Independent review of mental health treatment and care provided in Dorset and Nottinghamshire

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EXPERIENCE, KNOWLEDGE AND EXPERTISE IN MANAGING RISK

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EXECUTIVE SUMMARY

Independent review of mental health treatment and care provided in Dorset and in Nottinghamshire

1. Introduction

1.1 This independent review of health care and treatment in Nottinghamshire and in Dorset was commissioned jointly by the Heads of Investigations NHS England (South, and Midlands and East regions) following the death of Colin (not his real name)[1]. The incident occurred when, following an altercation in 2018, Mark hit Colin his step-grandfather with a lamp after an argument. Mark called his care coordinator, an ambulance was called, and Mark was detained under Section 38[2] of the Mental Health Act to permit assessments of his mental state. Colin, age 82, died of his injuries two weeks later. Mark was subsequently judged by the Court to be guilty of manslaughter on grounds of diminished responsibility.

1.2 The investigation was commissioned in August 2021. An initial Scoping/Startup meeting to discuss the approach was held on 3rd September 2021. Agreement was reached on Terms of Reference (Appendix 1 of the main report) and contacts were identified to support the provision of documentation, electronic records, and points of contact with NHS staff who had been in contact with Mark. The aim was to understand the background to the incident which sadly led to Colin's death, learn from any findings relating to the quality of services that were provided for Mark, and understand relevant changes in services since. A full account of the methodology used for the review can be found in the main report. Our review, prepared over the eight months to May 2022, builds on a Serious Incident Investigation (SI) undertaken by Dorset Healthcare immediately after the incident.

1.3 Our review was conducted independently. It was designed to support the family, staff and others who were involved and clarify what, if anything, went wrong with NHS care. The aim was to help minimise the possibility that such an event could recur, understand what happened, communicate clearly, and make recommendations for the delivery of health services in the future.

1.4 Our team would like to extend our regrets to all those who were affected by this tragic incident, and we would like to extend sincere condolences to Colin's family for their loss.

[1] It was formerly agreed with the family that their real names would be changed to protection their anonymity.
[2] Section 38 of the Mental Health Act enables detention for assessment prior to a Court judgement.

2 Methodology

2.1 Appendix 1 contains the Terms of Reference (TOR) underpinning our methodology which outlined a requirement to understand the care and treatment provided for Mark between October 2013 when he was admitted in Nottinghamshire to the date of the incident in Dorset in 2018.

2.2 Appendix 2 contains information about our team: a group of clinical professionals working independently with experience of services and of investigations appointed after consultation with NHSE. None of the team had contact with NHS provision in Dorset, Nottingham, the private sector provision at St Andrew's or The Sherwood Centre[3].

2.3 Our methodology consisted primarily of a desktop review of documentary evidence (see Appendix 3) coupled with personal interviews undertaken by videoconference. Information was gathered from electronic NHS notes in Nottinghamshire and Dorset; reports for the Court; and policy documents relating to the provision of care (e.g., care planning, risk assessment, etc). Conversations were held with NHS staff from Dorset and social care services from the Bournemouth, Christchurch and Poole (BCP) Council, and information from members of Colin's family.

2.4 Appendix 4 of the main report contains a list of the individuals who provided information about Dorset Healthcare. In each case, information about our review and our team was provided in advance and notes of confidential conversations were checked with participants for their accuracy. All witnesses were assured that their testimony would be confidential and that no personally identifying information would be included[4]. Colin's nephew maintained a link with our team at various intervals over the course of the review and acted as a representative for Colin's family.

3 Background

3.1 Appendix 5 of the main report attached contains a tabular list of events between October 2013 when Mark was admitted to St Andrews Hospital in Nottingham and the date of the incident.

3.2 As a child, Mark had a very long record of contact with mental health, education, and social services, largely due to problems interacting and socialising with others in an appropriate way. At age 8 Mark was enrolled into a school for children with educational and behavioural needs and in 2002 when he was ten,

[3] The Sherwood Centre was part of the Four Seasons Healthcare Group at the time of the incident in 2018 (it was formerly referred to as Huntercombe Hospital) and was sold to CareTech in March 2020, who are the current owners. The service will be referred to throughout this report as The Sherwood Centre.
[4] A Court may subpoena statements in certain circumstances.

his mother died. From an early age Mark evidenced sexually inappropriate behaviour (not uncommon amongst young victims of child sexual abuse) and it was known that he was insecure and could be aggressive.

3.3 Over the course of the next few years, Mark remained in care and moved to Kendal (Cumbria), Derbyshire and then Nottingham. He had a significant level of contact with Cumbria Police for theft, criminal damage and assault. Mark was diagnosed with Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactive Disorder (ADHD). In 2007, at age 15, Mark assaulted members of staff and a secure accommodation order was made to Clayfield's secure unit in Nottingham. In 2009, Mark was detained at St Andrew's Hospital under Section 37 off the Mental Health Act (MHA) following a conviction for assault, Actual Bodily Harm (ABH) and sexual assault.

3.4 In 2013 (age 21), cognitive testing at St Andrews Hospital suggested that Mark was functioning at the `borderline' level for intellectual ability and that he was finding it difficult to sustain his concentration, attention, or working memory. Despite this, Mark made progress and he completed GSCEs in psychology, Maths and English and subsequently acquired a driver's license. Discharge plans began to be developed.

3.5 In 2015 (age 23) following a period of rehabilitation, Mark was discharged from St Andrew's Hospital to The Sherwood Centre, an assisted living centre in the private sector. At this point, Mark was under a Guardianship Order[5] which meant that he was restricted to where he could live, and a local social worker was appointed to be his care coordinator. In September 2016 a multi-disciplinary Care Programme Approach Review (CPA) was undertaken; staff judged that Mark had improved sufficiently to enable him to move to a self-contained flat, and it was agreed to discharge him from his Guardianship Order and from the CPA framework. The electronic records show that Mark then began to talk about moving back to Dorset to be near his family (Colin).

3.6 By April 2017, Mark was very keen to leave Nottinghamshire and return to Dorset. Staff counselled Mark against the move but, aware of his legal status as an independent person (notwithstanding the Section 117 arrangements which were still operating at this time) Mark was free to move wherever he liked. The social worker in Nottingham provided Mark with information about GP services in Dorset and encouraged him to make contact with services. The records show that Nottingham City Council who retained Section 117 responsibility for Mark were in contact with Dorset staff and shared their information.

3.7 In May 2017, Mark registered with a new GP in Dorset. The psychiatrist that Mark had been seeing in Nottingham outpatients suggested to the GP that it

[5] A Guardianship Order is a court appointment authorising someone to make decisions and take action on behalf of someone else. The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 No. 1184 implemented 3 November 2008 provides guidance on the statutory forms and procedures to be used. The Mental Health Act Code of Practice 2015 (CoP) Chapter 30.16 requires the Local Social Services Authority (Local Social Services Authority) to "have a policy setting out the arrangements for the way in which it will discharge its responsibilities in relation to Guardianship".

would be appropriate to refer Mark to community mental health services. However, in the absence of more detailed information about his case and knowing that Mark had been treated before in learning disabilities services, the community mental health team did not accept the referral. Instead, the psychiatrist from Dorset suggested that Mark should be referred to the social care locality team. From there, he was transferred to the health element of the community learning disabilities team from whence, in June 2017, he was moved into the secondary specialised learning disabilities team.

3.8 We understand that full information about Mark's forensic and sexual abuse history was not shared until the following year, despite requests from Dorset, when Mark was identified under MAPPA (see footnote 6 in the main report) and information about Mark's history was prompted. A Multi-Agency Risk Meeting (MARM) in Dorset was called by the Adult Social Care team in Dorset in June 2018 under the auspices of the Community Learning Disability Team. The MARM team agreed to request a chronology to be completed, and they took steps to explore tenancy options about housing. Mark was recorded as status Level 3[6] under MAPPA which meant a clear focus on the management of risk, and he was allocated a Police Liaison Officer (PLO) who saw him weekly. A Learning Disability (LD) team member (a social worker) also re-instigated Mark's Guardianship arrangements.

