An independent investigation into the care and treatment of a mental health service user Mr T in Cornwall

January 2022

V3.5

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Our Report has been written in line with the terms as set out in the Terms of Reference on the independent investigation into the care and treatment of Mr T. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Although where there is evidence that the information is not accurate, this has been made clear in the report.

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1.3 Mr T went missing from his bail address and following a Mental Health Act assessment he was detained under Section 2 Mental Health Act on 29 June 2016. Following a period of inpatient treatment in both PICU (Psychiatric Intensive Care Unit), provided by Cornwall Partnership NHS Foundation Trust) and the local general hospital (provided by Royal Cornwall Hospitals NHS Trust) for rehydration Mr T was discharged into the community on 19 July 2016.

1.4 On 21 July 2016 Mr T was found unconscious following apparent self-strangulation and died in hospital two days later. The inquest for Child B recorded a verdict of unlawful killing.

1.5 Following Mr T's death there was no further criminal justice investigation into who was responsible for the death of Child B. The Trust subsequently commissioned an investigation into Mr T's care and treatment.

Independent investigation

1.6 NHS England (South) commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into Mr T's care and treatment. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.7 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance[2] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

[1] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf

[2] Department of Health Guidance ECHR Article 2: investigations into mental health incidents https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

1.8 The main purpose of this independent investigation is to ensure that the unlawful killing of Child B is investigated in such a way that any lessons, where appropriate, can be learned effectively to prevent recurrence.

1.9 The terms of reference for the internal investigation focussed solely on Mr T's care and treatment prior to his suicide and not on the impact that this may have had on the death of Child B. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

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

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

Internal investigation

1.12 Cornwall Partnership NHS Foundation Trust undertook a serious incident investigation following Mr T's death but did not critically examine the circumstances surrounding the death of Child B. The investigation was completed by an independent investigator commissioned by the Trust, with clinical advice provided by a consultant psychiatrist from elsewhere in the organisation.

1.13 The report identified a number of care and service delivery problems:

- Limited mental health assessment whilst in custody on 27 June 2016, due to the client not fully engaging with the process. No forensic medical examination was felt to be needed. A Mental Health Act assessment was not deemed appropriate at that time.

- Limited sharing of information on the client's mental health history with the police. Only basic risk information was disclosed. The client was unable to engage fully in the process and declined sharing information. As a result, it was not clear how information was taken into account by the police when bail conditions were arranged.

- Client was bailed by the police then went missing on 27 June 2016. The client was bailed as he had not been charged. It was unclear if police were fully cognisant of the client's additional vulnerability from lack of family support, of being taken to an unfamiliar geographical location, with the means but not the ability to contact mental health support services or housing. Caradon integrated community mental health team (ICMHT) were unable to contact him as he had no phone.

- No usual family support on 27 June 2016 due to very strict bail conditions.

- Nearest Relative was not advised of the client's detention under Section 2 [Mental Health Act].

1.14 Two recommendations were made:

R1 The Trust to discuss the findings of the investigation with the police lead, around information sharing in such high-risk cases, the decision not to ease the bail conditions, and public protection versus support of alleged perpetrators.

R2 Discussions with relevant staff to take place around the decision not to contact the Nearest Relative and action implemented if indicated.

1.15 The Trust developed an action plan to respond to these recommendations and we have seen partial evidence of these actions being completed.

Learning from Experience Review

1.16 The Cornwall and the Isles of Scilly (CIOS) Safeguarding Children Partnership is known as 'Our Safeguarding Children Partnership CIOS'. We will refer to it as Our Safeguarding Children Partnership throughout this report.

1.17 It is the responsibility of the Chair of Our Safeguarding Children Partnership to commission a serious case review in the event of the death of a child where abuse or neglect is known or suspected. This decision is informed by a multi-disciplinary team serious case review panel discussion.

1.18 However, a meeting of the serious case review panel concluded that the case did not meet the criteria for a serious case review.

1.19 The panel recommended that the Chair of Our Safeguarding Children Partnership commission an independently led 'Learning from Experience' review. This would include workshop activity that focussed on agencies' understanding and identification of parental disguised compliance.

1.20 The report that followed the Learning from Experience workshop identified two challenges for health agencies:

- Health providers to review how they ensure adult mental health staff consider the wider family, including children, as part of its full assessment of need. (Challenge 18 and Challenge 20)

- To provide staff seeking to work with adult mental health services advice and guidance regarding best practice in relation to engagement, access to information and joint working. (Challenge 18)

1.21 The completed action plan has been monitored by Our Safeguarding Children Partnership. It is the responsibility of NHS Kernow Clinical Commissioning Group (CCG) to ensure that the actions identified for NHS providers became part of routine reporting.

1.22 We understand that processes have been implemented in part, but we have not seen evidence of any impact assessments. We would expect to see an assessment of the effectiveness of the revised processes and training when they are fully implemented.

Inquests

1.23 The inquest into the death of Mr T's child found that he was unlawfully killed and that a post-mortem examination identified a recent severe head injury (within 12 hours of death) and rib fractures as well as an historical unexplained head injury and rib fractures. The inquest also commented that the baby was subject to a child protection plan at the time of his death.

1.24 We have not had sight of the Coroner's report into Mr T's death.

Conclusions

Relating to the death of Child B

1.25 We found a lack of evidence of action when children's social care was seeking information about Mr T's mental state.

1.26 There was insufficient attention paid by mental health staff to the safeguarding risks to the young children in the family. No risk assessments were completed that made any reference to potential child safeguarding risks posed by Mr T until after the death of Child B.

1.27 In addition, an opportunity to engage with the children's social workers was passed over on 17 June 2016 when both they and ICMHT staff were at Mr T's home at the same time.

1.28 We have set out below the care and service delivery issues in relation to Mr T's care and treatment that may have impacted on the death of Child B.

Figure 1: Care and service delivery issues that may have impacted on the death of Child B

Relating to the death of Mr T

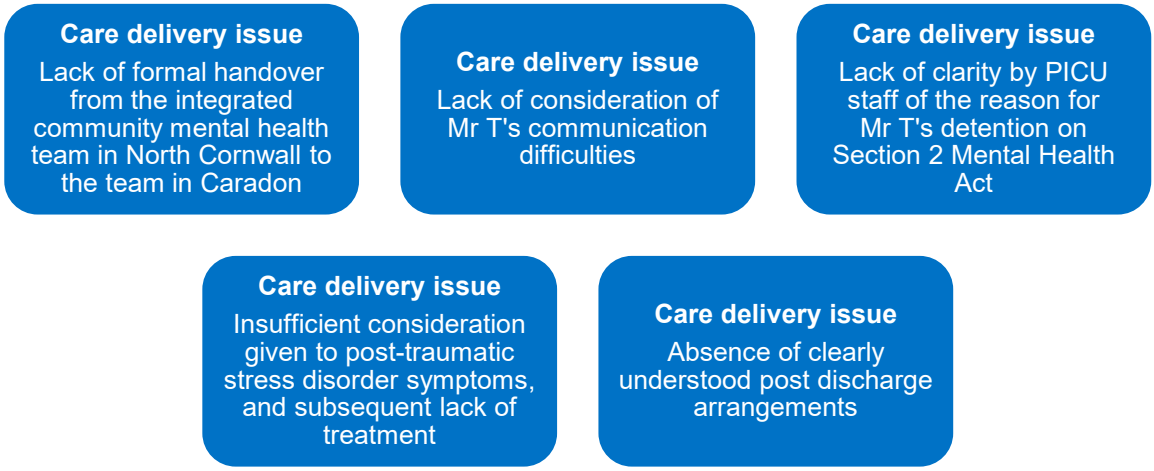
1.29 Mr T was a patient with a complex presentation, evidenced by the need for ICMHT staff to work with him in pairs and the difficulty that PICU staff had engaging with him.

1.30 Mr T's difficulties were evident in the weeks and months prior to the death of Child B, yet this information was given insufficient weight by the PICU team treating him.

1.31 ICMHT staff had identified potential symptoms of post-traumatic stress disorder related his alleged kidnap, rape and assault that Mr T had disclosed to his GP, to ICMHT staff in both North Cornwall and Caradon, and PICU staff. ICMHT staff working with Mr T at the time of his son's death had only met with him on three occasions and had not formulated a complete assessment of his needs.

1.32 PICU staff documented that Mr T had been admitted because he had been arrested on suspicion of the murder of his child and then bailed. This remained the legal position throughout Mr T's admission, and we consider it is probable that this coloured the way in which staff tended to interpret his presentation, specific behaviours and reported symptoms. We have set out below the care and service delivery issues that we consider were associated with the death of Mr T.

Figure 2: Care and service delivery issues associated with the death of Mr T



Predictability and preventability

1.33 It is our view Mr T's involvement in the death of Child B could not have been predicted or prevented by mental health services. However, we have identified care and service delivery problems that if addressed could have mitigated Mr T's risk to Child B.

Recommendations

1.34 This independent investigation has made 12 recommendations to improve commissioning and clinical practice.

Recommendation 1: The Trust must clarify the action that they expect staff to take when there is a question about whether to execute Duty of Candour.

Recommendation 2: The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide.

Recommendation 3: The Trust and the clinical commissioning group must ensure that families are offered appropriate involvement in serious incident investigations and that they are always offered a copy of the investigation report.

Recommendation 4: The Trust must provide robust assurance that they have fully implemented the actions arising from the recommendations of the internal investigation.

Recommendation 5: The Trust and NHS Kernow Clinical Commissioning Group must address the knowledge and skills gap present in their safeguarding children leads to ensure that those staff fully understand the Local Safeguarding Children Boards Regulations 2006, in particular the requirements relating to actions following the death of a child who was subject to abuse and how to action these.

Recommendation 6: The Trust and NHS Kernow Clinical Commissioning Group must assess and report on the impact of the revised processes and training programmes in relation to improving child safeguarding practices in adult mental health services.

Recommendation 7: If NHS Kernow CCG has not already done so, the potential missed opportunities for liaison between health practitioners as a consequence of health visitors moving to the employment of the council must be fully assessed and mitigated.

Recommendation 8: The Trust must ensure that staff understand and undertake their responsibilities for reporting safeguarding concerns when a patient reports historic or current abuse.

Recommendation 9: The Trust must provide assurance that there is an effective process for supporting patients who appear to be under duress due to criminal exploitation/cuckooing/county lines, and that these are addressed in care plans.

Recommendation 10: The Trust must conduct an audit of adult mental health staff active engagement in reporting child safeguarding concerns, identifying any areas of concern and implementing appropriate remedial actions where necessary.

Recommendation 11: The Trust must provide assurance that patients who are complex and whose risks are documented as high, are not discharged from Trust services without a clearly documented rationale.

Recommendation 12: NHS Kernow Clinical Commissioning Group must seek assurance from the Trust that improvements have been made to staff awareness and understanding of children's safeguarding issues that has led to a significant improvement in clinical practice.

2 Independent investigation

Incident

2.1 Mr T had been known to mental health services in Cornwall since childhood and had been accepted onto caseload and later discharged on a number of occasions.

2.2 On 26 June 2016 Mr T's four-week-old baby was taken to A&E in Truro and pronounced dead. Mr T and his partner were both arrested and bailed and told not to have any contact with each other.

2.3 Mr T went missing from his bail address and following a Mental Health Act assessment he was detained under Section 2 Mental Health Act on 29 June 2016. Following a period of inpatient treatment in both PICU (provided by Cornwall Partnership NHS Foundation Trust) and the local general hospital (provided by Royal Cornwall Hospitals NHS Trust) for rehydration Mr T was discharged into the community on 19 July 2016.

