An independent investigation into the care and treatment of Darren by Isle of Wight NHS Trust

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Sancus Solutions would like to offer their deepest sympathies to Keziah's mother and the wider family who have been deeply affected by this incident. It is our sincere wish that this report does not contribute further to their pain and distress.

Sancus Solutions wish to particularly thank Keziah's mother for agreeing to meet with the investigation team, as her contribution has been of great assistance in enabling a deeper understanding of the events that led up to the incident in June 2016.

Sancus Solutions' investigation team would also like to acknowledge the contribution and support of staff from Isle of Wight NHS Trust.

Date	Version	
21 January 2019	final draft sent to LC	

Contents

1. Executive summary

1.1. The incident

An inquest concluded that on 1 June 2016 Darren, aged 44 years unlawfully killed his six-year-old daughter, Keziah, and then took his own life.[1]

At the time of the incident Darren was separated from his wife but remained involved in parenting Keziah. On the day of the incident Darren was looking after Keziah at the family home while her mother was working.

Both the Serious Case Review[2] and Keziah's mother, who was interviewed as part of Sancus Solutions' investigation, described Keziah as a lively, well-adjusted child who had reached all of her developmental milestones. It was very evident to Sancus Solutions' investigation team that she was a much loved little girl and that both her death and the circumstances surrounding the incident continues to have a devastating effect on the family ,especially on Keziah's mother.

At the time of the incident Darren was receiving cognitive behavioural therapy (CBT)[3] from the Isle of Wight NHS Trust's Access to Psychological Therapies Plus Service (IAPT)[4]. The last session he attended was on 25 May 2016. Darren's GP was prescribing him the antidepressant medication mirtazapine[5] (45mg). His last prescription was issued on 20 May 2016.

The following section briefly outlines the findings and recommendations from Sancus Solutions' investigation

1.2. IAPT service 2016

- During Darren's first contact with the IAPT service in 2015 he disclosed that he had dyslexia. In 2016[6]. He subsequently reported to his GP that he had been not engaged with the IAPT support due to his dyslexia as he had been unable to complete the written homework given to him by the IAPT therapist.
- During Darren's second contact with IAPT (2016) he again disclosed that he had dyslexia but was provided with literature and was asked to complete the written homework.

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[1] Next of kin requested that Sancus Solutions investigation uses the forename of both Darren and Keziah
[2] Isle of Wight Safeguarding Children's Board. This case met the criteria for a Serious Case Review as identified in Working Together to Safeguard Children 2013 SCR
[3] Cognitive behavioural therapy *(*CBT*)* is a talking therapy. It is most commonly used to treat anxiety and depression, CBT
[4] Provides evidence based talking therapies to adults with anxiety disorders and depression IAPT
[5] Mirtazapine (Remeron) is an antidepressant used to treat major depressive disorder Mirtazapine
[6] 23 March 2016

Findings

- It was reported, by several of the IAPT team, to Sancus Solutions' investigation team, that as far as they were aware the only material available within Isle of Wight's IAPT service was in a written format and that it was only available in English. However the IAPT's operational manager reported that if a patient had specific needs there was the expectation that the IAPT therapist would adapt the literature to meet the patient's abilities. There is no evidence within Darren's patient records that any adjustments were made to accommodate his dyslexia.
- Sancus Solutions' investigation team would recommend that in order to ensure that Isle of Wight NHS Trust's IAPT service is fully accessible, to all patients, as part of the initial assessment process patients should be asked if they have any particular needs which might prevent them from accessing the written literature. If a patient discloses that they have specific needs the IAPT therapist should then undertake an assessment and access the support/adaptations they require so that they can fully participate in their therapy (recommendation 1).

1.3. Health of the Nation Outcomes Scales (HoNOS)[7] assessment and IAPT Operating Procedure

- Sancus Solutions' investigation team were informed that the IAPT service utilise HoNOS assessment to identify and score patients' risk factors. This is then reviewed with the patient at their subsequent appointments in order to identify any changes in their risk(s) and protective factors. This information is also used by the commissioners as part of the overall national outcome monitoring of IAPT.
- The HoNOS assessment has a question relating to safeguarding children and vulnerable adults. The IAPT therapist scored Darren's risk as 'none'.
- Sancus Solutions' investigation team noted that there was no correlation between the risks identified within the HoNOS assessment and those outlined in either Darren's risk narrative or the risk management plan.
- Sancus Solutions' investigation team also noted that the HoNOS assessment does not ask the assessor to consider the patient's risk to others.
- Sancus Solutions' investigation team reviewed the IAPT Operating Procedure, and noted that there was only one specific reference to risk, that was in relation to what action(s), dependent on the assessed risk level, should be taken if the patient disengages from the service.[8] Other than this, there was no reference/guidance as to:
    - How IAPT therapists are required to assess, document and monitor risk?

[7] HoNOS
[8] Standard Operating Procedure p11

- What action(s) the practitioners are expected to take if during the course of an assessment there are concerns regarding risk(s) to either the patient or others?

Sancus Solutions' investigation team have concluded that the HoNOS risk assessment tool currently being used by the IAPT service is inadequate. They would recommend that the trust should consider either introducing the mental health risk assessment that is used by the community mental health services to their IAPT service or develop a bespoke IAPT risk assessment (recommendation 2).

- It was reported that the IAPT service does not use the Isle of Wight NHS Trust's patient records system but used the national accredited IAPT's assessment and outcome documents to record, assess and monitor patients' assessments, risk(s), progress and outcome information.

Changes since the incident

- Sancus Solutions' investigation team were informed that since this incident and in response to one of the findings of the Serious Incident Report (SIR), [9]a number of changes have now been introduced to the Standard Operational Procedure for Crisis Resolution and Home Treatment to clarify the care pathways, increased the liaison between SPA and IAPT and address the suitability of patients being referred to IAPT. These include:
  - Daily and weekly liaison meetings between the SPA and IAPT, at which the operations managers from both services are present. Referrals are discussed to assess their suitability for IAPT. Weekly multidisciplinary team (MDT) liaison meetings where referrals and patients are discussed.
  - SPA team can now access IAPT's IT software in order to be able to review IAPT patients who are in contact with them via the crisis service. Certain members within the IAPT team can now access the SPA's patient record system so they can obtain information such as others services' involvement.
  - If an IAPT therapist assesses that the service is not able to meet the needs of a particular patient, due either to their level of risk and/or to the complexity of their mental health difficulties, the protocol outlines a clear pathway for a referral to be made, via SPA, to secondary care community mental health services.
- It was reported that there has been a number of meetings between IAPT and SPA practitioners in order to develop a greater understanding of the services' capacity. However during the course of this investigation a number of further deficits have been identified within IAPT's operating procedure and their risk assessment processes and Sancus Solutions' investigation team have made

[9]"IAPT sometimes work with people with moderate risks identified and as such need clear guidelines for transfer of care" SIR p6

a specific recommendation to address these issues (recommendation 2 and 3).

- Additionally it was reported to Sancus Solutions investigation team that despite these changes and increased awareness of the IAPT service patients are still being refered to the service who have considerable risk factors and therefore are unsuitable to be managed by the IAPT service. Sancus Solutions' investigation team have made a recommendation to address this issue (recommendation 12)

1.4. Single Point of Access

- Following Darren's telephone contact with the SPA service (12 May 2016), it was documented that "Darren feels stable at the moment and not at risk but [felt] his situation would change dramatically if his ex-partner says no to a reconciliation as he would harm himself"[10]. The practitioner concluded that there were "no risks identified at this time"[11].

Findings

- The Isle of Wight NHS Trust's Standard Operational Procedure for Crisis Resolution and Home Treatment (CRHT) – Single Point of Access states:

  "Following a referral a qualified member of SPA (nurse, social worker, OT etc.) will then make contact with the person to carry out a telephone risk assessment using the Mental Health Triage Risk assessment tool to aid their decision making…An initial HONOS[12] score and cluster score relating to [the patient's] current presentation should be documented…Assessments, whenever possible, will include the views of family and friends and they will be offered support and information about the needs of the service user, with the permission of the service user. "[13]

- Sancus Solutions' investigation team noted that the information recorded by the SPA team was minimal and that no risk assessment or care planning tools were used. Additionally, apart from one occasion, when the IAPT therapist contacted Darren's wife, there was no further effort made to contact his family.

[10] General case notes 12 May 2016
[11] General case notes 12 May 2016
[12] Health of the Nation Outcome Scales HoNOS (Health of the Nation Outcomes Scales) was developed during the early 90s by the Royal College of Psychiatrists as a measure of the health and social functioning of people with severe mental illness. It involves the assessment of 12 items measuring behaviour, impairment, symptoms and social functioning. The scales are completed after routine clinical assessments HoNOS
[13] Standard Operational Procedure for Crisis Resolution and Home Treatment (CRHT) – Single Point of Access p7

1.5. Care Quality Commission (CQC)

- Following a CQC inspection of Isle of Wight NHS Trust's adult mental health services[14] (completed November/December 2016), a Section 31 Notice[15] was served.
- At this inspection the CQC inspectorate team concluded that there were concerning omissions in the care assessments, risk assessments and care plans within the community mental health services, which include SPA service.
- The CQC inspection concluded that:

  "The electronic care records system was not fit for purpose and there were concerns with lack of guidance in relation to how staff should complete the records. The system was time consuming to use …There was no contemporaneous flow of information and there were clear risks that important patient information was not easily available to staff."[16]

- Currently the Section 31 Notice remains in place and CQC continues to rigorously monitor the community mental health service until such time as they are satisfied that services are meeting CQC key standards of safe, responsive, effective and well led[17] .

1.6. Safeguarding

- There were a number of occasions when Darren disclosed to SPA and IAPT services that he had a young daughter and that, at times, he had sole parental responsibility for her. Apart from the second IAPT assessment, where it was documented that Darren's daughter was six years old, in all other contacts with the SPA and IAPT services the practitioners did not make any further enquiries in order to obtain further details of Keziah and/or the extent of Darren's parental responsibilities after he had moved out of the family home.
- It was reported to Sancus Solutions' investigation team by all the practitioners who had been involved in the assessments and support of Darren, that in their opinion and based on the evidence that was available to them there was, no indication that Keziah or any other members of Darren's family were at risk. The only potential risk that they had been aware of was that to Darren himself.

[14] IAPT was not part of the CQC inspection
[15] Section 31 of the Health and Social Care Act 2008. CQC can serve a Notice of Decision on a registered person imposing, varying or removing a condition of registration on an urgent basis. CQC can deploy the power whenever it has reasonable cause to believe that any person (s) may be exposed to risk of harm in a service. Section 31
[16] CQC
[17] Caring, safe, effective and well led are CQC key standards

Findings

- The SPA's assessment of Darren's needs and potential risks to himself and others was primarily based on his self-reporting. Although it was documented by the SIR and also reported at the inquest hearing that on 26 May 2016 the IAPT therapist had contact with Darren's wife "to provide any relevant details to inform the risk assessment and treatment plan"[18]. Sancus Solutions' investigation team were unable to locate any documentation to confirm this contact. Keziah's mother reported that this telephone conversation did occur but she was not aware that it was part of any formal assessment process.
- With regard to Darren's "nightmares" disclosure: the IAPT therapist reported to Sancus Solutions' investigation team that Darren only disclosed having one nightmare and the "nightmares" was a typographical error .
- The IAPT therapist reported that following this disclosure he had discussed the contents of the nightmare at his peer supervision[19] and that his colleagues had agreed with his approach to this dream.
- With regard to the potential risk(s) to Keziah: Sancus Solutions' investigation team were of the opinion that although Darren denied that he would ever harm his daughter and that she was a protective factor, given that he had only just engaged with the IAPT and SPA services, little would have been known about him, his family situation and/or his risk history. Therefore, Sancus Solutions' investigation team would have expected following his nightmare disclosure, to have sought further information from members of Darren's family, including his wife and mother, rather than relying solely on his self-disclosures.
- Additionally the disclosure of the dream should have prompted the involved practitioner to have either sought the advice from Isle of Wight NHS Trust's children's' safeguarding team or triggered a safeguarding alert.
- Sancus Solutions' investigation team also noted that although Darren often discussed his family he consistently focused on his fears of the relationship ending and how the breakdown of his marriage was affecting him. There was no documented evidence that he was able to reflect on his relationship with Keziah, how she may have been being affected by her parent's separation and/or how he might support her to manage what was a very complex psychological time for his young child.

Changes since the incident

[18] SIR p4

[19] IAPT standard operating procedure states: "All Hi-Intensity therapists receive as a minimum the amount of supervision mandated by their governing bodies. All therapists have supervision for all modalities of treatment that they provide. Hi-Intensity CBT therapists receive weekly supervision in a group format. The majority of therapists in each group will have received further training on supervision and be a qualified supervisor. The supervision will meet the criteria for accreditation with the BABCP in terms of frequency and quality." P13

- Since this incident Sancus Solutions' investigation team were provided evidence of the following actions have been introduced :

  - The IAPT service's assessment form now directs the assessor to obtain information about the dates of birth of any children the patient has parental responsibility for.
  - A new core assessment proforma has been introduced to all community and inpatient mental health services which prompts the assessor to directly enquire about any potential safeguarding issues.
  - IAPT therapists' supervision is no longer a peer-led group but a clinician now leads the supervision, which Sancus Solutions' investigation team suggested provides a greater level of scrutiny and clinical guidance.
  - In response to the findings of the SIR and SCR it was identified that the levels of child protection training within adult mental health services were not adequate. An extensive child protection training programme has now been introduced throughout Isle of Wight NHS Trust. Practitioners within both SPA and IAPT services are now required to undertake level 3 child protection training. A safeguarding children training policy has also been introduced (April 2017).
- It was noted that the IAPT Standing Operating Procedure does have hyperlinks to various national IAPT guidances and cites that "The Isle of Wight PCMHT/IAPT+ team adhere to the Isle of Wight NHS Trust policies, guidelines and protocols"[20]. However, it does not make any reference to any specific Isle of Wight NHS Trust's policies, such as safeguarding adults and children. This deficit needs to be addressed (recommedation3).

1.7. Domestic Abuse

- It was documented that, on a number of occasions, Darren had disclosed to the IAPT therapist that he suspected his wife of infidelity and that he was accessing her social media accounts and also her text messages. Darren's wife also reported to the police that after this her husband had started to follow her around the house in order to monitor her use of social media.

Findings

- Based on the information that was available at the time, Sancus Solutions' investigation team concluded that it was some evidence that Darren's self-reported actions were indicating a degree of escalating psychologically controlling and coercive behaviours within his relationship with Keziah's mother. The Home Office describe this category of domestic abuse as

[20] Standard Operating Procedure p14

"A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support … regulating their everyday behaviour"[21].

- It is Sancus Solutions' investigation team's opinion that Darren was disclosing significant behaviours that should have, at least, triggered some concerns among the involved practitioners that his relationship with his wife may have had some elements of domestic abuse. Therefore, at the very least, they should have sought the advice of the Isle of Wight NHS Trust's adult safeguarding team.
- Sancus Solutions' investigation team were informed that at the time of the incident the Isle of Wight NHS Trust did not have a separate domestic violence policy in situ. This lack of a policy was of concern to Sancus Solutions' investigation team and they suggest it may, in part, have contributed to the lack of awareness and action(s) being taken by the involved practitioner.
- Sancus Solutions' investigation team would suggest that clearly it is not solely the role of the individual practitioners to make the assessment of whether a child or adult may be at potential risk, because such a decision requires considerable skill and sensitivity. However it is all practitioners' responsibility to seek the advice and/or to inform the appropriate safeguarding team of any possible concerns regarding the welfare and safety of children and/or domestic abuse. To address this deficit Sancus Solutions' investigation team have made a recommendation that the involved IAPT and SPAs' practitioners and managers receive additional bespoke safeguarding and domestic violence training. Additionally to ensure that both safeguarding and domestic violence remains at the forefront of all actions they both are a standing agenda item within both supervision and team meetings (recommendation 5).
- The Isle of Wight NHS Trust's safeguarding nurse for adults and children reported that her department does not always receive copies of the CA/12 forms. Sancus Solutions' investigation team would suggest that it is essential that this department receives all CA/12 forms in order for them to be able to take appropriate action(s) (recommendation 4).

Changes since the incident

- To address the deficits highlighted within the SIR Sancus Solutions' investigation team were shown evidence of the following improvements that have been introduced:
  - A domestic violence policy has been written and is currently in the process of being approved. It is not clear if following the introduction of this policy the trust intends to provide domestic violence training (recommendation 5).

[21] HO

- An extensive child protection training programme has been introduced throughout Isle of Wight NHS Trust.

- The Isle of Wight NHS Trust's safeguarding nurse for adults and children reported that the Isle of Wight NHS Trust are currently remodelling and expanding their safeguarding teams with the aim of allocating safeguarding nurses to each service and clinical area. The intention is for this post to develop a close working alliance with team in order to develop and improve their responses to potential safeguarding issues.
- Since the CQC inspection in November/December 2016, a new core assessment has been introduced within the Trust's patient record system. This requires that the assessor asks direct questions regarding a patient's parental and caring responsibilities. It also asks for the details of those who are dependent on the patient to be recorded.
- The Isle of Wight NHS Trust's children's and adults' safeguarding team is also currently in discussions with the Isle of Wight's Safeguarding Children Board with regard to developing a multi-agency universal parenting assessment tool.

1.8. Think Family

- The Think Family Agenda was introduced in 2010. It recognised and promoted the importance of a whole-family approach, which was built on the principle of 'Reaching Out: Think Family'[22].

Findings

- Sancus Solutions' investigation team concluded that the Think Family Agenda did not underpin any of the practitioners' responses to Darren's assessment, disclosures or treatment/therapy plan.

Changes since the incident

- Sancus Solutions' investigation team were provided with the Isle of Wight Safeguarding Children Board's latest action plan update, which indicated that the revised Think Family Joint Working Protocol, which includes a short summary protocol, has been introduced throughout all services. When Sancus Solutions' investigation team enquired how Isle of Wight NHS Trust has actioned this Think Family Joint Working Protocol within their services, they were referred to:

  - A Think Family Banner: posted on the trust's intranet, and therefore available to all staff, throughout November 2017. It directed staff to consider the effects on children whose parents have mental health

[22]Supports a wide range of activities such as getting parents more involved in their children's learning, reducing family isolation from the wider community, and strengthening family relationships and communication. Reaching Out

problems and also provided a hyperlink to the Think Family Joint Working Protocol.
  - It was also reported that the Think Family Agenda and the Think Family Joint Working Protocol now underpin all of the safeguarding training.
- Sancus Solutions' investigation team were informed that in two recent interviews for safeguarding nurses, the candidates were asked to critique the concept of Think Family and the Think Family Joint Working Protocol with particular regard to their working practices.
- Sancus Solutions' investigation team would suggest that Isle of Wight NHS Trust should consider adopting a risk assessment tool, such as Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC)[23]. Such an assessment tool would prompt practitioners to consider the effects that a parent's mental health may be having on their children and to consider what support both the parent and child might require (recommendation 7).

