Independent review of the care and treatment of Mr G between 2014 and 2019

Extended Executive Summary for Publication

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The effective investigations company

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Acknowledgements and author's note

Following a conversation with the victim's mother and father, the report author was left with the conviction that their daughter would have wished for her full name to be revealed in this report. This was initially agreed on. However, the service user involved is now diagnosed with a severe mental health disorder and does not want his name used anywhere. This means it is not possible to state the victim's name in full in this report, as any Google search would reveal the identity of the mental health service user. The shortened name of the victim – Beth – is used. The service user is referred to as Mr G.

This review would not have been possible without the input and/or the support of the following:

- the parents of Beth
- several individuals close to Beth
- the advocate for Beth's parents
- the perpetrator of the attack that led to Beth's death, Mr G, and his current forensic care team
- the sisters of the perpetrator and two of his friends
- mental health professionals who had care contacts with Mr G between 2015 and 2019 and who provided information to the NHS England-appointed independent review team
- two mental health professionals involved in developing a specific personality disorder pathway in the trust who were responsible for Mr G at the time but had no contact with him between 2015 and 2019
- two senior managers within the trust who provided the independent review team with a range of information as and when it was requested
- the Chair of the Domestic Homicide Review panel commissioned by Kirklees Community Safety Partnership and panel members from all agencies involved in that review process, who each contributed their own assessment of their agency's involvement in the form of management reviews, which were available to the author of this report.

The independent review team were:

Maria Dineen – Director of Consequence UK Ltd
Dr Mark Potter – Consultant Psychiatrist, adults of working age
Sue Timms – Matron in community mental health services, adults of working age
Damien Kealy – Experienced mental health nurse, in intensive home treatment, and low secure forensic services. Currently service manager in community forensic services.

The reason why an extended executive summary only is being published:

The primary purpose of the independent review process commissioned by NHS England – North Region is to achieve:

- an objective and constructive analysis of the care and management of Mr G who was the mental health service user accused and then convicted of manslaughter by reason of diminished responsibility following the death of Beth.
- Insights that inform the necessity of learning lessons that can be translated into grounded patient safety improvement plans which deliver measurable outcomes of improvement

In this case, the full report contains much more detail than is required to be placed in the public domain. Its depth and breadth are such that it is unlikely that many readers would take the time to read in full, thus thwarting the overall purpose of the report. That is to drive necessary improvement in practice and process.

The full report is available on direct application via: england.ney-investigations@nhs.net to individuals and organisations for whom reading the full content will benefit internal learning and improvement

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Executive summary

This executive summary sets out the key issues emerging from the independent review of the mental health care and management of Mr G, who was convicted of the manslaughter of Beth in September 2019. She died following an unprovoked knife attack carried out by Mr G.

Before setting down key elements of this report, the independent review team express their condolences to the parents of Beth for the loss of their daughter under such tragic and shocking circumstances. It is important to acknowledge here that the attack was unprovoked and shocked an entire community. Everyone who knew Beth and Mr G was aware of his mental health issues. Following Beth's death, it has become clear that she was concerned, along with friends close to her, that Mr G posed a physical threat to her. A friend reported to this independent review that "one of our last conversations was that [Beth] would become another statistic, of yet another woman killed by her ex-partner". It is not within the scope of this independent process to explore how and why the concerns of near friends and family were either not communicated to, or not heard by, the range of agencies designed to take heed and act on such levels of concern.

The purpose of this independent review was to examine constructively and critically Mr G's mental health management from the time of his GP referral in 2014 to the time of Beth's death and the immediate post-incident assessment in the police cells in September 2019. This is the period agreed by NHS England, the Chair of the Domestic Homicide Review panel, involved agencies, the report author and the advocate for Beth's mother, given that Mr G was referred to local mental health services in 2014 and did not have a notable adult mental health history elsewhere.

Core elements included in the review are:

- Mr G's diagnosis of emotionally unstable personality disorder (EUPD)
- the quality of risk assessments conducted and their associated risk management plans
- Mr G's medication management
- whether or not the mental health service was aware of any domestic abuse risk posed by Mr G and/or domestic abuse issues in relation to him and Beth, and whether it acted on this knowledge
- the extent to which Mr G's family and friends, who acted in a friend/carer capacity, were engaged by the mental health service as partners in his care.

A core purpose of the review process is to deliver a report that facilitates learning and change by identifying necessary improvements in practice, process, quality and safety.

Finally, the independent review was asked to conclude regarding the predictability and preventability of the tragedy that occurred on 12 September 2019.

Conclusion
There were many elements of Mr G's care and management between 2014 and 2019 that met and, at times, exceeded reasonable expectations. However, there are also elements that could and should have been different. The most contentious element is Mr G's diagnosis. The mental health professionals involved do not accept that they missed a diagnosis of psychosis in addition to his EUPD. However, the independent team, based on the evidence it has seen and heard, considers that more careful consideration should have been given to Mr G's presentation and thus diagnosis. There are repeated examples in Mr G's clinical records that are suggestive of psychosis, notably the voice Osiris. Furthermore, information provided by Beth before her death, as well as by one of Mr G's friends, and concerns noted by the probation service in 2015 and 2016 also suggest psychotic elements to his presentation.