2.4 On 21 July 2016 Mr T was found unconscious following apparent self-strangulation and died in hospital two days later.

2.5 The inquest for Child B in August 2017 recorded a verdict of unlawful killing. Following Mr T's death there was no further criminal justice investigation into who was responsible for the death of Child B.

Approach to the investigation

2.6 The independent investigation follows the NHS England Serious Incident Framework[3] (March 2015) and Department of Health guidance[4] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

2.7 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring.

[3] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf

[4] Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

2.8 The investigation was carried out by:

- Naomi Ibbs, Senior Consultant for Niche (lead author);
- Dr John McKenna, retired Forensic Consultant Psychiatrist;
- Dr Catherine Powell, Child Safeguarding Consultant.

2.9 The investigation team will be referred to in the first-person plural in the report.

2.10 The report was peer reviewed by Dr Carol Rooney, Deputy Director, Niche.

2.11 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[5] The terms of reference required us to review the care and treatment that Mr T received from Cornwall Partnership NHS Foundation Trust from January 2016.

2.12 NHS England sought authorisation from the Caldicott Guardian for the relevant organisations for Mr T's clinical records held by them to be released.

2.13 We also received Child B's clinical records held by the Trust and Royal Cornwall Hospitals NHS Trust, again NHS England sought authorisation from the relevant Caldicott Guardian for release of these records to us.

2.14 We used information from the following organisations to complete this investigation:

- Cornwall Partnership NHS Foundation Trust;
- Royal Cornwall Hospitals NHS Trust;
- Mr T's GP surgery;
- Cornwall Council;
- NHS Kernow Clinical Commissioning Group.

2.15 As part of our investigation we interviewed:

- Occupational Therapist (Mr T's care coordinator), community mental health team, employed by Cornwall Partnership NHS Foundation Trust;
- Consultant Psychiatrist, Harvest Ward psychiatric intensive care unit, employed by Cornwall Partnership NHS Foundation Trust;

[5] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

- Named Nurse for Safeguarding Children, employed by Cornwall Partnership NHS Foundation Trust;
- Named Doctor for Safeguarding Children, employed by Cornwall Partnership NHS Foundation Trust;
- Lead Investigator, funded by Cornwall Partnership NHS Foundation Trust;
- Executive Safeguarding Lead for NHS Kernow Clinical Commissioning Group;
- Independent Chair, Our Safeguarding Children Partnership for Cornwall and the Isles of Scilly.

2.16 All interviews were digitally recorded, and interviewees were subsequently provided with a transcript of their interview.

2.17 A full list of all documents we referenced is in Appendix B, and an anonymised list of all professionals is in Appendix C.

2.18 We have referred to individuals mentioned in this report as:

- Mr T – subject of the investigation into care and treatment;
- Miss B – partner of Mr T;
- Child A – first born child of Miss B and Mr T;
- Child B – second born child of Miss B and Mr T.

2.19 The draft report was shared with:

- NHS England;
- Cornwall Partnership NHS Foundation Trust;
- Royal Cornwall Hospitals NHS Trust;
- Mr T's GP surgery;
- Cornwall Council;
- NHS Kernow Clinical Commissioning Group.

2.20 This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with families

2.21 We have not had any contact with Mr T's parents or Miss B. NHS England did not receive a response to any correspondence with Mr T's family members. NHS England did not have contact details for Miss B. We have therefore not discussed the investigation nor shared a copy of the report with any of his family.

2.22 We remained committed to doing this prior to publication of the report, should we have access to their contact details, and should they wish to meet with or speak to us.

Structure of the report

2.23 Section 3 provides detail of Mr T's background.

2.24 Section 4 sets out the details of the care and treatment provided to Mr T with detailed information provided at Appendix D. We have provided an anonymised summary of those staff involved in Mr T's care and treatment for ease of reference for the reader. These can be found at Appendix C.

2.25 Section 5 examines the communication the Trust had with affected families after the death of Mr T.

2.26 Section 6 provides a review of the internal investigation and reports on progress made in addressing the organisational and operational matters identified.

2.27 Section 7 provides a review of the progress on the actions identified for NHS organisations from the Learning from Experience Review.

2.28 Section 8 examines the issues arising from the care and treatment provided to Mr T and includes comment and analysis.

2.29 Section 9 sets out our overall conclusions and recommendations.

3 Background of Mr T

3.1 Mr T was born in 1996 with the cord wrapped around his neck following an induced birth. An entry in September 2002 stated that he was a "blue baby"; this obstetric complication is not mentioned in any of the adult mental health records that we have reviewed.

3.2 At the age of 9 years Mr T was diagnosed with dyslexia[6] by a child psychiatrist and there was a suggestion that he had Asperger's syndrome[7] (but he had not in fact been formally diagnosed) and Attention Deficit Hyperactivity Disorder (ADHD).[8] No firm diagnosis of Asperger's syndrome was made and at times later in Mr T's life it was actively ruled out following clinical assessment.

3.3 There was input from children, young people and families services provided by Cornwall Council together with child and adolescent mental health services (CAMHS) support. Mr T had an educational 'statement'[9] and it is reported that he used cannabis and alcohol from aged 12 years. He had also been "expelled" from primary school for aggression.

3.4 Mr T was referred to CAMHS by his GP several times between 2011 and 2015 but his family did not consistently engage with services and he was discharged from the service.

3.5 Mr T reported to clinical staff that as a child he had witnessed domestic abuse at home. He also reported historic childhood sexual abuse by a male and that his relationship with his estranged father had been difficult and unstable.

3.6 Prior to his death Mr T had been living with Miss B for a number of years and together they had two very young children, aged two years and four weeks. The four-week-old baby, Child B, died in hospital from traumatic injuries on 26 June 2016, having been in the care of Mr T, who was arrested on suspicion of causing his death.

[6] Dyslexia is a learning disorder that involves difficulty reading due to problems identifying speech sounds and learning how they relate to letters and words (decoding). Dyslexia affects areas of the brain that process language.

[7] Asperger's Syndrome is a form of autism, which is a lifelong disability that affects how a person makes sense of the world, processes information and relates to other people. https://www.aspie.org.uk/what-is-aspergers-syndrome/

[8] ADHD (Attention Deficit Hyperactivity Disorder) is a mental health disorder that can cause above-normal levels of hyperactive and impulsive behaviours. People with ADHD may also have trouble focussing their attention on a single task or sitting still for long periods of time.

[9] A Statement of Special Educational Needs described the child's needs and the special help that they should receive in school. The current process for assessing and describing children's needs and planning the help they need in school is called an Education, Health and Care Plan.

4 Summary of events

4.1 This section provides a summary of events between January and July 2016.

Referral to the North Cornwall ICMHT

4.2 In January 2016 Mr T's GP referred him to the North Cornwall ICMHT[10] after Mr T presented complaining of anxiety related issues. Mr T was sent an appointment with the consultant psychiatrist on 19 January but did not attend. He instead attended his GP surgery where he reported significant difficulties leaving his home having been kidnapped, assaulted and raped over a sustained period four years previously. Mr T also reported having tied a rope around his neck and attempted to drown himself in the bath.

4.3 Mr T was assessed by the North Cornwall ICMHT two days later. During the assessment he disclosed childhood sexual abuse and repeated his disclosure of kidnap, rape and assault that reportedly took place when he was aged 17 years. The community mental health nurse documented that Mr T's symptoms appeared to be consistent with emotional instability and possible post-traumatic stress disorder. Mr T was asked to consider accessing support services offered by Pentreath[11] and Cornwall Rape and Sexual Abuse Centre (CRASAC)[12]. The community mental health nurse documented that Mr T would benefit from care coordination by a female member of staff in order to form a therapeutic relationship and to explore ways to manage impulsive behaviours. Mr T was later allocated to a different community mental health nurse (CCO1).

4.4 CCO1 saw Mr T on three occasions during February and March, Mr T did not attend a planned appointment on two other occasions.

4.5 On 22 February CCO1 was contacted by a social worker from children's social care (Cornwall Council) who advised that a safeguarding strategy meeting had been planned for the following day because of concerns about domestic abuse. It was documented that three incidents had been reported during the previous 12 months and there had been recent reports from Mr T's neighbours that he and his partner had been arguing. The social worker asked to be informed whether Mr T attended his appointment the following day. We can find no evidence that this occurred when Mr T did not attend this appointment.

4.6 Mr T was discussed in the North Cornwall ICMHT multi-disciplinary team meeting on 8 March when staff documented that he was not on any

[10] Integrated ICMHTs (IICMHTs) are a community based assessment and treatment service for people suffering mental health problems who are over the age of 18. Integrated ICMHTs (IICMHTS) include clinicians from a number of different professional backgrounds. These include mental health nurses, psychologists, psychiatrists and occupational therapists. https://www.cornwallft.nhs.uk/integrated-community-mental-health-teams/

[11] Pentreath is a service for people living with mental health and emotional difficulties. They offer support to help people believe in their own potential and achieve their vocational goals. https://pentreath.co.uk

[12] CRASAC (Cornwall Rape and Sexual Abuse Centre) offered counselling for anyone who is being sexually abused, or who has been sexually abused in the past. It appears that this service is now closed.

medication, did not want to engage with CRASAC and had not attended appointments with his care coordinator and the consultant psychiatrist. However, the multi-disciplinary team agreed to offer Mr T a further appointment with a locum consultant psychiatrist who would be covering the team consultant psychiatrist's absence during April 2016.

4.7 On 13 April Miss B reported to ICMHT staff that she had found Mr T with a cable tied around his neck. She told staff that he had bought cable ties in order to kill himself. ICMHT staff arranged for the home treatment team (HTT) to see Mr T the following day and asked Mr T's GP to prescribe lorazepam. Mr T's GP documented that Mr T was very agitated and that he had prescribed 14 tablets of lorazepam[13] 1mg.

4.8 HTT staff contacted Mr T and spoke to both him and his partner. Mr T told them that he did not want to be alive anymore and that he had felt this way since he had been attacked. Mr T also stated that he wished his partner had not found him. Mr T's partner told HTT staff that she did not feel able to keep him safe because she was eight months pregnant and was also caring for a one-year-old child. The HTT staff therefore agreed that they would liaise with Mr T's GP and deliver some medication to him later that day.

4.9 When HTT staff arrived at Mr T's home, they were unable to engage Mr T in conversation and documented that they had observed ligature marks around his neck.

4.10 A follow up visit the following day was unsuccessful because Mr T and his partner were not at home. When staff contacted Mr T's partner, she reported that he was "really great" that day and that the medication had been very effective. HTT staff therefore advised that his referral would be closed.

4.11 There was no follow up that week from Mr T's care coordinator from the ICMHT because they were absent from work due to sickness.

Move to St Blazey and referral to Caradon integrated community mental health team

4.12 The next contact was by telephone on 25 April when Mr T had not attended for his appointment with the consultant psychiatrist in the North Cornwall ICMHT. Mr T advised that he understood his partner had cancelled the appointment because they had moved from Bodmin to St Blazey.

[13] Lorazepam belongs to a group of medicines called benzodiazepines. It is used to treat anxiety and sleeping problems that are related to anxiety. https://www.nhs.uk/medicines/lorazepam/

4.13 The community mental health nurse advised that she would request a transfer of Mr T's care to the local ICMHT (Caradon). However, a later decision was taken to discharge Mr T following discussion at a multi-disciplinary team meeting.

4.14 The same day (25 April) there were attempts to contact a children's social worker in response to a message they had left, however attempts were unsuccessful and there is no indication that this was followed up.

4.15 On 28 April a Care Programme Approach review meeting took place. The record of this meeting documented that Mr T and his GP were present, but we have found no other evidence to indicate that this was the case. The outcome of the Care Programme Approach meeting was to discharge Mr T from the ICMHT caseload because he had not attended three appointments with the consultant psychiatrist.

