HASCAS
Health and Social Care Advisory Service

Executive Summary

Independent Investigation

Into the

Care and Treatment Provided to Ms X

By the

Berkshire Healthcare NHS Foundation Trust

Commissioned by NHS England

Report Prepared by: HASCAS Health and Social Care Advisory Service
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Contents

1. Investigation Team Preface

1.1. The Independent Investigation into the care and treatment of Ms X was commissioned by NHS England pursuant to *HSG (94)27.*[1] The Investigation was asked to examine a set of circumstances associated with the death of Ms X and her son who died on 23 September 2014.

1.2. Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of the Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to improve the reporting and investigation of similar serious events in the future.

1.3. Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's Senior Management Team who granted access to facilities and individuals throughout this process. The Trust's Senior Management Team has engaged fully with the root cause analysis ethos of this work. It is the conclusion of HASCAS that all NHS stakeholders and witnesses met Duty of Candour requirements in full.

2. Condolences to the Family and Friends of Ms X and her Child

2.1. The Independent Investigation Team would like to extend its condolences to the family and friends of Ms X and her youngest son. The HSG (94) 27 Independent Investigation Chair and the Independent Author of the Serious Case Review met with

1. Health Service Guidance (94) 27

Ms X's mother, eldest son and sister on 1 December 2015. The Independent Investigation Team met again with Ms X's sister on 7 January 2016. We would like to thank the family for their valuable insights and the contribution that was made to this investigation. We hope that their questions have been addressed in this report.

3. Incident Description and Consequences

Incident Description and Consequences

3.5. On 23 September 2014 at 09.40 Ms X entered Slough Railway Station with her youngest son who was aged 10 years. She and her son laid down on the tracks pointing towards a fast train travelling at speed through the station. Both Ms X and her son were killed instantly on impact.

4. Terms of Reference

4.1. The original terms of reference are set out below. They were extended to include a separate HSG (94) 27 report which necessitated key clinical witnesses requiring re-interview. This was due to two reasons:

1. The family wanted a full independent review of Ms X's care and treatment.
2. The Trust clinicians wanted a full independent review of the case.

1. "Purpose of the investigation

This is a concurrent Child Serious Review and mental health homicide investigation which involves the death of a mother and child. The mother was in receipt of mental health services and the aim is to produce a single report.

Any health recommendations or outcomes of this investigation will be managed through corporate governance structures in NHS England, lead clinical commissioning group and the provider's formal Board sub-committees.

The purpose of the review is to identify whether there were any gaps or deficiencies in the care and treatment that Ms X received, which could have been predicted or prevented the incident from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring.

2. Terms of Reference

2.1.1 Review the engagement, assessment, treatment and care that Ms X received from Berkshire NHS Foundation Trust from her first contact with services in June 2014 until her discharge in August 2014

2.1.2 Review the contact, information sharing and communication between the GP and Berkshire NHS Foundation Trust services in June 2014 and thereafter

2.1.3 To review the families specific questions and ensure these have been fully reviewed and addressed

2.1.4 Assess if Ms X's risks (to self and others) were fully understood and addressed particularly her history of self-harm, attempts to kill herself as

reported by her family

2.1.5 *To review if her care and treatment, including medication, was in line with best practice and national standards*

2.1.6 *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*

2.1.7 *Having assessed the above, to consider if this incident was predictable or preventable and comment on relevant issues that may warrant further investigation*

2.1.8 *To assess and review any contact and disclosures made to the family measured against the contractual and legal duty of candour*

2.1.9 *To review and test the Trust governance and Clinical Commissioning Group's governance, assurance and oversight of incidents against the new NHS England serious untoward incident framework*

3. Level of investigation

Type C: an investigation by a single investigator examining a single case (with peer reviewer)

4. Timescale

The investigation process has started, Individual Management Reviews from health are expected in six weeks and the final report should be completed in line with the timescales of the Serious Case Review

5. Outputs

5.1 *To offer independent input and review the Trust and primary care's Individual Management Reviews (IMR)*

5.2 *To contribute and offer expert advice and support to the Serious Case Review panel (meetings in Slough)*

5.3 *To help produce a final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed)*

