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Joint Domestic Homicide Review and independent mental health homicide investigation in April 2019 in Northumberland

August 2022

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Our Report has been written in line with the Terms of Reference on the independent investigation into the care and treatment of a 35-year-old woman in Northumberland. This is a limited scope review and has been drafted for the purposes of NHS England and the Safer Northumberland Partnership as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date.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

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Preface

This Domestic Homicide Review (DHR) was carried out following the death of a 73-year-old female (referred to as Mrs C in this report), resident in Northumberland.

We wish at the outset to express our deepest sympathy to her family and to her friends.

This review has been undertaken in order that lessons can be learned; we appreciate the information provided by her family through this difficult process.

We would like to thank those involved for their time and valuable input throughout this review process. We would also like to thank staff within all agencies that have contributed to this important review.

Safer Northumberland (Community Safety Partnership) and NHS England (North East And Yorkshire) agreed in May 2019 to commission a joint review.

It was agreed that the circumstances of Mrs C's death met the criteria of Section 9 (3) (a) of the Domestic Violence, Crime and Victims Act (2004) and a mental health independent homicide investigation within the NHS England Serious Incident Framework (March 2015), and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.

The family have requested that we include their statement:

'*As a family we have sadly lost our mam who was a great caring loving woman who would go out her way to help anyone. But she was brutally and violently killed and taken from us by our younger sister who has suffered from mental illness issues for a number of years. But she also took our mam away from her sisters, brothers, nephews, nieces, grandchildren, and friends.*

We as a family believe that the healthcare system had failed us and our sister as well as our mam.

Therefore, we believe that there should be better communications and reports and notes between various NHS services ie GPs, Hospitals, CPNs and other caseworkers. And better structures for the understanding of the patient and their families. Hopefully learning from these mistakes for it not to happen again'.

Contents

1. Executive Summary

1.1 This joint review examines the circumstances surrounding the death of Mrs C, a 73-year-old female resident of Northumberland. Mrs C was killed in her own home by her 35-year-old daughter Miss A, in early April 2019.

1.2 Following concerns for Mrs C's welfare the police entered her home in early April 2019. They found her deceased. Miss A was later arrested and charged with the homicide of her mother.

1.3 At the time of her arrest, Miss A was a patient of Northumberland, Tyne and Wear NHS Foundation Trust[1] now Cumbria, Northumberland, Tyne and Wear Community Mental Health Services (CNTW).

1.4 Miss A had a three-year history of contact with Children and Young Person's services up to 2000/2001. She had no further involvement with mental health services until 2009 when she was seen for an episode of self-harm and was referred to drug and alcohol services, but she did not engage well and was discharged. The drug and alcohol service referred her to the Early Intervention in Psychosis team (EIP).

1.5 She was seen by the EIP from 2009 to 2015. She moved away for several months and following her return to the CNTW catchment area she was seen by Central Northumberland Community Treatment Team (CTT) from 2016 to 2018.

1.6 Miss A was detained under Section 2 of the Mental Health Act 1983 (MHA)[2] in April 2018. She was reported to be mentally well when discharged from hospital, however, she was homeless upon her discharge.

1.7 She was discharged from the CTT in August 2018. Miss A's last face to face service contact prior to the homicide was in December 2018. Miss A was referred back to CTT and an assessment was completed on 5 December 2018. Following this appointment, Miss A had been placed on a waiting list to be allocated a female Care Coordinator (CCO).

1.8 A subsequent appointment to further review Miss A's placement on the waiting list on 29 March 2019 was scheduled to take place, however Miss A did not attend this appointment.

1.9 This report describes Miss A's contact with agencies from 2009, with a detailed focus on the period from April 2017 to the homicide in April 2019.

1.10 The principal people referred to in this report are:

[1] *Which became Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) in October 2019.*

[2] *Section 2 is admission for assessment for up to 28 days. https://www.legislation.gov.uk/ukpga/1983/20/section/2*

Person	Role	Relationship	Ethnicity
Mrs C (73 years old)	Victim	Mother of Miss A	White British
Miss A (35 years old)	Perpetrator	Daughter of Mrs C	White British

1.11 This joint review will examine agency responses and support given to Mrs C and her daughter Miss A. It will also examine the past to identify any relevant background, and/or trail of abuse before her death. It will look at whether support was accessed within the community and whether there were any barriers to accessing such support. By taking a holistic approach the review seeks to identify recommendations to ensure lessons are learnt to make services safer for those seeking care and treatment.

1.12 The joint review includes a review of the care and treatment of Mrs C and Miss A by NHS services.

1.13 The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learned. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.14 This joint review has taken place alongside a criminal investigation which followed Miss A's arrest and subsequently her charge for the homicide of Mrs C. This resulted in an admission of manslaughter by diminished responsibility in March 2020, after the court was provided with psychiatric reports. Miss A was convicted of manslaughter on the grounds of diminished responsibility, and she was detained under Sections 37[3] and 41[4] of the Mental Health Act (MHA)1983.

1.15 This report concentrates upon the focus of DHRs, i.e., the relationship between the individuals. It seeks to establish whether domestic abuse was a feature of that relationship and if it was, the impact of the abuse, if any on those involved. Moreover, it seeks to look at what can be learned and what changes can be made to better protect others in the future. It will make recommendations that are cross-agency or where a different approach may better protect others.

1.16 The independent investigation also follows the NHS England Serious Incident Framework[5] (March 2015) and Department of Health guidance[6] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The Terms of Reference for this investigation are given in full in Appendix A.

[3] *Section 37 is the power of courts to order hospital admission.* https://www.legislation.gov.uk/ukpga/1983/20/section/37

[4] *Section 41 is the power of higher courts to restrict discharge from hospital.* https://www.legislation.gov.uk/ukpga/1983/20/section/41

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

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

Events prior to early April 2019

1.17 Mrs C was last seen alive at her home in early April 2019. Family members visited her and left around 5.30 pm, on the day of the homicide.

1.18 Mrs C was killed by Miss A at some point in early April 2019. In early April 2019 Miss A visited an acquaintance, which led to a call to the police, expressing concern for mother and daughter.

1.19 As a result of this call police from Northumbria Police entered Mrs C's home and found her deceased.

1.20 Miss A was arrested and charged with her mother's murder.

Findings and recommendations

1.21 We have made the following findings and recommendations for systems accordingly.

Finding 1 - GP and Northumberland CCG

Mrs C was seen regularly and followed up appropriately for her chronic health concerns.

There was no cross communication between GPs in the same practice, although both the victim and perpetrator were registered there. Mrs C herself did not relay concerns, but there was detailed information in Miss A's notes about risk to her mother. There are no systems for linking family members who live at different addresses.

The GP practices have an electronic system which can flag vulnerability and risk of domestic abuse. This should have been used after reports of Mrs C's assault by Miss A and when Miss A took Mrs C's medication. A risk assessment should have been completed.

The GP practices have a process for multidisciplinary discussion of complex patients, which should have been instigated.

It is clear that Miss A presented with physical health concerns that could be seen as manifestations of her mental disorder. This appears to have escalated during 2018, when her beliefs about physical illness intensified. Her presentation became increasingly chaotic, and continuity was affected by her changing GP surgeries and being homeless.

Efforts were made by successive GPs to address the amount of pain medication Miss A was taking, and to contact mental health services, however no referral to substance misuse services was made.

Finding 2 - Bernicia Homes - domestic abuse

The service provided by Bernicia Homes in relation to potential domestic violence was within their policy expectations, however in our view it would be helpful to develop a systematised approach to respond to domestic abuse.

Finding 3 - Northumberland County Council - domestic abuse

The Northumberland County Council Domestic Abuse strategy is due for review over the next year, and plans are being developed to carry out a sexual violence and domestic abuse needs assessment.

Finding 4 - Home Office – Matricide and Parricide

There are several important studies concerning mental disorder, matricide, and parricide relevant to agencies working with domestic abuse prevention strategies with implications for risk management.

Finding 5 - CNTW - family involvement

There was no evidence of an evidence-based treatment plan in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management (2014) with regards to family engagement and carer support (see Appendix E).

Although Mrs C was identified by Miss A as her carer we did not find evidence of Mrs C being identified as a vulnerable carer with identified carer needs and actions recorded or a carer's assessment arranged for Mrs C after this had been offered. No domestic abuse support was provided, and there was little evidence of Mrs C being routinely involved in review meetings as she wished to be.

Finding 6 - CNTW - care and treatment in the community

There were no formally recorded CPA reviews or FACE risk assessment and management updates during 2017.

In February 2017 consideration to discharging Miss A was entirely inappropriate and not in line with the Trust CPA or Engagement Policy requirements.

In January 2018 there was poor understanding of the clinical presentation and the risks. Our view is that such clinical presentation required a medical review and an assessment under the Mental Health Act (MHA) to be undertaken without further delay.

It is clear that Miss A presented with physical health concerns that could be seen as manifestations of her mental disorder. This appears to have escalated during 2018, when her beliefs about physical illness intensified. Her presentation became increasingly chaotic, and continuity was affected by her changing GP surgeries and being homeless (see related finding for GP).

The fact that not one psychiatrist had personal knowledge of Miss A, the lack of a clear diagnosis, and the view that she showed no relapse indicators although she continued to hold bizarre beliefs, led to a lack of decisive action to review, and manage her symptoms and risk.

There should have been a thorough assessment of her substance misuse, including the impact of this on her mental health. A referral to substance misuse services for advice or assessment and treatment should have been made.

When Mrs C reported Miss A's non-compliance with medication and risks to herself, a clinical review with the consultant psychiatrist should have taken place to either consider a depot medication or an inpatient management along with a safeguarding referral. This did not take place.

Finding 7 - CNTW - care and treatment whilst an inpatient

There should have been a thorough assessment of her substance misuse, including the impact of this on her mental health. A referral to substance misuse services for advice or assessment and treatment should have been made.

It is our view that the team had developed an unconscious biased view of Miss A (countertransference), attributing her clinical presentation predominantly to personality traits and substance misuse. The team referred to the 'chronicity' of the illness leading to the acceptance of continued symptoms. This is likely to have influenced the team not to attempt a trial of depot medication or a subsequent trial of clozapine, if she showed a poor response to depot antipsychotic medication (see related findings for diagnosis, medication, risk assessment and safeguarding).

Finding 8 - CNTW care and treatment - diagnosis

We found a lack of clinical curiosity, given that Miss A did not always appear distressed by the delusions and hallucinations, leading to a perception that she was stable, her mental illness was 'chronic' in nature and latterly in 2018 that her needs were primarily social (see related findings for medication, risk assessment and safeguarding).

There were doubts about Miss A's diagnosis and a view that there was a significant personality element to her diagnosis with the psychosis influenced by the use of illicit substances. Attributing her clinical presentation predominantly to personality issues and use of illicit substances is likely to have led to lack of appropriate focus and treatment of her schizophrenia.

The fact that not one psychiatrist had personal knowledge of Miss A, the lack of a clear diagnosis, and the view that she showed no relapse indicators although she continued to hold bizarre beliefs, led to a lack of decisive action to review, and manage her symptoms and risk.

In our view there was sufficient evidence for a diagnosis of a schizophrenia/psychotic disorder, mainly schizophrenia in view of the presence of chronic and recalcitrant delusions of persecutions, bizarre somatic delusion and delusions of misinterpretation (Capgras syndrome).

Finding 9 - CNTW care and treatment - medication

There was no evidence of an evidence-based treatment plan in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management, particularly with regards to medication (see Appendix E).

We would have expected, particularly given Miss A's historical non-compliance and risk issues, to find that consideration had been given to the benefits of a depot or clozapine (an atypical antipsychotic medication), when her symptoms became more chronic and unresponsive to the antipsychotic medication prescribed.

Miss A was often treated with sub-therapeutic doses of antipsychotic medication in acute phases (for example risperidone 2 mgs/day was prescribed when most patients would require 4 to 6 mgs/day in an acute phase of illness). Sub therapeutic doses of antipsychotic medication along with poor compliance are likely to have contributed towards the chronicity of her symptoms.

Mirtazapine (an antidepressant) was prescribed in a way not in keeping with British National Formulary (BNF) or other recommended guidelines (NICE depression prescribing information). Miss A had some sleep difficulties and mirtazapine was prescribed to be taken 'a couple of times a week' to try to support positive sleep habits.

There were insufficient interventions to assess and address her medication compliance issues.

Finding 10 - risk and safeguarding

Police

The assessments and interventions provided by Northumbria Police in relation to domestic violence by Miss A were closely aligned and based upon the 'SafeLives'[7] risk assessment process recognised and used nationally.

However, the risk assessments were inaccurate and there were two missed opportunities to pay attention to Mrs C as a victim of domestic abuse and provide a multi-agency response from all the agencies who had insights into her life, her vulnerability and crucially Miss A's dangerousness. It was noted that police understanding of policy and decision making about applying a definition of vulnerability could be improved.

Risks arising from alcohol, drugs or mental health issues are joined together in the DASH as one 'tick box', which assumes they are one amalgamated risk. This has been identified from previous reviews within the Northumbria Police area however due to the introduction of the impending College of Policing risk assessment form, this has been deferred. Officers continue, however, to have the ability to highlight specific risks in free text using professional judgement regardless of the 'boxes' on the form.

Police vulnerable adult notifications due to concerns regarding Miss A's mental health issues and her calls to the police to complain about alleged crimes were viewed by the police in isolation and therefore accumulative risk was not considered.

Police responded to calls and concerns about Miss A and completed safeguarding referrals. Acts of violence towards Mrs C were 'crimed' and an ACN completed with the first occurring in June 2016 within a medical facility and the second at Mrs C's home address in April 2018. On 20 August 2018 an ACN was raised due to concerns that Miss A's mental health was deteriorating. A triage discussion was held and the concern was passed for the attention of the allocated CPN for ongoing support.

The assumption that the Domestic Violence Protection Order (DVPO) was not necessary as Miss A would be in hospital for at least 28 days detained under Section 2 MHA was false and indicates a lack of communication between the agencies and lack of understanding regarding the MHA.

CNTW

It is evident that up until 2014 Miss A was supported by an MDT approach, however following the removal of the Section 75 agreement it appears that health services worked with Miss A in isolation (see related findings for ASC below).

Capgras symptoms and familial risk were not appropriately assessed or managed. Risk was not explored with family members. There was no professional clinical curiosity about why Mrs C thought she was in danger.

A Multiagency Risk Assessment Conference (MARAC) referral was not progressed due to a lack of knowledge and understanding of the process and whether consent was required to proceed.

A MARAC referral would have notified the police automatically and allowed the Independent Domestic Violence Advisor (IDVA) to engage with the mother and hear her thoughts and fears, the sharing of information between agencies at the MARAC meeting and the development of a multi-agency safety plan.

Northumberland County Council ASC

There were a number of opportunities where a referral to ASC would have been appropriate.

The perception that many of the safeguarding concerns being raised by the Police and other partners were low level or the direct result of Miss A's mental health issues resulted in ASC repeatedly passing these on to CNTW for information and action without convening a formal multi agency safeguarding meeting.

Each individual incident, concern or referral about Miss A was seen in isolation and without the benefit of multi-disciplinary discussion (see related findings above).

There were missed opportunities to complete Miss A's social care assessment both as an inpatient and later when she had been discharged.

Adult social care has repeatedly passed safeguarding issues back to the mental health trust with the expectation that a medication review or CCO appointment would resolve the presenting issue.

There was no further escalation to senior leaders regarding the ASC concerns about her unsafe inpatient discharge.

All agencies

There were several opportunities where safeguarding for Mrs C should have been considered. As a result, there were missed opportunities across and between agencies to develop an in-depth understanding of the risks to Mrs C and formulate a risk management plan.

Although an ACN is the process that Northumbria police officers use to notify partners via the MASH of a particular concern, there was no process thereafter to consider sharing and considering the ACNs by those with direct involvement with Miss A's mental health care, or to flag up that there had been numerous low-level concerns, along with reports of acts of serious violence against her mother.

[7] *The purpose of the Safe Lives DASH risk checklist is to give a consistent and simple tool to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk.* *https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf*

Finding 11 - CNTW - CTT discharge and housing

The discharge on 6 August 2018 from the CTT was not in line with Trust CPA Policy. Medical staff were not involved in the decision to discharge and were only informed of the difficulties in engaging Miss A in November 2018.

Staff 'churn' in the CTT with retirements and consultant psychiatrist recruitment issues meant that their attendance at the clinical meeting was on a rotational basis and no one consultant psychiatrist had personal knowledge of Miss A.

Miss A was attempting to engage with the CTT and had rung several times to indicate she was dissatisfied with her discharge however due to human error the CTT referral was not actioned resulting in a gap in service between 20 September and 5 December 2018 following which Miss A was difficult to contact and re-engage.

In November 2018 when Miss A was not engaging, unable to be contacted by 'phone, requesting medication from her new GP and refusing a review, a CCO review was not undertaken, which was not in line with Trust CPA Policy. This was the first time a member of the medical staff was made aware of the situation with Miss A since her discharge 6 August 2018.

Finding 12 - CNTW - inpatient discharge

Miss A was formally allocated to a male CCO6, whilst she was an inpatient, and he received a brief handover from CCO4, although Miss A had requested a female CCO (which was agreed to). Trust CPA Policy was not followed in ensuring an effective hand-over of information. Our view is that this was a particularly important process considering Miss A's deteriorating mental state.

Plans for discharge were accelerated inappropriately for 22 May 2018 despite the view from CCO5 and ASC that Miss A would benefit from supported accommodation and a package of care targeted to her needs. Discharge was subsequently deferred to 30 May; however it was not a coordinated discharge plan in line with the Trust CPA Policy.

The request that Miss A could be referred to the St George's rehabilitation ward (comprising a ward and individual flats) was a reasonable one for Mrs C to make and should have been followed through, however it was not, based on an assumption that she would not fit the criteria (see findings related to diagnosis and care and treatment).

The long history of Miss A finding it difficult to engage and being non-compliant with medication suggests that assertive outreach services would have been helpful in supporting her.

Finding 13 – All agencies - interagency information sharing

The existing frameworks for information sharing and management of risk were not utilised. Local DHR reports have previously highlighted similar issues.

Finding 14 - CNTW - serious incident review

The internal report was lengthy, overly detailed and went well beyond the expected policy timescales.

There should have been medical input to provide clinical advice on the issues of diagnosis and medication management included in the report.

Recommendations are not based on findings and are not outcome focussed.

We have limited information about the progress of the action plan.

Family engagement by the Trust during the internal investigation process was positive, however the internal report findings, conclusions and actions were not shared with the family until summer 2021.

Recommendation 1 – GP, NHS Northumberland CCG and CNTW

NHS Northumberland Clinical Commissioning Group must provide assurance that GP surgeries:

a) Have the necessary knowledge and skills to recognise domestic abuse.

b) Use the systems in place to recognise and act on disclosures of domestic abuse.

c) Northumberland Clinical Commissioning Group should explore the inclusion of an established domestic abuse awareness programme for general practice, such as IRISi.[8]

d) NHS Northumberland CCG and CNTW should develop systems to ensure there is a shared care approach to the provision of physical and mental health care and treatment.

e) Specialist substance misuse services or staff must be requested to advise or to assess and contribute to care and treatment plans where there are substance misuse issues and associated risk to others.

[8] *IRISi is a social enterprise established in 2017, aiming to improve the healthcare response to gender-based violence through health and specialist services working together. https://irisi.org/*

Recommendation 2 – Bernicia Homes

Bernicia Homes should develop a systematised approach to responding to domestic abuse, such as that provided by the Domestic Abuse Housing Alliance.[9]

Recommendation 3 - Northumberland County Council - domestic abuse

Northumberland County Council must ensure that a comprehensive domestic abuse strategy includes measurable outcomes from previous reviews.

Recommendation 4 - Home Office - Matricide and Parricide

a) The Home Office should incorporate learning about matricide and parricide into domestic abuse prevention strategies.

b) Adult child to parent violence and mental illness should be incorporated into domestic abuse strategies.

Recommendation 5 - CNTW - family involvement

a) CNTW must ensure that families and carers are appropriately involved in care planning and risk assessment.

b) CNTW must ensure that referrals for carers' assessments are routinely part of care planning and risk assessment.

Recommendation 6 - CNTW - care and treatment in the community

a) CNTW must ensure that the CPA Policy is embedded in practice and supported by relevant training addressing the quality of risk assessment, management plans, discharge planning and involvement of carers.

b) CNTW must ensure their workforce strategy addresses and monitors the clinical risks associated with CTT medical and nursing recruitment and retention workforce issues.

c) CNTW must ensure that the NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management is embedded in practice with reference to medication management (also a recommendation in CNTW care and treatment, medication).

d) CNTW must review the arrangements for assessing the need for and providing assertive outreach support in the psychosis care pathway.

Recommendation 7 - CNTW - care and treatment whilst an inpatient

CNTW must ensure that the safeguarding adults at risk Policy is embedded in practice and supported by relevant training.

[9] *The Domestic Abuse Housing Alliance's (DAHA) mission is to improve the housing sector's response to domestic abuse through the introduction and adoption of an established set of standards and an accreditation process. https://www.dahalliance.org.uk/*

Recommendation 8 – CNTW care and treatment - diagnosis

CNTW must assure itself through regular audit that where appropriate, objective diagnostic criteria should be applied with reference to formulation and evidence base.

Recommendation 9 – CNTW care and treatment - medication

CNTW must assure itself through regular audit that NICE guidance is followed in the prescribing of antipsychotic medication for those with chronic symptoms who have not responded to initial treatment.

Recommendation 10 - risk and safeguarding

Northumbria Police

The Domestic Abuse, Stalking and Harassment (DASH) risk assessments conducted by Northumbria Police in relation to domestic violence should:

a) Be completed fully with officers ensuring that additional context is added to the comments section where 'yes' has been indicated. The Home Office and College of Policing are in the process of designing and testing a new domestic abuse risk indicator for the police service nationally. Northumbria Police has not made significant changes to the current process pending the implementation of this new process.

b) Northumbria Police must ensure that police officers are appropriately trained to:

- Identify escalation in abuse.
- Incorporate professional judgment to fully assess the threat, harm and, if necessary, raise the risk level towards victims.

CNTW

c) CNTW must ensure that adult safeguarding concerns are accurately documented within patient records and referrals are captured within clinical records.

d) CNTW must ensure that familial risks associated with Capgras syndrome, the impact of illicit drug use, the importance of exploration of risk with family members and the significance of assessing and monitoring medication compliance particularly in relation to familial risk are routine risk assessment and management considerations. Where risk to family members is reported, risk assessment must be updated, and victim safety planning must become part of the risk management plan.

All agencies

e) The Safer Northumberland (Community Safety Partnership) must seek assurance that the new joint working arrangements between Adult Social Care and CNTW are working effectively, and the risk of silo working has been addressed.

f) The Safer Northumberland (Community Safety Partnership) must ensure that MASH multi-agency protocols are able to identify and address risk to an adult raised through police ACNs.

g) Where a risk to an adult has been identified, agencies should demonstrate within their records that they have considered risk in relation to adult safeguarding criteria. Where risk to family members is reported, risk assessment must be updated, and victim safety planning must become part of the risk management plan.

Recommendation 11- CTT discharge and housing

CNTW

a) CNTW must ensure that robust CTT administration governance systems are in place to eliminate human error in the referral process.

Northumberland County Council ASC

b) Northumberland County Council must set quality standards for the timely allocation of social workers to accepted referrals.

Northumberland County Council – Strategic housing

c) To undertake a review, to involve all relevant partners (Northumberland County Council (Housing Services and Adult Social Care), CCG, CNTW and NHS Foundation Trust) to assess the adequacy of current supported emergency and temporary housing options for individuals with chronic and enduring mental illness, including referral pathways.

Recommendation 12- CNTW - inpatient discharge

CNTW must have services in place to meet the needs of patients requiring an assertive approach.

Recommendation 13 – interagency information sharing

The Northumberland Multi Agency Risk Assessment Conference protocol must be reviewed to incorporate learning from this review.

Recommendation 14 - CNTW and Northumberland CCG - serious incident review

CNTW and Northumberland CCG should ensure that standards for SI reports meet national guidance, to include:

- Identifying the timescale to be examined in detail.
- Review of root causes identified.
- Carried out with the support of appropriate clinical advice.
- Delivered within expected timescales.
- Recommendations are outcome focussed and flow from the evidence and findings.
- Appropriate family involvement.

2. Establishing the joint review

Decision-making

2.1 This Domestic Homicide Review (DHR) is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.[10] The independent investigation follows the NHS England Serious Incident Framework[11] (March 2015) and Department of Health guidance[12] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.

2.2 A DHR must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he/she was or had been in an intimate personal relationship, or
- a member of the same household, held with a view to identifying the lessons to be learnt from the death'.

2.3 A court case has established that Miss A took the life of Mrs C, and Miss A was under the care of mental health services at the time of the homicide, therefore the criteria for both were met.

2.4 Safer Northumberland (Community Safety Partnership) was notified of the death in April 2019. As a result of the notification, a meeting was chaired by the Safer Northumberland (Community Safety Partnership). At this meeting, the police provided a summary of the incident. At the time it was believed that there were two known instances of domestic violence, and that Miss A was known to mental health services. Agencies were asked to ensure that all records were secured in preparation to produce a chronology and Individual Management Review (IMR).

2.5 The following organisations were present at the first meeting:

- Safer Northumberland (Community Safety Partnership).
- Northumberland County Council.
- Northumberland Tyne & Wear NHS Foundation Trust (CNTW).[13]
- NHS Northumberland Clinical Commissioning Group.
- Northumbria Police.
- NHS England.

[10] *Domestic Violence, Crime and Victims Act 2004.* http://www.legislation.gov.uk/ukpga/2004/28/section/9

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

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

[13] *NTW became Cumbria Northumberland Tyne & Wear NHS Foundation Trust in October 2019.*

2.6 A chronology was prepared with the information known by the different agencies and reports and IMRs were commissioned from:

- Northumbria Police.
- Northumberland County Council.
- Northumbria Healthcare NHS Foundation Trust.
- NHS Northumberland Clinical Commissioning Group, covering GPs for both.
- North East Ambulance Service.
- Cumbria, Northumberland Tyne & Wear NHS Foundation Trust in the form of a Root Cause Analysis Investigation Report (provided in October 2019).
- Bernicia Homes.

2.7 Other agencies provided chronologies and relevant information when requested. Where this material is used within the body of this report, it is attributed accordingly.

2.8 This meeting of the Northumberland Community Safety Partnership made the decision that there should be one process only, and a joint review should be commissioned. This investigation will be referred to as the joint review, with NHS England taking the lead for commissioning and oversight.

2.9 Niche Health and Social Care Consulting (Niche) were appointed to carry out the joint review starting in August 2019. There were a number of delays regarding the provision of clinical information and reports. The joint review panel met for the first time in May 2020. There followed further meetings and discussions up to December 2020. All panel members fully engaged in the process, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings, additional work was undertaken via email, telephone, and face-to-face meetings.

2.10 The review was completed in March 2021.

2.11 The DHR Guidance states that a decision to hold a Domestic Homicide Review should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says that the review should be completed within a further six months.

2.12 It was not possible to complete the review within the six months set out within the Home Office Statutory Guidance as a result of delays in the production of the Trust internal report and practical restrictions due to COVID-19.

2.13 The joint review was carried out by Niche, with Dr Carol Rooney, Associate Director, as the Independent Chair. Dr Rooney has completed many mental health homicide independent investigations commissioned by NHS England, including two previous combined DHRs. She has completed the ‘Advocacy

After Fatal Domestic Abuse'[14] DHR Chair accredited training and attended training and seminars on domestic homicide issues. She is a member of the AAFDA DHR chairs network.

2.14 The Niche review panel consisted of:

Sue Denby Senior investigator	NHS report author
Dr Milind Karale Consultant psychiatrist	Mental health clinical expertise
Judith Vickress National Domestic Abuse Housing Alliance (DAHA) Development Manager, Standing Together Against Domestic Abuse	Domestic abuse expertise
Sharon Conlon Safeguarding lead	Safeguarding expertise
John Kelly Retired senior police officer	Police expertise

2.15 Internal supervision and quality assurance were provided by Elizabeth Donovan, Senior Investigator and Nick Moor, Partner, Niche.

Confidentiality

2.16 The findings of this review are confidential. Information is available only to participating officers and professionals and their line managers until the review has been approved by NHS England and the Home Office. Following approval, the report should be shared appropriately within and between organisations to disseminate the learning.

2.17 Information from records used in this review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998, which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders.

2.18 Medical records were shared by NHS organisations under the relevant Caldicott Guardian[15] processes.

Family involvement

2.19 The family had been involved in meetings and information sharing as part of the CNTW internal investigation review.

[14] Advocacy After Domestic Abuse (AAFDA) is a charity providing advocacy, training, and support. https://aafda.org.uk/

[15] A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. https://www.ukcgc.uk/

2.20 It was agreed by the panel that the Chair and NHS review author would seek to meet with the family and an introduction would be made with the involvement of the Charity 'Hundred Families'.[16]

2.21 We wrote to the family shortly after the appointment of Niche introducing ourselves, setting out the purpose of the review and providing the draft Terms of Reference.

2.22 We met Mrs C's family members in January 2020. One family member agreed to be the single point of contact with the family. The family were supported by the Hundred Families advocacy charity, and by the Victim Support National Homicide Service.

2.23 We kept in touch with a nominated family member by regular email and phone contact.

2.24 We had a Skype call with Mrs C's family in August 2020.

2.25 We would like to thank the family for their engagement and contribution that they have made to this review. It has been invaluable and has helped significantly in our understanding of the family.

2.26 The family were provided with a copy of the report in September 2021. They were pleased to see the report identified lessons across the various agencies, and recommendations had been made. They wanted to know how these actions would be checked, and it was agreed that we would ensure that the commissioners of the joint review were aware that the family wanted assurance.

2.27 We were unable to meet with Miss A in early 2020 due to her continuing to be very unwell. We had a call with her current Consultant Forensic Psychiatrist in July 2020 to help the review to understand her diagnosis and treatment. The final report was shared with her through her clinical team.

2.28 The family would have preferred that full names were used, however the unique aspects of the case precluded that as an option. The family agreed that the pseudonyms Mrs C and Miss A be used.

Terms of reference

2.29 The Terms of Reference are provided in full at Appendix A.

2.30 The overall purpose of the joint review is:

- To identify any gaps, deficiencies or omissions in the care and treatment received by the perpetrator which could have predicted or prevented the incident.

[16] *Hundred Families are a charity providing practical information for families affected by mental health homicides in Britain. http://www.hundredfamilies.org/*

- To identify any areas of best practice, opportunities for learning and areas where improvements to services are required, with a focus on the period from April 2017 to the incident occurring in April 2019.