1.9. Carer's assessment and support

- On a number of occasions Keziah's mother disclosed to primary and secondary healthcare services that she was providing the main parental role and also the emotional and financial support to her family. Darren also reported to services that his wife was his only source of emotional support.
- In the weeks leading up to the incident Darren was living with his mother who was, it was documented was also providing him with emotional and practical support: such as accompanying him to the GP.

Findings

- When questioned by Sancus Solutions' investigation team about what action(s) the involved practitioners were expected to take when they identified a person who had caring responsibilities, they reported that they would direct the individual to the carer's support service. There was no documented evidence that either Darren's wife or mother were provided with information about what support might be available to them as carers. Despite several requests made by Sancus Solutions' investigation team to the various clinicians and operational managers to have access to the Trust carer's policy, at the time of writing this report this has not been forthcoming. An internet search of the Trust's website also failed to locate a carer's policy or strategy.

[23] This procedure is to be used when considering the likelihood and severity of the impact of an adult's mental ill health on a child. It involves the practitioner thinking about the nature of risk and also the protective factors for the child PAMIC

1.10. Duty of Candour[24]

- The Isle of Wight NHS Trust's Serious Incident Report (SIR) documented that after the incident the Head of Nursing and Quality for Mental Health had written to Keziah's mother explaining the investigation process and to invite her to be involved in the investigation.
- It appears that Darren's family were not invited to contribute to the Isle of Wight NHS Trust's SIR.

Findings

- During Sancus Solutions' lead investigator's discussion with Keziah's mother regarding her recollections of the Isle of Wight NHS Trust's contact with her post-incident, it was very evident that she had, understandably, been so traumatised by the events that she was unable to recall her involvement with either the SIR or the Serious Case Review.
- Sancus Solutions' investigation team would suggest that clearly one of the main difficulties with involving families in SIRs is that families are often being asked to discuss what are often very difficult and recent memories. Additionally families are being asked to contribute to a SIR's terms of reference (ToR) and be involved in a process that they are completely unfamiliar with when they are understandably in a state of deep bereavement and may be experiencing post-traumatic stress.
- Sancus Solutions' investigation team were concerned about the decision not to invite Darren's family to be involved in Isle of Wight NHS Trust's SIR and the rationale behind this decision. As Darren had been living with his mother at the time of the incident, it is very likely that she would have been able to contribute valuable information. Her participation would also have given the author of the SIR the opportunity to discuss with Darren's family what support they might have needed, as inevitably they too had been deeply affected by the incident.
- Sancus Solutions' investigation team concluded that Isle of Wight NHS Trust did meet their Duty of Candour with regard to involving either Keziah's or Darren's family post incident and during the SIR process.
- Sancus Solutions' investigation team would also suggest that in future, if a serious incident occurs, which requires both Isle of Wight NHS Trust and either the Safeguarding Children Board to undertake investigations, every effort should be made to undertake a joint investigation.

1.11. Serious Incident Report

[24] CQC Regulation 20 providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. Regulation 20 also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Duty of Candour

- Based on the evidence that was provided, Sancus Solutions' investigation team were satisfied that Isle of Wight NHS Trust's SIR met its ToR. They were also provided with evidence of the ongoing development that has been undertaken to ensure that both the recommendations from the SIR have been implemented and that they are being monitored within Isle of Wight NHS Trust's business units and governance processes.

1.12. Serious Case Review's action plan

- Sancus Solutions' investigation team were provided with the most recent version of the SCR action plan. They were informed that it is the responsibility of the Isle of Wight NHS Trust's Director of Nursing to monitor the progress of recommendations that have arisen out of SCRs.

1.13. Predictability and preventability

Predictability:[25] Sancus Solutions' investigation team have concluded that it was not predicable that on 1 June 2016 he would harm his daughter. However, there was enough evidence to suggest that at the time that it was predictable that Darren was a significant risk of ending his own life by suicide.

Preventability:[26] Sancus Solutions' investigation team have concluded that the incident on 1 June 2016 that led to the tragic death of Keziah and the suicide of Darren was not preventable.

Keziah mother's comments: Having read this investigation report Keziah's mother reported that she disagreed with the conclusion reached by Sancus Solutions' investigation team. She believes that if her Darren had been offered the support from mental health services that he needed both his suicide and the death of Keziah would have been prevented.

Concluding comments: Clearly this is a most tragic case that has resulted in the death of a young child and her father. This tragedy will continue to affect the lives of

[25] 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

[26] 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. Preventability

all those involved, especially Keziah's mother. Sancus Solutions' investigation team hope that the findings and recommendations of their investigation will contribute to Isle of Wight NHS Trust's learning and improvement of practice and to the safety of patients and their families. It is also the hope of Sancus Solutions' investigation team that the findings and recommendations within this report will provide both Keziah's mother and Darren's family with at least some resolution to their concerns and questions.

Recommendations

Isle of Wight NHS Trust's Improving Access to Psychological Plus Therapies service (IAPT)

Recommendation 1: To ensure that Isle of Wight NHS Trust's IAPT service is fully accessible to meet the diverse needs of the population the IAPT therapist must, at the initial assessment, assess what support and aids may be required by the patient.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT)

Recommendation 2: Isle of Wight NHS Trust IAPT service must either develop a bespoke IAPT service risk assessment or utilise the community mental health risk assessment tool.

The IAPT risk assessment must include the identification and assessment of :

- All potential risk, including the patient's risk to self and others
- Documentation of all historical risks
- A narrative of all risk(s) identified
- A risk management plan should be agreed with the patient based on all current risk(s) identified:
- The risk management plan should identify a contingency and crisis plan
- Risk(s) identified must be reviewed at subsequent sessions.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT)

Recommendation 3: The IAPT service's operating procedure (SOP) need to be revised to include:

- A specific section on the assessment and monitoring of risk.
- A hyperlink to Isle of Wight NHS Trust's clinical risk and Care Programme Approach (CPA) policies.
- A section that clearly outlines the IAPT therapist's responsibilities with regard to safeguarding adults and children and the trust's Think Family Agenda. This section should have hyperlinks to the relevant safeguarding policies and the Think Family Joint Working Protocol.

Isle of Wight NHS Trust

Recommendation 4: A review should be undertaken to ascertain why the Named Nurse for Safeguarding Children does not always receive all CA/12 Child and Young Person at Risk forms (now referred to as Public Protection Notices). Any issues identified should be promptly addressed.

Isle of Wight NHS Trust Improving Access to Psychological Therapy (IAPT) and Single Point of Access services (SPA).

Recommendation 5: The involved IAPT and SPA practitioners and managers must receive additional bespoke safeguarding and domestic violence training. Safeguarding and domestic violence should be a standing agenda item within both IAPT and SPAs' supervision and team meetings.

Isle of Wight NHS Trust

Recommendation 6: As part of all primary and secondary mental health practitioners and service /operational managers' recruitment interviews the interviewee should be asked to demonstrate how the Think Family Agenda underpins their practice.

Isle of Wight NHS Trust

Recommendation 7: Isle of Wight NHS Trust should consider adopting an assessment tool, such as Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC), within its primary and secondary mental health services, including the IAPT service.

Isle of Wight NHS Trust, Clinical Commission Group (CCG) and NHS England South East

Recommendation 8: Isle of Wight NHS Trust should redesign the current IAPT service's assessment proformas to ensure that they are adequately identifying and risk(s) and potential safeguarding issues.

The CCG and NHS England South East should seek assurance and evidence from the Isle of Wight NHS Trust that the IAPT risk assessment adequately addresses any potential safeguarding issues.

Isle of Wight NHS Trust

Recommendation 9: Isle of Wight NHS Trust should develop a Carer's Support Policy.

Isle of Wight NHS Trust and Isle of Wight Safeguarding Adults and Children Boards

Recommendation 10: A joint protocol should be developed between Isle of Wight NHS Trust and the local Safeguarding Adult and Children Boards that identifies how and in what circumstances joint investigations will be undertaken.

Isle of Wight NHS Trust

Recommendation 11: Isle of Wight NHS Trust should consider recruiting a family liaison post who would be the single of point of contact and support for families throughout the Serious Incident investigation process.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT) and secondary community mental health services

Recommendation 12: The IAPT referral information requires further amendments in order to clarify the criteria of referrals, including any prohibitive risk histories.

2. The events that led to the death of Keziah

2.1. On 1 June 2016 Keziah, aged six years, was on half-term holiday from school. Shortly before 9am Darren arrived at the family home to look after Keziah while her mother went to work. This arrangement had been agreed the

previous evening, prior to Darren returning to his mother's house, where he was living at that time.

2.2. At approximately 10.09am Keziah's mother received a long text message from Darren which said, among other things, that he would "only leave her with memories"[27]. This text message gave Keziah's mother reason to be seriously concerned for the welfare of her daughter, so she contacted the police and immediately set off to drive back to the family home.

2.3. There was some delay in the police arriving, which resulted in Keziah's mother arriving at the family home at the same time as the police.

2.4. One of the attending police officers located Keziah upstairs. She was lying on one of the beds. The two family dogs were also laid out next to Keziah.

2.5. Evidence presented at the inquest by the police reported that both Keziah and the two dogs were wet, the bath was full of water and there was a blanket in the bath.

2.6. The attending police officer immediately commenced efforts to resuscitate Keziah and the paramedics arrived at 10.52am[28].

2.7. Keziah was taken by the paramedics to the local hospital and they arrived at 11.12am.

2.8. Further attempts were made at the Accident and Emergency Department to resuscitate Keziah, but these were unsuccessful and she was pronounced dead at 12.10pm.[29]

2.9. Darren, aged 44 years, was found hanging from the loft and was pronounced dead at the scene.

2.10. The inquest concluded that Keziah had been unlawfully killed by her father and that he had taken his own life.

2.11. Prior to the incident Darren and his wife had recently separated and he was living at his mother's house.

2.12. Prior to the incident (11 May 2016) Darren had commenced cognitive behavioural therapy (CBT)[30] provided by Isle of Wight NHS Trust's Improving

[27] Information documented in both the Isle of Wight Safeguarding Children Board Serious Case Review and Isle of Wight NHS Trust's Serious Incident Report
[28] Information provided by paramedics to the inquest
[29] Information documented in Isle of Wight NHS Trust's Serious Incident Report

[30] Cognitive behavioural therapy *(*CBT*)* is a type of talking treatment which focuses on how a patient's thoughts, beliefs and attitudes affect their feelings and behaviour. The therapy teaches coping skills for dealing with different problems. CBT

Access to Psychological Therapies (IAPT)[31] service. He was last seen by his IAPT therapist on 25 May 2016.

2.13. The IAPT therapist's assessment of Darren's risk level was moderate and the working diagnosis was "severe depression and anxiety"[32].

2.14. Darren's last appointment with his GP was on 14 April 2016. At the time of his death Darren was being prescribed the antidepressant mirtazapine[33] 45mg and his last prescription was issued and collected on 20 May 2016.

3. Independent 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[34], which aims:

"To facilitate learning by promoting a fair, open and just culture that abandons blame as a tool and promotes the belief that an incident 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."[35]

3.2. The criteria for the commissioning of an independent mental health homicide investigation within the Serious Incident Framework is:

"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"[36].

3.3. The Serious Incident Framework cites that a standardised approach to the investigation of 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

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[31] Improving Access to Psychological Therapies (*I*APT*)* services provide evidence-based psychological therapies to people with anxiety disorders and depression. IAPT

[32] IAPT assessment 11 May 2016, p2

[33] Mirtazapine *is* an antidepressant drug prescribed to treat Major Depressive Disorder, Obsessive Compulsive Disorder and a range of anxiety disorders. Mirtazapine

[34] The Serious Incident Framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and lessons are learnt to prevent the likelihood of similar incidents happening again. NHS Serious Incident

[35] NHS Serious Incident p10

[36] NHS Serious Incident p47

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."[37]

3.4. In March 2017 NHS England (South) commissioned Sancus Solutions to undertake an investigation into the care and treatment of Darren by Isle of Wight NHS Trust.[38]

Purpose and scope of the investigation

3.5. The full terms of reference (ToR) for this investigation are located in appendix A.

3.6. Briefly the aim of this investigation is:

"To identify whether there were any gaps, deficiencies or omissions in the care and treatment that [Darren] received from the Isle of Wight NHS Trust and relevant healthcare partners, which could have predicted or prevented the incident. The investigation process should also identify opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring."[39]

3.7. For the purpose of this investigation, Sancus Solutions will utilise the following definitions:

- Predictability: the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[40]
- Preventability: a preventable incident is one for which there are three essential ingredients present: the knowledge, legal means and opportunity to stop an incident from occurring.[41]

3.8. Sancus Solutions have been asked:

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[37] NHS Serious Incident p48
[38] Isle of Wight NHS Trust is an integrated trust that provides acute, ambulance, community and mental health services to a population of 140,000 people. NHS Trust
[39] ToR p1
[40] 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
[41] Preventability – to prevent 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. Preventability

- To review Isle of Wight NHS Trust's internal Serious Incident Report (SIR) and assess the adequacy of the findings and recommendations
- To review the trust's implementation of the action plan
- To comment on the trust's "enactment of the Duty of Candour"[42]
- To review the trust's family engagement policy for homicide and serious patient incidents, measured against best practice and national standards.

3.9. After the report has been published, Sancus Solutions will agree with NHS England (South) the timetable and format to review the involved stakeholders' implementation of their action plans.

3.10. The Isle of Wight Safeguarding Board commissioned a multi-agency Serious Case Review (SCR), which was published in February 2017. It is the intention of Sancus Solutions' investigation not to replicate either the SCR or the SIR but to review and seek evidence of the progress that Isle of Wight NHS Trust has made in its implementation of the recommendations from both their SIR and the SCR.

3.11. Six months after the report is published, Sancus Solutions' investigation team will undertake a further review to obtain and interrogate the evidence of the progress that Isle of Wight NHS Trust and their commissioners have made with regard to their action plans that have arisen from the recommendations from this report.

3.12. Sancus Solutions' investigation team will then submit a report, which will be published alongside this report on NHS England's website.

Methodology

3.13. Where relevant, Sancus Solutions' investigation team have utilised root cause analysis (RCA) as the methodology for this investigation.

3.14. RCA is a retrospective multidisciplinary approach designed to identify the sequence of events that led to an incident. It is an iterative[43] structured process that has the ultimate goal of preventing future adverse events by the elimination of latent errors. RCA 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

[42] ToR p2
[43] Iteration is the act of repeating a process with the aim of approaching a desired goal, target or result

common risks and opportunities to improve patient safety and informs recommendations regarding organisational and system learning.

3.15. As far as possible, Sancus Solutions' investigation team have aimed to eliminate or minimise hindsight or outcome bias[44] in their investigation. The investigation team have analysed information that was available to primary and secondary care services at the time. However, where hindsight has informed either the recollections of the interviewees or the family, or the investigation's judgements, this has been identified.

Structure of the report

3.16. Section 1 provides an account of the events that led up to the incident on 1 June 2016.

3.17. Sections 6-7 provide details of:

- Darren's childhood, education and employment history
- His marriage to Keziah's mother
- Keziah's early developmental progress, physical health, childhood and contact with children's universal services.

3.18. Sections 8 and 9 provide information regarding:

- Darren's primary healthcare contact from December 2010 to December 2014
- His first contact with the IAPT service from March 2015 to April 2015.

3.19. Section 10 provides information about:

- Darren's last contact with primary healthcare and his second referral and involvement of the IAPT service from 23 March 2016 to 25 May 2016.

3.20. From section 11 onwards the report addresses the specific issues raised within the ToR.

[44] 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 judgement 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

3.21. Alongside Sancus Solutions' investigation team conclusions regarding the predictability and preventability of the incident section 19 also documents a summary of Keziah mother's comments.

4. Sancus Solutions' investigation team

4.1. The lead investigator for this case was Grania Jenkins. Grania is a senior mental healthcare, performance and quality professional who has worked in primary, secondary and third sectors. Grania has extensive experience of undertaking investigations into suicides and unexpected deaths, critical and serious incidents, complaints, and cases of gross misconduct, as well as root cause analysis investigations and thematic reviews. Since 2014 Grania has been the lead investigator for several homicide investigations under NHS England's Serious Incident Framework. She is also an associate director of Sancus Solutions.

4.2. Dr Oliver White provided psychiatric advice to the panel and undertook interviews. Oliver is a forensic psychiatrist who has extensive experience of working within secure inpatient units. He has also delivered multidisciplinary training on risk assessment and risk management, and has been a Clinical Services Director and a Named Doctor for Safeguarding Children. Oliver has also provided expert evidence in high-profile criminal cases, including homicide cases.

4.3. Carol Dudley undertook a critical and forensic review of the safeguarding issues of this case. Carol is a safeguarding nurse who is currently an independent safeguarding consultant and a CQC Specialist Practice Adviser (safeguarding children and adults).

4.4. Tony Hester, who is one of Sancus Solutions' directors, provided the quality control and governance oversight of this investigation process. Tony has over 30 years' Metropolitan Police experience in Specialist Crime investigation.

Interviews

4.5. As this investigation was commissioned by NHS England, the primary focus of the investigation will be on Isle of Wight NHS Trust's services. However, where relevant the investigation team will review and comment on any other involved services.

4.6. As part of this investigation, Sancus Solutions' investigation team interviewed and/or had telephone contact with the following personnel:

- Two Interim Deputy Directors of Nursing

- Interim Chief Nurse
- Clinical Quality and Safety Lead and author of the SIR
- Clinical Director, Mental Health Services
- Consultant Psychiatrist and Medical Lead, Adult Services
- IAPT Manager
- Primary Care Mental Health Team administrator
- IAPT therapist
- Clinical Manager Crisis Resolution and Home Treatment team
- Interim Team Lead Crisis Resolution and Home Treatment team
- Head of Safeguarding – children and adults
- Named Nurse for Safeguarding Children
- Operational Manager community mental health services
- Isle of Wight Safeguarding Children Board Partnership Support Manager
- Author of the Serious Case Review
- Hampshire police officer who was a member of the Serious Case Review Panel.

4.7. Sancus Solutions' interviews are managed with reference to the National Patient Safety Agency's (NPSA) investigation interview guidance[45] and adhere to the Salmon/Scott principles[46]. Where there has been the potential for perceived criticism of individuals or their actions, we have adhered to the Salmon/Scott principles.

4.8. Where appropriate this report will refer to the relevant Isle of Wight NHS Trust policies that were in place at the time of the incident, as well as those that have been revised in response to the recommendations from the SIR and the SCR.

