse, with the aim of: • Establishing clear operational guidance and procedures which recognise thresholds for instigating multi-agency strategy meetings and action plans. Thresholds to include specifying the number of repeat incidents which should trigger a strategy meeting. • Updating all partners on multi-agency policy and procedure and guidance on domestic abuse. • Increasing awareness and understanding of common themes and practices in relation to domestic abuse, safeguarding adults and working with people who are vulnerable and have complex and multiple needs.

• Highlighting that agencies working in silos represents a major barrier to services for people with multiple and complex needs who are victims and/or perpetrators of domestic abuse. • Supporting all agencies to review their training needs and plan future training programmes.
Overview recommendation 3 There should be a multi-agency review of terminologies used in policies, procedure, notification and referral systems around adult safeguarding and domestic abuse. The aim should be to ensure that all partners work to common definitions and expectations of the actions to follow, in relation to terms such as: • referral • notification • vulnerable person referral form • safeguarding referral • safeguarding alert
Overview recommendation 4 There should be a one-day multi-agency learning event to share all of the learning from [the DHR].

1.36 We have sought not to replicate any recommendations already made by the DHR.

Conclusions

1.37 Ben had been under the care of the same CMHT since 2007. Although he had been allocated to three CCOs during the period of time we reviewed (August 2016 to August 2018), he had been seen by the same consultant psychiatrist throughout this time.

1.38 We found that Ben's treatment was compliant with NICE guidelines for EUPD and OCD. Ben's medication was regularly monitored and reviewed, and clinically appropriate changes made at Ben's request.

1.39 Ben's family was not always involved in his care planning. While this may have been appropriate, the rationale was not always documented.

1.40 Ben's hearing impairment meant that he found telephone calls difficult, and he had asked that staff communicate with him by text message when they were not in a face-to-face setting. This request was not always respected.

1.41 Risk assessments were not always completed in accordance with Trust policy. When risk assessments were undertaken, they did not document all known risks and more detailed risk assessments (Level 2 and Level 3) were not completed.

1.42 The internal investigation was of a high quality, meeting 21 of our 25 quality assessment standards. We agreed with the findings, but an aspect of Ben's care and treatment that was not identified by the internal investigation related to the quality and frequency of risk assessments.

1.43 Although the action plan and associated evidence provided to us showed that significant work had been undertaken, it was insufficient to demonstrate the implementation of learning specifically related to the recommendations in the Trust's internal investigation report.

1.44 The evidence provided by the local NHS Clinical Commissioning Group shows a high degree of scrutiny and oversight of the investigation report and action plan progress.

2 Recommendations

2.1 There have been two investigations already completed: a DHR and an internal investigation. We have not sought to replicate any recommendations already made and we have focused on aspects of Ben's care and treatment that were not addressed by the other investigations.

Recommendation 1: The Trust must ensure that mechanisms are in place and used by staff to use preferred methods of communicating with patients, particularly when the preference is linked to a known disability.

Recommendation 2: The Trust must ensure that risk assessments include all known risks and that they are completed in accordance with Trust policy.

Recommendation 3: The Trust must develop and implement a structured process to monitor the implementation of action plans and ensure that robust evidence is available to demonstrate effective progress. The Trust must also take urgent action to address Recommendation 4 from the internal investigation report.