Had Mr G received a diagnosis of psychosis during the early period of his contact with adult mental health services, it is difficult to know how that may have impacted on the sequence of events. It is reasonable to conclude that Mr G may have been placed on the enhanced care pathway, making him subject to the Care Programme Approach. This would have resulted in more effective multidisciplinary reviews, longitudinal assessments, and further consideration of his medication management in line with NICE guidance.

The lack of contemplation of an additional diagnosis for Mr G was a significant missed opportunity that may have altered the chronology. Whether this altered chronology would have prevented Beth's tragic death will forever remain a matter of speculation.

The reasons the independent team cannot conclude with any certainty that Beth's death would have been preventable by modifications to Mr G's clinical assessment and management are:

- Mr G was never fully compliant with his prescribed medication and refused to tolerate the relatively mild side effects of the antipsychotics he was being prescribed. It is unlikely therefore that he would have been compliant with medicines that delivered more noticeable side effects.
- At no point was Mr G assessed as lacking capacity.
- At no point between 2014 and September 2019 was Mr G assessed as requiring detention under the Mental Health Act (1983). He was assessed with a view to detention in August 2019, but the outcome of that assessment was that he was not detainable. Therefore, there was no scope to mandate and enforce treatment. This situation prevailed in the immediate aftermath of Beth's death.

Although the independent consultant psychiatrist has reservations regarding the mental health assessment of Mr G after his attack on Beth, Mr G was assessed in the police cells immediately after Beth's death by two mental health professionals, one of whom was an approved mental health practitioner. He was not considered psychotic and was considered fit to remain in police custody and fit for interview. This assessment therefore must stand. Furthermore, Mr G remained in custody for a month before consideration was given to a possible diagnosis of schizophrenia and the need for him to be cared for in a secure facility.

Regarding the assessment of Mr G's risks, although this was mostly in keeping with the expected local and national standards, there were two elements that deviated. These were in relation to Mr G's domestic abusive behaviour and his decision to carry a knife on his person.

Regarding the issue of keeping a knife nearby for self-protection, there was insufficient violent behaviour in Mr G's history for him to have been assessed as posing a high risk of harm to others. He had no convictions and no forensic history. The only reference to Mr G having a knife in a public place was on 12 September 2019, when he was threatening to harm himself, and had it to his own throat following a police car chase. Although the risk assessment documentation could and should have been more complete, the independent team is satisfied that Mr G's main healthcare professional was aware that Mr G reported hiding a knife at home and he had spoken with, and counselled, Mr G about this risky behaviour. Accepting that keeping a knife near to hand at home is risky behaviour, the independent team does not consider that mental health services could have predicted that Mr G posed a threat to Beth's life. He did not have a history of planning and carrying out acts of physical harm to others. That he is reported to have specifically purchased the weapon used to attack Beth, lain in wait for her and pursued her while she tried to escape has shocked an entire community, including the mental health professionals involved. This act was not predictable based on what was known and understood about him.

Mr G's past abusive behaviour, however, was a different matter. The lack of integration of what was known and what should have been known about Mr G's abusive behaviours towards an ex-girlfriend in 2015 was a serious miss in his risk profile and represents a serious miss in risk management planning and mitigation. It is not possible to say that had this happened, Beth would not have died as she did. However, better risk management practice in respect of domestic abuse presents the most tangible opportunity for a different narrative and therefore the potential for incident avoidance.

After the assessment of Mr G on 15 August 2019 and the Mental Health Act report compiled following this, which determined he was not detainable under the Mental Health Act, the mental health service had a clear duty of care to Beth given the domestic abuse risk Mr G posed to her. This duty encompassed:

- a duty to inform either Beth or another agency about the risk concern
- a duty to counsel Mr G about his behaviour towards Beth, her friends and her family when it was known that his and Beth's relationship had ended, and when he was articulating aggression including violence towards them
- a duty to try to achieve more complete information about any concerning behaviours that may have indicated domestic abuse was, or was becoming, an issue.

Although Mr G was counselled by his health professional about his threatening behaviours, and he was advised to go to the police to set down his own account, following a complaint about him made by Beth, these actions were not taken because of any domestic abuse awareness or concern. There was no situational

awareness in the mental health team of this risk. Therefore, they did not deliver their duty of care to Beth.

As above, it is not possible to determine the potential impact had any of these duties been delivered. However, it is reasonable to suggest that one possible consequence may have been the avoidance of the incident leading to Beth's death, or a mitigation of it.

Recommendations

The independent team is encouraged that the trust has already embarked on a substantial redesign of its approach to risk assessment. Its new approach has been piloted and has received significant support from senior clinicians across the trust. The new approach will help the trust overcome weaknesses in its historical approach, which has attracted criticism in previous independent reports. The trust is also committed to its development of a high-quality personality disorder pathway. Such a pathway would have applied to Mr G. The changes implemented and underway will reduce the likelihood of the modifiable factors in this case being repeated.

The recommendations by the independent team are intended to support the trust in the continuance of these activities and to ensure that they are complete so far as is reasonably practicable.

Recommendation 1: Learning event

The Director of Nursing and Quality at the trust is tasked with organising and facilitating an Oxford Model[1] learning event to ensure that the widest reflection and learning is achieved across adult services from this case.

Recommendation 2: The Care Programme Approach and care pathways

1: The trust must determine the extent to which there is a gap in service provision for those service users meeting Care Programme Approach criteria, to ensure that it is aware of its risk management position in relation to this gap, and to have a clear plan for mitigating its impact.

