



**An independent  
investigation into the  
care and treatment of  
a mental health  
service user (Miss A)  
by Oxford Health  
NHS Foundation  
Trust**

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Niche Health & Social Care Consulting Ltd is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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# 1 Executive summary

- 1.1 In January 2016 NHS England (South) commissioned Niche Health & Social Care Consulting Ltd (Niche) to conduct an independent investigation into the care and treatment of Miss A, to review the events that led up to the death of Mr X on 16 April 2015 and to consider if the incident was predictable<sup>1</sup> or preventable.<sup>2</sup>

## Summary of incident:

- 1.2 On the morning of 16 April 2015 Miss A called 999 to report a male, (Mr X), had been stabbed at her home. The victim was taken to hospital by the emergency services where he subsequently died. A post-mortem examination established Mr X, aged 23, died from a stab wound to his chest.
- 1.3 Miss A was found guilty of murder and was received a life tariff with a minimum sentence of eighteen years. She was 26 years old at the time.
- 1.4 At the time of the incident Miss A had an eighteen month old child. She was under the care of Oxford Health NHS Foundation Trust's early intervention service (EIS) and health visiting service (HV). Miss A was last seen by her health visitor on 20 August 2014<sup>3</sup> and by her EIS social worker on 27 October 2014. Miss A's GP was the last professional to see her on 8 April 2015.

## Summary of background information:

- 1.5 In 2003, when Miss A was aged 15, her parents reported to the family's GP that there had been a significant deterioration in their daughter's behaviour both at home and at school.<sup>4</sup> No further action was taken by the GP at this stage.
- 1.6 In 2004 Miss A was excluded from school and her GP referred her to CAMHS.<sup>5</sup> During their initial assessment Miss A's parents reported that their daughter's behaviours had now reached "a crisis point"<sup>6</sup> due to there being a "spiral of aggressive and oppositional behaviours ...and

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<sup>1</sup> Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. . [Predictability](#)

<sup>2</sup>Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring. [Prevention](#)

<sup>3</sup> When Miss A's child had a 8 month review

<sup>4</sup> 7 July 2003

<sup>5</sup> [CAMHS](#)

<sup>6</sup> CAMHS's assessment, 28 April 2004

mild/moderate depression.”<sup>7</sup> Miss A reported to the CAMHS assessor that she was “hearing voices telling {her} to misbehave”<sup>8</sup> and there was reference to her self-harming. The assessment concluded that “the most likely explanation for the deterioration in {Miss A’s} behaviours {was} developmental and that {was} part of the process of individuation”.<sup>9</sup> There appears to have been no further CAMHS involvement.

- 1.7 Miss A left school at the age of sixteen (2004) and she also moved out of the family home.<sup>10</sup> After leaving school Miss A was employed in number of temporary positions. At the time of her pregnancy she was working as a waitress but she left this position and was then unemployed until the offence in 2015.
- 1.8 **Substance misuse history:** At Miss A’s initial EIS assessment she disclosed that, in the past, she had used illegal drugs, such as cocaine and cannabis, but as they increased her feelings of paranoia and obsessive behaviours she was no longer using them.
- 1.9 **Relationship history:** During her EIS assessment Miss A reported that she had in the past three significant relationships, the longest lasting for four years. Miss A also disclosed that one of these relationships involved incidents of domestic violence, involving both physical and verbal abuse by both parties.
- 1.10 **Arising issues, comments and analysis:**
- 1.11 In an Accident and Emergency discharge summary, 2 January 2012, Miss A reported that she had been “punched in {the} left side of {her} face by an ex-partner.”<sup>11</sup>
- 1.12 This type of complex volatile relationship, where both individuals are victims and perpetrators of incidents of domestic violence, is known as Situational Couple Violence and can range from one act of violence over the course of a relationship to frequent and chronic violence.<sup>12</sup> As no further information was obtained by either the community mental health services (CMHT) or EIS about this particular relationship it has not been possible to ascertain the extent of the violence in this relationship.

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<sup>7</sup> CAMHS’s assessment, 28 April 2004

<sup>8</sup> CAMHS’s assessment, 28 April 2004

<sup>9</sup> The individuation process is a term created by the psychologist Carl Gustav Jung to describe the process of becoming aware of oneself, of one’s make-up, and the way to discover one’s true, inner self [Individuation process](#)

<sup>10</sup> Letter from community psychiatric nurse to GP, 14 February 2013

<sup>11</sup> A&E Department 2 January 2012, p1

<sup>12</sup> Situational couple violence is used to identify the type of partner violence that does not have its basis in the dynamic of power and control situational couple violence may be best understood as an inappropriate attempt to cope with conflict or stress. Situational couple violence occurs in response to a specific event or stressor rather than a result of a general pattern of domination and oppression Situational couple violence, also called common couple violence, is not connected to general control behaviour, but arises in a single argument where one or both partners physically lash out at the other [Situational Couple Violence](#)

- 1.13 The Trust's CPA policy in place at the time directs that 'risk management/CPA care plan must detail interventions and responses to all the risks identified in the risk assessment'.<sup>13</sup> Despite Miss A's disclosure that she had been involved in a relationship that involved Situational Couple Violence (i.e. that she had been both a victim and a perpetrator) she was not assessed by either Community Mental Health Service (CMHT) or EIS as being at potential risk of future domestic violence.
- 1.14 We reviewed Oxford Health NHS Foundation Trust's Guidelines for Staff in the Management of Domestic Abuse that was in place at the time.<sup>14</sup> The guidelines provided the reporting structures and assessment pathways, such as Multi Agency Public Protection Arrangements (MAPPA)<sup>15</sup> and Multi-Agency Risk Assessment Conferences (MARAC)<sup>16</sup>, and the Trust's on-going commitment for domestic violence training for its staff. However, it did not direct staff to utilise assessments, such as CAADA-DASH Risk Identification Checklist (RIC).<sup>17</sup> It also failed to highlight or direct staff on how to respond to the complexities in both identifying and responding to the different types of domestic violence situations such as Situational Couple Violence.
- 1.15 **Contact with criminal justice services:** Miss A's first conviction was in 2006, when she was aged 18, for affray and attempted robbery. In 2010 she was convicted for aggravated vehicle taking, driving without insurance and failure to stop. In 2011 Miss A was convicted of criminal damage and cautioned for battery which was related to a domestic violence incident involving an ex-boyfriend. In December 2012 Miss A was arrested for stabbing a friend with a pair of scissors. Miss A reported that she had no recollection of the incident as she was under the influence of alcohol.<sup>18</sup> Miss A was placed on a one year probation order for this incident and she saw her probation officer for anger management support.

### Arising issues, comments and analysis:

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<sup>13</sup> Oxford Health NHS Foundation Trust Care Programme Approach (including non CPA) October 2013,p9

<sup>14</sup> Guidance for staff in the management of domestic abuse, ratified 15 December 2010

<sup>15</sup> Multi Agency Public Protection Arrangements (MAPPA) MAPPA has a statutory responsibility to establish formal arrangements for the purpose of assessing and managing the risks posed by: relevant sexual or violent offenders and other persons who by reason of offences committed by them (wherever committed are considered by the responsible authority to pose a risk of serious harm to the public). Establish the nature and level of risk of serious harm posed by persons meeting the notification criteria through the sharing of relevant information and assessments. Share and co-ordinate risk management plans Identify gaps in risk assessment or risk management process d. Monitor and review multi agency risk management

<sup>16</sup> Multi-Agency Risk Assessment Conferences (MARAC) These conferences provide an opportunity to share information about high risk cases and to implement a multi-agency action plan to promote the safety of the aggrieved and any children

<sup>17</sup>CAADA-DASH Risk Identification Checklist (RIC): use to assist front line practitioners to identify high risk cases of domestic abuse, stalking and 'honour'-based violence. To decide which cases should be referred to MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management. To offer a common tool to agencies that are part of the MARAC process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence. To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognise models of risk assessment. [CAADA](#)

<sup>18</sup> Letter from community psychiatric nurse to GP, 14 February 2013

- 1.16 Despite efforts by the investigation team to make contact with the relevant probation service in order to invite them to participate in this investigation we were unsuccessful. However we did access the notes from the telephone interview with Miss A's probation officer undertaken by the authors of Oxford Health NHS Foundation Trust Serious Incident Report.<sup>19</sup> It reported that Miss A was initially being seen weekly and then monthly by her probation officer and that during this time there were no concerns regarding Miss A's mental health. The probation services ended their supervision of Miss A in October 2014.
- 1.17 During a visit by the EIS social worker (20 February 2014) Miss A gave her permission for her probation officer to be contacted. We could only identify one occasion when this occurred: this was on 26 February 2014, where the probation officer disclosed Miss A's past convictions and also reported that she had made "some major changes in her life since offending in 2012 and {was} now avoiding alcohol".<sup>20</sup>
- 1.18 Miss A's probation officer was invited to the CPA review in November 2013 but was unable to attend. There was no indication that the probation officer was sent a copy of this or any subsequent CPA reviews. There was no contact between probation and health visiting services. Miss A's health visitor (HV) reported to us that she had not been aware of Miss A's forensic history.

### **Psychiatric care - January 2013 to December 2013:**

- 1.19 Miss A first presented herself to her GP on 22 January 2013, reporting that over the previous twelve months she had been feeling low and paranoid. She also disclosed that she felt "like there {were} cameras in her flat watching her". The GP referred her to the CMHT.
- 1.20 Miss A was assessed by a CMHT community psychiatric nurse (CPN) and consultant psychiatrist (3 February 2013) who undertook a mental state examination<sup>21</sup> and a risk assessment. At this assessment interview Miss A disclosed her forensic history, her historic self-harming, her relationship history and her history of extensive alcohol consumption and substance misuse. It was documented that Miss A was experiencing auditory and visual hallucinations. The initial risk assessment assessed that Miss A was at low risk and that her family were significant protective factors.<sup>22</sup>
- 1.21 The assessment concluded that Miss A required "both psychological support and medication... {and was prescribed} an anti-psychotic (risperidone<sup>23</sup>)".<sup>24</sup> She was also advised to reduce her alcohol intake, which they suggested

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<sup>19</sup> Telephone interview 20 May 2015

<sup>20</sup> Care notes entry 26 February 2014

<sup>21</sup> The mental state examination or mental state examination, abbreviated MSE, is an important part of the clinical assessment process in psychiatric practice. It is a structured way of observing and describing a patient's current state of mind, under the domains of appearance, attitude, behaviour, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment [Mental state](#)

<sup>22</sup> Miss A's patient records

<sup>23</sup> Risperidone is used to treat schizophrenia and symptoms of bipolar disorder [Risperidone](#)

<sup>24</sup> Miss A's patient records, p33



might be contributing to some of the symptoms. When Miss A failed to attend two further appointments<sup>25</sup> she was discharged from the service.

- 1.22 On 15 April 2014 Miss A again presented herself to her GP reporting that she was still experiencing low moods, paranoid thoughts and that she was pregnant. The GP advised Miss A to discontinue taking the risperidone medication and to contact the CMHT. The next entry in the GP was on 10 July 2013 when Miss A's midwife contacted the GP: the entry documented "midwife v. concerned re pt's (sic) mental health, severe depression with paranoid delusions"<sup>26</sup> A referral was sent by the GP to the CMHT.
- 1.23 Miss A was seen by the CMHT care coordinator and a specialist locum registrar,<sup>27</sup> on 30 August 2013 and 18 September 2013 where she disclosed that her obsessional behaviours had worsened and that she had stopped taking her medication as it had made her feel "more paranoid".<sup>28</sup> The risk assessment concluded that she was a low risk. The care coordinator asked Miss A for the contact details of her midwife so they could discuss the support Miss A was receiving from the CMHT. Miss A was prescribed haloperidol (1mg)<sup>29</sup> and referred to EIS. Miss A was given a diagnosis of psychotic disorder Not Otherwise Specified (ICD -10: F29).<sup>30</sup>

#### **Psychiatric care - January 2014 to September 2014:**

- 1.24 Miss A's care was transferred to the EIS team at a CPA review meeting on 27 January 2014. A risk assessment was completed on 20 February 2014 which assessed Miss A's risk as "very low".<sup>31</sup> This was the last risk assessment completed by EIS.
- 1.25 At a care planning meeting, 5 March 2014, Miss A reported that her obsessive checking was causing a significant disruption to her life she again denied taking illegal drugs and disclosed only limited alcohol consumption. She was prescribed quetiapine<sup>32</sup> 50mg. At this meeting the care coordinating role was transferred to an Occupational Therapist (OT) who was to provide her with psycho-education to support her to manage her symptoms of Obsessive Compulsive Disorder (OCD).
- 1.26 At the next EIS review (8 April 2014) Miss A was diagnosed with an "unspecified non organic psychosis"<sup>33</sup> and citalopram<sup>34</sup> (10mg) was added to her medication regime. At Miss A's last CPA review (18 August 2014) it was agreed that she would be re referred to psychology in January 2015. Her citalopram was increased to 20mg. The next review, which was

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<sup>25</sup> 11 March 2014 and 25 March 2013

<sup>26</sup> GP notes 10 July 2013

<sup>27</sup> CT1-3 doctor

<sup>28</sup> Patient records, p28

<sup>29</sup> Haloperidol antipsychotic medication [Haloperidol](#)

<sup>30</sup> ICD The International Classification of Diseases [ICD](#)

<sup>31</sup> Risk assessment 20 February 2014, p2

<sup>32</sup> Quetiapine is used to treat schizophrenia and bipolar disorder [Quetiapine](#)

<sup>33</sup> Care notes 4 April 2014

<sup>34</sup> Citalopram is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSR) [Citalopram](#).

scheduled for 16 March 2015, was cancelled due to sickness of the psychiatrist.

- 1.27 A carer's assessment was sent out to Miss A's mother on 6 March 2014 as she was consistently identified as both providing support to her daughter and that she was also a significant protective factor. It is not evident if Miss A's mother completed the assessments and there is no mention of this being followed up.

#### **Involvement of Health Visitor and children services- December 2013 to August 2014:**

- 1.28 Miss A's pregnancy was without any significant incident and she attended all her prenatal appointments. After her baby was born and the midwives discharged her she was allocated a health visitor who she met thirteen times either at home or at the children's centre. Miss A also attended the children's centre's mother and baby groups and was receiving support from their outreach team.
- 1.29 Miss A was last seen by the HV on 20 August 2014 where a Universal Service<sup>35</sup> eight month review was undertaken by a community nursery nurse. The review concluded that there were no concerns regarding Miss A's parenting and her baby was assessed as meeting all her expected developmental milestones.
- 1.30 The children's centre withdrew their support on 28 November 2014 as it was assessed that Miss A no longer required their services.

#### **Multi-Agency Safeguarding HUB (MASH):<sup>36</sup>**

- 1.31 On 18 November 2014 police attended an altercation at Miss A's flat where it was reported that she was under the influence of alcohol. The police were concerned that Miss A's baby was present and a MASH referral was made. Following this incident Miss A reported that she was no longer in contact with that particular friend and that she was happy to re-engage with HV team for support".<sup>37</sup> The MASH team closed the case.<sup>38</sup> Following this incident to the point of Miss A's arrest (18 April 2015) neither the HV nor Miss A's care coordinator had any face to face contact with her as she repeatedly failed to attend appointments. There was no indication that Miss A's GP was notified of the MASH inquiry.

#### **Arising issues, comments and analysis:**

- 1.32 Miss A was a single mother who had a complex and considerable risk history with regard to her impulsive behaviours and alcohol was a significant contributory factor. During both CMHT and subsequently EIS involvement

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<sup>35</sup> Universal services from the health visitor team working with general practice to ensure that families can access the Healthy Child Programme, and that parents are supported at key times and have access to a range of community services [Universal Service](#)

<sup>36</sup> MASH is a multi-agency team which identifies risks to vulnerable adults and children [MASH](#)

<sup>37</sup> Health visitors notes, 3 December 2014

Miss A was going through a significant and major life event that was her pregnancy and the birth of her child. Yet these potential risk factors were not considered or reflected within the risk assessments that were undertaken. Nor was there any consideration given to possibility that Miss A's symptoms and presentation may have required an escalation of her assessments and care to a more specialised service, such as perinatal psychiatry.