4.9. Reference will also be made to:

[45] National Patient Safety Agency (2008) Root Cause Analysis Investigation Tools: Investigation interview guidance NPSA

[46] 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, among other things, set out principles of fairness to which public inquiries should seek to adhere. Salmon Scott

- Department of Health's (DH) Talking Therapies, a four-year action plan[47]
- Home Office Domestic Homicide Review 2016[48]
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[49]
- National Institute of Health and Clinical Excellence (NICE) guidelines for the diagnosis and management of adults with depression and anxiety[50]
- Royal College of Psychiatrists' Rethinking Risk[51]
- The Independent Mental Health Taskforce to the NHS in England: Five Year Forward View for Mental Health, 2016[52]
- The Improving Access to Psychological Therapies Manual (June 2018)[53]
- Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC), which is a tool to support practitioners when they are considering the likelihood and severity of the impact of a parent's mental ill health on their child and/or children[54].

Anonymity

4.10. For the purposes of this report:

- The identities of all those who were interviewed have been anonymised and they have been identified by their professional titles.
- At Keziah's mother's request, we have referred to both her daughter and her husband by their forenames names.

5. Involvement of Keziah's and Darren's family

5.1. The NHS 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."[55]

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[47] Talking Therapies
[48] Home Office Review
[49] Confidential Inquiry
[50] NICE
[51] Royal College
[52] Task force
[53] IAPT Manual
[54] PAMIC
[55] NHS England, Serious Incident Framework. Supporting learning to prevent recurrence Serious Incident Framework

5.2. Sancus Solutions always try to seek the views of the families of both the victim and the perpetrator, not only in relation to the incident itself, but also their wider thoughts regarding where they consider improvements could be made to services in order to prevent similar incidents from occurring.

5.3. Throughout the course of the investigation, Grania Jenkins has remained in contact with Keziah's mother to provide her with updates on the progress of this report. Sancus Solutions' investigation team have been extremely grateful for the information that Keziah's mother has provided, as this has been essential in assisting us to have an accurate chronology of events that led up to the incident itself. She has also provided valuable background information on the lives of her family.

5.4. Although this report focuses on Darren and the care and treatment he received from the various services, Sancus Solutions' investigation team have, throughout their investigation, kept at the forefront of their minds Keziah and the devastating and profound effects that this homicide had at the time and continues to have on her family, especially her mother.

5.5. After meeting with Grania Jenkins and the NHS England (South) mental health homicide lead, Darren's mother declined to take part in this investigation.

5.6. Keziah's mother and Darren's family have received a copy of the final report. And have received, verbal feedback on the report's findings and recommendations. They have had the opportunity to meet with representatives from Isle of Wight NHS Trust and their commissioners to hear their responses to the report's findings and recommendations.

5.7. If they wish, they will also receive a copy of Sancus Solutions' assurance report which will be undertaken six months after this report has been published. This report will evaluate the progress the trust has made on implementing their action plan.

5.8. Both Darren's family and Keziah's mother were invited to write about the impact this tragic incident has had on their lives. Keziah's mother has requested that Sancus Solutions include the following statement in this report:

"Thinking about what impact the loss of my daughter, my husband and my dogs has had on me comes in two totally separate types and pain levels

1st, The physical because it is the least important. I lost my beautiful home, the one I'd dreamed of since I was a little girl and had made as perfect for my

little family as I could. Making the garden child friendly and the house suitable for fun and friends. I lost friends who lived close and I spent time with because they couldn't face me after Keziah’s death. Yes I was given another accommodation and yes it is habitable, however it isn't as beautiful as my home and it will never be home just somewhere the council were kind enough to put me. I have always been scared of old houses, my house was built in the 1930s so most nights I have nightmares about it too. Minor I hear you think, but imagine waking up each day in a place that is suitable but not home. Every morning I wake up in a strange place and with no attachment to it other than it keeps me safe from the outside world. I ended up paying more rent for this new place and for a B&B I was put in while I waited.

Also without the kindness of the community I would have had to pack up what was left of my life and move it to my new house. Finally I now live half unpacked. Downstairs and the upstairs bathroom look presentable so that people can visit and think I'm "normal". The bedrooms, one I sleep in and it looks like I moved in a few days ago. The other is full of boxes because I can't face the boxes. They contain unknown items because someone else packed them so each one has the potential to have something in it that will send me right back to that moment. Also what is the point? I have no reason to make it "lovely” there is no" lovely in my life. I have out, absolute essentials nothing more and wear the same round of clothes again and again because looking for others is too much to cope with.

I also lost my job and any income because I physically was unable to work. It was commission based work so it didn't pay sick pay so I was immediately without cash except for what I had left until 8 weeks later when I started claiming for benefits. I also lost my ability to drive for a year, due to the medication I needed to cope with the horror I'd faced leaving me dependant on others. It's also left me without the major skill I had customer service. I now find it hard to deal with people because the fame makes them say the most unusual things. I once won £6000 in a competition for customer service. I'm now probably looking at cleaning for a living when I can cope with work after therapy.

2nd, the most painful loss, I lost my beautiful, funny, loving, playful, happy, amazing little girl. Since the day I knew I was pregnant I did everything I could to ensure her safe arrival. The pregnancy was a risky one so I followed every instruction to the letter. When she was born I joined the baby groups and classes so I'd be a good enough mum, and worked early hours without sleep to make sure I could give her the best childhood possible, by spending time with her. She was my career of choice and became my vocation. I loved every scary, tired, messy, laughter filled moment with her. Took her, to anywhere I

thought we could have fun.

When she died she was perfectly healthy. No concerns for her health so she was stolen from the world and me still benefitting the world, leaving me without purpose.
I lost the most important title I have ever had that of Mummy. I will never truly be that again. It's all kindness and sympathy now because mummies, look after, love, play, feed, clothe and teach their child about life. I can no longer do that.

Due to lack of early help despite my efforts I lost my husband. First because I could no longer cope with how he was and then because he hung himself. I did everything I could to support him and even told his councillor that I'd do anything to help. Yet no warning not to let him have sole care of his child!

I also lost my beautiful dogs insignificant to some but they were family to me and I loved them with all my heart. One of them Arnie a long haired dashund was 16yrs old and a faithful friend. The other Maximus a wirehaird dashund who was 9 months old, he didn't deserve to die.

I have lost my ability to go to public places because I feel scared now that I'm "famous" and never know what people will say. I can no longer see or hear an ambulance without crying, At least 4 an hr go passed the bottom of my road every single day. I no longer wake up without first having to remember I'm totally alone, that I'm no longer a mum or have any importance to anyone. I have lost all of those precious moments that I had imagined like university, marriage, grandchildren and all those teenage moments, girlie shopping, sleepovers and even the stroppiness too. I will never be a grandma. I've even had to prepay my funeral as I am my own responsibility and I want to be buried with my daughter.

There is no place on the island I can go where there isn't a Keziah memory. There is nowhere on the island, I cannot go without at least one person recognising me. To shorten it down entirely I lost everything that made me who I was. I no longer know me or what I can do or even what I like. If I'm honest I was also killed that day. Only they just forgot to bury me.

Why because no one saw his illness and because even when he said he'd dreamed about killing us it wasn't taken seriously. I was told that we weren't classified as a child protection case because my house was tidy!!! It could still happen today because when I was assessed for treatment knowing what I'd been through. I was put on an 18month waiting list!! Until it was chased up by Grania. There is probably someone in the system just like him who is waiting

their 18months. Their time bomb ticking."[56]

6. Darren

6.1. In 2016 Darren reported[57] that his father left the family home when he was five years old and he had not seen him since he was 16 years old.

6.2. Darren also recalled that as a young child he would spend most of his time on his own in his bedroom and that he went to a "special school but never fully learnt to read or write"[58]. He also disclosed that he had been bullied at school. After Darren left school he went to college, but he failed his exams.

6.3. Darren reported that during his adult life he had periods of employment but only held positions for short periods of time until he gained employment at a supermarket chain, a position that he held for 12 years.

6.4. Darren continued to live with his mother and stepfather until he married Keziah's mother. His stepfather died in 2013.

6.5. In February 2015 Darren reported to his GP that he had "walked out of his job [as] work did not understand his difficulties and … maintaining this employment [had become] too stressful"[59]. Darren had no further periods of employment.

Marriage

6.6. Darren and Keziah's mother met at work, where they were both employed. They were married in 2003.

6.7. Darren reported to the IAPT therapist (18 May 2016) that he recognised that his life had significantly changed after he met his wife. This relationship had helped him become more confident and independent. However, he recognised that he had become increasingly dependent, both emotionally and financially, on his wife after he became unemployed in 2015 and that this had contributed to the breakdown in their relationship in 2016.

7. Keziah

7.1. It was reported that Keziah reached all of her developmental milestones. Reports provided to the SCR consistently described Keziah as a lively, well-adjusted and socially appropriate little girl, who loved her pet dogs and had a favourite toy dog, which she often liked to have with her as a comfort toy. The

[56] Statement written by Keziah's mother
[57] IAPT appointment 18 May 2016
[58] IAPT appointment 18 May 2016
[59] IAPT assessment p2

SCR also noted that there were no reported safeguarding concerns or concerns regarding Keziah's welfare.

7.2. In 2014 a paediatrician had referred Keziah for counselling, as her mother reported that her daughter had been affected by two deaths within the family. She also reported that she was worried about how Keziah was going to react when her much-loved elderly family dog died. Keziah's mother had bought a puppy in the hope that this would help her daughter when the family dog eventually died.

7.3. In March 2015 the school reported to Keziah's mother that they had noticed that there had been some changes in her daughter's behaviour and presentation. Her mother took Keziah to the GP, disclosing to both the GP and the school that there had been some new stress factors within the family, particularly that Keziah's father had left his employment and that he was depressed. The GP suggested to Keziah's mother that she self-refer her daughter to the local Barnardo's service in order to access age-appropriate counselling.

7.4. Until their separation (2016) Keziah lived with both parents, but her mother described herself as the primary carer. After the separation Keziah's father would regularly visit the family home so that he could maintain ongoing contact with his daughter, and at times he looked after her while her mother was working. The family also continued to go on outings together, the last occasion being the weekend before the incident[60].

7.5. The only time that Keziah came to the attention of children's social services was on 10 March 2016, following an incident where police were involved in ascertaining Darren's welfare. As part of standard practice, the attending police officer completed a Child and Young Person at Risk form (CYP form).[61] This was subsequently reviewed by children's services' Multi-Agency Safeguarding Hub (MASH)[62]. They identified that the family had not been previously known to children's services and concluded that there were no immediate safeguarding concerns and that no further action was required. The SCR concluded that the "decision to take no further action [was] a justifiable one"[63].

8. Primary healthcare involvement from October 2010 to December 2014

[60] Reported by Keziah's mother to Sancus Solutions' lead investigator
[61] Used to notify children's social care when a child could be considered at risk
[62] IOW MASH
[63] Serious Case Review p19

8.1. Based on Sancus Solutions' review of Darren's GP records, it appears that he had little contact with his GP until 12 October 2010, when he reported that he was experiencing stress at work. No treatment was given, but he was provided with smoking cessation advice.

8.2. Darren next presented to his GP on 13 June 2013 with "depressed mood"[64]. It was noted that Darren disclosed during this appointment that he had "always had a negative view of life … [had] been depressed for several years now, but [had been] worse since Christmas … has suicidal ideation once per week, has thought of hanging but no definite plans … no enjoyment in life, no longer happy in job as delivery man, tends to withdraw [and] not interact … has lost motivation."[65]

8.3. The GP noted that his "wife & daughter [were] protective factors" and prescribed the antidepressant fluoxetine[66] 20mg qd[67] with the aim of reviewing Darren in two weeks.

8.4. Darren saw the GP on 28 June 2013, when he reported that there had been no improvement in his symptoms but that he had not had any further suicidal ideation. It was noted that he did not want to be referred to community mental health services.

8.5. At a subsequent appointment (12 July 2013) his GP increased the fluoxetine prescription to 40mg qd[68].

8.6. A Patient Health Questionnaire (PHQ-9)[69] Anxiety and Depression Scale was undertaken on 26 September 2013. Darren scored 22, which indicated severe depression.[70]

8.7. Following a telephone call with Darren on 26 September 2013, the GP referred him to the Single Point of Access (SPA) service. It was noted that Darren's wife reported that she was concerned about her husband's mental health and that it was the anniversary of his stepfather's death.

8.8. Darren was subsequently seen by the GP later that same day. His wife also attended this appointment. He disclosed that he was having "fleeting suicidal thoughts … [and was] feeling hopeless"[71]. He declined the involvement of the

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[64] GP notes 13 June 2013
[65] GP notes 13 June 2013
[66] Fluoxetine belongs to a class of medications called selective serotonin reuptake inhibitors (SSRIs). It is used for the treatment of depression and helps to elevate mood used in the treatment of depression, obsessive compulsive disorder s Fluoxetine
[67] qd: once a day
[68] qd: daily
[69] The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression PHQ
[70] A score of 20-27 indicates severe depression
[71] GP notes 26 September 2013

crisis service but was given their contact details. At this consultation the GP changed his antidepressant medication to sertraline[72] 100mg qd.

8.9. Darren was next seen by his GP on 8 October 2013, when he reported that his symptoms had significantly improved and he was not experiencing any suicidal thoughts or ideations.

8.10. Darren did not attend a subsequent appointment on 29 October 2013, but he was subsequently issued with a repeat prescription for sertraline 100mg qd on 10 December 2013. Darren was next reviewed by the GP on 16 January 2014, when he reported that he was "feeling stable on meds [but was] not keen on counselling"[73].

8.11. Repeat prescriptions of sertraline continued to be issued until 30 May 2014, when the primary care notes indicated that Darren discontinued this medication without consultation with his GP.

8.12. On 19 September 2014 Darren's wife contacted the GP surgery to report that such was her concerns about Darren that she had called the emergency services. Paramedics attended and assessed that Darren was suffering from a severe panic attack and advised that his wife should contact his GP.

8.13. The GP prescribed the beta blocker propranolol[74]10mg and subsequently saw Darren on 22 September 2014. During the consultation Darren reported that the medication had significantly helped. He also reflected on the "sources of [his] stress [and stated that] he [had] been supporting his partner and perhaps neglecting his own feelings"[75]. The GP again provided Darren with information about being referred to community mental health services, and documented that Darren had reported that he would consider accessing the service but that he found it difficult to talk about his feelings.

8.14. Again Darren did not attend any subsequent follow-up appointments but was issued with two repeat prescriptions for propranolol on 19 September 2014 and 19 October 2014[76].

8.15. The next contact the GP had with Darren's wife was on 31 December 2014. She reported that her husband was "very low in mood … unable to get out of bed … not feeling suicidal [and] no thoughts of self harm"[77]. Darren felt unable

[72] Antidepressant of the selective serotonin reuptake inhibitor class. It is primarily used for major depressive disorder, obsessive–compulsive disorder, panic disorder, and social anxiety disorders Sertraline
[73] GP notes 16 January 2014
[74] Beta blockers can be helpful in the treatment of the physical symptoms of anxiety, especially social anxiety. Physicians prescribe them to control rapid heartbeat, shaking, trembling, and blushing in anxious situations for several hours. Propranolol
[75] GP notes 19 September 2014
[76] On each occasion he was issued with a prescription for 84 tablets
[77] GP notes 31 December 2014

to talk to the GP, but his wife reported that he wanted to restart his antidepressant medication sertraline. A month's prescription was issued and the GP asked that he book a review appointment. This did not occur, but Darren was issued with a subsequent repeat prescription, which was issued on 28 January 2015.

9. Darren's contact with Improving Access to Psychological Therapy service – March 2015

9.1. Darren's GP initially referred him to the primary mental health team on 24 February 2015. Subsequently he was assessed by the IAPT service on 19 March 2015.

9.2. At the initial assessment appointment the IAPT therapist used the following depression and anxiety diagnostic assessment tools: Patient Health Questionnaire (PHQ-9)[78] Anxiety and Depression Scale and Generalised Anxiety Disorder (GAD)[79].

9.3. The scores for the two assessment tools were as follows:

- PHQ-9 was 19 (15-19 moderate severe depression)
- GAD was 7 (6-10 moderate anxiety).

9.4. Darren was assessed as being a "medium risk" and diagnosed, using the International Statistical Classification of Diseases and Related Health Problems (ICD) code, with an "F32 depressive episode"[80].

9.5. It was also documented that Darren disclosed that he had:

"longstanding low self-esteem … reported multiple family bereavements over the past two years, including [his] step father, mother in law and most recently his nephew (January 2015)"[81].

9.6. Darren also reported that he had been experiencing panic attacks and low mood since October 2014 and that the previous week he had "walked out of his job. Reports that work did not understand his difficulties and that maintaining this employment [had become] too stressful."[82] He also disclosed that he was experiencing daily suicidal thoughts and that although he had no

[78] The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression PHQ
[79] Generalized anxiety disorder (GAD) is an anxiety disorder characterized by excessive, uncontrollable and often irrational worry, that is, apprehensive expectation about events or activities. GAD
[80] classification of mental and behavioural disorders ICD code
[81] IAPT assessment p2
[82] IAPT assessment p2

definitive plans, he had considered various scenarios, which included hanging himself in a nearby wooded area.

9.7. Darren also described an incident that had occurred two years earlier when he had impulsively gone to a cliff and had thoughts of jumping. He was unable to recall what had prevented him from carrying out this suicide attempt.

9.8. The assessment noted that Darren's "wife and daughter [were] strong protective factors"[83].

9.9. With regard to his risk to others, it was documented that "none [were] disclosed or identified at the time of [the] appointment"[84].

9.10. It was also documented that Darren had "been motivated by his wife. She reported trying to get him involved with treatment for 2 years."[85]

9.11. The risk management plan identified that he should undertake activities such as walking to distract him from thoughts of harming himself, seek support from his wife and engage with treatment for his depression.

9.12. Following this assessment Darren was given a number of self-help-guide leaflets for depression and the contact details for the crisis service. He was also asked to complete a Patient Experience Questionnaire (PEQ). A follow-up appointment was scheduled for 25 March 2015.

9.13. At the next appointment it was assessed that his:

- PHQ-9 was 13 (10-14 moderate depression)
- GAD was 6 (6-10 moderate anxiety).

His risk was again assessed as medium.

9.14. Darren reported that there had been an "improvement" in his mood, his thoughts of self-harm had reduced and he was finding the support being provided by his wife helpful. The therapist documented that Darren's risk management plan was reviewed and no changes were noted.

9.15. It was noted that Darren reported that he was unable to read the self-help material he was sent as it had only arrived the previous day.

[83] IAPT assessment p3
[84] IAPT assessment p3
[85] IAPT assessment p2

9.16. The IAPT therapist asked Darren to complete a log of his thoughts and to "consider how he [viewed] himself to help inform [his] treatment plan"[86].

9.17. The therapist noted that they completed the Robson questionnaire[87] and also that she explained the use of the Exeter 'Get Active – Feel Good' workbook[88]. She also discussed with Darren the role of the employment advisers who could help him with searching for employment, which was one of his identified goals.