3.9 In November 2018 when he was listed on the register of sex offenders, Mark was allocated an offender manager from the Management of Sexual Offenders and Violent Offenders (MOSOVO) team in Dorset. He was also screened by the Safeguarding Team following a report of an incident with a woman whom Mark alleged had stolen from him when consideration was given to whether he was at risk of financial abuse.

4 The Incident

4.1 On 17th December 2018 Mark was at Colin's sheltered accommodation and, according to Mark's testimony and information from ambulance and hospital staff, they had an argument about a dog that Mark had been looking after. The dog had bitten him and run away, and Mark said afterwards that Colin had become aggressive and verbally abusive. Mark reported that he turned his phone to `record' because he was frightened of being assaulted by Colin. Mark apparently remembers curling up into a ball but did not remember anything else about the incident. Afterwards, when it appeared that there had been a fight involving a lamp, Mark called his support worker, and an ambulance was called. Colin died two weeks later on1st January 2019.

5 Findings

5.1 Our team believes that the incident that led to Colin's sad death could not reasonably have been prevented. However, it is clear that steps in Dorset could

[6] Level 3 MAPPA is defined as `other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management'. Levels 1 and 2 describe requirements for lower levels of management by sexual and/or violent offenders.

potentially have been taken sooner and that risks could have been reduced during the latter part of 2017 and in early 2018 if full information had been shared between The Sherwood Centre and Dorset Healthcare. For example, delays in accessing secondary services meant that staff were unaware of Mark's forensic history, his former Guardianship arrangements, or the potential risks he posed to vulnerable others. Had the information been known, MAPPA might have been established earlier, and it is possible that risks associated with the high volume of contacts between Mark and Colin might also have been reduced.

5.2 However, by the time that the incident occurred in 2018, it is also clear that a very good range of significant mitigations and sufficient information to reduce the known risks had been put in place. This means that whilst there were opportunities to strengthen care and reduce risks earlier, relevant mitigations (for example, Guardianship arrangements and restrictions upon single female staff seeing him alone) were in place by the time the incident occurred. Our team compliments health and social care services in Dorset for their later work across the system of care to deliver effective `joined-up' care for Mark and protect others.

5.3 We also note the very significant range of investigative information gathered for the DHR, MAPPA review and Safeguarding Review and the wide-ranging recommendations which are now being led by the BCP Council. Many of these clearly also apply to Dorset Healthcare given that they work closely in partnership and are managed by the Integrated Community Board (ICB), part of Dorset Integrated Care System (ICS).[7]

5.4 The main report contains details of all the findings of the review. These are presented in relation to the items in the Terms of Reference that were agreed. In making the following additional recommendations, our team hopes to enhance and supplement the work undertaken for the DHR.

6 Conclusions and recommendations

6.1 We would like to extend our condolences to Colin's family for their loss. We hope that information relating to the NHS services in Dorset which supplement the information which will be published in due course about the DHR will be helpful in supplementing their knowledge.

Recommendation 1

6.2 NHS England and NHS Digital to support delivery of information to be used within and across services to support information-sharing across geographical and service boundaries. It should be evidence-based and contain guidance for staff. The aim is to ensure that key elements of the care provided for a patient

[7] Integrated Care Systems (ICSs) replaced Clinical Commissioning Groups (CCGs) in 2021. They focus on core NHS services, with responsibilities including NHS funding, commissioning, and workforce planning. Integrated Care Plans (ICPs) have a broad focus, covering ICS-wide strategy, public health, social care, and wider issues impacting the health and wellbeing of the local population and are led by the IC Board (ICB).

can be shared (within legal restrictions) to support practitioners who take responsibility for care, and support management of risk when patients transfer. The overall purpose is to promote timely information sharing across NHS services and reduce the risk to service users themselves, to staff and the public.

6.3 **Recommendation 2** Our team recommends that Dorset Healthcare should provide an opportunity for representatives from Colin's family to meet representatives from the service to consider the circumstances of his death, understand the changes described in the report, and the ways in which recommendations will be acted upon.

6.4 **Recommendation 3** We recommend that the Action Plan that was developed by Dorset Healthcare in relation to the DHR recommendations should be revisited in the light of this report. The purpose would be to set out clearly the ways in which the impact of changes in the service will be measured.

FULL REPORT

Independent review of mental health treatment and care provided in Dorset and in Nottinghamshire

INTRODUCTION

6.5 This independent investigation was commissioned jointly by the Heads of Investigations NHS England (South, and Midlands and East regions) in Nottinghamshire and Dorset following the death of Colin (not his real name)[8] . The incident occurred when, following an altercation on 17th December 2018, Mark (age 26) hit Colin (age 82), his step-grandfather, with a lamp. Mark was detained under Section 38[9] of the Mental Health Act in a Medium Secure Unit to permit assessments of his mental state. Mark was subsequently judged by the Court to be guilty of manslaughter on grounds of diminished responsibility. Colin died of his injuries two weeks after the incident.

6.6 Our team would like to extend our sympathies to all those who were affected by this tragic incident, and we would like to extend sincere condolences to Colin's family for their loss.

6.7 This review was commissioned in August 2021. An initial Scoping/Startup meeting to discuss the approach was held on 3rd September 2021. Agreement was then reached on draft Terms of Reference (Appendix 1). Contacts were identified to support the provision of documentation, records, and points of contact with NHS staff who had been in contact with Mark. The aim was to understand the background to the incident which sadly led to Colin's death, learn from any findings relating to the quality of services that were provided for Mark, and understand relevant changes in services since.

6.8 Our review was conducted independently. It was designed to support the family, staff and others who were involved and clarify what, if anything, went wrong with NHS care and help minimise the possibility that such an event could recur. As part of this, our team was asked to consider whether it would be appropriate to make recommendations that could be applicable on a local, regional or national basis for the delivery of health services in the future. Our review was prepared over the eight months to May 2022.

7 METHODOLOGY

7.1 The Initiation/Scoping Meeting on 3rd September 2021 provided an opportunity from representatives of the services to discuss the incident, Mark's circumstances, and the likely nature of the evidence that it would be possible to

[8] Names of family members were chosen by them to protection their anonymity.
[9] Section 38 of the Mental Health Act enables detention for assessment prior to a Court judgement.

gather. Representatives were available from NHSE (South and Midlands & East regions), Nottinghamshire Healthcare NHS Foundation Trust, Dorset Healthcare University Healthcare NHS Foundation Trust, Nottingham Integrated Care System (ICS), Dorset ICS and health services in Nottinghamshire[10] provided at The Sherwood Centre.

7.2 Appendix 1 contains the Terms of Reference (TOR) underpinning our methodology. The TOR outlined a requirement to understand the care and treatment provided for Mark between October 2013 when he was admitted in Nottinghamshire to the date of the incident in Dorset in 2018.

7.3 The TOR refer to three additional reports. First, a Domestic Homicide (DHR) Report commissioned by Bournemouth, Christchurch and Poole Community Safety Partnership (BCP CSP) completed in September 2020, (unpublished at the time of writing). Second, a MAPPA[11] Serious Case Review (SCR) dated July 2019 and (c) a Safeguarding Adult Review (SAR). These reports concerned the way that different agencies worked together to deliver care for Mark; safeguard the family (the DHR) and assess how effectively his safety (MAPPA and SAR) was managed. Reference is made to them in our report and also to developments that have been made in services since.

7.4 Appendix 2 contains information about our team: a group of clinical professionals working independently with experience of services and of investigations appointed after consultation with NHSE. None of the team had previously had any contact with NHS provision in Dorset; Nottinghamshire; the private sector provision at St Andrew's, or the Sherwood Centre.

