Independent Review of care by Norfolk and Suffolk Mental Health NHS Foundation Trust

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Investigations
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Introduction

1. This is the report of a Mental Health Homicide Review (MHHR) commissioned by NHS England (Midlands and East region)[1] (NHSE) of care provided by Norfolk and Suffolk Mental Health NHS Foundation Trust (hereinafter called the Trust) for Brennan[2] who was responsible for the death of Sofia his grandmother.

2. This abbreviated report was designed for publication[3]. In trying to strengthen services and improve learning in the context of the evidence, the report outlines relevant information about the incident. It is designed to support learning and communicate an evidence-based formulation and a narrative to inform the NHS and the public. It identifies ways in which the mental health NHS service can be improved. However, all identifying information has been removed (family and staff names, locations, ages) to ensure a balance of interests between the rights (regarding confidentiality) of the individual (Brennan) and those affected (Sofia's family). Very specific details relating to the family's circumstances and some parts of the history have been removed.

3. Our team would like to acknowledge the degree of difficulty that Sofia's family has faced following what has clearly been an exceptionally traumatic event for them. In addition to their grief and anger, Sofia's children and grandchildren have been very affected by our investigation and the DHR process. Whilst our team has tried to identify learning which could be used to reduce risks for others who might face similar circumstances, we are aware that our report may be very difficult for them to read. We regret that we were not able to meet the expectations and wishes of all family members.

Methodology

4. Our team, a senior group of independent clinical professionals, was appointed by NHSE in early 2022 to lead the review. The team consisted of a consultant psychologist (chair of the MHHR), a consultant psychiatrist and a director of nursing. All had experience of NHS mental health care delivery, policy and service planning and none had connections previously with the Trust. Outline Terms of

[1] NHS England and NHS Improvement (2015). The Serious Incident Framework: Supporting Learning to Prevent Recurrence'. https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf
[2] Pseudonyms were chosen to protect the family.
[3] A more detailed report has prepared for the Home Office and for the coroner.

Reference (TOR) for the MHHR were developed in partnership with a Panel oversee work to deliver a Domestic Homicide Review (DHR)[4] and the NHSE.

5. Written information about the process of the two reviews (the MHHR and the DHR) was initially provided for members of Sofia's family, and final Terms of Reference were then agreed. The final TOR items were therefore informed by members of Sofia's family who raised many very specific questions about Brennan's NHS care, the support provided by social services for Sofia, the police, and Brennan's school and university. The following abbreviated summary of the TOR has been redacted in the interests of protecting the confidentiality of family members:

    - Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
    - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
    - Apply these lessons to service responses including changes to policies and procedures as appropriate.
    - Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
    - Contribute to a better understanding of the nature of domestic violence and abuse; and
    - Highlight good practice.

6. Specific items for our team for the NHS were also included:

    - Critically examine and quality assure the NHS contributions to the Domestic Homicide Review.
    - Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user.
    - Review and assess compliance with local policies, national guidance and relevant statutory obligation.

[4] The Domestic Homicide Review was commissioned according to statutory guidance under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004) by Norfolk County Community Safety Partnership (NCSP). https://www.norfolk-pcc.gov.uk/who-we-are/community-safety-partnership/

- Examine the effectiveness of the service user's Care Plan and Risk Assessment, including the involvement of the service user and his family.
- Review the appropriateness of the treatment of the service user in the light of any identified health needs/treatment pathway.
- Work alongside the Domestic Homicide Review panel and Chair to complete the review and liaise with the family.
- Provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or standalone.

7. Our NHS team initially undertook a desktop review of documentary evidence including electronic care records about Brennan provided by the NHS Trust, and records of care provided in the private but `within-area' hospital provision referred by the NHS where Brennan was initially admitted. Other documentary evidence from the Trust included policies on care planning, risk assessment, safeguarding, and post-incident forensic reports prepared for the Court. Our team also had access to the report of a comprehensive investigation commissioned by the Trust that had been developed immediately after the incident.

8. Our team held confidential interviews by videoconference with several members of the Trust clinical staff, including staff who had known Brennan, to understand the details of the assessments and care that was provided for him. All those interviewed personally were contacted in writing with information about the investigation and its Terms of Reference. All witnesses were assured that their testimony would be confidential and that no personally identifying information would be included. The staff who were interviewed included a consultant forensic psychiatrist, a consultant psychiatrist specialising in early intervention (EI) for people with first psychosis, a patient safety specialist, a consultant medical director, a specialist deputy chief operating officer, a senior nurse leading care planning, and a key worker from the EI team (EIT).