2: For all service users identified as meeting Care Programme Approach criteria, the trust must ensure that there is an auditable and defendable approach to determining which of them are accepted onto the Care Programme Approach as a matter of priority once capacity is released.

3: The trust has implemented a complex case forum, and other initiatives, for service users who may meet the threshold for enhanced care but cannot be accommodated on the enhanced care pathway, as well as service users who are presenting as more complex than the Core team can accommodate. The trust must audit the usage and effectiveness of the safety nets provided and provide assurance that the avenues to achieve a more enhanced and intensive package of support are being used as

[1] https://www.cambridge.org/core/journals/psychiatric-bulletin/article/six-years-experience-in-oxford/74A72AD39CBD0AC2F4A0958EF7059EDF

intended and to identify those service users for whom an enhanced care package must be achieved.

4: Where it is identified clinically that enhanced care must be delivered to a service user and the range of safety nets is not sufficient to deliver an effective or safe package of care, there must be tangible and measurable steps in the care pathway design to enable this to be escalated via the trust's risk/patient safety committees and brought to the attention of the commissioners.

5: The trust board should receive quarterly reports detailing the number of adult service users who meet the threshold for the Care Programme Approach but are not receiving this level of care package and explaining why not. Assurance regarding the delivery of safe and effective care will also be required.

Recommendation 3: Risk assessment
The development team for the trust's revised approach to risk assessment and the trust's Safeguarding Lead are tasked with ensuring that:

1: The revised FIRM model facilitates the consistent capture and consideration of information relating to the spectrum of domestic abuse (emotional, psychological, financial, physical). This must encompass risk posed by the service user to others, not only risks to the service user. Reasonable expectations are that assessed risk will include known episodes of police and/or probation involvement in relation to such behaviours. A reasonable expectation is that the risk assessment process will triangulate what a service user reveals with these agencies where it is clear that the service user has had contact/involvement with them.

2: Information captured via FIRM that highlights safeguarding concerns for adults, adults at risk and vulnerable adults, such as domestic abuse, should trigger a force-field alert for the assessing professional to consider whether a referral to adult safeguarding, or a domestic abuse agency, is necessary. If it is determined that no action is required, the system must require the professional to record their rationale for this.

Recommendation 4: Carer's assessments
A situation must be achieved where individuals/informal carers providing significant emotional, physical, or day-to-day living support to a service user are routinely offered a carer's assessment, and are provided with a carer's passport, by the team responsible for the care and management of the service user.

1 Introduction

On 12 September 2019, Beth was attending a local Irish club with two colleagues, one of whom was her current partner. They all worked for a company that provided musical services for people with disabilities and were putting on an event that evening. Beth was outside, unloading equipment from a vehicle, when Mr G (the mental health service user), Beth's previous boyfriend, approached her from a car park across the street. He had a kitchen-style knife and attacked her with it. Beth attempted to get away from him. However, she slipped, fell, and was subjected to a violent knife attack. She died of her injuries.

Because Mr G was being managed by adult mental health services at the time of Beth's death, NHS England commissioned an independent review of his mental health care and management, in line with NHS England's Serious Incident Framework (2015). It was agreed with the Chair of the Domestic Homicide Review (DHR) that the review report, or the Executive Summary, would be made available and be included as an appendix to the Domestic Homicide Review report. It was also agreed that the review report author would be a member of the Domestic Homicide Review panel and contribute to this process. Partnership working between NHS England, the report author and the DHR Chair had worked well in other cases where the perpetrator of a domestic homicide also had a significant mental health diagnosis.

Throughout the remainder of this report, the independent review team is referred to as the independent team.

1.1 This independent mental health review and its report

This review focuses on the mental health care and management of Mr G from the time he was referred to adult mental health services by his GP in 2014 to the day of Beth's death. It also includes the mental health assessment of him the following day.

The purpose of this independent review is to identify aspects of care that, if they had been done differently, may have altered the risk we now know Mr G posed to Beth and thus altered the outcome. The independent team was also alert to opportunities for improving other aspects of his management and/or the management of other service users, with a focus on reducing the risk of harm to others, where such opportunities materialised because of the review process.

It is the job of the wider Domestic Homicide Review to look at the role and responsibility of other agencies that had contact with Beth and Mr G, to identify any lessons that can be learned to prevent future domestic homicides.

The full report sets out:

- the approach taken to the review of the care and treatment of Mr G between 2014 and 2019, in line with the key questions posed in the agreed key lines of enquiry
- answers to questions posed by Beth's mother to the Chair of the Domestic Homicide Review panel and the independent team, in so far as they related to the mental health management of Mr G

- the considerations of the independent team in relation to the key lines of enquiry agreed by the Domestic Homicide Review panel, Beth's mother, her advocate and NHS England
- the overall conclusions of the independent team
- recommendations of the independent team to support improvements in practice, process, quality and safety within adult mental health services.

This extended executive summary makes clear the findings, conclusions and recommendations of the independent team, and information about the lessons learnt by the mental health trust involved, and the safety improvement interventions they have already committed to and commenced the implementation of.

So that this extended executive summary has the right context, a concise overview of Mr G, his healthcare, Beth, and her relationship with Mr G is set down below.

1.2 Mr G, a vignette

Mr G was an individual who had been troubled by mental health issues all his life.