7.5 It was agreed that our methodology would consist primarily of a desktop review of documentary evidence (see Appendix 3) coupled with personal interviews. Our team was able to identify members of staff in Dorset who had previously had personal contact with Mark, despite the length of time that had elapsed. Information was gathered from electronic NHS notes in Nottingham and Dorset; reports for the Court; and policy documents relating to the provision of care (e.g., care planning, risk assessment, etc). Conversations were held with NHS staff from Dorset and social care services from the BCP Council, and information was provided by a relative (a nephew) of Colin's who agreed to representative Colin's family. Mark himself was not interviewed and there is no

[10] The Sherwood Centre was part of the Four Seasons Healthcare Group at the time of the incident in 2018 and was sold to CareTech in March 2020, who are the current owners. The service will be referred to throughout this report as the Sherwood Centre.

[11] MAPPA Multi-Agency Public Protection Arrangements (MAPPA) are a set of statutory arrangements designed to assess and manage the risk posed by certain sexual and violent offenders established by Sections 325 to 327 of the Criminal Justice Act 2003. There are three formal MAPPA categories: Level 1: All Registered Sexual Offenders. Level 2: Violent or other sex offenders not subject to notification requirements. Level 3: Other dangerous offenders.

information in the notes about Mark's family. All conversations with staff were held by videoconference due to a combination of Covid restrictions and the distances involved.

7.6 Appendix 4 contains a list of the individuals who were able to provide information about Dorset Healthcare via videoconference. In each case, information about our review and our team was provided in advance and notes of confidential conversations were checked with participants for their accuracy. All witnesses were assured that their testimony would be confidential and that no personally identifying information would be included[12]. Colin's nephew maintained a link with our team at various intervals over the course of the review and had also been the link for the DHR panel.

7.7 In reporting our findings, and whilst our team has endeavoured to make it clear that the TOR items have been addressed, it is important to note that certain TOR Items have been presented out of sequence. This was done to best serve the chronology and the narrative. All information about TOR items in the text in bold have been presented in brackets for ease of reference.

8 BACKGROUND

8.1 Appendix 5 contains a tabular chronology (**TOR item 1.1**) of events between October 2013 when Mark was admitted to St Andrews Hospital in Nottingham and the date of the incident. However, a wider picture of Mark's history has been provided to provide important context of his needs and the challenges he represented.

Early life

8.2 Mark was born in Dorset in 1992 and records show that from an early age, he and his family were troubled. Police records indicate that Mark's mother abused him physically and he was placed on the Child Protection Register until he was three. When Mark's mother moved to Nottingham in 1993 it was suggested that this was allegedly due to sexual abuse by her stepfather, Colin (Mark's step-grandfather, the victim). Our team has no independent evidence about this history, but NHS notes contain reports of social and personal accounts that were noted at the time.

8.3 As a child, Mark had a very long record of contact with mental health, education, and social services, largely due to problems interacting and socialising with others in an appropriate way. From an early age he evidenced sexually inappropriate behaviour (not uncommon amongst young victims of child sexual abuse) and he was aggressive and insecure. Mark was also bullied at school,

[12] A Court may subpoena statements in certain circumstances.

and it was as a youngster 7yrs old that he first enrolled into martial arts classes – an interest that was maintained when he grew up. At age 8 Mark was enrolled into a school for children with educational and behavioural needs. In 2002 when Mark was ten, Mark's mother died from a seizure following an overdose, an event that he reported subsequently that he had witnessed.

8.4 Initially, Mark was taken into care when his mother died. Over the course of the following year there were at least 22 recorded occasions when he absconded. In 2004, he allegedly tried to strangle a woman who had formerly been a friend of his mother's. Mark also reported having re-established contact with his step-grandfather, Colin and grandmother (his only family, as he often said). Mark subsequently reported that it was about this time (age ten or eleven) that his step-grandfather Colin abused him sexually and physically. In 2005, a High Court Decision resulted in Colin and his wife being prevented from having contact with Mark (now age 13) owing to concerns about sexual abuse and concerns expressed by other family members that Colin and his wife were exploiting Mark for financial gain.

8.5 Over the course of the next few years, Mark remained in care and moved to Kendal (Cumbria), Derbyshire and then Nottingham. He had a significant level of contact with Cumbria Police for theft, criminal damage and assault. A psychiatric assessment at this time noted that he might have a diagnosis of bipolar disorder and he was treated with Risperidone. However, it was ultimately agreed that Mark had Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactive Disorder (ADHD) and he was treated using, for example, Methylphenidate.

8.6 In 2007, at age 15, Mark assaulted members of staff and a secure accommodation order was made to Clayfield's secure unit in Nottingham. He was reported as missing from the unit on more than one occasion and had been classified as high risk and a potential danger to the public. In 2009, Mark was detained at St Andrew's Hospital under Section 37 off the Mental Health Act (MHA) following an assault, Actual Bodily Harm (ABH) and sexual assault. During his time at St Andrew's, Mark frequently exhibited a range of challenging behaviour. He repeatedly phoned Colin asking to be collected, notwithstanding the Order that they should not have contact.

October 2013 – May 2017

8.7 In 2013 (age 21), cognitive testing at St Andrews Hospital suggested that Mark was functioning at the `borderline' level for intellectual ability[13]. His verbal skills were much better than his non-verbal skills, a fact which makes it inappropriate

[13] It is usual for the term `learning disability' (LD) to be used when IQ falls below 80, i.e., significantly below the population average. However, services may be flexible about their thresholds for access to LD services.

to generate a simple IQ quotient. The assessment also indicated that Mark was reported to find it difficult to sustain his concentration, attention, or working memory, or process visual material without making mistakes. Despite this, Mark made progress in psychology sessions, and he was able to address his early history of trauma and the staff team worked to help Mark structure his day, improve his social skills and reduce his tendency to breach social and other boundaries – a problem which continued. Mark completed GSCEs in psychology, Maths and English. He subsequently acquired a driver's license. Although Mark became preoccupied with a female shop assistant and then with a member of the nursing staff in 2014, there were improvements overall in his behaviour and discharge plans began to be developed.

8.8 In 2015 (age 23) the Intensive Community Assessment and Treatment Team (ICATT) offered Mark an assessment with a view to further rehabilitation. He was referred to the Community Learning Disability (CDLT) team. Mark's diagnosis of Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) was affirmed. Following a period of rehabilitation, Mark was discharged in September 2015 from St Andrew's Hospital to The Sherwood Centre, an assisted living centre focused on rehabilitation. This unit was staffed by nurses and support workers only. However, Mark also had regular contact with his psychiatrist from Nottingham mental health services in outpatients. At this point, Mark was under a Guardianship Order[14] which meant that he was restricted to living at the assisted living centre and a local social worker was appointed to be his care coordinator. For the next year, Mark's pattern of behaviour remained much as before according to the notes. He also obtained a couple of jobs: one in a charity shop and another as a driver, although his history represented a challenge in terms of DBS checks.

8.9 In September 2016 a multi-disciplinary Care Programme Approach Review (CPA) took place, and it was clear that Mark had improved enough to be discharged from the CPA framework and to move to a self-contained flat. It was agreed at a further meeting between professionals that Mark's Guardianship Order was no longer necessary and he began to talk about moving to Dorset to be near his family (Colin). Between November 2016 and March 2017, the Police then investigated Mark for an offence of inciting a child to engage in sexual activity. However, the hearing and verdict were not reached until the following year (2018).

[14] A Guardianship Order is a court appointment authorising someone to make decisions and take action on behalf of someone else. The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 No. 1184 implemented 3 November 2008 provides guidance on the statutory forms and procedures to be used. The Mental Health Act Code of Practice 2015 (CoP) Chapter 30.16 requires the Local Social Services Authority (Local Social Services Authority) to "have a policy setting out the arrangements for the way in which it will discharge its responsibilities in relation to Guardianship".