4.16 In May there were attempts by the children's social worker to engage the perinatal mental health team in Mr T's care, but this was not possible because the team were only commissioned to work with mothers with mental health problems.

4.17 Mr T was seen by the Caradon ICMHT on 18 May for initial assessment following referral from his GP in St Blazey. Discussion at a multi-disciplinary team meeting on 24 May resulted in him being allocated to a care coordinator (CCO2) to assess whether he could engage in treatment.

4.18 CCO2 arranged a Care Programme Approach review meeting on 27 May at which she asked a community mental health nurse colleague (ICMHT8) to accompany her. CCO2 documented that Mr T "struggled to engage" but reported that he still had suicidal ideation. Staff also documented that Mr T's second child had just been born and that both of his children were subject to child protection plans. The plan was to continue to assess Mr T jointly and a further appointment was arranged for 2 June. This appointment did not take place due to one member of staff being involved in a road traffic collision.

4.19 On 7 June a children's social worker (we believe from Cornwall Council) contacted the ICMHT to advise that a Review Child Protection Conference[14] was planned for 21 June. This contact was followed up the following day when the children's social worker gave an update on his concerns regarding Mr T's mental health and the impact of this on his children. It was agreed that CCO2 would attend the conference.

[14] The purpose of a Review Child Protection Conference is to look at how the child protection plan is working to promote and protect the child's welfare. This will include looking at how the parent/s are working with the professionals, how well they are following the child protection plan, whether or not the child is still considered to be at risk and how well you the parent/s care for, and protect, him/her. All professionals invited to the review conference should produce a report explaining their view about any improvements or any further concerns (if any) about the child's situation. https://www.frg.org.uk/child-protection-review-conferences-outcomes

4.20 ICMHT8 made an unannounced home visit on 9 June to attempt to assess Mr T's risk and documented that he appeared a little more engaging than on her previous visit.

4.21 A further visit was arranged for 17 June which was attended by Mr T and his partner, CCO2, and ICMHT8. Whilst these staff were at Mr T's home, two children's social care workers also arrived. Mr T's partner complained that they were unable to get on with their day due to the large number of professionals visiting them. ICMHT staff documented that Mr T did not engage but that his partner reported that his mood was slightly improved.

4.22 A Review Child Protection Conference was held on 21 June which was attended by CCO2 on behalf of the Trust. The Trust records relating to the meeting documented that both children were to remain on child protection plans, but positive steps taken by Mr T and his partner meant that there were fewer concerns about the children's welfare. The protection plan was amended to include a requirement for Mr T to engage with the community mental health team.

Death of Child B

4.23 On 26 June 2016 Child B was taken to A&E at the Royal Cornwall Hospital, Treliske, Truro and died later that day. Mr T and his partner were both arrested.

4.24 Mr T was assessed by the Trust criminal justice liaison and diversion team whilst in custody. Mr T denied any risks to himself and refused consent for information to be shared with other services, however he was informed that the criminal justice liaison and diversion team worker would liaise with his care coordinator.

4.25 Mr T was interviewed in the presence of an Appropriate Adult[15] and was bailed on 27 June 2016. On release from police custody the Appropriate Adult sought to understand whether Mr T needed any support the following morning to arrange accommodation for the following day. Mr T stated he did not.

4.26 Mr T went missing from his bail address overnight and was eventually located by police later on 28 June. Following a Mental Health Act assessment, he was detained on Section 2 Mental Health Act on 29 June 2016 and admitted to a psychiatric intensive care unit in Bodmin for assessment of low mood and suicidality.

[15] The role of the appropriate adult is to safeguard the interests, rights, entitlements and welfare of children and vulnerable people who are suspected of a criminal offence, by ensuring that they are treated in a fair and just manner and are able to participate effectively. https://appropriateadult.org.uk/information/what-is-an-appropriate-adult

4.27 Mr T presented as extremely anxious and distressed and declined nearly all food and fluids for two weeks. During that time staff monitored his physical health and on 12 July a consultant psychiatrist assessed Mr T as having "lost capacity to inform decisions on his treatment". Arrangements were made the following day to transfer Mr T to the Royal Cornwall Hospital (a general hospital) for refeeding.

Transfer to general hospital

4.28 Mr T was transferred from the PICU to the medical admissions unit at the Royal Cornwall Hospital (a general hospital). Shortly after admission ward staff reported that Mr T was accepting treatment and was eating and drinking. Ward staff also reported that Mr T told them he had been on hunger strike but had realised he was "wasting people's time".

4.29 Whilst on the medical admissions unit Mr T's behaviour became disturbed in a way that PICU staff had not observed earlier in his hospital admission. Mr T ripped out his cannula, attempted to secrete sharp items, attempted to leave the hospital site and was hostile towards staff supporting him.

4.30 He was transferred back to the PICU on 15 July after medical staff at the Royal Cornwall Hospital assessed him as being fit for discharge.

Transfer back to psychiatric intensive care unit

4.31 Mr T's disturbed behaviour continued after transfer back to the PICU and he declined the nutritional support advised following the recent assessment at the Royal Cornwall Hospital.

4.32 A multi-disciplinary team meeting was held in the PICU on 18 July. Records from the meeting show that staff believed that he had been admitted to the PICU because of his child's death and the subsequent police investigation. Staff documented that Mr T did not present as clinically depressed, confused or psychotic and that no evidence of mental disorder had been identified during his admission. The plan was to discharge him the following day unless evidence came to light in the interim that suggested the presence of a mental disorder.

4.33 A pre-discharge review meeting was held on 19 July to which a police detective sergeant was invited. The meeting heard that there were no legal grounds on which to continue to detain Mr T on Section 2 Mental Health Act, Mr T would therefore be discharged from hospital. The Trust records of the meeting indicated that the police officer present advised that Mr T would then be arrested and released again. PICU staff documented that Mr T's bail conditions could be amended to allow him more access to his family who would be able to provide emotional support which would make him less vulnerable. We have not seen any records kept by the detective sergeant who attended the meeting and we acknowledge that the Trust had, possibly mistakenly, relied upon the belief that the conditions would (rather than could) be altered.

4.34 Mr T was discharged from the PICU at 5:00pm on 19 July and was advised that a single follow up appointment would be offered within seven days by the ICMHT (as required following discharge from hospital). An appointment had not been arranged at the time of Mr T's discharge from hospital, however, after this appointment the plan was for Mr T to be discharged from mental health services.

4.35 On 21 July 2016 Mr T was found unconscious following self-strangulation. He was taken to the intensive care unit at the general hospital where he died two days later.

5 Duty of Candour

5.1 We have reviewed the Trust's recording of its actions under the Care Quality Commission Regulation 20: Duty of Candour. Regulation 20 was introduced in April 2015 and is also a contractual requirement in the NHS Standard Contract. In interpreting the regulation on the duty of candour, the Care Quality Commission uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- **"Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it."

5.2 To meet the requirements of Regulation 20, a registered provider has to:

- "Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person."

5.3 We have carefully considered whether Duty of Candour applied in this case and have concluded that it did, on two bases:

- because Mr T was an active user of services at the time of the death of his son;

- when he took his own life.

5.4 The regulations are clear that the "relevant person" to whom Duty of Candour applies means the service user, or on the death of the service user, a person acting lawfully on their behalf.

5.5 In Mr T's case persons acting on his behalf could have been his mother, his father, or his partner who was also the mother of his children.

Contact with Mr T's family

5.6 The Trust has not provided evidence of any contact with Mr T's parents or Miss B.

5.7 We asked the lead investigator of the internal investigation about how Duty of Candour responsibilities were fulfilled. She told us that she had asked the Trust governance team how Duty of Candour was being managed. Following some email communication between the governance team and the lead investigator it was decided that because Mr T refused consent to share information on 27 June 2016 the Trust would respect that decision and not contact his family.

5.8 It is our opinion that this decision was flawed on the basis that Mr T's refusal to consent for information to be shared was documented specifically as "other services" not family members. In addition, there had already been an inconsistency in the approach the Trust took to the issue of Mr T's consent:

- Mr T withheld consent to share information with other services during his assessment in custody on 27 June 2016, at the time that was upheld;

- PICU staff later shared a significant amount of clinical information about Mr T with other services (most notably the police) but no change to Mr T's consent was documented, therefore the withholding of consent to share information with other services dated 27 June still applied.

5.9 In addition, consent is not required for an organisation to say sorry for the death of a patient or apply the Duty of Candour.

5.10 The Trust policy in place at the time, Being Open and Duty of Candour Policy, clearly states that Duty of Candour "WILL apply" when the incident involves at least moderate harm. There is no discussion about a refusal to consent to share information prior to death overriding the statutory responsibility that rests with the Trust.

Recommendation 1: The Trust must clarify the action that they expect staff to take when there is a question about whether to execute Duty of Candour.

6 Internal investigation

6.1 The terms of reference for this independent investigation require us to review the internal investigation, in particular the adequacy of its findings, recommendations and implementation of the action plan and identify:

- if the investigations satisfied their 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.

6.2 We are also required to:

- review progress made against the action plans;
- review processes in place to embed any lessons learnt and any evidence to support positive changes in practice;
- review the clinical commissioning groups oversight of the resulting action plan.

6.3 We have developed a robust framework for assessing the quality of investigations based on international best practice. There are 24 standards based on credibility, thoroughness and impact. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency,[16] NHS England Serious Incident Framework (SIF) and the National Quality Board Guidance on Learning from Deaths.[17] We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

6.4 In developing our framework we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA[2] (or Root Cause Analysis and Action, hence 'RCA Squared')[18] which discusses how to get the best out of root cause analysis investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

[16] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

[17] National Quality Board: National Guidance on Learning from Deaths. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

[18] National Patient Safety Foundation (2016) - RCA2- Improving Root Cause Analyses and Actions to Prevent Harm –published by Institute of Healthcare Improvement, USA.

6.5 The warning signs of an ineffective RCA investigation include:

- There are no contributing factors identified, or the contributing factors lack supporting data or information.
- One or more individuals are identified as causing the event; causal factors point to human error or blame.
- No stronger or intermediate strength actions are identified.
- Causal statements do not comply with the 'Five Rules of Causation'.[19]
- No corrective actions are identified, or the corrective actions do not appear to address the system vulnerabilities identified by the contributing factors.
- Action follow-up is assigned to a group or committee and not to an individual.
- Actions do not have completion dates or meaningful process and outcome measures.
- The event review took longer than 45 days to complete

6.6 We also considered proposals for the new NHS Improvement Patient Safety Incident Response Framework on how to improve learning from investigations which has identified five key problems with the current application of the process:

- defensive culture/lack of trust e.g. lack of patient/staff involvement;
- inappropriate use of serious incident process e.g. doing too many, overly superficial investigations;
- misaligned oversight/assurance process e.g. too much focus on process related statistics rather than quality;
- lack of time/expertise e.g. clinicians with little training in investigations trying to do them in spare time;
- inconsistent use of evidence-based investigation methodology e.g. too much focus on fact finding, but not enough on analysing why it happened.

[19] Marx, D. Patient safety and the "just culture": a primer for health care executives. New York: Columbia University Press, 2001.

6.7 Our detailed review of the internal report is at Appendix D. In summary we have assessed the 24 standards as follows:

- Standards met: 9.
- Standards partially met: 3.
- Standards not met: 12.

6.8 We discuss our analysis below.

Analysis of Trust internal investigation

6.9 There were two points at which the Trust might have commissioned an internal investigation:

- upon notification of the death of Child B and Mr T's subsequent arrest in connection with that death on 27 June 2016;
- upon notification of the death of Mr T on 23 July 2016.