5.4 *Jointly make contact and engage with the family, initially sharing the terms of reference, ensuring their specific questions are included and examined and to provide ongoing input to the family*

5.5 *At the end of the investigation, to share the report with the Trust and meet the family to explain the findings of the investigation and engage the clinical commissioning group and Safeguarding Board with these meetings where appropriate*

5.6 *A final presentation of the investigation to NHS England, lead clinical commissioning group, provider Board and to staff involved in the incident as required*

5.7 *We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public*

KEY:
Type A: a wide-ranging investigation by a panel examining a single case
Type B: an investigation by a team examining a single case
Type C: an investigation by a single investigator examining a single case (with peer reviewer)".

5. The Independent Investigation Team

Selection of the Investigation Team

5.1. The Investigation Team was comprised of individuals who worked independently of the Berkshire Healthcare NHS Foundation Trust. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation work of this nature. The Independent Investigation Team also took advice from a series of specialist advisers regarding aspects of suicide and entrapment. The individuals who worked on this case as full team members are listed below.

Independent Investigation Chair

Dr Androulla Johnstone	CEO, Health and Social Care Advisory Service - Chair, nurse member and report author

Investigation Team Members

Dr Paul Warren	Health and Social Care Advisory Service Associate – Medical member
Ms Tina Coldham	Health and Social Care Advisory Service Associate – Service User Member
Ms Jasvinder Sanghera	Health and Social Care Advisory Service Associate – CEO Karma Nirvana

Support to the Investigation Team

Mr Greg Britton	Health and Social Care Advisory Service

Investigation Manager

Independent Advice to the Investigation Team

Ms Janet Sayers Solicitor: Kennedys

6. Identification of the Thematic Issues

Thematic Issues

6.1. The Independent Investigation Team found no root causes in connection to any act or omission on the part of Trust services and the deaths of Ms X and her child. However the Investigation identified 12 thematic issues that arose directly from analysing the care and treatment that Ms X received from the Berkshire Healthcare NHS Foundation Trust. These thematic issues are set out below.

1. **Diagnosis.** Ms X had a history of anxiety and depression directly associated with her marriage. In the four months before her death Ms X became highly distressed and received several different diagnoses namely: Reactive Depression, Severe Depressive Disorder, Recurrent Depressive Disorder, Acute Stress Reaction, Personality Disorder and Adjustment Disorder. Ms X was also noted to be suffering from anxiety and panic. Whilst the family suggested that some symptoms of psychosis were present these were not verified on thorough assessment by Ms X's treating teams. No coherent formulation was developed over time although it was universally acknowledged that Ms X's mental health problems were as a direct result of her husband's plans to reunite with her after a separation of six years.

   It would appear that the deterioration in Ms X's mental state from June 2014 was precipitated by her social circumstances which she felt powerless to alter and control. Ms X was treated medically in accordance with her presentation which fell short of providing the holistic assessment she required and the psychosocial intervention that was indicated. It should be noted that her treating teams were (quite rightly) keen to avoid medicalising what was in effect Ms X's social circumstances – however an explicit, honest and informed evaluation of the situation was lacking.

   That being said it must be understood that Ms X was a capacitous adult who did not want to continue contact with secondary care mental health services. There was a limit as to what else could reasonably have been done for her in the face of her wishes to disengage once her mental health problems appeared to resolve.

2. **Medication and Treatment. Medication:** The medication prescribed to Ms X was appropriate for the diagnoses that she was given; however it should be noted that medication has a limited efficacy for treating reactive/situational depression which is caused by adverse life events.

   It was noted that Ms X had a history of non-compliance with medication. However she appeared to be concordant with the regimen prescribed for her between June 2014 and the time of her death. There was no contemporaneous evidence to

suggest to either secondary or primary care that she had ceased to collect her prescription or take her medication.

Treatment: An evidence-based therapeutic approach was offered to Ms X in keeping with NICE guidance. However Ms X was resistant to either counselling or psychological assessment. This was because she felt such an approach would place her in a 'victim' role which ran counter to her self-image. In her previous voluntary roles Ms X saw herself as a provider of service, not a recipient; this created a barrier to her accepting the help and support that was offered to her.