May 2017 onwards

8.10 By April 2017, case notes show that Mark was very keen to leave Nottinghamshire and return to Dorset (it is possible that he may also have been keen to leave the area due to his pending Court case). No longer having any restrictions under the Mental Health Act (although Section 117 arrangements were still operating), and once Mark's Guardianship had been lifted, there were no legal means to restrain him. Staff at The Sherwood Centre counselled Mark against the move but, aware of his legal status and conscious of what he often reminded staff about the Human Rights Act, he was keen to move to be near his family (Colin). The social worker employed by Nottingham City Council who linked with The Sherwood Centre team provided Mark with information about local GP services and encouraged him to register with a GP. The records show that those with Section 117 responsibility for Mark[15] were in contact with social care services in Dorset and shared their information.

8.11 In May 2017, Mark registered with a new GP in Dorset. The psychiatrist in Nottingham who had been seeing Mark in outpatients sent a letter to Mark's new GP suggested that Mark should be referred to mental health services and he outlined brief information about him. The GP therefore wrote to the Community Adult Mental Health Team[16] to make a referral. In the context of quite limited information about Mark's history, knowledge that he had formerly been in a LD placement at The Sherwood Centre, and guidance about strict boundaries in Dorset around the different services in the context of budgetary restrictions, the referral was refused by the community mental health team. Instead, Mark was referred to the learning disability (LD) service, where he was seen by one of the social care LD staff.

8.12 According to the Dorset LD team lead, there was still no detailed psychiatric information about Mark's history of challenging sexual behaviour or his forensic history. They therefore felt concern that they he had potentially been at risk to lone workers and from female staff who were unaware of Mark's history, and potentially at risk from members of the public. For example, information about Mark's pending court case for which he was arrested in 2017 had not been shared. Although there was information from the Nottinghamshire social worker who liaised with Dorset social services in relation to Mark's Section 117 aftercare arrangements, psychiatric health information was not apparently shared either.

[15] Section 17 aftercare arrangements concern aftercare for a person who has been detained under the Mental Health Act. Under this section, ICSs/NHS and local authorities are obliged to provide care relating to needs that arise from the mental disorder or cognitive impairment that led to the Section.

[16] The locality name has been redacted to protect family members.

8.13 After a period of assessment which was provided by the LD social care team (a joint health and social care team led by BCP Council) the team learned that Mark had been referred to a `step down' service after being in secure care where he'd also been under Guardianship; they knew that he had been allowed to leave The Sherwood Centre, and that his Guardianship restrictions had been lifted. The Dorset Healthcare specialist learning disability consultant psychiatrist then saw Mark on 16th June 2017. The psychiatrist reported that he found Mark to be likeable young man and did not think him acutely unwell. He commented that although Mark had been fairly open about his history of mental ill health (if not his history of sexual offending) he thought that it was difficult for one worker to support him. The psychiatrist therefore transferred Mark to the secondary LD team. Detailed information, as had been requested, about Mark's forensic and sexual abuse history was not provided until the following year when Mark was listed under MAPPA (see footnote 6) when a history was mandated.

8.14 During 2017 and the early part of 2018, Mark was reported to have been occasionally aggressive and his behaviour was occasionally inappropriate. Colin's family believed that Colin had previously possibly been exploited by Mark, but also that Colin was helping him financially. Colin and Mark were both been offered Safeguarding referrals in Dorset but they both refused. The Police recorded two altercations in August and September 2017 both involving Colin (in one case Colin was allegedly the aggressor), and there were incidents involving an altercation in a pub from which Mark was subsequently banned. There were also concerns expressed the following year in May 2018 by Mark's neighbour who thought he was staring inappropriately at her children.

8.15 A Multi-Agency Risk Meeting (MARM) in Dorset was called by the Adult Social Care team in Dorset in June 2018 under the auspices of the Community Learning Disability (LD) Team. The MARM agreed an action for a chronology to be completed and took steps to explore tenancy options with housing. Mark was allocated a PLO, a very helpful intervention according to the LD consultant, because it helped the service to engage with MAPPA. The PLO saw him weekly, and he was recorded as status Level 3[17] under MAPPA which meant a clear focus on the management of risk.

8.16 On 22nd August 2018 an assessment was undertaken by the LD psychologist who indicated that Mark did not technically have a learning disability. His pattern of scores was very uneven (as previously described in para. 7.7 above). Instead, a General Ability Index (GAI) was calculated showing Mark to be functioning at the 10th percentile, (81), just within the low average range. On the

[17] Level 3 MAPPA is defined as `dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management'. Levels 1 and 2 describe requirements for lower levels of management by sexual and/or violent offenders.

verbal scale he obtained a score of 93 – his strongest area – with a surprisingly good vocabulary but he also showed marked deficiencies of perceptual reasoning, speed of functioning and working memory, all of which were potentially part of his ADHD. It was noted that Mark had a full driving license and that he could manage to live and shop for himself, although he found it difficult to manage his finances.

8.17 Despite Mark's IQ which meant that he was not technically eligible for LD services, the LD team nonetheless agreed to keep him on their books to support him. Arrangements were made to liaise across the different services that were involved. There was Risk Review, several MAPPA meetings were held, and a health colleague from social services helped Mark and the service to re-instigate Guardianship arrangements. This meant that Mark could be given support time which helped him to be safer. Mark nonetheless reported a minor assault by Colin in October 2018 which he subsequently rescinded, and his complex pattern of disorganised social and occupational relationships continued.

8.18 In November 2018 when he was listed on the register of sex offenders, Mark was allocated an offender manager from the Management of Sexual Offenders and Violent Offenders (MOSOVO) team in Dorset. He was graded as Very High Risk and, as such, had to be visited by the MOSOVO team every month. Mark was also screened by the Safeguarding Team following a report of an incident with a woman whom Mark alleged had stolen from him when consideration was given to whether he was at risk of financial abuse. In July 2018, the MAPPA team recorded Mark's risk as "*high risk of sexual harm to children and female adults. A medium risk to staff which could elevate to high. A high risk of harm to animals."* The integrated LD team attended all MAPPA meetings which were attended by at least one member on each occasion, normally two. The team included Consultant Psychiatrist, social worker and Community Learning Disability nurse.

9 THE INCIDENT

9.1 On 17th December 2018 Mark was at Colin's sheltered accommodation and, according to Mark's testimony and information from ambulance and hospital staff, they had an argument about a dog that he had been looking after. The dog had bitten him and run away. Mark said afterwards that Colin had become aggressive and verbally abusive. He reported that he turned his phone to `record' because he was frightened of being assaulted. He apparently remembers curling up into a ball but did not remember anything else. Afterwards, when it appeared that there had been a fight involving a lamp, Mark called his support worker, and an ambulance was called. Colin died two weeks late on1st January 2019.

10 FINDINGS

10.1 **TOR 1.1 A chronology from October 2013** A tabular list of Mark's contact with Mental Health, Primary Health Care and third sector services can be found in Annex 6. The tabular and narrative chronologies in our report are consistent with the accounts prepared for the DHR and were verified from the case notes and the Individual Management Reviews (IMRs) which were developed by the various services contributing to the DHR.

10.2 **Review the application of the Care Programme Approach, including risk assessment and management plans, discharge planning in line with Provider Guidance, National Policy and best practice, with particular reference to the transfer to The Sherwood Centre in September 2015 and Mark's planned relocation to Dorset in May 2017 (TOR 1.2)**. Our team reviewed the NHS electronic case records provided for St Andrews, the Sherwood Centre and by Dorset Healthcare. We could see clear evidence of a good quality of care planning in Dorset, also at St Andrews, and at the Sherwood Centre. Electronic records (care plans, internal correspondence, process notes, observation records and medication lists) were clear and, in the case of St Andrews and The Sherwood Centre in particular, we could see examples of excellent descriptions of Mark's needs.