9.18. During this session Darren disclosed that he was dyslexic. It was documented that his "homework" for the next session was to read through a chapter of the workbook and to keep a baseline activity diary.

9.19. His next appointment was scheduled for 15 April 2015. Darren did not attend and he was subsequently sent a letter requesting that he contact the service within 7 days or he would be discharged from the IAPT service[89]. As he did not respond, his GP was informed that he had been discharged from the service.

10. Events from 23 March 2016 -25 May 2016

10.1. Darren had no further contact with his GP until 23 March 2016, when it was documented that he was presenting with depression. He disclosed to his GP that he was experiencing anxiety and disruption to both his sleep and his appetite. He also reported that he had no motivation and was increasingly irritable, disclosing that he was having regular thoughts of self-harm but that he had not acted on these thoughts as he was "too cowardly"[90].

10.2. During this consultation Darren reported that he rarely left the house apart from taking his daughter to school. Darren also reported that although his wife was supportive, she was becoming increasingly frustrated with his lack of motivation and employment. Darren disclosed to the GP that he thought that his wife might be having a "texting affair"[91] and that he believed that this was his fault and that he wanted to save his marriage.

10.3. The GP outlined what support was available to Darren, who reported that he had not been able to manage the IAPT support due to his dyslexia. He agreed

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[86] IAPT notes p3
[87] Robson questionnaire: is used to inform the IAPT therapist's clinical assessment of the patient's level of self-esteem. Robson
[88] Workbook used to encourage patients who are suffering from depressive illnesses to undertake activities Get Active
[89] This was in line with the IAPT DNA policy
[90] GP records 23 March 2016
[91] GP records 23 March 2016

to recommence antidepressant medication and was prescribed mirtazapine[92] 15mg, which was to be reviewed in a week.

10.4. Darren was seen again by the GP on 30 March 2016, when he reported that there had been some improvement with his sleeping but his low mood remained unchanged. He also reported that his communication with his daughter was monosyllabic but that he intended to make more effort. The GP discussed counselling options, including Relate[93], with Darren and increased his mirtazapine dose to 30mg, issuing a prescription for 14 days.

10.5. On 9 April 2016 Darren's wife contacted the police to report that following a verbal dispute with her husband he had gone missing.

10.6. Darren was later located by the police at his mother's address. He reported that on the way to his mother's house he had tried to hang himself but was unable to carry it out. The police advised his mother that she should take him to his GP as soon as possible.

10.7. The police completed a Vulnerable Adult Form, on which it was documented that in the previous week Darren's wife had reported her husband missing on two occasions and that on each occasion he had made a threat to take his own life.

10.8. The Vulnerable Adult Form documented that Darren's wife had reported that her husband had found some text messages on her phone which he mistakenly believed indicated that she was having an affair. After this incident she reported that Darren had begun to follow her everywhere, even to the bathroom, to see if she was texting anyone.

10.9. On 9 April 2016, while Darren had been looking after Keziah at the family home, he had been looking at his wife's emails and text messages. She returned at about 6pm. Darren became angry, saying he had found evidence that she was having an affair. He then left the family home stating that he would kill himself if she left him. His wife became very concerned for his safety and contacted the police.

10.10. The attending police officer completed a Domestic Abuse Risk Assessment form (DASH[94]) in order to assess the potential risk of domestic violence within Darren's relationship with his wife. The assessment identified that the potential risks were physical and psychological. No further action was taken.

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[92] Mirtazapine
[93] Relate is a charity providing relationship support throughout the United Kingdom. Services include counselling for couples, families Relate
[94] The DASH risk checklist is for the identification of high-risk cases of domestic abuse, stalking and 'honour'-based violence DASH

10.11. The officer also completed a safeguarding referral form for adults (CA/12) and a CYP form[95] as part of standard practice. These forms were forwarded to the adult safeguarding team and Multi Agency Safeguarding Hub (MASH)[96]. Both reports were in line with police procedures and not because there were any specific concerns.

10.12. The following day (10 April 2016) the adult social care safeguarding team triaged the CA/12 form. The decision was made that there was no indication that Darren should be considered as an adult at risk, as having suicidal thoughts alone did not meet the criteria of the Care Act 2014[97]. He also had the support of his mother, who intended to take him to his GP.

10.13. MASH also considered the forms and concluded that the appropriate action had already been taken and therefore no further action was required by children's social care services.

10.14. The CA/12 form was then uploaded onto Darren's electronic patient records (PARIS) and was assessed by the Single Point of Access (SPA) team[98], who, it was documented, decided to refer it to Darren's GP.

10.15. After receiving a copy of the CA/12 form, the GP contacted Darren by phone (12 April 2016) and increased his mirtazapine to 45mg. He also arranged for him to attend an appointment on 14 April 2016.

10.16. At this appointment Darren reported that he had taken all his tablets prior to his suicide attempt, but that he no longer felt suicidal; that he was now staying with his mother, but he was seeing his daughter. Also that his wife was prepared to have him back when he had "sorted [himself] out"[99]. It was also documented that the GP suggested that Darren's mother should be dispensing him his medication.

10.17. At this appointment Darren agreed that he would "try"[100] to refer himself to the primary mental health service, i.e. IAPT. The GP agreed that Darren would be reviewed in two weeks. This was the last time Darren was seen by his GP prior to his death.

10.18. Darren was seen for an IAPT initial assessment for the high-intensity CBT service on 11 May 2016.

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[95] Used to notify children's social care when a child could be considered at risk
[96] IOW MASH
[97] The adult safeguarding duties under the Care Act 2014 apply to an adult, aged 18 or over, who has needs for care and is experiencing, or at risk of, abuse or neglect, and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect Care Act 2014
[98] SPA is the first point of contact for all referrals for secondary mental health services
[99] GP notes 12 April 2016
[100] GP notes 14 April 2016

10.19. It was assessed that Darren scored the following:

- PHQ-9: 24 (severe depression)
- GAD: 20 (moderate anxiety).

10.20. A Health of the Nation Outcome Scales (HoNOS)[101] assessment was also completed and concluded the following:

- Overactive, aggressive, disruptive or agitated behaviour – minor
- Non-accidental self-injury – minor
- Cognitive problem[102] – medium
- Problem with depressive mood – moderate to severe
- Other mental and behavioural problems – moderate to severe.

  In the section 'other mental and behavioural problems' it was documented that Darren was experiencing "obsessive"[103] problems.

10.21. The assessment also concluded that Darren had "no problem" with the following issues:

- relationships
- occupation and activities
- strong unreasonable beliefs
- agitated behaviour/expansive moods
- repeated self-harm
- safeguarding children and vulnerable dependent adults.

10.22. During the session Darren disclosed that he had suffered from depression since his childhood, had never had any peer friendships and found it difficult to engage in any form of social conversation or interaction. He also disclosed that the multiple bereavements within his family had increased his depression.

[101] HoNOS is an assessment tool which assesses a number of health and social domains: psychiatric symptoms, physical health, functioning, relationships and housing HoNOS
[102] Cognitive abilities includes learning, memory, perception and problem solving
[103] HoNOS p1

During the session Darren also spoke about his suspicions that his wife was having an affair, which he said began at Christmas 2015.

10.23. Darren also reported that he had previously disengaged from IAPT due to the amount of paperwork he was given, which was difficult to manage due to his "problems with his reading and writing"[104].

10.24. During this initial assessment, Darren disclosed that prior to the incident where he had tried to hang himself, he had taken some paracetamol tablets and five mirtazapine tablets and drunk several cans of lager before attaching a rope to his neck. He had hoped that he would fall asleep and then fall out of the tree, resulting in him hanging himself. He also disclosed that this incident was an "in the moment plan"[105] and that earlier in the month he had taken an overdose but had not sought any medical attention.

10.25. The IAPT therapist concluded that Darren's presenting problems were "depression and anxiety"[106] and assessed Darren's risk to be "moderate".

10.26. It was also documented that Darren's wife and daughter were "strong protective factors"[107].

10.27. During this session Darren disclosed to the IAPT therapist that he "had nightmares recently about murdering his wife and daughter"[108].

10.28. The IAPT therapist reported to Sancus Solutions' investigation team that this was a typographical error and that Darren had actually disclosed that he had only one nightmare and not several nightmares as the records indicated. Obviously it has not been possible for Sancus Solutions' investigation team to verify this correction.

10.29. A risk management plan was agreed which included what actions Darren could take if either his suicidal intent increased or if his relationship with his wife ended suddenly.

10.30. The IAPT therapist reported to Sancus Solutions' investigation team that following this initial assessment he had contacted, at Darren's request, his wife who reported that she did not, at the time, have any concerns that her husband was presenting any risk(s) to either herself and Keziah, This conversation was not clearly documented in any of the patient records that the investigation team had access to.

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[104] IAPT assessment 11 May 2016
[105] IAPT assessment 11 May 2016 p1
[106] IAPT assessment 11 May 2016 p2
[107] IAPT assessment 11 May 2016 p1
[108] IAPT assessment 11 May 2016 p3

10.31. Darren presented himself to his GP on 12 May 2016, when he reported that he was "still [having] suicidal ideation and no protective factors"[109]. He agreed that the GP should make an urgent fax referral to the SPA service.

10.32. The SPA service made telephone contact with Darren later that day, as initially he reported that he was unable to talk as he was looking after Keziah. During the subsequent telephone conversation Darren reported that he "was not feeling so bad today … he [was] hopeful that his ex-partner was considering reconciliation"[110].

10.33. Later in the assessment it was documented that Darren "felt stable at the moment and not at risk but feels his situation would change dramatically if his ex-partner says no to reconciliation as he would harm himself"[111]. It was assessed that there were "no risks at this time"[112]. He was provided with the contact details of the crisis service.

10.34. At Darren's request the assessor agreed that he would make contact with the service on 21/22 May, which was after his next IAPT appointment (18 May 2016). It was noted that his case would be "placed in the hold file"[113]. Darren made no further contact with this service and there was no follow-up action taken by SPA.

10.35. On 13 May 2016 SPA returned a call to Darren's IAPT therapist, who reported that he had not been aware that Darren had been referred to secondary mental health services. It was also noted that the IAPT was "aware of the CA/12 which was earlier this year and at present [Darren] is having good contact with his child and estranged wife"[114]. The IAPT therapist was informed that it was the intention to hold Darren's referral until 23 May 2016 and that "if [his] risks changed then the referral to secondary services [would] be actioned"[115].

10.36. Darren was seen for a second IAPT appointment on 18 May 2016. It was assessed that Darren's PHQ-9 and GAD scores both remained the same. The aim of the therapy was noted as being to increase Darren's confidence and independence.

10.37. Darren reported that his mood had remained low but that he had no increase in his suicidal thoughts. During this session Darren began to disclose and

[109] GP notes 12 May 2016
[110] Assessment 12 May 2016 at 6pm
[111] Assessment 12 May 2016 at 6pm
[112] Assessment 12 May 2016 at 6pm
[113] Assessment 12 May 2016 at 6pm
[114] General case notes 13 May 2016
[115] IAPT session 18 May 2016

reflect on his early life experiences and also on what he believed were the causes of the recent difficulties in the relationship with his wife.

10.38. During the session Darren and the IAPT therapist discussed some activities that Darren might be able to achieve before their next session, for example working on his car with a cousin.

10.39. The therapist reviewed Darren's risk assessment and documented that Darren had reported that "he still [felt] able to keep himself safe … He is aware that he can use the crisis [service] numbers and he agreed to do so if his suicidal ideation increased."[116]

10.40. Darren collected his last repeat prescription for mirtazapine 45mg on 20 May 2016. The prescription was for 14 tablets.

10.41. Darren next saw the IAPT on 25 May 2016. Although his PHQ and GAD remained at severe, the scoring had slightly reduced to:

- PHQ-9: 22 (severe)
- GAD: 19 (severe).

10.42. Darren reported that he had noticed a "slight improvement in his mood"[117].

10.43. The IAPT therapist documented that he began to discuss psycho-education with Darren regarding his depression[118] and his low-level activity. It was noted that Darren had some insight into his behaviours and lack of activity and how they were contributing to his depression. He also began to identify what activities he could begin to engage with, such as walking after his breakfast instead of going back to bed. It was also documented that Darren was intending to look for employment.

10.44. It was also noted that the therapist introduced the concept of thought challenging[119] when Darren reported that "his daughter was upset with him and he had thoughts [that] she [hated] me now"[120].

10.45. Darren was set some "homework", which included some physical exercise, which he needed to complete before the next scheduled appointment (15 June 2016). There was a delay in the next appointment due to the therapist's annual leave.

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[116] IAPT session 18 May 2016
[117] IAPT session 25 May 2016
[118] Psycho-education of depression
[119] Thought challenges
[120] IAPT session 25 May 2016

10.46. It was documented that Darren's risk management plan was unchanged, but due to the delay in the next appointment the therapist noted that he had reiterated the crisis service's contact details with Darren. It was also documented that Darren had "agreed verbally that if he had an increase in his suicidal ideation he would contact the crisis service"[121].

10.47. This was the last time Darren was seen by or had contact with any service.

10.48. It was documented by SIR and also reported at the inquest hearing that on 26 May 2016 the IAPT therapist had contact with Darren's wife "to provide any relevant details to inform the risk assessment and treatment plan"[122]. Sancus Solutions' investigation team were unable to locate any documentation to confirm this contact.

11. Arising issues, comments and analysis

The following sections of this report will review the services provided to Darren by Isle of Wight NHS Trust with reference to the policies that were in situ at the time. These sections will also highlight where any changes have been made to services and policies in response to either the SIR's or the SCR's findings and recommendations.

Where relevant the following sections will highlight concerns that were raised in relation to the community mental health service SPA by the Care Quality Commission (CQC) inspections in November/December 2016 and May 2017. The IAPT service was not among the Isle of Wight NHS Trust services that were inspected.

This section will also be addressing the following NHS England ToR:

> "Review the engagement, assessment, treatment and care that [Darren] received from Isle of Wight NHS Trust from his first contact with services in March 2015 up to the time of the incident in June 2016 with specific reference to the reasons for and actions taken following disengagement from services in 2015 against trust policy and national guidance.
>
> Review the documentation and record keeping of key information by the Isle of Wight NHS Trust against best practice and national standards."[123]

IAPT

[121] IAPT session 25 May 2016
[122] SIR p4
[123] ToR p1

11.1. In order to evaluate the involvement of Isle of Wight NHS Trust's IAPT service, it is important to understand the commissioning and objectives of IAPT services. In 2008 the government at the time launched the Improving Access to Psychological Therapies (IAPT) programme[124].

11.2. The goal of the IAPT programme is to ensure faster access to evidence-based psychological therapies, and it is National Institute of Health and Clinical Excellence approved for the treatment of patients with depression and anxiety disorders.

11.3. Underpinning the IAPT therapeutic model is that any patient can self-refer to an IAPT service. The benefit of this is that it can provide quicker access to trained mental health professionals, diagnosis and treatment, thereby preventing other problems developing, such as job losses, relationship difficulties and/or more serious mental health difficulties that can develop while a patient is waiting for an assessment and treatment from secondary mental health services.

11.4. The national aim is for at least 50% of patients within IAPT cluster 1-4 pathways to achieve 'recovery' – that is, to have improved as indicated in the appropriate outcome measures[125].

11.5. The Isle of Wight NHS Trust's IAPT service was initially developed in 2009 as part of the primary care mental health team (PCMHT)[126]. The service is commissioned and funded by the local Clinical Commissioning Group (CCG) and is currently working towards the outcomes-based payment approach funding arrangement, known as Payment by Results. One of the aims of this funding arrangement is for "commissioners and providers [to] develop a better understanding of the care they need to provide and the resources necessary to deliver the service in the area"[127].

11.6. In 2015/16, as part of Isle of Wight NHS Trust's organisational change, the pre-existing IAPT team became known as IAPT Plus. The management of the psychological therapies service, which was previously situated within community mental health services (CMHS), was transferred to the IAPT team. All the psychological therapies are now under one line management structure.

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[124] IAPT programme
[125] IAPT Operational Procedure p5
[126] Information taken from IAPT Operational Procedure reviewed March 2016 p1

[127] Outcomes are measured against areas that matter to people and support their daily activities, including: specific and relevant clinical outcomes, access standards, user experience, choice, employment. and more holistic measures of wellbeing Payment by results

11.7. The IAPT service is open to all adults over the age of 18 years who are registered with a GP on the Isle of Wight.

11.8. Sancus Solutions' investigation team was informed by the IAPT operations manager that currently the IAPT service sees approximately 4,000 patients a year.

11.9. The IAPT service is not open to patients who have complex mental health issues, for example schizophrenia, as the expectation is that they will be under the care of secondary mental health services and that they will receive the appropriate psychological therapy within that service.

11.10. For a limited period IAPT's patients can also be supported by the crisis service, which is situated within Isle of Wight NHS Trust's primary mental health services.

IAPT referral and assessment process

11.11. On both occasions in 2015 and 2016 during a consultation with his GP, it was identified that Darren was experiencing a depressive and/or an anxiety health disorder. The GP discussed the IAPT option with Darren and provided him with information and the contact details of the IAPT service. On both occasions Darren referred himself to the service by telephone.

11.12. IAPT's operational procedure documents that at the initial referral the administrator obtains details from the patient and completes the required data set.[128] They also offer the patient an initial assessment appointment. This can be either face to face or on the telephone.

11.13. The initial assessment for low-intensity support is undertaken by an IAPT psychological wellbeing practitioner (PWP). At both the initial assessment and at subsequent sessions the severity of the patient's symptoms and presentation are assessed by using the following:

- Patient Health Questionnaire-9 (PHQ-9)
- Generalised Anxiety Disorder Scale (GAD-7)
- Other anxiety disorder specific measures (ADSMs)
- HoNOS assessment.

[128] The web-based IT system containing notes and records of clinical information that is used by administrators and therapists is called IAPTus. The system collects all the Minimum Data Set (MDS) needs for the team, which enables the Key Performance Indicators (KPIs) to be reported on via the Open Exeter portal to the Health and Social Care Information Centre (HSCIC). This data is then analysed nationally and reported nationally, which allows performance benchmarking against all IAPT teams, which is then published on the HSCIC website.

These assessment tools are used to assess the level of the patient's needs, potential risks and outcome measures.

11.14. At both assessments Darren was assessed as meeting the criteria of cluster 1 -4 pathways, which provide low- and high-intensity therapies, both one to one and group therapies.

11.15. The IAPT's operational procedure states that in line with the national IAPT guidance and philosophy[129], a patient will always be offered the least intensive treatment possible.

11.16. In March 2015 Darren was offered low-intensity cognitive behavioural activation (BA) therapy, which is utilised to help a patient focus on activity scheduling both to encourage them to approach activities that they are avoiding and to analyse why they have been avoiding such activities and settings. The aim is to engage the patient with certain activities in order to regenerate and encourage their feelings of achievement and pleasure and develop and improve their interpersonal relationships in both their social and familial groups. Patients can be seen for up to eight sessions and can also access groups such as stress control and relaxation. There was no indication that Darren was offered access to such groups. Darren only attended two appointments with his IAPT therapist.

