NHS Review and Serious Incident Review: Oxford Health NHS Foundation Trust October 2022

Introduction

A review was commissioned by NHS England (South East) of care provided by Oxford Health NHS Foundation Trust for X, a 27yr old young woman who died alongside her three-year old daughter (B).

An independent team was appointed in November 2019 to review the internal investigation completed by the Trust after the incident. A Panel was commissioned by the local authority to complete a Serious Case Review (SCR).

Findings and Conclusions

The Independent review focused on the circumstances of care provided for X, a young single mother of (B) aged three and half years old, who tragically lost her life along with that of her daughter. The review report describes how, in the few months before her death, X's mother had been extremely concerned for her daughter's mental health tried very hard to solicit help from police, primary care, social services, specialised mental health services, several emergency departments, and the ambulance service.

A full mental health assessment by an experienced team completed on 29th December 2018 did not find any evidence that X was suffering from a mental disorder.

An assessment by an experienced social worker of (B)'s family circumstances also concluded that there were no risks for X's child.

Furthermore, an experienced GP was also not sufficiently concerned about her patient, whom she had seen quite frequently, to believe that she warranted onward referral.

The Trust investigation report concluded that if X had been experiencing psychotic symptoms (which now seems likely) then she must have been very adept at hiding them.

However, the Independent Review team thought that the assessment could have been strengthened if collateral information had been sought independently from X's family.

The internal investigation also said that improved system-wide communication, greater involvement of X's mother, and a further home visit, might have been helpful. It is possible that if clinicians had spoken directly (and alone) not only to X's mother

but to other family members; seen (B)'s father by himself, it might have broadened their evidence base and helped to inform their judgement.

The Independent review supports the findings of the internal investigation and believes that its recommendations should help to strengthen services. Three further recommendations were also made.

Recommendation 1. The Trust should take further steps to augment training to ensure that staff are fully competent to deal with complex questions relating to confidentiality. This is because it is essential that staff effectively balance the need for confidentiality and respect for the patient's wishes with their responsibility to safeguard others, particularly when a child is involved.

Recommendation 2. We recommend that t the Trust improve information provided to partners in care across agency and borough boundaries. Work between Oxfordshire mental health services and partner agencies has already started, but it should be possible to do more. Details about these areas are provided in the main report.

Recommendation 3. Our team recommends that when investigations are conducted in partnership, lead authors should always be involved fully in consultations with families. In this way, information about issues relating to data gathering, the processes of the review, reporting arrangements and separate governance can be shared fully and opportunities for questioning by families can be provided.