3. **Use of the Mental Health Act (1983 and 2007).** Ms X was admitted informally to Prospect Park Hospital on two occasions. Following assessment Ms X was deemed to have the capacity to consent to her admission, care and treatment on both occasions. Ms X was assessed as having a significant amount of insight and this supported the view that she was able to make her own decisions about her discharge and case management.
   However it should be noted that for both admissions a high degree of coercion was in play, in part due to familial anxiety. At the point of Ms X's first informal admission she was recorded as not going willingly into hospital and that she was entering *"under duress".* This was poor practice for a voluntary admission and should have been managed differently under the Act.

4. **Care Planning and CPA.** One of the hallmarks of the case is the lack of continuity of care provided to Ms X and the fact no one got to know this complex woman beyond the most superficial level. Had a more consistent input been made available then she might have been understood better and the response to her social circumstances more assured. Care planning was virtually non-existent for Ms X. Treating teams focused upon their response to her acute presentation and no work of substance was carried out with her around medium and long-term planning. This was a missed opportunity as it was Ms X's anxiety about her medium and long-term future that led to her mental anguish and need for secondary care intervention.

5. **Risk Assessment.** Risk assessment at the point of Ms X's first admission was robust and addressed child safeguarding issues in an appropriate manner. However it was weak at the point of discharge. It was inadvisable to discharge Ms X within 24 hours of her admission when the ward team retained concerns about her safety advising her family to never leave her alone during her first week back home. Whilst risk information about self harming was shared with primary care at this point it was not explicit enough to support effective future input from the GP.

   Risk assessments for the second admission were of a reasonable quality. However it should be noted that child safeguarding services were not alerted to the fact that Ms X's self harming activities had increased: another referral should have been considered at this point.

   In addition risk assessment (whilst acknowledging the dilemma Ms X found herself in relation to her marriage) did not specifically address the sense of entrapment Ms X felt about her pending marital reunion. Neither did assessment

explore the risk that Ms X's family posed to her in relation to their over involvement which Ms X herself felt added additional pressure causing her to self harm. Ms X had made it quite clear that her marriage was a forced marriage and that she was experiencing significant pressure to reunite with her husband against her will. At the time of Ms X's presentation to service in June 2014 forced marriage was headlining in the media due to its recent criminalisation. Whilst the legislation came in too late to protect Ms X from her marriage – the plight of women like her was being publicised widely at this time – together with the long-term risks associated with this practice. Whilst risk 'from others' was briefly considered during the risk assessment process no specific safegaurding issue was raised in relation to Ms X and her marital situation.

On discharge the GP was not informed of Ms X's additional self-harming behaviours which had led to the second admission. Whilst this may not have affected the care and treatment provided by the GP in September 2014 it was poor practice.

6. **Referral and Discharge Planning.** Referral to secondary care services was managed in an appropriate manner and Ms X was referred to the most appropriate service in June 2014 best equipped to support her and assess her situation. However it took 18 days for Ms X to be assessed by the service which was four days over the required limit for a routine case.

   The discharge process was less effective. The first discharge was managed poorly in that the family was advised to supervise Ms X on a continuous basis for the first week and it took three days before a home visit was conducted by the CRHTT. Whilst it was made clear that Ms X and her family could summon the CRHTT at anytime if in crisis, and telephone contact was maintained, a mixed message was given. The fact that Ms X was being 'supervised' by her family probably increased her anxiety as she had made it clear to the treating team that her family was over involved and caused her additional frustration.

   At the point of the second discharge Ms X was capacitous and both she and her family were in agreement that a discharge was appropriate. Ms X had a trial leave during which all had apparently gone well. However the family has since expressed dissatisfaction at the manner in which Ms X was discharged and feels that important information was not provided to them in relation to her ongoing needs. Also the follow up from the CRHTT lacked clarity of purpose and consistency of input.

7. **Safeguarding Children.** The Serious Case Review report addresses the issues in relation to child safegaurding. Based upon the information available to all concerned appropriate measures were taken by the CPE (Common Point of Entry) and risk assessments were conducted at the point of Ms X's first admission. Child and Family Services received a referral and discussions about Ms X and her children were held. Based upon what was known (and what should have been known) at the time all due process was followed.