6.10 We can see that an initial incident report was completed following notification that Mr T had been arrested in connection with his son's death. However, it was not clear to us why the Trust had not commissioned an internal investigation at that time. The Trust was involved in the care and treatment of both Mr T (mental health services) and his child (health visiting services).

6.11 We sought to understand this at interview and the lead investigator told us that she had been advised that the Trust would not be responsible for conducting a serious incident investigation into the death of Mr T's child because he had died whilst under the care of the local general hospital.

6.12 There was further email communication on 6 July 2016 to state that the clinical commissioning group had advised that the Trust should "not commence the serious incident process" but to gather information because the incident was being considered for a Serious Case Review.

6.13 An email from the Named Nurse for Safeguarding Children for the Trust (no longer in post) dated 19 August advised that following discussion at the Serious Case Review panel it had been decided that the death of Mr T's son did not meet the criteria for a Serious Case Review.

6.14 The Trust did commission an investigation into Mr T's care and treatment after his death on 23 July 2016. This was led by an independent investigator appointed by the Trust, with clinical advice from a consultant psychiatrist working in another part of the Trust.

6.15 The Trust's policy on engaging families affected by homicide and serious incidents is described in their Serious Incidents Policy. The version in use at the time of Child B's death states that where a patient has died their family/carer must be similarly cared for and involved, and that consideration

must be given to their needs first. This provided a framework for the Trust to have involved Mr T's wider family in the investigation following his death, but does not reference how the Trust should involve relatives of Child B, following their death. The current policy makes no reference to this either.

6.16 NHS England (London) Investigation issued guidance in April 2019 on engaging with families after a mental health homicide[20]. This provides clear best practice guidance to mental health provider organisations and states that "families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation". The Trust should review this publication and ensure that its own policy reflects the best practice referenced.

Recommendation 2: The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide.

Adequacy of findings and recommendations

6.17 The report identified a number of care and service delivery problems:

- Limited mental health assessment whilst in custody on 27 June 2016, due to the client not fully engaging with the process. No forensic medical examination was felt to be needed. A Mental Health Act assessment was not deemed appropriate at that time.

- Limited sharing of information on the client's mental health history with the police. Only basic risk information was disclosed as the client was unable to engage fully in the process and declined sharing information. As a result, it was not clear how information was taken into account by the police when bail conditions were arranged.

- Client was bailed by the police then went missing on 27 June 2016. The client was bailed as he had not been charged. It was unclear if police were fully cognisant of the client's additional vulnerability from lack of family support, of being taken to an unfamiliar geographical location, with the means but not the ability to contact mental health support services or housing. Caradon ICMHT were unable to contact him as he had no phone and the police initially refused to tell Trust staff where Mr T had been bailed.

- No usual family support on 27 June 2016 due to very strict bail conditions.

[20] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/08/Information-for-Mental-Health-Providers_V4.0.pdf

- Nearest Relative was not advised of the client's detention under Section 2 [Mental Health Act].

6.18 No root cause was identified but contributory factors were identified as patient factors. Mr T was:

"…an individual without any detectable severe or enduring mental health illness (after ICMHT assessments and a recent period of psychiatric admission for assessment); a possible historic diagnosis of ASD/ADHD but no obvious manifestation of these in interactions with various mental health professionals as an adult; a troubled childhood history, with a limited family engagement with CAMHs, a history of drug and alcohol abuse; and sexual assault aged 17; two significant self-harm attempts in 2016 and intermittent suicidal ideation since, but no disclosed plans; lack of engagement with mental health teams; reliance on his long term partner and mother with no personal resources to manage without their support when contact was prohibited by bail conditions."

6.19 Two recommendations were made:

R1 The Trust to discuss the findings of the investigation with the police lead, around information sharing in such high-risk cases, the decision not to ease the bail conditions, and public protection versus support of alleged perpetrators.

R2 Discussions with relevant staff to take place around the decision not to contact the Nearest Relative and action implemented if indicated.

6.20 There were no recommendations relating to the following care and service delivery problem:

- Information sharing – in relation to inconsistent decision making about whether to uphold or override Mr T's lack of consent to share information with other agencies.

6.21 The internal investigation report made reference to Mr T "lacking insight", "hostile blanking" and his behaviour "being unattributable to his prior diagnoses". None of these comments appear in Mr T's contemporaneous records and therefore at interview we sought to understand how these assessments of Mr T's presentation arose. We were advised that these were descriptive terms used by PICU staff who were interviewed by the internal investigation team. These accounts involved clinical interpretations of Mr T's presentation that were not made contemporaneously, but which were reported by staff interviewed after the event.

6.22 The language used by staff to describe Mr T's behaviour to the internal investigation team was pejorative and provided different descriptors (stubborn, rude etc) that were rarely or not at all present in his notes.

6.23 We suggest that where information is included in internal reports that comes from reports made after the incident, the report author clearly indicates that

the information has been subsequently reported by staff. This is important because:

- the report reader might otherwise mistakenly assume that what is reported is contemporaneous, rather than post-event and hence potentially influenced by hindsight;
- if staff thought it was important or significant enough to mention later, it is important to question why they did not think it was important enough to record at the time.

Clinical commissioning group sign off

6.24 The administrative process for managing the submission, quality assurance and closure of a serious incident investigation report is set out in the NHS Kernow Clinical Commissioning Group policy for managing serious incidents. That policy includes a detailed procedure for reviewing the quality of the reports submitted using the template set out in the NHS England Serious Incident Framework.

6.25 The clinical commissioning group completed a quality review of the Trust investigation into Mr T's care and treatment on 2 May 2017. The review highlighted no concerns regarding the report, a view that we do not share and that we have discussed earlier in this section. However, the review highlighted concerns that there was no evidence that the actions identified in the action plan had been completed.

6.26 The use of the quality assurance checklist is good practice. This provides a clear audit trail of the clinical commissioning group oversight of the report and any feedback to the relevant organisation.

6.27 However, its conclusions reflect significant weaknesses in practice and a lack of knowledge of national guidance from key NHS safeguarding leads in the clinical commissioning group. All child deaths are subject to Child Death Overview Processes, in accordance with statutory guidance. The Social Care Institute for Excellent (SCIE) model was used in the Learning from Experience review that was commissioned instead of a Serious Case Review. The Child Death Overview Processes and Learning from Experience Review are two separate processes.

6.28 Named and Designated Safeguarding colleagues, and the Safeguarding Executive Lead should have been aware that the death of this child should have been subject to a Serious Case Review, and those who were at the Panel should have challenged any decision to do otherwise. More detail on the criteria for commissioning a Serious Case Review is provided in Section 7.

6.29 We discussed the point at which families see the internal investigation report. The clinical commissioning group expectation was that this would happen prior to the report being submitted by the Trust for approval. However, the Trust told us that they do not share serious incident reports with families until after the clinical commissioning group had accepted the final report. This left

us with significant concern about how families' views are taken into account. In particular for this investigation, it appears that neither Mr T's family nor Miss B had ever had sight of the report.

Recommendation 3: The Trust and the clinical commissioning group must ensure that families are offered appropriate involvement in serious incident investigations and that they are always offered a copy of the investigation report.

6.30 The Trust process for quality assuring serious incident reports is managed through the Executive Clinical Risk Group. This is meeting held every two weeks that includes the medical director, director of nursing, and service line managers. This group receives the draft report and presentation from the lead author. The group may ask for further changes to be made to the report or simply approve it.

6.31 We have seen no evidence that the Trust has sought to provide assurance that the recommendations have been implemented effectively and we discuss this further in 'Implementation of action plan' below.

6.32 NHS Kernow Clinical Commissioning Group submitted an incident deletion request to NHS England on 28 September 2016 in relation to the incident report raised by the in relation to the death of Child B.

6.33 The incident deletion process is not referenced in the NHS England Serious Incident Framework nor in the NHS Kernow Clinical Commissioning Group Serious Incident Policy. However, the incident deletion checklist asks for a rationale for why the serious incident event originally reported does not meet the criteria for a serious incident. The response provided stated:

"In light of [the Local Safeguarding Children Board] decision that the incident did not occur due to a lack of care or communication between professionals and that there is also here is [sic] a police investigation and Child death overview process which seems more appropriate.

The child death overview process has commenced, and they are using the SCIE model which requires establishing two groups one consisting [of] frontline practitioner and another of managers, the [clinical commissioning group] has been asked [to] and agreed to support this process. A community paediatrician who is also the Designated Doctor for Children's Safeguarding and Designated Nurse for child protection will be overseeing the process. The [terms of reference] will address from [the] time of mothers booking to date of the incident.

[The Trust] is also undertaking a homicide review on the father…"

6.34 The consequence of this deletion was that the death of Child B was no longer considered a serious incident requiring investigation in accordance with NHS policy. In addition, the Trust never undertook a review into Mr T's care and treatment in relation to the death of Child B.

6.35 It is our opinion that the death of Child B remained a matter for investigation by NHS organisations, in that it met the criteria for a mental health homicide.

Implementation of action plan

6.36 As we stated above, the Trust developed an action plan that detailed two recommendations and associated actions. The action plan we have reviewed was marked as having been updated on 19 October 2016. However, this date is clearly incorrect because the evidence provided indicating the actions were completed included a report dated 1 February 2017 referring to action points regarding the Nearest Relative and information sharing.

Implementation of recommendation 1

6.37 Two documents were provided as evidence this recommendation was complete: the report referred to in the paragraph above and an agreement between "Devon and Cornwall Police Force and NHS". The agreement is undated and unsigned.

6.38 It is not clear whether the agreement has been implemented, and if it has for how long. The agreement described robust monitoring and review arrangements as being "crucial to the success of the agreement".

6.39 We have not been provided with any feedback in relation to the monitoring and review of the agreement.

6.40 In addition to the agreement, we received a document that appeared to have been prepared for the inquest. The relevant section is headed information sharing. This section provides a narrative of information held in the police records as well as reiterating information contained within the Trust serious incident report. It does not appear to us that findings discussed would have made any difference to the way information was shared in Mr T's case. The section does reference the fact that the Criminal Justice and Health Liaison group in Cornwall and across the south west peninsula will continue to provide a forum for the review and improvement of information sharing arrangements.

6.41 We have seen insufficient evidence to provide us with assurance that the learning in relation to information sharing has been disseminated and embedded across the organisation.

6.42 In order for us to fully assess this recommendation we would need to have been provided with:

- confirmation of the date the agreement was signed and adopted;
- confirmation of the date the agreement was implemented;
- monitoring and review data.

Implementation of recommendation 2

6.43 During the organisation's serious incident investigation, it was identified that the nearest relative had not been contacted as per statutory requirement under Section 11 of the Mental Health Act. The investigation identified that the AMHP was aware of their responsibility to inform or consult the nearest relative but felt constrained by the bail conditions and did not have a clear understanding of the scope of those bail conditions. The Trust asserted this has been appropriately addressed through the organisation's action plan and the professional supervision process.

6.44 The evidence provided by the Trust regarding implementation of this recommendation was a document that appeared to have been prepared for an inquest (it was not clear whether this was for Mr T's or Child B's inquest). The relevant section is headed Nearest Relative.

6.45 The author of that document had met with a Chief Inspector to review the details of Mr T's bail conditions and the AMHP report. The author states that they had clarified that the elements of the bail conditions "do not and need not inhibit or prohibit" the AMHP from attempting to contact Mr T's Nearest Relative, but that there "should be no suggestion that the AMHP acted other than sensitively and entirely in good faith". The suggested action in future is for the AMHP to obtain clearance from the custody sergeant managing the bail arrangements. The actions described in relation to this recommendation appear to have focussed on discussions with the police.