Equality and diversity

2.31 Throughout this review process the Panel has considered the issues of equality in particular the nine protected characteristics under the Equality Act 2010. These are:

- Age.
- Disability.
- Gender reassignment.
- Marriage or civil partnership (in employment only).
- Pregnancy and maternity.
- Race.
- Religion or belief.
- Sex.
- Sexual orientation.

2.32 Although Mrs C was not regarded as disabled, she had restricted mobility and had long term pain from ongoing health conditions which affected her life. Although she was seen as very independent, her family were worried about her safety, from Miss A in particular. She was physically slight, and her mobility problems would have been obvious to those agencies who met her face to face.

2.33 We note that there were missed opportunities for agencies to consider how her health conditions contributed to her vulnerability.

2.34 There were 241 female victims of murder, manslaughter, and infanticide in the 12 months to the end of March 2019, up 10% on the previous year. The number of separate homicide incidents rose to 662, up from 644 the previous year, according to the Office for National Statistics (ONS).[17] The ONS collects data on the relationship of victims to perpetrator of homicides under the headings partner/ex-partner, other family, friends or acquaintances, stranger, other known, and no suspect. There were nine female victims killed by 'another family member' in the year ending March 2019.

[17] *Homicide in England and Wales: year ending March 2019.*
https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2019

2.35 Between April 2014 and March 2017, the Home Office Domestic Homicide Index recorded 400 domestic homicides, of which 59 involved the killing of parents, or parricide (almost 15% of all domestic homicides).[18]

2.36 However, the annual numbers are too small for any statistical analysis to be made. There is no separate data which provide details of parents killed by adult children or linking parental homicide with a history of domestic abuse.

2.37 Recent research into domestic homicide of older people which showed that 'older people are almost as likely to be killed by a partner as they *are their child'*.[19] There is also the cumulative nature of discrimination that older women face and the '*triple jeopardy'* in that they are women, of older age and have experienced abuse.[20]

Structure of the report

2.38 Section 3 provides detail of the background of Mrs C, and the chronology of contact as known to relevant agencies, with analysis against the relevant Terms of Reference.

2.39 Section 4 is detailed chronology and case review of Miss A's contact with services.

2.40 Section 5 is a detailed analysis of clinical care and agency involvement for Mrs C and Miss A.

2.41 Section 6 reviews the Trust internal report and progress on the action plan.

2.42 Section 7 reviews lessons learned and sets out our overall conclusions and recommendations.

2.43 Appendix list:

- Appendix A – Terms of reference for the joint review
- Appendix B – Documents reviewed
- Appendix C – Internal investigation review
- Appendix D – Family questions
- Appendix E – NICE guidance review
- Appendix F – ICD 10 diagnostic criteria for schizophrenia

[18] *Domestic abuse in England and Wales: year ending March 2018.* https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2018#domestic-abuse-related-offences-specific-crime-types

[19] *Bows, H. (2018) Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK. British Journal of Social Work (2018) 0, 1–20.*

[20] *Penhale, B. (2003) Older Women, Domestic Violence, and Elder Abuse: A Review of Commonalities, Differences, and Shared Approaches. Journal of Elder Abuse & Neglect, Volume 15, 2003 - Issue 3-4.*

- Appendix G – Professionals interviewed

3. Background and agency involvement - Mrs C

3.1 Information about Mrs C was gathered from her family and her medical and other agency records. The agencies that submitted IMRs are dealt with in a narrative commentary which includes analysis relevant to the Terms of Reference.

3.2 We have had access to all Mrs C's previous healthcare records and related documents.

3.3 The family have provided us with their perspective, which has given an insight into their experiences. We have been given a sense of Mrs C's personality and her importance in the family, as well as the family's experience of caring for Miss A over many years.

3.4 Mrs C survived cancer and suffered ill health for a long time, despite this she lived independently and was a much-loved member of the family.

3.5 Mrs C was brought up in the Northumberland area and lived there most of her life. She first worked as a silver service waitress in a local hotel, and later as a nursery nurse. Mrs C had three children with her first husband, and the family moved to Mansfield for a period.

3.6 She moved back to Northumberland when her marriage broke up. She later married again, and had a fourth child, Miss A. The family were aware that her second husband was not a source of support to Mrs C.

3.7 Mrs C was described as someone who would keep your secrets and would always try to help you to solve a problem. Her family described her loyalty to Miss A, always taking her in despite their concerns about her safety. Family members were worried that Miss A might harm Mrs C, but she would reassure them that it would be okay.

3.8 Mrs C liked her garden and would sit out there. In the last year of her life her Raynaud's[21] symptoms made it painful to walk. A couple of times a week family members would take her out for a drink or a meal in her wheelchair.

3.9 One of her children was her carer in her last year, and although she had mobility issues and used some aids, she continued to live independently in her rented property.

3.10 Although she was seen as very independent, her family were worried about her safety, from Miss A in particular. She was physically slight, and her mobility problems would have been obvious to those agencies who met her face to face.

3.11 Her family told us that she would phone the EIP care coordinator and say Miss A was not taking her tablets, and she was frightened of her. The care

[21] *Raynaud's disease causes smaller arteries that supply blood flow to the skin to narrow in response to cold or stress. The affected body parts, usually fingers and toes, might turn white or blue and feel cold and numb until circulation improves, usually when they warm up.* https://www.nhs.uk/conditions/raynauds/

coordinator would then visit her and report that she was fine. The family told us that Miss A was very good at presenting well in front of professionals, and no-one spent time with Mrs C to hear her views.

3.12 While it is understandable that the primary focus of mental health services is on the individual in their care, there were a series of missed opportunities to consider Mrs C's vulnerability, and the effects of Miss A's mental health issues on her and the family.

GP Practice/NHS Northumberland CCG

3.13 Mrs C had several physical health issues, described in the GP/CCG IMR from January 2016.

3.14 The GP/CCG IMR describes her medical history from January 2016.

3.15 In June 2016 Mrs C was seen in the GP surgery for joint pain. She said it was a stressful time as her daughter (Miss A) had been violent to her and had been admitted to a mental health hospital. She said her daughter had said she did not know who she (Mrs C) was and had headbutted her. This was a missed opportunity, there was no record or coding in the health records to indicate Mrs C was vulnerable or a victim of domestic abuse. This was not explored, and no risk assessment was completed.

3.16 Mrs C was also seen by her GP in August 2017 for concerns about joint pain, and she was prescribed morphine.

3.17 In January 2018 it is noted that her daughter (although not named) attended the surgery[22] and told the GP she had taken her mother's morphine. Advice was given about substance misuse and taking other people's medication, but no discussion was had about the potential exploitation of her mother. This was a missed opportunity to tie together the information already known by the practice about the disclosure of domestic abuse and Mrs C's vulnerability from Miss A.

3.18 Her last contact before her death was in January 2019, with a breathing difficulty for which she was prescribed antibiotics.

3.19 The GP had not recorded who Mrs C lived with, and although she was twice accompanied by a daughter, they were not named. There was no information recorded under care plans, safeguarding, social service contacts or hospital admissions.

3.20 No actions were recorded after Mrs C disclosed that her daughter had assaulted her in June 2016 and taken her morphine.

3.21 For a period of time both were registered with the same GP practice. Miss A's GP received regular letters from CNTW mental health services which documented that there was violence/aggression between mother and

[22] *At this time Mrs C and Miss A were both registered at the same GP practice.*

daughter. This did not appear to be coded or shared with Mrs C's GP. We note that the systems used for GP records are not set up to be able to link the notes of family members who do not live at the same address.

3.22 There were no alerts from adult safeguarding or Multi Agency Risk Conference (MARAC)[23] teams.

3.23 It is clear from Mrs C's health records that she experienced a number of significant health issues. She accessed primary care appropriately and received repeat prescriptions.

3.24 The GP had a wealth of information regarding Mrs C and if an adult safeguarding referral had been made then ASC could have contacted the GP in accordance with their procedures, and have been better informed to make a safeguarding decision regarding Mrs C.

[23] *A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. Northumberland Multiagency Risk Assessment Conference procedures protocol 2017.* *https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Safeguarding/Northumbria-Northumberland-MARAC-Procedure-Protocol-2017.pdf*

Finding 1 - GP/NHS Northumberland CCG

Mrs C was seen regularly and followed up appropriately for her chronic health concerns.

There was no cross communication between GPs in the same practice, although both the victim and perpetrator were registered there. Mrs C herself did not relay concerns, but there was detailed information in Miss A's notes about risk to her mother. There are no systems for linking family members who live at different addresses.

The GP practices have an electronic system which can flag vulnerability and risk of domestic abuse. This should have been used after reports of Mrs C's assault by Miss A and when Miss A took Mrs C's medication. A risk assessment should have been completed.

The GP practices have a process for multidisciplinary discussion of complex patients, which should have been instigated.

Efforts were made by successive GPs to address the amount of pain medication Miss A was taking, and to contact mental health services, however no referral to substance misuse services was made.

Recommendation 1 – GP, NHS Northumberland CCG and CNTW

Northumberland Clinical Commissioning Group must provide assurance that GP surgeries:

a) Have the necessary knowledge and skills to recognise domestic abuse.

b) Use the systems in place to recognise and act on disclosures of domestic abuse.

c) Northumberland Clinical Commissioning Group should explore the inclusion of an established domestic abuse awareness programme for general practice, such as IRISi.

d) NHS Northumberland CCG and CNTW should develop systems to ensure there is a shared care approach to the provision of physical and mental health care and treatment.

e) Specialist substance misuse services or staff must be requested to advise or to assess and contribute to care and treatment plans where there are substance misuse issues and associated risk to others.

Northumberland County Council Adult Social Care

3.25 There were two contacts recorded for Mrs C from Adult Social Care.

3.26 The first was in relation to a social care assessment in 2009, after referral from a community psychiatrist (see CNTW section below). A community psychiatrist made a referral for help with her social isolation. Her mood had improved and as she did not need any intervention, the referral was closed.

3.27 In December 2017, a referral was received for a mobility assessment. She was having treatment for bladder cancer and had difficulty mobilising to attend her appointments.

3.28 Mrs C had a history of depression, arthritis, mobility issues and she was being treated for cancer.

CNTW mental health care

3.29 Mrs C had a period of mental health care in 2002 after her second marriage broke up. There were family issues, and she was experiencing increasing physical health problems.

3.30 She was treated with antidepressants and discharged to the care of community mental health services in December 2002. She was discharged back to the care of her GP in January 2003.

3.31 Mrs C became depressed after the death of her ex-husband in July 2004. There were family conflicts about funeral arrangements, and he had bequeathed a house to her daughter Miss A. Miss A had been living with Mrs C at this stage, and she planned to move there, which would mean less support and company.

3.32 In January 2005 Mrs C asked her daughter to take her to hospital as she could not cope. She was diagnosed with a recurrent depressive disorder and generalised anxiety disorder and was prescribed antidepressant medication. Stressors noted were noisy neighbours, death of her husband and her daughter moving to a new house recently. She was described as dependent on her younger daughter (Miss A) and other family members due to her arthritis.

3.33 She was discharged home in February 2005 and prescribed antidepressants and medication to help with chronic insomnia.

3.34 She remained under the care of a consultant psychiatrist, who reviewed her medication, and provided updates to her GP. In a letter to her GP in August 2008 it was stated she no longer needed an outpatient appointment.

3.35 A referral was made to an occupational therapist in February 2009 to review her support needs. The assessment concluded her outlook at that time was very positive, and she was provided with information about increasing her social contacts. She was discharged from the care of secondary mental health services in February 2009.

Northumbria Police

3.36 In summary, there were two incidents of domestic violence recorded. Both of these occurred while Miss A was suffering a mental health crisis. Mrs C did not report either of these incidents or support any prosecutions. There was little information known to the police to suggest coercive or controlling behaviour towards Mrs C.

3.37 Mrs C's family members have told us that they believe Mrs C wanted the police to arrest and prosecute Miss A, however the police records do not reflect this. In our view her disclosures of the abuse and her fears reflect that she wanted help.

3.38 Following the second assault (in 2018) Mrs C was afraid of further violence from Miss A. The police and other agencies spoke to her numerous times before and after the assault, however there is no evidence of coercive control in police records.

3.39 Prior to the second assault in 2018 Mrs C had said she wanted Miss A to live with her and was aware of her daughter's deteriorating mental health. After the 2018 assault Mrs C stated she could no longer have her back to her home.

3.40 Following this assault, Miss A did not return to Mrs C's address to live, and there are no further reported incidents involving Mrs C or police evidence of coercive or controlling behaviour.

3.41 We have provided a further detailed narrative analysis of the involvement of Northumbria Police, with findings and recommendations in the relevant section on risk assessment and safeguarding.

3.42 A chronology of police contacts with Miss A is at appendix I.

Bernicia Homes

3.43 Bernicia Homes is part of the Bernicia Group and is a registered social landlord managing over 14,000 properties in the North East of England between Berwick in the North and Redcar & Cleveland in the South.

3.44 Mrs C became a tenant of Bernicia Homes in May 1998. No adaptations had been carried out in that time. The only contacts made were in relation to her tenancy and repairs at her home. There are no records of engagement with the Tenancy Management Team or their Intensive Housing Management Team. In addition, there are no records of any safeguarding referrals.

3.45 The repair records were reviewed and indicate that the only reported repairs were in relation to heating, electrical or joinery. Whilst the number of repairs carried out over the period covered by this report was higher than the average number that the company would expect to be reported, there is no unusual pattern or indicators of any issues with the tenancy from the records.

3.46 In relation to the rent account, records indicate that in general Mrs C maintained her rent account in a satisfactory manner. Over the period of this report the account ranged from being in credit to being four weeks in arrears.

3.47 The main reason for arrears appears to be because of changes to her Housing Benefit payments. As a result, the only contact in relation to the rent account was due to changes in Housing Benefit and to plan to adjust payments accordingly. Mrs C managed her tenancy well and the only contact she had with Bernicia was when she needed to adjust her payments.

3.48 It is noted that in June 2017, Mrs C advised that her Housing Benefit was to change as her daughter (believed to be Miss A) had moved in with her. She contacted Bernicia again in June 2018 to advise she had moved out and had no forwarding address.

3.49 Bernicia have advised that they have provided training for their administration and maintenance staff about how to recognise potential signs of domestic abuse. There is a system of 'flags' that alert managers to concerns about domestic abuse, and these are then actioned.

3.50 It was reported that there were no discernible signs of domestic abuse in the contact that Bernicia had with Mrs C. We suggest that reflection on the higher numbers and types of repairs, and the detail of what these were e.g. fixtures and fittings, could have been explored further, and it would be helpful to develop a systematised approach to respond to alerts or suspicions of domestic abuse.

Finding 2 - Bernicia Homes

The service provided by Bernicia Homes in relation to potential domestic violence was within their policy expectations, however in our view it would be helpful to develop a systematised approach to respond to domestic abuse.

Recommendation 2 – Bernicia Homes

Bernicia Homes must develop a systematised approach to responding to domestic abuse, such as that provided by the Domestic Abuse Housing Alliance.[24]

[24] *The Domestic Abuse Housing Alliance's (DAHA) mission is to improve the housing sector's response to domestic abuse through the introduction and adoption of an established set of standards and an accreditation process.* https://www.dahalliance.org.uk/

4. Detailed case review – Miss A

4.1 This section provides an integrated narrative summary of relevant information provided in clinical records and the individual agency IMRs including Northumberland County Council (Housing, Adult & Children's Social Care), NHS Northumberland CCG, CNTW, North East Ambulance Services (NEAS), Northumbria Police and two GP practices.

4.2 Northumberland County Council Children's services provided an IMR to this review, but the detail is relevant only to Miss A's child, and has therefore not been included in this review. Northumberland County Council focused on records which referred to adult concern notices, safeguarding, and social care or housing involvement.

4.3 We have undertaken analysis of the issues within the wider system including interagency information sharing and communication, domestic abuse, domestic abuse local strategy and matricide. There are clear routes within and between the above services through safeguarding structures that provide a framework for multi-agency communication, particularly about risk. We have commented on these, and on learning identified in previous DHR reports.

4.4 We have had access to all Miss A's healthcare records, interviewed relevant staff members and spoken with members of Miss A's family to gather information about her background. We have not been able to speak to Miss A directly as she has been too mentally unwell to meet us during this investigation.

4.5 Background information from childhood to March 2017 is included for context, and a more detailed narrative summary is provided from April 2017. The family wanted us to review in detail from April 2017 as it appeared to them that Miss A was very unwell at this time, and Mrs C had been to trying to get help for her.

4.6 CNTW provided a serious incident investigation report, which is reviewed separately in Section 6.

Childhood

4.7 Miss A was Mrs C's youngest and the only child with her second husband. Mrs C's other children were older teenagers when Miss A was born. Miss A hurt family pets aged four or five years of age and was always angry at any attention Mrs C paid to the other children.

4.8 Miss A's siblings said that she was witness to violence from her father towards her mother. They attributed some of Miss A's behavioural difficulties such as self-harm to the parental conflict. Miss A is said to have stated that her mother's behaviour towards her changed following the death of her grandmother.

4.9 Aged 12 or 13 Miss A threw a teapot at Mrs C's head and ran away from home. In later years Miss A would punch her mother and had held a knife to

her throat. She would lock Mrs C in her house which the family thought was to stop people getting in to see her.

4.10 Miss A's father was said to be close to her, but Miss A alleged that he had been violent and aggressive towards her on several occasions. Physical injuries were noted both by Miss A's primary and middle schools.

4.11 Miss A visited her GP during her early years for normal childhood issues and injuries. However, aged 10 she was taken to the emergency department (ED) after being seen drinking acetone at school. Miss A said she was having problems at home and told the nurse 'in confidence' that she had tried to cut her wrists in the past and 'was not sure if she would do this again'.

4.12 At 12 years of age a school nurse made a referral to a paediatric specialist, because of her 'odd' behaviour at school. She told the school nurse that she wanted to go into care, however then changed her mind. She was described as unhappy and getting into trouble. The doctor who assessed her thought she was depressed and referred to the child and adolescent mental health team (CAMHS)[25] at the Linhope unit (she was discharged in April 2000), for individual sessions and family therapy. She was prescribed an antidepressant (amitriptyline)[26] 25 mg at night.

4.13 Miss A was placed in a 'special school' aged 12 or 13 years. Records suggest that Miss A did not particularly enjoy attending school and was subjected to name calling and bullying. In April 1997, the school special educational needs coordinator noted she had a 'general attitude of defiance and insolence with provocative and challenging behaviour'. Miss A was said to have been involved in 'several incidents of violent and aggressive behaviour' with two of the incidents being serious.

4.14 In May 1997, a school report states that Miss A had confided to the school nurse about 'attempted suicides and problems at home', as well as pouring water over herself on two occasions at school. It was not clear whether this was cold or hot water. The school report concluded by stating that over the previous three years, almost every member of staff had attempted to help or advise Miss A, but all had had 'very little success and no positive response'. On one occasion Miss A was missing from home for four nights after being suspended from school. She was diagnosed with mixed emotional and conduct disorder and social services were involved in her care.

4.15 In September 1998 (aged 14) Miss A was accommodated under Section 20 of the 1989 Children Act[27] with foster parents for a time limited period of four weeks. She lived with a family member for a time after this. In one of the CAMHS clinical reviews, Miss A referred to an incident which had taken place during her earlier years. She described it as painful and quite vivid in her

[25] *CAMHS at that time was provided by NTW.*

[26] *Amitriptyline is an antidepressant medicine. It is used to treat low mood and depression.* https://www.nhs.uk/medicines/amitriptyline-for-depression/

[27] *Section 20 of the Children Act 1989 provides the local authority with the power to provide accommodation for children without a court order when they do not have somewhere suitable to live. It is widely known as voluntary accommodation because the parents must agree to the child being accommodated.* https://www.legislation.gov.uk/ukpga/1989/41/section/20

mind, causing her a lot of distress but did not disclose the details of the alleged incident. There were no records available to us which give details of whether this was explored with her.

4.16 In July 1999, her behaviour at school had again deteriorated and she had once again been excluded. The Education Authority had made plans for her to attend a pupil referral unit in September 1999 before considering reintegration into the school system, where she stayed until January 2000. Her mother is said to have reported (it is not clear to whom) that Miss A had started to smoke cannabis and use alcohol excessively. We did not see records of any subsequent enquiry into this.

4.17 In January 2000 (aged 16) she moved to Seaton Park GP practice, where her mother was registered. She was attending college and family relationships had improved. She was living with a boyfriend five nights a week, smoking cannabis, and became pregnant in 2000 (aged 17), delivering a child in 2001.

4.18 Her father died of cancer in 2004 and Miss A (aged 20) is said to have struggled significantly to cope with this. Miss A's father had left her his house in his will, which was in disrepair, and later this became challenging for Miss A to manage.

Background 2003 to 2016

4.19 In 2003 the GP made a referral to CNTW community assessment and intervention service (CAIS) for Miss A for illicit drug use. She did not attend any appointments offered with CAIS and was discharged. In December 2008 and January 2009, Miss A presented both at the GP surgery and Wansbeck ED following self-harm lacerations and was referred to the CTT and substance misuse services.

4.20 Substance misuse services subsequently referred Miss A to EIP. She was under the care of EIP for five years between 2009 and 2015. Miss A formed a close relationship with the EIP care coordinator (CCO1) who retired in March 2016 and a new care coordinator (CCO2) was appointed.

4.21 In 2009, Miss A started a relationship which appears to have had a significant influence and impact on her life. She described her relationship as controlling and violent. This relationship ended by September 2009, although Miss A stayed in touch.

4.22 On 25 September 2009 Miss A reported she had been assaulted by her partner who had been drinking and a knife had been involved. Her partner had confronted her about a new relationship. Miss A was shaken and upset, had bruising to her face and a black eye.

4.23 Miss A entered into a new relationship, however after an argument she had 'snapped' and bit a chunk out of her new partner's cheek which she says she then chewed and swallowed. The next day they went to hospital together for treatment, and her new partner did not press charges.

4.24 Children's services made an initial assessment in February 2009 of the provision of safe care for Miss A's child. It established that the child was being cared for by their father at the time. Miss A was known to ASC from February 2010.

4.25 In September 2010 she was receiving 'shared care' for the treatment of a non-organic psychosis. The GP was responsible for prescribing and monitoring of antipsychotic medication (quetiapine).

4.26 In 2013 and 2014 Miss A began to complain to her GP about physical issues such as dysuria, believing there were problems with her uterus and her veins were pulsing and swelling. The GP could not find any physical causes and felt that mental health issues may be part of the problem.

4.27 During 2014 Miss A was selling the house left to her by her father to rent it back to herself.

4.28 In 2014 two 'Adult Concern Notifications' (ACN) were raised by the police. Both were following reports from Miss A that people were entering her house. The decision was made by ASC was that as the case was open to EIP the information was passed on with no need for further action from ASC.

4.29 In 2015 the police made a further two ACN's. The first was following neighbours complaining about noise and Miss A's deteriorating mental state. The second was following concerns about Miss A's living conditions, and reports that the house was in a poor state of repair with rubbish accumulated in the yard. Both ACN's were passed to EIP by ASC for action.

4.30 Miss A was subsequently admitted to Alnmouth Ward, St George's Hospital, Morpeth from 15 January until 21 January 2015 with psychotic symptoms.

4.31 She was last reviewed by the EIP consultant psychiatrist in March 2015 and subsequently discharged from EIP. She was referred to the local mental health team when she moved to Crook in June 2015.

4.32 In February 2016 Miss A returned to Durham. The police made an ACN with significant concerns about Miss A who was described as very paranoid and chaotic. Miss A later took a significant overdose and attended ED. Mrs C was described as very worried about Miss A's mental health. She had concerns that Miss A would neglect and harm herself again but would blame her for 'telling the truth'. Miss A was detained under Section 2 of the MHA, admitted to CNTW St George's Park and discharged in March 2016 with no follow up request for ASC involvement. Prior to the overdose, her family had reported that she had presented with increasing paranoia and had told them that she was keeping knives, an axe, and a loaded air rifle at her partner's house, for her own protection, as she did not feel safe when she was alone.

4.33 On 4 June 2016 an Emergency Duty Team (EDT) request was received for a MHA assessment. Miss A had presented at ED stating she was pregnant and bleeding. She was found not to be pregnant but was thought disordered and paranoid with acute psychotic symptoms. Prior to the arrival of the Approved

Mental Health Practitioner[28] (AMHP), Miss A seriously assaulted (head butted) her mother in the ED ward area.

4.34 Mrs C told the police officers, and the police records indicate, that this was the first time Miss A had assaulted her although the family told police subsequent to Mrs C's death that this was not true; however police would have had no reason to question this at the time.

4.35 Miss A was detained under Section 2 MHA, admitted to Beckfield psychiatric intensive care unit (PICU), Hopewood Park, transferred to Almouth ward and remained an inpatient there until 4 July 2016 when she was discharged to the CTT.

January 2017 to May 2018

4.36 During this time Miss A was appointed a new male care coordinator (CCO3) between January and September 2017, however Miss A requested a change to a female CCO which was agreed. Whilst this was being organised, a temporary (due to retirement) female CCO4 was appointed between September 2017 and April 2018.

4.37 In January 2017 Miss A was reviewed by a CTT consultant psychiatrist. No relapse indicators were found although Miss A reported she still had auditory hallucinations, which she found distressing. Miss A reported multiple voices, male and female, 'torturing her', passing derogatory comments about her, while at other times talking among themselves, and that the voices had taken over her thoughts. Her medication was reviewed, and the consultant psychiatrist added a further antipsychotic medication to her prescription.

4.38 During February 2017 Miss A reported pains in her legs, intrusive thoughts, and command hallucinations. She was reported as being quite '*high in her mood'*, reporting persons coming into the house and taking items. The clinical records suggest that Miss A may be relapsing, and the plan was to monitor her over the next few weeks. A one-off visit from the STEP-UP[29] team took place 8 February 2017 which identified no new risks.

4.39 Following this, the CTT made four unsuccessful attempts to see Miss A at home, she would not answer the door to them. Records indicate that because of this, consideration was being given to discharging Miss A. She was offered an appointment on 5 March 2017 with her CCO. She was told that if she did not attend the appointment, she ran the risk of being discharged from the service 'as per policy'. Miss A was also not attending the appointments with the consultant psychiatrist.

4.40 The clinical records of the following months detail a picture of deterioration in Miss A's mental state and difficulty engaging her in services despite attempted

[28] *AMHPs exercise functions under the Mental Health Act 1983. Those functions relate to decisions made about individuals with mental disorders, including the decision to apply for compulsory admission to hospital.* https://www.hcpc-uk.org/standards/standards-relevant-to-education-and-training/amh-criteria/

[29] *Newcastle and Gateshead Step Up Hub service is for men and women over the age of 18 years who need some specialist support to live in the community.* https://www.cntw.nhs.uk/services/newcastle-gateshead-step-hub-ntw206/

visits and calls. Although she said she was taking her medication, she was also reporting feeling that small worms had been placed in her food bags and feeling a wriggling sensation in her body. The GP was in contact with Miss A and was liaising with the CTT about her physical health concerns.

4.41 Miss A had called the police to report a burglary and items missing at her house and her mother had the locks changed to reassure her.

4.42 In March 2017 Miss A attended ED having jumped or stumbled out of a Land Rover car. She had jarred her leg and was worried about nerve damage as she was experiencing numbness.

4.43 Miss A requested a change of CCO as she felt the current CCO did not understand her enough. This was agreed and additional weekly support was offered to Miss A via a registered nurse in the CTT services (CCO5) reporting to CCO4 until a new CCO could be allocated to her. This additional support was in place between April and July 2017.

4.44 In July 2017 Miss A reported feeling that small worms had been placed in her food bags and feeling a wriggling sensation in her body. The GP found no physical abnormalities however tests were done for parasites and she was referred for x-rays. The GP thought her presentation showed concern about her mental health and requested a review with her consultant psychiatrist. Step Up responded to the GP but planned a review for 17 August 2017.

4.45 In October 2017, Miss A told staff that she was struggling to care for her mother. Family members have since told us that she was not in fact caring for her mother. Her mother was contacted by the CCO via 'phone. She said she was 'OK' and knew how to handle Miss A. She was provided with safety advice and the contact number for social services. She reported that Miss A was not taking her medication as she thought they were sugar pills, was hearing voices, had spat in her face and sometimes took the house keys locking her in. The police reported that Miss A had contacted them about several thefts. They had raised a safeguarding concern in response to reports from her mother that Miss A was making threats to the neighbours. However, they did not feel there was an imminent threat to herself or others.

4.46 On 20 October 2017, the police made an Adult Concern Notice (ACN) referral after Miss A had made frequent calls to say people had entered her house and stolen items. Miss A was living with her mother, who the police identified as unwell and not very mobile. They noted that the events reported by Miss A were very unlikely to have happened as all doors and windows were found to be locked on each occasion. Her mother told the police, out of earshot of Miss A, that no one had entered, and nothing had been stolen. This incident was to be notified to CCO4, with no ASC action needed because of the involvement of the CTT.

4.47 This was however referred to Victims First Northumbria,[30] and contact was made with Miss A on 26 October 2017. It was noted that she lived with her

[30] *Victims First Northumbria is a victim referral service. https://victimsfirstnorthumbria.org.uk/*

elderly mother and both were unnerved by the burglary. An infra-red sensor alarm was requested for them, and there was no further action required.

4.48 CCO4 recorded the police contact, updated the risk assessment, and arranged to see Miss A. Miss A was seen by CCO4 the following day and physical health checks were carried out. There was no update provided to police to suggest that the risk to Mrs C from Miss A should be increased as a result of this incident.

4.49 Miss A self-presented at Wansbeck Urgent Care Centre in November 2017 and was taken to NSECH by ambulance. She told the crew she had been assaulted earlier in the day which resulted in pain and tenderness to her lower back. It remains unclear if this allegation was brought to the attention of the police, but no safeguarding referral was made.

4.50 In November 2017 she also described longstanding abdominal symptoms with swelling on and off and passing various segments of what she suspected were tapeworms. Since a fall downstairs some years ago resulting in nerve damage and altered sensation Miss A experienced shooting pains down left leg, pins and needles and said she was struggling to lift her leg up.

4.51 In January 2018 Mrs C called an ambulance for her daughter saying she was breathing and conscious but was writhing about on the floor in pain. Miss A was taken to NSECH but stayed only for a short period. The GP spoke to the consultant psychiatrist, stating that a relapse in her mental health was clear.

4.52 At this time Miss A said that her mother was being hypnotised into believing that people visiting the house were family, but they were impostors out to do harm and make everyone think she was mentally unwell. She had delusions about her dog and other animals and reported she had been assaulted, injected, had her money and property stolen. Mrs C said she was not taking her medication.