What is clear from his own accounts and the accounts of others is that he often experienced extreme states of emotional distress, which triggered high-risk acts such as climbing onto bridges; thoughts and acts of hanging himself; and simply disappearing, telling no one where he was. This provoked high levels of anxiety in his friends, who would initiate searches for him and contact the police. Several relationships broke down because of this. However, prior to 2015, there was no information available to agencies that indicated he posed a domestic abuse risk to his female partners.

Mr G was, it seems, a private individual. It is now understood from a range of individuals who provided information to the report author that he withheld information from mental health services about his connections with his family, and the extent to which Beth provided support to him. This same range of informants also revealed that Mr G tended to paint a picture of events that did not always reveal the truth of a situation.

In terms of protective factors, an important coping mechanism for Mr G was music. He led a local band and had ambitions to make it in the music industry. His life appeared to have revolved around music.

Several individuals told the report author that although Mr G was known to be troubled and affected by mental health issues; his self-harming behaviours and erratic and obsessive personality were offset by good acts in the community and charitable work he undertook with others. These individuals reported him to be kind and willing to help.

However, a depth of information has been revealed by close acquaintances of Beth, following her death, about his behaviour that was not known by mental health services prior to it.

1.3 Beth and her relationship with Mr G

Beth's mother wrote the following about her daughter:

"Bethany touched people in a profoundly positive way, inspiring, lifting and boosting morale, self-esteem, by listening, motivating, and encouraging disadvantaged people to reach their full potential through music.

Bethany was a natural, genuine, honest, hardworking young woman, personable, graceful, dignified, humorous, of a high moral compass, wise beyond her years, yet modest and humble with the unique gift of naturally being able to intuitively sense a person's emotions (empathetic).

Bethany was charismatic, witty, fun, totally loveable, reliable, charitable, giving, loyal and protective. Such beauty and depth of heart and soul"

Other individuals confirmed this perspective of Beth.

In terms of her relationship with Mr G, Beth had known him via their shared enjoyment of music. The relationship between Mr G and Beth was a concern to her friends. Some of this concern related to Mr G's mental health diagnosis, some knowledge about the significant age gap between them. Despite these concerns Mr G and Beth progressed their relationship.

It is not the purpose of the independent process to set down an account of significant elements in Beth's life. Nor is it the purpose of the report to present a detailed account of what is now known publicly about her relationship with Mr G. This falls under the auspice of the Domestic Homicide Review report, to which this report will contribute. However, it is clear to the report author that Beth invested considerable time and energy in trying to support Mr G. She went on a course specifically aimed at persons who had a carer or support role for individuals with personality disorder. What is also clear to the report author is Beth did not always feel listened to by local mental health services. It is reported that Beth found the service to be inconsistent in terms of engaging with her, and this created an obstacle to proactive communication from her at the very time communication and alarm raising was needed. The information in Mr G's clinical record shows that Beth was a good advocate for him and raised several concerns about his presentation and a range of concerning behaviours. However, none of these concerns constituted abusive behaviour towards her. There was an incident where Mr G posed an accidental risk of harm to Beth. This involved him waving a knife around at home, and in her presence. However, there is no evidence at this time that he had any intent of harm towards her.

Regarding the weeks and months leading to her death, information provided to the report author confirms that Beth was aware that Mr G was acting in an abusive way towards her. She informed close friends about this and the police.

On 19 August 2019, four days after Mr G was assessed as not detainable under the Mental Health Act, and as having capacity, she filed a crime report against Mr G for harassment. The crime report included threats to harm/kill Beth's friends, family, and

colleagues. This behaviour spanned a near two-year period and had escalated, as expected, following the end of their relationship in June.

Because of the crime report Mr G's behaviour escalated in that he revealed personal electronic conversations between him and Beth to others, is reported to have tried to isolate her from her support network, and also targeted a long term friend of Beth's.

1.4 Mr G's contact with mental health services

Mr G had contact with mental health services as a child, but no substantive contact with adult mental health services until October 2014. This was initiated by his GP. At that time, Mr G was experiencing fleeting suicidal thoughts and paranoid and persecutory delusions. He was assessed within two weeks by an experienced mental health nurse. She considered that his presentation was more likely to be linked to the impact of his traumatic childhood than psychosis. The mental health assessment and the formulation made were discussed at a multi-professional team meeting. It was agreed that Mr G would benefit more from psychological therapies than from being taken onto the community mental health team caseload. Mr G was given an initial diagnosis of EUPD.

Mr G received his first clinical psychologist assessment on 13 March 2015. He continued to present as paranoid, and the psychologist suspected he was psychotic. The psychologist referred him, on the same day, for further assessment by the Intensive Home Treatment team. This team noted: "[Mr G] presenting with paranoid thoughts, possible auditory hallucinations and increasing thoughts about ending his life. [Mr G] has given consent for referral to [an Intensive Home Treatment team]. Initial [name] contact/assessment tomorrow (14.03.15); time to be arranged."

Following several assessments at home, and via telephone, Mr G attended for medical review on 17 March 2015. At this assessment, his diagnosis of EUPD was confirmed. The assessing doctor also recorded: "No perceptual abnormalities. Some thoughts of grandiosity. Well oriented in time, place and person."

Mr G was commenced on quetiapine[2] 100mg at night.

The Intensive Home Treatment team continued to visit Mr G at his home and follow up with him via telephone until 4 April 2015, when he was discharged from that caseload.