6.46 CFT Mental Health Act office had a clear process in place to scrutinise applications, this included contacting the AMHP (via email) to ask what action has or is to be taken to address the issue of lack of the safeguard of the nearest relative involvement. The Mental Health Act office is not accountable for the decision made by the AMHP but takes appropriate action to try to protect patient's rights.

6.47 The Trust employed a Mental Health Liaison Officer who commenced in November 2020, this role actively supports the development of communication pathways between Devon and Cornwall Police and the Trust including the ability to clarify the scope of bail conditions where required.

6.48 Notwithstanding all the above information, we have not seen any evidence that the Trust has shared the learning that was identified or tested the effectiveness of the suggestions. We understand that the clinical commissioning group does undertake multi-agency audits that feed into the monthly contract review meetings. These are conducted where there are areas of concern that have been identified. We have not seen any evidence of clinical commissioning group led multi-agency audits covering this area of concern.

Recommendation 4: The Trust must provide robust assurance that they have fully implemented the actions arising from the recommendations of the internal investigation.

7 Progress on actions identified by the Learning from Experience Review

7.1 The Safeguarding Children Board for Cornwall and the Isles of Scilly is known as Our Safeguarding Children Partnership for Cornwall and the Isles of Scilly.

7.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of Local Safeguarding Children Boards. This includes the requirement for Local Safeguarding Children Boards to undertake reviews of serious cases in specified circumstances.

7.3 Regulation 5(1)(e) and (2) set out a Local Safeguarding Children Boards' function in relation to serious case reviews, namely:

5(1)(e) undertaking of reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraphs 1(e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either – (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

7.4 The Serious Case Review panel met on 3 August 2016 to discuss the case. Agencies present for the panel meeting included Kernow Clinical Commissioning Group and the Trust.

7.5 The conclusion from the panel meeting was that there was no evidence that agencies had not been working closely together and therefore the case did not meet the criteria for a Serious Case Review. It was agreed to arrange a Learning from Experience workshop focussing on parental disguised compliance and how agencies understand and identify this. The conclusions and recommendations from the panel meeting were forwarded to the Independent Chair.

7.6 The Independent Chair told us that initially he questioned the fact that a Serious Case Review had not been recommended, particularly because Mr T's child had been on a child protection plan at the time of the child's death. The Independent Chair's concern was that domestic abuse between the parents could potentially have spilled over and "inadvertently caused physical harm to the child". However, he received a response saying that there were no fears regarding the child's physical safety.

7.7 On 13 September 2016 the Independent Chair did agree with the decision that the criteria for a Serious Case Review had not been met. However, at interview he told us that in retrospect he believes that there should have been a Serious Case Review and that he thinks he was not provided with a complete picture at the time.

7.8 In our view the Chair is right to assert that this case should have been subject to a Serious Case Review. The decision to commission a Learning from Experience Review, rather than a Serious Case Review may reflect a misinterpretation of the criteria, but also misguided optimism and assurance about the quality of multi-agency working. The criteria for commissioning a Serious Case Review were met, because Mr T's four-week-old baby died as a result of unexplained traumatic injuries.

7.9 It is not within the remit of our terms of reference to make recommendations for Our Children's Safeguarding Partnership. However, given our findings here we suggest that this report is brought to the attention of the Our Children's Safeguarding Partnership to consider whether the criteria are being consistently applied in the decision-making process about Serious Case Reviews.

7.10 There are other examples, nationally, of the criteria for commissioning a Serious Case Review being misinterpreted or misunderstood.[21] Nevertheless, the senior child safeguarding leads representing the NHS bodies involved in the commissioning and provision of healthcare to Mr T and his family, who were at the panel meeting should have advocated for a serious case review.

7.11 We found continuing evidence of misunderstandings during the interviews; which has led to a recommendation that this knowledge gap is addressed.

Recommendation 5: The Trust and NHS Kernow Clinical Commissioning Group must address the knowledge and skills gap present in their safeguarding children leads to ensure that those staff fully understand the Local Safeguarding Children Boards Regulations 2006, in particular the requirements relating to actions following the death of a child who was subject to abuse.

7.12 The Learning from Experience workshop identified a number of actions for health organisations specifically in relation to working with parents with mental health or development difficulties. We have considered those actions where NHS organisations were identified as the action lead and set out the actions with the agencies' comments in Table 1 below.

Table 1: Learning from Experience actions specifically for health organisations

Action	Comments from agencies involved
1. Health providers to review how they ensure adult mental health staff consider the wider family, including	Meetings between OSCP (Our Safeguarding Children Partnership) and Trust on 17 April 2018. The Trust has trained champions within adult mental health who have enhanced levels of

[21] Department for Education (2016) Third Report of the national panel of independent experts on Serious Case Reviews London: DfE.

Action	Comments from agencies involved
children, as part of its full assessment of need. (Challenge 18 and Challenge 20)	knowledge and will support their colleagues regarding child safeguarding advice and support. Training will be provided to all staff. The Named Nurse has made herself available to adult mental health staff. Staff are being trained to routinely enquire if any children are connected with their service user and consider child safeguarding concerns. Processes are being developed to make sure the questions about connection to children is prompted through the routine questions asked. The Trust is completing further checks when it is notified of initial child protection conferences to establish if children coming to notice are connected with service users of adult mental health services.
2. To provide staff seeking to work with adult mental health services advice and guidance regarding best practice in relation to engagement, access to information and joint working. 3. (Challenge 18)	Input provided during the Learning the Lessons event on 20 February 2018. This is being covered by training provided by the new training provider.

7.13 We understand that the action plan has been monitored by Our Safeguarding Children Partnership and that the clinical commissioning group's responsibility is to ensure that the actions identified for NHS providers became part of routine reporting.

7.14 We also understand that processes have been implemented in part, but we have not seen evidence of any impact assessments. We would expect to see an assessment of the effectiveness of the revised processes and training when they are fully implemented.

Recommendation 6: The Trust and NHS Kernow Clinical Commissioning Group must assess and report on the impact of the revised processes and training programmes in relation to improving child safeguarding practices in adult mental health services.

7.15 Additionally, the Chair of Our Safeguarding Children Partnership has advised that a scrutiny panel held on 10 June 2019 reviewed the progress being made by the Trust. The Chair has told us that he raised further concerns about staff not routinely checking if a patient had responsibility for a child. He recommended that a case audit be completed into the effectiveness of child safeguarding within adult mental health services but as of June 2020 this had not been completed. We have not made a specific recommendation in

relation to this matter as we consider that our existing recommendations address the issue.

7.16 At the time health visitors and school nurses were employed by the Trust, however since the time of this incident they have moved to being employed by Cornwall Council. We heard from the Named Nurse for Safeguarding for the Trust that there were some concerns that a consequence of this move was that it would create missed opportunities for liaison between health practitioners. We discussed this concern with the Executive Lead for Safeguarding for NHS Kernow Clinical Commissioning Group who agreed that there was potential for these missed opportunities to arise, unless they were explicitly mitigated.

7.17 If the clinical commissioning group has not already done so, we suggest that the potential missed opportunities for liaison between health practitioners as a consequence of health visitors moving to the employment of the council is fully assessed and mitigated.

Recommendation 7: If NHS Kernow CCG has not already done so, the potential missed opportunities for liaison between health practitioners as a consequence of health visitors moving to the employment of the council must be fully assessed and mitigated.

8 Discussion and analysis of Mr T's care and treatment

8.1 Review of Mr T's records from childhood indicate that his birth was induced because of obstetric distress. Mr T was subsequently born with the cord around his neck, he was blue and spent two days in an incubator. It is our opinion that this is noteworthy because it is possible that such complications may have relevance in formulating an individual's mental health presentation in adulthood. In addition, Mr T's negative experiences at school could have impacted on his mental state in adulthood.

8.2 These facts were available to adult mental health staff, but they would have needed to have researched Mr T's historic records to have obtained the information.

8.3 We have seen no evidence that this information was included in a summary of Mr T's history that was either handed over from the child and adolescent mental health service or formed part of any initial historic information gathering by adult mental health services.

8.4 These facts were not highlighted by the internal investigation team because the terms of reference indicated a start date of February 2011.

Vulnerable adult status

8.5 The 21 January 2016 is the first entry of Mr T having reported being kidnapped, raped, beaten and drugged at the age of 17 years. It was alleged that these assaults were linked to drug debts, but this was not explored by staff. Staff did document that Mr T had not reported the offence to the police for fear of the consequences. Mr T reported nightmares, flashbacks and being socially avoidant since the incident. He also reported low mood and alopecia.[22]

8.6 There is no evidence that staff showed professional curiosity about the experiences that Mr T reported. In addition, there is no evidence that staff considered Mr T as a vulnerable adult at this time, nor that the potential safety of his child and unborn child were considered by mental health staff. Mr T was still legally a child when the alleged prolonged assault happened. Failure to address his disclosures may have placed others in the community at risk.

8.7 On 16 February 2016 Mr T further reported that one of the individuals involved in his kidnap and associated offences was storing belongings in Mr T's shed. Mr T also reported that he was too afraid to tell him to move the items because of the connection to the earlier incident. This disclosure had relevance to safeguarding risks relating both to Mr T and to his children.

[22] Alopecia is the general medical term for hair loss. https://www.nhs.uk/conditions/hair-loss/

8.8 There has been increasing concern in recent years about 'county lines'[23] in relation to vulnerable young people. Dealers will frequently target children and young adults, often with mental health or addiction problems, to act as drug runners or move cash so they can stay under the radar of law enforcement.

8.9 There remained no evidence that staff either considered Mr T as a vulnerable adult or the potential risks to his child and unborn child.

8.10 The Trust safeguarding policies (relating to both adults and children) in place at the time clearly state that it is the role of all Trust staff to recognise abuse and report any concerns to the relevant Trust safeguarding team.

8.11 The Trust Safeguarding Adult Policy in place at the time identified the categories of abuse, at least two of which apply to the disclosure made by Mr T to staff:

- Physical: assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions

- Sexual: including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting to.

- Psychological: including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal if services or supportive networks.

8.12 It is of course of note that the offences that Mr T disclosed as an adult occurred when he was still under the age of 18 years.

8.13 The policy clearly states that staff should report the concerns using an identified process that is separate from the clinical record system and then a note placed in the clinical record system that safeguarding concerns have been raised.

8.14 We asked staff whether they considered making an adult safeguarding referral at the various points that Mr T disclosed the information to them. Nobody could recall a multi-disciplinary team discussion about raising a safeguarding alert.

[23] County Lines is where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs. The 'County Line' is the mobile phone line used to take the orders of drugs. Importing areas (areas where the drugs are taken to) are reporting increased levels of violence and weapons-related crimes as a result of this trend. https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/drug-trafficking/county-lines

Recommendation 8: The Trust must ensure that staff are clear about their responsibilities for reporting safeguarding concerns when a patient reports historic or current abuse.

Recommendation 9: The Trust must provide assurance that there is a strategy for supporting patients who appear to be under duress due to criminal exploitation/cuckooing/county lines, and that these are addressed in care plans.

8.15 PICU staff were aware of Mr T's experiences and this did prompt them to consider whether the experiences could have precipitated post-traumatic stress disorder. We were told that it was clear Mr T was hugely upset by his experiences, much of his accounts of his difficulties were related to those experiences, but staff did not see clear evidence of post-traumatic stress disorder.

Communication abilities

8.16 Mr T is varyingly described as:

- "not very communicative" – Trust internal investigation report;
- "not fully engaging" – criminal justice liaison and diversion team;
- "struggling to communicate" – care coordinator.