4.53 A CPA review took place in January 2018 and was in relation to assessing whether Miss A would benefit from crisis resolution team (CRT) services. This assessment outlined risks of self-harm, illicit drug use, aggression, poor compliance with medication and relapse but with no immediate risk of physical aggression towards self or others. The assessment included the views of her mother.

4.54 In February and March 2018 police made a further two ACN's. The first time Miss A called the police frequently stating people had been in the house, stolen her bank cards, medication, make up and food, taken out loans in her name and shaved her cats. When they attended there was no sign of forced entry, police officers had a discussion with the CTT who said she had not been taking her medication and had missed appointments. A medical review had taken place in January 2018, she had regular visits and support in place. It was concluded by ASC that no safeguarding action was required because she had ongoing CTT support. There was no update provided to police to suggest Miss A posed an increased risk to Mrs C.

4.55 The second ACN was made after the neighbours called the police following a series of threatening behaviours by Miss A which seemed to be due to paranoid thinking. This was noted to be the second ACN in six weeks, with the police asking for assistance from CTT and social services due to risk to neighbours and self. It was again noted as not needing any safeguarding action because she had ongoing CTT support.

4.56 In March 2018 Miss A saw the GP and said that she was worried that she had cancer. She had been assessed and nothing abnormal was found. Miss A reported that none of her usual pain medication was helping and asked for 'something else'. She was prescribed a short course of another analgesic (codeine) which was ceased later that month.

4.57 In March 2018, prior to admission, the police spoke to Mrs C after a neighbour called them to allege that Miss A had entered her house and accused her children of burglary. Miss A was apparently staying with a friend. Police records would suggest that Mrs C was competent to make decisions. The police spoke to her at length to seek her views and she said she had no concerns at the time.

4.58 On 10 April 2018 the Initial Response Team (IRT)[31] received a call from Mrs C concerned that Miss A was not taking her medication, Miss A had spat on her and called a family member a paedophile.

4.59 Miss A was seen at home and was found to be slightly hostile towards her mother but warm and engaging once her mother had left the room. A risk of further deterioration was noted if Miss A was non concordant with medication or with increased cannabis use. Miss A said she would harm others if she caught the person who was raping her at night.

4.60 On the same day Miss A was accompanied to her first psychology appointment at 3.30 pm with the aim of being able to develop a collaborative formulation. The risk summary from this found Miss A denying suicidal thoughts and no risks to others were disclosed or identified during the appointment. However, Miss A said that she felt someone was impersonating a family member, people were stealing from her and described hearing voices.

4.61 Mrs C was advised to contact the police if necessary. The CTT visited Miss A the following day. They noted some hostility towards her mother and a risk of further deterioration if non concordant with medication, or increased cannabis use.

4.62 On 11 April 2018 at 7.20 pm Mrs C rang the Initial Response Team (IRT) and said Miss A had thrown a chair at her. She was waiting for her son to arrive but was very shaken up, sore, swollen and felt in danger. She said Miss A had been calm when the CTT came to the house earlier but ‘kicked off’ in the evening arguing that the house was hers. She then ‘flipped’, striking her mother with a bath chair. Miss A was upstairs in the house when she made

[31] *Initial Response Team.* https://www.cntw.nhs.uk/content/uploads/2016/08/NLD-IRT.pdf

the call. Her mother was advised to contact the police but felt too shaken to do so. IRT made a call on her behalf. The police took positive action and arrested Miss A for common assault on her mother. She was taken into custody at Middle Engine Lane police station.

4.63 A Mental Health Act assessment was completed on 12 April 2018, and she was detained under Section 2 MHA. During the assessment she said the 'lady' she had hit with the chair was not her mother, could not remember when she had least seen her, and was upset the police had failed to safeguard her property leaving three strangers in there. She was admitted to Lowry ward.

4.64 Four days later Miss A was transferred to Alnmouth Ward. The Section 2 MHA was rescinded on 1 May 2018 and she remained on the ward as an informal patient until discharge on 30 May 2018. During her admission, Miss A was noted to be under the influence of illicit substances following periods of unescorted leave. Miss A was offered and took up some occupational therapy opportunities and psychological support while an inpatient. However, Miss A was not on the ward to engage in the OT daily living skills assessment as part of the discharge planning process.

4.65 A safeguarding alert was made in relation to the assault on Mrs C, and Mrs C was offered the opportunity to complete a safe lives risk assessment as part of the process of reporting the assault to the multi-agency risk assessment conference (MARAC). On 4 May 2018, a MARAC referral was not processed because Mrs C did not want to take the issue any further. A MARAC referral would have automatically raised Mrs C to high risk on the Northumbria Police system. Mrs C said she felt more vulnerable (she had an unrelated broken foot at the time) and felt that Miss A posed a risk to her as she thought family members were impostors.

4.66 Miss A spoke to her key nurse and expressed delusional beliefs about her mother being an impostor, that her appearance had changed, that the people acting as her mother may be her mother's family, that her adult daughter (someone she was close to but not her biological daughter) was also an impostor and that she had not mentioned this to her CCO as she feared being detained as a result. She said that she heard voices continuously, people had been trying to kill her over the years and repeatedly assaulting her during the night. Miss A said she was happy to move out of her mother's house but said she would need support with daily living skills. She said she did not feel safe anymore in hospital as things had been going missing from her room and people were being hypnotised in their sleep.

4.67 Her mother was contacted by Miss A's key nurse and they discussed not having Miss A live with Mrs C due to both the assault leading to the present and previous admission. The fact that Miss A had been intimidating, shouting, and blaming her due to her beliefs that she was not her real mother and most of her family were impostors, and said that Miss A had put the back of a knife across her neck saying it was just a joke.

4.68 On 9 May 2018, an inpatient multidisciplinary team (MDT) review outlined Miss A's risks as her non-compliance with medication, disengagement, and

vulnerability due to chronic delusional beliefs. The police were not involved in the MDT review and were not notified on any concerns that Miss A would pose a high risk to Mrs C on discharge.

4.69 The plan included consideration of depot medication, although later records state it would not be explored, and to liaise with the CTT regarding discharge. Miss A was appointed a new care coordinator (CCO6) who was on leave at the time and CCO5 continued to support her.

4.70 On 10 May 2018 Miss A climbed the roof of the main hospital stating she had seen 'round spheres on the roof from her window' and she went to investigate. She was encouraged to come down by security staff and returned to the ward. The police were not informed of this incident.

4.71 CCO5 made a referral for an ASC assessment whilst Miss A was in hospital because she would be homeless on discharge. A social work care manager was allocated to support her with housing, finance issues and longer-term support due to her vulnerability. They liaised with the CTT to discuss Miss A's needs. CCO5 expressed concern about her vulnerability if she had to present as homeless, however records state that the MDT would proceed with discharge as she no longer needed to be in hospital. The police were not notified by the MDT that Miss A might pose a risk to anyone she shared accommodation with.

4.72 On 24 May 2018, an MDT review stated that Miss A was accepting her medication and had utilised unescorted leave. She brought a bag of medication back with her to the ward saying that this was left over from when she was drinking and did not take it. She denied suicidal intent. This was noted as a risk to anyone who may share accommodation with Miss A, however there is no record of a risk pertaining to medication non-compliance being noted.

4.73 The Northumberland City Council Homeless Team advised CCO5 that Miss A would need to present herself as homeless on her discharge from hospital. Then the Homeless Team could complete an assessment to find accommodation for her. CCO5 stated that Miss A was too vulnerable to be accommodated in homeless accommodation, and she was awaiting an assessment to assess her ability to manage her daily living skills.

4.74 The ASC advice was that supported accommodation may be a better option, and that they would support her in finding suitable accommodation. They were advised that discharge was planned 30 May 2018. The Homeless Team later advised CCO5 to contact a supported housing provider who provide supported accommodation and assessment for people with mental health issues.

4.75 On 30 May 2018 Miss A was discharged from the ward without a CPA discharge meeting. Ward staff accompanied her to the homeless team. She was provided with telephone numbers for the CTT and crisis team. She was given seven days medication in a dossette box with instructions to contact her GP for a further prescription within seven days. The police were not notified

that Miss A had been discharged from the ward or that she posed a risk to Mrs C or the public.

4.76 Miss A was found an emergency accommodation vacancy at The Old Fire Station in Blyth. This is accommodation for people over 18 years of age who may have substance misuse and, or alcohol issues, or who are in recovery. The Old Fire Station was 'somewhere that you could sleep at night, but you had to be out all day'.

1 June 2018 to 6 August 2018

4.77 On 1 June 2018, CCO6 (who had returned from leave) reviewed the risk information for Miss A. They understood from this that Miss A was adamant she did not threaten her mother, rather that she had kicked an object and it had hit her mother accidentally. CCO6 was aware of Miss A's historic delusions about her mother being an impostor. Both CCO5 and CCO6 were aware of the previous MARAC referral discussion, however neither knew the outcome.

4.78 Miss A appeared committed to wanting to stay illicit substance free and was setting herself small achievable goals, such as seeking her own accommodation and obtaining her benefits. The plan was to keep her safe, devise a working plan, complete a social worker referral, monitor her medication compliance and mental state. Miss A indicated she did not want her mother to be informed of any aspects of her progress, care, and treatment.

4.79 In June 2018 Changing Lives[32] offered Miss A a six to nine month supported long-term placement in a shared women's house on a licence agreement.

4.80 To assist with compliance, staff at Changing Lives kept her medication in a safe place, handed it to her and watched her take it. Miss A had contacted the GP to order her medication and weekly prescriptions were provided. Miss A continued to hold delusional beliefs. She wanted to ring the police because she heard a body had been found and believed it might be her mother.

4.81 In June 2018 Miss A believed she had cancer. She thought her results were mixed up with someone else's and the GP was lying to her. She asked the GP for a prescription of analgesia which was prescribed (tramadol). CCO6 noted she was angry and unsettled, and it was decided that CTT appointments should be with two members of staff. Notes indicate that she was using cannabis heavily which fuelled her delusional thinking.

4.82 In July 2018 Miss A changed her GP to the Marine Medical Group. Miss A asked about her pelvic symptoms and said she had a history of cervical cancer. Miss A requested a referral to gynaecology. It was noted that she was examined at the last practice and although nothing was found a referral had recently been issued by Seaton Park.

[32] *Changing Lives is a nationwide charity helping people facing challenging times to make positive change, including the provision of accommodation.* https://www.changing-lives.org.uk/

4.83 Miss A was on several painkillers for pains in her legs and she said she needed to sleep. Different ways of managing chronic pain were discussed, including trying to reduce medication slowly and using psychological ways to help her with pain. The GP's plan was to reduce the pain medication because of their associated addictive properties. Due to her complexity Miss A was to be closely managed by a single GP. Miss A was advised to re-book to discuss with a senior GP however Miss A was not happy with this approach and the GP noted that she may not stay at the surgery.

4.84 On 2 August 2018 Miss A rang the CTT and asked if she had a psychiatrist appointment booked. Her records were checked, and a note was made to follow up as there was no medical appointment planned.

4.85 Miss A was reviewed by CCO6 on 3 August 2018. And she was formally discharged without discussion with the MDT. The discharge letter to her GP on 6 August 2018 noted that Miss A had been mentally stable for some time and requested that the GP prescribe her medication. The risk review stated there was no apparent risk of violence or harm to others.

23 August 2018 to April 2019

4.86 During August 2018 police made an ACN, stating that Miss A called to say someone had stolen her bank card. After investigation it was found it had been used by her in a shop that she denied entering. The ACN was emailed to the safeguarding triage team for action who found that Miss A was adequately supported for her mental health needs, and the supported housing staff assisted her with money management.

4.87 The ASC safeguarding triage team attempted to contact Miss A on 28 August and spoke to a supported housing support worker at her accommodation on 29 August 2018. It was stated that Miss A was currently adequately supported for her mental health needs, and the supported housing staff assisted her with money management. It was left that the duty worker 'urged' that an adult social care referral be made when she was due to move to independent accommodation. There is no formal record of the outcome of the safeguarding referral.

4.88 Miss A was dissatisfied with her discharge from the CTT and rang the team several times and informed them she had ongoing needs.

4.89 On 20 September 2018 Miss A asked for a crisis referral as she felt her life was dropping to pieces and she had no support from services. Miss A was assessed and no evidence of an acute mental health deterioration or risk factors which would warrant urgent care were found identified. She was referred to the CTT for a joint CPN and medical assessment. She was told she could self-refer to CRHT again if needed.

4.90 In September 2018 Miss A again seemed confused about her cervical smears, saying she had cervical cancer and that the smears undertaken in 2015 and 2018 were not hers and the last GP practice mixed them up. The GP felt her mental health problems had worsened and planned to request a

review by the in-house practice based CPN. The decision was not to increase her analgesic medication.

4.91 Miss A was absent from her supported accommodation for three consecutive weeks over a six-week period. During which Changing Lives had been in constant communication with her and had to report her missing. She was in breach of her terms and her licence was terminated. She had not picked up prescriptions from her GP and unsuccessful attempts were made by a social worker to contact Miss A.

4.92 Changing Lives stated that her mental health needs were too severe for their service, and although they had been in constant communication with Miss A when absent from her accommodation, they had to report her missing as she had been away from her supported accommodation for a consecutive period of three weeks over a six-week period. Her licence was terminated from 13 October 2018.

4.93 In October 2018 Miss A enquired about the CTT referral and it was discovered it had not been actioned due to human error. Miss A was homeless, staying with various friends and relatives and was not currently registered with a GP.

4.94 A family member called ASC, stating that Miss A was constantly calling and asking for help, Miss A had arrived with all her bags and was now sleeping on their couch. They said they could not let her stay and were unable to look after her. The Homeless Team could not provide temporary accommodation. Miss A would need to stay with friends or sofa-surf until her situation was assessed by a social worker.

4.95 In November 2018 Miss A requested medication but refused to attend a GP appointment, who could no longer prescribe without a review. Shortly after this Miss A registered with a new GP at Laburnum surgery where she presented in a state of considerable agitation. She was requesting a prescription for morphine, which was declined, but limited supply of tramadol was prescribed. Miss A rang the CTT again and asked about her referral. She said she remained homeless and provided details for her new GP.

4.96 Miss A's referral was discussed at the CTT triage meeting as a self-referral. She was allocated again to CCO6 to review her current needs and consider if she required 'top up sessions'. A full assessment was not required until the outcome of this review was known. However, CCO6 found it difficult to contact Miss A and a plan to discharge Miss A the following week was made if the services did not hear from her.

4.97 Miss A attended the CTT team base and said "Tell them I have shown my face" then left. Her family member came to meet her and gave the service her own address for any letters to Miss A. She asked CCO6 to contact her as she was very concerned about her. The duty nurse emailed CTT consultant psychiatrist (locum 2) stating that the service was currently unable to contact Miss A, that she was not engaged with CCO6 and discharge was being considered. The plan was for one more letter to be sent to Miss A at her family member's address for an appointment with CCO6 at the team base.

4.98 Miss A was found to be intoxicated and had tried to enter her friend's address via a window, became stuck and needed the fire brigade. Her friends were concerned about her mental health. Police called the street triage team[33] to ask for an assessment. She told police she had been taking her medication but also drinking.

4.99 In December 2018 it was noted that the ASC referral had to be finalised as incomplete. An ASC discussion confirmed that Miss A had a CCO, and that the team were aware of the recent safeguarding concerns. It was agreed that the social worker would attempt to contact her at the family member's address.

4.100 Miss A attended an appointment with CCO5 and CCO6 supported by an advocate who was a friend of her family member. Miss A appeared angry and paranoid about both CCO's, saying she did not want to work with them any further and wanted a different female worker. She was reported as functioning well within her delusional belief system and that her needs were primarily social. She said she was taking her medication and denied illicit substance misuse. Miss A needed accommodation as she was homeless and her family member was waiting to be admitted to hospital, so Miss A could no longer live with her.

4.101 Miss A was to be allocated a female CCO. The GP was to be contacted to check what medication was prescribed and if she was compliant. A joint meeting with her social worker was to be arranged to identify a discharge management plan.

4.102 Miss A attended the GP as an emergency saying she had pelvic bleeding and was referred to NSECH for investigations. At NSECH Miss A disclosed several assaults whilst she was living on the street but gave no details. She agreed for a safeguarding referral to be completed. She stayed in the emergency department (ED)[34] for a short assessment before discharging herself.

4.103 A healthcare safeguarding referral made by Northumbria ED stated that Miss A had disclosed in ED that she had been assaulted several times in the past year but gave no details, and she appeared to have substantial physical and mental health problems. The safeguarding triage worker attempted to contact Miss A. It was established she took her own discharge on the evening of 20 December 2018.

4.104 It was not possible to locate Miss A, messages were left on her voice mail, to encourage her to contact the crisis team, on-call social worker or the police. The ACN was formally recorded as a sexual abuse referral and did not indicate concerns over her mental capacity to make decisions in this area.

[33] *The Street Triage Team operates across Newcastle, North Tyneside, Northumberland, areas. The Team aims to improve access to mental health services and avoid preventable detentions when using section 136 of the Mental Health Act. Referrals are made by Police.* https://www.cntw.nhs.uk/services/street-triage-north-tyne/

[34] *Northumbria Specialist Emergency Care Hospital.* https://www.northumbria.nhs.uk/wards/northumbria-specialist-emergency-care-hospital/emergency-department/

4.105 In January 2019 Miss A attended ED about an assault allegation, it was noted that adult safeguarding were trying to follow her up. Miss A was still waiting for a female CCO to be allocated.

4.106 In March 2019 CTT appointment letters were sent inviting Miss A for an appointment. It stated that this was for a review of her mental health, would not be with her current CCO6 and that she was awaiting allocation of a new female CCO. The GP twice called Miss A without success and spoke to the CTT confirming that Miss A was picking up her medication and current prescription.

4.107 Miss A did not attend the planned review meeting with the CTT clinical lead and a female CCO. Her family member arrived, expecting Miss A to meet her in the waiting room. The staff spent some time with the family member to get information about her contact with or concerns about Miss A. She said Miss A remained homeless but was checking in once a week with her for a shower. They described Miss A as ‘quite well’ but needing help with accommodation and practical aspects of life. They thought Miss A was collecting her medication.

4.108 A referral to adult social care was made on 29 March 2019 by her allocated CPN. It was reported that Miss A's mental health had not deteriorated however the CPN had not seen her to assess her. The CPN reported that she was ‘sofa-surfing’ and her needs were more social, needing help with housing and claiming benefits.

4.109 The referral requested a social worker to provide daily support, support with housing, finance issues and longer-term support due to vulnerability. The case had not been allocated by ASC at the time of Mrs C’s death.

4.110 In early April 2019 Mrs C was found deceased. Northumbria Police had received concerns for her welfare and entered her home. Miss A was arrested and charged with the murder of her mother.

5. Detailed analysis – clinical care and agency involvement

5.1 The Terms of Reference require us to review specific areas of practice in relation to the mental health care and treatment provided to Miss A. We used the Terms of Reference to guide our analysis and in addition we examined issues that have emerged following our analysis with specific headings as follows:

- Domestic Abuse local strategy.
- Matricide and Parricide.
- Family involvement and carer support.
- CPA and the Care Act
- Care and treatment in the community and in hospital.
- NICE guidance, diagnosis, and medication.
- Risk assessment and safeguarding.
- Discharge and housing.
- Interagency information sharing and communication.
- Serious incident review and action plan progress (Section 6).

5.2 The specific terms of reference relevant to domestic homicide review are to establish what lessons are to be learned from the domestic homicide regarding the way in which professionals and organisations work individually and together to safeguard future victims.

5.3 As part of the overall report, we will consider the quality of both the health and social care assessments on which decisions were based and actions were taken. We will also include compliance with local policies, national guidance, and relevant statutory obligations as part of our analysis.

Domestic abuse local strategy

5.4 We accessed the Northumberland County Council Domestic Abuse strategy,[35] and met with the domestic abuse coordinator who provided information about how this has been operationalised. The strategy is due for review over the next year, and plans are being developed to carry out a sexual violence and domestic abuse needs assessment. It is intended that this should lead to a detailed action plan. There are four areas of focus currently: prevention, provision, partnership, and criminal justice.

5.5 There is an up-to-date protocol supporting MARAC, and a quarterly steering group is in place. This group incorporates lessons to be learned from previous

[35] *Northumberland Domestic Violence and Abuse and Sexual Violence Strategy 2018-2021* https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Public-Protection/Final-NCC-DA-SV-Strategy-2018-2021.pdf

DHRs, and there have already been issues identified as learning from this and previous homicides:

- Variable understanding of and use of DASH.
- Increasing understanding of domestic abuse being wider than intimate partner violence.
- Raising awareness amongst GPs.

5.6 In North Tyneside there is ongoing work with CCGs and GPs, and a toolkit for MARAC and domestic abuse has been updated. This has been developed with the Royal College of GPs, with a link directly to an adult safeguarding toolkit. Case audits are planned to review the effects of changes made.

5.7 Electronic recording systems can now incorporate risk assessments such as DASH, and flag risk of domestic abuse. The system can also flag previous history, linking both the perpetrator and victim. Training and refreshers are planned regarding the use of DASH and the threshold for referral.

Finding 3 – Northumberland County Council – Domestic abuse

The Northumberland County Council Domestic Abuse strategy is due for review over the next year, and plans are being developed to carry out a sexual violence and domestic abuse needs assessment.

Recommendation 3 - Northumberland County Council - Domestic abuse

Northumberland County Council must ensure that a comprehensive domestic abuse strategy includes measurable outcomes from previous reviews.

Matricide and Parricide in England and Wales

5.8 In this section we offer a perspective on the aspect of parricide and matricide, tragically illustrated in this homicide.

5.9 Matricide is defined as the killing of a mother by their son/daughter and patricide the killing of a father by their son/daughter. Parricide is defined as the killing of a parent by a child of any age. This could include biological parents, step-parents or adoptive parents.

5.10 A review of parricide undertaken as part of the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness identified two types of parricide offences, from their review of the literature. These are those offences committed by adolescents and those committed by adults. In the latter group, they found that the perpetrators were either mentally ill, particularly with psychosis or there were antisocial behaviour/violent personalities. They also noted that schizophrenia was the most common diagnosis.

5.11 In the first national analysis of parricide using the Home Office Homicide Index for England and Wales (Holt 2017),[36] all recorded cases of parricide over a complete 36-year period (January 1977-December 2012) were identified. There were 693 incidents of parricide recorded in England and Wales, suggesting a mean of approximately 19 incidents per year. There were 716 victims in total over this period. Despite the general downward trend in homicides that has been observed since 2002/03 across England and Wales, including domestic homicides, the rate of parricides has remained stable, at approximately 0.04 victims per 100,000 population per year. The study found that 35% of offenders were intoxicated at the time of the killing(s). For offenders, this is almost double the proportion found in all homicides in England and Wales.

5.12 The Homicide Index includes a category of an 'irrational act' for the killing(s). In the parricide cases with this category, it was more frequently used as the main circumstance with female victims (35%) compared with male victims (14%), this difference was statistically significant. Additionally, the use of diminished responsibility as a partial defence constituted 24% of homicide convictions in parricide cases, but only 5.5% of overall homicide conviction outcomes. Only 44% of parricide offenders were detained in prison (or its equivalent in the case of juveniles). This compares with the 94% of all homicide offenders that are detained in prison. Furthermore, while 62% of all homicide offenders received a sentence of life imprisonment, only 38% of parricide offenders received this sentence.

5.13 Hospital Orders were widely used in parricide cases, again much more so compared with homicide cases generally (31% vs. 6%). While the findings presented in this study does support the idea that mental illness plays an important role in the perpetration of parricide, the author was clear to point out that this study still suggests that most parricides are not the product of mental illness.

5.14 The rates of mental disorder in parricide offenders varies according to the population studied. For example, in a Canadian study (Bourget et al 2007), only 8% of matricide perpetrators and 6% of patricide perpetrators were found not to have a mental disorder. In that sample, two-thirds of the male parricide offenders were motivated by delusional thinking. This reflects other studies, for example in a study from the USA, they identified four factors which were significant in the parricide offences. These were:

- Acute psychosis – 47%
- Impulsivity – 28%
- Alcohol and substance misuse – 24%
- Escape from enmeshment[37] – 15%

[36] *Holt, A. (2017). Parricide in England and Wales (1977–2012): An exploration of offenders, victims, incidents, and outcomes. Criminology & Criminal Justice.*

[37] *Enmeshment is a psychological term that describes a blurring of boundaries between people, typically family members. Salvador Minuchin. (2005). Contemporary Authors Online. Retrieved from http://www.gale.cengage.com/InContext/bio.htm*

5.15 In another large study from a high secure hospital in England (Baxter et al, 2001),[38] they studied consecutive admissions over a 25-year period and identified 98 admissions over that period who had committed parricide offences, of whom six were double parricides. They compared this group with a group of patients who had killed strangers. They found that the group committing parricide offences had a higher proportion of patients with schizophrenia compared to the other group where the commonest diagnosis was of personality disorder.

5.16 They also found that the parricide group were less likely to have a criminal history, but there was a higher incidence of previous attacks on the victim. One important factor that they concluded that the parents may have placed themselves at risk by being more tolerant of violence and seeing it as an inevitable consequence of their son or daughter's schizophrenic illness.

5.17 In another study undertaken as part of the National Confidential Inquiry (Rodway et al 2009)[39] which was not specifically focussed on parricide, they studied the methods of homicide compared by diagnostic group. They found that just over half of all perpetrators with schizophrenia had killed a family member or current/former spouse. They found that the majority had active symptoms at the time of their offence, mostly delusions and/or hallucinations. And of these, over two-thirds reported experiencing delusions specifically related to their victim. They found that of all homicide offenders with severe mental illness, half also had a comorbid alcohol and/or drug dependence/misuse problem. They also found that these patients were more likely to use a sharp instrument in the homicide and therefore highlighted the importance of enquiring into the carrying of weapons by patients with schizophrenia.

5.18 A literature review of the relationship between schizophrenia and matricide (Schug 2011)[40] reviewed 61 publications, which included case reports, descriptive studies, and comparison studies. They found that offenders with schizophrenia were overrepresented and the prevalence of schizophrenia and other psychotic illnesses was significantly greater than in the general population. Also, the rates of schizophrenia were at the highest end of the range for all homicides (6% - 50%).

5.19 However, they concluded that matricide was not a specific schizophrenic crime and it was difficult to ascertain the motive for the offending in the studies that they reviewed. Even in perpetrators with schizophrenia, there was evidence of pathological family dynamics and increased violence which were present in other cases.

5.20 It could be argued from reviewing the literature on parricide and then comparing it with the broader work on homicide committed by mentally disordered offenders, that there may not be anything particularly different

[38] Baxter, H., Duggan, C., Larkin, E., Cordess, C., and Page, K. (2001) mentally disordered parricide and stranger killers admitted to high security care. The Journal of Forensic Psychiatry. 12, 287 – 299.

[39] Rodway, C., Flynn, S., Swinson, N., Roscoe, A., Hunt, I. M., Windfur, K., Kapur, N., Appleby, L., and Shaw, J. (2009) Methods of homicide in England and Wales: a comparison by diagnostic group. The Journal of Forensic Psychiatry & Psychology. 20, 286 – 305.

[40] Schug, R. (2011) Schizophrenia and Matricide: An Integrative Review. Journal of Contemporary Criminal Justice 27(2):204-229.

about those offenders who kill their parents compared to those who kill other family members. In fact, there have been several recent high-profile cases where a parent and sibling or other family member was killed at the same time. As parricide is so rare, it is probably not possible to distinguish this group from the rest of the mentally disordered offenders who kill a family member.

5.21 However, we wish to highlight three important factors:

- The importance of active symptoms of mental illness at the time of the offences. This is particularly true when these are delusions relating to family members. In turn, this then emphasises the importance of optimum clinical management of patients, particularly ensuring assertive treatment, including compliance with antipsychotic medication.
- Comorbidity of mental illness with alcohol and/or drug use. This has long been recognised as a very significant factor in increasing the risk of violence towards others in patients with schizophrenia.
- Effective liaison with the family, not only to obtain information related to risk but also to offer illness education for the family and highlighting the importance of compliance with medication for their family member. This was also highlighted by the National Confidential Inquiry who recommended that services should explore the relationship between family members and in particular, enquire about previous violence and delusional beliefs relating to family members.

5.22 Finally, at least one of these studies (Byoung-Hoon Ahn et al, 2012)[41] raise the issue of increasing risk of harm to parents who actively seek to promote treatment compliance in their children or who may be actively involved in their involuntary admission to hospital. This is particularly relevant to their role as the Nearest Relative under the Mental Health Act, where their consent is required for admission under Section 3.

Finding 4 - Home Office – Matricide and Parricide

There are several important studies concerning mental disorder, matricide and parricide relevant to agencies working with domestic abuse prevention strategies, in particular three important factors with implications for risk management.

Recommendation 4 – Home Office – Matricide and Parricide

a) The Home Office should incorporate this learning about matricide and parricide into domestic abuse prevention strategies.

b) Adult child to parent violence and mental illness should be incorporated into domestic abuse strategies.

[41] Byoung-Hoon Ahn, Jeong-Hyun Kim, Sohee Oh, Sang Sub Choi, Sung Ho Ahn and Sun Bum Kim. (2012) Clinical features of parricide in patients with schizophrenia. Australian & New Zealand Journal of Psychiatry, 46, 621 – 629.

Family involvement and carer support

5.23 It is clear from the history that there have been difficulties and challenges in the relationship between Mrs C and Miss A, over many years. There was limited understanding of the relationship between Miss A and Mrs C from 2014 onwards.

5.24 There was inadequate exploration of the belief repeatedly expressed by Miss A that her mother had been replaced by an impostor, and Mrs C was not in fact her mother.

5.25 There is evidence pre 2014 that describes the co-dependency of the relationship between mother and daughter. Miss A often resenting the role that she played in her mother's life, she talks about being her carer and how her mother has often been critical of her and making her feel devalued.

5.26 There is no exploration carried out with Mrs C regarding her perspective and concerns, beyond contact in crisis.

5.27 We have not seen any evidence that Miss A and her family were encouraged to collaborate in developing and implementing a care plan or risk management plan. The CPA Policy states that concern expressed from carers should be taken very seriously and should lead to the care coordinator (CCO) considering the need to initiate a review. The CPA Policy states that '*Carers form a vital part of the support required to aid a person's recovery. Their own needs will be recognised and directed for assessment through Adult Social Care in accordance with the Care Act 2014'*.

5.28 While she was in hospital in 2016, Miss A was granted Section 17 leave to her mother's address and later discharged to her mother's address. This demonstrated little insight into the relationship and the risk Miss A may pose to Mrs C.