9. Conversations by videoconference with Brennan's family and communications by email were undertaken separately over the course of the Reviews in partnership with the chairs of the MHHR and DHR This was undertaken to ensure that separate members of the family could be assured of a confidential opportunity to discuss their different opinions, and to ensure that all family members could be involved in the process. No response from Brennan's mother was received. Brennan also declined several times to meet a representative of the team.

10. Our team was fortunate to have the benefit of working alongside the DHR Panel. We had access to reports of Individual Management Reviews (IMRs) commissioned by the DHR Chair, and information shared by the DHR Panel

meetings, including police, social care services, Higher Education, primary health care, NHS staff from specialised mental health services and others. A full account of all the points raised over the course of the review which focused on non-NHS as well as NHS information can be found in the report of the DHR which will be published in due course.

Background

11. Brennan was born outside the UK and his parents separated when he was six. He apparently had a `normal' childhood and he was a clever child, but he was bullied due his mixed race and spent considerable amounts of time in his room playing video games. Brennan's family said that his conduct and behaviour were sometimes disorderly, but mental health difficulties were formally recognised when an aggressive episode directed towards his mother triggered an admission for `gaming addiction.' Although there is no formal documentary evidence relating to this time (we were unable to solicit any information from overseas), Brennan's family said he had allegedly tried to kill his mother. After this, Brennan's father brought him to England to a state Boarding School in England to complete his `A' levels.

12. After finishing school, which he completed successfully, Brennan started a course at university. However, he did not enjoy his course and made arrangements to transfer and complete a course in Artificial Intelligence. This period coincided with the development of Covid-19 and its associated restrictions.

13. Brennan's mental ill health appeared to break down shortly afterwards; he was detained on Section 136[5] of the Mental Health Act (MHA) and transferred to psychiatric hospital when it seems that he believed that there were people trapped in the walls of a neighbouring house. He was then detained on Section 2[6] of the Mental Health Act (MHA) when further evidence of auditory hallucinations emerged. Brennan was diagnosed with a transient psychosis[7] with mental ill health secondary to the use of cannabinoids; he was treated with anti-psychotic medication and referred to an NHS community-based specialised EIT. Brennan was then discharged home to Sofia's house where Brennan's father and his partner

[5] Section 136 of the Mental Health Act permits police to detain someone without a warrant in a place of safety if it appears they have a mental disorder and are judged to need urgent assistance.
[6] Section 2 of the Mental Health Act allows compulsory admission for up to 28 days in hospital for a mental health assessment.
[7] The International Classification of Diseases – v.10 (ICD-10) 2016 - describes this under the code: F23.9 - Acute and Transient Psychotic Disorder, Unspecified. The code is used for a brief reactive psychosis not otherwise specified in relation to other causes, such as substance misuse or a physical illness which lasts less than about a month. The ICD-10 code (F12) is used when the mental health effects of harmful use of substances persists.

were providing support for her. A period of contact with the EIT team then followed, and further information is provided about this can be found below.

14. As the new university term was approaching, Brennan was keen to make a start on his new course and he telephoned the EIT to say that he would be moving imminently; the consultant encouraged him to register with a new GP near the university. The consultant encouraged Brennan to contact EIT services locally. The consultant also kept Brennan `open' to the EIT to ensure that he could come back if needed.

15. Two to three months after term started, staff and students in Brennan's Hall of Residence began to express their concern because he had continued (against advice) to smoke cannabis 2-3 times per week and to drink. He seemed withdrawn, was behaving in an irritable manner with student colleagues and falling behind in his coursework. His tutor asked Brennan to come and see him, but he did not attend.

16. When a Covid lockdown began, Brennan then returned unannounced (against advice provided by the university in relation to Covid) to his grandmother's house (the wider family were unaware). Shortly afterwards, Brennan's father contacted the EIT because he was worried about him. However, on discussion, there was no evidence to consider that an emergency or crisis response was needed and the EIT offered Brennan an appointment for five days later. The incident occurred just before that appointment was due.