- 1.33 Miss A fully engaged with both mental health and HV services up until September 2014, this was also the period that she was under the supervision of a probation officer. However after this point she then disengaged with all services.
- 1.34 At the time of Miss A's involvement with the EIS they did not have any maternal/family expertise on the team. Although since this incident the EIS teams have had training in working with families and are now familiar with Infant Parent Perinatal Services (IPPS) that are currently available within the Trust.<sup>39</sup>
- 1.35 We would suggest that even with this increased skills base within EIS that with any patient who is either pregnant or in the post-partum phase there should be an ongoing consideration and assessment of the potential risks to their mental health. Where there are particular concerns about their mental health during their pregnancy or in the post-partum period EIS should either seek the advice from the Trust's Infant Parent perinatal Service (IPPS) or consider referring the mother to Oxford University Foundation NHS Trust's specialist perinatal psychiatric service.
- 1.36 Following this incident and the subsequent Trust's internal investigation HV services convened a conference in October 2015 where Adult Mental Health Service (AMHS) provided a briefing on their services. The HV staff, who we interviewed, reported that this conference was very informative and that they now feel they have a greater understanding of AMH services within the Trust and the referral pathways.
- 1.37 Additionally there have, since this incident, been multi service discussions within Oxford NHS Foundation Trust with regard to the barriers operating within the Think Family agenda. Following the findings of the SIR nine actions were identified to raise awareness with all practitioners and to embed the Think Family Agenda throughout the Trust's services
- 1.38 We concluded that clearly considerable work was undertaken immediately post incident to improve HV and Adult Mental Health Services (AMHS) understanding of each other's services and the referral pathways. However we would recommend that in order for this to be embedded within future clinician's understanding information about both services must be part of the on-going core training for all practitioners and that any changes in services or to Trust or national guidelines should be communicated to all staff within the Trust.

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<sup>39</sup> [Oxford Perinatal Service](#)

- 1.39 **CMHT and EIS risk assessments and care planning:** Miss A disclosed on several occasions to her EIS care coordinator and consultant psychiatrist that she had a significant risk history of impulsive and violent behaviours. She also identified that she had a significant history of excessive alcohol consumption and that on at least occasion Miss A reported that she had been intoxicated to the point where she had no memory of the incident (December 2012). Despite these disclosures Miss A's risks to herself and others were repeatedly being assessed by initially CMHT and then EIS as either "low" (13 February 2013) and "very low" (18 September 2013 20 February 2014). There was also little or no consideration of how Miss A's past risk history may have been an indicator of future possible risks and there were no details of other agencies involved or their contact details either on Miss A's care plan.
- 1.40 Additionally during Miss A's involvement with CMHT and EIS she had experienced several significant life events: the birth of her baby, when her probation order ended, the outreach support from the children's centre ended (October 2014), a change in her medication (September 2015) and a MASH inquiry (November 2014). Despite these known significant incidents there was no occasion when a risk review was triggered. In fact Miss A's risk assessment had not been updated since September 2013, and her crisis/relapse plan was not updated after the first plan in March 2014.
- 1.41 The Trust's Clinical Risk Policy at the time clearly directs that:
- "Any change of circumstances affecting an individual or their care plan which could lead to a change in the level or nature of their risk will prompt a review of the risk assessment and management plan."<sup>40</sup>
- 1.42 This failure by successive care coordinators to appropriately assess Miss A's risks not only was non-compliant with the Trust's policy but it also resulted in no longitudinal assessment undertaken of Miss A's risks and protective factors. Her risk assessment was not being regularly updated. The Trust's Care Programme Approach Policy (including non CPA)<sup>41</sup> states that the care coordinator must "ensure that there is ongoing assessment (to include risk) of the service user's mental and physical health and social needs... Update the care plan and safety and risk management plan as and when required and at intervals of no more than 6 months."<sup>42</sup>
- 1.43 None of the agencies involved with Miss A, that is probation, the children's centre or the health visitors, were provided with copies of either her risk assessment or care plan.
- 1.44 We were concerned about EIS lack of compliance with the Trust's Care Programme Approach Policy and the fact that the EIS managers at the time failed to identify that Miss A's risk assessments were not being reviewed and that the assessments that were completed were not responsive to the significant events in Miss A's life. The policy states that it is the responsibility

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<sup>40</sup> Oxford Health NHS Foundation Trust Clinical Risk Assessment and Management 10 February 2006 , p1

<sup>41</sup> Oxford Health NHS Foundation Trust Care Programme Approach Policy (including non CPA) 28 July 2010

<sup>42</sup> Oxford Health NHS Foundation Trust Care Programme Approach Policy (including non CPA) 28 July 2010, p3

of the management team “to monitor compliance; 3 monthly audits will be undertaken by the audit team.”<sup>43</sup> We can only conclude that such audits either did not occur or they failed to identify the issues with the management of Miss A within the EIS service.

- 1.45 It was evident from our interviews with EIS managers that since this incident their service has made considerable efforts to both address the Trust’s internal report’s findings and associated actions plans with regard to their assessments and monitoring processes of patients in this low risk group. However we would recommend that an audit of clinical supervision should be undertaken to ensure that such patients are being regularly discussed within clinical supervision and to ensure that there is consistency within the EIS with regard to the criteria being utilised in the assessment of the patients within this “low risk category.”
- 1.46 **MASH:** When we reviewed the events and support Miss A was receiving leading up to the MASH incident it was evident that after her probation supervision ended she failed to engage with either EIS or HV service.
- 1.47 Up until October 2014 Miss A was seen initially weekly and then monthly by her probation officer and she attended all her appointments as clearly she would have been aware that if she failed to attend these appointments or if she committed any further offences during this period there would have been a possibility that she would receive a custodial sentence. At the time when the supervision order ceased the support provided by the children centre’s outreach service also ended. Also at her last CPA review (August 2014) her medication was changed and her subsequent failure to engage further with EIS resulted no one monitoring either her compliance or her mental health. Despite these significant changes there was no consideration given by EIS that this may have been a time of increased risks for Miss A when she might require more support and/or closer monitoring.
- 1.48 When EIS were informed of the MASH incident in November 2014 it was reported that alcohol had been identified as a significant and contributing factor in the incident. Despite EIS being aware that alcohol had been previously been a significant past trigger to Miss A’s impulsive behaviour, they took no action to instigate a review of her risk assessment.
- 1.49 The HV also did not take any proactive action to see Miss A after the MASH until January 2015 when she offered Miss A several appointments which she did not attend. No further proactive action was taken by the HV despite the fact that engagement with the HV was part of the requirement for the closure of the MASH. It was not until February 2015 that the HV considered reporting Miss A’s lack of engagement to the MASH.
- 1.50 Miss A reported to us that she had not understood what MASH was and that it had increased her concerns about her baby being removed therefore she actively avoided seeing her HV or contacting EIS for support.

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<sup>43</sup> Oxford Health NHS Foundation Trust Care Programme Approach Policy (including non CPA) 28 July 2010, p6.

- 1.51 There was no indication that either agency gave any consideration that Miss A's baby may have been at risk and that they needed to consider making a safeguarding referral. This lack of action is concerning as the majority of EIS staff at the time had completed the level 3 safeguarding children's e-learning which is the mandatory training for staff in the team. Yet they failed to recognise or seek advice regarding this possible being a safeguarding situation.

#### **Review of Oxford NHS Foundation Trust (OHFT) internal report (SIR):**

- 1.52 We concluded that the SIR report was a thorough and accessible report providing the chronology of Miss A's involvement with both the HV and community mental health services. The SIR presented to the Trust SMART recommendations. <sup>44</sup> We were provided with evidence that all the actions from the SIR have now been fully implemented.
- 1.53 We would however suggest as with any action plan there always needs to be on going monitoring of compliance to ensure that all areas of learning are fully embedded within both the operational policies of individual services and the Trust's Directorates. We would suggest that it is vital that there is on-going review process, via service reviews, reviews of documentation supervision and feedback from patients and their families and carers, being undertaken by the Trust of how the Think Family Agenda, with regard to inter agency communications and information sharing, changes in the EIS service, are affecting and underpinning the daily practices of all clinicians. Additionally the Trust should ensure that the Think Family agenda is part of the core training for all staff.

#### **Involvement of Miss A and families:**

- 1.54 With regard to the Involvement of Miss A and her mother in the SIR, the authors reported that the police advised that against this as it was, at the time, an on-going investigation. The co-author of the report advised us that following the completion of their report they had met with Miss A.
- 1.55 The authors also documented that "the name of the victim and the victim's family is unknown to us. We will endeavour to try to make contact via the police and victim liaison."<sup>45</sup> Representatives from the Trust and the commissioning CCG, who attended the start-up meeting for this case, were unsure if anyone from OHFT had made direct contact with either Miss A or the victims' families after the incident. This is a requirement of the NHS Duty of Candour <sup>46</sup> that was introduced in April 2015. We would suggest that it should be clarified if the Trust made contact with both families after the

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<sup>44</sup> **S** - specific, significant, **M** - measurable, meaningful, motivational **A** - agreed upon, attainable, achievable, acceptable, action-oriented **R** - realistic, relevant, reasonable, rewarding, results-oriented **T** - time-based, time-bound, timely, tangible, trackable

<sup>45</sup> SIR, p20

<sup>46</sup> Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. • Duty of Candour aims to help patients receive accurate, truthful information from health providers [Duty of Candour](#).

incident and if not this failure to comply with Duty of Candour must be addressed.

## **Predictability and Preventability**

### **Predictability**

- 1.56 Miss A had a history of impulsive and volatile behaviour in which alcohol was a significant contributing factor. In the six months prior to the incident there was an incident that caused the police such concern, regarding the well-being of Miss A's baby that they reported it to MASH. Our investigation has clearly identified that after her probation order was completed Miss A disengaged with all involved services therefore it is not possible for us to comment on her mental health presentation during this time. Neither is it possible to ascertain if her alcohol consumption had increased during the months leading up to the incident.
- 1.57 Given that there is limited information available regarding Miss A in the weeks preceding the incident we have had to conclude that the events of 15 April 2015, which led to the death of Mr X, were not predictable. However we can conclude that given Miss A's history it was highly predictable that she would be involved in future impulsive act(s) and that it was highly likely that alcohol would be a significant contributory factor.

### **Preventability**

- 1.58 In our consideration of the preventability of this incident, we have asked ourselves the following two questions: based on the information that was known, were Miss A's risk factors and support needs being adequately assessment and addressed by the involved agencies? Additionally was the incident on the 15 April 2015 preventable?
- 1.59 Clearly both EIS and HV services should have been more proactively trying to engage Miss A especially after the MASH incident. But given Miss A's reluctance to either engage with services or fully disclose her difficulties it is difficult to see how based on the information that was known, services could have prevented the incident that lead to the death of Mr X .We have therefore concluded that the incident was not preventable.

### **Concluding comments:**

- 1.60 It is clearly evident that Miss A was a very vulnerable woman, who had complex psychosocial difficulties and who at times was experiencing debilitating mental health symptoms. Despite these known symptoms she was assessed initially by CMHT and then by EIS as a low risk patient. We have concluded that there was, in our opinion, enough evidence available to all involved agencies to indicate that Miss A had considerable on going risks and support needs. Specialist perinatal advice should have been sought to ensure that both Miss A and her baby were receiving the appropriate level of support. As it was after probation and the children centre withdrew their support Miss A was isolated having to manage her very debilitating and life

limiting mental health symptoms without the level of care that she clearly needed.

## **Recommendations**



**Recommendation 1:**

Any reduction in support provided to a patient by other agencies should be considered as a possible increase in risk factors and a risk assessment review must be undertaken by Oxford Health NHS Foundation Trust's community mental health services.

**Recommendation 2:**

Oxford Health Foundation Trust's mental health services must invite all involved agencies to a patient's CPA review. If they are unable to attend they should be asked to contribute to the review and receive a copy of the CPA review and associated risk assessments.

**Recommendation 3:**

Oxford Health NHS Trust should update its Management of Domestic Abuse guideline to provide staff with a more comprehensive overview of the various types of domestic violence, including Situational Couple Violence.

**Recommendation 4:**

Where there has been a disclosure by a patient that they have previously been involved in a relationship where there has been situational couple violence this should be considered and documented within their risks assessments as a significant risk factor. Consideration should be given to referring them to the appropriate domestic violence support services.

**Recommendation 5**

For any patient within Oxford Health NHS Foundation Trust's Early Intervention Service who is either pregnant or in the post-partum phase, the potential risk factors need to be considered and regularly reviewed. There should be on going liaison with the patient's Health Visitor and any other involved agency and they should be invited to contribute to the patient's CPA reviews.

**Recommendation 6:**

Where there are particular concerns about a patient who is either pregnant or during the post-partum phase Early Intervention Service should seek the advice of the Trust's Infant Parent perinatal Service (IPPS) or refer them to Oxford University Foundation NHS Trust's specialist perinatal psychiatric service.

**Recommendation 7:**

Information about Oxford Health Foundation Trust's Adult Mental Health services should be a part of the health visitor's core induction training.

**Recommendation 8:**

Oxford Health NHS Foundation Trust's must ensure that information regarding referral pathways and any changes to their mental health services are communicated to their health visiting services.

**Recommendation 9:**

An audit of clinical supervision should be undertaken within Oxford Health Foundation Trust's Early Intervention Service to ensure that patients who have been assessed as being low risk (i.e. green) are being regularly discussed within supervision. To also ensure that there is consistency within the service with regard to the criteria being utilised in the assessment of the patients within this category.

**Recommendation 10:**

Oxford Health Foundation Trust's Early Intervention and the Health Visitors service should develop a joint protocol which identifies a multi-agency approach to communication, information sharing and contingency planning for patients with mental health issues who disengage with either service.

**Recommendation 11:**

Oxford Health NHS Foundation Trust should undertake an audit of patients within its Early Intervention Services who are either pregnant or have children under the age of 5 years to ascertain if midwives and health visitors are being routinely invited or asked to contribute to CPA reviews. This audit should also review the standard of information sharing between these services.

**Recommendation 12:**

Oxford Health NHS Foundation Trust should ascertain if they have made contact with both the families of Miss A and the victim after this incident. If this did not occur then their failure with regard to their Duty of Candour must be immediately addressed.

**Recommendation 13:**

Oxford Health NHS Foundation Trust induction training should include developing practitioners' understanding and responsibility with regard to the Think Family Agenda.

## 2 Summary of incident

- 2.1 On the morning of 16 April 2015 Miss A called 999 to report a male, (Mr X), had been stabbed at her home.
- 2.2 The victim was taken to hospital by the emergency services where he subsequently died.
- 2.3 Miss A was arrested at her mother's home and was charged with the murder of Mr X. At the time of the homicide Miss A was 26 years old and had an eighteen month old child.
- 2.4 A post-mortem examination established Mr X, aged 23, died from a stab wound to the chest. The weapon used was a kitchen knife.
- 2.5 It was reported at the trial<sup>47</sup> that after attending a party Mr X had gone with a friend to Miss A's home. Evidence presented during the trial indicated that an argument broke out after Miss A had asked Mr X and his friend to leave. At the time of the incident Miss A had been drinking alcohol.
- 2.6 Miss A reported that she had known the deceased prior to that evening.
- 2.7 Miss A was found guilty of murder and was given a life tariff with a minimum sentence of eighteen years.
- 2.8 Miss A was under the care of Oxford Health NHS Foundation Trust, the early intervention service in Oxford (EIS) and the Health Visiting Service in Banbury.
- 2.9 Miss A was last seen by her health visitor on 20 August 2014<sup>48</sup> and by her EIS social worker on 27 October 2014.
- 2.10 Miss A's GP was the last professional to see her on 8 April 2015.

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<sup>47</sup> 15 October 2015

<sup>48</sup> Miss A's child's 8 month review with universal services

## 3 Independent investigation

### Approach to the investigation

- 3.1 From 2013 NHS England assumed overarching responsibility for the commissioning of independent investigations into mental health homicides and serious incidents. On 1 April 2015 NHS England introduced its revised Serious Incident Framework<sup>49</sup> which “aims to facilitate learning by promoting a fair, open, and just culture that abandons blame as a tool and promotes the belief that incidents cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring.”
- 3.2 The Serious Incident Framework identifies the following criteria for the commissioning of an independent investigation:
- “When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced care programme approach, or is under the care of specialist mental health services in the 6 months prior to the event.”
- 3.3 The Serious Incident Framework also cites that a standardised approach to investigating such incidents is to:
- “Ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. Facilitate further examination of the care and treatment of the patient in the wider context and establish whether or not an incident could have been predicted or prevented, and if any lessons can be learned for the future to reduce the chance of recurrence. Ensure that any resultant recommendations are implemented through effective action planning and monitoring by providers and commissioners.”
- 3.4 In January 2016 NHS England (South) commissioned Niche to undertake an investigation into the events that led up to the homicide of Mr X on 16 April 2015.

### Purpose and scope of the investigation

- 3.5 The full terms of reference for this investigation are located in appendix B.

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<sup>49</sup>[Serious Incident Framework](#)

3.6 In summary Niche's investigation team has been asked to:

- Review the engagement, assessment, treatment and care that Miss {A} received from Oxford Health NHS Foundation Trust, with specific reference to the Early Intervention Service (EIS).
- Review the contact and communication between agencies within Oxford Health Services (e.g. GP, Health Visiting Services).
- To review Miss {A's} risk assessments and management plans with specific regard to her risk to others.
- Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and the implementation of the action plan.
- To consider whether the incident on 16 April 2016, which led to the death of {Mr X} was predictable<sup>50</sup> or preventable.<sup>51</sup>

3.7 The overall aim of this independent investigation is to identify common risks and opportunities, to improve patient safety and to make further recommendations about organisational and system learning.

3.8 This report does not directly comment on the actions of the Health Visiting service; however we will be making reference to their involvement, national guidelines and Oxford NHS Foundation Trust's perinatal services.