In May 2015, he attended the emergency department at his local hospital and was assessed by the Psychiatric Liaison team following several minor to moderate acts of self-harm. No follow-up was required.

Then, on 19 May 2015, the Intensive Home Treatment team received contact from the local police following an allegation of harassment about Mr G from his ex-partner. The police were concerned about Mr G, who appeared to be distressed and talking about suicide.

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[2] Quetiapine has anti-anxiety qualities alongside its antipsychotic effect.

Mr G was offered psychological therapies and initially agreed to this but did not then engage.

Through May and June, Mr G was regularly contacted by the Intensive Home Treatment team because of his suicidal ideation.

By 12 July 2015, he was feeling more settled and was placed on a higher dose of quetiapine. He was discharged from the Intensive Home Treatment team back to his community team.

The next date of note was 8 August 2015, when Mr G's care coordinator received a call from police advising that Mr G had been interviewed following an allegation of harassment made by his ex-girlfriend. The then care coordinator recorded:

> "Interviewed for harassment, (not arrested) re: behaviour towards his ex-girlfriend and [Mr G] has received a harassment warning (his ex-girlfriend has contacted [Mr G]. They have met up. Ex-girlfriend then terminated contact and [Mr G] has sent several abusive messages). No further action to be taken."[3]

The care coordinator contacted Mr G, who reported no thoughts of self-harm.

In the days immediately following, there were several records made of Mr G counter-accusing his ex-girlfriend of abuse.

On 28 August 2015, Mr G was detained, by the police, under section 136 of the Mental Health Act. He had been reported as a high risk missing by a friend. He was threatening to harm himself and had reported being upset about the allegations being made against him by an ex-girlfriend. He was also talking about an entity called Osiris. He had an assessment under the Mental Health Act at 1am on 29 August but did not meet the criteria for compulsory admission to hospital.

On 30 August 2015 Mr G requested admission to hospital. An informal admission was agreed. This happened the following day and he was discharged on 9 September 2015. He was then admitted again two days later and discharged on 25 September 2015.

On admission in September, the admitting doctor wrote: "31-year-old thin built Caucasian. Well kempt. Slightly over familiar. Speech was slightly pressured and animated. Mood was slightly elated out of context. There were some ideas of grandiosity about himself but no formal thought or perceptual disorder. He has good insight.

"Impression: Although he has diagnosis of EUPD but affective disorder (mixed affective) should be considered as well. [A first degree relative] had severe schizophrenia. The records record on several occasions no evidence of psychosis or thought disorder."

[3] This was the first opportunity for contemplating a review of Mr G's risk assessment in terms of risks towards others.

There are no further references to additional diagnoses or features of psychosis during this admission[4].

From this point forwards the voice of Osiris is a feature of Mr G's presentation. Contacts with Mr G between September and December 2015 focused on medication management and Mr G's threats of self-harm.

On 12 December 2015, he was issued a 12-month restraining order for 'non-violent harassment'[5]. At 4am the following morning, he reported being on a "knife edge" and police were requesting mental health input. Mr G was assessed the same day by the Intensive Home Treatment team, who recorded that he was well kempt, his concentration was intact and he had no evidence of psychosis. Mr G denied any risk to himself or others. The nurse also recorded a further discussion about Osiris and noted that Mr G had pleaded guilty in the recent court case against him. At this time, Mr G had stopped his medication but agreed to restart it.

Between December 2015 and 12 September 2019, Mr G continued with periods of relative stability, punctuated with periods of erratic behaviour. These were mostly characterised by reckless acts and threats of self-harm. However, from time to time, he acted in a bizarre way, and inappropriately to others. Examples of this are:

- 3 January 2016: The records show he had shouted at the manager of his place of work, who he believed was spying on him. The presence of Osiris was becoming more pronounced, as were his suggestions of suicide or threats to go out and harm someone, although he mentioned no one by name. He was tense, agitated and smiling inappropriately.
- 11 September 2017: Mr G was feeling increasingly paranoid at this time. The records report he stated he was also worrying about a benefits reassessment which was due towards the end of the year. Assessment notes show Mr G saying: "When my paranoia gets that high that's when I start attacking people." They also show that Mr G had been to an amusement venue with a friend where he stated he had become paranoid and had been shouting abuse at passers-by. He told an assessor: "I was shouting '[redacted]' at some people. Man, that's so uncool." This record also revealed that Mr G felt he was being observed, felt that something bad was going to happen and had reached the point where he was unable to tolerate the uncertainty anymore. He believed he had behaved in this manner in the hope of provoking something concrete.
- 9 January 2018: The patient record revealed that a telephone call was made from Mr G's house to the Intensive Home Treatment team at 12.45am asking for a member of staff to speak to him. Mr G spoke of thoughts he had of wanting to harm paedophiles. He was aggressive, shouting and swearing down the phone. At 3.30am four police officers brought him into A&E. Mr G had picked up a knife in the kitchen and had been threatening to go and kill a paedophile. He was assessed by Psychiatric Liaison. His girlfriend was sitting

[4] This was the first opportunity for the mental health service to have demonstrated a reasonable diagnostic approach. The lack of documentation means this cannot be confirmed. How clinical records are now made in an in-patient setting has changed and it is more likely that now a reasonable diagnostic process would be evidenced.

