An independent investigation into the care and treatment of Mr N

Learning Summary

March 2024

Executive summary

Incident

1.1 Mr N had been in a relationship with Ms B from early 2019, with whom she already had one child. They lived together and then split up in late 2019. After this, Mr N moved between different addresses. Ms B gave birth to her second child in August 2020.

1.1 Following the relationship breaking down, Mr N was arrested for assaulting Ms B in November 2020 and a 'Child in Need'[1] safety plan was put in place for both children by children's services.

1.2 Mr N breached a no-contact order twice between November 2020 and January 2021 and assaulted Ms B and other family members on two separate occasions. Domestic abuse, stalking and harassment (DASH)[2] risk assessments were completed on each occasion. Mr N was sentenced to a community order and a restraining order was imposed in January 2021.

1.3 Mr N fatally assaulted Ms B and her first child in May 2021.

1.4 In February 2022 Mr N was convicted of both murders and sentenced to life imprisonment.

Investigation

1.5 NHS England, Midlands and East, commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of mental health service user Mr N. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.6 The independent investigation follows the NHS England Serious Incident Framework (SIF, March 2015)[3] and Department of Health guidance Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in Mental Health Services.[4]

1.7 This investigation was carried out alongside two combined statutory reviews: a domestic homicide review (DHR) and local child safeguarding practice review (CSPR).

1.8 The lead author attended the combined DHR and CSPR panel meetings and had access to the chronologies and reports prepared as part of this investigation.

1.9 This document is a summary intended to highlight learning for health agencies.

Findings and conclusions

1.10 Mr N had a history of occasional contact with health services dating back to his early teens.

1.11 He had a short period of care from mental health services from 2020 onwards, all of which occurred during the COVID-19 pandemic. Changes to the teams and working practices due to the pandemic included:

- managing increased staff sickness absence and shielding;
- meeting times and assessment/waiting periods were longer; and

[1] Children in Need (CIN) Plan - A CIN Plan is drawn up following a Single Assessment which identifies the child as having complex needs and where a coordinated response is needed in order that the child's needs can be met.
[2] Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Mode. https://www.dashriskchecklist.co.uk/
[3] NHS England (March 2015) Serious Incident Framework
[4] Department of Health (2015) Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in Mental Health Services

- arranging telephone and video meetings rather than face-to-face meetings.

1.12 While it is impossible to assess exactly what effects these may have had on Mr N's care, mental health services nevertheless tried hard to engage with him, despite his frequent changes of address and mobile phone number. This included arranging phone calls, following up when there was a lack of response, and arranging for letters to be picked up in person. However, the assessment of risk and care planning fell below expected standards. This was not identified until after the homicide, suggesting that quality oversight was insufficient.

1.13 In Mr N's contact with mental health services, clear indicators of risk to others were not assessed appropriately, and there was a lack of professional curiosity about his situation which aligned with his view of himself as a victim of circumstances beyond his control (i.e. his belief that he was autistic). The risk to others that he presented, and the events of November 2020 (domestic violence, crisis calls, re-referral), should have triggered a review of his care plan across the various teams involved.

1.14 The system for allocating assessments and managing waiting times for autism diagnoses has been addressed; however, there remained the issue that the policy allowed the referral for an autism assessment to be submitted without a clinical justification. We reviewed the notes in detail for any references to possible autism by clinicians. We found that there were two references to possible autism (in 2017 and in April 2019), although both are questions raised by Mr N about his diagnosis to professionals rather than observations by professionals themselves. During his contact with the Child and Adolescent Mental Health Service (CAMHS) as a teenager, no concerns about autism were raised by professionals, Mr N, or his stepmother. We therefore made a recommendation on this aspect.