Accessibility of IAPT information and literature

11.18. At his second appointment (25 March 2015) Darren disclosed to the IAPT therapist that he was dyslexic. In preparation for the next session, he was asked to read some self-help literature and a chapter of a workbook and to complete an activity diary. Darren did not attend his subsequent scheduled appointment and was then discharged from the service.

11.19. When Darren next presented himself to his GP (23 March 2016), he reported that he had been unable to manage the IAPT support in 2015 due to his dyslexia. Darren's wife also reported to Sancus Solutions' investigation team that her husband was unable to complete the work that the IAPT therapist had given him and that this prevented him from engaging any further with IAPT.

11.20. It was reported to Sancus Solutions' investigation team by several of the IAPT team that as far as they were aware, the only material available within Isle of Wight's IAPT service was in a written form and the material was only available in English.

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[129] IAPT

11.21. However, the IAPT operational manager reported to Sancus Solutions' investigation team that if a patient had specific needs, then there was an expectation that the IAPT therapist would adapt the literature to meet their abilities.

11.22. However, in Darren's contact with the IAPT service there is no evidence that this occurred, and both he and his wife reported that his dyslexia was the main reason why he disengaged from the service in 2015.

11.23. As part of this investigation, Sancus Solutions' investigation team undertook a brief internet review of available IAPT self-help literature. It was evident that IAPT literature is available in audio form and also in translation.

11.24. Sancus Solutions' investigation team would recommend that in order to ensure that Isle of Wight NHS Trust's IAPT service is fully accessible to all patients, as part of the initial assessment process all patients should be asked if they have any particular needs that might prevent them from accessing the written literature. If a patient discloses that they have such additional needs the IAPT therapist should assess the level of needs, including what support and aids they may require, and ensure that the appropriate alternative formats and support are made available.

Isle of Wight NHS Trust's Improving Access to Psychological Plus Therapies service (IAPT)

Recommendation 1: To ensure that Isle of Wight NHS Trust's IAPT service is fully accessible to meet the diverse needs of the population the IAPT therapist must, at the initial assessment, assess what support and aids may be required by the patient.

May 2016 to 25 May 2016

11.25. Following his second IAPT referral in May 2016, Darren was offered high-intensity CBT therapy.

11.26. IAPT 's high-intensity therapy patients are usually offered 20 sessions of this type of therapy, although the operating procedure does note that "the length of treatment does have some limited flexibility in it to suit the patient's needs"[130].

[130] Operational procedure p10

11.27. Darren attended sessions for three consecutive weeks; the fourth session was delayed by two weeks due to the therapist's annual leave. It was due on 15 June 2016, but the incident had occurred by then.

11.28. At the initial and second appointments (11 May and 18 May 2016), there was evidence that the IAPT therapist completed comprehensive documentation on Darren's psychosocial situation. His mental health presentation was also scored using PHQ-9 and GAD-7, and other key indicators such as home, private and social phobias were also numerically scored.

11.29. It was identified that Darren was very socially isolated and that his wife, who at the time he was separated from, was his main source of support. It was also documented that Darren continued to have contact with Keziah, who, it was recorded, was six years old.

11.30. The initial appointment documented that Darren had reported that he had gained little benefit from his antidepressant medication, but he was due to see his GP the following day. However, it was noted by Sancus Solutions' investigation team that the therapist did not, at subsequent sessions, enquire what the outcome of the GP's appointment had been or whether Darren's medication had been changed.

11.31. The therapist noted that the aim of this therapy was "increasing [Darren's] confidence and independence again"[131].

11.32. By the third session (25 May 2016), Darren agreed that he would begin to undertake certain activities. It was also noted by the therapist that Darren was showing some degree of "insight" into his behaviours.

11.33. At this session the therapist also advised Darren that as his next appointment was to be delayed, he could access the crisis service if he was experiencing increasing suicidal ideation. It was documented that "the [patient] agreed verbally that he would do this"[132].

12. Risk assessments

SPA assessment – May 2016

12.1. Following Darren's telephone contact with the SPA service (12 May 2016), it was documented that "Darren feels stable at the moment and not at risk but

[131] IAPT session 18 May 2016
[132] IAPT session 25 May 2016

feels his situation would change dramatically if his ex-partner says no to a reconciliation as he would harm himself"[133].

12.2. Isle of Wight NHS Trust's Standard Operational Procedure for Crisis Resolution and Home Treatment (CRHT) – Single Point of Access states that:

- Following a referral a "qualified member of SPA (nurse, social worker, OT etc.) will then make contact with the person to carry out a telephone risk assessment using the Mental Health Triage Risk (TAG) to aid their decision making"[134].

- At the initial contact the assessor should obtain details of the patient's "marital status, housing status, number of dependent children, known aliases and details of other involved agencies"[135].

- "The clinician will triage the referral using the TAG risk assessment and Mental Health Triage Scale to decide on the urgency of assessment needed"[136].

- "Risk issues, recorded in the appropriate risk assessment format on PARIS, physical health needs, family, housing or occupational difficulties and Mental State Examination. An initial HONOS (Health of the Nation Outcome Scale) score and cluster score relating to this current presentation will be documented. Assessments, whenever possible, will include the views of family and friends and they will be offered support and information about the needs of the service user, with the permission of the service user."[137]

- The assessor (nurse, mental health social worker, mental health occupational therapist, doctor, etc.) will "fully document their assessment on PARIS, including full core assessment, risk assessment and formulation, mental state examination, care plan and crisis plan"[138].

12.3. The assessor agreed with Darren that he would make contact with SPA following his next IAPT appointment on the weekend of 21/22 May 2016 and the referral was placed in the "hold file"[139]. Darren made no further contact with SPA and this was not followed up.

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[133] General case notes 12 May 2016
[134] Standard Operational Procedure for Crisis Resolution and Home Treatment (CRHT) – Single Point of Access p7
[135] Standard Operational Procedure for Crisis Resolution and Home Treatment (CRHT) – Single Point of Access p9
[136] Standard Operational Procedure for Crisis Resolution and Home Treatment (CRHT) – Single Point of Access p9
[137] Standard Operational Procedure for Crisis Resolution and Home Treatment (CRHT) – Single Point of Access p10
[138] Standard Operational Procedure for Crisis Resolution and Home Treatment (CRHT) – Single Point of Access p11
[139] General case notes 12 May 2016

12.4. Sancus Solutions' investigation team was unable to locate any evidence to indicate that any of the above processes had been undertaken during the initial contact with SPA. All that was documented was that the practitioner who was undertaking the initial assessment concluded that there were "no risks identified at this time"[140].

Comments and analysis

12.5. Isle of Wight NHS Trust's SIR documented that at the time there was no protocol or procedural document in place around the monitoring of the "hold file", but since this incident this system has been stopped.

12.6. Following the CQC inspection of Isle of Wight NHS Trust's adult mental health services in November/December 2016, a Section 31 Notice[141] was imposed, which required the trust to take action to address safety concerns at both its community and its inpatient mental health services, including the SPA service.

12.7. The CQC inspectorate team concluded that mental health services' care records lacked detail and had gaps and omissions in the care assessments, risk assessments and care plans. Overall, crisis contingency plans reviewed contained significant gaps and information was of poor quality, and risk assessments were incomplete in information and lacked detail.

12.8. Sancus Solutions' investigation team found similar failings in the SPA assessment and documentation of Darren's risks factors and would have been making several recommendations for improvements within the SPA risk assessment process. However, in subsequent inspections (November/December 2016 and May 2017) CQC inspectors reported that they were satisfied that Isle of Wight NHS Trust had begun to address the issues. The trust had provided evidence to the inspectorate team that remedial actions and a significant restructuring of services were being undertaken within the community mental health services. A new matron had been recruited at the SPA and crisis home treatment service. At the CQC inspection in May 2017 it was assessed that there had been "some positive changes but more work was needed to ensure that referrals were managed appropriately"[142].

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[140] General case notes 12 May 2016
[141] Section 31 of the Health and Social Care Act 2008. CQC can serve a Notice of Decision on a registered person imposing, varying or removing a condition of registration on an urgent basis. CQC can deploy the power whenever it has reasonable cause to believe that any person will or may be exposed to risk of harm in a service. Section 31
[142] The independent regulator of all health and social care services in England. CQC

12.9. Currently CQC's Section 31 Notice remains in place and CQC will be continuing to rigorously monitor the community mental health service until such time as they are satisfied that this service is able to demonstrate that services are meeting CQC key standards of safe, responsive, effective and well led services[143]. As this service, including SPA is under such intense scrutiny and there are action plans in place, Sancus Solutions' investigation team is satisfied that their concerns regarding the SPA team are being addressed. Therefore, they have decided not to make any specific recommendations for this service.

IAPT assessment – March 2015

12.10. Sancus Solutions' investigation team were informed that HoNOS is used within the IAPT service at the initial assessment appointment to identify and score certain risk factors. The patient's risk(s) should then be reviewed at subsequent appointments in order to identify any changes.

12.11. This information is uploaded onto the IAPT Data Set and utilised by the IAPT's commissioners as part of the overall outcome monitoring of the service.

12.12. Sancus Solutions' investigation team were unable to locate evidence to indicate if a HoNOS assessment had been completed during Darren's first contact with IAPT in March 2015.

12.13. However, a narrative of Darren's risk factors was documented in his initial appointment notes. This also included a self-disclosure by him that in 2013 he had previously tried to take his own life by suicide.

12.14. Darren's overall risk was assessed as medium and a risk management plan was documented.

IAPT assessment – May 2016

12.15. At Darren's second contact with IAPT services in 2016, a HoNOS was completed at the initial assessment appointment (11 May 2016). Under the category 'other mental and behavioural problems', "obsessive" was documented and this problem was scored as minor. Sancus Solutions' investigation team noted that there was no explanation of this and no further reference to it within the risk narrative or management plan.

[143] Caring, safe, effective and well led are CQC key standards

12.16. The overall assessment of risk was assessed as a "risk to self", and the overall risk level was assessed as medium.

12.17. The risk management plan identified that if Darren's suicidal ideation increased, he would contact the crisis service.

12.18. It was documented that in the two subsequent appointments, Darren "reported that he [had] not had any increase in suicidal ideation since the previous session"[144]. The therapist concluded that Darren's risks remained as medium.

Comments and analysis

12.19. The authors of the trust's SIR concluded that the "risk assessment tools within the patient record (PARIS) do not prompt or support clinicians in gathering information regarding risks to children"[145].

12.20. Sancus Solutions' investigation team noted that the HoNOS assessment tool did not ask the assessor to consider the patient's risk to others but did have a question relating to safeguarding children and vulnerable adults, which the IAPT assessor scored as 'none'. Sancus Solutions' investigation team would suggest that this is a significant deficit, as there is nowhere within the assessment documentation that prompts the assessor to consider and score a patient's potential risk factors to others. 21.22. Sancus Solutions' investigation team concluded that the assessment tool used by IAPT is inadequate. The National Collaborating Centre for Mental Health's Improving Access to Psychological Therapies (June 2018) states with reference to risk assessments that a:

> "Person centred assessment [should] include …A risk assessment (including self-harm or suicide, or harm to others)… Rating of degree of risk. If risk is [known] the clinician has recognised this and agreed a plan"[146].

12.21. The Royal College of Psychiatrists underlines the importance of undertaking a robust and comprehensive risk assessment in order to ascertain the potential risk of harm to others. It is suggested that:

> "A detailed understanding of the patient's mental state, life circumstances and thinking is a major contributor to the prevention of harm. … [The College] reiterates the importance of longitudinal risk assessments being undertaken in order to assess a patient's risk to others … which includes a combination of … historical variables, current crucial variables and contextual or environmental

[144] IAPT session 18 May 2016
[145] SIR p6
[146] IAPT manual p23/24

factors …[If] an assessment of the patient [indicates] there is concern regarding their risk of harm to others, it should trigger a more structured risk assessment process, with the use of an assessment tool that is appropriate for the group, such as a HCR-20 assessment."[147]

12.22. Sancus Solutions' investigation team noted that there was no correlation between the risks identified within the HoNOS and those outlined in either the risk narrative or the risk management plan.

12.23. When Sancus Solutions' investigation team reviewed the IAPT Operating Procedure, they noted that there was only one specific reference to risk, and that was in relation to what action(s) should be taken if a patient disengages from the service[148], dependent on their risk level. Other than this, there is no reference as to:

- How the IAPT therapists are required to assess, document and monitor risk
- The actions that are expected to be taken if during the course of an assessment there are concerns regarding risk(s) to either the patient or others.

12.24. The IAPT's service Standard Operating Procedure provides hyperlinks to various pieces of national IAPT guidance and notes that "The Isle of Wight PCMHT/IAPT+ team adhere to the Isle of Wight NHS Trust policies, guidelines and protocols"[149]. However, it does not make any reference to particular trust policies, such as policies relating to safeguarding adults and children, or clinical risk.

- Since this incident, in response to one of the SIR's findings that "IAPT sometimes work with people with moderate risks identified and as such need clear guidelines for transfer of care", a number of changes have now been introduced to

- clarify the care pathways
- address the suitability of patients being referred to IAPT
- increase the dialogue and liaison between SPA and IAPT.
- Amendments have been made to the Standard Operational Procedure for Crisis Resolution and Home Treatment – Single Point of Access, which now

[147] Rethinking risk to others in mental health services, Royal College of Psychiatrists, London, p38
[148] Standard Operating Procedure p11
[149] Standard Operating Procedure p14

includes clear expectations of what and where referral information should be documented.

12.25. Sancus Solutions' investigation team were also provided with a protocol that has been introduced that provides guidance with regard to the liaison between IAPT and mental health primary care services, which includes:

- Daily and weekly liaison meetings between SPA and IAPT at which the operations managers are present. Referrals are discussed to assess their suitability for IAPT.

- The SPA team can now access IAPT's IT software in order to be able to review patients who are known to IAPT and who contact them via the crisis service.

- Certain members within the IAPT team can access SPA's IT system, again to seek information as part of the assessment process.

- If an IAPT patient makes contact with the out-of-hours crisis service, this information is forwarded to IAPT.

- If IAPT assess that they are not able to meet the needs of a particular patient due either to the patient's level of risk and/or the complexity of their mental health difficulties, the protocol outlines a clear pathway for a referral to be made via SPA to secondary care mental health services.

- There are weekly multidisciplinary team (MDT) liaison meetings at which managers from both IAPT and SPA are present and referrals and patients are discussed.

- There have been a number of meetings between IAPT and SPA practitioners in order to develop a greater understanding of the services' capacity.

12.26. Despite these changes one IAPT therapist reported to Sancus Solutions' lead investigator that he felt that IAPT were still receiving patients who were at too high a risk for the service and that their needs and risks could be better managed and supported within secondary mental health services (refer to 17.32 and recommendation 8) .

12.27. One of the operational managers reported to Sancus Solutions' investigation team that although there had been some improvement, more effort needed to be made to further develop and streamline processes and protocols

12.28. During the course of this investigation, Sancus Solutions' investigation team have identified a number of deficits within IAPT's operating procedure and the risk assessment processes within the IAPT service. Sancus Solutions'

investigation team therefore recommends that trust should consider either introducing the risk assessment that it is utilised within its other mental services or developing a bespoke risk assessment tool to be utilised by the IAPT service that identifies and assesses:

- All potential risk(s), including the patient's risk to self and others
- Documentation of all historical risks
- A narrative of all risk(s)
- A risk management plan agreed with the patient for all current risk(s):
- The risk management plan should identify a contingency and crisis plan for all risk(s)
- Risk(s) identified must be reviewed with the patient at subsequent sessions.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT)
Recommendation 2: Isle of Wight NHS Trust IAPT service must either develop a bespoke IAPT service risk assessment or utilise the community mental health risk assessment tool.
The IAPT risk assessment must include the identification and assessment of :

- All potential risk, including the patient's risk to self and others
- Documentation of all historical risks
- A narrative of all risk(s) identified
- A risk management plan should be agreed with the patient based on all current risk(s) identified:
- The risk management plan should identify a contingency and crisis plan
- Risk(s) identified must be reviewed at subsequent sessions.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT)
Recommendation 3: The IAPT service's operating procedure (SOP) need to be revised to include:

- A specific section on the assessment and monitoring of risk.
- A hyperlink to Isle of Wight NHS Trust's clinical risk and Care Programme Approach (CPA) policies.
- A section that clearly outlines the IAPT therapist's responsibilities with regard to safeguarding adults and children and the trust's Think Family Agenda. This section should have hyperlinks to the relevant safeguarding policies and the Think Family Joint Working Protocol.

13. Record keeping

The ToR asks Sancus Solutions' investigation team to:

"Review the documentation and record keeping of key information by the Isle of Wight NHS Trust against best practice and national standards".

13.1. The SIR identified that there were several occasions when information was not documented on Darren's patient records. For example, there was no record to indicate when the CA/12 form was sent to Darren's GP.

13.2. The CQC inspection of Isle of Wight NHS Trust in November/December 2016 concluded that:

"The electronic care records system was not fit for purpose and there were concerns with lack of guidance in relation to how staff should complete the records. The system was time consuming to use, requiring staff to constantly come out of one part of the system to access information and updates from other teams. There was no contemporaneous flow of information and there were clear risks that important patient information was not easily available to staff."[150]

13.3. In addition, the CQC inspection in May 2017 assessed that

"The quality of care records continued to vary, with gaps in key information and poor evidence of appropriate assessment and management of risk in some records"[151] .

[150] CQC
[151] CQC

13.4. The CQC inspection did not include the IAPT service. This service does not use Isle of Wight NHS Trust's records system but is required to utilise the national accredited IAPT assessment and outcome documents to record and monitor both progress and outcome information

13.5. During the course of their investigation of SPA's involvement, Sancus Solutions' investigation team noted that the information recorded by the SPA team was minimal and no assessment tools were used. They would again have been making recommendations to improve this; however, they have been informed that:

- As part of the trust's action plan, a new core assessment has been developed within the patient records system that is to be utilised by all secondary mental health services, including SPA.

13.6. The safeguarding nurse for adults and children reported to Sancus Solutions' investigation team that she has been involved in this development and is satisfied that the new core assessment now requires that the details of any children and/or adults that the patient has responsibility for are documented. In addition, the assessment tool prompts the assessor to enquire about any potential safeguarding issues.

13.7. She also reported to Sancus Solutions' investigation team that she has written to NHS England's Safeguarding Team to report her concerns regarding the lack of inquiry prompts, within the IAPT forms, with regard to ascertaining information about a patient's children and dependants. (See section 14.)

13.8. It is currently unclear if the changes made to the core assessment will meet the requirements of CQC. However, there has been a recent CQC inspection (January 2018), and Isle of Wight NHS Trust is currently waiting for the pertaining CQC report.