The incident

17. Police were called when Brennan's father told the Police that he was frightened of his son who had behaved aggressively towards him. A discussion took place and, thinking the matter resolved, the police left. However, in the early hours the following day, Brennan lit a fire under the stairs, and left the house. Sofia subsequently died in the fire where she had been left alone (Brennan's father had gone out). Brennan was detained and Mental Health Act assessment papers say that his thoughts were disorganised. For example, he said he had been `meditating his way to enlightenment'; was `guided by lights,' and talked incoherently about Elon Musk. Brennan subsequently reported that the fire had got out of control. Brennan was judged to lack capacity or to have any insight and he was detained on Section 2[8] of the MHA. Brennan was detained initially in a Psychiatric Intensive Care Unit (PICU) consistent with the requirement for the GP's location to determine his referral for specialised care. His diagnosis was given as paranoid schizophrenia

[8] Detained for a short time for assessment and possibly treatment if personal health is at risk or for the protection of other people.

with polysubstance misuse. Brennan was transferred to a local Medium Secure Unit (MSU): under Section 2 of the MHA which was then amended to Section 3[9].

Findings and recommendations

Critically examine and quality assure the NHS contributions to the Domestic Homicide Review

18. Our team was very grateful to have the opportunity of working in partnership with the Chair and the Panel for the DHR. As outlined above, attendance at the Panel meant an opportunity to participate in a considered discussion of the circumstances of this tragic incident, and consider the different contributions made by those in the wider public services.

19. Working together made it possible for those involved to take a wide perspective of the support provide for perpetrators and victims' families and develop their conclusions together. In this case, our team had information from primary care, social care services, NHS staff from specialised mental health services, police, and Higher Education. We also had the benefit of conclusions drawn in an internally commissioned review of care provided in the Trust; Individual Management Reviews (IMRs) commissioned by the DHR Chair.

20. Importantly, working together reduced the risk that members of Sofia's family might be required to duplicate their communications; this not only reduced their stress, but it also helped to strengthen a broad perspective on Brennan's needs and Sofia's vulnerability. Our team considers that working practices were managed effectively the NHS contributions to the DHR were strengthened significantly.

Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user.

Review and assess compliance with local policies, national guidance and relevant statutory obligations

21. Contact with, and the decisions made in relation to Brennan's detention, admission and discharge appear to be based in sound clinical evidence. For example, our team found no reason to suppose that that the Mental Act

[9] Section 3 of the MHA allows for a person to be admitted to hospital for treatment if their mental disorder is of a nature and/or degree that requires treatment in hospital. A trained Adult Mental Health Practitioner (AMHP) makes an application for S.3 and two medical practitioners are required. A Section 3 can be renewed after 6 months and then after 12 months.

Assessment was inadequate or inappropriate or that Brennan should not have been detained under Sections 2 and 3 of the MHA. The records show that Brennan was exhibiting clear symptoms of mental ill health including that he could hear voices which were controlling him, was distractable, and lacked insight which meant that he also lacked mental capacity at that time.

22. When it was clear that Brennan needed to be admitted, there were no NHS psychiatric beds available in the Trust. Brennan was therefore referred to a `within-area' private provider with a contractual relationship with the NHS. This arrangement is normal (although not ideal) in circumstances when beds are in short supply in mental health services and waiting lists can be challenging. In this case, the arrangements to find Brennan a bed were managed appropriately.

23. Our team noted that the Trust now has an appropriate and well-qualified senior member of staff to maintain oversight of bed arrangements. Furthermore, an examination of Trust Board papers makes it clear that the Trust has now been able to significantly reduce its dependence upon `Out of Area Treatments' (OATs). Our team is content to conclude that staff shortages, staff training, and arrangements for supervision of staff were not causing difficulty at the time of this incident and there was no ongoing restructuring.

24. Brennan's provisional diagnosis was `Acute and Transient Psychotic Disorder, Unspecified with Mental and Behavioural Disorder Secondary to the use of Cannabinoids'[10]. The clinical team judged that his psychotic symptoms would go if he remained abstinent and there is no reason to suppose that this was an inappropriate conclusion. However, the clinical team knew that they could not predict whether Brennan would maintain his health in the long term, or whether his psychosis would develop. In this case, the wider research base suggests a plan for treatment which was in line with the care he received.

25. The electronic records contain a copy of the assessments completed by appropriately qualified staff and the description of Brennan's symptoms are clear in the process notes of his treatment. Brennan was treated with an appropriate dose of anti-psychotic medication (3mg Risperidone). Covid and other physical checks were made. Our team considers that the decisions taken by the clinical team were underpinned by evidence and were sound. Brennan was observed directly to reduce any risk of harm; formal risk assessments were completed, and he was encouraged (although he was not keen) to engage with the ward milieu.