1.15 A summary of the care and service delivery problems that we identified is provided below:

Care delivery problems
There was no communication made by the Trust with children's services to establish whether there was any involvement. Concerns raised by email to the Trust's safeguarding team by the CJLD and copied in the CMHT did not receive a response. This was not followed up by the CJLD or CMHT and there is no evidence of any action being taken.
There were no attempts to make contact with family members to triangulate the information being shared by Mr N with mental health services and no attempts were made to involve family members or a carer in his care planning.
Throughout Mr N's contact with the CMHT, his risk assessments were not completed in line with Trust policy.
Risks identified through contact with the CJLD service were not acted upon by the CMHT.
Discharge from the CMHT was arranged due to resource issues rather than a change in the assessment of Mr N's needs.
The referral for the autism diagnostic assessment was based on self-report, not supported by clinical opinion.
Service delivery problems
Changes made to working practices due to the COVID-19 pandemic impacted face-to-face assessments and direct contact with Mr N and the delivery of the service was directly affected by resource management issues related to the pandemic.
The community psychiatric nurse believed that he must be discharged from CMHT involvement for a referral to the psychological treatment service to be made.
Risk assessments made in outpatient letters were not in line with Trust policy expectations.

The absence of a properly completed risk assessment was not identified through quality oversight structures or processes.
Risk assessments completed by the CJLD service used a different structure to that described in the Trust policy.
There were no standards set for the time between a referral for an autism assessment and a triage assessment by the autism diagnostic and liaison team. This has been addressed by the service through the introduction of a waiting list management tool.

Critical learning points

1.16 Good risk assessment practice is critical to making care planning and discharge decisions. Including families in gathering risk information is part of developing a rounded and thorough assessment of risk including risk to others.

1.17 Referrals between different teams within a Trust that are not coordinated across services risk patients falling between services on long waiting lists.

1.18 Not following Trust policy and processes means that there is a risk of variable practice developing where staff may not understand requirements. Oversight of the implementation of Trust policy is a critical part of ensuring professionals follow best practice.

Recommendations

1.19 The independent investigation made three recommendations to be addressed to improve learning from this event.

Recommendation 1: The Trust does not have sufficiently sensitive quality oversight and monitoring processes to provide assurance that standards for risk assessment and care planning are being met.

The Trust should review its current controls and develop a range of measures that can provide oversight of risk assessment and care planning, through the use of supervision and quality monitoring. Including:

- The involvement of families and carers in risk assessment and care planning.
- A single risk assessment completed using the Five Ps, reflecting the full range of risk information in the records and leading to a risk management plan.

Recommendation 2: There was a lack of clarity regarding the assessment of domestic abuse and children at risk.

Assessment questions about domestic abuse should include the possibility that the service user is a potential perpetrator.

The wording in the child safeguarding tool should be clear on how and when the tool should be used where there are issues of parental responsibility and/or domestic abuse.

Recommendation 3: An autism diagnostic assessment was instigated without the expected supporting clinical opinion. The assessment is a scarce resource, and allocation to a waiting list should only follow if clinical opinion supports the referral.

The Trust should provide assurance that the criteria for processing a referral for an autism diagnostic assessment are always met.

Learning quadrant

Individual practice

- Have I involved the families and carers in risk assessment and care planning?
- Have we triangulated information with family members to get a clearer understanding?
- Have I recorded the full range of information from facts and conversations in the care records?
- Does the risk assessment completed reflect the full range of information in the records?
- Do I recognise when verbal opinion starts to venture outside of the 'facts' and does my clinical opinion support this information?
- Have I considered who is the potential perpetrator in domestic abuse assessments?

Governance focused learning

- Are we compliant with Trust policy when completing risk assessments?
- Is our single risk assessment completed using the Five Ps?
- Are we assured that the criteria for processing a referral for assessment are always met?
- How are we assured that risks identified by other agencies are acted upon?
- How are we assured that service users are discharged based on an assessment of their needs rather than resources available?

Board assurance

- Are there sufficiently sensitive quality oversight and monitoring processes to provide assurance that standards for risk assessment and care planning are being met?
- Do audit and quality monitoring measures include a focus on relevance and quality as a standard expectation?
- Are there information sharing agreements in place with other key agencies?
- Do we have sufficient quality and oversight structures to provide assurance that we are undertaking high quality assessments?
- Has learning from previous independent investigations been embedded across the Trust?

System learning points

- Have we recognised the need for collaboration and communication between agencies concerning domestic abuse and children at risk?
- Are there clear guidelines on how and when tools should be used when there are issues of parental responsibility and/or domestic abuse?
- Have we recognised the need for a case review involving all teams particularly following a further event?
- Is there clear guidance regarding referral criteria and care pathways across services?
- Have we implemented and embedded the learning from previous independent investigations?

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