[5] This was the second missed opportunity to have updated the risk assessment regarding Mr G's risks towards others.

next to him. He had been drinking. The assessing nurse suggested some consideration should be given to removing his handcuffs. Mr G was noted to have stated that this would be OK providing that Osiris didn't make an appearance, describing this as some kind of 'alter ego'. Following discussion with the police, it was decided that it would be more appropriate for Mr G to be assessed in the section 136 suite. Mr G's girlfriend of six months accompanied Mr G to the 136 suite where he was described as pleasant, cheerful and chatty. However, he also expressed potentially delusional religious ideas and concerns about the current financial state of the NHS. He was subsequently discharged with Intensive Home Treatment team support. He left the 136 suite in a taxi with his girlfriend.

- 4 July 2018: Following his first break-up with Beth, the notes report that at a home visit with his lead healthcare professional, Mr G presented as: Orientated to time, place, person. His speech was appropriate in rate, tone, volume, content. There was no evidence of responding to unseen, unheard, stimuli. However, the record shows that, Mr G described panic attacks, intrusive thoughts and a voice, getting louder, telling him that he was going to die. He said that he had "been having to punch myself in the face and walk the street till 2am, my paranoia's huge", and he was experiencing stress from a voice in his head, which he reported caused him to "shout out inappropriate things to people in the street even if what he is shouting is something against his own beliefs or opinions".

Between July 2018 and April 2019 there were no serious incidents or high-risk behaviours demonstrated by Mr G that mental health services were aware of. This independent review was informed by a friend of Beth's that she had received a text from Beth in September 2018, reporting that Mr G was lying to his CPN about being fine, was not talking about his depression or his meltdowns, and felt useless. The same friend reported that over this time, she and Beth had to cancel various meetings because of the crisis points Mr G reached. In addition, although Beth contacted mental health services when Mr G was in crisis, which resulted in assessments of Mr G, she did not reveal his behaviours towards her. There are a range of reasons why she did not do this (as suggested by friends and acquaintances); however, these cannot be validated. They include a misplaced loyalty to Mr G, the need to preserve his relationship with his mental health team, and not always feeling listened to by the service.[6]

The records show that on 4 April 2019, Mr G felt his aggression was rising. He was off his medication and agreed to restart this to manage his aggressive feelings. Then, on 24 April 2019, Beth contacted the mental health service as she was concerned about him. The records report that Mr G told Beth he had heard a "voice" that morning and had been told he was a "special being" and that it was for him to determine whether the world is good or bad; he also needed to go out and hug 1,000

[6] **Author's note:** Notwithstanding the fact that mental health services could and should have been more proactive regarding the matter of domestic abuse, relapse indicators and a risk management plan, had Beth told them about Mr G's behaviour, it would have trigged a proactive risk management response by the service. What difference this would have made to the sequence of events cannot be guessed at. Beth alerted the police three weeks prior to her death; she had advised the right agency about her concerns regarding her own and others' safety.

people. She stated that she did not feel that he was an urgent threat at that moment; however, she felt his care team needed to be aware and requested someone contact him the next day. Contact did take place between Mr G and his lead health professional, but Mr G declined a home visit.

On 1 May 2019, during a home visit, Mr G reportedly called Beth and handed the phone to his lead health professional and left the room. The patient record shows that Beth explained Mr G had found out that a person whom he was close to and thought highly of did not like him. This had had a negative impact on him. The result was an increase in paranoia, a decrease in sleep and an increase in intrusive thoughts. Beth is noted to have stated that Mr G had been ringing her at 1am stating that he alone could determine the good and evil in the world and that he had to go out and either hug 1,000 people or murder 1,000 people. The record also says: "Beth stated Mr G had been seeing things in shadows and shapes on the wall and attempting to strangle the shapes as these appear to have been the faces of past abusers." According to the record, when Mr G returned to the room he agreed that this had been the case, but things had improved. At the end of this visit he reported that he had no suicidal or self-harm ideas. The plan was for Mr G to engage with the emotional stabilisation group, which he did on 7, 14 and 21 May 2019.

His next home visit from his lead health professional occurred on 22 May 2019.

17 June 2019[7]: Mr G rang the Intensive Home Treatment team at 9.45pm saying that he had a cable around his neck. When the nurse rang the police, they were already on their way to his address. Beth had broken up with him that day and rung the police to inform them that he was making threats to kill himself. The police liaison nurse reported speaking to him twice. Each time he was dismissive, abusive and personally offensive. It is noted that Mr G had opened the door to the police while he was on the phone. Mr G was taken to the local emergency department, where he was assessed. The records show Mr G mentioned that Osiris had been niggling him the past few days, telling him to significantly harm other people. He had not been taking his medication as prescribed and he provided conflicting information to assessors. However, he consistently maintained that he did not feel safe to go home. This situation changed by 5.30am and he was discharged home, recovering from excessive alcohol intake. Testimony from Beth's friends and family also revealed that Mr G had texted her twice as an inpatient – at six minutes after midnight and then at 1.30am – before his phone was removed from him.

On 18 and 19 June 2019, Mr G refused home visits.