8.17 Staff described Mr T as difficult to assess because of these communication difficulties. These difficulties also prompted the allocation of an Appropriate Adult to accompany Mr T during interview with the police following the death of Child B.

8.18 There is evidence that Miss B did much of the communication on Mr T's behalf during appointments with clinical staff and liaising with Mr T's community mental health team.

8.19 However, we found little evidence that staff considered how these difficulties impacted on Mr T's ability to engage in assessments. ICMHT staff did engage with Miss B to get a better understanding of his presentation, but criminal justice liaison and diversion team staff and staff in the PICU did not.

8.20 We did find evidence that PICU staff liaised with the manager of the Caradon ICMHT to get information about how best to support and manage Mr T. However, this team had not had much engagement with him at this point: it was June 2016 and Mr T had only been referred to the Caradon ICMHT in May 2016.

Liaison with children's social care

8.21 The child social worker working with Mr T and Miss B as parents to Child A and unborn Child B informed staff in the North Cornwall ICMHT that a strategy meeting had been planned for 23 February because of concerns of domestic abuse. The information was shared the day before the strategy meeting and there is no indication in the records that ICMHT staff were expected to attend.

8.22 However, the child social worker made a specific request to be informed about whether Mr T attended his planned appointment with the consultant psychiatrist (CP1) and his care coordinator (CCO1) the following day. Mr T did not attend and when staff spoke to Miss B she advised that they were not at home and they believed the appointment was the following day (24 February).

8.23 There is no evidence that the social worker was informed of the outcome of this planned meeting. This is particularly concerning given that Mr T did not attend.

8.24 We can see evidence of some attempts by Trust staff to contact children's social care, but attempts were inconsistent and sometimes not followed up.

8.25 In May 2016 the children's social worker attempted to engage the perinatal mental health team in Mr T's care, but was told that this was not possible because the perinatal mental health team were only commissioned to work with mothers with mental health problems. We found this entry in Mr T's Trust records, made by perinatal mental health team staff. We have not seen any evidence that the unusual request was picked up by any of the staff working with Mr T at the time.

8.26 At this time there would have been both a midwife and a health visitor involved with the family. These staff could have been contacted by the children's social worker or by ICMHT staff after they had read the entry by the perinatal mental health team. ICMHT staff should also have actively involved in the children's protection plans as part of a 'think family' approach.

8.27 The "Think Family" agenda promotes the importance of a whole-family approach when working with parents with a mental health problem. We can see that the Trust Care Programme Approach policy references the Triangle of Care[24] but only in relation to considering the support needs for the patient's carer. There is no reference to considering a whole family approach when describing the risks and support requirements for the patient. There have been some structural and process changes and the development of an integrated safeguarding service. However we have not seen any evidence of the effectiveness of those changes.

[24] The 'Triangle of Care' is a working collaboration, or "therapeutic alliance" between the service user, professional and carer that promotes safety, supports recovery and sustains well-being. The Triangle of Care was initially developed to improve mental health acute services by adopting six principles.

8.28 We are aware that there has been an increase in awareness of child safeguarding issues amongst Trust staff working in adult mental health services. However, the evidence we have seen for this investigation does not allow us to assess the effectiveness of this awareness campaign.

Recommendation 10: The Trust must conduct an audit of adult mental health staff active engagement in reporting child safeguarding concerns, identifying any areas of concern and implementing appropriate remedial actions where necessary.

8.29 A publication by Cornwall Council in 2009[25] referred to developing best practice for services for young fathers in St Blazey. The proposal was developed after it was recognised that there were no young fathers' services in Cornwall and that St Blazey had high rates of teenage parents, domestic violence and disaffected young men.

8.30 In October 2012 this research was referenced by Brook Young Fathers Cornwall[26] when describing the young fathers support group they had been commissioned to provide.

8.31 In addition to service provided by Brook, a support group for young parents is provided by WILD[27]. WILD runs support group especially for young fathers and can provide one-to-one support with things like mental health, relationships and parenting.

8.32 ICMHT staff could have referred Mr T to either of these projects but we found no evidence that these options were ever discussed with him.

Liaison with maternity services

8.33 We found no evidence of liaison between adult mental health services and maternity services. Adult mental health staff were aware that:

- Mr T's partner, Miss B, was pregnant;
- there were concerns about the impact of domestic abuse in the family home on his child (Child A) and unborn child (Child B) when a children's social worker contacted the ICMHT on 22 February 2016;
- sufficient concerns remained for the children to be made subject to child protection plans at the Initial Child Protection Conference (ICPC) held on 1 April 2016.

[25] Young Fathers in Cornwall is a learning and development project for young fathers and their children https://www.cornwallhousing.org.uk/media/3623880/Young-fathers-in-Cornwall-proof-1206.pdf

[26] Brook Young Fathers Group is a community resource providing support to young fathers.

[27] Wild was set up by a small group of young parents in 1992 to help young parent families have the best possible future https://www.wildproject.org.uk/about

8.34 Miss B reported to HTT staff on 13 April 2016 that she was struggling to cope with Mr T's behaviour, as well as caring for her one-year-old child and being eight months pregnant. We found limited evidence of staff consideration of liaison with other services working with the family at that time.

8.35 We share the concerns raised in the Learning from Experience review that neither midwifery, nor mental health services, were represented at the ICPC, and that parents also failed to attend. The ICPC would have facilitated a key opportunity for mental health professionals and midwifery to share information pertinent to planning for the safety of Child A and Child B. Also, it provided the opportunity to ensure joined-up provision of services that may have addressed the parents' subsequent expressed concerns about the numbers of professionals visiting their home.

8.36 Our Safeguarding Children Partnership has in place guidance on the conduct of pre-birth assessments and this outlines the central role and expectations of midwifery services as well as an expectation that pre-birth assessment includes "details of the mother's partner, wider social and family history and environmental factors …as well as the obstetric history". This guidance was in place in 2015.[28]

Change of address and access to integrated community mental health team services

8.37 Mr T was initially on the caseload of the North Cornwall integrated community mental health team. Integrated community mental health teams are a community-based assessment and treatment service for patients who have a mental health problem that has not been addressed by counselling or is more complicated.

8.38 Mr T had talked to ICMHT staff about wanting to move away from Bodmin due to his anxieties about ongoing contact with the person he believed was responsible for his kidnap and associated assaults. On 14 April 2016 home treatment team and ICMHT staff attempted to make a planned home visit but there was no response. When staff called Miss B's mobile, she advised them that she and Mr T were out because they had to sign a tenancy agreement. Following this failed visit, the home treatment team closed Mr T's referral based on the information Miss B provided during the call.

8.39 Miss B contacted the team the following day to ask the time of Mr T's appointment that day. She was informed that Mr T's care coordinator was off sick and that a duty worker would telephone if they still wanted an appointment. Records show that a duty worker attempted a call and left a message to advise again that Mr T's care coordinator was off sick and Miss B should call the following week if Mr T needed support.

[28] Our Safeguarding Children Partnership for Cornwall and the Isles of Scilly (OSCP) Guidance Note 3 Arrangements for Pre-Birth Assessments (2015) updated in 2018.

8.40 Due to staff sickness and no follow-up until 25 April 2016 there was a missed opportunity for staff to explore more information about where the new tenancy was, and therefore to plan a transfer to the Caradon integrated community mental health team.

8.41 The next contact was on 25 April when Miss B advised that they had moved to St Blazey. ICMHT support for St Blazey was provided by the Caradon integrated community mental health team. Following receipt of this information the North Cornwall ICMHT discussed Mr T's case in their multi-disciplinary team meeting. Staff documented that Mr T's situation was complex with a history of trauma, difficulties engaging with services and high risks. Despite this picture the decision was taken to discharge Mr T from the caseload and advise Mr T to seek re-referral via his GP.

8.42 The Trust operational policy for integrated community mental health teams states that before any transfer between teams occurs there must be a full review of the patient's needs to establish that they continue to require ongoing input from an integrated community mental health team.

8.43 We can see that Trust policy was followed in respect of the multi-disciplinary team discussion. However, we question the decision to discharge him from ICMHT support given that his situation was described as complex and risks were documented as remaining high. We would expect to have seen a documented rationale for discharging Mr T from ICMHT caseload given the high risks documented by staff.

Recommendation 11: The Trust must provide assurance that patients who are complex and whose risks are documented as high, are not discharged from Trust services without a clearly documented rationale.

Risk assessment

8.44 Mr T's experiences within the education system were challenging. His absences, truancy and exclusions were risk factors for his later misuse of substances, worklessness and lack of self-worth.

8.45 We have considered what risk assessments and risk management plans were in place for Mr T prior to the death of Child B.

8.46 We can see that Mr T's risk was formally assessed and documented on one occasion prior to the death of Child B. This was on 19 May 2016 and it rated his overall risk as medium. Mr T's risks of suicide were documented as were his historical reports of being kidnapped, raped and beaten. These risks were documented by ICMHT staff in January 2016, but no formal risk summary was completed at that time.

8.47 There is no documented reason for the completion of the risk summary to have been prompted on 19 May 2016, but it would be reasonable to believe that this was as a result of the home visit undertaken by Caradon ICMHT staff

the previous day. We can see that on 16 May 2016 discussions took place between the ICMHT and a children's social worker regarding child protection issues for Child A and Child B, but those concerns are not referenced in the risk summary completed on 19 May. Indeed, in the section "evidence of risk to others" the risk to children remained blank.

8.48 The Trust policy on clinical risk management applicable at the time states that a risk assessment should be commenced and recorded at first contact with the service and updated:

- when there is a change in presentation or new information available;
- on entry or exit to other areas of service;
- prior to discharge from services provided by the Trust.

8.49 In accordance with the policy Mr T's risk should have been assessed and documented following:

- The Care Programme Approach review meeting held on 4 February 2016 – this was the first face to face contact with services following the referral by Mr T's GP in January 2016.
- Receipt of information from children's social care on 22 February 2016 advising of concerns about domestic abuse.
- Receipt of further information from children's social care on 16 March 2016 regarding the plans to manage the safeguarding risk to Child A and unborn Child B.
- Reports from Miss B of a further ligature attempt on 13 April 2016.
- The decision at a multi-disciplinary team meeting on 24 April 2016 to discharge Mr T from Trust services.

8.50 Trust staff had previously documented a history of domestic abuse between Mr T and Miss B and that Child A had previously been on a Child in Need plan which had been closed a year previously. Although initially there was no current evidence to warrant concerns, Miss B was pregnant and due to have her baby in May 2016, and staff needed to be mindful of recurring domestic abuse.

8.51 No attention was given by Trust staff to the domestic abuse that mental health staff were aware of in the family home. The risk of domestic abuse (either from Mr T or Miss B) was not assessed either.

8.52 There was insufficient attention paid by mental health staff to the safeguarding risks to the young children in the family. We found evidence of inaction when children's social care was seeking information about Mr T's mental state. In addition, an opportunity to engage with the children's social workers was

passed over on 17 June 2016 when both they and ICMHT staff were at Mr T's home at the same time.

8.53 Concerns about Mr T's risk to children were only documented on a risk assessment following the death of Child B in June 2016. Mr T's risk was appropriately formally assessed and documented on five occasions between 29 June and 16 July 2016. On each occasion the review appears to have been prompted by a change in information or Mr T's presentation.

8.54 We are aware that the Trust and the clinical commissioning group have taken steps to improve awareness of child safeguarding issues, but we have not seen any evidence of assurance of the associated improvements to clinical practice.

8.55 We have considered whether a further recommendation is required to ensure that the Trust addresses the gaps in their response to safeguarding issues. It is our opinion that the clinical commissioning group should seek assurance from the Trust that improvements have been made to staff awareness and understanding that has led to a significant improvement in clinical practice.