10.3 Dorset notes also contain thorough care plans containing personal statements (particularly towards the latter part of 2018) from Mark about his history, his history of absconding, his aggression and sexually inappropriate behaviour, and his own personal history as a victim of child sexual abuse. The notes show evidence of Mark's vulnerability as well as his level of risk to others. The occasional mistake, for example, at The Sherwood Centre when Mark's Guardianship Order was allowed unintentionally to lapse, was corrected and the GP wrote in detail about the circumstances.

10.4 Our team could see evidence relating to very good practice in 2018 in relation to the establishment in Dorset of a Guardianship Order for Mark. The electronic notes in both sites show that Mark was actively involved in his care and that he was provided structure and prompting to manage his behaviour, including his lack of social and communication skills. Our team could find no reason to doubt the diagnoses given by St Andrews, at The Sherwood Centre, or in Dorset for Mark of ADHD and ASD although there had been occasional discussion of whether it would be appropriate to give him a diagnosis of personality disorder. There were also several discussions over time and different opinions of Mark's degree of learning disability (variation in scores is normal when individuals are at the borderline), but regardless of the diagnostic labels, appraisals of Mark's

behaviour and statements of his needs were generally very clear and his presentation (at least when he went to Dorset) remained stable.

10.5 In the light of the time that has elapsed since the time of the incident, our team has included a recommendation for Dorset Healthcare to refresh the work that they undertook when they initially completed an Action Plan for the DHR.

10.6 **Risk assessment.** Risk assessment should always involve a thorough, up-to-date, comprehensive assessment of all the factors associated with the prediction of risk, and the consequences for the patient and other people. The factors which are typically associated with risk may include diagnosis, past behaviour, substance misuse, thoughts, intentions and/or mood, social and a range of demographic factors. Risk assessments should include information about the likely causes of risk, the triggers for risky behaviour, and information about the potential impact and mitigations.

10.7 We could see that whilst the risk assessment tools used in Dorset and Nottinghamshire, were different, both services used similar techniques. We could see that tools (such as questionnaires and other evidence-based systematic measures) and thorough clinical judgements were used to assist the judgements of risk. In Dorset as well as at St Andrews and at The Sherwood Centre (especially in the latter), records relating to risks were full and informative; they were updated frequently and risks as well as mitigations and crisis plans were articulated clearly.

10.8 Services provided in Nottinghamshire and Dorset both took appropriate steps to support Mark using a Guardianship Order and when Mark was registered as a sex offender in 2018, MAPPA arrangements and Safeguarding arrangements were managed very effectively. These latter arrangements are addressed clearly in the DHR report which is due for publication in due course. Steps to mitigate Mark's identified level of risk were also taken appropriately. For example, Mark was given time to discuss, manage and control aggressive thoughts; he was not seen alone by female staff; and he was actively encouraged to keep his use of alcohol under control.

10.9 Our conversations with healthcare staff in Dorset in partnership with BCP show that positive steps to improve have already been made to strengthen services since the time of the incident. For example, Multi-agency Risk Management systems (MARMs) have been reviewed and a new policy has been developed and audited. MARM is designed to enable agencies to share information where there are concerns about an individual living in the community. Any agency can convene a MARM meeting and there are a wide range of circumstances when this might be appropriate (e.g., if someone is at risk of abuse or neglect, self-neglect, hoarding or domestic violence). Although MARMs is not a substitute

for a Safeguarding Adults Inquiry, our conversations with staff suggest that safeguarding systems are also working effectively (these are also managed by BCP in partnership with health).

10.10 Risk policy in Dorset Healthcare has also been reviewed and a training suite is currently being developed, including for LD-specific risk assessment and management. The new system is simpler and is now more formulation-specific rather than based in diagnostic labels. In reviewing the records and this information, our team does not have additional comments or recommendations to make.

10.11 **Discharge and relocation plans.** Mark's transfer from St Andrew's to the Sherwood Centre in 2015 and his relocation from there to Dorset in 2017 were notably different from one another. In 2015, when Mark moved from St Andrews to The Sherwood Centre (which sits within the County and has organisational ties) the electronic notes show clear information about Mark's needs. Care was provided, information was shared, and MHA Section 117 aftercare arrangements and a Guardianship Order were in place.

10.12 However, the picture was much less clear after Mark's move to The Sherwood Centre when in 2016 Mark's MHA Section was removed, his Guardianship Order was allowed to lapse and following a period of rehabilitation at The Sherwood Centre he began to talk about wanting to return to Dorset. In September 2016 a multi-disciplinary Care Programme Approach Review (CPA) was undertaken at the Sherwood Centre; staff judged that Mark had improved sufficiently to enable him to move to a self-contained flat, and it was agreed to discharge him from his Guardianship Order and from the CPA framework. The electronic records show that Mark began to talk more actively about moving to be near his family (Colin). Although there is no reason to doubt that this was an appropriate decision given Mark's improvement and his mental health, it meant that (despite the behavioural risk he had posed formerly) there were no legal or other obstacles to prevent it.

10.13 A referral was sent to Mark's GP from the psychiatrist in Nottinghamshire included general information when he first moved; this contained a recommendation that Mark should be referred to the mental health team. However, it apparently contained little detailed information about Mark's history or the history of his challenging behaviour, his forensic history, the personal risk that had formerly been posed to staff, or his pending Court case. Although S.117 aftercare arrangements were maintained when Nottinghamshire social care made contact with Dorset social services, and our team were told that despite requests from Dorset to Nottinghamshire for more detail, psychiatric information was not sent until close to the date of the incident when it was

prompted at a MAPPA meeting in 2018 and statutory obligations made it a requirement.

10.14 It is known that staff in the NHS commonly find it difficult to obtain information about patients who have moved to a new area, particularly if there is no legal framework (for example, in connection with Safeguarding, the Care Act, Children Act, MAPPA, or MARMs). There are (sometimes misplaced) concerns about confidentiality and data protection[18], particularly if the patient has a forensic history or a criminal record. Communications with health and social care or housing services can be similarly restricted.

10.15 In this case, our team was able to see that information had been shared between social care staff in Nottinghamshire and in Dorset, and that communication had been supported under Section 117 arrangements. However, by contrast, the NHS staff in Dorset had not initially had the benefit of information shared by Nottingham until MAPPA arrangements were established. They reported their frustration to us about the difficulty of obtaining information and commented that they thought professional curiosity or `mindfulness' should have triggered a report or a phone call to potentially reduce the risk to lone workers or members of the public. The evidence nonetheless shows that Mark's healthcare needs and risks and the plans for his treatment were identified quite quickly. Whilst our team does not therefore believe that the omissions were material in relation to the incident which ultimately led to Colin's death, we do believe that improvements in information-sharing are needed.

10.16 Our team has therefore included a new recommendation designed to strengthen the quality and content of digital information shared between NHS services when a patient is referred, moves to a new geographical location and care needs to be continued (see Recommendations section below).

10.17 **Determine whether there were any missed opportunities to engage other services and/or agencies to support Mark during his relocation to Dorset (TOR item 1.3**). In meetings with our team, Colin's family raised concerns about access to services for Mark. They were concerned about whether services had been limited by Mark's LD status (as described in Section 7) or his diagnosis which they fear might have been missed. This is because there were doubts about whether Mark had a learning disability at all, whether he had autism, whether he should have been seen by community mental health services, and because he did not fit easily into either mainstream LD or adult mental health services. Staff reported to us that it is not unusual in the context

[18] HM Government. `Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers'. July 2018

of budgetary and service pressures for services to `police' their boundaries around mental and learning disabilities services. Very complicated patients or those who fit both categories can sometimes `bounce around' the NHS system. Whilst Mark might potentially have been seen by community mental health services rather than in learning disabilities, our team has no doubt that his needs, in our opinion, were eventually met. Mark's needs were largely behavioural rather than diagnosis-based or clinical, and although there were clear delays due to a lack of information, we cannot agree that the delays were causative in relation to Colin's death.