### **Investigation team**

3.9 The investigation was led by Niche's senior investigator Grania Jenkins.

3.10 Due to the complexities of this case, the following professionals contributed to the investigation: specialist psychiatric advice was provided by Dr Andrew Leahy and Dr Ben Nereli provided perinatal psychiatric advice.

3.11 This report was peer-reviewed by Carol Rooney, Niche Deputy Director.

3.12 For the purpose of this report, the investigation team will be referred to in the first person plural.

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<sup>50</sup> Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. [Predictability](#)

<sup>51</sup> Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring. [Prevention](#)

## Methodology

- 3.13 This report was written with reference to the National Patient Safety Agency (NPSA) Root Cause Analysis Guidance.<sup>52</sup>
- 3.14 Root Cause Analysis (RCA) methodology has been utilised to review the information obtained throughout the course of this investigation.
- 3.15 RCA is a retrospective multidisciplinary approach designed to identify the sequence of events that lead to an incident. It is an iterative<sup>53</sup> structured process that has the ultimate goal of the prevention of future adverse events by the elimination of latent errors.
- 3.16 RCA also provides a systematic process for conducting an investigation, looking beyond the individuals involved and seeking to identify and understand the underlying system features and the environmental context in which an incident occurred. It also assists in the identification of common risks and opportunities to improve patient safety and informs recommendations regarding organisational and system learning.
- 3.17 The prescribed RCA process includes data collection and a reconstruction of the event in question through record reviews and participant interviews.
- 3.18 As part of the investigation process, we have utilised an RCA fishbone diagram to assist the investigative team in identifying the influencing contributory factors which led to the incident (the fishbone diagram is located in appendix A).
- 3.19 As far as possible we have tried to eliminate or minimise hindsight or outcome bias<sup>54</sup> in our investigation. We analysed information that was available to primary and secondary care services at the time. However, where hindsight informed our judgments, we have identified this.

## Investigation process

- 3.20 As part of this investigation we interviewed the following practitioners and senior managers from oxford NHS Foundation Trust:

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<sup>52</sup> National Patient Safety Agency (NPSA) Root Cause Analysis [NPSA](#)

<sup>53</sup> Iteration is the act of repeating a process with the aim of approaching a desired goal, target or result

<sup>54</sup> Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgment and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008) [NPSA](#)

- Head of Public Health.
- Family health visitor.
- Health Visitor's service manager.
- Locality and operational manager health visitors.
- Clinical Director of adult mental health services and consultant psychiatrist.
- EIS service managers.
- Consultant psychiatrist from EIS.
- Author of internal investigation.
- Head of Nursing children and young people.
- Patient Safety Lead.
- Primary care GP (telephone interview).

3.21 Our interviews were managed with reference to the National Patient Safety Agency (NPSA) investigation interview guidance<sup>55</sup> and adhered to the Salmon/Scott principles.<sup>56</sup>

3.22 We accessed Miss A's primary and secondary mental health care notes. Where relevant we accessed Oxford NHS Foundation Trust's operational policies and guidelines that were in place at the time of the incident. We have also reviewed the relevant policies that have been reviewed since this incident.

3.23 Where required we have made reference to various Department of Health (DH) Best Practice guidelines and to the relevant NICE<sup>57</sup> guidance.

## Anonymity

For the purpose of this report:

3.24 The identities of all those who were interviewed have been anonymised and are identified by their professional titles.

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<sup>55</sup> National Patient Safety Agency (2008) Root Cause Analysis Investigation Tools: Investigation interview guidance

<sup>56</sup> The 'Salmon Process' is used by a public inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry, whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere [Salmon/Scott](#)

<sup>57</sup> NICE: National Institute for Health and Care Excellence



3.25 Services have been anonymised and are referred to by their service type only.

3.26 The patient is referred to as Miss A and the victim as Mr X.

### **Involvement of members of Miss A and Mr X's families**

3.27 NHS England's Serious Incident Framework directs that all investigations should:

“Ensure that families (to include friends, next of kin and extended families) of both the deceased and the perpetrator are fully involved. Families should be at the centre of the process and have appropriate input into investigations.”

3.28 As part of all Niche's investigations we will always try to obtain the views of the patient and the families of both the victim and the perpetrator, not only in relation to the incident itself but also their wider thoughts regarding where improvements to services could be made in order to prevent similar incidents from occurring again.

3.29 Both Miss A and Mr X's family were contacted by NHS England. Mr X's family responded that they did not want to be involved or be contacted, so chose not to be involved in our investigations. We wrote to Miss A's mother twice, and also suggested to Miss A that she talk to her mother about involvement in the investigation, but received no response.

3.30 At the end of the investigation both families were sent a copy of the report by NHS England. They did not wish to make any comments or attend the pre-publication meeting.

### **Involvement of Miss A**

3.31 Members of the investigation panel have met with Miss A on two occasions.

3.32 We met Miss A to discuss the findings of the report and provided her with a copy. She hopes the report will be used to help others in the future.

### **Structure of the report**

3.33 A chronology of Miss A's care and the events that led up to the incident is located in Appendix C.

3.34 The report is divided into the following sections:

- Background information about Miss A and her life experiences, including her contact with the criminal justice service.
- Miss A's psychiatric care and the support she was also receiving from health visiting services. This section also includes Miss A's pre and post-natal care.
- Oxford NHS Foundation Trust internal report. It also reviews the progress the Trust has made regarding its implementation of the action plan that was based on the findings of the internal report's recommendations.
- Predictability and preventability.
- Recommendations.

3.35 Where it is required sections have an arising issues and commentary subsection, which provides either additional information or an analysis of the issues that have been highlighted within that section.

## 4 Childhood, family background, employment and housing

### Family background and involvement of CAMHS

- 4.1 Miss A was the eldest of three children. As a child Miss A lived with her mother and step-father and two half siblings. Her ethnicity was Afro-Caribbean and White British.
- 4.2 Miss A reported<sup>58</sup> that throughout her childhood she had very little contact with her biological father who had schizophrenia. In 2011 she reported meeting him but had decided not pursued this relationship any further.
- 4.3 There were no reported concerns regarding Miss A's early developmental progress although a later CAMHS assessment noted that Miss A had been bullied at primary school.

### Involvement of CAMHS

- 4.4 In 2003, when Miss A was aged 15, her parents reported to the family's GP that there had been a significant deterioration in their daughter's behaviour both at home and at school.<sup>59</sup> They also reported that she was experimenting with illegal drugs and that they were receiving letters from the

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<sup>58</sup> Letter from adult community mental health team to GP, 14 February 2014

<sup>59</sup> 7 July 2003

school regarding their daughter being verbally abusive towards her teachers. They also expressed concerns about the effects that Miss A's behaviour was having on the whole family.

- 4.5 Miss A reported to the GP that she felt that her parents were being "overprotective".<sup>60</sup> No further action was taken by the GP at this stage but it was noted that Miss A's school and her parents worked closely together to try and improve her behaviour. There was also ongoing Health Visitor involvement with the family.
- 4.6 In 2004 Miss A was excluded from the school that she was attending and her GP referred her to Child and Adolescent Mental Health Services (CAMHS).<sup>61</sup> During their initial assessment Miss A's parents reported that their daughter's behaviours had now reached "a crisis point" due to there being a "spiral of aggressive and oppositional behaviours ...and mild/moderate depression". Miss A had also run away from home for two days and was return by the police.
- 4.7 Miss A reported to the CAMHS assessor that she was "hearing voices telling {her} to misbehaviour" and there was reference to her self-harming. The assessment concluded that there was no evidence of auditory command hallucinations and that "the most likely explanation for the deterioration in {Miss A's} behaviours {was} developmental and that {was} part of the process of individuation."
- 4.8 The assessment concluded that they would keep Miss A's referral open during the transitional phase whilst she was settled into a new school. There appears to have been no further CAMHS involvement.
- 4.9 Miss A left school at the age of sixteen (2004) and she also at this time moved out of the family home.<sup>62</sup>

## Employment

- 4.10 When Miss A left school she had a number of temporary positions, such as working in a laundry and in a factory where she was dismissed due to her having a physical altercation with her manager. At the time of her pregnancy, in 2013, she had recently been working as a waitress but had left this position and was then subsequently unemployed until the offence in 2015.

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<sup>60</sup> GP notes, 7 July 2003

<sup>61</sup> CAMHS, assessment, 28April 2004

<sup>62</sup> Letter from community psychiatric nurse to GP, 14 February 2013

- 4.11 Miss A was receiving employment and support (ESA) and was being issued with a fitness to work statement (MED 3) by her GP who cited depression as being the reason she was not fit to seek work.
- 4.12 After Miss A's baby was born (December 2013) her benefits were initially changed to income support and child benefit. She then reapplied for ESA in February 2014.

## Housing

- 4.13 Miss A reported that when she left the family home she initially moved in with friends and then into a Foyer<sup>63</sup> for a period of time, where she was receiving support. She then moved into various bedsits and prior to the birth of her baby she obtained a one bedroom social housing flat.
- 4.14 After her baby was born Miss A was reporting to her health visitor and GP that her flat had considerable damp issues due to poor heating in her flat that she and her baby were living in one room. With the assistance of her health visitor these issues were resolved in January 2014. However during Miss A's last visit to her GP in April 2015 she reported that she was still experiencing damp issues in her flat.
- 4.15 During Miss A's last face to face contact with her Early Intervention Service (EIS) social worker (27 October 2014) she requested help to apply for a social housing 2 bed property. There is no documented evidence that this occurred.

## Substance misuse history

- 4.16 The CAMHS assessment documented that whilst Miss A was at school she was referred to a drug counsellor. It was not evident if she was still seeing this counsellor at the time of the CAMHS assessment nor was there any documented information, within the CAMHS notes, as to what drugs she had been taking or the extent of her use.
- 4.17 The GP noted, at the time of the referral to CAMHS, that Miss A's parents reported that their daughter was associating with known drug users and they were concerned that she was experimenting with drugs.
- 4.18 When Miss A was referred to adult mental health services (2014) she disclosed that, in the past, she had used illegal drugs, such as cocaine and

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<sup>63</sup> Foyers provide housing for young people and help with education, training and finding work. They offer affordable accommodation for young people, usually between the ages of 16 to 25, who are homeless or in housing need, and want to develop skills and prepare for living independently [Foyers](#)

cannabis, but as they increased her feelings of paranoia and obsessive behaviours she was no longer using them.

- 4.19 During our interview Miss A confirmed her previous drug use and also that she had stopped as she had realised that it was affecting her mental health.

### **Contact with criminal justice service**

- 4.20 Miss A's first conviction was in 2006, when she was aged 18, for affray and attempted robbery. In 2010 she was convicted for aggravated vehicle taking, driving without insurance and failure to stop.
- 4.21 In 2011 Miss A was convicted of criminal damage and cautioned for battery which was related to a domestic violence incident involving an ex-boyfriend.
- 4.22 In December 2012 Miss A was arrested after she stabbed a friend with a pair of scissors. The friend required treatment in A&E for her injuries. Miss A reported to the community mental services (CMHT) that she had no recollection of the incident as she was under the influence of alcohol<sup>64</sup> and that she expected to receive a custodial sentence. However in October 2013 Miss A was placed on a one year probation order for this incident and it was documented in the EIS records that she was seeing her probation officer on a weekly basis for anger management support

### **Arising issues, comments and analysis**

- 4.23 Despite efforts to make contact with the relevant probation service to invite them to participate in this investigation we were unsuccessful. However we did access the notes from the telephone interview with Miss A's probation officer undertaken by the authors of Oxford Health NHS Trust Serious Incident Report.<sup>65</sup> It was reported that Miss A was initially being seen weekly and then monthly by her probation officer as her probation order progressed. It was also reported that during the order there were no concerns regarding Miss A's mental health.
- 4.24 There was no documentation of when EIS became aware of the timing of the reduction in involvement of Miss A's probation officer but it was documented in an EIS care plan review on 5 March 2014. This reduction in Miss A's probation support did not trigger any consideration of possible new or increased risk factors by mental health services.
- 4.25 During a visit by the EIS social worker (20 February 2014) Miss A gave her permission to contact her probation officer. We could only identify one

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<sup>64</sup> Letter from community psychiatric nurse to GP, 14 February 2013

<sup>65</sup> Telephone interview 20 May 2015

occasion when this occurred, this was on 26 February 2014, where the probation officer disclosed Miss A's past convictions and also reported that she had made "some major changes in her life since offending in 2012 and {was} now avoiding alcohol".<sup>66</sup>

- 4.26 Miss A's probation officer was invited to the CPA review in November 2013 but was unable to attend. There was no indication that the probation officer was sent a copy of this or subsequent CPA reviews.
- 4.27 It was documented in the EIS notes (27 October 2014) that the care coordinator intended to make contact with Miss A's probation officer but there is no indication that this occurred.
- 4.28 There was no contact between probation and health visiting services. Miss A's health visitor (HV) did not receive copies of Miss A's care plan reviews or risk assessments and was therefore unaware of Miss A's forensic history.

**Recommendation 1:**

Any reduction in support provided to a patient by other agencies should be considered as a possible increase in risk factors and a risk assessment review must be undertaken by Oxford Health NHS Foundation Trust's community mental health services.

**Recommendation 2:**

Oxford Health Foundation Trust's mental health services must invite all involved agencies to a patient's CPA review. If they are unable to attend they should be asked to contribute to the review and receive a copy of the CPA review and associated risk assessments.

## Relationships

- 4.29 During her EIS assessment Miss A reported that she had had three significant relationships, the longest lasting for four years.
- 4.30 Miss A also disclosed that one of these relationships involved incidents of domestic violence, involving both physical and verbal abuse by both parties.

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<sup>66</sup> Care notes entry 26 February 2014

## Arising issues, comment and analysis

- 4.31 No further information was obtained by either the community mental health services (CMHT) or EIS about this particular relationship therefore it is difficult to accurately identify the extent of the violence in this relationship, however we did obtain two discharge summaries from Accident and Emergency departments (A&E) where Miss A presented with injuries. On 28 October 2010 Miss A presented with a laceration to her forehead.<sup>67</sup> There was no further information documented as to how she sustained this injury but given the date it is a possibility that it may have occurred during this relationship. On 2 January 2012 Miss A presented herself to an A&E department reporting that she had been “punched in {the} left side of {her} face by an ex-partner”.<sup>68</sup> She was discharged with head injury advice and analgesia. It is not evident if she was provided with advice regarding support available for victims of domestic violence.
- 4.32 In all the risk assessments<sup>69</sup> that were undertaken by CMHT and then EIS it was identified that Miss A had been in a long term relationship that involved domestic violence. Yet despite this information being known she was not assessed within the various risk assessments as being at potential risk of future domestic violence, either as a victim or as a perpetrator.
- 4.33 We suggest that based on the information that Miss A did disclose to the CMHT and EIS assessors the initial and subsequent risk assessments should have identified and considered the potential and significant further risk(s) factors to both herself and others. It should also have been identified and considered within Miss A’s CPA plan as to what particular support she needed in this area.
- 4.34 The Trust’s CPA policy in place at the time directs that “risk management/CPA care plan must detail interventions and responses to all the risks identified in the risk assessment”.<sup>70</sup> This did not occur.
- 4.35 This type of complex volatile relationship, where both individuals are victims and perpetrators of incidents of domestic violence, is known as Situational Couple Violence and can range from one act of violence over the course of a relationship to frequent and chronic violence.<sup>71</sup> It is suggested that it

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<sup>67</sup> A &E Discharge summary , 28 October 2010

<sup>68</sup> A&E Department 2 January 2012, p1

<sup>69</sup> 13 February 2013, 18 September 2013, 20 February 2014

<sup>70</sup> Oxford Health NHS Foundation Trust Care Programme Approach (including non CPA) October 2013,p9

<sup>71</sup> Situational couple violence is used to identify the type of partner violence that does not have its basis in the dynamic of power and control situational couple violence may be best understood as an inappropriate attempt to cope with conflict or stress. Situational couple violence occurs in response to a specific event or stressor rather than a result of a general pattern of domination and oppression Situational couple violence, also called common couple violence, is not connected to general control behavior, but arises in a single argument where one or both partners physically lash out at the other [Situational Couple Violence](#)

“is the most common type of physical aggression in the general population of married spouses and cohabiting partners, and is perpetrated by both men and women ... violence is not based on a relationship dynamic of coercion and control, is less severe, and mostly arises from conflicts and arguments between the partners (Johnson, 2006)<sup>72</sup> ... Perhaps most importantly, the violence that is identified in these studies has a long developmental history, preceding the current adult relationship”.<sup>73</sup>

4.36 As part of this investigation we reviewed Oxford Health NHS Foundation Trust Guidelines for Staff in the Management of Domestic Abuse that was in place at the time Miss A’s disclosed that she had been involved, as both the victim and perpetrator, in incidents of domestic abuse.<sup>74</sup> This guideline was ratified on 15 December 2013 and a review of the guideline was underway at the time of the offence.