   However further child safeguarding considerations were absent following Ms X's continued self harm attempts and no assessment was forthcoming during her second inpatient admission. No risk assessment in relation to Ms X's children and

the impact of her mental illness/social circumstances upon them was undertaken at the point of her discharge in August 2014.

8. **Service User Involvement in Care Planning and Treatment (including issues around suicide and entrapment).** Ms X was assessed and interviewed the majority of the time with her family present. It was quite obvious that Ms X only disclosed her real anxieties and concerns when seen on her own. It is evident from reading the clinical record that Ms X found her family to be over involved and their constant presence, and pressure placed upon her by them, exacerbated her low mood and distress. On several occasions clinical staff had to urge members of Ms X's family to take a less assertive approach as she was in effect lost in their own anxieties and views about her future. From the evidence available it would appear that family members were allowed to dictate the care and treatment programme beyond the extent of what was helpful and which ran counter to Ms X wishes.

   People who complete suicide are often not driven by depression or mental illness. Suicide is more often about the distress, despair and pain a person feels, not being able to see other ways out of a situation they deem to be intolerable. Mental illness may also be part of the picture but in relation to suicide (whilst it might increase vulnerability) it is often not the reason a person takes their life. The Independent Investigation Team acknowledges that the fact Ms X also took the life of her son makes this tragic case more complicated. However it is important to recognise that the possible contribution Ms X's mental illness might have played should not be overshadowed by the other factors in her life that were in play; in this case her marital reunion. In the interests of learning it is essential that these issues are understood as fully as possible to ensure that other people such as Ms X are understood better in the future.

   Ms X did not meet the legal criteria as a Vulnerable Adult; she was an intelligent, insightful and capacitous woman. However she was rendered vulnerable by her social circumstances. It was evident that the treating teams involved were aware of the forced marriage issue and the pending marital reunion which filled Ms X with dread. However whilst the situation was discussed with Ms X and some of her family members no assertive leadership was shown by the treating teams and specialist input provided. Treating teams were 'paralysed' to a large extent by the situation they found themselves in not wanting to be culturally insensitive or inappropriate. The Trust has identified this as a key lesson for learning.

9. **Family Involvement.** Treating teams worked with Ms X's family with courtesy and respect. However the family was described in the clinical record as being a 'high expressed emotion' family and it was obvious that as a whole the family was over involved on occasions to the detriment of Ms X's wellbeing. This had an impact upon Ms X's mental state and her ability to resolve her problems. The situation is confusing as Ms X appeared to consent to family members being present during assessment and interview. However when asked in private to sign a consent form for information sharing she made it quite clear that she did not want her information shared or discussed with anyone – with the exception of her eldest son. Unfortunately it was evident that her confidentially and privacy were not maintained with assessments and interviews continuing with family members being present. Ms X's wishes were disregarded.

On another note it was recognised that Ms X's elderly parents had struggled to cope with her behaviour and feared for her safety. No carer assessment was offered or plan of support provided.

10. **Documentation and Professional Communication.** Entries in the ward-based clinical records are, on the whole, clear and well written; although on occasions key clinical discussions were not recorded in depth. This should not detract from the fact that mental state examination and clinical assessment processes are recorded to a high standard. However the CRHTT clinical record was often incomplete and not kept up-to-date.

    Professional communication was not optimal on occasions. Information recorded about Ms X's place of residence was confused and communicated poorly leading to delays to her being followed up by the CRHTT after her second discharge. The discharge summaries to the GP did not make explicit the fact that Ms X had self harmed prior to her admissions and gave a potentially misleading representation of her risks and ongoing situation. In addition Child and Family services were not informed of the circumstances pertaining to Ms X's second inpatient admission.

11. **Adherence to Local and National Policy and Procedure, Clinical Guidelines.** Trust polices are well-written, evidence-based and concise. However Trust policies and procedures appear to have been adhered to in an inconsistent manner and on occasions a 'tick box' approach appears to have been taken. This might be due to the pressures that the service was under at the time Ms X received her care and treatment.