10.18 Staff from local services (as elsewhere in the NHS) report continuing difficulty identifying services for people with autism and staff know it can be difficult to obtain information about or deliver oversight of forensic issues unless they fall clearly within the LD ambit. In this case, the evidence shows that whilst Mark was referred for an assessment by the forensic service, he was not deemed to meet criteria for acceptance. Our team would like to compliment the team in Dorset for maintaining their contact with Mark in this case, even when his IQ scores were shown to be `borderline'.

10.19 Our team could also see evidence that support for Mark had been made by Police, Probation, Social Care services and Housing Departments, and that these services liaised reasonably well together. Mark's Guardianship Order was re-instituted, MAPPA and MARM arrangements were made, and Safeguarding arrangements were monitored.

10.20 Our team could also see that since the time of the incident, Dorset Healthcare has clarified their policy for access to services: people are seen in the service to which they are initially referred and/or supported to access other more appropriate service. We also note a recent development in Dorset designed to deliver a `No wrong door' policy which is designed to reduce the likelihood that patients and service users must repeat themselves or be re-referred when it is unclear which service should be managing care. However, it will be important to understand the impact (see below). Our team have no further recommendations to make in these areas.

10.21 **Identify any factors that hindered the risk assessment and management processes and what plans were put in place to mitigate those risks. (TOR item 1.4)**. Our team was able to see that summaries of correspondence to Mark's GP in Dorset (and also in Nottingham) were good and, for the most part, information was shared appropriately between health and social care services and vice versa. Documentation relating to MAPPA was also of a fair standard, although several steps have now been taken to strengthen this area in Dorset.

10.22 At the end of 2018 when the incident occurred, patients with a risk of sexual and violent offending were not as well engaged as they might be across the various systems (Police, Probation, NHS and social care). However, following this case, there was an internal review of MAPPA and it now appears much better embedded. For example, MAPPA is flagged on RiO (the NHS electronic records system) which has its own page and although there are a few Level 2 and 3 MAPPA patients who still need some work, and Level 1 patients have not yet been fully mapped, communication and information are much improved. An e-package of training and some face-to-face training is also now available.

10.23 There were delays and gaps in the NHS information provided by The Sherwood Centre when Dorset asked for more detailed information, as outlined above. Fortunately, the LD service kept contact with Mark without having full information so whilst this problem continued to represent a concern, our team is content to say that this issue was not material in relation to the incident that ultimately led to Colin's death. Our team would like to compliment the Dorset team for the quality of their decision making (the Guardianship Order and Safeguarding arrangements in particular).

10.24 An Accountability and Assurance Framework for Vulnerable People in the Reformed NHS[19] sets out the safeguarding roles, duties and responsibilities in NHS health and social care services and these flow from duties under the Care Act 2014. There are several entries in the electronic records relating to safeguarding. For example, in January 2017 Mark attended the surgery with wrist pain. His support worker mentioned to the GP that Mark had been involved in an altercation with neighbours and this had led to a safeguarding concern being raised. The Borough Helpdesk in Dorset was also contacted by Nottingham City Council (NCC) to say that Mark might have welfare concerns and in mid-May 2018 he was screened by the Safeguarding Team following a report of an incident with a woman who had allegedly stolen money from him. In October 2018 concerns were raised about Mark's relationship with Colin during the MAPPA meeting and both were offered a Safeguarding assessment but they both refused.

10.25 Normally, a clinical member of Dorset Healthcare staff in discussion with a client and/or their family will assess the need for support when a person may be vulnerable and there is a risk of abuse or neglect. Arguably, a question should always be asked about very vulnerable elderly close relatives providing care, but practice varies and there is no sense in which risks associated with abuse or neglect should automatically be identified solely on the basis of age.

[19] http://www.surreyheathccg.nhs.uk/doc-engagement/nhs-england-safeguarding/470-nhs-england-safeguarding-accountability-assurance-framework/file

In this case, we could see that Colin did not want input from services. Our team is content to report that the evidence from the notes and records relating to MAPPA and Safeguarding and the reviews are consistent with the electronic notes, and we have no further comments.

10.26 **Review the quality of interagency and inter-service liaison, communication, decision making and planning over the period 2013-2019 (TOR item 1.5)**. The information summarised in Section 7 (Background), the IMRs, MAPPA, Safeguarding Reviews and our own checks of electronic notes and interviews are consistent with one another and, with the exception of the points raised in relation to sharing information between NHS services in Nottingham and Dorset, the quality of interagency and inter-service liaison, communication, decision making and planning over the period appear to have been of a generally good quality.

10.27 Since 2018, according to the staff to whom we spoke, information sharing and communication between Police, Probation and other partners have also improved. Dorset Healthcare now has a Memorandum of Understanding (MoU) about information sharing and protocols are now in place. Our team has no further comment to make about these areas.

10.28 **Review the Providers application of its Duty of Candour to the family of the perpetrator and the victim (TOR item 2.1)** Our team could see that an initial approach had been made to at least one member of Colin's family after Colin's death. According to the electronic records, an offer to make contact had been refused. However, when representatives of our team spoke to Colin's nephew, it became clear that the family felt that they had insufficient information about aspects of the NHS care provided. Our team has therefore recommended that Dorset Healthcare should provide an opportunity for representatives from Colin's family to meet representatives from the service to consider the circumstances of his death and understand how changes and recommendations described in our report will now be acted upon.

10.29 **Determine whether there were any missed opportunities to engage other services and/or agencies to support Mark's Family (TOR item 1.6).** Mark did not have any siblings and his mother had died in 2002, so Colin was Mark's only real family. Although Colin was one of several siblings himself, contact between Colin and some of his siblings was extremely limited following a family argument about Colin's continuing contact with Mark during the time he was legally prevented from having access. Colin's nephew also thought it likely that Colin had been reluctant to engage with services and the family were not even aware that Mark had come back to Dorset in 2017. Our team hopes that the recommendation for Dorset Healthcare to meet with the family to discuss

the case and the work to develop the review will help to achieve a measure of closure for the family.

10.30 **Comment on relevant issues that may warrant further investigation (TOR item 1.7)** Our team has no further areas that in our view warrant investigation. However, we note that a new service in Dorset funded by BCP has recently been established to address concerns which are very close to those presented by Mark in 2017 and 2018. The Assertive Engagement Team (AET) (currently being established) will be focused upon people who are difficult to engage and who have a high level of risk of self-harm or harm to others. It consists of two full time equivalent Advanced Social Workers (Adult Mental Health Professionals) who will be managed within the Adult Safeguarding Hub. The AET will work with adults who present to Adult Social Care (ASC) with complex needs where it is not clear which service should meet their needs for assessment and care provision. The AET service will be focused upon people who are difficult to engage who have high level of risk of self-harm or harm to others. The AET will assess, triage and peer-support services to maintain delivery of care, provide advocacy and escalate unmet needs to support statutory functions to clients.

10.31 Although this team is a new one, and is very small at the current time, our team believes it has the scope to meet what staff believe to be a significant gap in services for people like Mark who can be difficult to place. It will be important to monitor outcomes carefully.

11 CONCLUSIONS

11.1 It is clear that steps in Dorset could potentially have been taken sooner and that risks could have been reduced during the latter part of 2017 and in the first half of 2018 if full information from The Sherwood Centre had been shared. For example, the delays in accessing secondary services would likely have been reduced; Guardianship and MAPPA might have been established earlier, and it is possible that risks associated with so high volume of contacts between Mark and Colin might also have been reduced. However, when the incident occurred in 2018, it is also clear that a very good range of significant mitigations to reduce the known risks were in place. Our team compliments health and social care services in Dorset for their later work across the system of care to deliver effective `joined-up' care, and the mitigations designed to improve those.

11.2 Our team concludes that the incident that led to Colin's sad death could not reasonably have been prevented.

11.3 We would like to extend our condolences to Colin's family for their loss. We hope that information relating to the NHS services in Dorset which supplement

the information which will be published in due course about the DHR will be helpful in supplementing their knowledge.