5.29 As a summary in 2017, the family noted Miss A was chaotic and, as an example, had the door locks changed to reassure her. The picture during 2017 is of deterioration in Miss A' s mental state. She was feeling her physical health deteriorating, wriggling in her body and worms in her bag. Miss A reported having problems caring for her mother.

5.30 We note that on 6 October 2017, her mother said that she was not taking her medication and was 'flaring up' at times, swearing and throwing things and on one occasion had spat in her face. She said that sometimes Miss A would insist on locking her in the house when she went out and took the keys with her.

5.31 However, in October 2017, Miss A said she was struggling to care for Mrs C. Mrs C was contacted via 'phone and although she said she was 'OK' and knew how to handle Miss A, was provided with safety advice and the contact number for social services. The GP was updated regarding the contact with Mrs C.

5.32 Our view is that as Miss A's mother had reported non-compliance to medication and risks to herself, a clinical review with the consultant psychiatrist should have taken place to either consider a depot medication or an inpatient management along with a safeguarding referral. The CCO however asked Miss A's mother to make a self-referral to adult social care and updated the GP regarding the contact with Miss A's mother.

5.33 NICE guidance for psychosis and schizophrenia in adults: prevention and management[42] advises that carers, relatives, and friends of people with psychosis and schizophrenia are important both in the process of assessment and engagement, and in the long-term successful delivery of effective treatments.

5.34 It is recommended that carers should be given written and verbal information in an accessible format about:

- Diagnosis and management of psychosis and schizophrenia.
- Positive outcomes and recovery.
- Types of support for carers.
- Role of teams and services.
- Getting help in a crisis.

5.35 In our view, psychosocial education should have been provided for Miss A and Mrs C in understanding the nature of her diagnosis, how the family could support Miss A what could be expected in terms of recovery, and how medication may affect Miss A.

5.36 During her admission in 2018 Miss A identified her mother as her main carer, that Mrs C was willing to continue in her caring role with Miss A, however had concerns about her own safety and had not been offered time to speak to a clinician on her own. Although Miss A was resentful towards her mother as she perceived her to be demanding and very critical of her (including her parenting style), Miss A also perceived her mother to be a source of support.

5.37 Mrs C was provided with information about her rights as a carer, her entitlement to a full assessment and given information about local carer resources. She expressed a wish to be involved in review meetings (by 'phone) and contacted beforehand for her views. However, we did not find evidence of this being actioned and a carer's assessment was not facilitated for her.

[42] *Psychosis and schizophrenia in adults: prevention and management Clinical guideline [CG178]. Published date: February 2014.* https://www.nice.org.uk/guidance/cg178/chapter/Introduction

Finding 5 - CNTW - family involvement

There was no evidence of an evidence-based treatment plan in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management (2014) with regards to family engagement and carer support.

Although Mrs C was identified by Miss A as her carer we did not find evidence of Mrs C being identified as a vulnerable carer with identified carer needs and actions recorded or a carer's assessment arranged for Mrs C after this had been offered. No domestic abuse support was provided, and there was little evidence of Mrs C being routinely involved in review meetings as she wished to be.

Recommendation 5 - CNTW - family involvement

a) CNTW must ensure that families and carers are appropriately involved in care planning and risk assessment.

b) CNTW must ensure that referrals for carers' assessments are routinely part of care planning and risk assessment.

Care and treatment

Care Programme Approach (CPA)

5.38 The CNTW Care Programme Approach (CPA) Policy[43] describes CPA as providing an overarching framework for the assessment, care, support, planning, treatment, and review of people referred to the Trust's secondary, tertiary mental health, learning disability services and short-term psychological therapy services but excludes primary care mental health services.

5.39 The Policy applies at times of transfers across care pathways and sets out the CPA principles for assessment and care planning for service users receiving mental health or learning disability services within the Trust and its partner agencies where there is shared care.

5.40 This is a new and comprehensive Policy which was not in place at the time of the incident. It covers referral and initial assessment, assessment, care planning and review. The accompanying seven appendices cover consent, information sharing, recording the outcome of risk assessment, community care planning, epilepsy, learning disability and moving on plans. The CPA Policies address the incident themes regarding the involvement and assessment of carers.

[43] *Care Programme Approach (CPA) Policy, reference CNTW(C)20 - V06.3. implemented March 2020; review date March 2023.*

5.41 The previous CPA Policy[44] was also comprehensive and had the same scope and appendices. However, it is difficult to view the changes made to this as the review and amendment logs for both policies do not provide the detail.

5.42 The CPA framework incorporates arrangements for people with complex characteristics who are at higher risk and need support from multiple agencies and thus require care coordination and an allocated care coordinator (CCO).

5.43 The CPA Policy has relevant sections on patient safety management plans and risk assessment addressing risk themes arising and should include exploration of any risk with carers and family members who live with and or provide care to support the service user.

5.44 The CPA Policy section on risk assessment states it is required in the following circumstances:

- As part of initial assessment/ongoing assessment/reassessment.
- When admitting and discharging from hospital and as part of planning and agreeing leave.
- As part of community or inpatient care coordination or MDT reviews.
- When there are major changes to presentation/personal circumstances or following an incident.
- When alerted by carers/relatives to their concerns. e.g., about changes to presentation/personal circumstances/an incident.
- When referring service users to other professional teams/service providers to ensure that there is a shared understanding of current risks to inform the referral process.
- When transferring service users to other teams/service providers to ensure that there is a shared understanding of current risks to inform the transfer process.
- When alerted by other members of the care team about major changes to presentation/personal circumstances/an incident.

5.45 In terms of the themes of safeguarding adult and public protection, the CPA Policy has minimal sections on these issues, but refers to the Safeguarding Adults at Risk Policy,[45] and the Local Authority Safeguarding Adults Policies and the Trust's CNTW (C) 25 'MAPPA (Multi Agency Public Protection Arrangements) including non-MAPPA' Policy.

5.46 Both CPA Policies address how to promote engagement with guidance where the service user misses appointments. As an example of how the Policies address engagement themes they state that service users should not be discharged back to primary care simply because they have missed a number of appointments. Consideration must be given to the individual circumstances including, where appropriate, the degree of mental illness, the level of risk

[44] CNTW(C) 20 V06.3 implemented January 2018; review date January 2020.

[45] Safeguarding Adults at Risk Policy CNTW(C)24 January 2020.

posed and where the situation warrants prompt intervention, an assessment under the Mental Health Act should be considered.

5.47 Our view is that it was therefore appropriate for Miss A to be treated under the CPA framework and Trust Policy. We have reviewed both the previous and new CPA Policies to consider whether the Policy principles were applied. Our narrative analysis is contained within the relevant sections concerned with Miss A's care and treatment both in the community, as an inpatient and in relation to the arrangements for her discharge and housing.

The Care Act 2014

5.48 The Care Act 2014 defines an 'adult at risk' as someone over the age of 18 who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs);
- Is experiencing, or is at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

5.49 The local authority safeguarding team review the Adult Safeguarding Notifications (ACNs) raised by the Police, for any adult that they have had contact with who presents as vulnerable, and determine what action is required.

5.50 We have determined that both Mrs C and Miss A were vulnerable 'adults at risk' and have provided a narrative analysis of the issues associated with this in the relevant section on risk and safeguarding.

NICE guidance

5.51 The NICE guidance[46] for treatment of psychosis provides evidence-based guidance and advises that carers, relatives, and friends of people with psychosis and schizophrenia are important both in the process of assessment and engagement, and in the long-term successful delivery of effective treatments.

5.52 We benchmarked Miss A's care in relation to these standards on the following best practice elements of treatment in the table at Appendix E, and in addition have provided a narrative analysis in the family involvement and engagement (5.23 - 5.37), diagnosis and medication (5.117 - 5.146) sections of the report.

Care and treatment in the community April 2017 - April 2019

5.53 For context, when Miss A was receiving services from EIP from 2009 – 2015 it was thought she suffered from trauma, low mood, relationship issues with her mother and partner(s), personality traits and psychosis. Near the end of her

[46] *NICE CG178: Psychosis and schizophrenia in adults: prevention and management (2014).* https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations

time with EIP it was suspected she was suffering from a psychosis however Miss A denied any symptoms. One of the main working issues with Miss A was her concordance with medication. The EIP team manager told us that they were working to engage with Miss A to maintain compliance, and although depot medication was discussed, she did not want to receive this.

5.54 Miss A had a long history of chronic pain due to injury and ill health, for which she was prescribed painkillers including morphine. The notes refer to cannabis and alcohol abuse. In January 2015 EIP recorded that she had been taking cannabis and morphine, prior to her admission to Alnmouth ward. Morphine was prescribed by her GP in February 2016 for pain in her kidneys. In February 2016 she took an overdose of psychiatric medication and morphine. In June 2016 she has referred to taking her mother's morphine also.

5.55 During February 2017 Miss A reported pains in her legs, intrusive thoughts, and command hallucinations. She was reported as being quite 'high in her mood', and still reporting persons coming into the house and taking items. A one-off visit took place on 8 February 2017 which identified no new risks although it was thought she may be relapsing.

5.56 During February 2017 in total four attempts were made by CTT staff to see Miss A at home, but they were unsuccessful in doing so as she would not answer the door. Records indicate that because of this, consideration was being given to discharging Miss A, providing her with a letter offering a further appointment on 5 March 2017 with CCO4, indicating that if she did not attend this further appointment, then she ran the risk of being discharged from the service '*as per policy'*.

5.57 We view this as being an entirely inappropriate consideration given that she was subject to CPA and in view of her clinical presentation and risks at the time. Our view concurs with the Trust Engagement Policy requirements in that patients with psychotic illness should not be discharged when they disengage as this is often a feature of relapse.

5.58 The clinical records of the following months detail a picture of deterioration in Miss A's mental state and difficulty engaging her in services despite attempted visits and calls. Although she said she was taking her medication, she was also reporting feeling that small worms had been placed in her food bags and feeling a wriggling sensation in her body. The GP was in contact with Miss A and was liaising with the CTT about her physical health concerns.

5.59 On 1 November 2017, Miss A did not attend her appointment with the CTT consultant psychiatrist and noting her non-compliance, she was referred to the intensive community management and rehabilitation (ICMR) team. However, the records indicate that Miss A did not meet the criteria for this service but do not provide explanatory details. It is our view that considering her risk profile, poor compliance, co-morbid conditions and safeguarding issues, Miss A would have benefitted by intensive community approach offered by the ICMR team.

5.60 Miss A self-presented at Wansbeck Urgent Care Centre in November 2017 and was taken to NSECH by ambulance. She told the crew she had been assaulted earlier in the day which resulted in pain and tenderness to her lower back. It remains unclear if this allegation was brought to the attention of the police, but no safeguarding referral was made.

5.61 There were no formally recorded CPA reviews or FACE risk assessment and management updates during 2017. Risks were described narratively and included her lack of engagement, medication compliance, risks to her mother and her neighbours.

5.62 There are many instances which should have triggered a review of Miss A's risk assessment and management plans. Our view is in view of Miss A's clinical presentation during 2017 that there were missed opportunities to hold and plan future care coordination reviews including a risk assessment and management plan. These care coordination reviews should have involved Miss A, the consultant psychiatrist, the CCO, the police and Miss A's GP and included the views of Miss A's mother.

5.63 In January 2018 during a home visit, there were concerns that Miss A was relapsing. She said that her mother was being hypnotised into believing that people visiting the house were her family, but they were impostors out to do harm and make everyone think she was mentally unwell. She expressed delusions about her dog and other animals and reported she had been assaulted, injected, had her money and property stolen. We view the fact that Mrs C was spoken to separately before Miss A as good practice.

5.64 The situation was discussed with the CTT consultant psychiatrist (locum 1) and a telephone consultation with Miss A was requested. Locum 1 was unable to do this at the time due to leave arrangements and the team then decided to leave the assessment until locum 1 returned to work and could assess Miss A at home. This shows poor understanding of the clinical presentation and the risks. Our view is that such clinical presentation required a medical review and an assessment under the MHA to be undertaken without further delay.

5.65 Miss A had called the police to report a burglary and items missing at her house, and her mother had the locks changed to reassure her. Miss A requested a change of CCO as she did not feel CCO4 understood her enough.

5.66 Her request to change CCO was supported and as a result additional weekly support was offered to Miss A via CCO5 reporting to CCO4 until a new CCO could be allocated to her as there was a waiting list for CCO allocation at the time due to structural changes in service provision.

Finding 6 - CNTW - care and treatment in the community

There were no formally recorded CPA reviews or FACE risk assessment and management updates during 2017.

In February 2017 consideration to discharging Miss A was entirely inappropriate and not in line with the Trust CPA or Engagement Policy requirements.

In January 2018 there was poor understanding of the clinical presentation and the risks. Our view is that such clinical presentation required a medical review and an assessment under the Mental Health Act to be undertaken without further delay.

It is clear that Miss A presented with physical health concerns that could be seen as manifestations of her mental disorder. This appears to have escalated during 2018, when her beliefs about physical illness intensified. Her presentation became increasingly chaotic, and continuity was affected by her changing GP surgeries and being homeless.

The fact that not one psychiatrist had personal knowledge of Miss A, the lack of a clear diagnosis, and the view that she showed no relapse indicators although she continued to hold bizarre beliefs, led to a lack of decisive action to review, and manage her symptoms and risk.

There should have been a thorough assessment of her substance misuse, including the impact of this on her mental health. A referral to substance misuse services for advice or assessment and treatment should have been made.

When Mrs C reported Miss A’s non-compliance with medication and risks to herself, a clinical review with the consultant psychiatrist should have taken place to either consider a depot medication or an inpatient management along with a safeguarding referral. This did not take place.

Recommendation 6 - CNTW - care and treatment in the community

a) CNTW must ensure that the CPA Policy is embedded in practice and supported by relevant training addressing the quality of risk assessment, management plans, discharge planning and involvement of carers.

b) CNTW must ensure their workforce strategy addresses and monitors the clinical risks associated with CTT medical and nursing recruitment and retention workforce issues.

c) CNTW must ensure that the NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management is embedded in practice with reference to medication management.

d) CNTW must review the arrangements for assessing the need for and providing assertive outreach support in the psychosis care pathway.

Care and treatment whilst an inpatient April - May 2018

5.67 In March 2018, the police became involved as Miss A had contacted them due to her concerns that someone had been in her house and also because neighbours had themselves contacted the police due to their concerns about her mental health. Her mother said she could no longer cope with Miss A living at home due to her beliefs and she was concerned Miss A was not taking her medication. Her mother was advised to contact the police if necessary.

5.68 On 11 April 2018 at 7.20 pm Mrs C rang IRT and said Miss A had thrown a bath chair at her and she was waiting for her son to arrive but was very shaken up, sore, swollen and felt in danger. The police were contacted by IRT, Miss A was arrested and taken into custody at Middle Engine Lane police station where she was assessed by the Criminal Justice Liaison Team.

5.69 She said the 'lady' she had hit with the chair was not her mother, could not remember when she had last seen her, and was upset the police had failed to safeguard her property leaving three strangers in there. Miss A was arrested for common assault, assessed at Middle Engine Lane police station, detained under Section 2 of the MHA and admitted to Lowry ward between 12 April and 30 May 2018.

5.70 On 13 April 2018 Miss A was provided with her MHA rights and when these were repeated on 22 April, she demonstrated a full understanding. Miss A was assessed and found to be capable of understanding the nature, purpose, and likely effects of the proposed treatment, and was consenting to this being given under the MHA. She requested and was referred to an Independent Mental Health Advocate (IMHA) on 17 April 2018. Although records indicate the IMHA referral was subsequently being followed up we have not found evidence of this being concluded.

5.71 At the first ward round review on 13 April 2018 Miss A said her mother became an impostor three months earlier when she had stents inserted in hospital. It was planned to observe her mental state and review her medication.

5.72 On 14 April 2018 we found an assessment and treatment of mental state care plan was initiated, updated 1 and 22 May and ended 31 May 2018. This clearly detailed Miss A's increased paranoia, her belief that her mother and another family member were impostors, her concern about people stealing her belongings and money and that she was physically unwell with cancer.

5.73 On 18 April 2018 Miss A was provided with an Occupational Therapy care plan. Initially, when she came in, she was quite active and would engage in some activities. Miss A was also referred for an Occupational Therapy based functional assessment to assess her daily living skills on 10 May 2018 however as she was often not present on the ward this was not completed. We have not found evidence that Miss A was offered art therapy to commence during her inpatient stay or after her discharge in line with NICE guidance on schizophrenia.

5.74 On 1 May 2018 Miss A was discharged from Section 2 MHA by the inpatient consultant psychiatrist. The records indicate that this was because she had agreed to remain on an informal basis, and throughout her stay in hospital she had appeared quite relaxed and comfortable on the ward although it was recorded that she continued to be unwell with delusions about her mother being replaced by an impostor and other bizarre delusions. Nursing staff told us that they were trying to engage with Miss A using the least restrictive options.

5.75 At this point, we would have expected to see evidence of the consideration of further detention, and the assessment of Miss A's capacity, in the context of Miss A's historical lack of engagement, non-compliance with medication, her illicit substance misuse and the fact that she continued to express Capgras symptoms with the associated risk to her mother and other members of the family.

5.76 We note that if the police are not informed of increased risk from a mental health perspective, the police cannot include unknown risk factors into the 'SafeLives' process to potentially identify Miss A as being high risk.

5.77 Throughout her stay in hospital the records indicate that she did not appear paranoid, distressed, or showed signs of responding to voices. She did not report her previous experience of believing she was assaulted regularly at night.

5.78 In accordance with the MHA, Miss A had a Section 17 MHA leave care plan until the 1 May 2018 when she became an informal patient. Miss A had her first period of Section 17 escorted home leave on 14 April 2018 and had one period of absence without leave recorded on 20 April 2018 between 1 pm and 7 pm, however she returned of her own accord. As an informal patient she

was late returning to the ward from arranged unescorted leave on 12 May 2018.

5.79 Her mother was involved in the decisions or discussions about having escorted leave home when Miss A needed to obtain some of her belongings. It was made clear to her that her mother did not want her at home and so if Miss A wanted to go home to obtain items from the house, her mother would be contacted to ascertain her agreement and staff would escort her there. When Miss A was escorted home, it was noted that there was little interaction between Miss A and her mother, and her mother did not talk to the staff either.

5.80 Miss A also had unescorted leave in the general locality however staff could not provide us with assurance both that Miss A would not venture home on these occasions, or that there was an associated risk management plan to address this. We note that the police had not been notified of Miss A's unescorted leave or if she posed a risk to Mrs C or the public.

5.81 It was noted on 17 April 2018 that there were no risk behaviours to others since admission, however it was noted the risk of substance misuse remained high but contained. The plan was to continue assessment of her mental health; complete a urine drug screen and to have engagement with a psychologist.

5.82 During May 2018 MDT reviews found that Miss A had been settled in presentation, warm and pleasant with no evidence of thought disorder or perceptual abnormalities and she had not expressed any delusional beliefs during interactions. She had utilised unescorted leave on one occasion and there was suspicion she had used illicit substances. The outstanding actions included confirming the plans for her discharge and support needs, the functional OT assessment, the consideration of depot medication and housing options and to contact the CTT.

5.83 We were told that when Miss A started to have some periods of unescorted leave she returned under the influence of illicit substances. She was observed slurring her speech and tested positive to cannabis (and other illicit substances at times). It was evident to the nursing staff that they were going to have some difficulty reducing her cannabis use as Miss A said she had been using cannabis since she was a teenager and did not intend to give it up. The nursing staff therefore felt this was her lifestyle choice. Additionally, Miss A had also indicated in the past that she did not want to be referred to drug services to address her use of illicit substances.

5.84 This may have been the case; however, given her long history of substance misuse, we would have expected to find evidence of the MDT actively addressing and attempting to manage this issue. In our view there should have been a thorough assessment of her substance misuse, including the impact of this on her mental health.

5.85 On admission, Miss A was allocated a key nurse, although we have not been able to find evidence that the records of the one-to-one sessions were

subsequently recorded on the associated form. However, we saw appropriate progress note records of one-to-one time between them.

5.86 An 'inpatient arrangement form' and 'getting to know you' assessment was also completed. These documented that her mother was identified by Miss A as her main carer, that she was willing to continue in her caring role with Miss A, however had concerns about her own safety and had not been offered time to speak to a clinician on her own. Although Miss A was resentful towards her mother as she perceived her mother to be demanding and very critical of her (including her parenting style), she also perceived her mother to be a source of support.

5.87 Mrs C was provided with information about her rights as a carer, her entitlement to a full assessment and given information about local carer resources. She expressed a wish to be involved in review meetings (by 'phone) and contacted beforehand for her views. However, we did not find evidence of this being actioned and a carer's assessment was not facilitated for her mother.

5.88 In terms of consent, on admission Miss A informed staff that she agreed to her mother receiving copies of letters about assessment or care planning at her home address but would not agree to this information being shared with her three siblings. However, nursing staff told us that Miss A generally didn't want her mother involved, and it appeared that there was a bit of a distance between them. They were aware that in the past, Miss A became upset with her CCO for talking to her mother. The nursing staff told us, and it was evident in the records that there was some contact, both from and to Miss A's mother whilst she was on the ward.

5.89 Miss A was discharged from Section 2 MHA on 1 May 2018. The records indicate that this was because she had agreed to remain on an informal basis, and throughout her stay in hospital had appeared quite relaxed and comfortable on the ward. Within this context it was felt she did not need to stay in hospital, and she could be monitored in the community. However, she continued to express delusional beliefs as noted in the risk assessment and management plan i.e., believes mother and another family member are impostors.

5.90 Miss A was discharged from Lowry ward on 30 May 2018 (see relevant section on discharge and housing). The discharge summary states that her diagnosis at discharge was 'mental and behavioural disorders due to multiple drug use and use of other psychoactive substances – schizophrenia like predominantly delusional (F19.51).' No signs of bipolar affective disorder were seen during the admission (see relevant section on diagnosis).

5.91 The records stated that the differential diagnosis should remain under review, and that other diagnostic possibilities such as drug induced psychosis on a background of chronic substance misuse should be considered (see relevant section on diagnosis).

Finding 7 – CNTW – care and treatment whilst an inpatient

There should have been a thorough assessment of her substance misuse, including the impact of this on her mental health. A referral to substance misuse services for advice or assessment and treatment should have been made.

It is our view that the treating team had developed an unconscious biased view of Miss A (countertransference), attributing her clinical presentation predominantly to personality traits and substance misuse. The team referred to the 'chronicity' of the illness leading to the acceptance of continued symptoms. This is likely to have influenced the team not to attempt a trial of depot medication or a subsequent trial of clozapine, if she showed a poor response to depot antipsychotic medication (see related findings for diagnosis, medication, risk assessment and safeguarding).

Recommendation 7 - CNTW - care and treatment whilst an inpatient

CNTW must ensure that the safeguarding adults at risk Policy is embedded in practice and supported by relevant training.

Diagnosis

5.92 For context, whilst Miss A was in the care of the EIP services she was described as somebody who took EIP a while to understand, but at the beginning the suspicion from her presentation was probably psychotic symptoms arising from a mixture of trauma and substance misuse. Her diagnosis shifted from a psychosis to schizoaffective with some underlying personality issues and at the point of discharge, that the mood component probably predated the psychosis.

5.93 The recorded diagnoses in 2015 - 2016 were:

- January 2015 - F319 - Bipolar affective disorder, unspecified.
- July 2016 - F29.X - Unspecified nonorganic psychosis.
- March 2016 - F22.0 - Delusional disorder.
- July 2016 - F11.1 - Mental and behavioural disorders due to use of opioids/harmful use.

5.94 In January 2017 Miss A reported that she still had auditory hallucinations, which she found distressing, these being multiple voices, male and female, 'torturing her', passing derogatory comments about her, while at other times talking among themselves, and that the voices had taken over her thoughts. Her medication was reviewed with an antipsychotic (aripiprazole) being prescribed and added to her medication regime.

5.95 We found that Miss A was prescribed risperidone and aripiprazole together from January to November 2017. After this olanzapine was also added,

however this was to manage the change-over to olanzapine alone in January 2018. However, it is evident from the records that Miss A had poor compliance to medication and hence, instead of continued efforts with oral medication, a depot medication should have been initiated. Treatment periods in inpatient units, particularly when detained under the MHA were missed opportunities to initiate depot medication.

5.96 From January 2017 the diagnosis of schizophrenia should have been evident given Miss A's reported delusions, particularly Capgras symptoms. Although the diagnosis of schizophrenia was not made and remained under review, the prescribed oral medication was within a therapeutic range and in line with NICE guidance on psychosis and schizophrenia. Our view at this point is that, given her clinical presentation and the nature of her delusions, a diagnosis of a psychotic disorder should have been evident to the treating team.

5.97 In late January 2017, the CCO recorded several bizarre somatic delusions (her bowels were crushing her ovaries leaving her in a lot of pain; her and her mother were being assaulted in their sleep and people were cutting her).

5.98 The Section 2 MHA assessment in April 2018 listed several persecutory delusions, and stated that since January 2018, she had an on-going belief that her mother had been replaced with someone else; she was not aware where her real mother was, and another family member were imposters.

5.99 Our view is therefore, at this point on admission to hospital, the diagnosis of schizophrenia should have been evident given Miss A's reported delusions, however we did not find evidence that her beliefs were formally recorded as Capgras' syndrome. We view these omissions to be of particular importance in terms of the assessment and management of risk to her mother and other family members and for the clarity of the care pathway.

5.100 On admission the inpatient consultant psychiatrist told us that his impression was that she was suffering from a psychotic disorder, however said there were so many possibilities at that time that he could not clarify exactly what it was. He wondered if it was primarily functional psychotic disorder, a drug-induced disorder, and because of the information about differential diagnoses that had been considered for her over the years, all those possibilities were considered. In addition, at the inpatient multidisciplinary review meeting on 13 April 2018 it was reported that Miss A said her mother became an impostor three months previously. Whilst an inpatient, Miss A continued to experience delusions about her mother being replaced by an impostor, of being assaulted and her ovaries being crushed.

5.101 Presence of a persistent bizarre delusion for a period of more than a month satisfies the criteria for schizophrenia. Miss A had additional symptoms such as command hallucinations and persecutory delusions which should have led the consultant psychiatrist to clearly establish the diagnosis of schizophrenia.

5.102 On 1 May 2018 Miss A had escorted home leave to collect her belongings (her mother had agreed to this), and records indicate that she expressed delusional beliefs during the journey and little interaction with her mother. The

following day she expressed beliefs that the person at home was not her mother and the people living there had kidnapped her.

5.103 In May 2018, an MDT review took place and actions from the review included determining whether a children's safeguarding referral was required, to chase the IMHA referral, contact housing, offer a family meeting, and gather views on her mental state from the psychologist.

5.104 We found that the offer of a family meeting met the expectations of the NICE guidance on schizophrenia although the nursing staff told us that they asked Miss A on several occasions about having a family meeting, however Miss A's response to this was that she did not have family, saying that her mother was missing, and her twin had come to the house to replace her.

5.105 It is clear there were doubts about her diagnosis and care pathway and a view that there was a significant personality element to her diagnosis with the psychosis influenced by the use of illicit substances. We found that from January 2017 the diagnosis of schizophrenia should have been evident given Miss A's reported delusions, particularly Capgras symptoms. There was a lack of understanding about Capgras and the ICD10 diagnostic classification criteria. The ICD 10 diagnostic criteria for schizophrenia have been listed in Appendix F.

5.106 The recorded diagnoses in 2018 were:

- May 2018 - F19.5 - Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances/psychotic disorder.
- May 2018 - F31.9 - Bipolar affective disorder, unspecified.

5.107 The inpatient discharge summary states that her diagnosis at discharge was 'mental and behavioural disorders due to multiple drug use and use of other psychoactive substances – schizophrenia like predominantly delusional (F19.51).' No signs of bipolar affective disorder were seen during the admission. The records stated that the differential diagnosis should remain under review, and that other diagnostic possibilities such as drug induced psychosis on a background of chronic substance misuse should be considered.

5.108 The discharge summary stated that although on the surface, her beliefs about her mother and another family member looked like delusional beliefs, there were some aspects of her presentation which were unusual for example, she said that her mother and another family member had been replaced by someone else but in a detached manner without appearing worried or distressed. Additionally, several aspects of her presentation were more consistent with a diagnosis of personality disorder, for example, displaying disregard for ward rules, verbal hostility, and a tendency to blame staff members when her perceived needs were not met immediately to her satisfaction. The team including the consultant psychiatrist continued to discuss the lack of clear diagnosis and the clinical records indicate that there

were no relapse indicators present. As a result, our view is that the team did not act decisively to manage Miss A's symptoms during this time.

Finding 8 – CNTW care and treatment - diagnosis

We found a lack of clinical curiosity, given that Miss A did not always appear distressed by the delusions and hallucinations, leading to a perception that she was stable, her mental illness was 'chronic' in nature and latterly in 2018 that her needs were primarily social.

There were doubts about Miss A's diagnosis and a view that there was a significant personality element to her diagnosis with the psychosis influenced by the use of illicit substances. Attributing her clinical presentation predominantly to personality issues and use of illicit substances is likely to have led to lack of appropriate focus and treatment of her schizophrenia.

The fact that not one psychiatrist had personal knowledge of Miss A, the lack of a clear diagnosis, and the view that she showed no relapse indicators although she continued to hold bizarre beliefs, led to a lack of decisive action to review, and manage her symptoms and risk.

In our view there was sufficient evidence for a diagnosis of a schizophrenia/psychotic disorder, mainly schizophrenia in view of the presence of chronic and recalcitrant delusions of persecutions, bizarre somatic delusion and delusions of misinterpretation (Capgras syndrome).

Recommendation 8 - CNTW - care and treatment - diagnosis

CNTW must assure itself through regular audit that where appropriate, objective diagnostic criteria should be applied with reference to formulation and evidence base.

Medication

5.109 Between 2017 and 2018 we found no evidence to suggest that full consideration was given to discussing with Miss A the benefits of a depot antipsychotic or clozapine, in line with the NICE guidance for psychosis and schizophrenia, given Miss A's historical non-compliance and risk issues. Details of medication prescribed for Miss A 2017 and 2019 are attached at Appendix E.

5.110 Records generally refer to Miss A's risk of medication non-compliance in the community although there are a couple of records indicating she was compliant on discharge from her hospital admissions. There are regular accounts in the records of Miss A stating that she did not think the medication was working. In 2014, the staff began to feel that her delusions, substance misuse, disengagement and non-compliance were of a chronic nature.

5.111 Miss A was prescribed two antipsychotics together (risperidone[47] and aripiprazole[48]) from January to November 2017. After this olanzapine was also added, however this was to manage the change-over to olanzapine alone in January 2018. We found this was in keeping with the NICE guidance for psychosis and schizophrenia which states that regular combined antipsychotic medication should not be initiated, except for short periods (for example, when changing medication).