12. **Clinical Governance and Performance.** The Trust's clinical governance arrangements appear to be robust and fit for purpose. Whilst it is acknowledged that services were under significant pressure during the summer of 2014 the Independent Investigation Team made no link between any governance failures and the death of Ms X and her child.

7. Conclusions Regarding the Care and Treatment Mr X Received

Predictability and Preventability

Predictability

7.1. Ms X had made one previous, relatively serious attempt on her life in July 2014 – she had also self harmed. However when questioned closely about this she denied ever having genuine intent. Ms X described her previous self harm attempts as having taken place in the context of anger, despair, frustration and distress – not as a result mental illness. It was acknowledged by Ms X's treating team's that she would remain at risk if her social circumstances did not alter and that she could cause actual harm to herself if she continued to *"act out"*. Past behaviour is a predictor of future behaviour – it should have been recognised that Ms X would

remain at risk of self harm if she continued to be stressed and unhappy about her marriage. However Ms X appeared to make a recovery. She also appeared to be resigned to a reunion with her husband. In the weeks following discharge from her second inpatient admission she appeared to be bright and optimistic for the future. There was no indication that she harboured any thoughts of harming either herself or others. That Ms X would take her life and that of her child was not predictable in the days and weeks before her death. This is reinforced by the findings of the Serious Case Review that stated no causal or contributory factors were found in relation to any act or omission on the part of statutory services and the death of Ms X's child.

Preventability

7.2. Following Ms X's discharge from secondary care mental health services it would appear that she appeared to be recovered; she was actively seeking work and had no signs or symptoms of mental illness. Ms X had been assessed to be capacitous and was unwilling to remain engaged with services. In the days and weeks before Ms X and her child died there were no signs to suggest her mental health had deteriorated to the point where secondary care services needed to be involved again. Based upon what was known and should have been known statutory services would not have been able to prevent the deaths of Ms X and her child. The rationale for this is examined below using the three tests of reasonability.

1. **Knowledge:** mental health secondary services had no knowledge that Ms X was distressed and/or depressed before she took her life. The GP understood Ms X was suffering from depression once again but there was no indication that this had reached a stage where secondary mental health services were required. When examined there was no indication that Ms X was at risk of either suicide or any act of violence against another person. Even had the GP been made more explicitly aware of Ms X's former self harm attempts she presented with no indication that she was going to do anything of this kind again.
2. **Opportunity:** Ms X continued to go about her business in the days before her death. It was reported by her close friend that she appeared to be back to her old self – there was no indication of what she planning. Because there were no alerts raised there was no opportunity for services to intervene.
3. **Legal Means (use of the Mental Health Act 1983 & 2007):** Ms X gave no indication of what she was planning to do. On examination by the GP she denied any thoughts of self harm or suicide. At this stage there was no indication that Ms X would qualify for an assessment under the Mental Health Act or that she required detention for her own safety or that of others. There were no grounds for legal invention and therefore no legal means could have realistically been brought to bear.

Summary

7.3. There are two main issues to consider for the future. **First:** secondary care mental health services should acknowledge in a clear and transparent manner any scenario where entrapment is present – whether there is continued evidence of mental illness or not. Detailed risk formulations should be prepared and structured risk management plans put in place. Whilst it has to be recognised that individuals with capacity may choose to reject the help and support offered to them clear formulations should be developed so that services can work with individual service

users with increased insight and a clearer understanding of psychosocial risk in a holistic manner. This will be of benefit in the future to all service users in contact with secondary care services when facing a life crisis. This will help secondary care services to understand what they can realistically achieve and what they cannot. It will also facilitate the relevant signposting to other agencies and services who might be better placed to support service users outside of a traditional NHS model.

7.4. **Second:** in addition a Trust ethos needs to be built where culturally sensitive issues can be discussed openly, with full guidance and support made available to healthcare professionals. This will ensure that service users like Ms X will have an honest formulation of their case in the future.

8. Notable Practice

8.1. The Trust's senior management team and health and social care practitioners have all worked with the Independent Investigation Team in an open and transparent manner in order to establish lessons for learning based upon an examination of Ms X's care and treatment. The manner in which witnesses have engaged with HASCAS has been exceptional with all parties continuing to reflect upon and challenge practice. The Trust has supported its clinical teams to identify recommendations and has pledged full support in order to improve service delivery in the future.