12 RECOMMENDATIONS (TOR item 1.8)

Recommendation 1

NHS England and NHS Digital to support delivery of information to be used within and across services to support information-sharing across geographical and service boundaries. It should be evidence-based and contain guidance for staff. The aim is to ensure that key elements of the care provided for a patient can be shared (within legal restrictions) to support practitioners who take responsibility for care, and support management of risk when patients transfer. The overall purpose is to promote timely information sharing across NHS services and reduce the risk to service users themselves, to staff and the public.

Recommendation 2 Our team recommends that Dorset Healthcare should provide an opportunity for representatives from Colin's family to meet representatives from the service to consider the circumstances of his death, understand the changes described in the report, and the ways in which recommendations will be acted upon.

Recommendation 3 We recommend that the Action Plan that was developed by Dorset Healthcare in relation to the DHR recommendations should be revisited in the light of this report. The purpose would be to set out clearly the ways in which the impact of changes in the service will be measured.

APPENDIX 1

TERMS OF REFERENCE

Background to The Review.

In December 2018 Mark assaulted his step-grandfather X with a lamp. X was conveyed to hospital and died of his injuries on 1st January 2019.

Mark was convicted of manslaughter by reason of diminished responsibility, sentenced in July 2020 and received a hospital order.

Purpose of the Review

- To independently assess the quality of the care and treatment provided to Mark against best practice, national guidance and Trust Policy.
- To identify further opportunities for learning that may be applicable on a local, regional or national basis.

The outcome of this review will be managed through corporate governance structures in NHS England, the Clinical Commissioning Group(s) and the provider's formal Board sub-committees.

1.Terms of Reference

NB: The following Terms of Reference remain in draft format, until they have been reviewed at the formal initiation meeting and agreed with the families concerned.

Bournemouth, Christchurch and Poole Community Safety Partnership commissioned a combined Domestic Homicide Review, MAPPA Serious Case Review and Safeguarding Adult Review in July 2019.

The purpose of the combined review was to establish the facts that led to the incident in December 2018 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family and to assess whether MAPPA was effectively applied, and whether the agencies worked together to do all that they reasonably could have done to manage the risk of further offending

This review will build on those findings to review the care, treatment and management of ML against best practice and national guidance for healthcare providers.

1.1 Produce a full chronology (from inpatient admission in October 2013) of Mark's contact with Mental Health, Primary Health Care and third sector services to determine if his healthcare needs and risks were fully understood and that is reflected in the treatment plans.
1.2 Review the application of the Care Programme Approach, including risk assessment and management plans, discharge planning in line with Provider Guidance, National Policy and best practice, with particular reference to the transfer to the Sherwood Centre (Huntercombe Hospital as is has been known) in September 2015 and Mark's planned relocation to Dorset in May 2017.
1.3 Determine whether there were any missed opportunities to engage other services and/or agencies to support Mark during his relocation to Dorset.
1.4 Identify any factors that hindered the risk assessment and management processes and what plans were put in place to mitigate those risks.
1.5 Review the quality of interagency and inter-service liaison, communication, decision making and planning over the period 2013-2019.
1.6 Determine whether there were any missed opportunities to engage other services and/or agencies to support Mark's Family
1.7 Having assessed the above, comment on relevant issues that may warrant further investigation.
1.8 Make recommendations for the Provider(s), ICS (formerly CCG) and/or NHS England as appropriate.
2.1 Review the Providers application of its Duty of Candour to the family of the perpetrator and the victim.

3. Timescale

The review process starts when the investigator receives the Provider documents and the review should be completed within 6 months thereafter.

4. Initial steps and stages

NHS England will:

4.1 Ensure that the relevant families are informed about the review process and understand how they can be involved including influencing the terms of reference
4.2 Arrange an initiation meeting between the Provider, commissioners, investigator and other agencies willing to participate in this review

5. Outputs

5.1 We will require monthly updates and where required, these to be shared with families, ICSs and Providers
5.2 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, proofread and shared and agreed with participating organisations and families (NHS England style guide to be followed)

5.3 At the end of the review, to share the report with the Provider and meet the victim and perpetrator families to explain the findings of the review and engage the clinical commissioning group with these meetings where appropriate

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

5.5 A briefing document of key learning points that can be shared with the Regions, ICGs and Providers.

5.6 The investigator will deliver learning events/workshops for the Provider, staff and commissioners if appropriate.

6. Other

6.1 Should the families 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 2

Investigation team

Anne Richardson, BSc, MPhil, FBPsS, Director of Anne Richardson Consulting Ltd is a clinical psychologist by training. She specialised formerly in clinical work with adults with severe mental ill health and long-term needs. She is an experienced teacher/trainer and communicator, having worked as joint Course Director of the DClinPsy at UCL before moving to take a post at the Department of Health. Subsequently, as Head of mental health policy at the DH, she was instrumental in the development and delivery of the National Service Framework for Mental Health and, with Sir Jonathan Michael, led development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008). Since 2010, Anne has worked independently to lead NHS investigations into homicide and/or suicide, including work in partnership with local authority/Home Office to deliver Domestic Homicide Reviews.

Hugh Griffiths, MBBS FRCPsych, is a former consultant psychiatrist in the North-East of England where he carried responsibility for inpatient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, and liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as National Clinical Director for Mental Health (England) at the Department of Health, he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework. He retired from this post in March 2013 and until recently worked as a non-Exec in a mental health trust in the north of England.

Adrian Childs RMN, RGN, DipN (Lond), MSc, Dip Exec Coaching, trained as a general and mental health nurse. He was director of nursing in Newcastle, Devon, Manchester and Leicester; he holds a diploma in leadership, mentoring and executive coaching. Adrian has contributed to several national working parties including the development and appointment of Consultant Nurses and development packages for nurses working with severe personality disorders. In 2014 Adrian was made Honorary Professor for the Faculty of Health and Life Sciences at De Montfort University, Leicester and in 2019 he was made an Honorary Senior Fellow at Leicester University. He currently works as a Director of Nursing in the south west.

APPENDIX 3

Documents and policies reviewed

Bournemouth, Christchurch and Poole Community Safety Partnership Domestic Homicide Overview Report Regarding Colin who died in January 2019 (unpublished).

Dorset Healthcare electronic records.

Nottinghamshire electronic records, including records at the Sherwood Centre.

Court reports relating to the case.

Pan-Dorset Diagnostic Pathway for DHUFT Learning Disabilities Services December 2015.

Mental Health Integrated Community Care Programme July 2021 and Newsletters.

Safeguarding Adults Procedures)

Bournemouth, Christchurch and Poole and Dorset Safeguarding Adults Boards Multi-Agency Risk Management (MARM) Principles and Guidance (https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.bcpsafeguardingadultsboard.com%2Fuploads%2F7%2F4%2F8%2F9%2F74891967%2Fmarm_guidance_-_final_-_november_2021.docx&wdOrigin=BROWSELINK)

Confidential medical report prepared for the Court by an Approved Clinician under Section 12/2 of the 1983 Mental Health Act May 2019.

Pan-Dorset Diagnostic Pathway for DHUFT Learning Disabilities Services LD pathway.

Dorset CMHT policy.

BCP Council. Assertive Engagement Team - Service Specification – 2022

DHC Guidance for the Management of a Multi-Agency Risk Management Meeting (April 2021).

Dorset Healthcare. September 2020. `Information Governance Guidance on Information Sharing and Exchanges of Information.'

Joint Mental Health. Standard Operating Procedure for working between South Western Ambulance Service NHS Foundation Trust, Dorset Healthcare NHS Trust and Dorset Police.

Dorset Healthcare Multi-Agency Public Protection Arrangements (MAPPA)

APPENDIX 4

Personal consultations

Consultant Psychiatrist in Learning Disabilities, Dorset Healthcare

Head of Statutory Services, Adult Social Care Services, BCP

Team Manager, BCP Adult Learning Disability Service (Dorset – town redacted).