4.37 The guidelines provides some clarity regarding the reporting structures, explains pathways such as Multi Agency Public Protection Arrangements (MAPPA)<sup>75</sup> and Multi-Agency Risk Assessment Conferences (MARAC)<sup>76</sup>, and the Trust’s commitment to training for its staff it states:

“The main focus of this policy is the needs of women. It is acknowledged that men also experience domestic abuse but approximately 90% of cases are committed by men against women. (Department of Health 2005) It is recognised that one in four women will experience domestic abuse.”<sup>77</sup>

4.38 We would suggest that the Trust guideline definitions of domestic abuse were, in our opinion, quite limited. It also does not highlight or direct staff on how to respond to the complexities in both identifying and responding to different types of situations where domestic violence maybe be an issue, for example Situational Couple Violence.

4.39 It also does not direct staff to utilise assessments, such as CAADA-DASH Risk Identification Checklist (RIC)<sup>78</sup> or refer to the Trust’s risk assessments

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<sup>72</sup> Apples and oranges in child custody disputes: Intimate terrorism vs. situational couple violence. MP Johnson (2006) Journal of Child Custody, 2006 - Taylor & Francis

<sup>73</sup> Johnson, Michael P. (May 1995). "Patriarchal terrorism and common couple violence: two forms of violence against women". Journal of Marriage and Family. Wiley for the National Council on Family Relations. 57 (2): 283–294DHR, p94/95

<sup>74</sup> Guidance for staff in the management of domestic abuse, ratified 15 December 2010

<sup>75</sup> Multi Agency Public Protection Arrangements (MAPPA) MAPPA has a statutory responsibility to establish formal arrangements for the purpose of assessing and managing the risks posed by: relevant sexual or violent offenders and other persons who by reason of offences committed by them (wherever committed are considered by the responsible authority to pose a risk of serious harm to the public). Establish the nature and level of risk of serious harm posed by persons meeting the notification criteria through the sharing of relevant information and assessments. Share and co-ordinate risk management plans Identify gaps in risk assessment or risk management process d. Monitor and review multi agency risk management

<sup>76</sup> Multi-Agency Risk Assessment Conferences (MARAC) These conferences provide an opportunity to share information about high risk cases and to implement a multi-agency action plan to promote the safety of the aggrieved and any children

<sup>77</sup> Guidance for staff in the management of domestic abuse, ratified 15 December 2010, p1

<sup>78</sup>CAADA-DASH Risk Identification Checklist (RIC): use to assist front line practitioners to identify high risk cases of domestic abuse, stalking and ‘honour’-based violence. To decide which cases should be referred to MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management. To offer a common tool to agencies that are part of the MARAC process and provide a shared understanding of risk in relation to



in order to identify and assess potential victims and their associated risk factors.

- 4.40 These areas might be covered within the Trust's domestic violence training but we would suggest that Oxford NHS Foundation Trust needs to review its current 'Guidelines for Staff in the Management of Domestic Abuse' to provide staff with a more comprehensive overview of the types of domestic violence, and what responses and actions are expected from its staff with regard to risk identification and care planning.

**Recommendation 3:**

Oxford Health NHS Trust should update its s Management of Domestic Abuse guideline to provide staff with a more comprehensive overview of the various types of domestic violence, including Situational Couple Violence.

**Recommendation 4:**

Where there has been a disclosure by a patient that they have previously been involved in a relationship where there has been situational couple violence this should be considered and documented within their risks assessments as a significant risk factor. Consideration should be given to referring them to the appropriate domestic violence support services.

## 5 Psychiatric care - January 2013 to December 2013

- 5.1 Miss A first presented to her GP on 22 January 2013, reporting that over the previous twelve months she had been feeling low and paranoid. She also disclosed that she felt “like there {were} cameras in her flat watching her”. The GP noted that Miss A “cannot be dissuaded although {she} acknowledges that it was unlikely”.<sup>79</sup>
- 5.2 Miss A reported to us in her interview that she would constantly ask her friends if they had secreted cameras in her flat, although they denied this she did not feel reassured and continued to have these intrusive thoughts.
- 5.3 The GP completed a Patient Health Questionnaire PHQ 9<sup>80</sup> where Miss A scored 15/27.<sup>81</sup> The GP referred her to the CMHT.
- 5.4 Miss A was assessed by a CMHT community psychiatric nurse (CPN) and consultant psychiatrist on 3 February 2013. A mental state examination<sup>82</sup> and a risk assessment were undertaken.
- 5.5 At this assessment interview Miss A disclosed her forensic history, her historic self-harming, her relationship history, including the relationship that involved domestic violence, and her history of extensive alcohol consumption and substance misuse.
- 5.6 It also documented that Miss A was experiencing auditory and visual hallucinations. The initial risk assessment highlighted the following risk factors:
- “Risk to self-low. She told us that she does not have suicidal ideation and her mother is a strong protective factor.
  - Risk to others -low although may increase when drinking alcohol.
  - Neglect-low.
  - Exploitation-low”.<sup>83</sup>
- 5.7 During this assessment Miss A disclosed the circumstances around an incident in December 2012 when she reported that she had been “severely

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<sup>79</sup> GP notes 22 January 2013

<sup>80</sup> PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression

<sup>81</sup> 15 /19 score major/moderate depression, recommended treatment antidepressants or psychotherapy [PHQ-9](#)

<sup>82</sup> The mental state examination or mental state examination, abbreviated MSE, is an important part of the clinical assessment process in psychiatric practice. It is a structured way of observing and describing a patient's current state of mind, under the domains of appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment [Mental state](#)

<sup>83</sup>Miss A's patient records, p33

intoxicated and had a fight with {a} friend and stabbed her four times with a {pair of} scissors”.<sup>84</sup>

- 5.8 The assessment also documented that Miss A “describe {d} herself as having {a} short temper as part of her usual personality”.<sup>85</sup>
- 5.9 The assessment concluded that Miss A required “both psychological support and medication... {and was prescribed} an anti-psychotic (risperidone<sup>86</sup>)”.<sup>87</sup> It also documented that the use of an antidepressant should also be considered.
- 5.10 Miss A was to be referred to the EIS and the assessor also noted that she was advised to reduce her alcohol intake, which they suggested might be contributing to some of the symptoms she was experiencing.
- 5.11 Miss A’s “overall risk rating”<sup>88</sup> was assessed as being low.<sup>89</sup>
- 5.12 After Miss A failed to attend two further appointments<sup>90</sup> her GP was informed that she was being discharged from the CMHT.
- 5.13 Miss A again attended her GP on 15 April 2013, reporting that she was still experiencing low moods and paranoid thoughts and that she did not think that the risperidone had “helped much and that she had stopped taking it 4 days ago with no worsening symptoms” She also reported that she had not attended the appointment at the CMHT as she was “stressed that day”.<sup>91</sup> Miss A advised her GP that she was pregnant.
- 5.14 The GP advised Miss A to discontinue taking risperidone and to contact the CMHT for a review. This does not appear to have occurred as the next entry in the GP was on 10 July 2013 when Miss A’s midwife contacted the GP: the entry documented “midwife v. concerned re pt’s (sic) mental health, severe depression with paranoid delusions. Requesting CMHT/EIS re-referral. Not suitable for IPPS<sup>92</sup> as too complex”.<sup>93</sup> A referral was sent by the GP to the CMHT.
- 5.15 Miss A’s maternity antenatal care assessment was completed on the 26 June 2013. On the assessment form relating to her mental health history it

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<sup>84</sup> Risk assessment 13 February 2013, p3

<sup>85</sup> Risk assessment 13 February 2013,p2

<sup>86</sup> Risperidone is used to treat schizophrenia and symptoms of bipolar disorder [Risperidone](#)

<sup>87</sup>Miss A’s patient records, p33

<sup>88</sup> Risk assessment 13 February 2013,p4

<sup>89</sup> Risk assessment 13 February 2013,p4

<sup>90</sup> 11 March 2014 and 25 March 2013

<sup>91</sup> GP notes 15 April 2013

<sup>92</sup> IPPS: Children and Young People Infant-Parent Perinatal Service : The Infant-Parent Perinatal Service (IPPS) offers support to women who are experiencing or who are at risk of experiencing moderate mental health difficulties. The service is multi-professional [Oxford Perinatal Service](#)

<sup>93</sup> GP notes 10 July 2013

was documented that Miss A had “paranoia and on-going depression”<sup>94</sup> and that she had previously been assessed by the CMHT. It also documented that Miss A had stopped her medication. The summary noted Miss A was advised to see her GP as she disclosed that she was feeling “depressed”.<sup>95</sup>

- 5.16 Miss A did not see her GP until 13 August 2013: at this appointment she agreed that she would contact the CMHT to ask to be reviewed as soon as possible.
- 5.17 Miss A was seen by the CMHT, initially on 30 August 2013 and again on 18 September 2013, she was reviewed in both appointments by a care coordinator<sup>96</sup> and a specialist locum registrar.<sup>97</sup>
- 5.18 At the initial meeting Miss A disclosed that she was currently awaiting a court case<sup>98</sup> (see 4.28), that she was feeling paranoid and that the intrusive thoughts about cameras being in her flat had returned. She also disclosed that she was obsessively checking things in her flat, for example doors and windows, and that this can “take her an hour until she can go to bed”.<sup>99</sup> She reported that she had taken the risperidone for two months but had stopped as it had made her feel “more paranoid”.<sup>100</sup>
- 5.19 The risk assessment concluded the following:
- “Risk self: low and that she denied thoughts of self-harm
  - Risk to others : low
  - Risk of neglect: low
  - Safeguarding issues: {Miss A} is pregnant. She seems to care about her baby and was concerned about if she will be able to look after her baby”.<sup>101</sup>
- 5.20 Miss A agreed to be referred to EIS.
- 5.21 The specialist locum registrar documented that after seeing Miss A he liaised with the CMHT consultant psychiatrist and pharmacist and also

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<sup>94</sup> Maternal Booking Summary 26 June 2013, p5

<sup>95</sup> Maternal Booking Summary 26 June 2013,p16

<sup>96</sup>Miss A was not on a CPA. EIS refer to key worker as care coordinator

<sup>97</sup> CT1-3 doctor

<sup>98</sup> 30 September 2013

<sup>99</sup> Patient records, p28

<sup>100</sup> Patient records, p28

<sup>101</sup> Patient records, p29

referred to NICE guidelines<sup>102</sup> with regard to the prescribing of psychiatric medication during pregnancy.

- 5.22 On 25 September 2013 the specialist locum registrar documented that after he had discussed with Miss A the possible side effects of taking this medication in her third trimester on her baby, she agreed to take a low dose of haloperidol (1mg).<sup>103</sup>
- 5.23 At this meeting the care coordinator also suggested to Miss A that she gave her midwife her contact details so they could discuss the support Miss A was receiving from CMHT.
- 5.24 Miss A's overall risk rating was assessed as being very low.<sup>104</sup> The care plan identified crisis support to be provided by the CMHT duty worker and out of hours by the Crisis Team. The Crisis, Relapse and Contingency Plan documented that if Miss A's "needs cannot be met in the community by support from CMHT, crisis and/or Acute Day Hospital then admission to hospital needs to be considered. Additional support from family to help them understand {Miss A's} mental well-being".<sup>105</sup>
- 5.25 Miss A was given a diagnosis of psychotic disorder Not Otherwise Specified (ICD -10: F29).<sup>106</sup>
- 5.26 Following this meeting a letter was sent to Miss A's GP<sup>107</sup> outlining the rationale for prescribing haloperidol and associated risks during pregnancy.
- 5.27 Miss A was subsequently assessed by the EIS who informed CMHT that they were willing to accept her once the outcome of the court case was known and on the basis that a non-custodial sentence was given to Miss A.
- 5.28 At a team meeting where Miss A's referral was discussed, Miss A's risks were assessed as being amber.<sup>108</sup>

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<sup>102</sup> NICE guidelines are evidence-based recommendations for health and care in England [NICE Guidelines](#)

<sup>103</sup> Haloperidol antipsychotic medication [Haloperidol](#)

<sup>104</sup> Risk assessment 18 September 2013, p4

<sup>105</sup> Crisis, Relapse and Contingency Plan 24 October 2013, p2

<sup>106</sup> ICD The International Classification of Diseases [ICD](#)

<sup>107</sup> 10 October 2013

<sup>108</sup> EIS assessment of risks as amber medium risk within the team meetings

## 6 Psychiatric care - January 2014 to September 2014

- 6.1 After Miss A failed to attend three appointments<sup>109</sup> with the CMHT, her care was transferred to the EIS team at a CPA review meeting on 27 January 2014.
- 6.2 A risk assessment was completed on 20 February 2014 which assessed Miss A's risk as very low.<sup>110</sup> This was the last risk assessment completed by EIS.
- 6.3 Miss A reported her increasing concerns to both her health visitor and the EIS social worker regarding the lack of heating in her flat and that she and her baby were having to live in one room. Also her concerns about the cost of her heating bills since her baby was born, she was also anxious about her ongoing debts and that she was receiving advice from Citizen Advice Service (CAB). In response to her concerns the EIS social worker phoned the benefit agency regarding reinstating Miss A's ESA benefit and the health visitor contacted the managing housing association regarding her heating.
- 6.4 During a home visit by the EIS social worker on 11 February 2014 Miss A reported that her anxiety symptoms were the most prominent issue as they were affecting her daily life, these included compulsorily checking electric items and locks before she could leave her flat or go to bed. Miss A requested help and a referral was sent to the psychological service on 20 February 2014.
- 6.5 Miss A also gave her consent for the EIS social worker to contact her probation officer. This contact occurred on 26 February 2014, where the probation officer disclosed Miss A's past convictions and also reported that Miss A had, made "some major changes in her life since offending in 2012 and {was} now avoiding alcohol".<sup>111</sup>
- 6.6 After several communications between EIS and the psychological service, regarding Miss A's history of offending and her mental health history, she was offered an assessment.
- 6.7 It was documented that the psychological service reported to EIS that they had some reservations regarding the suitability of the support they could offer due to Miss A's complex history, her offending behaviour and her presenting symptoms.<sup>112</sup> They also questioned whether there were any

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<sup>109</sup> 20 December 2013, 3 January 2014, 20 January 2014

<sup>110</sup> Risk assessment 20 February 2014, p2

<sup>111</sup> Care notes entry 26 February 2014

<sup>112</sup> E mail to EIS social worker from psychological service, 5 March 2014

child protection issues, to which they were advised that there were no current safeguarding concerns and no evidence of any psychosis.

- 6.8 As Miss A failed to respond to the initial letter from the psychological service she was discharged from the service on 31 March 2014.
- 6.9 A letter from the psychological service confirming that Miss A had been discharged from the services was sent to both EIS and Miss A's GP on 16 June 2014.
- 6.10 On 5 March 2014 an EIS review was held with the consultant psychiatrist and care coordinator. At this review Miss A again reported that her obsessive checking was causing a significant disruption to her life, she denied any auditory hallucinations and had reduced ideas of reference.<sup>113</sup> However she reported that she was continuing to experience some ideas that cameras were watching her and that the haloperidol,<sup>114</sup> which had been prescribed by the CMHT after the birth of her baby, was not helping her and that she was unhappy with the extrapyramidal<sup>115</sup> side effects.
- 6.11 It was documented that Miss A again denied taking illegal drugs and disclosed only limited alcohol consumption. It was noted that Miss A's alcohol consumption had previously been a significant factor in her offending.
- 6.12 The consultant psychiatrist recommended a change of medication to quetiapine<sup>116</sup> 50mg and noted that a psychology assessment was needed.
- 6.13 Miss A also reported that she had not responded to the letter from the psychological services as she had been confused about the service and had thought that it was from the EIS. A referral letter was sent again to the psychological service but again as Miss A failed to respond the referral was closed (19 June 2014).
- 6.14 At this meeting the care coordinating role was passed to an Occupational Therapist (OT).
- 6.15 Following this review a letter was sent by EIS to Miss A's GP.
- 6.16 A carer's assessment was sent out to Miss A's mother on 6 March 2014 as she was consistently identified as both providing support to her daughter and that she was also a significant protective factor. It is not evident if Miss

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<sup>113</sup> Ideas of reference and delusions of reference describe the phenomenon of an individual's experiencing innocuous events or mere coincidences and believing they have strong personal significance

<sup>114</sup>haloperidol a drug prescribed for the treatment of acute psychosis, schizophrenia [Haloperidol](#)

<sup>115</sup> Abnormal involuntary movements, alterations in muscle tone, and postural disturbances

<sup>116</sup> Quetiapine is used to treat schizophrenia and bipolar disorder [Quetiapine](#)

A's mother completed the assessments and there is no mention of this being followed up.