5.112 In October 2017 Mrs C reported that Miss A was not taking her medication as she thought they were sugar pills, was hearing voices, had spat in her face and sometimes took the house keys locking her in. Our view is that as her mother had reported non-compliance to medication and risks to herself, a clinical review with the consultant psychiatrist should have taken place to either consider a depot medication or an inpatient management along with a safeguarding referral. This did not take place.

5.113 We understand from records and staff we interviewed that this was because she was not keen to pursue this and because it was not thought that it would change her mental state (which was viewed as chronic). We found a lack of clinical curiosity, given that Miss A did not always appear distressed by the delusions and hallucinations, leading to a perception that she was stable.

5.114 The inpatient consultant psychiatrist did not feel that changing from an oral to a depot prescription would be of benefit just at the point at which she was showing willingness to take it. He told us that as olanzapine is not available as depot medication, a different class of medication would have to have been prescribed, involving taking a risk, and his view was that compliance could be difficult to ensure, even if other additional measures such as a community treatment order (CTO) were used alongside the depot medication.

5.115 The inpatient consultant psychiatrist told us that considering Miss A had a long history of non-resolution of psychotic symptoms and the fact that she had improved significantly on olanzapine, he did not think her mental state was unwell to a level where he needed to consider clozapine for her. There were some background delusional beliefs in her mental state, but they were not prominent in her presentation, or influencing her day-to-day living.

5.116 His view was that deterioration in her symptoms occurred mainly when she was using cannabis or other drugs, and that whether or not clozapine or a depot was prescribed, that risk was an ever present. The inpatient consultant psychiatrist did not believe her mental state would have been modified by keeping her in hospital for a longer period, or even by detaining her.

5.117 On 19 October 2018, the GP practice contacted the IRT stating they had been trying to contact Miss A about her medication without success and she had not been picking up her prescriptions.

[47] Risperidone is an antipsychotic used to treat schizophrenia and other psychoses. https://bnf.nice.org.uk/drug/risperidone.html

[48] Aripiprazole is an antipsychotic used to treat schizophrenia and other psychoses. https://bnf.nice.org.uk/drug/aripiprazole.html

5.118 Miss A rang the GP in November 2018 requesting medication, she was informed that no more medication could be prescribed without a face-to-face review, which was offered the same day. She refused to attend to see the GP, and it was noted she had been talking of changing GP surgeries.

5.119 The GP contacted the CTT to inform them that she had last been given a week's supply in October, and they could no longer prescribe without a review. The community pharmacy had advised that a urine drug screen should be carried out before prescribing. The urine drug screen was obtained, results were noted as positive for cannabis but negative for cocaine, amphetamine, and opioids.

5.120 There was inadequate planning to monitor her compliance with oral medication, insufficient assessment of the risks with non-compliance and the experience of Capgras symptoms posed to others, particularly her mother.

5.121 We found that depot medication was considered following her last admission, and given her historical non-compliance and risk issues, we view this as standard good practice in line with the NICE guidance for psychosis and schizophrenia. However, this was not followed through, and we understand from records and staff we interviewed that this was because she was not keen to pursue this. The view was that her mental state was chronic, and a depot medication would not change this.

5.122 Miss A had ongoing schizophrenic symptoms which did not respond to the prescribed antipsychotics; hence a trial of clozapine should have been considered due to the treatment resistant nature of her symptoms.

5.123 We have not found any evidence to indicate that clozapine[49] was considered in line with the NICE guidance for psychosis and schizophrenia. This states that clozapine should be offered to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least two different antipsychotic drugs (at least one of the drugs should be a non-clozapine second-generation antipsychotic).

[49] *Clozapine is used to treat schizophrenia in patients unresponsive to, or intolerant of, conventional antipsychotic drugs. https://bnf.nice.org.uk/drug/clozapine.html*

Finding 9 – CNTW - care and treatment - medication

There was no evidence of an evidence-based treatment plan in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management, particularly with regards to medication. We would have expected, particularly given Miss A's historical non-compliance and risk issues, to find that consideration had been given to the benefits of a depot or clozapine (an atypical antipsychotic medication) when her symptoms became more chronic and unresponsive to the antipsychotic medication prescribed.

There were insufficient interventions to assess and address her medication compliance issues.

Mirtazapine was prescribed in a way not in keeping with BNF or other recommended guidelines (NICE depression prescribing information). Miss A had some sleep difficulties and mirtazapine (antidepressant) was prescribed to be taken 'a couple of times a week' to try to support positive sleep habits.

Miss A was often treated with sub-therapeutic doses of antipsychotic medication in acute phases (for example risperidone 2 mgs a day was prescribed when most of the patients would require 4 to 6 mgs/day in acute phase). Sub therapeutic doses of antipsychotic medication along with poor compliance are likely to have contributed towards the chronicity of her symptoms.

Recommendation 9 – CNTW care and treatment - medication

CNTW must assure itself through regular audit that NICE guidance is followed in the prescribing of antipsychotic medication for those with chronic symptoms who have not responded to initial treatment.

Risk assessment and safeguarding

5.124 For context, Miss A had been known to ASC since February 2010 and was provided with this input as part of the provision of the EIP. During that time social workers were commissioned to work alongside community mental health nurses in working age mental health teams, as part of a Section 75[50] partnership agreement. The partnership arrangements were dissolved in 2013.

5.125 For information, and as a consequence, the ASC notes for this time formed part of the CNTW clinical records and as a result the ASC analysis for this review focussed on Miss A's records which refer to adult concern notices, safeguarding, and social care or housing involvement which continued after the integrated provision ended.

[50] *Section 75 partnership agreements, legally provided by the NHS Act 2006, allow budgets to be pooled between local health and social care organisations and authorities. Resources and management structures can be integrated, and functions can be reallocated between partners.* https://www.legislation.gov.uk/ukpga/2006/41/section/75

5.126 Although the scope of this review commences in 2017, it is important to understand the safeguarding opportunities prior to this which could have brought the difficulties, the relationship between Miss A and Mrs C and safeguarding concerns to the attention of the agencies to act.

5.127 There were no adult safeguarding referrals or adult safeguarding notifications regarding Mrs C. However, in our view there were several opportunities where safeguarding should have been considered. There were two assaults on Mrs C (2016 and 2018). ACNs were raised but these were raised in relation to Miss A not Mrs C. Miss A was recorded as vulnerable because of her mental health. Mrs C was not recorded as vulnerable; however, should have been recorded on these ACNs under the field 'Carers, suspects, involved'.

5.128 If an adult safeguarding referral had been raised regarding Mrs C then this would have been an opportunity for ASC to explore if Mrs C had care and support needs.

5.129 Northumbria Police Policy is to create an ACN where a person meets the criteria. The Policy states 'A person is vulnerable if as a result of their situation or circumstances, they are unable to take care of, or protect themselves or others from harm or exploitation'. This is a subjective test applied by the police officer at the time. It is noted that police understanding of policy or decision making could be improved.

5.130 The GP had a wealth of information regarding Mrs C and if adult safeguarding referrals had been made then ASC would have contacted the GP in accordance with their procedures, and better-informed decisions regarding safeguarding could have been made.

5.131 It was known that her ex-partner had moved back into Miss A's house in October 2014 and that there had been difficulties in the relationship previously. In November 2014 Miss A fell down the stairs in the house, and an account was given by her ex-partner as to how this happened. However, this was not explored any further and there was no consideration of her ex-partner being a risk to Miss A despite the previous history. In our view it would have been appropriate to have made a domestic abuse risk assessment at this point.

5.132 During 2014, it was known that Miss A was selling her house. It is recorded that the plan was for her to sell it and rent it back to herself. There does not appear to be any consideration to protecting Miss A's finances at this point or considering her capacity to make those decisions. There could have been a role here for ASC to ensure that Miss A was not being financially exploited. If a social care assessment had been completed at this point, then Miss A may have been offered alternative housing options which would have given her a tenancy in her own right negating the need for her to later move in with her mother.

5.133 In January 2015 there were reports of poor living conditions and unknown males in Miss A's property, this could have been an opportunity to raise an adult safeguarding concern. Miss A was vulnerable to exploitation and an

adult safeguarding referral being raised at this point could have led to a social care assessment.

5.134 In March 2015 there were multiple concerns about her home conditions, relationship with her previous partner, financial issues, and difficulties with neighbours. These should have triggered a referral to ASC for an assessment and a joined-up approach taken to meeting her needs and protecting Miss A.

5.135 In June 2016 Mrs C called the GP with shoulder pain which was worse on movement and spreading to her neck and arm. Mrs C was seen in the GP surgery that day. She said it was a stressful time as her daughter (Miss A) had been violent to her and had been admitted to a mental health hospital. She said her daughter had said she did not know who she (Mrs C) was and had headbutted her. This was a missed opportunity, there was no record or coding in the health records to indicate Mrs C was vulnerable or a victim of domestic abuse. This was not explored, and no risk assessment was completed.

5.136 In February 2016 there was an adult safeguarding referral raised for online fraud and we were informed that an ACN was submitted. No other action is noted. This further highlighted Miss A's vulnerability and should have raised questions about her ability to protect herself and her finances.

5.137 On 4 June 2016 an Emergency Duty Team (EDT) request was received for an MHA assessment. Miss A had presented at ED stating she was pregnant and bleeding. She was found not to be pregnant but was thought disordered and paranoid with acute psychotic symptoms. Prior to the arrival of the AMHP, Miss A seriously assaulted (head butted) her mother in the ED ward area resulting in bruising to forehead and right eye. Miss A was detained, admitted, and remained an inpatient until 4 July 2016.

5.138 The police spoke to Mrs C at length who stated that she was normally a calming influence on Miss A however on this occasion Miss A had seen her as the devil and attacked her kicking and punching her about the body and pulling her hair. Mrs C did not wish to provide a statement and did not support a prosecution. Mrs C believed Miss A was quite unwell at this time and this was the first time she had been assaulted by Miss A. The police crime was referenced as 'offender too ill to prosecute'.

5.139 Victims First Northumbria is the referral service for victims of crime locally. Referrals come through the police, other agencies, or self-referral. Referrals to Victims First Northumbria are made for all victims of crime in the Northumbria region. Exceptions are made for victims of high risk domestic abuse who are referred to the local IDVA service. When a crime is committed the officer attending completes a victim needs assessment with the victim which asks them a series of questions about their needs and whether they consent to a referral being made. If they have a need identified and consent to the referral their case will be referred to Victims First Northumbria via the case management system. The case is then reviewed by a Victims First Northumbria supervisor and allocated to a coordinator to make contact within 48 hours.

5.140 For domestic incidents, where there is no crime, these are also referred to Victims First Northumbria via an automated process if the victim consents to referrals to support agencies.

5.141 A victim needs assessment was made by the police officer after the assault on Mrs C in June 2016, but Mrs C answered 'no' to every question about her needs and did not consent to a referral to the Victims First Service.

5.142 In April 2018 Mrs C rang the IRT and said Miss A had thrown a bath chair at her, was very shaken up, sore, swollen and felt in danger. Miss A was arrested for common assault on her mother and taken into custody by the police.

5.143 Miss A was deemed too unwell for a criminal justice outcome and was detained and admitted to hospital. Mrs C is recorded as being happy with the outcome and believed it was the best outcome for Miss A as a criminal conviction would not have been suitable.

5.144 In respect of this, it is noted that 'no police action' may be an appropriate outcome on occasions when an alternative outcome is deemed more suitable. The police are constrained by the law and the threshold test set for any case to proceed to the Criminal Prosecution Service (CPS) for advice as to a charging decision. Unless the contrary is specified, every criminal offence requires both a criminal act, expressed in Latin as the 'actus reus', and a criminal intention, expressed as 'mens rea'.[51] Once this has been established the evidential and public interest test must be passed for a charging decision.

5.145 In April 2018 the Northumbria Police raised a domestic violence notification and completed a Safe Lives 'DASH'[52] risk checklist with Mrs C, who disclosed that Miss A had been violent towards family members in the past; however no further information was shared or further explored. The information disclosed may have suggested that there was unreported domestic violence by Miss A against her family, however it did not lead to any further investigation or review. Mrs C was assessed as 'standard risk'.

5.146 The local model is 'remove, avoid, reduce, accept' (RARA)[53] and using this model the following actions were taken:

- Miss A was arrested, and a Domestic Violence Protection Order (DVPO)[54] was considered. (remove)
- The DVPO was discussed with Mrs C who stated that she did not want Miss A back at the address. She was advised not to contact Miss A. (avoid)

[51] *Mens Rea refers to criminal intent. The literal translation from Latin is "guilty mind."*

[52] *The purpose of the DASH risk checklist is to give a consistent and simple tool to help identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk.*

[53] *https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/DASH-2009.pdf*

[54] *DVPO can be put in place as a protective measure in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions. https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010*

- Home security was discussed and was adequate. Mrs C was advised to get a mobile phone and 'silent solutions' were discussed. A safe number was recorded. (reduce)
- Mrs C was referred to 'Victims First Northumbria'. (accept)

5.147 The total DASH risks identified for Mrs C were nine and seven risk indicators were highlighted:

- Incident resulted in injury.
- Victim frightened.
- Afraid of further violence/injury.
- Abuse happening more often.
- Abuse getting worse.
- Suspected mental health issues/alcohol/drugs.
- Suspected threat/attempted suicide.

5.148 However, details had been omitted on the electronic record when it was transferred from the paper records. These were the use of weapons, a previous 'strangle/choke', 'abuser had hurt anyone else', and 'abuser's criminal history'.

5.149 Mrs C was recorded as saying that Miss A had tried to strangle her in the past and had assaulted other family members. These details should have escalated her risk to 'medium'. However, we were informed that this would not have altered the Northumbria Police approach, as 'standard' and 'medium' are managed in the same way.

5.150 The DASH (SafeLives) forms assume that 'professional judgment' will be exercised by police, but in these two instances the assessment refers to the 'tick boxes' as determining the level, and there is no detailed consideration of the injuries she received, the degree of violence used, or the contextual information about Miss A's reasons for attacking Mrs C:

- Mrs C attended the ED for treatment for her face.
- The bath chair was thrown with such force it splintered a cupboard, and Mrs C fell backwards down the stairs.
- Miss A claimed she was not her real mother.

5.151 The police DVPN is automatically sent to the Multi-Agency Safeguarding Hub (MASH)[55] who could have provided a fuller assessment and enabled Mrs C to access specialist domestic abuse support (see 7.13). However, the MASH did

[55] *A Multi-Agency Safeguarding Hub (MASH) for Northumberland has been set up to deal with safeguarding concerns about a child or adult. The MASH involves different agencies working together in the same location and sharing information to provide a faster more coordinated approach to investigate reports of abuse or neglect of a child or adult.* *https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Looked%20after%20children/Virtual%20School/Northumberland-MASH-Guide-for-Professionals.pdf*

not undertake an assessment and our view is that this was a missed opportunity to consider Mrs C's perspective as a victim of domestic abuse.

5.152 Northumbria Police have several related policies in relation to domestic abuse including Safeguarding Department - Investigation of Domestic Abuse (In support of Protecting Vulnerable People (PVP) policy; Incident Grading and Deployment Criteria (In support of Call Handling Policy); Crime Investigation (in support of Crime Investigation) and Safeguarding Department - Rape: Investigation and Prosecution.

5.153 Northumbria Police use their Domestic Violence Protection Notices and Orders: Protecting Vulnerable People (PVP) Policy and a 'Domestic Violence Notification' system (DVN) to assess and manage risk, rather than care plans for domestic abuse. Three kinds of assessment are used based on a number of risk indicators on the Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment form:

High risk	14 or more ticks in the relevant fields, or four incidents in four months, or repeated Multi Agency Risk Conference (MARAC) victim within the last 12 months, or honour-based violence, forced marriage or female genital mutilation, or professional judgement.
Medium risk	8 -13 ticks in the relevant fields, or three incidents in four months.
Standard risk	Incidents falling outside the above.

5.154 Northumbria Police use the risk identification checklist section of the DASH form to establish a 'starting point' for the risk assessment process. On viewing the domestic abuse victim risk identification/assessment screen the risk assessor checks questions 1-27 have been completed to ensure the victim can be correctly assessed. Any questions left blank are answered 'NO'. The total number of ticks in all 'YES' boxes are counted, and the total noted.

5.155 Risks arising from alcohol, drugs or mental health issues are joined together as one 'tick box', which assumes they are one amalgamated risk. Our view is that separating these to allow the individual elements to be assessed would improve the accuracy and relevance of the information.

5.156 The number of incidents reported by the victim in the last six or 12 months are established by looking at the police intelligence domestic summary screen and looking through the associated address history screens. We understand this has been identified from previous reviews within the Northumbria Police area however due to the introduction of the impending College of Policing risk assessment form, this has been deferred. Officers are encouraged and continue to have the ability to highlight specific risks in free text using professional judgement and increase the risk level regardless of the 'boxes' on the form.

5.157 Thorough checks should be made through police intelligence and the Police National Computer (PNC). This should be to explore the suspect's previous convictions, arrests, and intelligence to establish if the offender has a history of violence, drugs, or breach of a court order. If research confirms a history of domestic abuse against a previous partner or partners, this should be brought to the attention of the duty Detective Sergeant of the rape/domestic abuse team so that disclosure to the victim may be considered.

5.158 Northumbria Police have provided training to equip police officers and staff with knowledge and understanding of coercive and controlling behaviour so they can see what is behind assaults and other domestic abuse incidents they attend, giving them a better insight into this behaviour and how to deal with it.

5.159 The DVPO was not formally applied for. This was explained by police as ‘because the DVPO only lasts for 28 days, and Miss A had been detained under Section 2 MHA which lasts for 28 days.’ The assumption was that Miss A would be in hospital for at least 28 days, therefore the DVPO was not necessary. We found this assumption to be false, as Miss A was discharged from Section 2 MHA on 1 May 2018 and indicates a lack of communication between the agencies, and a lack of understanding of the MHA by police.

5.160 A Domestic Violence Protection Notice (DVPN) and DVPO enables Police and Magistrates to put into place immediate protection for the victim and other associated persons in the immediate aftermath of a domestic abuse incident. The Notice is issued by the Police and can last for a maximum of 48 hours.

5.161 The Notice instigates an application to the Magistrates for an Order; this can be substantiated or refused. If substantiated, the Order can impose conditions on the subject for a minimum of 14 days and a maximum of 28 days.

5.162 The court must be satisfied ‘that the DVPO is necessary to protect the person from violence or threat of violence by the perpetrator’. In a case where the person is already in detention such as under sec 2 Mental Health Act this test may not be met. We understand the Police were not informed of the release of Miss A.

5.163 In April 2018 contact was made by Victims First Northumbria with Mrs C and the service was again explained. Mrs C said she had been given a “head scan”, she had two black eyes and a sore head. Mrs C said she did not want her daughter back to the house and had told the police this. She thought her daughter may go back to hospital as she had not been taking her medication but had been using drugs.

5.164 She said there have been incidents where her daughter has damaged the house. Mrs C said she had her son for support, and that he was her carer. No other support was required at that time. Contact numbers were shared, and Mrs C was advised to call the police if she had concerns for her safety. The case was then closed.

5.165 At this time, the policy was that no further action would be taken. However, Victims First Northumbria policy was changed in June 2019, and since then a

DASH risk assessment is completed at each assessment for all stalking or domestic abuse cases.

5.166 It is recorded that whilst Miss A was an inpatient an adult safeguarding concern was raised for Mrs C by ward staff regarding the assault on Mrs C, and the disclosure that Miss A had placed the blunt end of a knife to Mrs C's throat and that she was frightened of her. There is no evidence in the records to confirm if this referral was made to adult social care in line with multi agency procedures. A MARAC referral was made.

5.167 However, on 4 May 2018, the MARAC referral was concluded, and records indicated that her mother advised she did not want the referral to be processed or to take the issue any further. She did say that she felt more vulnerable (she had an unrelated broken foot at the time) and that Miss A posed a risk as she thought that Mrs C and another family member were impostors. She was adamant that Miss A could not return home.

5.168 Our view is that the safeguarding review action to offer the mother a MARAC referral only if she wished was wrong and poor practice. Consent is not required to make a referral. The referral should have been made to MARAC and to the local domestic abuse service, specifically to IDVA (Independent Domestic Violence Advisor) for support for Mrs C. These views demonstrate a lack of knowledge and understanding of the MARAC process which works to safeguard victims of domestic abuse who have been assessed as high risk of serious harm or homicide.

5.169 MARAC is based on the premise that no single agency has the full picture of the life of a victim of domestic abuse, nor, indeed of a perpetrator but that many agencies may have pieces of information that when considered together and in context by those with specialist expertise in their fields will enable an accurate risk assessment and an opportunity to create a multi-agency safety plan to reduce the risk posed by the perpetrator and to safeguard the victim and any children of the household.

5.170 The threshold for MARAC is met by three criteria:

- Visible high risk using a tool (DASH) which has 14 tick box questions. 'Yes' answers mean there is visible high risk.
- Professional judgment in that in the professional's opinion the victim is at high risk of serious harm or homicide (the mother's vulnerability and Miss A's mental health concerns would have meant that a professional who understood risk would have assessed her as high risk).
- Escalation in severity and/or frequency of the abuse.

5.171 A MARAC referral would have allowed the IDVA to engage with the mother and hear her thoughts and fears, the sharing of information between agencies at the MARAC meeting and the development of a multi-agency safety plan.

5.172 The inpatient consultant psychiatrist understood that as her mother did not feel the need for a MARAC referral, they did not need to pursue this further.

The inpatient consultant psychiatrist told us he was not aware of the guidance on whether MARAC consent is required or not in order to proceed with a referral. We were told by the nursing staff that if a relative refuses or declines the MARAC referral offer, then there is very little they can do apart from being aware of the risks during admission and reporting this back to the safeguarding team.

5.173 We were informed by the nursing staff that in general, they understood that consent was required for a MARAC referral unless there was concern about somebody's capacity to make that decision and that capacity would be assumed, unless there was a reason to doubt this, and there were no issues raised about Miss A's mother's capacity at the time. As Miss A was in hospital, the view was that the risks to her mother were reduced however they understood they needed to be mindful of those risks when discharge planning. The nursing staff told us they felt that they managed the risk by helping Miss A to not return to the home environment, which seemed to be where the tensions arose. We found no evidence that the risk of familial violence was factored into discharge planning.

5.174 In terms of risk, the nursing staff told us they understood that there was a history that was suggestive of her being a risk to others. That there had been instances where she was alleged to have kept knives and an axe and a loaded rifle at her partner's house.

5.175 However, their understanding was she had held weapons for protective purpose because she thought she was in danger, as opposed to having thoughts about using them on other people. Miss A told staff that assaulting her mother was an accident and if she had moved out of the way it would not have happened. There was no professional clinical curiosity about why Mrs C thought she was in danger. The police were not notified of concerns around the potential risk Miss A posed to Mrs C.

5.176 Most of the risk to others was felt to be when she was perhaps under the influence of illicit substances. We concur that this increased the risk to her mother and potentially others, however we have not been able to find evidence of the MDT actively addressing and attempting to manage this issue.

5.177 In May 2018, prior to taking over the role of CCO for Miss A, CCO6 reviewed Miss A's FACE risk assessment and told us that he understood that Miss A was adamant she did not threaten her mother, that she'd kicked an object and it had hit her mother accidentally. CCO6 told us that in his view there was no current high risk, she wasn't acutely psychotic, voicing any thoughts of wanting to harm anybody else or herself and she was not taking illicit substances at the time, Miss A appeared committed to wanting to stay illicit substance free and was setting herself small achievable goals, such as seeking her own accommodation and obtaining her benefits.

5.178 He told us he was aware of her delusions about her mother being an impostor being historical, and both CCO5 and CCO6 were aware of the previous MARAC referral discussion, however neither knew the outcome.

5.179 On 1 June 2018, CCO6 (who had returned from leave at this point) further reviewed the risk information for Miss A and understood from this that Miss A was adamant she didn't threaten her mother, rather that she'd kicked an object and it had hit her mother accidentally. CCO6 was aware of Miss A's historic delusions about her mother being an impostor. Both CCO5 and CCO6 were aware of the previous MARAC referral discussion, however neither knew the outcome.

5.180 The CTT discharge letter to her GP on 6 August 2018 noted Miss A was formally discharged, that she had been mentally stable for some time and requested that the GP prescribe her medication. The risk review stated there was no apparent risk of violence or harm to others and did not address the known risks including familial risk.

5.181 During August 2018 police raised an ACN, stating that Miss A called to say someone had stolen her bank card. After investigation it was found it had been used by her in a shop that she denied entering. The ACN was emailed to the safeguarding triage team for action who found that Miss A was adequately supported for her mental health needs, and the supported housing staff assisted her with money management.

5.182 The ASC safeguarding triage team attempted to contact Miss A on 28 August and spoke to a supported housing support worker at her accommodation on 29 August 2018. It was left that the duty worker 'urged' that an adult social care referral be made when she was due to move to independent accommodation. There is no formal record of the outcome of the safeguarding referral.

5.183 On 25 November 2018 Miss A was found to be intoxicated and had tried to enter her friend's address via a window, became stuck and needed the fire brigade. Her friends were concerned about her mental health. Police called the street triage team to ask for an assessment. She told police she had been taking her medication but also drinking.

5.184 Miss A was too intoxicated to be assessed, and the street triage team reported that she was 'open' to mental health services but not engaging, therefore there was no role for them. The police agreed that she would stay at her friends' and contact the crisis team in the morning. An ACN was forwarded to safeguarding for triage. On 26 November 2018, the ASC safeguarding triage manager recorded that there were no safeguarding issues identified at that time and notified the allocated social worker. The allocated social worker asked for a manager's supervision meeting to discuss Miss A's issues. It was agreed they would try again to contact Miss A, and if she did not respond, the case would be closed. No information was shared with the police to indicate Miss A's mental health posed an increased risk to Mrs C.

5.185 Several more attempts were made, and on 2 December 2018 it was noted that the ASC safeguarding referral had to be finalised as incomplete. A discussion was held on 2 December 2018 with the duty worker for the CTT. It was confirmed that Miss A had a CCO, and that the team were aware of the

recent safeguarding concerns. It was agreed that the social worker would attempt to contact her at the family member's address.

5.186 In December 2018 Miss A attended the GP as an emergency saying she had pelvic bleeding and was referred to NSECH for investigations. At NSECH Miss A disclosed several assaults whilst she was living on the street but did not disclose further details and agreed to a safeguarding referral which was completed.

5.187 On 20 December 2018, a healthcare safeguarding referral was made by NSECH ED stating that she had presented saying she had been assaulted several times in the past year but would not give details and appeared to have substantial physical and mental health problems.

5.188 If the hospital staff had telephoned their concerns through to the safeguarding team as well as completing the referral form, they could have been informed that ASC were trying to contact Miss A and asked to encourage her to stay in the department until a social worker could attend. Attempts were made by the safeguarding triage worker to contact Miss A however it was established that she was discharged by ED on the evening of 20 December 2018.

5.189 On 21 December 2018, the ACN was formally recorded as a sexual abuse referral. The referral did not indicate concerns over client's mental capacity to make decisions in this area. It was decided to continue to contact her, inform her GP, and inform the police.

5.190 On 4 January 2019 there was further follow up on the actions by the safeguarding triage worker. On 29 March 2019, a referral was received for ASC from CCO6. With an understanding that Miss A had more of a social care need for support with claiming benefits, obtaining housing as she is currently homeless and sofa surfing, and some sort of stability. A joint visit was suggested, and the referral was passed to the locality team manager for allocation which had not been processed at the time of the incident.

Finding 10 – risk and safeguarding

Police

The assessments and interventions provided by Northumbria Police in relation to domestic violence by Miss A were closely aligned and based upon the 'SafeLives' risk assessment process recognised and used nationally.

However, the risk assessments were inaccurate and there were two missed opportunities to pay attention to Mrs C as a victim of domestic abuse and provide a multi-agency response from all the agencies who had insights into her life, her vulnerability and crucially Miss A's dangerousness. It was noted that police understanding of policy and decision making about applying a definition of vulnerability could be improved.

Risks arising from alcohol, drugs or mental health issues are joined together in the DASH as one 'tick box', which assumes they are one amalgamated risk. This has been identified from previous reviews within the Northumbria Police area however due to the introduction of the impending College of Policing risk assessment form, this has been deferred. Officers are encouraged and continue to have the ability to highlight specific risks in free text using professional judgement and increase the risk level regardless of the 'boxes' on the form.

Police vulnerable adult notifications due to concerns regarding Miss A's mental health issues and her calls to the police to complain about alleged crimes were viewed by the police in isolation and therefore accumulative risk was not considered.

Police responded to calls and concerns about Miss A and completed safeguarding referrals. Acts of violence towards Mrs C were 'crimed' and an ACN completed with the first occurring in June 2016 within a medical facility and the second at the home address in April 2018. On 20 August 2018 an ACN was raised due to concerns that Miss A's mental health was deteriorating. A triage discussion was held and the concern was passed for the attention of the allocated CPN for ongoing support. All events were seen as attributable to her mental illness and a criminal justice outcome was not pursued.

The assumption that the Domestic Violence Protection Order (DVPO) was not necessary as Miss A would be in hospital for at least 28 days detained under Section 2 MHA was false and indicates a lack of communication between the agencies and lack of understanding regarding the MHA.

CNTW

It is evident that up until 2014 Miss A was supported by an MDT approach, however following the removal of the Section 75 agreement it appears that health services worked with Miss A in isolation.

Capgras symptoms and familial risk were not appropriately assessed or managed. Risk was not explored with family members. There was no professional clinical curiosity about why Mrs C thought she was in danger.

A Multiagency Risk Assessment Conference (MARAC) referral was not progressed due to a lack of knowledge and understanding of the process and whether consent was required to proceed.

A MARAC referral would have notified the police automatically and allowed the Independent Domestic Violence Advisor (IDVA) to engage with the mother and hear her thoughts and fears, the sharing of information between agencies at the MARAC meeting and the development of a multi-agency safety plan.

Northumberland County Council ASC

There were several opportunities where a referral to ASC would have been appropriate.

The perception that many of the safeguarding concerns being raised by the Police and other partners were low level or the direct result of Miss A's mental health issues resulted in adult social care repeatedly passing these on to the mental health trust for information and action without convening a formal multi agency safeguarding meeting.

Each individual incident, concern or referral about Miss A was seen in isolation and without the benefit of multi-disciplinary discussion.

There were missed opportunities to complete Miss A's social care assessment both as an inpatient and later when she had been discharged.

Adult social care has repeatedly passed safeguarding issues back to the mental health trust with the expectation that a medication review or CCO appointment would resolve the presenting issue.

There was no further escalation to senior leaders regarding the ASC concerns about her unsafe inpatient discharge.

