Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 28th February 2018

Title and Author of Paper: Domestic Homicide Review "Sarah", Jan Grey, Associate Director Safer Care

Executive Lead: Gary O'Hare, Executive Director of Nursing & Chief Operating Officer

Paper for Debate, Decision or Information: Information

Key Points to Note:

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. The purpose of a DHR is to:

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

This paper provides a brief overview of the Domestic Homicide Review in Northumberland for Sarah, including; NTW involvement with the perpetrator, investigations undertaken, findings and lessons learned for the organisation.

The incident took place in 2015 and was subject to the Trust parallel SI investigation undertaken by Independent Investigators and the internal SI panel reviewed the report in 2016, ahead of publication on the 8th February 2018.

The DHR was commissioned in 2016 by the Northumberland Domestic Homicide Review Panel on behalf of the Safer Community Partnership. The draft has been subject to Home Office routine approval but has been with the Home Office for 12 months which is unprecedented. The DHR Panel which is local authority led published the findings on the 8th February 2018.

Risks Highlighted to Board: Potential media interest and reputational damage.

Does this affect any Board Assurance Framework/Corporate Risks? Please state No

Equal Opportunities, Legal and Other Implications:

Outcome Required: The Board of Directors are asked to note the content of this report for information and discussion.

Link to Policies and Strategies: Home Office Guidance Domestic Homicide Reviews 2013

Domestic Homicide Review 'Sarah'

Background to the investigation

This Domestic Homicide Review relates to the death of 'Sarah' (aged 45), who was killed in November 2015. On the day of the homicide a member of the public contacted Northumbria Police stating they had come across a young male 'Michael' aged 16 who stated that he had killed his mother. Northumbria Police attended the address and found his mother dead with multiple stab wounds.

The criminal investigation concluded in April 2016 and Michael pleaded guilty to Manslaughter. It was accepted that Michael was not fit to stand trial due to his mental health, but that he was competent to enter a plea.

NTW Involvement

Michael's involvement began in August 2005 at the age of five, since then he had numerous assessments for ADHD, ASD, LD and was formally diagnosed in 2010 some years later with ADHD and LD. He was treated predominantly for diagnosis of ADHD / ASD via a number of clinical staff but most latterly monitored via medical reviews within ADHD clinic appointments. In 2015 he was assessed as having an emerging presentation of psychosis leading up to the incident with increased levels of aggression towards his mother and challenging behaviour. Post incident Michael was an inpatient in a medium secure CYPS ward where he resided until late 2017 where he has moved to an out of area Adult Medium Secure Ward.

Investigations undertaken

An Independent SI review was commissioned by NTW and was completed in March 2016. NTW SI Review Panel took place on 14th April 2016.

The Home Office Domestic Homicide Review was commissioned in December 2015 by Safer Northumberland Partnership. A NTW DHR Individual Management Review (single agency) was completed by the Head of Safeguarding and Public Protection.

In parallel NHS England, North commissioned Niche Health and Social Care Consulting to carry out an independent investigation into the care and treatment of a mental health service user Michael by Northumberland Tyne & Wear NHS Foundation Trust (NTW), commencing in May 2016. The terms of reference were set by NHS England North and agreed by Safer Northumberland Partnership.

The multi-agency Independent DHR report was submitted to the Home Office in July 2016.

Findings

The DHR found weaknesses across all partner agencies, however there were specific weaknesses in NTW CYPS service in respect of care and treatment to Michael.

- Specifically, he was not receiving appropriate interventions for his psychosis for example specialist early intervention in psychosis services which would have provided a holistic assessment of his needs and risks and appropriate management plans, including inpatient care, if needed.

- There were prescribing variances i.e. Michael was prescribed a low dose of antipsychotic medication that had not been titrated against symptoms as well as being prescribed a medication that was prescribed above manufacturer's recommendations that may have worsened his psychotic symptoms. His medication was not being monitored in accordance with NICE guidelines.

- Michaels care was not coordinated and he was not provided with an appropriate care plan.

- His family were not adequately involved in care planning and risk management. Crucially, risk information, including threats, aggression and violence towards his mother and family members was not properly recorded or acted upon.

- On that basis the SI Investigation, the NTW IMR and the Niche Independent Investigation concluded that the incident was both predictable and preventable.

Lessons Learned

The DHR highlighted lessons learned across all agencies involved with Michael and his mother. Each have submitted individual action plans. The most significant Multi Agency action relates to the lack of a defined Pathway for Domestic Violence perpetrated from child to adult. We have highlighted that this is a National issue and this has received attention from the Police and Crime Commissioner as an area which requires action. All training and Policies have been updated and delivered to reflect the need to focus on Children as perpetrators where there is significant behavioural disturbance too

NTW specific recommendations were in respect of: Care & Treatment, Assessment & Management of Risk, Parents Needs/Think family, Pharmacology, Post Incident Family Contact, Duty of Candour, Multi Agency Working, Safeguarding and Public Protection and Supervision.

All recommendations have been rolled out across CYPS services and associated action plans have been completed. Individual Personal Development plans were implemented for 2 staff members one of which was a locum and sessions ceased and the other retired from the organisation

Four further audits are currently underway to provide assurance that the completed actions are embedded in practice.

DHR next steps

The Home Office Quality Assurance panel reviewed the DHR in August 17 and provided a response to the Chair of Safer Northumberland Partnership Board in October 17 with an apology for the delay in reviewing the report. The Panel concluded it was a well written, powerful review in which the family's views were sensitively presented.

The DHR panel subsequently met on two occasions, the first to acknowledge the letter and the second to consider the Executive Summary for publication on the Safer Northumberland Partnership website.

The Executive Summary was published on the Safer Northumberland Partnership website on the 8th February 2018.

The Executive Medical Director met with family members prior to publication of the report.

Jan Grey,
Associate Director Safer Care