- 6.17 An EIS review was held on the 8 April 2014 where Miss A was diagnosed with an "unspecified non organic psychosis"<sup>117</sup> and citalopram (10mg)<sup>118</sup> was added to her medication regime. A letter informing her of medication and her diagnosis was sent to Miss A's GP.
- 6.18 Over the next few appointments the EIS OT met with Miss A providing her with psycho-education to support her to manage her symptoms of Obsessive Compulsive Disorder (OCD). These meetings occurred in Miss A's accommodation. When the OT saw Miss A it was documented that she was interacting appropriately with her baby.
- 6.19 Miss A missed several of the scheduled appointments or they were shortened with the OT due to her reporting that she had other commitments, for example the dentist or college interviews.
- 6.20 At a meeting on 14 July 2014 Miss A reported an increase in her symptoms and that her hands were aching from her continual checking locks and doors.
- 6.21 The EIS OT informed Miss A at this appointment that she was leaving and that her care would be transferred to a social worker within the team at the next review.
- 6.22 During this time Miss A applied for a beautician course, which she reported was commencing in September and that she had also begun driving lessons.
- 6.23 The next CPA review in, 18 August 2014, was attended by the EIS doctor, OT and the new care coordinator (social worker). It was documented that Miss A reported that she was making some progress in being able to challenge some of her obsessive and compulsive symptoms but that her anxiety increased if she did not perform obsessional rituals.
- 6.24 The plan agreed was that Miss A would be referred again to psychology in January 2015 (this was at the six months point advised by psychological services following her previous non-attendance) and for the care coordinator to continue working with her to reduce her OCD symptoms. Her citalopram was increased to 20mg daily and quetiapine was to remain at 50mg at night and that the new care coordinator would continue with supporting her with

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<sup>117</sup> Care notes 4 April 2014

<sup>118</sup> Citalopram is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSR) [Citalopram](#).



her obsessive rituals. It was also documented that the probation service was due to end their supervision of Miss A in October.

- 6.25 This was also the last time Miss A was reviewed by the EIS consultant psychiatrist as the next review, which was scheduled for 16 March 2015, was cancelled due to sickness of the EIS psychiatrist.
- 6.26 Following this appointment a letter was sent to Miss A's GP, this was also the last correspondence between EIS and Miss A's primary care service.

### **Health Visitor and children's services December 2013 to August 2014**

- 6.27 Miss A's pregnancy continued without incident, she attended all her prenatal appointments.
- 6.28 Miss A's maternity notes indicated that she had stopped taking haloperidol two months prior to her delivery. There were records of one occasion when the midwife communication with EIS regarding her medication.
- 6.29 Miss A delivered her baby on 11 December 2013.
- 6.30 The maternity unit notes made several references to Miss A's mental health and a Proforma for Paediatric Alert System was completed noting that the intention was to make contact with CMHT to ascertain what plans were in situ for supporting Miss A when she was discharged (12 December 2013) .
- 6.31 Miss A was first visited by the community midwife on 13 December 2013 and telephone contact was made by the CPN from the CMHT on 17 December 2013.
- 6.32 Miss A was discharged from the community midwives services on 21 December 2013 and she was then transferred to the health visitor's service (HV).
- 6.33 During the HV's initial visit it was documented that Miss A was "feeling low but had no suicidal thoughts and that she was adapting to motherhood".<sup>119</sup> It was also documented that Miss A reported that she was in contact with her CPN from the CMHT.
- 6.34 After Miss A's baby was born she attended the children's centre's mother and baby groups and was receiving support from their outreach team.

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<sup>119</sup> Community mid wife notes 13 December 2013

- 6.35 On the 30 December 2013 the HV saw Miss A with the intention of conducting a maternal mood review however a male friend was present, so the HV documented that she was only able to partially assess Miss A's mood.
- 6.36 It was documented that Miss A reported feeling well and that her mood was good, she was also enjoying the baby and was now becoming more sociable. It was also documented that Miss A appeared to be well supported by her family and the support provided by community mental health service and the children centre.
- 6.37 Miss A also reported that she felt that she no longer required regular HV contact and it was agreed that she would be contacted in six weeks for a review.
- 6.38 Miss A was seen again by the HV on the 14 February 2014: she reported that she had restarted her psychiatric medication and there were no concerns about her mood. It was agreed that a further review would take place in four weeks to review the level of support Miss A required. It is unclear if this review occurred as there were no entries within the HV's notes.
- 6.39 The HV met with Miss A and her baby a total of thirteen times either at home or at the children's centre. She was last seen by the HV on 20 August 2014 where a Universal Service<sup>120</sup> eight month review was undertaken by a community nursery nurse.
- 6.40 The review concluded that there were no concerns regarding Miss A's parenting and her baby was assessed as meeting all her expected developmental milestones. Miss A also reported during the assessment that her mother was continuing to be the main source of her support and that she had agreed to look after her baby when she started her beauty course at college in September 2014.

### **Involvement of services from September 2014 to April 2015**

- 6.41 From September 2014, Miss A reported that she had started to attend college; she was seen by her new care coordinator on 1 September 2014. It was noted that her on going OCD symptoms were continuing to cause her

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<sup>120</sup> Universal services from the health visitor team working with general practice to ensure that families can access the Healthy Child Programme, and that parents are supported at key times and have access to a range of community services [Universal Service](#)

“distress.”<sup>121</sup> She also reported that her mother had told her that as a child she had “checking rituals.”<sup>122</sup>

- 6.42 The EIS care plan was to provide Miss A with more self-help literature and a CD on OCD.
- 6.43 On 27 October 2014 Miss A’s Probation Order ended.
- 6.44 Miss A did not attend the next two appointments<sup>123</sup> with her EIS care coordinator and was next seen on 27 October 2014 at her home.
- 6.45 At this meeting it was documented that Miss A had reported that she was taking her medication and she wanted to be referred back to the psychological therapy service in January 2015.
- 6.46 This was the EIS care coordinator’s last face to face contact with Miss A.
- 6.47 Miss A cancelled the next scheduled appointment with the EIS care coordinator (17 November 2014) but she phoned the team on 22 November 2014 reporting that she had run out of medication and was feeling “anxious and depressed”.<sup>124</sup> She was advised to contact the out of hours GP service and was offered a home visit both on that day and also on 24 November 2014 but she declined both.

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<sup>121</sup> Care notes 1 September 2014

<sup>122</sup> Care notes 1 September 2014

<sup>123</sup> 15 September 2014, 26 September 2014

<sup>124</sup> 22 November 2014

## 7 Multi-Agency Safeguarding HUB (MASH)

- 7.1 On 18 November 2014 police attended an altercation at Miss A's flat where it was reported that she was under the influence of alcohol. The police were concerned that Miss A's baby was present and a MASH referral was instigated.
- 7.2 The HV's notes (3 December 2014) provided the following information regarding the incident: Miss A had a party at her flat, her baby was being looked after by her mother but she had been returned to Miss A the following morning earlier than expected. Miss A and a friend were arguing and a neighbour took the baby and reported the disturbance to the police. On arrival the police observed that Miss A's flat was in a state of disarray and there was broken glass on the floor. Miss A was under the influence of alcohol and the police had concerns about the presence of the baby while this altercation was taking place. Miss A was reported to have been "remorseful and no longer in contact with that particular friend and that she was happy to re-engage with HV team for support".<sup>125</sup> It noted that she had been seen by a member of the MASH team and that the case to be closed.<sup>126</sup>
- 7.3 On the 27 November 2014 a Multi-Agency Safeguarding HUB enquiry was made to EIS in relation to a "domestic abuse notification"<sup>127</sup> There were no further details in Miss A's EIS patient records except that "mother had consented to info sharing".<sup>128</sup> Her EIS care coordinator was on leave at the time of this incident.
- 7.4 The management of this MASH will be discussed further within this report (see 12.57).

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<sup>125</sup> Health visitors notes, 3 December 2014

<sup>127</sup> Care notes 27 November 2014

<sup>128</sup> Care notes 27 November 2014

## 8 Health Visitor and Children's Centre

- 8.1 There was no contact made by the HV from August 2014 until 30 December 2014, Miss A either did not attend her scheduled appointments or when the HV tried to make telephone contact with she did not answer her phone.
- 8.2 Following the MASH, the HV first contacted Miss A on 6 January 2015, when she offered her an appointment at the children's centre. Miss A declined the appointment and a further message was left by the HV offering her another appointment on 19 January 2015. Miss A again did not attend this appointment.
- 8.3 On 3 February 2015 Miss A telephoned the HV's office asking what time her appointment was, she was advised that she had missed the appointment and was offered an appointment that day. Miss A did not attend this appointment. This was the last contact the health visitor service had with Miss A before the incident.
- 8.4 As HV support had been part of the decision to close the MASH investigation, the HV documented that it was her intention to contact the MASH coordinator to inform them that Miss A had not attended a number of appointments. It is not documented if this contact occurred.
- 8.5 There are no further entries in the HV's notes prior to the arrest of Miss A on the 18 April 2015 so we assume that no further efforts were made by the HV to contact Miss A.

### Children's Centre

- 8.6 The children's centre withdrew their support on 28 November 2014 as it was assessed that Miss A no longer required their services.
- 8.7 The HV was aware of this but the EIS care coordinator was not informed.

### Early Intervention Service

- 8.8 Following the MASH incident Miss A did not attend her next appointment with EIS on 1 December 2014. At this point Miss A's risk rating had been assessed as "green" i.e. low risk.
- 8.9 The next contacted by the EIS care coordinator was on 23 January 2015 when she telephoned Miss A to confirm their meeting on the 26 January 2015. Miss A did not attend this appointment reporting that she was unwell.

- 8.10 Miss A's next appointment with EIS was scheduled for 16 March 2015; this was to be a review by the EIS psychiatrist: however it was cancelled due to the psychiatrist being on sick leave.
- 8.11 Miss A did not attend her next scheduled meeting with the EIS social worker (24 March 2015). The social worker then went on annual leave and on her return Miss A again did not attend their scheduled appointment (14 April 2015). The social worker telephoned Miss A who apologised for not attending reporting that she had forgotten and was at her grandmother's house, also that "all {was} going well".<sup>129</sup>
- 8.12 This was the last contact EIS had with Miss A before the incident on 16 April 2015.

### Primary care

- 8.13 There was no indication that Miss A's GP was notified of the MASH inquiry.
- 8.14 The GP records indicated that from August 2014, when Miss A's medication was changed by the EIS psychiatrist, that she was collecting prescriptions regularly up until the incident in April 2015.
- 8.15 Miss A was last seen by her GP on 8 April 2015 when she presented with symptoms of a cold. She reported that she had not been out of her flat for a week and that her accommodation was still damp.
- 8.16 There was no indication that the GP enquired, during this or in any consultations with Miss A, about her mental health, her medication or about her contact with secondary mental health and HV services.
- 8.17 The GP reported that as their last communication from EIS was on 18 August, the letter did not make it evident that EIS was to continue to support Miss A they had assumed that she had been discharged from the service.

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<sup>129</sup> Care notes 14 April 2015

## 9 Arising issues, comments and analysis

- 9.1 This section will review the care and treatment of Miss A with particular regard to the agreed terms of reference. The relevant section of the terms of reference is documented at the beginning of each section. We will also be commenting on the changes that have taken place within services since the incident:

The terms of reference asked that we:

- “Review the engagement, assessment, treatment and care that {Miss A} received from Oxford Health NHS Foundation Trust from her first contact with services to the time of the incident on 16 April 2015 with specific reference to the Early Intervention Service (EIS).
- Review the documentation and record keeping of key clinical information by Oxford Health NHS Foundation Trust against its own policies, best practice and national standards and comment on any identified variances”.<sup>130</sup>

### CMHT and EIS

- 9.2 During the course of our investigation we considered the suitability of the initial referral to EIS and their subsequent treatment of Miss A.
- 9.3 During Miss A’s engagement with CMHT she was pregnant and was awaiting the outcome of a court case. She was reporting high levels of anxiety, depression, paranoid thoughts and severe and life limiting obsessive compulsive symptoms. It was also documented at the initial CMHT assessment that Miss A was reporting both auditory and visual hallucinations. It was known that she had both a forensic history and impulsive patterns of behaviour that were often linked to excessive alcohol use. That, on at least one occasion, she had physically attacked someone whilst under the influence of alcohol and had been involved in one relationship where domestic violence was a factor.
- 9.4 It was apparent that Miss A fully engaged with both mental health and HV services up until September 2014, this was also the period that she was under the supervision of a probation officer. As far as we are able to ascertain during this time she had reduced her drinking and was compliant with her medication regime. Although she continued to experience ongoing compulsive symptoms, and paranoid thoughts.

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<sup>130</sup> Terms of Reference 28 January 2016, p1

9.5 The NICE Antenatal and postnatal mental health guidelines, regarding clinical management and service guidance that was in place at the time (December 2014 )<sup>131</sup> stated that there needed to be :

“An integrated care plan for a woman with a mental health problem in pregnancy and the postnatal period that sets out:

- the care and treatment for the mental health problem:
- the roles of all healthcare professionals, including who is responsible for
- coordinating the integrated care plan:
- the schedule of monitoring: and
- providing the interventions and agreeing the outcomes with the woman.

The healthcare professional responsible for coordinating the integrated care plan should ensure that:

- everyone involved in a woman's care is aware of their responsibilities
- there is effective sharing of information with all services involved and with the woman herself
- mental health (including mental wellbeing) is taken into account as part of all care plans
- all interventions for mental health problems are delivered in a timely manner, taking into account the stage of the pregnancy or age of the baby.

Healthcare professionals working in universal services and those caring for women in mental health services should:

- Assess the level of contact and support needed by women with a mental health problem (current or past) and those at risk of developing one.
- Agree the level of contact and support with each woman, including those who are not having treatment for a mental health problem.
- Monitor regularly for symptoms throughout pregnancy and the postnatal period, particularly in the first few weeks after childbirth.
- Discuss and plan how symptoms will be monitored (for example, by using validated self-report questionnaires, maternal mental health would be assessed using the integrated maternal mental health pathway using Whooley questions and GAD2 assessment tool.”<sup>132</sup>

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<sup>131</sup> [NICE](#)

<sup>132</sup> [NICE](#)



- 9.6 It was evident that at no point, during Miss A's involvement with mental health and health visitor's services, was there any consideration given by either the HV or EIS to the fact that her symptoms and presentation may have required an escalation of her assessments and care to a more specialised service, such as perinatal psychiatry. Neither was consideration given by the HV to place Miss A on a Partnership Plus Pathway, that would have involved more intensive assessments, and support provided by perinatal specialists and interagency communication.<sup>133</sup>
- 9.7 Miss A was a single mother who had a complex and considerable risk history with regard to her impulsive behaviours and alcohol was a significant contributory factor. Throughout Miss A's contact with community services she continued to experience significant ongoing mental health symptoms. During both CMHT and subsequently EIS involvement Miss A was going through a significant and major life event that was her pregnancy and the birth of her child. Yet these potential risk factors were not considered or reflected within the risk assessments that were undertaken.
- 9.8 We were informed that at the time of Miss A's involvement with the EIS they did not have any maternal/family expertise on the team. Although since this incident the EIS teams have had training in working with families and are now familiar with Infant Parent Perinatal Services (IPPS) that are currently available within the Trust.<sup>134</sup>
- 9.9 It was reported to us by the EIS managers that now the standard practice where they have a patient who has children they discuss the patient with the child and family nurse who is now part of the team.
- 9.10 However we would suggest that even with this increased skills base within EIS that with any patient who is either pregnant or in the post-partum phase there automatically should be an ongoing consideration and assessment of the potential risks to their mental health and the possible effects their mental health might have on their pregnancy or child.
- 9.11 We would also suggest that EIS should be regularly liaising with the patient's HV and any other involved agency and that they should all be invited to contribute to the patient's CPA reviews.
- 9.12 Where there are particular concerns about the patient's mental health during their pregnancy or in the post-partum period EIS should either seek the advice from the Trust's Infant Parent perinatal Service (IPPS) or consider

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<sup>133</sup> [Oxford Perinatal service](#)

<sup>134</sup> [Oxford Perinatal Service](#)

referring the mother to Oxford University Foundation NHS Trust's specialist perinatal psychiatric service.

### **Infant Parent perinatal Service (IPPS)**

- 9.13 We reviewed the IPPS that was both operating at the time Miss A presented to EIS and the changes that have since been implemented.
- 9.14 The Integrated Mental Health Care Pathway from Birth to One Year provides both acute services and ongoing assessment of mental health of the mother and developmental progress of the child. The service also identifies the referral pathways and communication protocol between the midwife and health visitors' services, primary care and secondary mental health community and inpatient services. Also the referral pathway to various therapeutic programmes, such as PND Wellbeing Group Programme and low support to intensive multi agency involvement (Partnership Plus Service).
- 9.15 We were informed that currently the IPPS does not have a perinatal psychiatrist on the team. If a mother has been identified as requiring this specialist perinatal psychiatric assessment and support then a referral has to be made, via IPPS to Oxford University NHS Foundation Trust. However we were informed that the Trust's Clinical Commissioning Group (CCG) has recently tendered to NHS England for funding for a perinatal psychiatrist who will be situated within the Adult Directorate Pathway.

#### **Recommendation 5:**

For any patient within Oxford Health NHS Foundation Trust's Early Intervention Service who is either pregnant or in the post-partum phase, the potential risk factors need to be considered and regularly reviewed. There should be on going liaison with the patient's Health Visitor and any other involved agency and they should be invited to contribute to the patient's CPA reviews.