Recommendation 12: NHS Kernow Clinical Commissioning Group must seek assurance from the Trust that improvements have been made to staff awareness and understanding of children's safeguarding issues that has led to a significant improvement in clinical practice.

8.56 The risk assessments completed after Mr T's admission to the PICU highlight the following risks:

- self-neglect;
- harm from others;
- harm to others.

8.57 Mr T's overall risk rating remained high from 28 June to the final risk rating on 16 July 2016, just five days before he was found with a fatal ligature.

Admission to psychiatric intensive care unit

8.58 Mr T was admitted to the Trust PICU on 28 June 2016 under Section 2 Mental Health Act following a Mental Health Act assessment.

8.59 The Mental Health Act assessment documented that Mr T was on bail following the death of his four-week-old baby and that Mr T had admitted previous self-harm, notably:

- drinking bleach;
- hitting his head with a hammer;

- tying a ligature.

8.60 Staff documented a high risk of self-harm and that further hospital-based assessment was required.

8.61 Mr T was described by staff as "extremely anxious", but staff documented that he had no plans to end his life. He was initially nursed with close observations not exceeding five-minute intervals and had to be medicated with lorazepam and promethazine[29] when he sobbed uncontrollably.

8.62 Mr T refused food and fluid from the time of his admission, he reported that he did not feel like eating and told staff that he could not recall the last proper meal he had eaten. Staff encouraged him to take small amounts of food and fluid and planned to conduct regular blood tests.

8.63 PICU staff contacted the ICMHT to obtain information about how best to support and manage Mr T. Caradon ICMHT staff advised that Mr T had been "jointly worked" (two members of staff from the same community mental health team) because he was so complex and difficult to engage, and that female staff were less threatening to him because of his childhood and adolescent trauma involving men.

8.64 Mr T remained outwardly very distressed and refusing food and fluids for two weeks, at which point staff were so concerned about his physical health that transfer to the local general hospital was arranged. We deal with this in more detail in the relevant section on page 45 below.

8.65 A multi-disciplinary team meeting held on 7 July on the PICU documented simply that Mr T had been admitted because he had been on bail for the possible murder of his child. However, the Mental Health Act paperwork clearly stated that his admission was for assessment of low mood and suicidality, problems that were present for a number of months prior to the death of his child.

8.66 It is our opinion that Mr T's status as a suspect in the death in of his child may have overshadowed some aspects of the clinical assessment process. By the day after admission it was felt that he was inappropriately placed on the PICU and early references to post-traumatic stress disorder were not then explored and formally considered in detail.

Transfer to general hospital

8.67 Mr T was transferred to the general hospital on 13 July 2016 following a period of two weeks of limited or no food and fluid intake. Mr T initially refused observations and physical interventions on arrival at the general hospital ward but reports later that day document that he was accepting treatment and was both eating and drinking. During his admission Mr T was

[29] Promethazine is an antihistamine medicine that relieves the symptoms of allergies, and for short term sleep problems. https://www.nhs.uk/medicines/promethazine/

supported by healthcare assistants from the PICU and nursing staff from the psychiatric liaison service.

8.68 At interview we asked staff if they considered the psychological impact on Mr T of him being:

- transferred to the same hospital where his baby son had died;
- restrained in order to permit invasive procedures (taking of blood samples, insertion of nasogastric tube and cannula), given his reports of being kidnapped, raped and injected with drugs against his will.

8.69 Those we asked told us they did not know to what degree these issues were considered prior to Mr T being transferred from the PICU to a general hospital ward. Staff did confirm the evidence that we found in Mr T's clinical records, that they considered what the consequences might be of Mr T continuing to restrict food and fluids whilst on the psychiatric intensive care unit, and what their options were for treating him.

Discharge into the community

8.70 Mr T was discharged from Section 2 Mental Health Act and from the PICU on 19 July 2016. PICU staff stated at the discharge planning meeting that they had found no evidence of a depressive illness. Mr T was not on any treatment and would be discharged without any treatment. The records of the meeting clearly state that because of these facts there would be no treatment in the community and no input from the ICMHT after discharge, with the exception of the seven-day follow-up appointment.

8.71 We asked Mr T's care coordinator at interview about whether she shared the view that Mr T had no treatable mental illness. She told us that she had deferred to the view of the PICU staff because they had spent more time with Mr T than she had.

8.72 We have referenced the discharge and clinical risk management policies elsewhere in this report. Discharge from Section 2 Mental Health Act is a clinical decision and there is no statutory guidance in relation to clinical follow up, beyond the requirement to offer a follow-up appointment within seven days after discharge from inpatient services.

Post-traumatic stress disorder

8.73 Mr T had at least three early risk factors for being more likely to develop post-traumatic stress disorder:

- alleged childhood sexual assault;
- alleged witness to domestic abuse whilst a child;

- alleged childhood kidnap, assault and rape over a sustained period of time.

8.74 ICMHT staff had identified that Mr T presented with potential symptoms of post-traumatic stress disorder. There is no evidence that this diagnosis was actively considered, assessed or discounted whilst in the psychiatric intensive care unit. As we have stated elsewhere, PICU records show that staff considered that Mr T's suicidal ideation was due to his "current circumstances and personality type" rather than depression or post-traumatic stress disorder.

8.75 The NICE guidelines[30] for recognition, assessment and treatment for patients with post-traumatic stress disorder were published in December 2018 and replaced existing guidelines that had been published in 2005.

8.76 Good practice relating to assessment and diagnosis, as referred to in the 2005 guidance, stated that assessment should be undertaken by competent practitioners where symptoms suggest possible post-traumatic stress disorder. We found no evidence that formal assessment of Mr T's potential post-traumatic stress disorder symptoms was ever considered or arranged.

[30] Post-traumatic stress disorder NICE guideline https://www.nice.org.uk/guidance/ng116/chapter/Recommendations

9 Conclusions and recommendations

Relating to the death of Child B

9.1 We found evidence of inaction by Trust staff when children's social care was seeking information about Mr T's mental state.

9.2 There was insufficient attention paid by mental health staff to the safeguarding risks to the young children in the family. No risk assessments were completed that made any reference potential child safeguarding risks posed by Mr T until after the death of Child B.

9.3 In addition, an opportunity to engage with the children's social workers was passed over on 17 June 2016 when both they and ICMHT staff were at Mr T's home at the same time.

9.4 We have set out below the care and service delivery issues in relation to Mr T's care and treatment that may have impacted on the death of Child B.

Figure 3: Care and service delivery issues that may have impacted on the death of Child B

Relating to the death of Mr T

9.5 Mr T was a patient with a complex presentation, evidenced by the need for ICMHT staff to work with him in pairs and the difficulty that PICU staff had engaging with him.

9.6 Mr T's difficulties were evident in the weeks and months prior to the death of his baby, yet this information was given insufficient weight by the PICU team treating him.

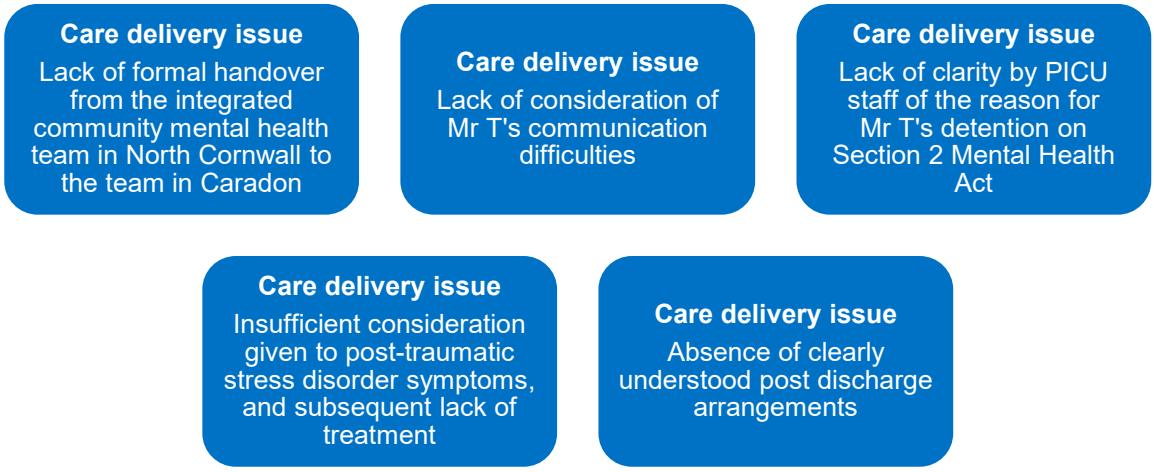
9.7 ICMHT staff had identified potential symptoms of post-traumatic stress disorder related his alleged kidnap, rape and assault that Mr T had disclosed to his GP, to ICMHT staff in both North Cornwall and Caradon, and PICU staff. ICMHT staff working with Mr T at the time of his son's death had only

met with him on three occasions and had not formulated a complete assessment of his needs.

9.8 PICU staff documented that Mr T had been admitted because he had been arrested on suspicion of the murder of his child and then bailed. This remained the legal position throughout Mr T's admission, and we consider it is probable that this coloured the way in which staff tended to interpret his presentation, specific behaviours and reported symptoms.

9.9 We have set out below the care and service delivery issues that we consider were associated with the death of Mr T.

Figure 4: Care and service delivery issues associated with the death of Mr T



Predictability and preventability

9.10 It is our view Mr T's involvement in the death of Child B could not have been predicted or prevented by mental health services. However, we have identified care and service delivery problems that, if addressed, could have mitigated Mr T's risk to Child B.

Recommendations

9.11 This independent investigation has made 12 recommendations to improve commissioning and clinical practice.

Recommendation 1: The Trust must clarify the action that they expect staff to take when there is a question about whether to execute Duty of Candour.

Recommendation 2: The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London)

Investigation guidance issued in April 2019 on engaging with families after a mental health homicide.

Recommendation 3: The Trust and the clinical commissioning group must ensure that families are offered appropriate involvement in serious incident investigations and that they are always offered a copy of the investigation report.

Recommendation 4: The Trust must provide robust assurance that they have fully implemented the actions arising from the recommendations of the internal investigation.

Recommendation 5: The Trust and NHS Kernow Clinical Commissioning Group must address the knowledge and skills gap present in their safeguarding children leads to ensure that those staff fully understand the Local Safeguarding Children Boards Regulations 2006, in particular the requirements relating to actions following the death of a child who was subject to abuse and how to action these.

Recommendation 6: The Trust and NHS Kernow Clinical Commissioning Group must assess and report on the impact of the revised processes and training programmes in relation to improving child safeguarding practices in adult mental health services.

Recommendation 7: If NHS Kernow CCG has not already done so, the potential missed opportunities for liaison between health practitioners as a consequence of health visitors moving to the employment of the council must be fully assessed and mitigated.

Recommendation 8: The Trust must ensure that staff understand and undertake their responsibilities for reporting safeguarding concerns when a patient reports historic or current abuse.

Recommendation 9: The Trust must provide assurance that there is an effective process for supporting patients who appear to be under duress due to criminal exploitation/cuckooing/county lines, and that these are addressed in care plans.

Recommendation 10: The Trust must conduct an audit of adult mental health staff active engagement in reporting child safeguarding concerns, identifying any areas of concern and implementing appropriate remedial actions where necessary.

Recommendation 11: The Trust must provide assurance that patients who are complex and whose risks are documented as high, are not

discharged from Trust services without a clearly documented rationale.

Recommendation 12: NHS Kernow Clinical Commissioning Group must seek assurance from the Trust that improvements have been made to staff awareness and understanding of children's safeguarding issues that has led to a significant improvement in clinical practice.