All agencies

There were several opportunities where safeguarding for Mrs C should have been considered. As a result, there were missed opportunities across and between agencies to develop an in-depth understanding of the risks to Mrs C and formulate a risk management plan.

Although an ACN is the process that Northumbria police officers use to notify partners via the MASH of a particular concern, there was no process thereafter to consider sharing and considering the ACNs by those with direct involvement with Miss A's mental health care, or to flag up that there had been numerous low-level concerns, along with reports of acts of serious violence against her mother.

Recommendation 10 – risk and safeguarding

Northumbria Police

The Domestic Abuse, Stalking and Harassment (DASH) risk assessments conducted by Northumbria Police in relation to domestic violence must:

a) Be completed fully with officers ensuring that additional context is added to the comments section where 'yes' has been indicated. The Home Office and College of Policing are in the process of designing and testing a new domestic abuse risk indicator for the police service nationally. Northumbria Police has not made significant changes to the current process pending the implementation of this new process.

b) Northumbria Police must ensure that police officers are appropriately trained to:

- Identify escalation in abuse.
- Incorporate professional judgment to fully assess the threat, harm and, if necessary, raise the risk level towards victims.

CNTW

c) CNTW must ensure that adult safeguarding concerns are accurately documented within patient records and referrals are captured within clinical records.

d) CNTW must ensure that familial risks associated with Capgras syndrome, the impact of illicit drug use, the importance of exploration of risk with family members and the significance of assessing and monitoring medication compliance particularly in relation to familial risk are routine risk assessment and management considerations. Where risk to family members is reported, risk assessment must be updated, and victim safety planning must become part of the risk management plan.

All agencies

e) The Safer Northumberland (Community Safety Partnership) must seek assurance that the new joint working arrangements between Adult Social Care and the Trust are working effectively, and the risk of silo working has been addressed.

f) The Safer Northumberland (Community Safety Partnership) must ensure that MASH multi-agency protocols are able to identify and address risk to an adult raised through police ACNs.

g) Where a risk to an adult has been identified, agencies must demonstrate within their records that they have considered risk in relation to adult safeguarding criteria.

Discharge and housing

Inpatient discharge and housing

5.191 For context, the Northumberland City Council Homelessness and Housing Options Team were involved with Miss A between 24 April 2018 until 19 October 2018. There were numerous emails between the Homeless and Housing Options team, the CCO and ASC with advice and guidance about housing options provided to the professionals prior to and following her discharge from hospital.

5.192 In April 2018, Miss A contacted CCO5 to ask for her cats to be put in foster care as she did not believe her mother was looking after them properly, that she would be homeless on discharge, that she could not return home and wanted to live in the Newcastle area. CCO5 spoke to the inpatient nursing staff about her concerns that Miss A's daily living skills were unclear, and Miss A had said herself that she would not be able to cope on her own.

5.193 On 11 May 2018, a referral was made by the CTT for an ASC assessment. Miss A was still in hospital and the referral was made because she would be homeless on discharge, after her mother stated she could not return to live with her following the assault. A care manager was allocated to support her with housing, finance issues and longer-term support due to her vulnerability. Contact was made with the CTT to discuss her needs.

5.194 CCO5 had been liaising with the Homelessness and Housing Options Team who advised that Miss A would need to present herself as homeless on her discharge from hospital so that they could complete an assessment to find accommodation for her. CCO5 stated that she was too vulnerable to enter homeless accommodation, and she was awaiting an Occupational Therapy assessment to assess her ability to manage. The ASC advice was that supported accommodation may be a better option, and that they would support her in finding suitable accommodation. They were advised that discharge was planned for a week later, on 30 May 2018.

5.195 On Thursday 17 May 2018 an email was sent from the inpatient ward to CCO5 and CCO6 advising of the plans to discharge Miss A on the following Monday 21 May 2018, that the ward were going to accompany her to the council to self-present as homeless and wait with her until she was allocated temporary accommodation.

5.196 Miss A was formally allocated to CCO6, whilst she was an inpatient, from CCO4's caseload (as she was retiring from the service). CCO6 told us he had a brief handover from CCO4 who felt Miss A was doing quite well and did not think there were any problems with her being handed over to him.

5.197 We note that Miss A had requested a female CCO and that Trust CPA Policy states that the service user should be, wherever practicable, involved in the choice of CCO and whenever possible should be agreed through the CCO review process to ensure there is an effective hand-over of information. Our

view is that this was a particularly important process considering Miss A's deteriorating mental state and did not take place.

5.198 CCO5 continued to provide support for Miss A, feeding back on progress to CCO6, who was coordinating her care, and provided cover for CCO6 when he was not working or on leave.

5.199 The CCOs were asked for a seven day follow up date and time and this was confirmed for 22 May 2018. The plans at this point appear to have accelerated inappropriately and did not consider the outstanding MDT actions.

5.200 CCO5 received a response to the care management referral from duty social worker 1 who expressed concern about Miss A's vulnerability should she be discharged as homeless. Both CCO5 and duty social worker 1 felt that Miss A would benefit from supported accommodation and a package of care targeted to her needs. We concur with this view.

5.201 CCO5 discussed the concerns with the ward and requested that discharge was delayed whilst the possibility of shared housing and a funded package of care was explored. However, the inpatient ward records indicate that if the placement was not available or the time frame was longer than expected then Miss A should still be discharged as she no longer needed to be in hospital. We believe that this view was inappropriate and other alternatives should have been considered if the placement was not available in the timeframe.

5.202 CCO5 contacted ASC on 18 May 2018 to say that discharge was still planned, as the view was that there had been enough time to plan accommodation by now, and that the option of a homeless hostel was not seen as barrier to discharge. At this point an OT assessment had not been completed, due to Miss A being off the ward on leave all day. The concerns of both CCO5 and ASC about these decisions were noted to be documented in the records.

5.203 We were informed that Miss A told staff she did not want to leave hospital, she felt it was too early and that she would be readmitted fairly quickly. As part of the discharge planning, the MDT were trying to assist Miss A with her housing options however she was difficult to engage and was missing 'phone calls and arranged meetings.

5.204 We were told that the inpatient services were aware that living with her mother would not be safe, and when undertaking discharge planning, they were trying to find an alternative place for Miss A to live. They were aware that considering how she had acted towards her mother in the past, if her delusional beliefs and intermittent illicit drug use were to recur, then her mother would be at risk. The inpatient consultant psychiatrist told us that this risk was acknowledged, and that her mental state would need to be monitored regularly.

5.205 On 21 May 2018, an MDT review took place, and the focus of the discussion was her need for accommodation. Discharge was discussed and appropriately deferred whilst the formulation was discussed 'with regards to the appropriate discharge care pathway'.

5.206 Miss A's mother asked whether Miss A could be referred to the St George's rehabilitation ward (comprising a ward and individual flats). However, a referral was not made, assuming that she would not meet the criteria in terms of her engagement, and as she was not engaging with the ward based functional OT assessments, the staff could not assess her suitability for this service. Our view is that this was a reasonable suggestion for her mother to make and the referral should have been progressed in discussion with Miss A and St George's especially given the circumstances associated with Miss A's accommodation and support needs and the fact that a funded care package was being progressed.

5.207 Discharge was planned for 30 May 2018 and a further seven day follow up date was confirmed to take place at her temporary address once known. On the day of discharge Miss A was accompanied by ward staff to the Northumberland City Council Homeless team with a copy of her discharge plan (also available on the Trust's electronic system (RiO) so that the CTT could access it).

5.208 The discharge plan was for staff to assist Miss A to present at Northumberland City Council Northumberland City Council Homelessness and Housing Options team as homeless, to supply her with telephone numbers for the CTT and crisis team and seven days medication in a dossette box with instructions to contact her GP for a further prescription within seven days. We were told that the discharge plan was done from 'the ward side of things' and it was expected that the CTT would then pick up the long-term care plan through the CCO. Our view is that this lack of a coordinated discharge plan was not appropriate nor in line with the Trust CPA Policy.

5.209 We were told that the inpatient services were aware that living with her mother would not be safe, and when undertaking discharge planning, they were trying to find an alternative place for Miss A to live. They were aware that considering how she had acted towards her mother in the past, if her delusional beliefs and intermittent illicit drug use were to recur, then her mother would be at risk. The inpatient consultant psychiatrist told us that this risk was acknowledged, and that her mental state would need to be monitored regularly.

5.210 The inpatient consultant psychiatrist told us that when she was discharged her mother had already made it clear that she would not have her back at home, so the view was that the risk to her mother was not immediate. He told us that there was nothing at any time in Miss A's mental state while she was an inpatient that indicated she was actively considering going to her mother's house and causing her any harm. She did not express any wish, idea, or thoughts of wanting to harm her mother.

5.211 The inpatient nursing staff told us that ideally, they should have had a CPA discharge meeting. They knew that this was not an ideal situation as Miss A had not met the new CCO6 beforehand as he was on leave, however the plan was for Miss A to meet with CCO5, who had provided consistency of input, and the new CCO6 on 31 May 2018 at her temporary address. We were told

that Miss A had been involved with the CTT previously, she knew them quite well, and was not someone who was brand new to them.

5.212 Our view is that the long history of Miss A finding it difficult to engage and being non-compliant with medication suggests that assertive outreach services would have been helpful in supporting her. Assertive outreach teams are specialist teams offering intensive support, a long-term relationship and can assist where there are issues of engagement.

5.213 Nursing staff told us that at the time the service did not have an assertive outreach team. We were told that the model of care at the time meant that the assertive outreach team had been subsumed within the CTT and named the Intensive Care Management team.

5.214 Discussions were ongoing about whether to 'disband' the Intensive Care Management team meaning patients would remain as a CTT patient with a recovery plan in place. We were told that although CCO5 had quite a lot of experience in working with an assertive approach, Miss A was thought to be a good candidate for assertive outreach services. We concur with the view of staff, in hindsight, that an assertive model of care would have been helpful.

5.215 The inpatient discharge summary stated that although on the surface, her beliefs about her mother and another family member looked like delusional beliefs, there were some aspects of her presentation which were unusual for example, she said that her mother and another family member had been replaced by someone else but in a detached manner without appearing worried or distressed. Additionally, several aspects of her presentation were more consistent with a diagnosis of personality disorder, for example, displaying disregard for ward rules, verbal hostility, and a tendency to blame staff members when her perceived needs were not met immediately to her satisfaction.

5.216 On 30 May 2018, the Homelessness and Housing Options team informed ASC that Miss A had been discharged and had been brought to them for hostel accommodation. Multiple calls were made, and a vacancy was found at 'Changing Lives' who offered Miss A a six to nine month supported long-term placement in a shared women's house on a licence agreement. Initially Miss A was placed in their emergency accommodation 'crash pad' provision.

5.217 Further discussions with CCO5 ensued; Miss A was currently in temporary homeless accommodation, sharing a property next to the Crash Pad, with other females. She was identified as needing help with applying for benefits and also support to find long term accommodation. CCO5 stated that she would also need a care package of support with shopping and enabling as she had delusional thoughts when in the community that people were stealing money from her.

Finding 12 – CNTW - inpatient discharge

Miss A was formally allocated to a male CCO6, whilst she was an inpatient, and had a brief handover from CCO4, although Miss A had requested a female CCO. Trust CPA Policy was not followed in ensuring an effective hand-over of information. Our view is that this was a particularly important process considering Miss A's deteriorating mental state.

Plans for discharge were accelerated inappropriately for 22 May 2018 despite the view from CCO5 and ASC that Miss A would benefit from supported accommodation and a package of care targeted to her needs. Discharge was subsequently deferred to 30 May and was not a coordinated discharge plan in line with the Trust CPA Policy.

The request that Miss A could be referred to the St George's rehabilitation ward (comprising a ward and individual flats) was a reasonable one for Mrs C to make and should have been followed through, however it was not, based on an assumption that she would not fit the criteria.

The long history of Miss A finding it difficult to engage and being non-compliant with medication suggests that assertive outreach services would have been helpful in supporting her.

Recommendation 12- CNTW - inpatient discharge

CNTW must have services in place to meet the needs of patients requiring an assertive approach.

CTT discharge and housing

5.218 On 1 June 2018, CCO6 (who had returned from leave) reviewed the risk information for Miss A. They understood from this that Miss A was adamant she did not threaten her mother, rather that she had kicked an object and it had hit her mother accidentally. CCO6 was aware of Miss A's historic delusions about her mother being an impostor. Both CCO5 and CCO6 were aware of the previous MARAC referral discussion, however neither knew the outcome.

5.219 Miss A appeared committed to wanting to stay illicit substance free and was setting herself small achievable goals, such as seeking her own accommodation and obtaining her benefits. The plan was to keep her safe, devise a working plan, complete a social worker referral, monitor her medication compliance and mental state. Miss A indicated she did not want her mother to be informed of any aspects of her progress, care, and treatment.

5.220 In June 2018 Changing Lives[56] offered Miss A a six to nine month supported long-term placement in a shared women's house on a licence agreement.

5.221 To assist with compliance, staff at 'Changing Lives' kept her medication in a safe place, handed it to her and watched her take it. Miss A had contacted the GP to order her medication and weekly prescriptions were provided. Miss A continued to hold delusional beliefs. She wanted to ring the police because she heard a body had been found and believed it might be her mother.

5.222 In June and July 2018 CCO6 noted Miss A was angry and unsettled, and it was decided that CTT appointments should be with two members of staff.

5.223 On 2 August 2018 Miss A rang the CTT and asked if she had a psychiatrist appointment booked. Her records were checked, and a note was made to follow up as there was no medical appointment planned. An appointment was arranged, Miss A was reviewed by CCO6 on 6 August 2018 and discharged from the CTT by CCO6 to her GP. She was reported as being 'stable for some time', although Miss A said she felt dissatisfied with the decision to discharge her as she had ongoing needs.

5.224 The discharge process was not subject to the Trust CPA Policy requirements and, by way of explanation, we were told that at the time there was what was known as an 'episodic model of care' being embedded due to the service experiencing waiting lists and the large caseload sizes of practitioners. It was thought that this model of care worked particularly well with patients on the non-psychosis care pathway but not so well with patients on the psychosis pathway as they required a much slower throughput.

5.225 This model of care included a review of caseloads (especially the caseloads of consultant psychiatrists) to ensure patients were receiving appropriate interventions and to identify which patients could be offered a recovery package and referred back to the care of the GP.

5.226 It was explained that staff saw the introduction of this 'episodic' model of care as being of benefit with their large caseloads and the waiting lists. Unfortunately, the way the new model of care was interpreted at the time also meant that it was thought of as being applicable to Miss A without an appropriate balanced reflection of the historic and current risks associated with her care and treatment.

5.227 We were informed by staff that at the time there was a level of community psychiatric nurse (CPN) staff 'churn' in the CTT with retirements and consultant psychiatrist recruitment issues. This meant that their clinical meeting attendance was on a rotational basis and no one consultant psychiatrist had personal knowledge of Miss A.

5.228 During August 2018 police made an ACN, stating that Miss A called to say someone had stolen her bank card. After investigation it was found it had been used by her in a shop that she denied entering. The ACN was emailed

[56] Changing Lives is a nationwide charity helping people facing challenging times to make positive change, including the provision of accommodation. https://www.changing-lives.org.uk/

to the safeguarding triage team for action who found that Miss A was adequately supported for her mental health needs, and the supported housing staff assisted her with money management.

5.229 The ASC safeguarding triage team attempted to contact Miss A on 28 August and spoke to a supported housing support worker at her accommodation on 29 August 2018. It was stated that Miss A was currently adequately supported for her mental health needs, and the supported housing staff assisted her with money management. It was left that the duty worker 'urged' that an adult social care referral be made when she was due to move to independent accommodation. There is no formal record of the outcome of the safeguarding referral.

5.230 Miss A was dissatisfied with her discharge from the CTT and rang the team several times and informed them she had ongoing needs. On 31 August 2018 Miss A rang the CTT and informed them she had ongoing needs and was dissatisfied with the decision to discharge her from the CTT, that she had a long-term mental health condition, was previously detained and was now homeless. Miss A asked for staff to speak with her previous EIP care coordinator (CCO1).

5.231 On 20 September 2018 Miss A rang the North of Tyne initial response team (IRT). She asked for a crisis referral as she felt her life was dropping to pieces and she had no support from services. Miss A was assessed by CRHT at the GP practice and no evidence of an acute mental health deterioration nor risk factors which would warrant urgent care were found at that point.

5.232 It was thought that Miss A was presenting with long term delusional ideation and personality traits which would benefit from further community services input. Miss A was discussed at the CRHT MDT meeting the following day, was referred again to the CTT for a joint CPN and medical assessment and was informed she could self-refer to CHRT again if needed.

5.233 In September 2018, the GP felt her mental health problems had worsened and planned to request a review by the in-house practice based CPN. The decision was not to increase her analgesic medication.

5.234 Miss A was absent from her supported accommodation for three consecutive weeks over a six-week period. During which 'Changing Lives' had been in constant communication with her and had to report her missing. She was in breach of her terms and her licence was terminated. She had not picked up prescriptions from her GP and unsuccessful attempts were made by a social worker to contact Miss A.

5.235 'Changing Lives' stated that her mental health needs were too severe for their service, and although they had been in constant communication with Miss A when absent from her accommodation, they had to report her missing as she had been away from her supported accommodation for a consecutive period of three weeks over a six-week period. Her licence was terminated from 13 October 2018.

5.236 In October 2018 Miss A enquired about the CTT referral and it was discovered it had not been actioned due to human error. Miss A was homeless, staying with various friends and relatives and was not currently registered with a GP.

5.237 On 19 October 2018, a family member called ASC, stating that Miss A was constantly calling and asking for help, after which Miss A arrived with all her bags and was now sleeping on their couch. They said they could not let her stay and were unable to look after her.

5.238 The duty ASC social worker contacted the family member and advised that the homeless team could not provide any other temporary accommodation and Miss A would need to stay with friends or sofa-surf until her situation is assessed by a social worker. There was no guarantee that any accommodation would be provided.

5.239 The duty ASC social worker called the CTT and was advised she had been discharged from services in August 2018 because her mental state had been stable for some time. The ASC duty social worker contacted 'Changing Lives' who confirmed that Miss A had been given an ultimatum that she must stay in her accommodation as her licence stated that if she continued to stay away from the property over the three days allowed, then she would be in breach of her terms and this could result in her losing her accommodation. She had apparently received a cheque for rent but had not paid and was in arrears.

5.240 Considering this information, it was stated that ASC considered that Miss A's support needs were too high and there was no suitable temporary accommodation available to her, as 'Changing Lives' were the most accommodating support provider they could access.

5.241 The advice (although it is not clear to whom this advice was given) would be for ASC to link with referrals who have dispersed properties who offer support for mental health clients and who also have emergency beds if required. Northumberland County Council did not have direct access to link to these services. It was noted that the County Council could still provide Miss A with housing advice to look at longer term options through Homefinder or the Private Rented Sector, however it would be expected that a care plan is in place to assess the risk/needs of Miss A before such action.

5.242 On 29 October 2018 attempts were made by a social worker from ASC to contact Miss A about accommodation, with no response. The ASC social worker contacted Mrs C for information, who said she had received no contact from Miss A for two weeks, but thought she was staying with friends. Mrs C said Miss A had long term mental health needs and mentioned she had been assaulted by Miss A. Several more attempts were made, and the ASC social worker eventually spoke to Miss A on 5 November 2018. Miss A confirmed she was still 'sofa surfing' and was happy to meet to discuss accommodation and her support needs.

5.243 On 1 November 2018 Miss A rang the CTT and asked about her referral. She said she remained homeless and provided her GP details as being Marine Medical Centre in Blyth. She said her mood was up and down, she was

feeling hopeless, was reporting suicidal ideas and thoughts of self-harm but not with plans and thoughts to harm others, describing these thoughts as a feeling rather than having any plans to act. She admitted to using cannabis but not drinking. During November, she complained of ongoing severe pain and requested that the GP prescribe morphine.

5.244 On 5 November 2018, the assessment of Miss A was discussed at the CTT triage meeting as a self-referral. She was allocated again to CCO6 to review her current needs and consider if she required 'top up sessions' given she had recently been discharged from the CTT. The records state that a full assessment was not required until the outcome of this review was known. The social worker spoke to Miss A who confirmed she was still 'sofa surfing' and was happy to meet to discuss accommodation and her support needs.

5.245 On 6 November 2018 CCO6 attempted to contact Miss A without success. The arrangements for a further appointment the following day were relayed via telephone to her mother as Miss A was sofa surfing with friends. Miss A did not attend the appointment, her 'phone was switched off, and her mother had not been able to inform Miss A of the planned arrangements.

5.246 The GP was contacted, and a note put in her record should she attend there. The records indicate a plan to discharge Miss A the following week if the services did not hear from her. A note was again made to visit her in pairs of staff with one person being female due to the risk of allegations being made about the staff.

5.247 On 8 November 2018 Miss A attended the CTT team base and said "Tell them I have shown my face" then left. Her family member came to meet her and gave the service her own address for any letters to Miss A and asked CCO6 to contact her as she was very concerned about her.

5.248 Miss A did not attend the planned review meeting with the CTT clinical lead and a female CCO, however her family member arrived, with the expectation that she would meet Miss A in the waiting room beforehand. The staff spent some time with the family member to get some sense as to whether she had had any contact with or concerns about Miss A.

5.249 Her family member said Miss A remained homeless but was checking in once a week with her for a shower. Miss A had been seen smiling and laughing at the TV and expressing thoughts that she had cancer, however the family member acknowledged that this was chronic in nature and was exacerbated by cannabis or alcohol use. She did not share any information to suggest Miss A or others were at risk or that there was a deterioration in her mental health. The family member described Miss A as *'quite well'* but needing help with accommodation and practical aspects of life. The family member said she thought Miss A was collecting her medication.

5.250 On 12 November 2018, an email was sent by the duty nurse to the CTT consultant psychiatrist (locum 2) stating that the services were currently unable to contact Miss A by 'phone; that she was not engaged with CCO6 and discharge was being considered. The records indicate that Miss A had

contacted her old GP requesting medication, saying she was between GP practices; however, the GP would not prescribe further medication without review (which was offered the same day but refused).

5.251 Locum 2 was made aware that Miss A wanted the CTT to prescribe her medication and was likely to stop taking her medication completely rather than see her GP. Miss A was advised that locum 2 was informed, however an appointment would be required, and she may find the GP able to prescribe her medication sooner than this could be arranged.

5.252 This appears to be the first time a member of the medical staff was made aware of the situation with Miss A following her discharge from hospital. There are no records indicating any action taken as a result or that a CCO review was undertaken at this point.

5.253 On 13, 14 and 15 November 2018 CCO6 made attempts to contact Miss A via the family member but was unsuccessful as the 'phone calls were screened by 'call guardian' and were not accepting the 'phone number for CCO6. An appointment letter was then sent to the family member's address.

5.254 On 21 November 2018 CCO6 discussed the situation with the CTT team manager and it was decided that one more letter would be sent to Miss A at her family member's address for an appointment with CCO6 at the team base.

5.255 A CRHT assessment had taken place and concluded that Miss A would not agree to engage in any meaningful way with CRHT. The plan was to monitor her, to increase her antipsychotic medication and to consider a mental health act assessment if she deteriorated further.

5.256 On 12 December 2018 Miss A contacted mental health services to ask for a manager to return her call as she wanted to report harassment from a community psychiatric nurse however, she did not provide any further details. Subsequent messages were left for Miss A to get in contact with the services again however she did not respond.

5.257 Miss A attended an appointment with CCO5 and CCO6 supported by an advocate who was a friend of the family Miss A appeared angry and paranoid about both CCO's saying she did not want to work with them any further and wanted a different female worker. She was reported as functioning well within her delusional belief system and that her needs were primarily social. She said she was taking her medication and denied illicit substance misuse. Miss A needed accommodation as she was homeless and the family member was waiting to be admitted to hospital, so Miss A could no longer live with her.

5.258 Miss A attended ED in January 2019 about a recent assault allegation, it was noted that adult safeguarding were trying to follow her up. On 2 January 2019 it was noted that Miss A was still waiting for a female CCO to be allocated having requested this change prior to admission to hospital in April 2018.

5.259 On 6 February 2019, the records state that CCO6 raised the issue with the CTT manager of Miss A still being on his caseload although he was no longer

involved. The action was to remove her from CCO6 caseload and place Miss A on the waiting list for a female CCO.

5.260 CTT appointment letters were sent on 6 and 13 March for an appointment on 21 March 2019 which was subsequently rearranged by the services for 29 March 2019. The appointment letters clearly stated that this was for a review of her mental health, that the appointment would not be with her current CCO6 and that she was awaiting allocation of a new female CCO.

5.261 Miss A did not attend the planned review meeting with the CTT clinical lead and a female CCO. Her family member arrived, expecting Miss A to meet her in the waiting room. The staff spent some time with the family member to get information about her contact with or concerns about Miss A. She said Miss A remained homeless but was checking in once a week with her for a shower. The family member described Miss A as 'quite well' but needing help with accommodation and practical aspects of life. She thought Miss A was collecting her medication.

5.262 On 29 March 2019, the GP tried to call Miss A twice without success and spoke to the CTT confirming that Miss A was picking up her medication and current prescription. A referral to ASC was received from CCO6. A joint meeting was planned, and ASC requested the allocation of a social worker to provide daily support, support with housing, finance issues and longer-term support due to vulnerability. ASC informed CCO6 that they had attempted to assess Miss A in November 2018, but she had attended late and was not seen.

5.263 ASC agreed to accept a new referral and send an appointment letter to the family member's address. The duty worker requested allocation, with the referral being forwarded to the ASC central team for allocation. The case had not been allocated by ASC at the time of Mrs C's death in April 2019.

Finding 11 - CNTW - CTT discharge and housing

The discharge 6 August 2018 from the CTT was not in line with Trust CPA Policy. Medical staff were not involved in the decision to discharge and were only informed of the difficulties in engaging Miss A in November 2018.

Staff 'churn' in the CTT with retirements and consultant psychiatrist recruitment issues meant that their attendance at the clinical meeting was on a rotational basis and no one consultant psychiatrist had personal knowledge of Miss A.

Miss A was attempting to engage with the CTT and had rung several times to indicate she was dissatisfied with her discharge however due to human error the CTT referral was not actioned resulting in a gap between 20 September and 5 December 2018 and subsequently Miss A being difficult to contact and re-engage.

In November 2018 when Miss A was not engaging, unable to be contacted by 'phone, requesting medication from her new GP, refusing a review, a CCO review was not undertaken, and this was the first time a member of the medical staff was made aware of the situation since her discharge 6 August 2018.

Recommendation 11 - CTT discharge and housing

CNTW

a) CNTW must ensure that robust CTT administration governance systems are in place to eliminate human error in the referral process.

Northumberland County Council ASC

b) Northumberland County Council must set quality standards for the timely allocation of social workers to accepted referrals.

Northumberland County Council - Strategic housing

c) To undertake a review, to involve all relevant partners (Northumberland County Council (Housing Services and Adult Social Care), CCG, CNTW and NHS Foundation Trust) to assess the adequacy of current supported emergency and temporary housing options for individuals with chronic and enduring mental illness, including referral pathways.

Interagency information sharing and communication

5.264 The agencies relevant to this section of the review are:

- Northumbria Police.
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

- Northumberland County Council.
- NHS Northumberland CCG.
- Two GP practices.

5.265 We reference the material discussed in the individual sections above, using the detailed Terms of Reference to guide our analysis:

5.266 Northumberland County Council published a DHR review in 2018.[57] We reference this because there are recommendations made about several areas that have arisen during this review:

- Lack of care coordination, full information sharing and a robust multi-agency approach to risk management.
- Lack of full exploration of concerns being raised by the family, and lack of consideration given to further support that they may have needed.

5.267 We have not reviewed this action plan but in our view these issues remain directly relevant to our findings in this case.

5.268 There are clear routes within and between the above services that provide a framework for multi-agency communication, particularly about risk: these are within the safeguarding structures. We have commented on these, and on learning identified in previous reports.

5.269 The police, ASC and the Trust all identified risks in isolation and there was a cycle of each passing on to another agency for solutions.

5.270 As discussed in the risk and safeguarding section above we have concluded that there were several missed opportunities in relation to adult safeguarding. This relates to the expected statutory functions in relation to potential 'adults at risk'.

Finding 13 - interagency information sharing

The existing frameworks for information sharing and management of risk were not utilised. Local DHR reports have previously highlighted similar issues.

Recommendation 13 - interagency information sharing

The Northumberland Multi Agency Risk Assessment Conference protocol must be reviewed to incorporate learning from this review.

[57] https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Safeguarding/Seven-Minute-Guide-Sarah-DHR.pdf

6. Serious incident review

6.1 The Terms of Reference require us to review the adequacy of the Trust's response to the serious incident in relation to CNTW internal investigation and the progress they have made in implementing the associated action plan.

6.2 The Trust internal report has been reviewed using our structured approach, which is detailed at Appendix C. We have developed a robust framework for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency, NHS England Serious Incident Framework and the National Quality Board Guidance on Learning from Deaths.[58] We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

6.3 In developing our framework, we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA2 (or Root Cause Analysis and Action, hence 'RCA Squared') which discusses how to get the best out of root cause analysis investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

6.4 Our detailed review of the internal report is at Appendix C. In summary we have assessed the 25 standards as follows:

- Standards met: 12.
- Standards partially met: 6.
- Standards not met: 7.
- We discuss our analysis below.

Analysis of Trust internal investigation

6.5 The internal investigation was conducted by an Independent Investigating Officer (IO) commissioned by Northumberland Tyne and Wear NHS Foundation Trust (NTW) with a professional background in mental health and organisational governance. A Clinical Advisor (CA) employed by the Trust as Consultant Clinical Psychologist, Pathway Professional Head for Older Adult Community Psychology Services and Associate Director for Psychology Service (North Locality CBU), independent of the services associated with the provision of care and treatment to Miss A, supported the IO by providing guidance on NTW clinical policy and practice.

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

6.6 The Trust Incident and Serious Incidents that Require Investigation Policy[59] describes three levels of investigation: concise, comprehensive, and independent. It was noted that the internal investigation was commissioned as a 'Level 2 comprehensive investigation'. This is explained as:

'Suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable. The investigation should be completed, and final report submitted to the CCG, within 60 working days of the incident being reported'.

6.7 This was the appropriate level of investigation, however in reality the investigation was commissioned to be completed by an independent associate as the investigating officer (IO), with support from a Clinical Advisor employed by the Trust. The IO is an experienced senior nurse who has many years' training and experience in carrying out serious incident investigations.

6.8 No care and service delivery areas were identified, however the report identified 36 findings. The findings include a determination as to whether the finding is considered an incidental finding,[60] a root cause,[61] or is a statement of fact in relation to the incident.