#### **Recommendation 6:**

Where there are particular concerns about a patient who is either pregnant or during the post-partum phase Early Intervention Service should seek the advice of the Trust's Infant Parent perinatal Service (IPPS) or refer them to Oxford University Foundation NHS Trust's specialist perinatal psychiatric service.

## Health Visitors Service

- 9.16 It was reported within the Trust's internal report, and this was also confirmed in our interviews with clinicians from services, that at the time they had not been familiar with community mental health services, especially EIS.
- 9.17 Following this incident and the subsequent Trust's internal investigation HV services convened a conference in October 2015. It was reported that at the conference the following three questions were asked of the delegates:
- “Do you have any suggestions for improving communication with adult mental health services?  
Do you have any examples of existing good practice?  
Can you identify any barriers to joint working?”<sup>135</sup>
- 9.18 At this conference AMHS and EIS also provided a briefing on their respective services to HV delegates.
- 9.19 The HV staff, who we interviewed, reported that this conference was very informative and that they now feel they have a greater understanding of AMH services within the Trust and the referral pathways.
- 9.20 It was also reported to us that a discussion about barriers to joint working was undertaken at a multi services 'Think Family' meeting convened on 9 Sept 2015. The findings from this meeting were cascaded to all the Trust's team managers via the monthly safeguarding update publications.
- 9.21 Clearly considerable work was undertaken immediately post incident to improve HV and Adult Mental Health Services (AMHS) understanding of each other's services and the referral pathways. However in order for this to be embedded within future clinician's understanding we would suggest that information about both services and the referral pathways must be part of the on-going core training for both services and that any changes in services or to Trust or national guidelines should be communicated to all staff .

### **Recommendation 7:**

Information about Oxford Health Foundation Trust's Adult Mental Health services should be a part of the health visitor's core induction training.

**Recommendation 8:**

Oxford Health NHS Foundation Trust's must ensure that information regarding referral pathways and any changes to their mental health services are communicated to their health visiting services.

**CMHT and EIS risk assessments and care planning**

- 9.22 Miss A disclosed on several occasions to her EIS care coordinator and consultant psychiatrist that she had a significant risk history of impulsive and violent behaviours and was in a previous relationship that involved domestic violence. Excessive alcohol consumption was also identified as a significant factor and in at least one incident Miss A reported that she had been intoxicated to the point where she had no memory of the incident (December 2012). The victim had required hospital treatment and Miss A was sentenced to a year's probation order. Miss A also disclosed on several occasions that she had a significant past history of substance misuse.
- 9.23 Despite these disclosures Miss A's risks to herself and others were repeatedly being assessed by initially CMHT and then EIS as either "low" (13 February 2013) and "very low" (18 September 2013 and 20 February 2014).
- 9.24 At the EIS team meeting she was being assessed as "green" (low) in regard to her risks and needs and therefore, it was reported to the investigation team, patients in this category were not regularly reviewed in the team meetings as they were considered as being low risks. It was also reported to us that the management and monitoring of such patients should be being discussed within the care coordinators' clinical supervision. As Miss A's various care coordinators have now left the services it is not possible to verify if this occurred.
- 9.25 When we reviewed the risk assessments we noted that they provided little or no background information, answering with only a Yes/ No response to the various risk questions. There was also little or no consideration of how Miss A's past risk history may have been an indicator of future possible risks and there were no details of other agencies involved or their contact details either on Miss A's care plan.
- 9.26 During Miss A's involvement with EIS there were several significant life changes: the birth of her baby, when her probation order ended, the outreach support from the children's centre ended (October 2014), a change in her medication (September 2015) and a MASH inquiry (November 2014). In the later incident, it was identified within the MASH report that Miss A had

been intoxicated, known to be a significant trigger to her past impulsive behaviours, and there had been some concern expressed by the police regarding the wellbeing of her baby during the incident. Despite these known significant incidents there was no occasion when a risk review was triggered. In fact Miss A's risk assessment was not updated since September 2013. The crisis/relapse plan was not updated after the first plan in March 2014 and within this plan there was no specific reference to what action(s) should be considered when it was known that Miss A's alcohol use was becoming an issue.

9.27 The Trust's Clinical Risk Policy clearly directs that

"Any change of circumstances affecting an individual or their care plan which could lead to a change in the level or nature of their risk will prompt a review of the risk assessment and management plan".<sup>136</sup>

9.28 This failure by successive care coordinators to appropriately assess Miss A's risks not only was non-compliant with the Trust's policy but it meant that there was no longitudinal assessment being undertaken of Miss A's risks and protective factors.

9.29 An assessment of risk needs to cover the likely frequency, imminence, severity and time frame of the risk. The recommendations from Royal College of Psychiatrists at the time stated that "risks assessment should be viewed as a process rather than a toolkit, in order to capture the dynamic features of patient risk...Within a single individual, risk will vary with time, context and intervention therefore risk assessments must be "an integral, constant and fluid element in the relationship between psychiatrist and patient, rather than a one-off duty discharged by completion of a form."<sup>137</sup>

9.30 Not only were Miss A's risk assessments not being regularly updated but also her last care plan was in May 2014. The Trust Care Programme Approach Policy (including non CPA)<sup>138</sup> states that the care coordinator must

"Ensure that there is ongoing assessment (to include risk) of the service user's mental and physical health and social needs... Update the care plan and safety and risk management plan as and when required and at intervals of no more than 6 months... Ensure that there is a plan of care for the service user, that is formulated in conjunction with the service user, their carer, where appropriate, and other members of the care team. It is

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<sup>136</sup> Oxford Health NHS Foundation Trust Clinical Risk Assessment and Management 10 February 2006 , p1

<sup>137</sup> Royal College of Psychiatrists 'Giving up the Culture of Blame' Risk assessment and risk management in psychiatric practice February 2007 , p8 [Royal College of Psychiatrists](#)

<sup>138</sup> Oxford Health NHS Foundation Trust Care Programme Approach Policy (including non CPA) 28 July 2010, p3

the responsibility of the care coordinator to ensure that all those involved in the CPA have a copy of the care plan.”

- 9.31 None of the agencies involved with Miss A, that is probation, the children’s centre or the health visitors, were provided by EIS with copies of either her C’s risk assessment or care plan. Apart from one occasion, when her probation officer was invited to a CPA review, no other agency was invited or asked to contribute to the risk or care plan review.
- 9.32 The Trust’s Care Programme Approach Policy also states that
- “Care planning is a continuous and dynamic process and care plans can be updated as and when needs and interventions change. The purpose of the care planning meeting is to formally share, amend and agree the care plan with the service user and carers... Detail the arrangements for meeting the identified needs of service user’s children in terms of safeguarding and social opportunity...The potential impact over time that parental mental health can have upon the parent-child relationship and any safety issues that may ensue should be considered.”<sup>139</sup>
- 9.33 However Miss A’s risk assessments and care plans were not being reviewed in response to changes in her life, e.g. the birth of her baby, change in medication, MASH inquiry or when probation ceased to be supervising her. There were also no efforts made by the EIS care coordinators to liaise with the HV to ascertain if there were any issues known that needed to be considered within Miss A’s CPA.
- 9.34 When we asked EIS staff why this did not occur it was reported that Miss A was not regarded as a high risk patient and the managers who had been in post at the time reported that if Miss A had been referred to the current EIS service she would not be assessed as requiring their support.
- 9.35 We were concerned about EIS lack of compliance with the Trust’s Care Programme Approach Policy and the fact that the EIS managers at the time failed to identify that Miss A’s risk assessments were not being reviewed and that the assessments that were completed were not responsive to the significant events in Miss A’s life. The policy states that it is the responsibility of the management team “to monitor compliance; 3 monthly audits will be undertaken by the audit team”.<sup>140</sup> We can only conclude that such audits either did not occur or they failed to identify the issues with the management of Miss A within the EIS service.

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<sup>139</sup> Oxford Health NHS Foundation Trust Care Programme Approach Policy (including non CPA) 28 July 2010, p15

<sup>140</sup> Oxford Health NHS Foundation Trust Care Programme Approach Policy (including non CPA) 28 July 2010, p6.

9.36 Oxford Health NHS Foundation Trust's RCA investigation that was undertaken after this incident also identified these deficits within EIS with regard to their application of the CPA policy and made the following recommendations:

- "EIS undertakes regular quality audits to monitor the application of CPA.
- That the CPA policy should be amended to include as a standard that all patients with caring responsibility for children under the age of five must seek information from and invite the relevant health visitor to the CPA reviews.
- Review of rag rating system and development of clear guidance for EIS in relation to the process for reviewing all patients on the caseload".<sup>141</sup>

9.37 As part of this investigation we reviewed the progress the Trust has made on implementing the action plan that was based on the findings of their investigation with regards to this particular action it was reported that

"Service manager confirmed 28/4/16 that clinical lead carries out routine audit of CPA in line with AMHTS <sup>142</sup>and that EIS participate in quarterly audit. The EIS teams use the RAG Rating System in the weekly clinical team meetings and are about to start to have a slot in these meetings to discuss any green/low risk clients. All clients are discussed with care co-ordinators in supervision along with caseload management and {Clinical Lead} will be reviewing random green/low risk clients as part of the regular audits that look at CPA, risk assessments, clinical notes and correspondence".<sup>143</sup>

9.38 It was evident from our interviews with EIS managers that since this incident their service has made considerable efforts to both address the Trust's internal report's findings; and associated actions plans with regard to their assessments and monitoring processes of patients in this low risk group. However we would suggest that an audit of clinical supervision should be undertaken to ensure that such patients are being regularly discussed within clinical supervision and to ensure that there is consistency within the EIS with regard to the criteria being utilised in the assessment of the patients within this category.

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<sup>141</sup> Oxford Health NHS Foundation Trust's root cause analysis investigation, 25 August 2015, p1

<sup>142</sup> AMHTS adult mental health teams

<sup>143</sup> Oxford Health NHS Foundation Trust's action plan 27 April 2016, p8

**Recommendation 9:**

An audit of clinical supervision should be undertaken within Oxford Health Foundation Trust's Early Intervention Service to ensure that patients who have been assessed as being low risk (i.e. green) are being regularly discussed within supervision. To also ensure that there is consistency within the service with regard to the criteria being utilised in the assessment of the patients within this category.

- 9.39 During our interviews with clinicians and the EIS team managers we were informed that the service was, at the time Miss A was referred to them and until recently, undergoing extensive and prolonged periods of change. These changes were with regard to their commissioner's arrangements, EIS national standards, and the restructuring of the staffing and the management team. All of which created reportedly a culture of considerable uncertainty within the team.
- 9.40 The EIS practitioners and managers who were in post at the time reported that given Miss A's presentation, she appeared to be engaging with OCD self-help treatment, she was not reporting any increase in her symptoms, she appeared to be compliant with her medication regime, was starting college and both her and the baby were well presented at each appointment. She was not seen as a risk to herself or others and there were no concerns about the child's welfare. It was assessed that she was making good progress; she reported that she was managing to restrict her alcohol consumption and had successfully completed a probation period. Those were all seen as positive signs of a recovery from her mental health issues. Miss A was also reporting that she had good family support and that her housing and financial situation had been resolved. The plan was that in January 2015 Miss A would engage with psychological services who would continue to address her OCD symptoms. It was suggested that the fact that there had not been a proactive discharge plan in place for Miss A, prior to the incident in April 2015, was due to pressures the team were facing regarding maintaining patient numbers on its case load.
- 9.41 It was reported that at the time there was an underlying pressure by commissioners and the Trust to keep patients on their patient list. It was admitted that this pressure at the time that Miss A was a patient had some impact on their decision not to discharge Miss A. It was reported that now the service is measured on quality outcomes, and NICE guidelines for early



intervention psychology<sup>144</sup> rather than patient numbers. The team also now has a psychologist and has a more multi-disciplinary team.

9.42 Since this incident EIS has developed an operational policy which states that

‘The service will offer evidence-based interventions, which may include pharmacological treatment, psychological treatment with individuals, family interventions, group and vocational work.... Relapse prevention, risk assessment and physical health monitoring will also be undertaken as part of the overall care package.... The team will provide a seamless, patient-centred service through joint working and regular communication with patients and their families, and other professionals within the Trust, other healthcare providers and other agencies’.<sup>145</sup>

### EIS care coordinators

9.43 The Trust’s Care Programme Approach Policy at the time also stated that the role of the care coordinator was to

‘{Keep} in close contact with the service user and their carers and advising the other members of the multi-disciplinary team of changes in the service user’s circumstances which may require a review or modification of the care plan.... Changes in CPA Care Coordinator must be kept to an absolute minimum’.<sup>146</sup>

9.44 It was unfortunate that due to successive staff leaving Miss A was allocated several different care coordinators and therefore no individual clinician was able to develop an in-depth relationship with her. During our interviews with Miss A we asked what she felt would have been helpful for her in regard to EIS, she reported that she “never saw the same person”.

9.45 With regard to involving Miss A’s family in her care, apart from one brief conversation with Miss A’s mother there was no further effort made by the successive care coordinators to seek her views about her child.

9.46 When we interviewed both the EIS clinicians and the HV who had been involved they all reported that both Miss A and her baby were always immaculately presented and that they had used this as an indicator that Miss A was managing well both her mental health issues and motherhood. No agency seem to have considered how unreliable a self-historian Miss A

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<sup>144</sup> [NICE](#)

<sup>145</sup> Early Intervention Service Operational Policy, p2-3

<sup>146</sup> Oxford Health NHS Foundation Trust Care Programme Approach Policy (including non CPA) 28 July 2010, p4

was; especially with regard to her alcohol consumption and the effects of what she was reporting were clearly debilitating mental health symptoms or the effects that they may be having on the wellbeing of her baby.

- 9.47 However when we look at the chronology of Miss A's involvement with both EIS and HV it is evident that she was frequently cancelling appointments and reporting that she had run out of medication suggesting perhaps that she was a little more chaotic than she was presenting at her scheduled appointments.
- 9.48 Miss A expressed to us that she had been very concerned, especially after the incident that led to the MASH inquiry, that if she disclosed to agencies the true extent of her difficulties and symptoms or asked for help she was fearful that her baby may have been removed from her care. Although this disclosure was made to us in hindsight the possibility that Miss A may have been withholding information and was an unreliable self-historian was never considered and there was, we would suggest, an overreliance on Miss A's self-disclosures and hers and her baby's appearances.
- 9.49 Clearly as our investigation has highlighted EIS did not develop a contingency plan with Miss A with regard to what action(s) should be taken if she disengaged with the service. During our interviews it was acknowledged by both EIS managers and the HV that it would have been helpful if after the MASH, they had taken more proactive actions, such as communication with each other to discuss their concerns and to agree what action(s) need to be taken. This, we suggest, could have included an unscheduled visit, by either the HV or the care coordinator, to Miss A's flat or contact with Miss A's mother who was known to be her daughter's primary support. We would suggest that both HV service and EIS need to review their approach to contingency planning as part of their risk management processes.

## **Interagency communication**

The terms of reference asked that we:

Review the contact and communication between agencies within Oxford Health Services (e.g. GP, Health Visiting Services) to assess if Miss A's treatment plans and risk management plans (to self and others) were fully understood addressed and that those plans were implemented appropriately'.

- 9.50 The evidence clearly indicates that there was some telephone contact between the midwife and CMHT regarding medication and to inform them that Miss A had given birth to her baby. The only time EIS sought to obtain Miss A's consent to communicate with the HV service was to ask her to

pass on their details. Neither the HV nor the probation officer was invited to contribute to Miss A's risk assessments or care plans.

- 9.51 The HV was not provided with any information regarding Miss A's past forensic history and therefore based her assessment of needs on limited information obtained from Miss A and the initial maternity assessment. She reported that if she had been aware of Miss A's history she would have assessed her as requiring the Universal Partnership Plus that is for the most vulnerable, high risk patients. Under this pathway the mother would have more contacts and visits by the HV, access to associated services and interagency communication to monitor both the mother and baby.
- 9.52 EIS sent letters to Miss A's primary care service after each contact, however the last clinical letter was sent on 3 August 2014 and after that the GP reported that they were under the impression that Miss A had been discharged from EIS. After this date there was no indication that she was asked by the GP about either her mental health or if she was experiencing any issues with regard to the change of medication following the last EIS review.
- 9.53 There was no evidence that either the GP or the HV ever discussed Miss A. Clearly the GP's role is pivotal as they are the conduit for all correspondence about a patient they have information about all services' involvement and treatment.
- 9.54 We were informed that health visitors are allocated specific primary care surgeries and that in some they also have access to a patient's GP notes. In Miss A's case the HV reported that she did not liaise with the GP as she did not assess that Miss A was a high risk patient nor was her baby considered to be at risk.
- 9.55 We concluded that given Miss A's situation as a vulnerable single mother, who was on a supervision order and was experiencing mental health issues to the extent that they were affecting hers and by default that of her baby's daily life; it was the responsibility for both primary and secondary care services as well as the health visitors and probation services to have taken more proactive measures to obtain and share information.
- 9.56 As it was, all the involved agencies were assessing and providing support to Miss A and her baby in separate silos and significant triggers were overlooked. This was especially significant with regard to Miss A's disengagement from services from September 2014 and the MASH incident and therefore a potential that hers and her baby's risk factors were universally overlooked by all involved agencies.