Head of Mental Health at Dorset HealthCare University NHS Foundation Trust

Head of Children's and Adult Learning Disability Services, Dorset Wheelchair Service and Vocational Services.

Members of Colin's family (his sister, a nephew and a niece).

APPENDIX 5

CHRONOLOGY OF CARE (abbreviated)

DATE	EVENT
1992	Mark was born in Poole. He and his mother moved to Nottingham shortly afterwards. Records indicate a history of abuse.
1998/9	Mark was referred to Child and Adolescent Mental Health Services with difficulties interacting with others. He was enrolled into a school for educational and behavioural needs.
2002	Mark's mother died from a seizure following an overdose; he called for an ambulance. Initially, he was cared by members of his family, including Colin his step-grandfather and her wife (Mark's grandmother).
2004	Mark allegedly attempted to strangle a woman who had been his mother's friend. He disclosed at this time that between the ages of 11 and 13 he had been sexually abused by Colin.
2006	Colin and his wife were refused custody of him and Mark was placed in foster care. The Court imposed a restriction upon their contact and Colin was given a 2yr suspended sentence and then an eighteen-month prison sentence for breaking it. Mark absconded multiple times from foster care where he subsequently reported bullying, sexual and physical abuse.
2007	Mark was detained under MHA Section 25 (Children Act) charged with assault, ABH and sexual assault. In 2007, at age 15, Mark assaulted members of staff and a secure accommodation Order was made to Clayfield's secure unit in Nottingham. He was reported as missing from the unit on more than one occasion and had been classified as high risk and a potential danger to the public.
2008	Mark moved to Derbyshire.
2009	In 2009, Mark was detained at St Andrew's Hospital under Section 37 off the Mental Health Act (MHA) following an assault, Actual Bodily Harm (ABH) and sexual assault Mark (age 17) and he moved to Clayfield House, a specialist secure residential unit for young people at risk of sexual

	offending. He had been classified as high risk and a potential danger to the public, with an IQ in the LD range.
2010	At age 18 Mark moved into St Andrews' adult service where he remained until 2015.
2011	Mark's grandmother (Colin's' wife) died.
2013	Cognitive testing (WAIS IV) suggested Mark to be functioning at the borderline level in the verbal range and his non-verbal skills were extremely low. Mark could not sustain concentration, attention, working memory, or process visual material without making mistakes. Some progress was made in psychology sessions when he was able to discuss his history of trauma. Mark's treatment also consisted of nursing, occupational therapy and speech and language therapy. Diagnoses of Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder were identified, and Mark's aggressive behaviour lessened; however, he continued to challenge boundaries socially, sexually, and in his daily living.
2014	Mark became preoccupied with a female shop assistant and then with a nurse but, overall, there were improvements and discharge planning began. He was referred to the Intensive Community Assessment and Treatment Team (ICATT) service. This offers rapid response, short-term advice and interventions for adults with intellectual disabilities experiencing an increase in emotional and/or behavioural difficulties with adults (18-65) with a diagnosis of an intellectual disability. The interventions consisted of nursing, psychology, occupational therapy and speech and language therapy.
2015	On 24th September 2015 Mark was formally discharged from to St Andrews Hospital to the Sherwood Centre, a rehabilitation and assisted living centre. Although no longer detained under the Mental Health Act, mental health aftercare arrangements were in place in the form of a care coordinator, a social worker working in the local authority. During his time at the Sherwood Centre, there were 23 incidents when Mark made threats and had verbal altercations with staff and other residents. These included: altercations with peers and attempts to manage others' challenging behaviour, allegations of stalking, and verbal abuse of staff. In September

	Mark was also placed under a Guardianship Order, which meant he was restricted to living at the Sherwood Centre.
2016	During 2016 Mark was responsible for assault and causing criminal damage to staff property and he was also convicted of sending sexually explicit messages to a female under the age of 16. The Police investigated and Mark was charged for the offence of inciting a child to engage sexual activity, but the hearing and the verdict were not reached until the following year (2017). Although Mark clearly still lacked insight and his behaviour could still be challenging, it was agreed to discharge him from the CPA framework towards the Autumn of that year, and from his Guardianship Order. Clear information from the Nottingham NHS team was provided for the LD and Transitions North team social worker.
2017 April	In April 2017 Mark moved to Dorset. Although this went against the advice of staff, there was no base in either the Mental Health or Mental Capacity Acts to prevent him. Mark therefore went to live with Colin whilst he looked for a flat. Mark subsequently reported to the forensic psychiatrist that he and Colin had many arguments and fights when Mark had been bullied and hit; some of these involving the Police.
May	Mark had been advised to make contact with a GP in Dorset in order that his prescriptions relating to his ADHD could be continued and the Notts consultant wrote to Mark's GP with information suggesting that Mark should be referred to local psychiatric services. The GP referred him to the mental health team (it is protocol for a secondary specialised assessment to be made in order for ADHD prescriptions to be made). Information about Mark's history was limited, but it had been known that he had previously been detained under Section of the MHA and that he had been treated in the Sherwood Centre in a LD unit. The mental health team thought Mark unsuitable for them and they referred him to the primary care LD team (a joint NHS/local authority managed service) for assessment where he was assessed by a member of the team.
June	The consultant psychiatrist in LD saw Mark for an assessment. He decided to move Mark under the care of the secondary, more specialised LD team owing to his complex history and his challenging behaviour. Requests for

	more information from the Sherwood Centre about Mark's history were made but were not responded to. Although Mark frequently missed appointments, and the staff were unaware of his pending Court conviction, he was generally open to sharing information about himself. Mark was also a frequent attender in primary care, having a range of health anxieties and minor injuries partly due to his martial arts sessions and possibly due to having had fights.
July	A photocopy of Mark's risk assessment dated May 2016 was received from the Sherwood Centre; the risk assessment contains information about Mark's absconding and inappropriate sexualised behaviour, but no detailed psychiatric or social history was provided.
August	In August 2017 the notes outline the plan 1) to remain in LD services 2) unless new information arises `we must assume he has capacity to make complex decisions around risk of sexual exploitation from Colin. There is nothing from the last assessment to suggest we can coerce him into treatment or support'. 3) provide support to obtain a tenancy to decrease reliance on Colin. Mark appears to have ASD features, which means he can misread social cues and is unlikely to safely manage shared accommodation. 4) needs coaching and support around work, sexual relationship and supportive therapy and ongoing monitoring of complex medication. 5) allocate case worker from social services locally in LD team and nurse to try and engage him.
2018	In September the clinical psychologist assessed Mark and judged that he was not technically eligible for the LD service because his abilities placed him as `borderline', at the lower end of the low/average range for intelligence. The team nonetheless kept Mark on their caseload because of his level of risk. His attendance was poor, and his engagement limited. At this time, Mark was placed under a MAPPA 3 process, and he was also given a police liaison officer following a conviction for his earlier offence in Nottingham. The consultant psychiatrist in LD referred Mark for an assessment by a forensic psychiatrist for an assessment of the possibility that he had a personality disorder.

October	When he continued to fail to support himself in the community, Mark who was clearly still vulnerable, was then managed under a Guardianship Order at the instigation of the secondary LD team. He also received support from UK SLS, a private provider with experience of managing challenging people under the auspices of the Bournemouth, Dorse and Poole Adult Protections Policy and Procedures.
The Incident	
December 2018	On 17th December 2018 Mark went to Colin's home after a dog he had been looking after had bitten him and had subsequently run off. Mark had contact with his support worker and Probation Officer, and then went into the town centre to buy a lead, and when he went back to Colin's flat in the afternoon, there was an argument. Colin was allegedly angry and critical towards Mark who apparently put his phone to record because he was worried that Colin would hit him. Mark pushed over a lamp and then `blacked out' and could not remember what happened afterwards. Mark put Colin in the recovery position and called his support worker, who called an ambulance.