14. Safeguarding

The ToR asks Sancus Solutions' investigation team to:

- "Review the contact and communication between agencies and services: i.e. GP Services, the Police, Children's Services and Health Visiting Services and the Isle of Wight NHS Trust and assess if [Darren's] risks (to self and others) were fully understood
- Review the enactment of local safeguarding children and vulnerable adult policies
- Consider whether further multi-agency working may have assisted in assessing the risks presented (to and by [Darren]) and the formulation of effective care and risk management plans for [Darren] to others."

The aim of this section is to identify and consider if there were any indications in Darren's presentation and his disclosures that might have been suggesting that either Darren and/or members of his close family were at risk of harm.

In this section, reference will be made not only to Isle of Wight NHS Trust's safeguarding policies, but also to research into filicide (the killing of one's son or daughter) and filicide-suicide.[152]

14.1. There were a number of occasions when Darren disclosed to services that he had a young daughter and that at times he had sole parental responsibility for her:

- At the initial IAPT assessment (19 March 2015), when the IAPT therapist documented that Darren's wife and daughter "were strong protective factors"[153].

- At the second IAPT assessment (11 May 2016), when Darren talked about his daughter and it was assessed that his "wife and daughter were strong protective factors"[154].

- During the SPA assessment (12 May 2016), when Darren reported that he was looking after Keziah as his wife was out at work.

14.2. Apart from during the second IAPT assessment, where it was documented that Darren's daughter was six years old, in all his assessments and contacts with the SPA and IAPT services the practitioners did not make any further enquiries to obtain details of Keziah and/or the extent of Darren's parental responsibilities after he had moved out of the family home.

14.3. Sancus Solutions' investigation team were informed that following this incident, the IAPT service have revised the assessment pro forma, and it now asks the assessor to obtain information about any dependants the patient might have, including the dates of birth of any children.

14.4. When Darren's wife reported to the police that he was missing (10 April 2016), she disclosed that he had recently been following her in the house and accessing her social media accounts and text messages. The attending police officer completed a:

- Vulnerable Adult Form (CA/12)

[152] Filicide-suicide refers to when a parent kills one or more of their children, sometimes their partner, and themselves, usually all at the same time (O'Hagan, 2014)
[153] IAPT session 19 March 2015
[154] IAPT risk management plan 11 May 2016

- Child and Young Person at Risk Form (CYP)[155]
- Domestic Violence Assessment (DASH).

14.5. The attending police officer reported to the SCR panel that she had completed these forms as a "routine part of the police force's practice in any situation that has a domestic component, not because she had any specific reason to be concerned"[156].

14.6. These forms were sent by the police, again as standard practice, to the adult safeguarding team and MASH. Both concluded that the incident did not meet the criteria for further action and the cases were subsequently closed.

14.7. The CA/12 was uploaded onto Darren's patient records (PARIS), which the SPA assessor would have had access to. The GP also received a copy of the CA/12.

14.8. The referral information sent by the GP to SPA included a medical summary, which documented an entry (10 April 2016) that Darren was a "vulnerable adult"[157] and that there had been a police report. It also documented that Darren intended to self-refer to SPA.

14.9. The SPA assessor would have had access to both the GP's referral information and the CA/12, but there was no reference made to either in the assessment records. As previously stated, the SPA assessment of Darren's needs and potential risks to himself and others appeared to have been based solely on his self-reporting.

14.10. After the initial IAPT assessment, there was a telephone conversation (13 May 2016) that was documented within the SPA notes but not referred to in the IAPT notes. The IAPT therapist reported that he had not been aware that Darren had been referred to secondary mental health, although he was aware of the CA/12. It is not evident how the IAPT therapist knew about the CA/12 and it was not referred to in either the initial assessment or the subsequent session's records.

14.11. It also appears that the SPA practitioner did not advise the IAPT therapist that Darren had disclosed to their assessor the previous day that his situation would "dramatically"[158] change if there was no prospect of reconciliation with his wife (12 May 2016).

[155] Now called a Public Protection Notice (PPN)
[156] SCR p11
[157] GP medical contact summary sent to SPA on 12 May 2016
[158] General case notes 12 May 2016

14.12. It was during the initial IAPT assessment (11 May 2016) that Darren disclosed that he had at least one "nightmare recently about "murdering his wife and daughter"[159]. It was documented that:

"When we explored this [Darren] said it was never something that he would actually do. He said he loves them both enormously and could never hurt them. He said he had never harmed anyone else in the past."[160]

14.13. The IAPT therapist reported to Sancus Solutions' investigation team that he had discussed this dream at his peer supervision[161] and that his colleagues agreed with his approach/response to Darren's disclosure.

Comments and analysis

14.14. It was reported by all the practitioners who had been involved in the assessments and support of Darren that in their opinion and based on the evidence that was available to them at the time, there was no indication that Keziah or any other members of Darren's family were at risk. Therefore, they had not considered either discussing the case with Isle of Wight NHS Trust's safeguarding team or instigating a safeguarding alert. The only potential risk that they had been aware of was that to Darren himself.

14.15. One of the key findings of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI)[162] is the over-representation of mental illness in cases of filicide. The NCI reports that:

- 37% of parents and step-parents who killed their children were suffering from some form of mental illness.
- 12% had been in contact with mental health services within a year of the offence.
- Of the 297 filicide cases recorded during the 10-year period, 13% of perpetrators took their own life after killing their child/children.[163]

14.16. Based on information from the Office of National Statistics from 2007-08 to 2011-12, the National Society for the Prevention of Cruelty to Children

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[159] IAPT assessment 11 May 2016
[160] IAPT assessment 11 May 2016
[161] IAPT standard operating procedure states: "All Hi-Intensity therapists receive as a minimum the amount of supervision mandated by their governing bodies. All therapists have supervision for all modalities of treatment that they provide. Hi-Intensity CBT therapists receive weekly supervision in a group format. The majority of therapists in each group will have received further training on supervision and be a qualified supervisor. The supervision will meet the criteria for accreditation with the BABCP in terms of frequency and quality." P13
[162] Confidential Inquiry 2016
[163] Homicide followed by suicide is defined here as when the offender dies by suicide within three days of committing the homicide NCI

(NSPCC) reported that “one child is killed at the hands of their parent every 10 days”[164].

14.17. Other studies into filicide suggest that:

- Revenge and/or jealousy are often the motive.
- Sexual jealousy or suspected infidelity and ongoing child and custody access disputes can increase the risk of harm to a parent – usually female – and children.
- Fathers are more likely than mothers to commit suicide after killing a child.[165]

14.18. Darren had on a number of occasions disclosed to the IAPT therapist that he suspected his wife of infidelity and that he was accessing her social media accounts and also her text messages. He also disclosed that he had always been very socially isolated and that his wife provided him with all his emotional and financial support.

14.19. He had also disclosed at the SPA assessment that if there was no chance of reconciliation, his situation would change “dramatically … and he would harm himself”[166].

14.20. Darren reported that his mental health symptoms had significantly increased since the breakdown of his marriage and that he spent a lot of time in bed “thinking about his wife and daughter which [brought] his mood down”[167]. The IAPT therapist did not appear to have enquired as to what these thoughts were.

14.21. Although Darren did often discuss his family, it was nearly always focused on his fears of the relationship ending and how it was affecting him. On one occasion, Darren did report to the IAPT therapist that his daughter had been upset with him and that he thought that “she hates me now”[168].There was no documentation that he was able to reflect on his relationship with Keziah and/or how he might, as a parent, be supporting her to manage the separation of her parents.

14.22. Darren’s wife reported to Sancus Solutions’ investigation team that after Darren had moved out, there was one occasion when she had woken up to find him in her bedroom. He had just been standing watching her. She reported that she had found this to be very disturbing.

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[164] The National Society for the Prevention of Cruelty to Children is a charity campaigning and working in child protection in the United Kingdom and the Channel Islands NSPCC
[165] Myra Dawson 2015
[166] SPA assessment 15 May 2016
[167] IAPT session 25 May 2016
[168] IAPT session 25 May 2016

14.23. The CY/12, which both IAPT and SPA had access to, documented that Darren's wife had reported to the police that he would often follow her around the house and that he would not let her even go to the toilet without following her to see if she was text-messaging other men.

14.24. The Home Office's latest definition of domestic violence is

> "any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:
>
> - psychological
> - physical
> - sexual
> - financial
> - emotional."[169]

14.25. Based on the information that was available, Sancus Solutions' investigation team concluded that it was evident that Darren's disclosures were indicating an escalating degree of psychologically controlling and coercive behaviours.

14.26. The Home Office describe this category as "a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support … regulating their everyday behaviour"[170].

14.27. It is Sancus Solutions' investigation team's opinion that Darren did disclose enough of these behaviours to have triggered some concerns among the involved practitioners that his relationship with his wife may have had some elements of abuse and for there to have been some consideration of the possibility that she may have been at risk and vulnerable. We would have expected the involved practitioners to have considered that there was enough information available to them to indicate that there were signs of a potentially abusive relationship and therefore, at the very least, they should have sought the advice of the trust's adult safeguarding team.

14.28. Sancus Solutions' investigation team were informed that at the time of the incident, Isle of Wight NHS Trust did not have a separate domestic violence policy in place. Since the CQC inspection (November 2016), a policy has been written, and it is currently in the process of being internally approved. The lack of a policy being in situ and therefore no specific training being in place was of concern to Sancus Solutions' investigation team and may have

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[169] HO
[170] HO

contributed, in part, to the lack of awareness and action taken by the practitioners.

14.29. With regard to the potential risk(s) to Keziah, Darren did not describe having a fleeting thought of harming his daughter but stated that he had at least one nightmare of murdering his wife and daughter. Although Darren denied that he would ever harm them, given that he had only just engaged with the IAPT and SPA services, little would have been known about him, his family situation and his risk history. Therefore, Sancus Solutions' investigation team would have expected that rather than relying solely on Darren's self-disclosures to inform their decision regarding whether Keziah and/or her mother were at risk, the involved practitioners should have sought the advice of the Trust's children's and adults' safeguarding teams.

14.30. Sancus Solutions' investigation team were informed that since this incident, it was identified that the levels of child protection training within adult mental health services were not adequate. An extensive child protection training programme has now been introduced throughout Isle of Wight NHS Trust.

14.31. Practitioners within both SPA and IAPT services are now required to undertake level 3 child protection training. Sancus Solutions' investigation team were provided with the training log for IAPT practitioners and managers who have all now completed the higher level 3 child protection training[171]. In addition, a safeguarding children training policy was introduced in April 2017. This policy states that:

"All staff that come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about child protection. This responsibility also applies to staff working primarily with adults who have dependent children that may be at risk because of their parent/carers health or behaviour."[172]

14.32. Sancus Solutions' investigation team had concerns that during the interviews with the involved practitioners and managers, who had since the incident received increased safeguarding training, appeared to be unable to critically reflect on their responses to Darren's nightmare disclosure and/or the possible affects that his mental health may have had on Keziah. Clearly it is not solely the role of the individual practitioners to make the assessment of whether a child or adult may be at potential risk, because such a decision is extremely complicated and requires considerable skill and sensitivity. But it is their responsibility to seek advice and to inform the appropriate safeguarding

[171] This course provides advanced knowledge of child protection procedures
[172] Isle of Wight NHS Trust Safeguarding Policy 17 April 2017 p5

services, whose role it is to review the evidence within a multidisciplinary team.

14.33. Sancus Solutions' investigation team would recommend that the involved IAPT and SPA practitioners and managers receive additional bespoke safeguarding and domestic violence training.

14.34. Additionally, to ensure that any possible issues regarding either safeguarding and/or domestic violence remains at the forefront of all practitioners' actions both should be a standing agenda item within IAPT and SPAs' supervision and team meetings.

14.35. With regard to the peer supervision structure within the IAPT service, Sancus Solutions' investigation team were informed that this is no longer a peer-led group but that a clinician now leads the supervision sessions. This leadership now ensures that the IAPT therapists' group supervision has a greater degree of impartiality and accountability.

14.36. The IAPT assessment form also now directs the assessor to obtain the dates of birth of a patient's children. Sancus Solutions' investigation team were informed that this ensures that if there are any reports about the welfare of a child, documenting this detail will assist in the identification of IAPT involvement.

14.37. It was of concern to Sancus Solutions' investigation team that Isle of Wight NHS Trust's Named Nurse for Safeguarding Children reported that her department does not always receive copies of the CA/12 forms. Sancus Solutions' investigation team would suggest that it is essential that this department receives all CA/12 forms and that as a matter of priority the reason(s) as to why this does not occur should be identified and addressed. If the issue is due to a lack of a robust process being in place with external agencies, then action(s) should be taken to establish a protocol.

Isle of Wight NHS Trust

Recommendation 4: A review should be undertaken to ascertain why the Named Nurse for Safeguarding Children does not always receive all CA/12 Child and Young Person at Risk forms (now referred to as Public Protection Notices). Any issues identified should be promptly addressed.

Isle of Wight NHS Trust Improving Access to Psychological Therapy (IAPT) and Single Point of Access services (SPA).

Recommendation 5: The involved IAPT and SPA practitioners and managers must receive additional bespoke safeguarding and domestic violence training.

Safeguarding and domestic violence should be a standing agenda item within both IAPT and SPAs' supervision and team meetings.

15. Think Family

15.1. One of the findings of the SCR was that at the:

"Forefront of professional thinking was whether, in the absence of a specific safeguarding concern, there was an equally clear understanding that [Keziah] might also benefit from a wider assessment of her needs, or offer Early Help[173] support given the pressures that existed within the family"[174].

15.2. In early 2016 Keziah received some child-centred counselling when it was identified by her school and then by her GP that she was presenting with some out-of-character behaviours. It was identified that this was likely due to the emotional effects of the breakdown of her parents' marriage. However, there is no other evidence to indicate that any of the involved mental health practitioners considered or focused on either her or her mother's emotional wellbeing. The focus was on Darren and his mental health needs.

15.3. The Think Family Agenda was introduced in 2010. It recognised and promoted the importance of a whole-family approach, which was built on the principle of 'Reaching Out: Think Family'[175]. Its underpinning principle was that there was:

- "No wrong door – contact with any service offers an open door into a system of joined-up support. This is based on more coordination between adult and children's services.
- Looking at the whole family – services working with both adults and children take into account family circumstances and responsibilities."[176]

15.4. The Crossing Bridges Family Model[177] was also a useful conceptual framework that aimed to support staff to consider the parent, the child and the

[173] Early Help is provided to children, young people and families who are struggling and feel in need of some additional support. Early Help
[174] SCR p16
[175]Support a wide range of activities such as getting parents more involved in their children's learning, reducing family isolation from the wider community, and strengthening family relationships and communication. Reaching Out
[176] Thinking Family
[177] Crossing Bridge

family as a whole unit when assessing the needs of and planning care packages for families where a parent was suffering from a mental health problem. The model illustrated how the mental health and wellbeing of the children and adults, in a family where a parent is mentally ill, are intimately linked in at least three ways:

- "parental mental health problems can adversely affect the development, and in some cases the safety, of children
- growing up with a mentally ill parent can have a negative impact on a person's adjustment in adulthood, including their transition to parenthood
- children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill health in their parents/carers"[178].

15.5. The model also identified that there are risks, stressors and vulnerability factors that may increase the likelihood of a poor outcome, as well as strengths, resources and protective factors that enable families to overcome adversity.

15.6. The NCI also reported that there "needs to be greater awareness for patients who are parents and especially those with severe mood disorders"[179].

15.7. One of the SCR recommendations was:

"The Isle of Wight Safeguarding Children Board to work with its partner SCBs to
- review the current 4LSCB Joint Think Family Protocol for safeguarding children and young people whose parents/carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress with a view to developing a more accessible document with practitioner friendly information for the wider multi-agency partnership.

- seek assurance from partner agencies that effective means have been put in place for developing staff knowledge and practice as identified within the Think Family Joint Working Protocol."[180]

15.8. Sancus Solutions' investigation team were provided with the Isle of Wight Safeguarding Children Board's latest action plan update, which indicates that the revised Think Family Joint Working Protocol has been completed and a short summary protocol has been introduced. One of the key messages is that:

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[178] Crossing Bridge
[179] Confidential Inquiry
[180] SCR p24

"If a service user expresses delusional beliefs involving their child and/or they may harm the child as part of a suicide plan, a referral to Children's Social Care must be made immediately."[181]

15.9. When Sancus Solutions' investigation team enquired how Isle of Wight NHS Trust, since this incident, has made efforts to embed the Think Family Agenda and the Think Family Joint Working Protocol within its services, they were referred to the Think Family Banner, which was posted on the trust's intranet, and therefore was available to all staff, throughout November 2017. It directed staff to consider the effects on children whose parents have mental health problems and also provided a hyperlink to the Think Family Joint Working Protocol.

15.10. It was also reported that the Think Family Agenda and the Think Family Joint Working Protocol now underpin all of the safeguarding training.

15.11. Sancus Solutions' investigation team were also informed that in two recent interviews for safeguarding nurses, the candidates were asked to critique the concept of Think Family and the Think Family Joint Working Protocol.

15.12. Sancus Solutions' investigation team would suggest that as part of all mental health practitioners' interviews, the interviewee is also asked to explain how the Think Family Agenda should underpin their practices with patients who are parents and how they would respond if they became aware that a child might be at risk.

Isle of Wight NHS Trust

Recommendation 6: As part of all primary and secondary mental health practitioners and service /operational managers' recruitment interviews the interviewee should be asked to demonstrate how the Think Family Agenda underpins their practice.

15.13. During their interview with Isle of Wight NHS Trust's safeguarding team, Sancus Solutions' investigation team were informed of a number of actions that have been taken since this incident. These are:

: The head of Isle of Wight NHS Trust's children's and adults' safeguarding teams[182] reported that she has undertaken a review of the national accredited IAPT tools and has identified a number of significant deficits with regard to prompting enquiry by the IAPT therapists into the assessment of risk(s) to both children and vulnerable adults whom the patient may have contact with and/or

[181] Protocol p2
[182] This post works across both the trust and their CCG

responsibility for. She reported that she has now written to NHS requesting that the IAPT assessment tools be reviewed. Sancus Solutions' investigation team have been informed that IAPT assessment forms should be developed locally. Therefore it is the responsibility of the Isle of Wight NHS Trust to re-design the current IAPT services assessment proformas.
: Additionally Sancus Solutions' investigation team would suggest that both NHS England South East and the trust's Clinical Commissioning Group (CCG) should seek assurance that the assessment forms being used by the Isle of Wight NHS Trust's IAPT services are robust enough so that any safeguarding issues are identified, assessed and appropriate action take in order to mitigate the potential risk(s).
: Isle of Wight NHS Trust are currently remodelling and expanding their safeguarding teams with the aim of allocating safeguarding nurses to each service and clinical area. The intention is for this post to develop a close working alliance with teams in order to develop and improve their responses to potential safeguarding issues.