9.57 Miss A's forensic history that was known to both probation and EIS indicated clearly that her alcohol use had been a significant issue and a causal factor in most of her criminality and contact with judicial services. Miss A disclosed to her CPN on 14 February 2014 that she was drinking "roughly every fortnight ...approximately half a bottle of vodka each night".<sup>147</sup> This disparity between what she was reporting to her probation officer, that she had considerably reduced her alcohol intake and to her EIS care coordinator was not identified or discussed. Nor was her on going drinking documented in her risk assessments which were undertaken by the EIS.

**Recommendation 10:**

Both Oxford Health Foundation Trust's Early Intervention and the Health Visitors service should develop a joint protocol which identifies a multi-agency approach to communication, information sharing and contingency planning for patients with mental health issues who disengage with either service.

9.58 Since the incident EIS reported that when a patient has a child, aged between nought to five, the health visitor is invited to CPA and any multi-agency meetings. As it was not in our remit to review other cases within EIS where there is HV involvement we were unable to verify if this was occurring. We would suggest that a random audit occurs of such patients within AMHS<sup>148</sup> and EIS to ascertain if HV were being invited to CPA reviews and if information is being routinely shared between agencies.

**Recommendation 11:**

Oxford Health NHS Foundation Trust should undertake an audit of patients within its Early Intervention Services who are either pregnant or have children under the age of 5 years to ascertain if midwives and health visitors are being routinely invited or asked to contribute to CPA reviews. This audit should also review the standard of information sharing between these services.

9.59 It was reported to us that at the time there was a further compounding factor that was and to some extent still prevents information sharing between HV and community mental health services; this was that although they both used the same electronic patient record system (RiO) neither was able to access each other's entries. Since this incident and at the time of the internal RCA report, the Trust was in the process of changing its electronic

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<sup>148</sup> AMHS adult mental health services

patient records system to CareNotes. It was reported to us that the mental health services CareNotes process went live in April 2015 and the community health, including health visitors' patient notes went live in October 2015. However it was also reported<sup>149</sup> that since the roll out in April 2015 there have been "teething problems" that have yet to be fully resolved and the facility for community mental health and health visitor services to be able to access each other's electronic patient records has yet to be achieved. The team who are managing this process is led by the Trust's Chief Executive.

## Health Visiting Service

9.60 It was reported to us that since this incident there have been several significant changes with regarding to the Oxford NHS Foundation Trust's Health Visiting Services :

- All women now have a pre-natal visit by HV.
- The evidence-based tool is 'Promotional Guides'<sup>150</sup> which is used at both the antenatal and at the initial post birth visit. This includes both a social and preparation for parenthood assessment.
- There is on-going assessment by the HV of the maternal mental health utilising the integrated maternal mental health pathway using Whooley Questions<sup>151</sup> and GAD2.
- As part of the Healthy Child Programme<sup>152</sup> the HV now undertakes both a maternal mental health assessment using the NICE's recommended Edinburgh Postnatal Depression Scale.<sup>153</sup> They utilise the evidence-based tool called Ages and Stages<sup>154</sup> to assess the baby's developmental progress.

## MASH

The terms of reference ask that we:

'Review the referral pathway in and out of the MASH in this case, identifying any barriers to communication and/or actions'.

9.61 When we reviewed the events and support Miss A was receiving leading up to the MASH incident it was evident that after her probation supervision ended she failed to engage with either EIS or HV services.

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<sup>150</sup> AMHS adult mental health services

<sup>151</sup> The Whooley questions were introduced by the National Institute for Clinical Excellence (NICE 2007) when they reviewed their guidelines for Antenatal and Postnatal Mental Health. You can expect to be asked these questions at regular intervals by health professionals both antenatal and postnatally. [Whooley](#)

<sup>152</sup> [Healthy Child](#)

<sup>153</sup> [Edinburgh post-natal](#)

<sup>154</sup> [Age to Stage](#)

- 9.62 Up until October 2014 Miss A was seen initially weekly and then monthly by her probation officer as the condition of her Probation Order. During this supervision the probation officer reported that Miss A was making changes to her life with regard to her drinking and also the company she was keeping. Miss A attended all her appointments with her probation officer as clearly she would have been aware that if she failed to attend these appointments or if she committed any further offences during this period there would have been a possibility that she would receive a custodial sentence.
- 9.63 At the time when the supervision order ceased the support provided by the children centre's outreach service also ended.
- 9.64 Also at her last CPA review (August 2014) Miss A's medication was changed and her subsequent failure to engage further with EIS resulted in that no agency was monitoring either her compliance or her mental health.
- 9.65 Despite these significant changes there was no consideration given by EIS that this may have been a time of increased risks for Miss A when she might require more support and/or closer monitoring by EIS.
- 9.66 Furthermore when EIS were informed of the MASH incident in November 2014 it was reported that alcohol had been identified as a significant and contributing factor in the incident. Despite EIS being aware that alcohol had been previously been a significant past trigger to Miss A's impulsive behaviour, they took no action to instigate a review of her risk assessment.
- 9.67 The EIS care coordinator was on annual leave at the time the MASH report was sent to EIS, no action was taken either by the team in her absence or on her return. We would have expected that a meeting with Miss A should have been convened by the EIS in order to discuss the MASH and to ascertain if in the light of the incident her risks had increased and what support she needed.
- 9.68 The HV also did not take any proactive action to see Miss A after the MASH until January 2015 when she offered Miss A several appointments which she did not attend. No further proactive action was taken by the HV despite the fact that engagement with the HV was part of the requirement for the closure of the MASH. It was not until February 2015 that the HV considered reporting Miss A's lack of engagement to the MASH.
- 9.69 As Miss A was not seen by either EIS or the HV it is not clear if she knew that this was a requirement and what were the consequences if she did not comply.

- 9.70 Miss A reported to us that she had not understood what MASH was and that it had increased her concerns about her baby being removed therefore she actively avoided seeing her HV or contacting EIS for support.
- 9.71 There was no indication that either agency gave any consideration that Miss A's baby may have been at risk and that they needed to action a safeguarding referral. This lack of action is concerning as the majority of EIS staff at the time had completed the level 3 safeguarding children's e-learning which is the mandatory training for staff in the team. Yet they failed to recognise or seek advice regarding this possible being a safeguarding situation.
- 9.72 In the action plan that was developed from the recommendations from the Trust's internal report, it was noted that the following actions have now been completed with regard to increasing clinicians' understanding and required responses to MASH as well as developing a more robust Trust wide response:
- 'In high risk cases, the clinician working with the patient/family will receive a phone call from the MASH health team to alert them.
  - MASH processes have been highlighted via all Directorate governance meetings, and the Think Family to Safeguarding network meeting.
  - MASH processes have been highlighted via Trust announcements and are on the Intranet.
  - A relaunch and awareness of the MASH process across the Trust'.<sup>155</sup>
- 9.73 For the EIS there were the following specific actions with regard to increasing the team's understanding of safeguarding :
- 'Safeguarding reviews booked for both EIS teams (10 February and 1 March), this review provides assurance in regard to safeguarding knowledge within the team, is an opportunity to update on any current safeguarding issues and also allows the team to feedback any gaps or concerns which require improvement.
  - The action plan is managed by the safeguarding team alongside the team manager.
  - Think Family lead {have} been identified to the safeguarding team. ..To confirm if there will be a think family/safeguarding lead for EIS.
  - Safeguarding reviews completed in Feb and March 16 by the safeguarding children team. Part of this process is to ensure staff are

aware of how to access support and advice from the safeguarding children team'.<sup>156</sup>

9.74 Progress to April 2016 was that all the reviews and actions with regarding to increasing EIS staff's understanding of their issues and their responsibilities in regard to safeguarding and MASH have been undertaken.

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<sup>156</sup> Action Plan April 2016 p 3



## 10 Oxford NHS Foundation Trust internal report

- 10.1 Oxford Health NHS Foundation Trust (OHFT) provides physical, mental health and social care for people of all ages across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset. Its mental health service provision includes inpatient units and community services as well as specialised eating disorder and forensic services.

### Post-incident Serious Incident Review (SIR)

The terms of reference asked us to

“Review the Trust’s internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

- “If the investigation satisfied its own terms of reference
- If all key issues and lessons have been identified and shared
- Whether recommendations are appropriate, comprehensive and flow from the lessons learnt and review progress made against the action plan. Review processes in place to embed any lessons learnt. To assess and review any contact made with the victim and perpetrator families involved in this incident. To review the Trust’s family engagement policy for homicide and serious patient incidents, measured against best practice and national standards and its application in this case”.

- 10.2 We benchmarked the Trust’s Level 2 Serious Incident Review (SIR) utilising the National Patient Safety Agency’s RCA Investigation Evaluation Checklist.
- 10.3 Following the incident the Trust commissioned a root cause analysis investigation (Level 2) which was completed in August 2015. The authors of the report were a consultant psychiatrist, adult mental health services, and Learning from Incidents Lead. Specialist advice was provided by Senior Named Nurse Safeguarding Children Team.
- 10.4 The internal investigators interviewed all involved mental health staff and managers, did not interview the HV involved with Miss A but did interview the HV operational manager. It is unclear why they did not interview the HV as clearly their insight into Miss A would have been very helpful with their understanding of both the events and also in their analysis of the issues.
- 10.5 The investigators also did not have access to the GP notes but they did have a telephone conversation with the GP.

- 10.6 The report presented care and service delivery problems, influencing factors, a policy/procedural gap and provided an analysis and contributory factors.
- 10.7 It also identified the actions that had been taken since the incident.
- 10.8 We concluded that the internal investigation produced a thorough and accessible report, providing the chronology of Miss A's involvement with both the HV and community mental health services. It provided a Root Cause Analysis and presented the following:
- Affinity Mapping
  - Gap analysis against policy/guidance
  - Contributory factors analysis.
- 10.9 The internal report presented SMART recommendations to the Trust.

### **Involvement of Miss A and both families**

- 10.10 With regard to the Involvement of Miss A and her mother in the internal investigation, the authors reported that they took advice from the police with regard to interviewing Miss A. They were initially advised that against this as
- “To interview her about her involvement in the offence would cause the investigation a number of issues. Firstly her account would not be under caution but would be fully disclosable”.<sup>157</sup>
- 10.11 Subsequent to Miss A's plea and case management hearing on 17 July 2015 police again asked the authors of the SIR to postpone their meeting as Miss A had pleaded not guilty and was in the process of getting independent psychiatric reports. The authors wrote to Miss A and wrote to her mother to advise them of the situation.
- 10.12 The co-author of the report advised us that following the completion of their report they had met with Miss A.
- 10.13 The authors also documented within the SIR that “the name of the victim and the victim's family is unknown to us. We will endeavour to try to make contact via the police and victim liaison.”<sup>158</sup> It is not clear what action was taken or if this occurred.
- 10.14 Representatives from the Trust and the commissioning CCG, who attended the start-up meeting for this case, were unsure if anyone from OHFT had

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<sup>157</sup> SIR, p19

<sup>158</sup> SIR, p20

made direct contact with either Miss A or the victims' families after the incident. This is a requirement of the NHS Duty of Candour<sup>159</sup> that was introduced in April 2015. We would suggest that it should be clarified if the Trust made contact with both families after the incident and if not this failure to comply with Duty of Candour must be addressed.

**Recommendation 12:**

Oxford Health NHS Foundation Trust should ascertain if they have made contact with both the families of Miss A and the victim after this incident. If this did not occur then their failure with regard to their Duty of Candour must be immediately addressed.

## Think Families

10.15 The SIR also made reference to a recent Oxfordshire Serious Case Review (SCR) published in 2011<sup>160</sup> which highlighted many areas of learning that had direct relevance to Miss A's case such as:

“An improvement in care planning would be for the Mental Health team to make direct contact with the Health Visiting team, with the client's consent, when a parent with a child under five has a significant mental health event. This would have ensured that relevant information sharing was undertaken to inform future care planning by the Health Visiting team”.<sup>161</sup>

10.16 Following the SCR the Trust agreed the following :

“Improving multiagency responses to vulnerable children, especially when parental mental health problems were present alongside child safeguarding issues. Continue to ensure all staff in Children's Universal services (health visiting) are aware of roles and responsibilities within maternal mental health pathway. For Mental Health Professionals to share information directly with Health Visitors if a parent of a child under five experiences a significant mental health event”.<sup>162</sup>

10.17 The Trust also reiterated its commitment in a press statement following the publishing of the SCR to the Think Family Agenda<sup>163</sup> that:

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<sup>159</sup> Duty of Candour is a legal duty on hospital, community and. mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. • Duty of Candour aims to help patients receive accurate, truthful information from health providers [Duty of Candour](#).

<sup>160</sup> SCR

<sup>161</sup> SIR, p29

<sup>162</sup> SIR , p30

<sup>163</sup> Think Family Agenda : recognises and promotes the importance of a whole-family approach which is built on the principles of 'Reaching out: [Think Family](#)

“The Trust has implemented a Think Family Programme of work across adult mental health services including an audit programme to ensure evidence that children of parents with mental health needs are considered.”<sup>164</sup>

10.18 In Miss A’s case despite her giving consent for information to be shared apart from one occasion there was no communication between the HV and EIS services and neither agency proactively responded to the MASH incident.

10.19 The SIR made the following recommendation :

“A review of the Think Family agenda needs to take place to establish why joint working does not appear to be usual clinical practice. To do this:

- A project needs to be undertaken to establish what actions are required to move this forward. This should include cross directorate focus groups with clinical staff who work in the community to establish why this is not happening and identification of barriers.
- Findings and resulting actions must then be disseminated across the Trust.
- In the interim the EIS service must identify a Think Family lead to establish principles and processes within the team.
- Standards must be explicit for recording in CareNotes in regard to family and friends”<sup>165</sup>

10.20 Following the findings of the SIR nine actions were identified in order to raise awareness with all practitioners and to embed the Think Family Agenda throughout the Trust’s services. These have included:

- “Safeguarding reviews have been undertaken by the safeguarding children team to establish why joint working does not appear to be usual clinical practice within the HV and EIS services
- Written guidance on the Care Notes patient records system regarding identifying and recording information about dependents.
- Identified safeguarding lead within teams to attend think family to safeguard network meeting and share relevant items at team meetings”.<sup>166</sup>

10.21 These actions have been implemented by the Trust’s safeguarding team alongside the relevant team managers.

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<sup>164</sup> SIR, p31

<sup>165</sup> SIR, p31 to 32

<sup>166</sup> Action plan, p2

10.22 It was reported to us and we saw evidence that all these actions have now been implemented and reported to the Trust's respective governance teams and are continuing to be monitored by the safeguarding team.

### **Oxford Health NHS Foundation Trust action plan**

10.23 The Trusts' Quality and Risk Team monitors all the action plans from serious incidents and regular reports are presented to the directorates with reminders of outstanding actions.

10.24 We were provided with evidence that all the actions from this SIR have now been fully implemented.

10.25 We would suggest as with any action plan there always needs to be on going monitoring of compliance to ensure that all areas of learning are fully embedded within both the operational policies of individual services and the Trust's Directorates.

10.26 We would suggest that it is vital that there is on-going review process, via service reviews, reviews of documentation supervision and feedback from patients and their families and carers, being undertaken by the Trust of how the Think Family Agenda, with regard to inter agency communications and information sharing, changes in the EIS service, are affecting and underpinning the daily practices of all clinicians.

10.27 Additionally the Trust should ensure that the Think Family agenda is part of the core training for all staff.

#### **Recommendation 13:**

Oxford Health NHS Foundation Trust induction training should include developing practitioners' understanding and responsibility with regard to the Think Family Agenda.

## 11 Overall analysis

- 11.1 Throughout the course of this investigation, we have remained mindful of one of the requirements of NHS England's terms of reference, which was that we should consider if the incident which resulted in the death of Mr X was either predictable or preventable.
- 11.2 Whilst analysing the evidence we obtained, we have also borne in mind the following definition of a homicide that is judged to have been predictable, which is one where "the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it".<sup>167</sup>

### Predictability

- 11.3 Miss A had a history of impulsive and volatile behaviour in which alcohol was a significant contributing factor. There was at least one known occasion where Miss A had caused physical harm to another person who had required hospital treatment.
- 11.4 In the six months prior to the incident there was an incident that caused the police such concern, regarding the well-being of Miss A's baby that they reported it to MASH. Our investigation has clearly identified that after her probation order was completed Miss A disengaged with all involved services therefore it is not possible for us to comment on her mental health presentation during this time. Neither is it possible to ascertain if her alcohol consumption had increased during the months leading up to the incident.
- 11.5 Given that there is limited information available regarding Miss A in the weeks preceding the incident we have had to conclude that the events of 15 April 2015, which led to the death of Mr X, were not predictable.
- 11.6 However we can conclude that given Miss A's history it was highly predictable that she would be involved in future impulsive act(s) and that it was highly likely that alcohol would be a significant contributory factor.