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[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6861931/# ` Cannabis and Psychosis Through the Lens of DSM-5' by Nathan T. Pearson* and James H. Berry published in the International Journal of Environ Res Public Health (2019).

26. Although autistic traits had been suggested at one point by the inpatient team because Brennan had been noted to stare at the wall for long periods, there were no other clear signs of autism and therefore no formal assessment of autism was completed. Our team has no reason to suppose that the Trust failed to elaborate questions relating to the possibility that Brennan was showing signs of an autistic spectrum disorder. However, we provided a link to Royal College of GPs guidance[11] in the main report for the Trust to provide further information because we are aware that this can be difficult to identify.

27. Our team could see from the electronic notes that staff had discussed Brennan's domestic circumstances, including in conversation with Brennan's father, and the notes show that the team judged Sofia not to be at risk although no formal safeguarding assessment was completed. Once Brennan improved and plans were made to discharge him, a member of the Trust EIT team participated in the discharge meeting. Although the discharge meeting was partly held by videoconference owing to Covid restrictions, the EIT care coordinator followed up quickly with a face-to-face meeting with Brennan at his grandmother's house, and a second meeting was held later. The care coordinator saw Sofia briefly in the hallway but did not speak to her. Our team does not believe that there were any resource issues which affected those decisions.

28. Our team reviewed evidence relating to the provision of EI services in the Trust. The EIT supports people for up to a three-year period and provides interventions designed to reduce the impact of symptoms associated with psychosis (e.g., hallucinations, delusions, low mood). Support is provided for the patient and for the Next of Kin to understand more about the symptoms of psychosis and the treatments that are available, including `talking therapy' (such as cognitive behavioural therapy), advice and psychoeducation (for example, about substance misuse) and support and prompting to take medication.

29. Our team believes that the EIT team provided a good quality of information for Brennan. He was then encouraged to register with a GP close to the university and the EIT consultant followed Brennan up and arranged for him to get in touch. It was also made clear that the EIT would keep Brennan `open' to another referral by their team if he needed help. At this point Brennan was no longer under Section of the Mental Health Act. This meant that there was no requirement for him to follow advice (such as medication) and although the EIT consultant gave Brennan information, and discussed the fact that drugs could trigger another psychotic episode, he was no longer under any obligation to comply. Like many

[11] https://www.rcgp.org.uk/representing-you/policy-areas/autistic-spectrum-disorders

young people finding it difficult to sustain a drug treatment regime, Brennan did not like taking tablets and it is now known that he left his medication at home.

Examine the effectiveness of the service user's Care Plan and Risk Assessment, including the involvement of the service user and his family.

30. Care planning and risk assessments are normally based upon family, social and health-related information. In addition to information about his psychotic symptoms, the records show that Brennan had a range of potentially challenging social, familial and cultural circumstances which were recorded, although the information was relatively thin. When Brennan was in hospital, and whilst he was in contact with the community based EIT, members of the team discussed Brennan's domestic circumstances with him and spoke with his father (Brennan's Next of Kin).

31. Brennan's care plan was designed to deliver medication (an antipsychotic drug) and address the bigger picture of his social circumstances; for example, he was provided with psychoeducation (about the relationship between cannabis use and psychosis), the opportunity to attend groups focused on the management of his symptoms, and other conversations with the staff including his care coordinator. The EIT also discussed Brennan's care with his father who participated in several ward meetings with the consultant psychiatrist and Brennan spoke on the telephone several times with the EIT care coordinator.

32. When Brennan was discharged from hospital into the care of the EIT, the notes show that there had been four meetings with the consultant psychiatrist and other contacts including on the telephone with the care coordinator which Brennan's father attended. Brennan's father, for his part, has also said that his mother (Sofia) had welcomed Brennan into the house. The Trust had no reason to suppose that the wider family lacked knowledge or might have opposed the arrangements for his discharge.

33. On this basis, and from the perspective of the NHS clinical team liaising in good faith with Brennan's father, it is not possible to conclude that the clinical team was negligent. However, our team considers that it would have been wise to seek a more complete level of information about the social and familial context circumstances of Brennan's presentation. Such information is very important in

relation to risk management and crisis planning and we urged the clinical team to reinforce their policy for `Think Family[12].