- Since the CQC inspection in November/December 2016, a new core assessment has been introduced within the patient record system. This requires the assessor to now ask direct questions regarding a patient's parental and caring responsibilities. It also asks for the details of those who are dependent on the patient to be recorded.

- The head of Isle of Wight NHS Trust's children's and adults' safeguarding teams also reported that she is currently in discussions with the Isle of Wight's Safeguarding Children Board with regard to developing a multi-agency universal parenting assessment tool.

15.14. Sancus Solutions' investigation team would suggest that Isle of Wight NHS Trust considers adopting a risk assessment tool, such as Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC)[183], within its primary and secondary mental health services, including the IAPT service. Such a tool prompts practitioners to consider the effects that a parent's mental health may be having on their children and to consider support the children might require.

Isle of Wight NHS Trust

Recommendation 7: Isle of Wight NHS Trust should consider adopting an assessment tool, such as Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC)[184], within its primary and secondary mental health services, including the IAPT service.

[183] PAMIC
[184] PAMIC

Isle of Wight NHS Trust, Clinical Commission Group (CCG) and NHS England South East

Recommendation 8: Isle of Wight NHS Trust should redesign the current IAPT service's assessment proformas to ensure that they are adequately identifying and risk(s) and potential safeguarding issues.

The CCG and NHS England South East should seek assurance and evidence from the Isle of Wight NHS Trust that the IAPT risk assessment adequately addresses any potential safeguarding issues.

16. Carer's assessment and support

16.1. On a number of occasions Keziah's mother disclosed to primary and secondary healthcare services that she was providing the main parental role and also the emotional and financial support to her family. Darren also reported to services that his wife was his only source of emotional support.

16.2. When questioned about what action they were expected to take when they identified a person who had caring responsibilities, the involved practitioner reported that they would direct them to the carer's support service. However, based on the evidence available, it appears that at no point was Keziah's mother provided with information about what support was available to her as a carer.

16.3. Sancus Solutions' investigation team were concerned that Keziah's mother was not directed to a carer's assessment and support services, as she was clearly under significant pressure supporting Darren. Also after Darren became unemployed she was the sole breadwinner in the family, as well as being the primary parent to Keziah after the separation.

16.4. The definition of a carer is an adult or child who provides and/or intends to provide care to an adult.[185] Both the Care Act 2014 and the Department of Health's National Carers' Strategy clearly recognise the role and support needs of carers. They both outline that carers have specific rights to have an assessment of their needs undertaken and to be provided with the appropriate support structures.

[185] NICE carers

16.5. Despite several requests made by Sancus Solutions' investigation team to various clinicians and operational managers to have access to a trust carer's policy, at the time of writing this report this has not been forthcoming.

16.6. An internet search of the trust's website also failed to locate a carer's policy or strategy.

16.7. The only policy that Isle of Wight NHS Trust appears to have in place that relates to carers is a Service User and Carer Involvement Policy (December 2014), which focuses on the role and support for patients and carers, who are referred to as "experts by experience"[186].

16.8. This apparent lack of a carer's policy being in place was a concern to Sancus Solutions' investigation team, who suggest that this deficit must be addressed as soon as possible by Isle of Wight NHS Trust.

Isle of Wight NHS Trust
Recommendation 9: Isle of Wight NHS Trust should develop a Carer's Support Policy.

17. Duty of Candour

The ToR asks Sancus Solutions' investigation to

"Comment on the Trust's enactment of the Duty of Candour[187].
To assess and review any contact made with the 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."

17.1. The SIR documented that the Head of Nursing and Quality for Mental Health wrote to Darren's wife explaining the investigation process and invited her to be involved in the internal investigation.

17.2. It was documented in the SIR that:

"In liaison with the Independent Investigating Officer commissioned by Children's Safeguarding, it was agreed that as part of their investigation they would make contact with the patient's mother who was also involved in supporting the patient."

[186] Service User and Carer Involvement policy p2
[187] CQC Regulation 20 providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. Regulation 20 also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Duty of Candour

17.3. During the course of Sancus Solutions' investigation, the lead investigator met with Darren's wife a number of times, where she discussed her rather hazy recollection of involvement with both the SIR and the SCR.

17.4. Understandably Keziah's mother reported that she was unable to recall the exact timing and course of events with regard to the contact she had with Isle of Wight NHS Trust and the support they provided her post-incident.

17.5. On the day of the incident she reported that she had been informed that she would have to return to the hospital to see an out-of-hours GP. She recalled that the prospect of returning to the place where her daughter had just died was intolerable. She was staying with a friend, who eventually managed to arrange for her GP to come out to the house to see her.

17.6. Keziah's mother also recalled that at some point Isle of Wight NHS Trust's home treatment team began to support her, but she was not sure who made the referral. Also, at some point her support worker accompanied her to a meeting at the hospital, although she was unable to recall who the meeting was with. She thought that she had, at this meeting, been asked if she wanted any particular questions to be included within the SIR's ToR.

17.7. Keziah's mother reported that as far as she could remember, at the time of the meeting she had been very preoccupied, not only due to her grief and shock but also because neither Keziah's funeral nor the inquest had taken place. Keziah's mother also recalled that someone came to see her and briefly went through the report with her. Again, as she was so distressed, she reported that she felt unable to manage to hear the outcomes of the report and had told the person that she would read through the report on her own at a later date.

17.8. One clear recollection that Keziah's mother reported was that she had been given one of the reports, presumably the SCR, just prior to publication, and therefore she had not had time to read it fully before it was in the public domain.

Comments and analysis

17.9. NHS trusts are required to complete their internal investigations within 60 days of an incident. If there are extenuating circumstances, they can apply to their CCG for a limited extension period.

17.10. During Sancus Solutions' investigation team's discussion with Keziah's mother about Isle of Wight NHS Trust's contact with her post-incident, it was very evident that she had understandably been so traumatised by the events

that she was not fully aware of the purpose of the SIR, let alone able to contribute any key lines of enquiry.

17.11. In addition, the Safeguarding Children Board was undertaking their investigation at the same time and it was very evident and understandable that Keziah's mother was and remains unclear as to who she had met and the purpose of the two investigations.

17.12. In Sancus Solutions' investigation team's experience families have frequently reported that one of the main difficulties that have caused then additional distress is that they are often being asked to recall and reflect on what are very difficult recent memories, often even before the inquest and – as in this case – the funeral have taken place.

17.13. In this case there were two investigations being undertaken concurrently, which clearly caused Keziah's mother considerable confusion. She reported that she was unable either to contribute to the terms of reference or to read the reports within a time frame that was manageable for her.

17.14. Families are also being asked to contribute to a ToR and be involved in a process that they are often completely unfamiliar with when they are understandably in a state of deep bereavement and may be experiencing post-traumatic stress.

17.15. NHS England's Serious Incident Framework, which outlines the requirements for healthcare providers and the processes in relation to SIRs, states:

> "There are occasions where the processes described in this Framework will coincide with other procedures. In such circumstances, co-operation and collaborative working between partner agencies is essential for minimising duplication, uncertainty and/or confusion relating to the investigation process. Ideally only one investigation should be undertaken (by a team comprising representatives of relevant agencies) to meet the needs/requirements of all parties. However, in practice this can be difficult to achieve. Investigations may have different aims/ purposes and this may inhibit joint investigations. Where this is the case efforts must be made to ensure duplication of effort is minimised."[188]

17.16. In this case there appeared to be little coordination between the two organisations, which resulted in Keziah's mother having to manage two different investigative processes at a time of unimaginable grief. Sancus Solutions' investigation team would suggest that this further added to her distress.

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[188] Serious Incident Framework p18

17.17. Sancus Solutions' investigation team were also concerned about the decision not to invite Darren's family to be involved in Isle of Wight NHS Trust's SIR and the rationale behind this decision. As Darren had been living with his mother at the time of the incident, it is very likely that she could have contributed valuable information. Her participation would also have given the author of the SIR the opportunity to discuss with Darren's family what support they might have needed, as inevitably they too had been deeply affected by the incident.

17.18. Sancus Solutions' investigation team concluded that Isle of Wight NHS Trust did meet their Duty of Candour. However in the future every effort should be made to involve both the victims and perpetrators'' families at a time that is sensitive to their situation and not dictated by a time frame imposed by the commissioners.

17.19. Sancus Solutions' investigation team would suggest that in order to minimise intrusion with families at such a complex and traumatic time the Isle of Wight NHS Trust considers recruiting a family liaison post. Their role would act as the trust's single of point of contact with families and also provide support to families throughout the SIR process.

17.20. Sancus Solutions' investigation team would also suggest that in future, if a serious incident occurs which requires both Isle of Wight NHS Trust and either the Safeguarding Children Board or the Safeguarding Adults Board to undertake investigations, then every effort should be made to undertake a joint investigation. In order to ensure that the appropriate multi-agency protocols are agreed Sancus Solutions' investigation team suggests that a joint investigation protocol is developed,

Isle of Wight NHS Trust and Isle of Wight Safeguarding Adults and Children Boards

Recommendation 10: A joint protocol should be developed between Isle of Wight NHS Trust and the local Safeguarding Adult and Children Boards that identifies how and in what circumstances joint investigations will be undertaken.

Isle of Wight NHS Trust

Recommendation 11: Isle of Wight NHS Trust should consider recruiting a family liaison post who would be the single of point of contact and support for families throughout the Serious Incident investigation process.

18. Isle of Wight NHS Trust's Serious Incident Report

The ToR asks Sancus Solutions to:

"Review the Trust and Primary Care/CCG level 2 internal investigation report and assess the adequacy of the findings, recommendations and implementation of the action plan and identify:

- if reporting between the initial incident report and the RCA was consistent
- 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 the evidence of the embedding of practice within frontline services
- Comment on the CCG and Trust assurance processes and what evidence is provided to assure the respective boards those positive changes are embedded and routine."

18.1. Isle of Wight NHS Trust's SIR was completed on 8 August 2016. This was a level 2 comprehensive root cause analysis investigation.

18.2. The author of the report was the acute mental health service's Clinical and Quality Safety Lead.

18.3. The report was reviewed by a panel (10 August 2016) that included:

Deputy Director of Nursing
Head of Nursing and Quality
Clinical Director/Head of Mental Health and Learning Difficulties
Operations and IAPT managers
Clinical Quality and Safety Lead for Acute and Inpatient (Mental Health) Services
CCG Senior Quality Manager
CCG Director of Quality

Prior to submission to the CCG (8 September 2016), the report was approved by the trust's Business Unit Lead, the Clinical Director/Head of Mental Health and Learning Disabilities, and the Director of Nursing (22 August 2016). The final approval by the internal governance process was on 19 October 2016.

18.4. The SIR's author concluded:

"In reviewing the patients' care pathway within the service the investigation has identified several care and service delivery problems … These problems

have not been found to be linked to any one individual clinician but appear to be as a result of some process/procedure/training deficits … In light of the fact that the patient appeared to be engaging with their treatment plan at the point of death, it would be difficult to make the assumption that these deficits would have made a difference to the interventions offered and the outcome of the incident."[189]

18.5. Alongside a number of areas of good practice and lessons learned, the SIR's author identified the following:

CARE AND SERVICE DELIVERY PROBLEMS

Receipt of CA/12's from Adult Safeguarding Team; outcome of referral not entered on PARIS referral form

Risk Assessment; full assessment not undertaken which may have identified further risks and was a missed opportunity

Safeguarding and Risk; the Local Safeguarding Children's Board's Joint Working Protocol sets out factors that potentially increase risks to children of parents with mental illness or psychological distress. On reviewing all clinical documents for the patient these factors are all identified, however there appears to have been no consideration given to the assessment and management of these in relation to safeguarding patient's child.

Communication; it is not always possible for practitioner to know if patient is open to another part of the service. The clinician from IAPT had identified patient's spouse and child as protective - unaware GP referral had stated that there were currently no protective factors.

CONTRIBUTORY FACTORS

The patient had undergone a recent relationship breakdown.
The patient had a diagnosed depressive illness.
There was a known history of suicidal ideation."[190]

18.6. There was no documentation within the SIR to indicate if the author gave any consideration to whether there was a root cause.

[189] SIR p3
[190] SIR Executive Summary p1

18.7. Alongside the approved SIR there was an action plan developed which identified the required action(s), timescale, key performance indicators[191] and lead professional for each recommendation.

18.8. It was identified within the action plan that the reporting structure for each completed action was the Corporate Quality Assurance Lead's responsibility.

Comments and analysis

18.9. Sancus Solutions' investigation team were provided with the most up-to-date action plan in February 2018.

18.10. As has already been identified, since this incident Isle of Wight NHS Trust was placed under special measures by CQC an extensive transformation process is currently being undertaken.

18.11. The latest action plan makes reference to and situates the SIR's recommendations within the developing restructuring of secondary community mental health services.

18.12. The latest action plan reports that the following progress has been made:

Recommendation 1: There is liaison between the adult safeguarding team, the local authority, the trust, the police and the SPA team, to gain an understanding of CA/12 processes within all organisations.

Action

- A meeting was convened (13 September 2016) with the local authority adult and children's' safeguarding team and the police to discuss local CA/12 processes. This meeting enabled trust staff to have a clearer understanding of the safeguarding referral processes for inclusion in local protocols.

Update

- 15 June 2017: Every CA/12 that now comes through the team has a triage assessment.

Recommendation 2: Information gathered at the above meeting should be clearly set out for information within the CRHT Standard Operating Procedure (SOP).

[191] Key performance indicators: "quantitative performance measurements to gauge or compare performance to evaluate success of a particular action" SIR p9

Action

- The SOP within the Crisis Resolution and Home Treatment Team (CRHT) has been amended to include clear information and guidance regarding CA/12 processes.

Update

- 30 December 2016 – the CRHT SOP was presented to a Quality Meeting, but the SOP was not agreed as further amendments were required. It was due for resubmission in January 2017.

- 20 April 2017: SOP again was not accepted. The matron is now in post and has been tasked to review the SOP.

Sancus Solutions' investigation team were provided with and reviewed the latest version of the SOP for the CRHT and SPA teams. This report has highlighted that despite the revised SOP it was reported that the service was still receiving referrals for patients that have a too high a risk history (see 17.16).

Recommendation 3: The draft CRHT SOP is reviewed and amended to include clear expectations of what referral information will be documented, and where it should be documented.

Action

- The CRHT SOP has been amended to include this information (December 2016).

Update

- 16 June 2017: The capacity of the SPA remained an issue. A decision was made to create an operational post to work alongside the CRHT team leader.

- Agency staff have temporarily been deployed into the SPA team while a new demand and capacity tool is rolled out.

- The team now have a daily MDT meeting to discuss all cases coming through the SPA team.

- Latest update (13 December 2017): vacant posts remain filled with agency staff and recruitment work continues.

- Latest update (13 December 2017): It was agreed at the Quality Meeting that following the CQC inspection, the SOP will need a further review in light of the changes currently being planned within the service.

Recommendation 4: A plan should be put in place with the Clinical Lead SPA, the CRHT team leader and the matron to ensure that protected time to monitor and develop practice within the team is facilitated.

Action

- A meeting has taken place with the relevant staff. The staffing rotas were reviewed and the SPA lead allocated times to monitor and develop practice.

- Ongoing responsibility was agreed with the SPA clinical lead who provides feedback to the team leader and the matron.

Recommendation 5: A review of what the 'on hold' process was achieving should be carried out, so that any positive factors are not lost in removing the system.

Action

- The practice and function of the folder was reviewed immediately following the SIR; it was agreed that there was no sound clinical reason for an on-hold folder, so this process was terminated.

Recommendation 6: A written protocol for liaison and referral between IAPT and SPA should be written.

Action

- Clinical Director will ensure that a protocol will be written.

- Protocol written and approved by the Corporate Quality Assurance group (15 December 2016).

Sancus Solutions' investigation team were provided with a copy of the protocol.

Recommendation 7: Communication should be given to staff regarding the required standards for documenting risk assessments – to include risk formulation.

Action

- Clinical Risk Assessment and Management training has been rolled out across the business unit. This training covers expectations of recording standards.

- A monthly newsletter is sent to all staff which identifies best practice and lessons learned from untoward incidents.

Update

- 16 June 2017: Further work related to risk assessment processes has been undertaken since the CQC inspection. This included further clinical risk training. Additional e-learning refresher training was also planned.

- Core competency documents for all registered practitioners. National CPA audit tool used on a monthly basis in all teams and reported as part of performance reporting.

- 13 December 2017: A new assessment document has been developed and introduced onto PARIS (27 November 2017). Prior to roll-out all clinical staff received training on the guidance and expectations of completion. The template contains clear instructions on the use of risk formulation.

The Head of Nursing reported to Sancus Solutions' investigation team that they are currently in the process of developing reflective practice sessions within secondary mental health services.

Recommendation 8: Work is undertaken to ensure that the content of the 4LSCB Joint Working Protocol[192] is embedded within all mental health teams.
Action

- The joint working protocol has been developed and cascaded to all teams (December 2016).

- After the initial sharing of the protocol, team leaders were expected to discuss and reflect on its content within team meetings.

- Minutes from team meetings will evidence these discussions.

- In addition, the content of the protocol will be included within the coming year's updated mandatory staff clinical risk training programme.

Update

[192] The purpose of the Think Family Joint Working Protocol is: "To safeguard and promote the welfare of children and young people, including young carers, whose lives are affected by parents/carers using drugs/alcohol or by parents/carers with mental health needs, learning disabilities, autism, or other complex needs e.g. acquired brain injury, progressive neurological condition, that may adversely affect their ability to parent or care. To promote effective communication between adult drugs/alcohol, mental health, learning disability, primary GP and community health care (health visitors, school nurses), other services and Children's Social Care" Joint Working Protocol

- 16 June 2017: Children and Adolescent Mental Health Services (CAMHS) have undertaken training with the CRHT team.

- Children's Safeguarding training compliance is being monitored as part of clinical business unit (CBU) performance. Additional sessions have been procured for mental health services to ensure compliance.

- Further work is required to provide reflective space and discussion regarding Think Family and lessons learned. This responsibility has been placed with the Head of Nursing and Quality and will be monitored as part of the trust-wide improvement plan for the coming 12 months.

- 13 December 2017: The new assessment template contains guidance and prompts around Think Family. The Head of Mental Health Nursing is currently working to develop reflective sessions so that all staff have a forum to explore lessons learned.

Sancus Solutions' investigation team were provided with a copy of the Joint Working Protocol and were also provided with some evidence of how Isle of Wight NHS Trust is attempting to embed the Think Family Agenda within its policies and practitioners' practice.

This is obviously work in progress and should be continually monitored at both operational and governance levels throughout the trust's services.

Recommendation 9: There should be work undertaken within the trust in partnership with the local authority to ensure the timely availability of level 3 safeguarding children training.