6.9 The report identifies four findings that indicate a root cause, 25 findings indicating an incidental finding and seven findings that are a statement of fact.

6.10 The findings identified as root causes are:

- CTT discharge.
- Diagnosis.
- FACE risk assessment and management prior to the incident.
- Historical FACE risk assessment.

6.11 There were 25 areas identified as gaps in care, and seven 'statements of fact'. Themes included: care and treatment, risk and organisational systems and processes.

6.12 There were 36 findings and nine recommendations made. The adequacy of the report is discussed in detail in Appendix C of this report.

6.13 Whilst very comprehensive, in our view the authors have produced a report which has attempted to provide the breadth and depth of an independent report, when the Policy requirement was for a Level 2 report. The outcome of this is a lengthy report which took from January to October 2019 to produce.

6.14 The report is 150 pages long and contains 80 pages of narrative chronology, with commentary on events dating back to 1994. While attempting to gain the

[59] NTW (April 2016) Incident Policy (Including the management of serious incidents) Updated September 2017 due to clinical transformation. This has been replaced by CNTW(O)05 – Incident Policy, and practice guidance note IP-PGN-04 serious incident review panel.

[60] An incidental finding is a gap in care but one which did not contribute to the outcome.

[61] A root cause is an underlying or initiating cause of a causal chain which led to the outcome.

perspective of history is generally laudable, we question the relevance of this level of detail and comment to more current events.

6.15 There is no explanation for the time delay, and no clarification provided about whether permission for an extension was sought from NHS Northumberland CCG.

6.16 NHS England and NHS Improvement (London) investigations team issued guidance in April 2019 on engaging with families after a mental health homicide.[62] This provides clear best practice guidance to mental health provider organisations and states that 'families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation'.

6.17 The report acknowledges the assistance and co-operation provided by the family of Miss A, in sharing their views regarding care and treatment of Miss A, particularly at a time of significant distress associated with their loss. Therefore, implied rather than specifically stated. The report author kept in touch with the family monthly via telephone and had two meetings with the family during the investigation process.

6.18 The findings and recommendations have not however been shared with the family, and they have not seen the final internal report.

Adequacy of findings and recommendations

6.19 There were 36 findings made in total. The IO explained that each finding has a determination letter as to whether the finding is considered an incidental finding[63] (letter I), a root cause[64] (letter R), or is a statement of fact (letter F) in relation to the incident. There is no explanation of how these determinants were reached, and we believe there are potential linkages between issues that are not explored.

6.20 Nine recommendations were made:

[62] *Mental Health-Related Homicide Information for Mental Health Providers April 2019.* https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/08/Information-for-Mental-Health-Providers_V4.0.pdf

[63] *IO explanation: An incidental finding is a gap in care but one which did not contribute to the outcome.*

[64] *IO explanation: A root cause is an underlying or initiating cause of a causal chain which led to the outcome.*

Recommendation	Description
1	**Care Coordination** Inpatient services should ensure the Care Coordination Policy is followed in relation to discharge planning and coordination with community services. The relevant audit for the past two years should be reviewed in relation to discharge arrangements and assurance provided regarding action plans. The findings of this investigation should be utilised by the Trust Innovations Team in work relating to patient flow**.**
2	**Central Northumberland Adult Community Treatment Team (CNACTT) discharge** Guidance should be developed and introduced to ensure formal CPA/lead professional reviews are undertaken as part of safe discharge planning from the Community Treatment Team.
3	**Mental Health Assessment inclusive of Risk** The need to ensure Trust policy is followed relating to assessment should be discussed within all individual supervision meetings/Community Treatment Team meetings/MDT post assessment clinics. Compliance should be monitored by caseload supervision and audit.
4	**Carers needs** The in-patient and community service should review, within three months, how to ensure carer needs assessment is offered and facilitated. This should be inclusive of how risk issues relating to carers are integrated into discharge planning. Awareness should be raised regarding the completion of the 'safelives' checklist in situations of domestic abuse. The clinician involved must always review the outcome with the Safeguarding and Public Protection (SAPP) advisor and consider whether referral is warranted on clinical judgement grounds if consent is refused. Awareness should be raised within the Safer Care Bulletin as well as being the standard advice provided within the SAPP team following receipt of an incident report.
5	**CNACTT service pressures** The recent changes to improve access to medical/medication review within the CTT should be monitored by the CTT manager on an ongoing basis and escalated should the situation require further management intervention.
6	**CMHART capacity** Compliance to ensure Trust guidance is followed relating to waiting list monitoring should be reviewed on a regular basis.

7	**Supervision** The CNACTT manager will ensure compliance to the Supervision Policy and review any underperformance issues within their performance management framework on a monthly basis.
8	**Duty of Candour** An opportunity for the outcome of this investigation to be shared should be made available to: a) [Miss A] at a point in the future, subject to the advice/guidance of her current Responsible Clinician and having regard for issues of confidentiality and the need for redaction as deemed necessary, following review of the report by appropriate Trust officers. b) The family of Mrs C, having regard for issues of patient confidentiality and the need for redaction as deemed necessary, following review of the report by appropriate Trust officers.
9	**Service Delivery** a) This report should be utilised to ensure that the lessons learnt are discussed and integrated into the Care Coordination process. Also, individual team members should have the opportunity to reflect on their contribution to the care process through clinical and management supervision and the Learning Improvement Group. b) This case should be reviewed and discussed within the Central Business Unit (CBU) lessons learnt forum.

6.21 The recommendations are provided in a list at the end of the report, rather than as they arise in relation to findings. This makes it difficult to see how they have been synthesised from the analysis and findings that are within the body of the report.

6.22 The recommendations do not easily map on to findings, and do not appear to relate directly to the findings which are identified as root causes. There is no ordering of themes or level of priority provided.

6.23 In terms of the 25 incidental findings (defined as a gap in care which did not contribute to the outcome) there are three recommendations relating to supervision, demand, and capacity.

6.24 The recommendation for supervision is concerned with policy compliance through regular audit. Supervision is also part of the recommendation regarding risk and service delivery (learning lessons). Taken together this would lead to a change in practice. The recommendation relating to demand refers to recent changes being monitored and escalated for further intervention if needed; it is therefore difficult to assess whether this would lead to a change in practice.

6.25 The recommendation relating to capacity is concerned with following and reviewing adherence to waiting list guidance and would lead to a change in

practice. We have assumed the use of the word ‘CMHART’ is a typographical error, and that it should in fact refer to CNACTT.

6.26 Three further recommendations (not related to findings) are detailed concerning carers’ needs, duty of candour and service delivery.

6.27 Carer’s assessments were mentioned in the report as part of the chronology, the commentary, a risk themed narrative and in the conclusion (an assessment advised by safeguarding was not carried out) but was not detailed as a specific finding; the recommendation is concerned with a review process and raising awareness and would lead to a change in practice if the recommendation was measurable.

6.28 Duty of Candour was not detailed as a specific finding; the recommendation is a general one relating to sharing the findings of the investigation. However, in our view it should not be necessary for there to be a recommendation about sharing the report under Duty of Candour, this is a clear policy expectation.

6.29 Service delivery, in terms of the CNACTT episodic recovery model of care, was mentioned in the care and treatment theme section of the report but was not detailed as a specific finding. The recommendation rationale states that this model was not responsive to [Miss A’s] needs and suggests two actions not relating to the model but relating to learning lessons being integrated into both the care coordination process and CBU (sic) forum. This recommendation would not lead to a change in practice, and again is unnecessary because there is a clear policy expectation that the findings and recommendations should be shared and implemented in the service.

6.30 In summary, the report took longer than 45 days to complete without clarity about the different timescales contained within the report. The report is long and detailed but lacks the evidence that RCA tools have been utilised to arrive at the findings. It also lacks clearly identified contributory factors and care and service delivery problems. There is limited evidence of human factor analysis.

6.31 There are however considerable findings detailed. Four findings are identified as root causes. One of these does not have an associated recommendation. 25 findings are acknowledged as being gaps in care, however not all of these are translated into recommendations with actions.

6.32 The recommendations and actions identified have completion dates for some, and in part only, with no stronger or intermediate strength actions identified. The actions are not assigned to individuals, a group or committee. A separate trust action plan has been developed as a result.

6.33 In analysing whether the causal statements complied with the ‘Five rules of Causation’, we note that root causes were described as [Miss A’s] diagnostic position, suffering a psychotic illness, a lack of an up-to-date risk assessment alongside the initiating cause of several events as a result of the decision to discharge [Miss A] from CNACTT services in August 2018.

6.34 If these are all regarded as root causes, it would be expected that they would map onto the recommendations, to address fundamental systems issues.

6.35 A root cause can be defined as:

'The most significant contributory factor, one that had the most impact on system failure and one that if resolved would minimise the likelihood of a re-occurrence.'[65]

6.36 It is our view that Miss A's diagnostic position cannot be determined as a root cause as it is not a system vulnerability or procedural violation.

6.37 In terms of the CNACTT discharge, FACE risk assessment and management prior to the incident and historically, there are specific and accurate descriptions of what occurred in respect of each of these and they clearly show the cause-and-effect relationship and the preceding procedure violation; however, there is a lack of analysis as to why.

6.38 In terms of predictability and preventability, the standard definitions were used in the report:

'Predictability is 'the quality of being regarded as likely to happen, as behaviour or an event.' It necessitates the consideration as to whether there were any missed opportunities which, if actioned, may have resulted in a different outcome. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it'.[66]

'Preventability means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable, there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring'.[67]

6.39 To address predictability, the investigation considered Miss A's diagnosis (in particular, her chronic delusional beliefs of impostors in her family) and past risk related behaviour, concluding that it was predictable that Miss A would, at some point, be involved in a specific act of impulsive, violent behaviour, even if a high level of engagement and monitoring had been evident, however it was contended that the extent or veracity of the violence towards her mother was not predictable. We concur with this view.

6.40 To address preventability, the investigation stated that that there was no up-to-date knowledge of Miss A's mental health state, therefore no legal means could be taken to protect herself or others, and therefore no opportunity to stop the incident from happening.

[65] *Root cause analysis - using five whys.* http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

[66] http://dictionary.reference.com/browse/predictability

[67] http://dictionary.reference.com/browse/preventability

6.41 Our view is that this was not a reasonable conclusion to reach and that services had opportunities to review her mental health status, the clinical risk, and legal means available, to potentially prevent an incident of violence occurring through anticipatory counteraction.

6.42 With regards to preventability, the report further contends that if there was a contemporary understanding of her mental health status and clinical risk there may have been knowledge, and the legal means, to prevent the incident occurring through anticipatory counteraction.

6.43 We concur with this view and we found missed opportunities to do this were established in the report findings, conclusion and recommendations. In summary these missed opportunities were concerned with:

- Safeguarding Miss A's mother (finding 4, 20, 27; recommendation 4).
- An uncoordinated discharge from hospital May 2018 (finding 4; recommendation 1).
- Discharge 3 August 2018 from CNACTT and the fact that Miss A did not receive care coordination for a period of 250 days from 3 August 2018 up until the time of the incident. (Finding 6, 10; recommendation 2 and 3).
- The appointment of a new care coordinator without a handover and who did not know Miss A well (finding 3; recommendation 1).
- A care plan which did not reassess issues of disengagement, relapse prevention, risk management or medication needs (finding 5, 13, 17, 18; recommendation 3).

6.44 In our view these findings are sufficient evidence to demonstrate that the homicide was preventable.

Action plan progress

6.45 We have been provided with information about implementation of the action plan. Each of the nine recommendations has had actions developed to address this issue. We have had a narrative report on the implementation only, without supporting evidence.

6.46 It is evident that the action plan remains on the Trust agenda because updates have continued up to January 2021. We will review the evidence for implementation of the action plan when evidence has been received.

6.47 We note however that the issue of sharing the internal report with family and with Miss A remains unresolved in June 2021. The family have confirmed to us that they have not seen the internal report or had any discussion about the findings.

6.48 The Trust informed us that Miss A does not have capacity to consent regarding release of the full report and on the advice of the Responsible Clinician (RC), the Trust will review this position at six monthly intervals with the hospital in order to share their findings, conclusions and actions.

6.49 The family were offered the option of a meeting to feedback in this regard via an online Teams meeting during the Covid 19 pandemic, however chose to wait as they preferred a face to face meeting. This was scheduled to take place when Covid 19 restrictions were lifted and was achieve din summer 2021. In the meantime, the investigating officer has continued to have regular (approximately monthly contact throughout with the family link person) to ensure the matter is followed through to conclusion.

Finding 14 - CNTW - serious incident review

The internal report was lengthy, overly detailed and went well beyond the expected policy timescales.

There should have been medical input to provide clinical advice on the issues of diagnosis and medication management included in the report.

Recommendations are not based on findings and are not outcome focussed.

We have limited information about the progress of the action plan.

Family engagement by the Trust during the internal investigation process was positive, however the internal report findings, conclusions and actions were not shared with the family until summer 2021.

Recommendation 14 - CNTW & NHS Northumberland CCG - Serious incident review

CNTW and NHS Northumberland CCG should ensure that standards for SI reports meet national guidance, to include:

- Identifying the timescale to be examined in detail.
- Review of root causes identified.
- Carried out with the support of appropriate clinical advice.
- Delivered within expected timescales.
- Recommendations are outcome focussed and flow from the evidence and findings.
- Appropriate family involvement.

7. Lessons identified/summary

Lessons identified

7.1 As part of the Safer Northumberland Partnership and NHS England Terms of Reference we are asked to identify what lessons could be learned from the death of Mrs C regarding the way in which professionals and organisations work individually and together to safeguard future victims.

7.2 Everyone who had knowledge of the risks and abuse focussed on the mental health of Miss A, this included the police who had enough evidence to charge Miss A with assault, apply for a restraining order that could have lasted for 12 months, and could be done without her mother's support for a prosecution. Particularly the incident in the hospital/health setting should have been an evidence-led prosecution; it appears that the focus again was on Miss A's mental health.

7.3 Mrs C was not heard when she said she was frightened and needed help. She was not listened to.

7.4 There were many signs that Mrs C was at risk from Miss A; threats, Mrs C's fear, her escalating mental disorder and her history of harming pets, her assault on her boyfriend, use of weapons. These all demonstrate Miss A's propensity to causing serious harm. Mrs C was a consistent target for harm, and it follows that she was at greatest risk from Miss A.

7.5 Mental health services failed to consider Capgras syndrome which would have highlighted the potential risk to Mrs C.

7.6 The police made inaccurate risk assessments, not considering the victim's vulnerability and the perpetrator's dangerousness and the clear escalation of abuse, failing to use professional judgment. Risk was high on both occasions they had the opportunity to risk assess.

7.7 GP's did not appear to consider domestic abuse at any opportunity. The ASC response to safeguarding issues was to refer back to the Mental Health Trust. The Mental Health Trust also failed to properly assess Miss A's risk to her mother.

7.8 In our opinion, the system emphasis on the question of whether Mrs C wanted to pursue prosecuting her daughter distracted services from addressing the evident risk of harm from Miss A. It is natural that a mother would be reluctant to do this, although her family confirmed to us that she did want something to happen.

7.9 If Mrs C had been provided with access to domestic abuse specialists such as an IDVA, they would have been able to explain what was happening and what help she could receive. In our view Mrs C was denied the opportunity to access this help.

7.10 Lack of an integrated health and social care service led to silo working and a lack of communication. We understand that community mental health services were being reintegrated with CNTW in a way which will bring health and ASC teams back under the same roof, but without the previously shared management structures. Such co-location should allow and encourage multi-disciplinary discussion and shared risk assessment to occur daily. Work is also being undertaken to better align documentation and information technology systems to support this.

7.11 We have been told that local arrangements for both reviewing safeguarding referrals and MASH referrals have been changed, a review of how the duty social work team works has been completed and there is now an 'inquiry referral coordinator' whose role is described as 'sift and send' either to the duty social worker or to safeguarding.

7.12 Additionally, when there are multiple concerns raised for an individual, an allocated social worker now reviews the case via an MDT and explores if there is a role for ASC. There is also an alert system in place that monitors and flags the recurrence of low-level concerns. The system will identify if there have been three concerns in one month, or three concerns in three months.

7.13 The introduction of local multiagency safeguarding hub (MASH) arrangements in February 2018 could have ensured that her issues were reviewed at a MASH meeting, where all available information about Miss A's vulnerabilities were shared, and decisions made in the context of historical risk.

7.14 Information sharing amongst agencies was very poor. Information that is necessary and proportionate for the purpose for which it is required/being shared (a risk assessment) is allowed particularly when there are concerns about safety/safeguarding which there clearly was.

7.15 It is evident that in this case the information about the risk of harm to Mrs C from Miss A was within the individual systems in primary care, police, ASC and mental health services. There were several opportunities for a multi-agency response to Mrs C. A MARAC would have tied together information from health, from police and given Mrs C herself an opportunity to speak in a supportive environment.

7.16 MARAC is not just a meeting, it is a process, and in our view that seems to have been fundamentally misunderstood locally, which is not helped by the description of MARAC in the local protocol.

7.17 Consent is not required for a MARAC referral to be made; this was a fundamental misunderstanding in this case. One of the roles of MARAC is to manage the behaviour of the perpetrator to reduce the risk to the victim: all agencies, including housing, would have had a better picture of the risk and of Mrs C's vulnerability and she would have had better support and an advocate i.e., the IDVA, to ensure that her voice was heard.

Opportunities

7.18 We suggest two clear areas where improvements to wider systems would address the gaps identified in this case:

- Actions for police and the Crown Prosecution Service following the recommendations in the January 2020 report on evidence-led domestic abuse prosecutions.[68]

- Implementation of a coordinated community response such as that proposed by Standing Together.[69] A coordinated community response (CCR) '*is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor and their children. Instead, agencies hold information that can be shared within an effective and systematic partnership, to increase the safety of survivors and their children. Central to the CCR is the aim of holding perpetrators to account, underpinned by a full understanding of the perpetrators' pattern of coercive control, abusive behaviour and the impact this has on the survivor'.*

Findings and recommendations

7.19 We have made the following findings and recommendations for systems accordingly.

[68] *Evidence led domestic abuse prosecutions, January 2020.* https://www.justiceinspectorates.gov.uk/hmicfrs/publications/evidence-led-domestic-abuse-prosecutions/

[69] *In Search of Excellence©, A refreshed guide to effective domestic abuse partnership work –The Coordinated Community Response (CCR).* https://www.standingtogether.org.uk/blog-3/in-search-of-excellence

Finding 1 - GP and NHS Northumberland CCG

Mrs C was seen regularly and followed up appropriately for her chronic health concerns.

There was no cross communication between GPs in the same practice, although both the victim and perpetrator were registered there. Mrs C herself did not relay concerns, but there was detailed information in Miss A's notes about risk to her mother. There are no systems for linking family members who live at different addresses.

The GP practices have an electronic system which can flag vulnerability and risk of domestic abuse. This should have been used after reports of Mrs C's assault by Miss A and when Miss A took Mrs C's medication. A risk assessment should have been completed.

The GP practices have a process for multidisciplinary discussion of complex patients, which should have been instigated.

It is clear that Miss A presented with physical health concerns that could be seen as manifestations of her mental disorder. This appears to have escalated during 2018, when her beliefs about physical illness intensified. Her presentation became increasingly chaotic, and continuity was affected by her changing GP surgeries and being homeless.

Efforts were made by successive GPs to address the amount of pain medication Miss A was taking, and to contact mental health services, however no referral to substance misuse services was made.

Finding 2 - Bernicia Homes - domestic abuse

The service provided by Bernicia Homes in relation to potential domestic violence was within their policy expectations, however in our view it would be helpful to develop a systematised approach to respond to domestic abuse.

Finding 3 - Northumberland County Council - domestic abuse

The Northumberland County Council Domestic Abuse strategy is due for review over the next year, and plans are being developed to carry out a sexual violence and domestic abuse needs assessment.

Finding 4 – Home Office – Matricide and Parricide

There are several important studies concerning mental disorder, matricide and parricide relevant to agencies working with domestic abuse prevention strategies with implications for risk management.

Finding 5 - CNTW - family involvement

There was no evidence of an evidence-based treatment plan in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management (2014) with regards to family engagement and carer support (see Appendix E).

Although Mrs C was identified by Miss A as her carer we did not find evidence of Mrs C being identified as a vulnerable carer with identified carer needs and actions recorded or a carer's assessment arranged for Mrs C after this had been offered. No domestic abuse support was provided, and there was little evidence of Mrs C being routinely involved in review meetings as she wished to be.

Finding 6 - CNTW - care and treatment in the community

There were no formally recorded CPA reviews or FACE risk assessment and management updates during 2017.

In February 2017 consideration to discharging Miss A was entirely inappropriate and not in line with the Trust CPA or Engagement Policy requirements.
In January 2018 there was poor understanding of the clinical presentation and the risks. Our view is that such clinical presentation required a medical review and an assessment under the Mental Health Act (MHA) to be undertaken without further delay.

It is clear that Miss A presented with physical health concerns that could be seen as manifestations of her mental disorder. This appears to have escalated during 2018, when her beliefs about physical illness intensified. Her presentation became increasingly chaotic, and continuity was affected by her changing GP surgeries and being homeless.

The fact that not one psychiatrist had personal knowledge of Miss A, the lack of a clear diagnosis, and the view that she showed no relapse indicators although she continued to hold bizarre beliefs, led to a lack of decisive action to review, and manage her symptoms and risk.

There should have been a thorough assessment of her substance misuse, including the impact of this on her mental health. A referral to substance misuse services for advice or assessment and treatment should have been made.

When Mrs C reported Miss A's non-compliance with medication and risks to herself, a clinical review with the consultant psychiatrist should have taken place to either consider a depot medication or an inpatient management along with a safeguarding referral. This did not take place.

Finding 7 - CNTW - care and treatment whilst an inpatient

There should have been a thorough assessment of her substance misuse, including the impact of this on her mental health. A referral to substance misuse services for advice or assessment and treatment should have been made.

It is our view that the team had developed an unconscious biased view of Miss A (countertransference), attributing her clinical presentation predominantly to personality traits and substance misuse. The team referred to the 'chronicity' of the illness leading to the acceptance of continued symptoms. This is likely to have influenced the team not to attempt a trial of depot medication or a subsequent trial of clozapine, if she showed a poor response to depot antipsychotic medication (see related findings for diagnosis, medication, risk assessment and safeguarding).

Finding 8 - CNTW - care and treatment - diagnosis

We found a lack of clinical curiosity, given that Miss A did not always appear distressed by the delusions and hallucinations, leading to a perception that she was stable, her mental illness was 'chronic' in nature and latterly in 2018 that her needs were primarily social (see related findings for medication, risk assessment and safeguarding)**.**

There were doubts about Miss A's diagnosis and a view that there was a significant personality element to her diagnosis with the psychosis influenced by the use of illicit substances. Attributing her clinical presentation predominantly to personality issues and use of illicit substances is likely to have led to lack of appropriate focus and treatment of her schizophrenia.

The fact that not one psychiatrist had personal knowledge of Miss A, the lack of a clear diagnosis, and the view that she showed no relapse indicators although she continued to hold bizarre beliefs, led to a lack of decisive action to review, and manage her symptoms and risk.

In our view there was sufficient evidence for a diagnosis of a schizophrenia/psychotic disorder, mainly schizophrenia in view of the presence of chronic and recalcitrant delusions of persecutions, bizarre somatic delusion and delusional misidentification (Capgras syndrome).

Finding 9 - CNTW - care and treatment - medication

There was no evidence of an evidence-based treatment plan in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management, particularly with regards to medication (see Appendix E).

We would have expected, particularly given Miss A's historical non-compliance and risk issues, to find that consideration had been given to the benefits of a depot or clozapine (an atypical antipsychotic medication when her symptoms became more chronic and unresponsive to the antipsychotic medication prescribed.

Miss A was often treated with sub-therapeutic doses of antipsychotic medication in acute phases (for example risperidone 2 mgs/day was prescribed when most patients would require 4 to 6 mgs/day in an acute phase of illness). Sub therapeutic doses of antipsychotic medication along with poor compliance are likely to have contributed towards the chronicity of her symptoms.

Mirtazapine (an antidepressant) was prescribed in a way not in keeping with British National Formulary (BNF) or other recommended guidelines (NICE depression prescribing information) Miss A had some sleep difficulties and mirtazapine was prescribed to be taken 'a couple of times a week' to try to support positive sleep habits.

There were insufficient interventions to assess and address her medication compliance issues.

Finding 10 - risk and safeguarding

Police

The assessments and interventions provided by Northumbria Police in relation to domestic violence by Miss A were closely aligned and based upon the 'SafeLives' risk assessment process recognised and used nationally.

However, the risk assessments were inaccurate and there were two missed opportunities to pay attention to Mrs C as a victim of domestic abuse and provide a multi-agency response from all the agencies who had insights into her life, her vulnerability and crucially Miss A's dangerousness. It was noted that police understanding of policy and decision making about applying a definition of vulnerability could be improved.

Risks arising from alcohol, drugs or mental health issues are joined together in the DASH as one 'tick box', which assumes they are one amalgamated risk. This has been identified from previous reviews within the Northumbria Police area however due to the introduction of the impending College of Policing risk assessment form, this has been deferred. Officers are encouraged and continue to have the ability to highlight specific risks in free text using professional judgement and increase the risk level regardless of the 'boxes' on the form.

Police vulnerable adult notifications due to concerns regarding Miss A's mental health issues and her calls to the police to complain about alleged crimes were viewed by the police in isolation and therefore accumulative risk was not considered.

Police responded to calls and concerns about Miss A and completed safeguarding referrals. Acts of violence towards Mrs C were 'crimed' and an ACN completed with the first occurring in June 2016 within a medical facility and the second at the home address in April 2018. On 20 August 2018 an ACN was raised due to concerns that Miss A's mental health was deteriorating. A triage discussion was held and the concern was passed for the attention of the allocated CPN for ongoing support.

The assumption that the Domestic Violence Protection Order (DVPO) was not necessary as Miss A would be in hospital for at least 28 days detained under Section 2 MHA was false and indicates a lack of communication between the agencies and lack of understanding regarding the MHA.

CNTW

It is evident that up until 2014 Miss A was supported by an MDT approach, however following the removal of the Section 75 agreement it appears that health services worked with Miss A in isolation.

Capgras symptoms and familial risk were not appropriately assessed or managed. Risk was not explored with family members. There was no professional clinical curiosity about why Mrs C thought she was in danger.

A Multiagency Risk Assessment Conference (MARAC) referral was not progressed due to a lack of knowledge and understanding of the process and whether consent was required to proceed.

A MARAC referral would have notified the police automatically and allowed the Independent Domestic Violence Advisor (IDVA) to engage with the mother and hear her thoughts and fears, the sharing of information between agencies at the MARAC meeting and the development of a multi-agency safety plan.

Northumberland County Council ASC

There were a number of opportunities where a referral to ASC would have been appropriate.

The perception that many of the safeguarding concerns being raised by the Police and other partners were low level or the direct result of Miss A's mental health issues resulted in ASC repeatedly passing these on to CNTW for information and action without convening a formal multi agency safeguarding meeting.

Each individual incident, concern or referral about Miss A was seen in isolation and without the benefit of multi-disciplinary discussion.

There were missed opportunities to complete Miss A's social care assessment both as an inpatient and later when she had been discharged.

Adult social care has repeatedly passed safeguarding issues back to the mental health trust with the expectation that a medication review or CCO appointment would resolve the presenting issue.

There was no further escalation to senior leaders regarding the ASC concerns about her unsafe inpatient discharge.

All agencies

There were several opportunities where safeguarding for Mrs C should have been considered. As a result, there were missed opportunities across and between agencies to develop an in-depth understanding of the risks to Mrs C and formulate a risk management plan.

Although an ACN is the process that Northumbria police officers use to notify partners via the MASH of a particular concern, there was no process thereafter to consider sharing and considering the ACNs by those with direct involvement with Miss A's mental health care, or to flag up that there had been numerous low-level concerns, along with reports of acts of serious violence against her mother.

Finding 11 - CNTW - CTT discharge and housing

The discharge 6 August 2018 from the CTT was not in line with Trust CPA Policy. Medical staff were not involved in the decision to discharge and were only informed of the difficulties in engaging Miss A in November 2018.

Staff 'churn' in the CTT with retirements and consultant psychiatrist recruitment issues meant that their attendance at the clinical meeting was on a rotational basis and no one consultant psychiatrist had personal knowledge of Miss A.

Miss A was attempting to engage with the CTT and had rung several times to indicate she was dissatisfied with her discharge however due to human error the CTT referral was not actioned resulting in a gap in service between 20 September and 5 December 2018 following which Miss A was difficult to contact and re-engage.

In November 2018 when Miss A was not engaging, unable to be contacted by 'phone, requesting medication from her new GP and refusing a review, a CCO review was not undertaken in line with Trust CPA Policy. This was the first time a member of the medical staff was made aware of the situation with Miss A since her discharge 6 August 2018.

Finding 12 - CNTW - inpatient discharge

Miss A was formally allocated to a male CCO6, whilst she was an inpatient, and he received a brief handover from CCO4, although Miss A had requested a female CCO (which was agreed to). Trust CPA Policy was not followed in ensuring an effective hand-over of information. Our view is that this was a particularly important process considering Miss A's deteriorating mental state.

Plans for discharge were accelerated inappropriately for 22 May 2018 despite the view from CCO5 and ASC that Miss A would benefit from supported accommodation and a package of care targeted to her needs. Discharge was subsequently deferred to 30 May; however it was not a coordinated discharge plan in line with the Trust CPA Policy.

The request that Miss A could be referred to the St George's rehabilitation ward (comprising a ward and individual flats) was a reasonable one for Mrs C to make and should have been followed through, however it was not, based on an assumption that she would not fit the criteria (see findings related to diagnosis and care and treatment).

The long history of Miss A finding it difficult to engage and being non-compliant with medication suggests that assertive outreach services would have been helpful in supporting her.

Finding 13 - interagency information sharing

The existing frameworks for information sharing and management of risk were not utilised. Local DHR reports have previously highlighted similar issues.

Finding 14 - CNTW - serious incident review

The internal report was lengthy, overly detailed and went well beyond the expected policy timescales.

There should have been medical input to provide clinical advice on the issues of diagnosis and medication management included in the report.

Recommendations are not based on findings and are not outcome focussed. We have limited information about the progress of the action plan.

Family engagement by the Trust during the internal investigation process was positive, however the internal report findings, conclusions and actions were not shared with the family until summer 2021.