34. Risk assessments in the Trust are undertaken in accordance with national NHS guidance and guidance published by the Royal College of Psychiatrists. They include questions about what are called `static' factors (historical evidence relating to, for example, harms or child abuse) as well as `dynamic' factors which change over time, such as alcohol, mental state, attitudes, or social factors. Care planning and risk assessment are both informed by formal assessments of mental illness (diagnosis) and a formulation (influenced by social and other factors which have a bearing upon its manifestation).

35. The electronic records show that risk assessments in hospital as well as within the EIT appear to have been managed well. Attention was paid in the risk assessment to diagnosis, social and familial factors (albeit limited in this case), social behaviour, substance misuse, cognitions, and mood. Information about triggers for risk behaviour (such as substance misuse or alcohol) and its potential mitigations were included, and the risk assessments include information about the arrangements in a crisis.

36. In the early stages of Brennan's admission, Brennan's risk was rated `medium' owing to the altercation he had had with his father when the police were called. Prior to his discharge, Brennan's risk was assessed as low. Although our team has no reason to believe that the risk assessment was inadequate, it should be noted that members of Brennan's family indicated that, in their opinion, Brennan's risk should not have been rated this way.

37. For the future, our team notes that the Trust has been moving towards a new system of care planning and risk assessment called DIALOG+. This is an evidence-based user-led process designed to record patient-reported experience (PREMS) and patient-reported outcome measures (PROMS) which directly assess the lived experience of service users. The aim is to capture perspectives on a person's health status and essential subjective constructs such as health, quality of life, goals, and social inclusion. Our team believes that this system will improve the extent to which service users and their wider families are engaged in their care. Plans are in place to audit the new system, record the impact and adjust plans as needed in the future.

[12] `Think Family' is an initiative that was introduced by the Department for Children, Schools and Families (DCSF) in 2008 following the Cabinet Office 'Families at Risk' Review. Since then, the approach has been expanded and developed, particularly in mental health services.

38. Our team also reviewed policy and practice in relation to safeguarding. We note that there is now a robust team headed by the Director of Nursing, with a deputy and seven safeguarding practitioners who are qualified clinicians. Training arrangements appear thorough and are consistent with national guidance. A Duty system also means that a 'phone line or email is always available to support staff on safeguarding issues during office hours and the team takes around 500 enquiries per month. Some training is also delivered at Level 3 for patient-facing staff and bespoke training (for example, on MARAC[13]) in more specialised areas.

39. Our team thought it would have been appropriate to complete a formal safeguarding assessment in relation to the impact upon Sofia of having her grandson staying in her house and, in this matter, a greater awareness of risk (what has been described as staff `professional curiosity') would have been desirable. However, whilst there is no doubt that Sofia was frail, it does not appear that she lacked capacity. There is therefore no certainty that a safeguarding assessment would have revealed neglect.

Conclusions and recommendations

40. This is the report of a Mental Health Homicide Review (MHHR) commissioned by NHS England (`East Midlands region) of care provided by the Trust for Brennan who was responsible for setting a fire in which his vulnerable grandmother Sofia died. We are aware that members of Sofia's family have, in their different ways, all been extremely distressed by Sofia's death, and by the process of participation in the various investigations (MHHR, DHR, criminal investigation, coronial process); they have rejected many of the DHR and MHHR conclusions. However, Brennan's contact with specialised NHS mental health services was relatively brief and our team has concluded that the NHS elements of care provided for him were of a generally good standard, although there were shortcomings. We hope that the following recommendations will help to strengthen services going forward.

Recommendation 1 The trust will explore the possibility of additional scenario-based training in respect of mental capacity and application of the Mental Capacity Act (this recommendation was made in the IMR and has been included here for completion).

[13] MARAC stands for: multi-agency risk assessment conference where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and others.

Recommendation 2 The trust will ensure that mandatory domestic abuse and safety planning/risk assessment training addresses assessment of risk and is relevant to all parties living or staying within a household.

Recommendation 3 The Trust will strengthen arrangements for assessments of safeguarding and teams (in team meetings and in supervision) should strengthen the way that they engage with families to maintain their professional curiosity about the wider impact in families. The clinical team should reinforce their policy for `Think Family[14].

Recommendation 4 Development and roll-out of DIALOG and DIALOG + must be maintained and reviewed and audited to ensure that social, cultural, familial, and other patient-based information can be built into care more effectively.

[14] `Think Family' is an initiative that was introduced by the Department for Children, Schools and Families (DCSF) in 2008 following the Cabinet Office 'Families at Risk' Review. Since then, the approach has been expanded and developed, particularly in mental health services.