Action

- October 2016: Provision of level 3 Children's Safeguarding training discussed at the trust's Patient Safety, Experience and Clinical Effectiveness committee.

- November 2016: Further discussion at Joint Safeguarding Meeting.

- Ongoing assessment required to identify the number of training places required.

- 21 April 2017: training sourced by the Training and Development team; mental health services have been prioritised to receive the training.

Sancus Solutions' investigation team were provided with the most up-to-date training log for IAPT practitioners. All staff have completed level 3 children and adult safeguarding training.

Recommendation 10: Planned changes to the PARIS patient records should support the routine assessment of risks to dependants.

Action

- January 2017: the new version has been developed and is ready to be trialled.

Update

- 16 June 2017: roll-out delayed due to feedback received from CQC inspection.
- Service user feedback was obtained.
- Further developments were made to proformas that included a section on dependants and referrals required linked to any risks identified.
- 13 December 2017: launch of new template. Contains guidance notes requiring staff to consider risks to dependants.

Recommendation 11: All teams within the service should have some level of access to other systems used within the Clinical Business Unit, i.e. IAPTUS[193], BOMIC[194] and PARIS.

Action

- 15 December 2016: Crisis Resolution and Home Treatment team have received training and access to the IRIS system (BOMIC).
- IAPT have access to the PARIS system.
- Team access to other systems is in the process of being organised and will be completed during January 2017.

Update

- 16 June 2017: Requested more access to BOMIC.
- Access to IAPTUS not yet in place. Delayed due to Sec 31 work within the CBU [195]however, this has been discussed and agreed for follow-up.

[193] IAPT IT system
[194] BOMIC drug and alcohol IT system

[195] Clinical Business Units

- 13 December 2017: Access to IAPTUS is now in place within the Crisis Resolution and Home Treatment team.

18.13. Sancus Solutions' investigation team were satisfied that Isle of Wight NHS Trust's SIR met its ToR and that the reporting between the initial incident report and their RCA was consistent.

18.14. Sancus Solutions' investigation team were satisfied that all key issues and lessons have been identified and shared and that the recommendations within the SIR were appropriate, comprehensive and "flow from the lessons learnt".[196]

18.15. Furthermore based on the evidence that was provided, Sancus Solutions' investigation team were satisfied that ongoing work has been undertaken to ensure that the recommendations from the SIR have been implemented and are being monitored within Isle of Wight NHS Trust's business units and its and CCG's governance processes.

18.16. However as previously noted it was reported that since this incident despite a revised protocol been introduced for the liaison between Improving Access to Psychological Therapies and Primary Care it was reported by one of the IAPT practitioners that IAPT service was still receiving patients who were at too high a risk for the service. It was also acknowledged by one of the operational managers that although there had been some improvement, more effort needed to be made to further develop and streamline processes and protocols between IAPT and primary and secondary mental health services. Therefore Sancus Solutions' investigation team have concluded that, at the time of their investigation, there was some evidence of deficits in the embedding of lessons learnt from the SIR within the front line services practices.

18.17. During the course of their investigation Sancus Solutions' investigation team were provided with evidence that further extensive improvements have been made throughout secondary community mental health services as a direct consequence of the CQC inspections in 2016 and 2017.

18.18. Sancus Solutions' investigation team were informed that Isle of Wight NHS Trust are currently waiting to receive the CQC report from their most recent inspection visit (January 2018). They were informed that when this has been received, the transformation programme will be reviewed and further action plans formulated.

[196] NHS England's ToR

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT) and secondary community mental health services

Recommendation 12: The IAPT referral information requires further amendments in order to clarify the criteria of referrals, including any prohibitive risk histories.

Serious Case Review action plan

18.19. Sancus Solutions' investigation team were provided with the most recent version of the SCR action plan. The actions that directly related to Isle of Wight NHS Trust were:

Action

IOW SCB[197] to seek written assurance from GPs and Adult Mental Health Services that all staff understand that children can never be seen as a protective factor, and that any assessment of responses to caring for children being seen as a protective factor can very quickly change over time and should be reviewed regularly. Target Completion Date: April 2017.

Update

- November 2017: to be built into guidance re Think Family Joint Working Protocol and training.
- Highlighted within the new Joint Working Policy and Summary.
- LSCB learning workshops to be held in February and March 2018.

Currently this action is amber[198].

Action

- Need to provide information and/or guidance to increase clinician understanding in relation to these key issues:

  Children as protective factors
  Cognitive behaviour therapy (CBT) with learning difficulties
  Information sharing

Update

[197] Isle of Wight Safeguarding Children Board
[198] Amber: in progress

- Information sharing – specific safeguarding guidance is available, which is national.

- LSCB learning workshops to be held in February and March 2018. Activity around child as a protective factor.

- Highlighted within the new Joint Working Policy and Summary.

- Guidance for clinicians was to be devised by Isle of Wight NHS Trust's mental health team, but it was documented that "capacity has been an issue, further compounded by changes in key posts across mental health services". The Head of Safeguarding (children and adults) reported to LSCB that she would raise this with the new Director for Mental Health and Learning Disability Services.

Currently this action is amber[199].

Action

- Clinical staff to complete a minimum of level 3 safeguarding children training, and managers (band 7 and above) to complete level 5 safeguarding training.

Update

- Level 3 compliance within the Trust is 85% with only 34 more people to complete to hit 95%. Compliance was 54% at this time last year. Significant improvements.

- Currently this action is "new green"[200].

Action

- The IOWSCB will seek a report from Isle of Wight CCG and Isle of Wight NHS Trust outlining agreed roles and operating procedures between primary mental healthcare and mental health services.

Update

- Mental health services are currently under review/consultation as part of the transformation process. A detailed report will be brought to the Board in Q3 and authorised by both the trust and the commissioners.

Currently this action is amber.

Action

[199] Amber: in progress
[200] New green: for signing off

- Need to establish the extent of the issues via an adult mental health audit.

Update

- Survey undertaken and results reviewed with overall view that requests for urgent advice are reasonably well responded to, less urgent less so.

Currently this action is new green.

Action

- My Life a Full Life Programme (MLFL) team to be consulted on plans for information system sharing, e.g. SystmOne and PARIS. Mental Health CBU to attend GP training afternoon for a presentation on mental health services. Stakeholder events to be held in relation to mental health and learning-and-development changes.

Update

- Mental health services are currently under review/consultation as part of the transformation process. A detailed report will be brought to the Board in Q3 authorised by both the commissioners and the trust.

Currently this action is amber.

18.20. Sancus Solutions' investigation team were informed that it is the responsibility of the Director of Nursing to monitor the progress of recommendations that have arisen out of SCRs.

18.21. As monitoring and commenting on the progress made by Isle of Wight NHS Trust with regard to the SCR's recommendations was not included within the terms of reference for Sancus Solutions' investigation, the investigation team did not seek evidence of the trust's implementation and monitoring of these recommendations.

18.22. However, Sancus Solutions' investigation team were provided with a report, completed by an external company, which had been commissioned by Isle of Wight NHS Trust "following a number of external reports describing ineffective governance systems"[201] with regard to serious incident processes. The review assessed Isle of Wight NHS Trust's serious incident processes against their compliance with the NHS England Serious Incident Framework (2015).

18.23. The review concluded that the following principles were all non-compliant:

[201] Review and report presented October 2017

- Open and transparent
- Objective
- Timely and responsive
- Systems based
- Proportionate
- Collaborative.

18.24. It was noted that "the findings of the review were accepted unanimously by the Executives and Clinical Business Units"[202]. The report also documented what remedial actions have been instigated.

18.25. It was also stated that the aim of the review and subsequent actions was "promoting and supporting learning from incidents across the organisation whilst ensuring the correct information is escalated to the Trust Board without delay"[203].

18.26. The next stages of implementing the improvements were to:

- "Formalise the changes by developing a new policy for approval
- Continue to work with the CCG to improve the quality of investigations
- Implement the reporting table in Section 5
- Identify an appropriate lead for Duty of Candour to improve daily monitoring of compliance"[204].

19. Predictability and preventability

19.1. Throughout the course of this investigation, we have remained mindful of one of the requirements of NHS England's ToR, which was that Sancus Solutions' investigation team should consider if the incident that resulted in the death of Keziah and the suicide of her father was predictable or preventable.

19.2. In this investigation we have used the following definitions:

- 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

[202] Report p4
[203] Report p4
[204] Report p5

of violence, at that time, was high enough to warrant action by professionals to try to avert it.[205]

- 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.[206]

Predictability

19.3. Darren was only in contact with SPA and IAPT services for two very brief periods of time, which gave the involved practitioners little opportunity to develop a comprehensive profile of this patient's needs and risk factors.

19.4. However, Darren did disclose certain concerning potential risk issues:

- He was recently separated from his wife.
- He was socially isolated and indicated that if reconciliation did not occur, it would have "dramatic" consequences.
- He expressed his suspicions and paranoia that his wife was having contact with other males.
- He was disclosing certain behaviour towards his wife that appeared to indicate some controlling and coercive behaviours within his marriage – for example, accessing his wife's private social media account and text messages and following her around the house to ensure that she was not making contact with anyone.
- He showed very limited capacity to reflect on the potential effects that his behaviours and his recent separation from his wife may have been having on his daughter.
- He disclosed that he had at least one nightmare that he had murdered his wife and child.
- He also disclosed that he had made at least one serious attempt to take his life by suicide.

19.5. All of these disclosures do indicate that Darren's potential risk to himself was high. There was also significant evidence to suggest that the marriage, at

[205] http://www.dictionary.com/browse/predictability
[206] http://www.dictionary.com/browse/preventable

least since the separation, contained elements of controlling and coercive behaviours.

19.6. Sancus Solutions' investigation team concluded that all of the above indicated that Darren's situation had several significant risk factors and more limited protective factors than the various assessments were indicating.

19.7. Additionally, based on Darren's various disclosures, it was evident that he was a vulnerable adult, and the known recent history of his potential risks appeared to be indicating that he was at risk of death by attempted suicide.

19.8. It is not possible to definitely conclude that his nightmare disclosure, just a few weeks prior to the events of 1 June 2016, was anything other than a disturbing dream rather than him indicating that he had actually formulated a plan to hurt Keziah or his wife.

19.9. Therefore, Sancus Solutions' investigation team have concluded that it was not predicable that on 1 June 2016 he would harm his daughter.

19.10. However, there was enough evidence to suggest that it was predictable that he might end his own life by suicide.

Preventability

19.11. In Sancus Solutions' investigation team's consideration of the preventability of this incident, the following two questions have been asked:

- Based on the information that was known, were Darren's risk factors and support needs being adequately assessed and addressed by the involved agencies?
- Additionally, based on the information that was known at the time, was the incident on 1 June 2016 preventable?

19.12. A preventable incident is one for which there are three essential ingredients present: the knowledge, legal means and opportunity to stop an incident from occurring.

19.13. It is Sancus Solutions' investigation team's conclusion that Darren disclosed a number of significant behaviours and responses to his situation that should have triggered some concerns among the involved practitioners that his relationship with his wife contained some elements of domestic abuse.

19.14. These disclosures should have prompted further enquiries, such as referring the case to Isle of Wight NHS Trust's safeguarding team for advice and/or contacting Darren's wife to discuss her needs.

19.15. There was also no apparent consideration given by the involved practitioners to the possible effects that Darren's mental health may have been having on a young child's wellbeing.

19.16. Sancus Solutions' investigation team have concluded that the Think Family Agenda was not underpinning any of the mental health practitioners' responses to the situation.

19.17. The response to Darren's disclosure, that he had experienced at least one nightmare in which he had murdered his wife and Keziah, was of some concern to Sancus Solutions' investigation team. Apart from a discussion in peer supervision, no further action was instigated, such as seeking the expert advice of the Isle of Wight children's safeguarding team or triggering a safeguarding alert.

19.18. However, Sancus Solutions' investigation team have concluded that Darren's presentation and risk factors did not meet the referral threshold that was in place within Isle of Wight NHS Trust's secondary mental health services[207], where he would have received more intensive support and assessments. Therefore, Sancus Solutions' investigation team have concluded that the incident on 1 June 2016 that led to the tragic death of Keziah and the suicide of Darren was not preventable.

Keziah mother's comments

19.19. Having read this investigation report Keziah's mother reported that she disagreed with the conclusion reached by Sancus Solutions' investigation team. She believes that if her Darren had been offered the support from mental health services that he needed both his suicide and the death of Keziah would have been prevented.

20. Concluding comments

20.1. Obviously not every patient who has parental responsibilities and mental health issues will go on to kill their child and/or themselves. However, what this case has highlighted is that mental health practitioners should always be giving consideration to the effects that a parent's mental health may be having on the whole family, including their children.

20.2. Sancus Solutions' investigation team were very concerned about the lack of the Think Family agenda underpinning the support that services were offering

[207] Threshold for entry into secondary mental health services: person is suffering from an unstable psychotic illness or bipolar affective disorder, complex personality disorder, moderate to severe depression, OCD, moderate to severe anxiety and eating disorders. Person has mental health issues that have been treatment resistant and extend over more than a 12-month period. Person is experiencing an acute mental health crisis, of which there are significant risks to self or others. If the referrer is expecting secondary mental health services input, then a clear rationale is required. SOP p3

to Darren and his family. It is expected that the Isle of Wight NHS Trust take urgent action to rectify this significant deficit.

20.3. Clearly this is a most tragic case that has resulted in the death of a young child and her father, who was at the time experiencing mental health difficulties. The effects of this tragedy will continue to affect the lives of all those involved, especially Keziah's mother. Sancus Solutions' investigation team hope that the findings and recommendations of their investigation will contribute to Isle of Wight NHS Trust's learning and improvement of practice and to the safety of patients and their families.

20.4. It is also the hope of Sancus Solutions' investigation team that the findings and recommendations within this report will provide Keziah's mother and Darren's family with at least some resolution to their concerns and questions.

21. Recommendations

Isle of Wight NHS Trust's Improving Access to Psychological Plus Therapies service (IAPT)

Recommendation 1: To ensure that Isle of Wight NHS Trust's IAPT service is fully accessible to meet the diverse needs of the population the IAPT therapist must, at the initial assessment, assess what support and aids may be required by the patient.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT)

Recommendation 2: Isle of Wight NHS Trust IAPT service must either develop a bespoke IAPT service risk assessment or utilise the community mental health risk assessment tool.
The IAPT risk assessment must include the identification and assessment of :

- All potential risk, including the patient's risk to self and others
- Documentation of all historical risks
- A narrative of all risk(s) identified
- A risk management plan should be agreed with the patient based on all current risk(s) identified:

- The risk management plan should identify a contingency and crisis plan
- Risk(s) identified must be reviewed at subsequent sessions.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT)

Recommendation 3: The IAPT service's operating procedure (SOP) need to be revised to include:

- A specific section on the assessment and monitoring of risk.
- A hyperlink to Isle of Wight NHS Trust's clinical risk and Care Programme Approach (CPA) policies.
- A section that clearly outlines the IAPT therapist's responsibilities with regard to safeguarding adults and children and the trust's Think Family Agenda. This section should have hyperlinks to the relevant safeguarding policies and the Think Family Joint Working Protocol.

Isle of Wight NHS Trust

Recommendation 4: A review should be undertaken to ascertain why the Named Nurse for Safeguarding Children does not always receive all CA/12 Child and Young Person at Risk forms (now referred to as Public Protection Notices). Any issues identified should be promptly addressed.

Isle of Wight NHS Trust Improving Access to Psychological Therapy (IAPT) and Single Point of Access services (SPA).

Recommendation 5: The involved IAPT and SPA practitioners and managers must receive additional bespoke safeguarding and domestic violence training. Safeguarding and domestic violence should be a standing agenda item within both IAPT and SPAs' supervision and team meetings.

Isle of Wight NHS Trust

Recommendation 6: As part of all primary and secondary mental health practitioners and service /operational managers' recruitment interviews the interviewee should be asked to demonstrate how the Think Family Agenda underpins their practice.

Isle of Wight NHS Trust

Recommendation 7: Isle of Wight NHS Trust should consider adopting an assessment tool, such as Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC)[208], within its primary and secondary mental health services, including the IAPT service.

Isle of Wight NHS Trust, Clinical Commission Group (CCG) and NHS England South East

Recommendation 8: Isle of Wight NHS Trust should redesign the current IAPT service's assessment proformas to ensure that they are adequately identifying and risk(s) and potential safeguarding issues.

The CCG and NHS England South East should seek assurance and evidence from the Isle of Wight NHS Trust that the IAPT risk assessment adequately addresses any potential safeguarding issues.

Isle of Wight NHS Trust

Recommendation 9: Isle of Wight NHS Trust should develop a Carer's Support Policy.

Isle of Wight NHS Trust and Isle of Wight Safeguarding Adults and Children Boards

Recommendation 10: A joint protocol should be developed between Isle of Wight NHS Trust and the local Safeguarding Adult and Children Boards that identifies how and in what circumstances joint investigations will be undertaken.

Isle of Wight NHS Trust

Recommendation 11: Isle of Wight NHS Trust should consider recruiting a family liaison post who would be the single of point of contact and support for families throughout the Serious Incident investigation process.

Isle of Wight NHS Trust Improving Access to Psychological Therapies Plus service (IAPT) and secondary community mental health services

Recommendation 12: The IAPT referral information requires further amendments in order to clarify the criteria of referrals, including any prohibitive risk histories.

[208] PAMIC

Appendix A: Terms of reference

Review the engagement, assessment, treatment and care that [Darren] received from Isle of Wight NHS Trust from his first contact with services in March 2015 up to the time of the incident in June 2016 with specific reference to the reasons for and actions taken following disengagement from services in 2015 against trust policy and national guidance.

- Review the contact and communication between agencies and services: i.e. GP Services, the Police, Children's Services and Health Visiting Services and the Isle of Wight NHS Trust and assess if [Darren's] risks (to self and others) were fully understood.
- Review the enactment of local safeguarding children and vulnerable adult policies.
- To consider whether further multi-agency working may have assisted in assessing the risks presented (to and by [Darren]) and the formulation of effective care and risk management plans for [Darren] to others.
- Review the documentation and record keeping of key information by the Isle of Wight NHS Trust against best practice and national standards.
- Comment on the Trust's enactment of the Duty of Candour.
- Review the Trust and Primary Care/CCG level 2 internal investigation report and assess the adequacy of the findings, recommendations and implementation of the action plan and identify:

- If reporting between the initial incident report and the RCA was consistent
- 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 the evidence of the embedding of practice within frontline services.

- Comment on the CCG and Trust assurance processes and what evidence is provided to assure the respective boards that positive change is embedded and routine.

- 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 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.

- Assist the family in the production of an impact statement for inclusion in the final published report, if appropriate.
- Should the family formally identify any further areas of concern or complaint, about the care received or the final report, the investigation team should highlight this to NHS England for escalation and resolution at the earliest opportunity.