9. Lessons for Learning

9.1. Ms X told mental health services that she had been subject to a forced marriage when she was a young woman. She also made it clear that her distress was due solely to the pressure she felt her family was subjecting her to; to reunite against her will with her estranged husband on his return to England from Pakistan. It must be understood that forced marriage was made illegal in the United Kingdom on 16 June 2014. Honour-based abuse is defined as *"An incident or crime which has or may have been committed to protect the honour of the family and or community".*

Forced Marriage, Coercion and Family Honour

9.2. Girls and boys, men and women (from Asian cultures in particular) can be subject to coercion in order to maintain the notion of family honour or 'izzat'; this coercion often falls short of physical abuse. A level of unacceptable emotional and social pressure can be placed upon individuals to either marry or reunite with estranged partners against their will. This pressure is often placed upon individuals by loving families who honestly believe that they have their loved one's best interests at heart. Sadly this can lead to entrapment and provide the conditions where despair, panic and mental illness flourish. At present this is something that the NHS as a whole does not always understand and responses are varied across the country.

9.3. NHS Practitioners should follow the HM Government *"The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage"* (June 2014)

guidance[2]. Best practice for working with any individual who approaches any statutory agency should include:

Entrapment

9.4. It should be remembered that individuals do not always self harm or complete suicide due to major mental illness; entrapment is also a prime cause. Mental health professionals should understand the elevated risk in relation to individuals who have decreased options open to them and a building sense of failure, distress and panic. This will necessitate comprehensive risk assessment and management plans.

The Central Role of the Service User

9.5. Service users must always be at the centre of the care and treatment provided. Culture and religion must not be allowed, in themselves, to prevent health and social care professionals from conducting safe, private and dignified interventions.

10. Recommendations

10.1. The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

10.2. The Independent Investigation Team worked with the Berkshire Healthcare NHS Foundation Trust to formulate the recommendations arising from this investigation process and held a Trust workshop for this purpose. This has served the purpose of ensuring that current progress, development and good practice have been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process.

Diagnosis

Recommendation 1. The Trust will ensure that in future when complex cases present, or where multiple diagnoses are forthcoming within a short period of time, a robust and holistic diagnostic formulation is made. This formulation should be multidisciplinary (and where appropriate multi-agency) in nature. Guidance should be made available in existing CPA, risk assessment and safeguarding policy documentation.

Medication and Treatment.

Recommendation 2. To-date the Trust has reviewed its discharge processes from inpatient wards and CHRTT services. They are now more robust and monitored. In addition each multidisciplinary team meeting has a team lead present who knows the patient.

[2]. HM Government *"The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage"* (June 2014)

The Trust also should ensure that service users with complex health and social care issues should follow a care pathway that allows for a short, medium and long-term approach to support, and care and treatment provision; operational policies should be amended so that consideration is given to:

- Those service users who have experienced two or more inpatient admissions and who have also required Home Treatment services, should be assessed as to whether they meet CPA criteria.
- Women such as Ms X with complex social issues (and who meet the criteria for CPA) should be assigned a consistent key worker, such as a Care Coordinator, who can build up a therapeutic relationship and who can also build trust and provide continuity of care.

NHS England recognises that the development of a specialist care pathway would be an onerous task for a single NHS Trust and will take the lead in this regard in order to support the process.

Recommendation 3. The Trust should develop a multiagency care pathway for women such as Ms X. This to ensure that:

- Communication is seamless;
- Continuity of approach is assured;
- Risk assessment processes are shared across all agencies and processes (e.g. MARAC, safeguarding etc.).
- Follow up processes are in place following discharge from secondary care services.

Use of the Mental Health Act (1983 & 2007).

Recommendation 4. All service users who are considered for informal admission should:

- Have their capacity to consent to treatment assessed and recorded.
- Ensure that all assessments for women such as Ms X be conducted in private with no family or community members present.
- Ensure that If any aspect of either coercion or duress is evident then a full mental health act assessment be considered in order to determine the appropriateness and legality of any further action.

Care Planning and CPA

Please see Recommendation 2.