### Preventability

- 11.7 In our consideration of the preventability of this incident, we have asked ourselves the following two questions: based on the information that was known, were Miss A's risk factors and support needs being adequately assessment and addressed by the involved agencies? Additionally was the incident on the 15 April 2015 preventable?

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<sup>167</sup> Munro E, Rungay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000), 176: 116-120 [Munro](#)

- 11.8 Clearly both EIS and HV services should have been more proactively trying to engage Miss A especially after the MASAH incident. But given Miss A's reluctance to either engage with services or fully disclose her difficulties it is difficult to see how based on the information that was known, services could have prevented the incident that led to the death of Mr X .
- 11.9 We have therefore concluded that the incident was not preventable.

### **Concluding comments**

- 11.10 It is clearly evident that Miss A was a very vulnerable young woman, who had complex psychosocial difficulties and who at times was experiencing debilitating mental health symptoms. Despite these known symptoms she was assessed initially by CMHT and then by EIS as a low risk patient.
- 11.11 It is well recognised the importance of maternal mental health to the developmental wellbeing of the child: in our opinion there was enough evidence available to all involved agencies to indicate that Miss A was a vulnerable single mother who had considerable on going risks and support needs. There was too much reliance on her self-disclosures and on hers and her baby's physical appearance and little consideration given to consideration the possible effects Miss A's difficulties may have had on her baby. Specialist perinatal advice should have been sought to ensure that both Miss A and her baby received the appropriate support. As it was after probation and the children centre withdrew their involvement Miss A was isolated having to manage her very debilitating and life limiting mental health symptoms without the level of care that she clearly needed.

**Recommendation 1:**

Any reduction in support provided to a patient by other agencies should be considered as a possible increase in risk factors and a risk assessment review must be undertaken by Oxford Health NHS Foundation Trust's community mental health services.

**Recommendation 2:**

Oxford Health Foundation Trust's mental health services must invite all involved agencies to a patient's CPA review. If they are unable to attend they should be asked to contribute to the review and receive a copy of the CPA review and associated risk assessments.

**Recommendation 3:**

Oxford Health NHS Trust should update its Management of Domestic Abuse guideline to provide staff with a more comprehensive overview of the various types of domestic violence, including Situational Couple Violence.

**Recommendation 4:**

Where there has been a disclosure by a patient that they have previously been involved in a relationship where there has been situational couple violence this should be considered and documented within their risks assessments as a significant risk factor. Consideration should be given to referring them to the appropriate domestic violence support services.

**Recommendation 5**

For any patient within Oxford Health NHS Foundation Trust's Early Intervention Service who is either pregnant or in the post-partum phase, the potential risk factors need to be considered and regularly reviewed. There should be on going liaison with the patient's Health Visitor and any other involved agency and they should be invited to contribute to the patient's CPA reviews.

**Recommendation 6:**

Where there are particular concerns about a patient who is either pregnant or during the post-partum phase Early Intervention Service should seek the advice of the Trust's Infant Parent perinatal Service (IPPS) or refer them to Oxford University Foundation NHS Trust's specialist perinatal psychiatric service.



**Recommendation 7:**

Information about Oxford Health Foundation Trust's Adult Mental Health services should be a part of the health visitor's core induction training.

**Recommendation 8:**

Oxford Health NHS Foundation Trust's must ensure that information regarding referral pathways and any changes to their mental health services are communicated to their health visiting services.

**Recommendation 9:**

An audit of clinical supervision should be undertaken within Oxford Health Foundation Trust's Early Intervention Service to ensure that patients who have been assessed as being low risk (i.e. green) are being regularly discussed within supervision. To also ensure that there is consistency within the service with regard to the criteria being utilised in the assessment of the patients within this category.

**Recommendation 10:**

Oxford Health Foundation Trust's Early Intervention and the Health Visitors service should develop a joint protocol which identifies a multi-agency approach to communication, information sharing and contingency planning for patients with mental health issues who disengage with either service.

**Recommendation 11:**

Oxford Health NHS Foundation Trust should undertake an audit of patients within its Early Intervention Services who are either pregnant or have children under the age of 5 years to ascertain if midwives and health visitors are being routinely invited or asked to contribute to CPA reviews. This audit should also review the standard of information sharing between these services.

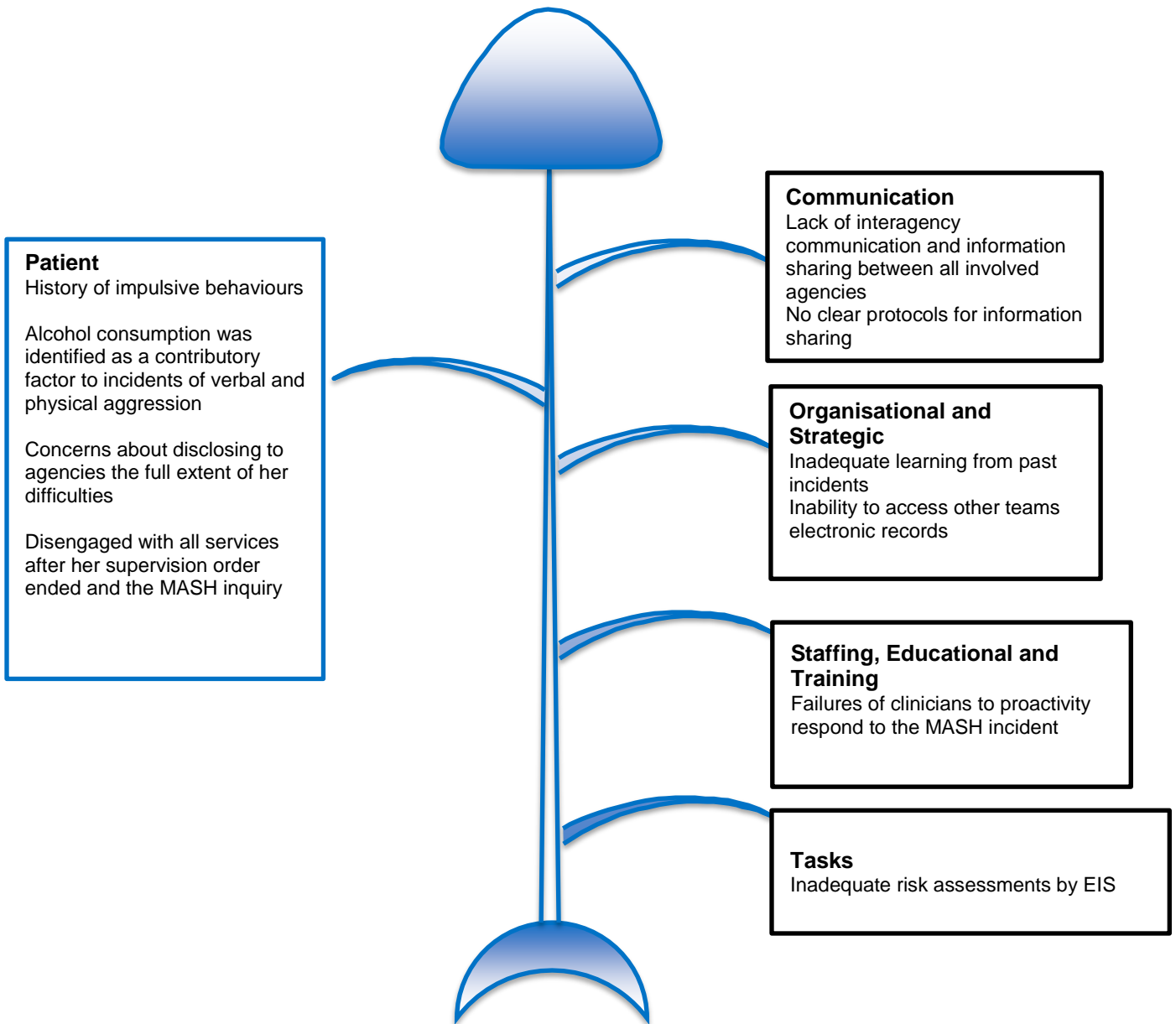
**Recommendation 12:**

Oxford Health NHS Foundation Trust should ascertain if they have made contact with both the families of Miss A and the victim after this incident. If this did not occur then their failure with regard to their Duty of Candour must be immediately addressed.

**Recommendation 13:**

Oxford Health NHS Foundation Trust induction training should include developing practitioners' understanding and responsibility with regard to the Think Family Agenda.

## Appendix A Fishbone diagram



## Appendix B – Terms of reference

- To identify whether there were any gaps or deficiencies in the care and treatment that {Miss A} received, which, if they had been in place, could have contributed to the predictability and/or preventability of the incident.
- The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could prevent similar incidents from occurring. The outcome of this investigation will be managed through corporate governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.
- Review the engagement, assessment, treatment and care that {Miss A} received from Oxford Health NHS Foundation Trust from her first contact with services to the time of the incident on 16<sup>th</sup> April 2015 with specific reference to the Early Intervention Service (EIS)
- Review the contact and communication between agencies within Oxford Health NHS Foundation Trust Services (e.g. GP, Health Visiting Services) to assess if {Miss A's} treatment plans and risk management plans (to self and others) were fully understood addressed and that those plans were implemented appropriately.
- Review the documentation and record keeping of key clinical information by Oxford Health NHS Foundation Trust against its own policies, best practice and national standards and comment on any identified variances.
- Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:
  - If the investigation satisfied its own terms of reference
  - If all key issues and lessons have been identified and shared
  - Whether recommendations are appropriate, comprehensive and flow from the lessons learnt
- Review progress made against the action plan
- Review processes in place to embed any lessons learnt
- Having assessed the above, to consider if this incident was predictable or

preventable and comment on relevant issues that may warrant further investigation.

- To assess and review any contact made with the victim and perpetrator families involved in this incident. To review the Trust's family engagement policy for homicide and serious patient incidents, measured against best practice and national standards and its application in this case.
- Review the referral pathway and out of the MASH in this case, identifying any barriers to communication and/or actions.

## Appendix C – Chronology from February 2013

| Date                   | Primary and secondary services | Health visiting and midwife and children's services | Event   |
|------------------------|--------------------------------|---|---|
| 13 February 2013       | Referred by GP to CMHT         |   | Seen by consultant psychiatrist. Directed GP to check bloods then prescribe risperidone 1mg nocte. Referral made to EIS |
| 25/03/2013             | EIS service                    |   | Miss A missed two appointments with EIS social worker. GP informed that referral cancelled                              |
| 30 August 2013         | GP and assessed by CMHT        |   | Pregnancy confirmed medication stopped. She was due to court for stabbing friend  |
| 18 September 2013      | Reviewed CMHT                  |   | No risks identified   |
| 25 September 2013      | Reviewed CMHT                  |   | Prescribed Haloperidol 0.5 mg. advised to discuss mental health with midwife  |
| 7 November 2013        |                                | Antenatal appointment                               | Discussed Miss A's feelings of anxiety, depression and isolation. Agreed to attend children and family centre           |
| 6 and 11 November 2013 | Reviewed in EIS meeting        |   | assessed as 'amber' risk due to court case and ongoing issues   |
| 27 November 2013       | letter from probation          |   | Received 1 year probation order   |
| 12 December 2013       |                                | Maternity hospital                                  | Miss A's baby born  |
| 23 December 2013       |                                | Home visit by midwife                               | Home visit No concerns reported   |
| 30 December 2013       |                                | Home visit Health visitor (H/V)                     | first home visit by H/V   |
| 3 January 2014         | Appointment EIS                |   | DNA   |
| 7 January 2014         |                                | Home visit H/V                                      | No concerns reported  |
| 9 January 2014         |                                | T/C with Miss A                                     | distressed re lack of action on repairs to her accommodation  |
| 15 January 2014        | Reviewed in EIS meeting        |   | Risk rating amber. Further appointment to be made   |
| 20 January 2014        | Appointment at EIS             |   | DNA, reported she had forgotten appointment   |

|                  |   |                                |  |
|------------------|---|--------------------------------|--|
| 27 January 2014  | CPA review                                | 6 week review undertaken by HV | CPA review: GP prescribed haloperidol. Seeing H/V 3 weekly no concerns regarding care of baby or mental state. Care coordinate transferred to EIS  |
| 11 February 2014 |   | Home visit H/V                 | No concerns reported   |
| 20 February 2014 |   | Home visit H/V                 | No concerns reported   |
| 26 February 2014 | T/C from probation to EIS                 |                                | Probation Officer reported Miss A has made changes to her life and is avoiding alcohol. Gave EIS full forensic history   |
| 4 March 2014     | letter from psychological services to EIS |                                | Requested more information re Miss A. Plan to offer 1-1 assessment but uncertain whether psychological therapy is suitable at present.   |
| 5 March 2013     | CPA review by EIS                         |                                | Plan: stop haloperidol change to quetiapine 50mg   |
| 6 March 2014     | letter sent to Miss A's mother            |                                | Letter sent to Miss A's mother as an identified carer offering a carer's assessment. Did not take this up  |
| 31 March 2013    | Home visit by EIS OT                      |                                | Aim to provide support for OCD symptoms  |
| 8 April 2013     | Reviewed by EIS consultant psychiatrist   |                                | Medication review: Diagnosis: Unspecified non organic psychosis. 50mg Quetiapine at night. Added citalopram 10mg for anxiety (2 weeks prescription given). Anxiety management work to be undertaken by OT. |
| 14 April 2014    | EIS OT                                    |                                | Home visit   |
| 28 April 2014    | EIS OT                                    |                                | Home visit   |
| 7 May 2014       |   | Attended children centre       | Reviewed by H/V. No concerns reported.   |
| 9 May 2014       | EIS OT                                    |                                | Home visit   |
| 11 June 2014     | Psychological services                    |                                | Discharged from services as failed to respond to appointment letters   |
| 18 June 2014     |   | Children centre                | Reviewed by H/V. No concerns reported  |

|                   |                     |                         |   |
|-------------------|---------------------|-------------------------|---|
| 19 June 2014      | EIS OT              |                         | Home visit OT advised Miss A that she was leaving team. Miss A requested female replacement   |
| 14 July 2014      | EIS OT              |                         | Miss A reported slight increase in OCD symptoms. She decided not to make contact psychological services   |
| 18 July 2014      |                     | T/C with health visitor | Reported baby had been admitted to hospital with pyrexia and lethargy. Discharged and was recovery well   |
| 22 July 2014      | Meeting with OT     |                         | DNA contact   |
| 4 August 2014     | Meeting with OT     |                         |   |
| 18 August 2014    | CPA review          |                         | Care coordinator transferred to Social worker (S/W). Medication review: citalopram increased to 20mg, quetiapine to continue at 50mg  |
| 20 August 2014    |                     | 8 month review          | no concerns   |
| 1 September 2014  | Meeting with S/W    | first meeting           | Reported that her OCD rituals continue.   |
| 15 September 2014 | Meeting with S/W    |                         | Miss A cancelled appointment  |
| 17 September 2014 | Meeting with S/W    |                         | DNA   |
| 27 October 2014   | Meeting with S/W    |                         | Home visit : plan<br>Plan: SW to speak to Miss A's housing provider re moving and to liaise with probation officer.   |
| 17 November 2014  | Meeting with S/W    |                         | cancelled appointment due to illness  |
| 18 November 2014  | MASH enquiry opened |                         | Baby dropped off at approx 17.00. Miss A and female friend arguing and throwing vodka bottles. Police attended and found house to be messy, covered in alcohol and broken glass. Miss A under influence of alcohol and child in the house when they attended. |



|                  |  |   |   |
|------------------|--|---|---|
| 22 November 2014 | T/C from Miss A to S/W                     |   | Miss A reported that she was feeling anxious and had run out of medication. Advised to contact her GP. Offered to visit but Miss A declined visit   |
| 24 November 2014 | T/C from S/W                               |   | Declined visit<br>And she reported that she had no medication for a week. Reported she had phoned GP and is waiting for a telephone confirmation. Plan: SW to phone GP surgery to check if Miss A prescription was ready. GP surgery advised that ready to collect and SW informed Miss A by telephone. |
| 27 November 2014 | MASH inquiry to EIS                        |   | Information share request in relation to domestic abuse notification  |
| 28 November 2014 |  | Family centre stopped working with Miss A |   |
| 3 December 2014  |  | H/V failed T/C contact with Miss A        | re MASH   |
| 30 December 2014 |  | H/V failed T/C contact with Miss A        | re MASH   |
| 14 January 2015  |  |   | GP review: no concerns  |
| 22 January 2015  |  | H/V appointment                           | DNA   |
| 23 January 2015  | S/W telephoned Miss A                      |   | to confirm appointment on the 26 January 2015   |
| 26 January 2015  | S/W H/V                                    |   | Miss A cancelled visit due to sickness  |
| 30 January 2015  | GP   |   | GP review : no concerns   |
| 16 March 2015    | CPA review                                 |   | CPA review cancelled  |
| 8 April 2015     | GP   |   | Seen by GP: Miss A unwell with cold symptoms  |
| 14 April 2015    | S/W visit                                  |   | Miss A cancelled  |
| 16 April 2015    | Miss A was arrested for the murder of Mr X |   |   |