On 20 June 2019, Beth again contacted the police who, in turn, notified the police liaison nurse. The records show Beth had reported that Mr G was under the influence of alcohol and cocaine in Halifax. He had left her, stating that he was

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[7] One of Beth's friends also reported that on 5 June 2019, Beth had tried to end her relationship with Mr G. His response was to send a message that an ambulance was on its way. Beth is reported to have contacted the Single Point of Access (SPA) to find out if Mr G was OK and if he had been detained. Because there was no consent to share information in place, no information could be provided to Beth. This, it is reported, was a persistent source of frustration to Beth, as sometimes she felt professionals perceived her as Mr G's carer and communicated with her as such, and at other times they did not.

suicidal. The police conducted a search of the town centre. In the early hours of the morning, police found Mr G and had allowed him to keep walking. They further reported that Beth had called them to say that she believed he was just “saying all the right things” and that she remained concerned.

Between 21 and 22 June 2019, attempts were made to contact Mr G, but these were unsuccessful. He, however, called the Intensive Home Treatment team in the early hours of 22 June 2019 and reported significant suicidal ideation. He self-presented at A&E. He subsequently agreed he was fit to go home and meet with his lead healthcare professional, which he did on 25 June 2019.

There were no significant events recorded between the end of June and 14 August 2019.

The independent team are aware from information shared after Beth’s death that there was a break in communications between Beth and a key friend and support person for her in July. This was triggered by Mr G’s behaviours, and the strong counsel of the friend that Beth should distance herself from Mr G, for her own well being. Further that mental health services should be made more aware about what was happening. Beth did not agree. The impression formed by Beth’s friend was that one of the reasons Mr G was not admitted in June 2019 was that Beth was perceived as a protective factor for Mr G. The perspective of friends and family at this time was that Beth felt “forced to be [Mr G’s] carer when they had broken up, and that he was controlling her and no one was helping”[8].

On 14 August 2019, at a medical review, Mr G reported that he had plans for his own suicide and had got his affairs in order. He claimed to have set up a noose in his garage and showed some suicide videos he had on his phone. He was calm and reasoned regarding his intent throughout the meeting. The psychiatrist noted that medication increase was discussed but was refused. Also noted was the need for a Mental Health Act assessment. Mr G was also assessed at home by his lead healthcare professional, who was equally concerned.

On the same day, Mr G contacted the Intensive Home Treatment team to report that his ex-partner had been telling people that he had hit her. He said he was annoyed about this claim and denied it. He said he felt angry and would like to take revenge but knew that he should not. He continued to vent his feelings and said that he planned to take his own life the following week.

On 15 August 2019 arrangements were made to assess Mr G under the Mental Health Act. The records show that on the same day, the facilitator from the music studio that Mr G used had contacted the Intensive Home Treatment team to report that Mr G had been asked to leave the studio due to threats and unpleasant behaviour towards others at the studio. They also reported that Mr G had stated that

[8] Although it is clear Beth was very supportive of Mr G, her relationship with him did not influence decisions regarding admission / non-admission to hospital. Mr G always at the point of assessment presented as not requiring assessment with a view to compulsory hospital admission. He was also assessed a having capacity to make his own decisions and choices. Admission to hospital is not always the right route. Support by the Intensive Home Treatment team can be better. This team provided Mr G with several episodes of support in the community.

he would kill himself. The record shows the music studio had also reported this to the police.

A section 12 approved doctor, an approved mental health practitioner and Mr G's lead health professional attended at his home to conduct the assessment. He was not there. The team established his whereabouts and then met with him to conduct the assessment. However, the records made it clear that Mr G's presentation to the section 12 doctor – the approved mental health practitioner – did not justify assessment under the Mental Health Act with a view to compulsory admission to hospital. It was very different to how he had presented to the previous consultant. A plan was made regarding contact with his lead health professional, the removal of the noose in his garage and recommencement of his medication.

On 18 August 2019, Mr G contacted the Intensive Home Treatment team reporting that he had made threats to Beth's new partner. The records show that he said that he had no intention of acting on the threat and had advised that if he did any harm, it would be to himself. He went on to say, however, that he had no plans to end his life.

On 19 August 2019, Mr G received a home visit from his lead health professional during which the occurrences over the previous few days were discussed. The discussion included an exchange over the police speaking to Mr G about his behaviours. Mr G also said that he had shared his life-ending thoughts with his daughter, who, according to the lead health professional's notes, had told him "in no uncertain terms what she thought of this given her current situation".

The record says: "[Mr G] stated he felt if [the allegations made against him] was taken further he would face a custodial sentence given his past record. [Mr G] stated he had past conviction for violence and had completed two years' probation for threats to kill following a conviction in 2013. I put it to [Mr G] that this was a difficult situation to advise on, I suggested that "legging it " as he had suggested was not addressing the consequences of his behaviour and that he needed to be available for his daughter at this important time . I suggested that the responsible thing to do would be to go to the police station and to give a statement to the police regarding the incident with the threats. [Mr G] accepted this and stated "I know I just needed to hear it from someone else." [Mr G] agreed this as a way to address the situation and confirmed he will attend a police station to give a statement.

On 20 August 2019, Mr G contacted his named healthcare professional reporting that he had received information that his ex-partner had raised safeguarding concerns about him and his friend who is disabled. He was advised to contact the police to make his own statement regarding the allegations. He stated there were no problems at present but that he wanted to record the fact that he had contacted the Community Mental Health team to report it. He was reminded of his appointment for the following week, which he confirmed he would attend[9].