Risk

Recommendation 5. To-date the Trust has rolled out new risk assessment and suicide prevention training for CRHTT staff. This programme should be audited within six months of the publication of this report to ensure effectiveness and take up.

Recommendation 6. A multiagency risk assessment protocol should be developed to guide all local services when working with women like Ms X. This should be based on national best practice guidance.[3] This guidance should provide a seamless process and guide services though complex situations when neither MARAC nor safeguarding frameworks can legally apply. Assessment should include:

- A full patient mental health and social history;
- A record of all multiagency involvement to-date;
- Multiagency meetings and reviews;
- A shared implementation plan.

Referral and Discharge Planning.

Please see Recommendations 2 and 3.

Safeguarding Children and Vulnerable Adults

Recommendation 7. Thames Valley Police have a team of officers trained in Honour Based Abuse. The Trust and Clinical Commissioning Groups will work with the Police to utilise this resource and obtain key local contacts for advice and signposting purposes. The Clinical Commissioning Group should act as the lead body.

Recommendation 8. Additional work will be conducted with the NHS Trust, Clinical Commissioning Groups and local safeguarding Boards to ensure a streamlined process is developed in relation to NHS patients with particular attention to those women who fall 'sub' current MARAC, Vulnerable Adult and Safeguarding processes.

Recommendation 9. Legal clarification should be sought by the Trust (in conjunction with its multiagency partners) regarding patient rights in relation to confidentiality and reporting on to other statutory agencies. This guidance is of particular relevance to those women who fall 'sub' current MARAC, Vulnerable Adult and Safeguarding processes.

Recommendation 10. The Trust will provide additional training for its staff to specifically address Forced Marriage and Honour-Based Abuse. The Trust will build up an internal resource of trained advisors to support professionals in the field and service users.

Recommendation 11. The Trust will make available a resource pack for health and social care professionals. This pack will contain national guidance, Trust advisor contact details and national signposting organisations. Advice and guidance will also be developed to ensure Trust staff does not breach any confidentiality or privacy codes.

[3] HM Government *"The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage"* (June 2014)

Service User Involvement in Care Planning (including issues around suicide and entrapment)

Recommendation 12. Clear Trust guidance will be developed in relation to the confidentially and privacy needs of women like Ms X. Currently national guidance recommends that carers and families are always involved in full. New guidance needs to provide direction for health and social care professionals who have to navigate a complex path when ensuring the wellbeing and safety of their patients.

Recommendation 13. Current advocacy services should be reviewed and steps taken to ensure that each service can provide specialists in Forced Marriage and Honour-Based Abuse. Steps should also be taken to ensure that these advocates are **not** drawn from local communities in order to maintain confidentiality and privacy. The Local Authority to lead on this.

Recommendation 14. The Trust must establish (with support from the Clinical Commissioning Groups) a revised interpreter service in order to ensure that no person subject to Forced Marriage or Honour-Based Abuse issues has to use a family member, a member of their local community, or anyone who could be seen to potentially breach confidentially and privacy.

Family Involvement.

Recommendation 15. To-date the Trust has rolled out carer workshops for families in order to provide support. These workshops have been well evaluated.

In addition the Trust should review its management of carers, particularly young carers and carers over the age of 65 years. An audit should be undertaken to establish the frequency of carer assessments being offered and the efficacy of any plans subsequently put in place.

Documentation and Professional Communication

Recommendation 16. The Trust is now conducting a robust monthly records audit. When completed each month the issues identified by the audit are directly raised with staff to improve practice. This audit covers most areas noted in the action plan. The Trust should continue with this work and review six months following the publication of this report.

In addition please see the recommendations above in relation to privacy, confidentiality and further training needs in relation to Forced Marriage, risk assessment and Honour-Based Abuse.

Adherence to Local and National Policy and Procedure

Please see the recommendations above in relation to privacy, confidentiality and further training needs in relation to Forced Marriage, risk assessment and Honour-Based Abuse.

Staff Support

Recommendation 17. The Trust should ensure that in future additional staff support is made available following serious incidents. Witnesses should be provided with a skilled approach to ensure:

- Counselling (if required);
- Support with statement writing;
- Support during interview;
- Support when analysing findings and implementing change.