Recommendation 1 – GP, NHS Northumberland CCG and CNTW

Northumberland Clinical Commissioning Group must provide assurance that GP surgeries:

a) Have the necessary knowledge and skills to recognise domestic abuse.

b) Use the systems in place to recognise and act on disclosures of domestic abuse.

c) Northumberland Clinical Commissioning Group should explore the inclusion of an established domestic abuse awareness programme for general practice, such as IRISi.[70]

d) NHS Northumberland CCG and CNTW should develop systems to ensure there is a shared care approach to the provision of physical and mental health care and treatment.

e) Specialist substance misuse services or staff must be requested to advise or to assess and contribute to care and treatment plans where there are substance misuse issues and associated risk to others (also a recommendation for CNTW care and treatment inpatient and community).

[70] IRISi is a social enterprise established in 2017, aiming to improve the healthcare response to gender-based violence through health and specialist services working together. https://irisi.org/

Recommendation 2– Bernicia Homes

Bernicia Homes should develop a systematised approach to responding to domestic abuse, such as that provided by the Domestic Abuse Housing Alliance.[71]

Recommendation 3 - Northumberland County Council - domestic abuse

Northumberland County Council must ensure that a comprehensive domestic abuse strategy includes measurable outcomes from previous reviews.

Recommendation 4 - Home Office - Matricide and Parricide

a) The Home Office should incorporate learning about matricide and parricide into domestic abuse prevention strategies.

b) Adult child to parent violence and mental illness should be incorporated into domestic abuse strategies.

Recommendation 5 - CNTW - family involvement

a) CNTW must ensure that families and carers are appropriately involved in care planning and risk assessment.

b) CNTW must ensure that referrals for carers' assessments are routinely part of care planning and risk assessment.

Recommendation 6 - CNTW - care and treatment in the community

a) CNTW must ensure that the CPA Policy is embedded in practice and supported by relevant training addressing the quality of risk assessment, management plans, discharge planning and involvement of carers.

b) CNTW must ensure their workforce strategy addresses and monitors the clinical risks associated with CTT medical and nursing recruitment and retention workforce issues.

c) CNTW must ensure that the NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management is embedded in practice with reference to medication management.

d) CNTW must review the arrangements for assessing the need for and providing assertive outreach support in the psychosis care pathway.

[71] *The Domestic Abuse Housing Alliance's (DAHA) mission is to improve the housing sector's response to domestic abuse through the introduction and adoption of an established set of standards and an accreditation process.* https://www.dahalliance.org.uk/

Recommendation 7 - CNTW - care and treatment whilst an inpatient

CNTW must ensure that the safeguarding adults at risk Policy is embedded in practice and supported by relevant training.

Recommendations 8 - CNTW care and treatment - diagnosis

CNTW must assure itself through regular audit that where appropriate, objective diagnostic criteria should be applied with reference to formulation and evidence base.

Recommendation 9 - CNTW - care and treatment - medication

CNTW must assure itself through regular audit that NICE guidance is followed in the prescribing of antipsychotic medication for those with chronic symptoms who have not responded to initial treatment.

Recommendation 10 - risk and safeguarding

Northumbria Police

The Domestic Abuse, Stalking and Harassment (DASH) risk assessments conducted by Northumbria Police in relation to domestic violence should:

a) Be completed fully with officers ensuring that additional context is added to the comments section where 'yes' has been indicated. The Home Office and College of Policing are in the process of designing and testing a new domestic abuse risk indicator for the police service nationally. Northumbria Police has not made significant changes to the current process pending the implementation of this new process.

b) Northumbria Police must ensure that police officers are appropriately trained to:

Identify escalation in abuse.

Incorporate professional judgment to fully assess the threat, harm and, if necessary, raise the risk level towards victims.

CNTW

c) CNTW must ensure that adult safeguarding concerns are accurately documented within patient records and referrals are captured within clinical records.

d) CNTW must ensure that familial risks associated with Capgras syndrome, the impact of illicit drug use, the importance of exploration of risk with family members and the significance of assessing and monitoring medication compliance particularly in relation to familial risk are routine risk assessment and management considerations. Where risk to family members is reported, risk assessment must be updated, and victim safety planning must become part of the risk management plan.

All agencies

e) The Safer Northumberland (Community Safety Partnership) must seek assurance that the new joint working arrangements between Adult Social Care and CNTW are working effectively, and the risk of silo working has been addressed.

f) The Safer Northumberland (Community Safety Partnership) must ensure that MASH multi-agency protocols are able to identify and address risk to an adult raised through police ACNs.

g) Where a risk to an adult has been identified, agencies should demonstrate within their records that they have considered risk in relation to adult safeguarding criteria. Where risk to family members is reported, risk assessment must be updated, and victim safety planning must become part of the risk management plan.

Recommendation 11 – CTT discharge and housing

CNTW

a) CNTW must ensure that robust CTT administration governance systems are in place to eliminate human error in the referral process.

Northumberland County Council ASC

b) Northumberland County Council must set quality standards for the timely allocation of social workers to accepted referrals.

Northumberland County Council – Strategic housing

c) To undertake a review, to involve all relevant partners (Northumberland County Council (Housing Services and Adult Social Care), CCG, CNTW and NHS Foundation Trust) to assess the adequacy of current supported emergency and temporary housing options for individuals with chronic and enduring mental illness, including referral pathways.

Recommendation 12- CNTW - inpatient discharge

CNTW must have services in place to meet the needs of patients requiring an assertive approach.

Recommendation 13 - interagency information sharing

The Northumberland Multi Agency Risk Assessment Conference protocol must be reviewed to incorporate learning from this review.

Recommendation 14 - CNTW & NHS Northumberland CCG - serious incident review

CNTW and NHS Northumberland CCG should ensure that standards for SI reports meet national guidance, to include:

- Identifying the timescale to be examined in detail.
- Review of root causes identified.
- Carried out with the support of appropriate clinical advice.
- Delivered within expected timescales.
- Recommendations are outcome focussed and flow from the evidence and findings.
- Appropriate family involvement.

Appendix A – Terms of Reference for the joint review

The following Terms of Reference for Independent Investigation 2019/8149 have been drafted by NHS England North in consultation and with the agreement of Safer Northumberland (Community Safety Partnership).

The Terms of Reference will be developed further in collaboration with the offeror and affected family members. However, requirements under Appendix 1 above and Domestic Homicides Reviews under the Domestic Violence, Crime and Victims Act published by the Home Office in 2016, are expected to be met for this case.

Purpose of the investigation/commission

- To identify any gaps, deficiencies or omissions in the care and treatment received by the perpetrator which could have predicted or prevented the incident.

- To identify any areas of best practice, opportunities for learning and areas where improvements to services are required, with a focus on the period from April 2017 to the incident occurring in April 2019.

Involvement of the affected family members and the perpetrator

- Ensure that the family is; fully informed of the investigation, the investigative process and understand how they can contribute to the process.

- Involve the affected family as fully as is considered appropriate, in liaison with Victim Support, Police and other support organisations.

- Offer a meeting to the perpetrator so that she can contribute to the investigation process.

Care and treatment

In the absence of the internal investigation report, compile a detailed chronology of contacts and service access (dependent on level of IMR).
Undertake a critical review of the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence (from April 2017).
Review the appropriateness of the treatment of the service user and the victim in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
Examine the effectiveness of the service user's care plan including the involvement of the service user and the family. Comment on how the family's views and concerns were addressed.
Consider the quality of both health and social care assessments on which decisions were based and actions were taken.

Interagency working and communication.

Establish what lessons are to be learned from the domestic death regarding the way in which professionals and organisations work individually and together to safeguard future 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 required service responses including changes to policies and procedures as appropriate.
Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement.
Explore whether the victim's family had any knowledge of domestic violence by the service user, if so, how was this knowledge acted upon?
Consider any issues with respect to safeguarding (adults) and determine if these were adequately assessed and acted upon?
Identify any issues in relation to capacity or resources in any agency that impacted the ability to provide services to the victim and perpetrator and to work effectively with other agencies?
Was information sharing within and between agencies appropriate, timely and effective?
Were there effective and appropriate arrangements in place for the escalation of concerns and how were these shared?
Identify from both the circumstances of the case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in the future and make this available to the Home Office.

Risk Assessment
Review the adequacy of risk assessments and risk management, including specifically the risk posed to others and how this was shared**.**
Review and assess compliance with local policies, national guidance and relevant statutory obligations.
Whether the service user had any previous history of abusive behaviour towards the victim and whether this was known to any agencies.
Examine the effectiveness of the service user's care plan including the involvement of the service user and the family, specifically in relation to risk assessment/risk of violence and effectiveness of CPA review.
Review the Trust's assessment of vulnerable carers, who are known to be caring for adults with mental health issues (to be determined).

Serious Incident Review
Review the Trust post incident internal investigations and assess the adequacy of their findings, recommendations and action plans.
Review the progress that the Trust has made in implementing the action plan associated with their internal investigation.

Deliverables
Provide a final written report to NHS England and Northumberland CSP (that is easy to read and meets NHS England accessible information standards) within six months of receipt of all clinical and social care records.

Based on investigative findings, make organisational specific outcome focused recommendations with a priority rating and expected timescale for completion.
Share the findings of the report in an agreed format, with the affected family and the perpetrator, seek their comments and ensure appropriate support is in place ahead of publication.
Deliver an action planning event for the Trust and other key Stakeholders to share the report's findings and to provide an opportunity to explore and fully understand the intention behind all recommendations.
Support the commissioners (where required) in developing a structured plan for review of implementation of recommendations. This should be a proposal for measurable change and be comprehensible to those with a legitimate interest.
In consultation with NHS England, hold a learning event for involved practitioners and services to share the report's findings and recommendations.
Conduct an assurance follow up visit with key stakeholders, in conjunction with the relevant CCG, 6 months after publication of the report to assess implementation and monitoring of associated action plans.

Provide a short-written report, for NHS England and the CSP that will be shared with families and stakeholder and which will be made public.

Appendix B – Documents reviewed

CNTW NHS Foundation Trust documents

Clinical records.

Internal investigation report.

Training and supervision records

Staffing establishment April 2019

Policies:

- Incident and Serious Incidents that Require Investigation (SIRI) Policy. May 2019.
- Serious incident February 2020
- Incident reporting and Management June 2020
- How to investigate an incident July 2020
- Incident review panel July 2020
- Learning lessons from incidents and near misses July 2020
- Supporting staff involved in an incident July 2020
- Risk Management Policy October 2019
- Care Programme Approach March 2020
- Domestic Abuse January 2020
- Safeguarding Adults at Risk March 2020
- Supervision
- CRHT

Other documents

Individual Management Reports.

Northumberland Domestic Violence Policy

Primary care clinical records.

General hospital records.

Appendix C – NIAF: internal investigation review

Rating	Description	Number
	Standards met	10
	Standards partially met	8
	Standards not met	7

Standard		Niche commentary	
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident.	The report identifies that it is a root cause analysis investigation report, in accordance with the NHS England Serious Incident Framework, and is a Level 2 investigation. It is stated that the aim is in supporting learning to prevent recurrence, in addition to complying with the Trusts' own Incident Policy requirements.	
1.2	The investigation has Terms of Reference that include what is to be investigated, the scope and type of investigation.	The Terms of Reference for this investigation were clear on all these requirements apart from specifically stating that it is a Level 2 investigation. The internal report itself stated it was a Level 2 investigation, however.	
1.3	The person leading the investigation has skills and training in investigations.	The investigation was conducted by an associate investigator employed as the investigating officer (IO) by the Trust, with a consultant psychologist as clinical advisor. No information is provided within the report about the skills and training of the psychologist in relation to investigations. However, there were many issues of diagnosis and medication which required a systematic review. The report would have benefitted from the input of a consultant psychiatrist. At interview we established that the IO has professional background as a senior mental health nurse and has extensive training and experience in investigations and organisational governance.	
1.4	Investigations are completed within 60 working days	The homicide occurred in early April 2019. The Terms of Reference state that the report was to be presented to the Trust Incident Panel on 14 November 2019. The report was completed in October 2019 and signed off in November 2019. The report author stated they required more than the 60 days to complete the investigation to a high standard. The investigation provides on the front page a report date of October 2019 and a date agreed at panel of 19 March 2020.	

Standard		Niche commentary	
		The report does not provide detail of the timeline of the investigation; there are three different dates provided, and it therefore remains unclear.	
1.5	The report is a description of the investigation, written in plain English (without any typographical errors).	The report is very detailed, and densely written but with some typographical errors. There are several formatting errors which interfere with the flow of the report.	
1.6	Staff have been supported following the incident.	There is no description of how staff were supported following the incident. The report notes the Trust recognised the importance of a supportive culture as an important principle and reflective of the recently published NHS plan. The report goes on to say that the IO and CA consider such an approach as being essential in maximising learning opportunities and states it is important to acknowledge this leadership within the organisation. The report does not contain any further detail of staff support.	
Theme 2: Thoroughness			
2.1	A summary of the incident is included, that details the outcome and severity of the incident.	There is a summary of the background to the incident, and of the actions after the Trust became aware of the incident.	
2.2	The Terms of Reference for the investigation should be included.	The Terms of Reference are included.	
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people.	The report describes the process of the investigation in detail. There is a description of the methodology used. A chronology and supporting narrative are provided. Staff interviews were conducted with no reference to relevant staff being unavailable. The report states that root cause analysis methodology was used to analyse information, to determine what contributed or impacted on care and treatment and to enable a clear rationale for the recommendations. The recommendations are identified as either being a statement of fact, an incidental finding, or a root cause.	
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process.	The report acknowledges the assistance and co-operation provided by the family of Miss A in sharing their views regarding care and treatment of Miss A, particularly at a time of significant distress associated with their loss. Therefore, implied rather than specifically stated. The report author kept in touch with the family monthly via telephone and had two meetings with the family during the investigation	

Standard		Niche commentary	
		process. The Clinical Advisor did not participate in meetings with the family.	
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	There is evidence of input from the bereaved family, but not the patient. The Terms of Reference have specific questions posed by the family.	
2.6	A summary of the patient's relevant history and the process of care should be included.	A summary of the relevant history and process of care was included.	
2.7	A chronology or tabular timeline of the event is included.	A chronology and supporting narrative are embedded within the report.	
2.8	The report describes how RCA tools have been used to arrive at the findings.	The report describes how the methodology of a systematic review, an after-action review meeting, reports and guidelines were used to undertake the investigation. Once all the evidence had been assimilated the IO and CA analysed the information with reference to the National Patient Safety Agency (NPSA) Root Cause Analysis (RCA) Guidance. The recommendations are identified as either being a statement of fact, an incidental finding, or a root cause. However, it is not clear which RCA tools were utilised and how.	
2.9	Care and Service Delivery problems (CDP & SDP) are identified (including whether what were identified were actually CDPs or SDPs).	Findings and themes were identified however not specifically categorised as care and service delivery problems. The recommendations are identified as either being a statement of fact, an incidental finding, or a root cause.	
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors).	The report states that root causes analysis methodology was used to analyse information, to determine what contributed or impacted on care and treatment and to enable a clear rationale for the recommendations designed to address any significant findings and learning from this incident. Contributory factors are not clearly identified in the findings of the report, however, are contained within the narrative body of the report. The human factors context included the situation the team was working in; including service pressures referrals, waiting lists, and the ability for the community services to manage someone with a chronic illness (i.e., an episodic model of care and an unconscious pressure to keep the system moving on).	

Standard		Niche commentary	
2.11	Root cause or root causes are described.	The report details four findings as root causes. Root causes were determined as her '*diagnostic position, suffering a psychotic illness, a lack of an up-to-date risk assessment alongside the initiating cause of a number of events as a result the decision to discharge [her] from CNACTT services.'* These do not meet the definition of root cause.	
2.12	Lessons learned are described.	The report states that there are lessons to be learnt prior to the report detailing the recommendations. Each recommendation starts with a rationale which could be interpreted as a lesson learnt. In addition, there is a specific recommendation (number 9) to ensure that the lessons learnt are integrated into various service delivery strands. However, specifically, lessons learnt are not described.	
2.13	There should be no obvious areas of incongruence.	We regard the root causes attributed to the patient as incongruent.	
2.14	The way the Terms of Reference have been met is described, including any areas that have not been explored.	Some sections do specifically detail this such as assessment and management of risk, however it is not clear in the report how all the findings and recommendations relate specifically to the Terms of Reference to ensure they have been met.	
Theme 3: Lead to a change in practice – impact			
3.1	The Terms of Reference covered the right issues.	The Terms of Reference were aimed at ensuring a comprehensive investigation proportionate to the severity and complexity of the incident.	
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence.	The report does not specifically outline human factors. However, some human factors are detailed within the narrative of the report, e.g., regarding supervision, resources, and service pressures such as recruitment, establishment, team capacity and demand. It would have been helpful to explore human factors further in relation to, e.g., the human error which took place in Miss A not being referred to CNACTT, why she was not seen for 79 days after IRT assessment and why the support worker did not discuss her with the care coordinator.	
3.3	Recommendations relate to the findings and that lead to a change in practice are set out.	There were 36 findings made. There are nine recommendations, however it is not easy to map these onto the findings. There were nine recommendations made each with a rationale included followed by a set of actions. The four root causes identified were CNACTT discharge,	

Standard		Niche commentary	
		diagnosis, FACE risk assessment and management prior to the incident and historical FACE risk assessment. There is a specific recommendation regarding CTT discharge; the action would lead to a change in practice. There is a recommendation relating to risk assessments; the action would lead to a change in practice. There is no specific recommendation relating to diagnosis.	
3.4	Recommendations are written in full, so they can be read alone.	Recommendations are written in full and can be read alone. They are detailed as actions with an accompanying rationale.	
3.5	Recommendations are measurable and outcome focussed.	The recommendations were mostly transactional, focussing on policy adherence, rather than transformative. However, the recommendation on care coordination had, in part, a suggestion that findings should be utilised by the innovations team to inform work on patient flow, and the recommendation for CNACTT discharge was to develop new guidance. Only two recommendations (care coordination and carers needs) had, in part, a time frame included. However, the time frame for the carers recommendation was concerned with a review process rather than a measurable outcome.	

Appendix D – Family questions

	Family questions	Section
1	Housing	Page 89, 5.178 to Finding 10 & Recommendation 11
2	What happened about the restraining order?	Page 111; 7.2
3	The lack of support from the community services when her mother asked for help with her not taking her medication	Page 73, 5.108 to Finding 9 & Recommendation 9, and finding 6
4	Why she was allowed out again after she was arrested following the bath chair incident	Page 80, 5.134 to 5.163

Appendix E – NICE guidance review

This is not a comprehensive analysis against the standards as a whole - relevant sections of the guidance only have been used.

Standards	Available to Miss A
Service user experience	
Use this guideline in conjunction with service user experience in adult mental health (NICE clinical guidance 136) to improve the experience of care for people with psychosis or schizophrenia using mental health services, and: • work in partnership with people with schizophrenia and their carers • offer help, treatment, and care in an atmosphere of hope and optimism • take time to build supportive and empathic relationships as an essential part of care.	Good continuity of care coordinator and well-developed relationships when Miss A was receiving EIP services. However, during this time there was little engagement with her mother.
Physical health	
People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.	Yes. Comprehensive physical health monitoring records found although Miss A would generally not engage.
If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance (see obesity [NICE clinical guideline 43], lipid modification [NICE clinical guideline 67] and preventing type 2 diabetes).	Not applicable. However comprehensive physical health monitoring records found.
Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine.	Yes. Comprehensive physical health monitoring records found.
Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report.	Yes. Comprehensive physical health monitoring records found.

Trusts should ensure compliance with quality standards on the monitoring and treatment of cardiovascular and metabolic disease in people with psychosis or schizophrenia through board-level performance indicators.	Yes. Comprehensive physical health monitoring records found.
Support for carers	
Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually.	No. We were told that Miss A did not see her mother as a carer, rather the other way round, that she was caring for her. However, this was not explored with her mother.
Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this.	No. See above.
Give carers written and verbal information in an accessible format about: • diagnosis and management of psychosis and schizophrenia • positive outcomes and recovery • types of support for carers • role of teams and services • getting help in a crisis. When providing information, offer the carer support if necessary.	No. See above.
As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users and carers and respects their individual needs and interdependence.	Yes. It is clear in the records when Miss A decided she did not want her mother to be informed of her progress, care, and treatment. The care plan explained that they would try and engage her and listen to her concerns and review every six months however there was no evidence this took place.
Review regularly how information is shared, especially if there are communication and collaboration difficulties between the service user and carer.	No.

Offer a carer focussed education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should: be available as needed, have a positive message about recovery.	No.
Include carers in decision-making if the service user agrees.	No. Prior to the records stating she did not want her mother involved there was little involvement of and engagement with her and no record about Miss A's thoughts about confidentiality in this respect. As an example, her mother was present at the 2015 inpatient discharge meeting, but not at the 2018 inpatient discharge meeting. Inpatient staff told us that her mother did not visit the ward, and the consultant had not met her, although nursing staff spoke to her on the 'phone.
Peer support and self-management	
Consider peer support for people with psychosis or schizophrenia to help improve service user experience and quality of life. Peer support should be delivered by a trained peer support worker who has recovered from psychosis or schizophrenia and remains stable. Peer support workers should receive support from their whole team, and support and mentorship from experienced peer workers.	No.
Subsequent acute episodes of psychosis or schizophrenia and referral in crisis	
Offer crisis resolution and home treatment teams as a first-line service to support people with psychosis or schizophrenia during an acute episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it.	Yes. Miss A was assessed by crisis resolution as appropriate and also offered Step Up services to provide support when she was at risk of relapsing.
Crisis resolution and home treatment teams should be the single point of entry to all other acute services in the community and in hospitals.	Yes.

Consider acute community treatment within crisis resolution and home treatment teams before admission to an inpatient unit and as a means to enable timely discharge from inpatient units. Crisis houses or acute day facilities may be considered in addition to crisis resolution and home treatment teams depending on the person's preference and need.	This was not appropriate as Miss A had been arrested for the assault of her mother and was assessed in the police station and detained under Section 2 MHA.
If a person with psychosis or schizophrenia needs hospital care, think about the impact on the person, their carers, and other family members, especially if the inpatient unit is a long way from where they live. If hospital admission is unavoidable, ensure that the setting is suitable for the person's age, gender, and level of vulnerability, support their carers and follow the recommendations in service user experience in adult mental health (NICE clinical guidance 136).	Yes.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer: • oral antipsychotic medication in conjunction with • psychological interventions (family intervention and individual CBT).	Yes. Psychological interventions were offered however Miss A did not engage.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer oral antipsychotic medication or review existing medication. The choice of drug should be influenced by the same criteria recommended for starting treatment (see sections 1.3.5 and 1.3.6). Take into account the clinical response and side effects of the service user's current and previous medication.	Yes.
Psychological interventions	
Offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. Deliver CBT as described in recommendation 1.3.7.1	Psychological interventions were offered however Miss A did not engage. It is not clear that this would include CBT.
Offer family intervention to families of people with psychosis or schizophrenia who live with or are in close contact with the service user. Deliver family intervention as described in recommendation 1.3.7.2	Partial. Family meetings were mentioned as being set up however it is not evident that they took place.

Consider offering arts therapies to assist in promoting recovery, particularly in people with negative symptoms.	Yes. Creative activities were offered to Miss A including art therapy on the ward and/or as a future option in 2016. Occupational therapy as part of a recovery plan was also offered when she was an inpatient in 2018 however, she would not engage.
Pharmacological interventions	
The choice of drug should be influenced by the same criteria recommended for starting treatment.	No.
Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication).	Yes. Miss A was prescribed risperidone and aripiprazole together from January to November 2017. After this olanzapine was also added, however this was to manage the change-over to olanzapine alone in January 2018.
Review antipsychotic medication annually, including observed benefits and any side effects.	Yes.
Consider offering depot/long-acting injectable antipsychotic medication to people with psychosis or schizophrenia: • who would prefer such treatment after an acute episode • where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan.	Partial. This was discussed but not followed through for reasons of Miss A apparently not wishing to pursue and because the consultant did not think it would make a difference in terms of her mental state.
Using depot/long-acting injectable antipsychotic medication	
When initiating depot/long-acting injectable antipsychotic medication: • take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and organisational procedures (for example, home visits and location of clinics)	No.

• take into account the same criteria recommended for the use of oral antipsychotic medication (see sections 1.3.5 and 1.3.6), particularly in relation to the risks and benefits of the drug regimen • initially use a small test dose as set out in the BNF.[72]	
Employment, education, and occupational activities	
Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.	Yes. Miss A was encouraged in her employment goals which was working with dogs.
Routinely record the daytime activities of people with psychosis or schizophrenia in their care plans, including occupational outcomes.	Yes.
Recovery	
Consider intensive case management for people with psychosis or schizophrenia who are likely to disengage from treatment or services.	Partial. This was considered although the minimal records regarding this indicate that she did not meet the criteria for intensive case management, without any further information or explanation as to why. Given her history this would appear to be erroneous. Service changes at the time may have had an impact in that intensive case management was being subsumed within the CTTs at the time and waiting lists were long.
Interventions for people whose illness has not responded adequately to treatment	
Review the diagnosis.	Yes. However, this needs to be seen in the context of Miss A being on the psychosis care pathway but with uncertainty about her diagnosis. This may have led to decisions being made about her care and treatment that were not in line with NICE guidance for psychosis and schizophrenia.

Establish that there has been adherence to antipsychotic medication, prescribed at an adequate dose and for the correct duration.	Not evident.
Review engagement with and use of psychological treatments and ensure that these have been offered according to this guideline. If family intervention has been undertaken suggest CBT; if CBT has been undertaken suggest family intervention for people in close contact with their families.	Not evident.
Consider other causes of non-response, such as comorbid substance misuse (including alcohol), the concurrent use of other prescribed medication or physical illness.	Yes. Comorbid substance misuse was considered.
Offer clozapine to people with schizophrenia whose illness had not responded adequately to treatment despite the sequential use of adequate doses of at least two different antipsychotic drugs. At least one of the drugs should be a non-clozapine second-generation antipsychotic	No.

Diagnosis and medication

Date	Medication	Diagnosis	Comment
Jan/Feb/17	Risperidone 2 mgs at night, mirtazapine 30 mgs at night, aripiprazole 10 mgs for a week then 15 mgs.	January 2015 - F319 - Bipolar affective disorder, unspecified. July 2016 - F29.X - Unspecified nonorganic psychosis. March 2016 - F22.0 - Delusional disorder; July 2016 - F11.1 - Mental and behavioural disorders due to use of opioids/harmful use.	Aripiprazole added. No consideration at this point of a depot or clozapine. Working to engage with Miss A regarding her medication and compliance.

[72] *British National Formulary.* https://bnf.nice.org.uk/

1/11/17	Risperidone 2 mgs changed to olanzapine 5 mgs sertraline 50 mgs.		
20/1/18	Olanzapine 10mgs, sertraline 100mgs.		Miss A started feeling that olanzapine was not working in January 2018. Olanzapine and sertraline increased. In view of the limited response to the prescribed dose of olanzapine, the dose could have been increased to a maximum dose of 20 mgs/day.
13/1/18	Olanzapine 10 mgs am, sertraline 100 mgs am.		
23/4/18	Olanzapine changed to at night rather than a am dose.		
1/5/18	A depot was considered.	F19.5 - Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances/psychotic disorder; F31.9 - Bipolar affective disorder, unspecified.	
21/5/18	A depot was no longer being explored.		
4/6/18	Olanzapine 15 mgs at night, sertraline 100 mgs am.		
20/9/18	Olanzapine 15 mgs at night.	Difficulties seen as primarily social, personality issues.	Records indicate she did not think this was working.

Appendix F – ICD 10 diagnostic criteria for schizophrenia

The normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear-cut) belonging to any one of the groups listed as (a) to (d) above, or symptoms from at least two of the groups referred to as (e) to (h), should have been clearly present for most of the time during a period of 1 month or more.

Symptoms	
a	thought echo, thought insertion or withdrawal, and thought broadcasting;
b	delusions of control, influence, or passivity, clearly referred to body or limb movements, or specific thoughts, actions, or sensations; delusional perception;
c	hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;
d	persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities.
e	persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear affective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;
f	breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;
g	catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;
h	"negative" symptoms such as marked apathy, paucity of speech, and blunting or
i	incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication
j	a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

Appendix G – Professionals interviewed

Role and organisation	
Northumberland County Council	Strategic Safeguarding Manager
	General Manager Adult Social Care
	Domestic Abuse and Sexual Violence Coordinator
North Tyneside Council	Domestic Abuse and Sexual Violence Coordinator
Nottinghamshire NHS Foundation Trust	Consultant Forensic Psychiatrist
	Forensic Social Worker
Bernicia Homes	Head of Housing
CNTW	Investigating Officer
	Inpatient Consultant Psychiatrist
	Community Consultant Psychiatrists
	Care Coordinators
	CTT Managers
	Clinical Lead - psychosis pathway
	EIP lead consultant psychiatrist and care coordinator

Appendix H – Table of abbreviations

ACN	Adult Come to Notice
AMHP	Approved Mental Health Professional
ASC	Adult Social Care
BNF	British National Formulary
CA	Clinical Advisor
CAIS	community assessment and intervention service
CAMHS	child and adolescent mental health service
CCO	Care Coordinator
CCG	Clinical commissioning group
CCR	coordinated community response
CNACTT	Central Northumberland Adult Community Treatment Team
CNTW	Cumbria, Northumberland, Tyne and Wear Community Mental Health Services
CPA	Care Programme Approach
CPS	Criminal Prosecution Service
CRT	crisis resolution team
CSP	Community Safety Partnership
CTO	community treatment order
CTT	Community Treatment Team
DAHA	Domestic Abuse Housing Alliance
DASH	Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment
DHR	Domestic Homicide Review
DVPO	Domestic Violence Protection Order
DVPN	Domestic Violence Protection Notice
ED	Emergency Department
EIP	Early Intervention in Psychosis team
EDT	Emergency Duty Team
FACE	Functional Analysis of Care environments
ICD 10	International Classification of Diseases version 10
IDVA	Independent Domestic Violence Advisor
IMHA	Independent Mental Health Advocate IMHA
IRT	Initial Response Team
IO	Investigating Officer
IMR	Individual Management Review
MARAC	Multiagency Risk Assessment Conference
MAPPA	Multi Agency Public Protection Arrangements
MASH	Multi-Agency Safeguarding Hub
MDT	Multidisciplinary Team
MHA	Mental Health Act
NEAS	North East Ambulance Services
NICE	National Institute for Health and Care Excellence
NSECH	Northumbria Specialist Emergency Care Hospital
ONS	Office for National Statistics

PICU	Psychiatric Intensive Care Unit
PNC	Police National Computer
PVP	Protecting Vulnerable People
RC	Responsible Clinician
RiO	Trust electronic record system
RARA	remove, avoid, reduce, accept
SAPP	Safeguarding and Public Protection