Appendix A - Terms of reference for independent investigation

To identify whether there were any gaps, deficiencies or omissions in the care and treatment that Mr T received, which, had they been in place, could have predicted or prevented the incident. The investigation should identify opportunities for learning and areas where improvements to local, regional and national services are required that could prevent similar incidents from occurring.

The outcome of this investigation will be managed through corporate governance structures within NHS England, Clinical Commissioning Groups and the Providers.

Terms of reference

Cornwall Partnership NHS Foundation Trust did not commission a level 2 investigation following the incident on 26 June 2016. Cornwall Partnership NHS FT has provided a level 2 RCA report following the perpetrators suicide on 23 July 2016. Cornwall and Isles of Scilly Safeguarding Children Partnership commissioned a Learning from Experience Review.

This investigation will build on those reviews in the following areas:

1. Review the care and treatment Mr T received from Cornwall Partnership NHS Foundation Trust from January 2016 following an episode of self harming behaviour, specifically:

    - The appropriateness of any diagnosis and treatment plans, and whether they were evidence based and in line with best practice guidelines/national guidance

    - the quality of the risk assessments, risk management and crisis plans and in place in the months leading up to and including the fatal incident and at the time of the completion of suicide by Mr T.

2. Review the information sharing, communication and liaison between Cornwall Partnership Trust and other agencies (e.g. Health Visiting, Midwifery, Social Care, Housing, Drug and Alcohol, Police services) during the same period and determine if that was in line with local and national policy.

3. Determine whether there were any missed opportunities to engage other services and/or agencies, to support Mr T and his family and manage any presenting risks, for example MAPPA or vulnerable adult processes.

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

    - If the investigations satisfied their 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 plans.

- Review processes in place to embed any lessons learnt and any evidence to support positive changes in practice.

- Review the CCGs oversight of the resulting action plan.

5. Review progress made against the recommendations made by the local safeguarding boards "Learning from Experience Review"

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

7. To review and comment on Cornwall Partnership NHS Foundation Trust and/or the Clinical Commissioning Group' enactment of the Duty of Candour.

8. To assess and review any contact made with the victim and perpetrator families involved in this incident, measured against best practice and national standards.

9. To review the Trust's family engagement policy for homicide and serious incidents, measured against best practice and national standards.

10. To review and test the Trust and Clinical Commissioning Group's governance, assurance and oversight of serious incidents with particular reference to this incident.

11. Assist the family in the production of a personal statement for inclusion in the final published report, if appropriate.

Timescale

12. The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter.

Initial steps and stages

NHS England will:

- Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved including influencing the terms of reference

- Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this investigation

- Seek full disclosure of the perpetrator's clinical records to the investigation team

Outputs

13. We will require monthly updates and where required, these to be shared with families.

14. A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care

15. A chronology of Mr T's mental health history.

16. A clear and up to date description of the incident and any Criminal or Coroner Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome.

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

18. A synopsis of the identified learning and recommendations that can be shared with NHS commissioning, provider organisations and partnership organisation as an aid to learning.

19. At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to discuss the findings of the investigation and engage the Clinical Commissioning Group with these meetings where appropriate.

20. A concise and easy to follow presentation for families.

21. A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

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

23. The investigator will deliver learning events/workshops for the Trust, staff and commissioners as appropriate.

Other

24. We expect the investigators to include a Safeguarding expert on their investigation panel.

25. 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.

Appendix B – Documents reviewed

Cornwall Partnership NHS Foundation Trust documents

- Clinical records for Mr T
- Policies and procedures

Royal Cornwall Hospitals NHS Trust documents

- Clinical records for Mr T
- Clinical records for Mr T's child

Other documents

- GP clinical records
- Cornwall Council safeguarding children records
- Our Safeguarding Partnership for Cornwall and the Isles of Scilly Learning from Experience report and supporting documentation

Appendix C – Professionals involved

CFT: Cornwall Partnership NHS Foundation Trust
RCHT: Royal Cornwall Hospitals NHS Trust

Pseudonym	Role and organisation
AA1	Appropriate Adult, CFT
CJLD1	Social Worker, Criminal Justice Liaison and Diversion Team, CFT
CJLD2	Service Lead, Criminal Justice Liaison and Diversion Team, CFT
ICMHT1	Community Mental Health Nurse, North Cornwall ICMHT, CFT
ICMHT2	Community Mental Health Nurse, North Cornwall ICMHT, CFT
CCO1	Community Mental Health Nurse, North Cornwall ICMHT, CFT
ICMHT4	Occupational Therapist, North Cornwall ICMHT, CFT
ICMHT5	Community Mental Health Nurse, Caradon ICMHT, CFT
ICMHT6	Community Mental Health Nurse, Caradon ICMHT, CFT
CCO2	Occupational Therapist, Caradon ICMHT, CFT
ICMHT8	Community Mental Health Nurse, Caradon ICMHT, CFT
ICMHT9	Acting Team Manager, Caradon ICMHT, CFT
CP1	Consultant Psychiatrist, Banham House
CP2	Consultant Psychiatrist, CFT
CP3	Consultant Psychiatrist, Criminal Justice Liaison and Diversion Team, CFT
CP4	Consultant Psychiatrist, CFT
CP5	Consultant Psychiatrist, CFT
CP6	Psychiatrist, Harvest Ward, CFT
CP7	Consultant Psychiatrist, CFT
CP8	Consultant Psychiatrist, CFT
CP9	Consultant Psychiatrist, CFT
CSW1	Child Social Worker, Cornwall Council
CSW2	Child Social Worker, Cornwall Council
CSW3	Child Social Worker, Cornwall Council
FW1	Family Worker
GP1	General Practitioner, Carnwater Practice
GP2	General Practitioner, Carnwater Practice
GP3	General Practitioner, Carnwater Practice
GP4	Medical Student, Carnwater Practice
GP5	General Practitioner, Carnwater Practice
GP6	General Practitioner, Carnwater Practice

Pseudonym	Role and organisation
GP7	General Practitioner, Middleway Surgery
H1	Housing Officer, Cornwall Council
HTT1	Psychologist, home treatment team, CFT
HTT2	Support Time & Recovery Worker, home treatment team, CFT
HTT3	Role unknown, home treatment team, CFT
HTT4	Community Mental Health Nurse, home treatment team, CFT
HTT5	Community Mental Health Nurse, CFT
HV1	Health Visitor
HW1	Ward nurse, CFT
HW2	Ward nurse, CFT
HW3	Psychologist, CFT
HW4	Pharmacist, CFT
HW5	Ward Manager, CFT
HW6	Ward nurse, CFT
HW7	Ward nurse, CFT
HW8	Occupational therapist, CFT
HW9	Ward nurse, CFT
MC1	Medical Consultant, Treliske Hospital, RCHT
PLN1	Psychiatric Liaison Nurse, CFT but based at Treliske Hospital
PMHT1	Community Mental Health Nurse, Specialist Perinatal Mental Health Team
RCHT1	Medical Consultant, RCHT
SHO1	Senior House Officer, CFT
SW1	Social Worker, Cornwall Council
TC1	Role unknown, Trelil Court, CFT

Appendix D – NIAF: internal investigation report

Rating	Description	Number
	Standards met	9
	Standards partially met	3
	Standards not met	12

Standard		Niche commentary	
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident	The report identifies that it is a comprehensive internal (Level 2) investigation. The SI (GOV-015-15) policy identifies this level as required for complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable.	
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	The nature of the incident is noted as: "Fatal…Probable self-strangulation and severe respiratory problems resulting in brain stem death." This reflects that that SI report investigated the death of Mr T, not the death of Child B. Standard terms of reference and case specific terms were provided, and the scope and level and type of investigation are described.	
1.3	The person leading the investigation has skills and training in investigations	The lead investigator is named as the investigating officer, it is stated that a root cause analysis was conducted by the investigator using NPSA training, guidance and tools. Their training or experience is implied but not provided in detail.	
1.4	Investigations are completed within 60 working days	The incident occurred on 21 July 2016, and Mr T died on 22 July 2016. The "Date of final sign off by Executive" on the front of the report is blank. There is however a section in the template entitled "Date approved by ECRG or Director of Quality and Governance or Medical Director" and this is noted as approved on 19 October 2016. This is beyond 60 working days, and there is no explanation of whether there was an extension or 'stop the clock' agreed.	
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The report is written in plain English without typographical errors. We note the language attributed to staff working with Mr T however is pejorative and could be said to be judgmental. It was not made clear in the report, but clarified	

Standard		Niche commentary	
		at our interviews, that this pejorative language was used by staff in interviews for the SI report.	
1.6	Staff have been supported following the incident	There is a significant amount of detail about staff support in relation to what was provided to specific staff groups. This standard was therefore met. However the report goes on to give details of staff personal responses to the incident, which we consider inappropriate.	
Theme 2: Thoroughness			
2.1	A summary of the incident is included, that details the outcome and severity of the incident	There is a summary of the background to the incident, and of the actions after the Trust became aware of the incident. The report does not make clear how, where or precisely when the incident occurred.	
2.2	The terms of reference for the investigation should be included	The terms of reference are included.	
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people	The methodology is clearly described, including method of analysis, documentation and interviews.	
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	Neither Mr T's parents nor his partner were invited to be involved in the investigation process.	
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	Neither Mr T's parents nor his partner were invited to be involved in the investigation process.	
2.6	A summary of the patient's relevant history and the process of care should be included	A summary of Mr T's relevant history and process of care was included.	
2.7	A chronology or tabular timeline of the event is included	A chronology of Mr T's care was included prior to his discharge. There is no chronology or tabular timeline regarding the incident.	
2.8	The report describes how RCA tools have been used to arrive at the findings	The report does explain how the RCA analysis was carried out.	

Standard		Niche commentary	
2.9	Care and Service Delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	Some care delivery/and or service delivery issues, without clearly identifying which is which.	
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	There is a list of contributory factors, and all except 'patient factors' are noted to have 'none identified'. We note that there were no communication contributory factors identified, despite there being care delivery problems/service delivery problems identified as 'sharing of information' with police, and also not informing the Nearest Relative of the detention under Section 2 Mental Health Act. There is a long list of patient factors identified.	
2.11	Root cause or root causes are described	The report is contradictory on root cause. It is described in several different ways: • No root cause could be identified. • The issues raised in this internal report were identified as a root cause or contributory factor in the death of this person. • The single root cause for this incident is the grave situation the client found himself in having been arrested (but not yet charged) on suspicion of the murder of [Child B].	
2.12	Lessons learned are described	The 'lessons learned' section of the template has not been completed. There is however a narrative description of 'some potential learning points' to be carried forward.	
2.13	There should be no obvious areas of incongruence	The conflicting statements on root cause are incongruous. The rationale for not involving either family refers both to restrictive bail conditions, and to Mr T's wish that information was not shared with other services. Neither is an acceptable rationale for not involving families.	
2.14	The way the terms of reference have been met is described, including any areas that have not been explored	The way the terms of reference have been met is described.	
Theme 3: Lead to a change in practice – impact			
3.1	The terms of reference covered the right issues	The terms of reference cover the patient death only, and do not attempt to review the care and	

Standard		Niche commentary	
		treatment provided in relation to the death of Child B.	
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	The report cites patient factors only as contributory, with no system or human factors, and does not consider how a recurrence might be prevented.	
3.3	Recommendations relate to the findings and that lead to a change in practice are set out	There were two recommendations made, which are said to be incidental findings. neither of which suggest a change in practice	
3.4	Recommendations are written in full, so they can be read alone	Recommendations are written in full, so they can be read alone.	
3.5	Recommendations are measurable and outcome focused	Both recommendations refer to discussions to be had, with no intended outcome, and are not measurable.	