[9] Also, the recommendation to make direct contact with the police was reasonable, this was a missed opportunity to enquire further about the safeguarding concerns raised, and to re-consider Mr G's past domestic abuse behaviours. Ideally given the level of concern around Mr G re harm to self, his past domestic abuse behaviour, and the fact he had recently broken up with Beth, communication between mental health

By 24 August 2019, Mr G was reporting he felt in crisis and wanted to end his life. Because of this, he was discussed at a multidisciplinary meeting on 27 August 2019. A note was made that an increase of medication had been recommended but refused by Mr G. His medication at that time was quetiapine 200mg nocte and 50mg twice daily. The records noted that this dosage would help if compliance was as prescribed. A further prescription for 20mg fluoxetine was also written to address Mr G's depression.

On the same day, at a home visit, the following was recorded: "Mr G presented less stressed than previous contacts but stated things had not gone well for him over the weekend. … He had decided to get away and give himself some space but had not given thought to how he did this or the effect he had on some others.

"He had posted his keys, wallet, and phone through next door's letterbox so that he wasn't tempted to spend more money than he needed, to look at his phone, and to prevent the police breaking the door down. He had not left a note. He did not realise that he had been reported as a missing person. The police had attended his daughter's room in [redacted] hospital. [3rd party information removed] Mr G was agreeable to the psychiatrist's suggestion of a course of anti-depressants (Fluoxetine 20mg). He had no thoughts of self-harm, no suicidal intent, and no current plans."

On 26 August 2019 A friend of Beth's reported, the police contacted Beth to see if Mr G had been in contact. The friend recalled that this caused significant stress to Beth, who later found out Mr G was in a police cell in [name].

On 2 and 3 September 2019 Mr G was not available for a scheduled visit. Phone contact occurred with him on 3 September 2019. Mr G was noted to have apologised for missing his appointment. This was rearranged as a home visit for 11 September 2019.

On 6 September 2019 Mr G attended A&E believing his drink had been spiked. The acute clinicians were concerned that Mr G lacked capacity, and that he may be having a psychotic episode. He was subsequently assessed by two mental health professionals from the psychiatric liaison team. When they arrived to assess him he was "lying on the sofa in the discharge lounge relaxed on our arrival and remain like that throughout [the] assessment"

The remainder of the mental health record says:
"[Mr G] spoke about wanting to end his life but clearly stated that he would not act on these thoughts due to his daughter. He spoke about the noose he had made and films that have previously been documented. He became more animated when he was discussing his ways that he has explored ending his life. [Mr G] stated that he felt that he was now coming down off the drugs that he had been spiked with. There was no evidence of any psychosis or agitation. [Mr G] presented as reactive in mood and was able to share humour. Speech rate and flow was normal. [Mr G] is adamant that he was spiked as he reports that he has never had a reaction like tonight from 4

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and the local police may have helped both agencies have a more complete understanding of what was happening.

pints. He said that he regularly sinks a lot more than this. [Mr G] felt that he is being well supported by mental health services and he is happy with his medication. He does not feel that there is anything more that can be offered to him. “

The plan was to inform Mr G’s care team of the assessment conducted, and to discharge Mr G home.

0n 9 September 2019 the social work team received a referral about Mr G from his lead professionals. The purpose was to seek support for Mr G in making social contacts following the breakdown of his relationship with Beth. However, the social work team no longer provided such a service.

On 11 September 2019, five days later, Mr G was not available for his scheduled home visit. No message had been received from Mr G. The plan was to send him a further appointment.

On 12 September 2019 the mental health service were informed about the fatal attack on Beth.

2 Terms of reference

The terms of reference (subsequently referred to as key lines of enquiry) and terms of engagement have been developed by Consequence UK in agreement with NHS England following the initial review of information provided by South West Yorkshire Partnership Foundation Trust and the information shared with Consequence UK by the mother of the deceased. The key lines of enquiry also meet the needs of the mandatory Domestic Homicide Review, which was undertaken in parallel with this NHS process. All agencies, including the Chair of the Domestic Homicide Review, are aware of the key lines of enquiry. Beth's mother, the service user Mr G and his family have also been involved in setting them.

Purpose of the investigation
The purpose of this independent process is to:

- identify whether there are lessons that can be learned to improve the delivery of safe, quality care
- identify whether there are lessons that can be learned in relation to the identification of, and amelioration of, domestic abuse risk, from the perspective of mental health care provision locally, regionally or nationally
- make recommendations to address any identified significant lapses in system, process or care so that the risk of recurrence is minimised.

Approach
The independent review process provides a constructive analysis of the perpetrator's (Mr G's) mental health care and management between 2014 and 2019. Any necessary variation to this scope has been agreed with NHS England and explained in this final report.

Consequence UK considered Mr G's care and treatment against relevant local and national guidelines and standards of practice to determine:

- aspects of care that met the required standards
- aspects of care and management which did not meet the required standards.

Where lapses were identified in the care and management of Mr G, the independent team considered these and determined their significance in terms of:

- the extent to which they impacted on the overall systems, approach and consistency of care standards within the services involved
- whether there is a contemporary threat to the ongoing safety of service users, carers and NHS staff if the lapses are not remedied
- whether any identified lapses contributed to the sequence of events that occurred between Beth and Mr G in the time leading up to her death
- formulating a view as to whether, had Mr G's care and management been different, the incident between Mr G and Beth might have been avoided.

The independent team considered the areas of specific interest to Beth's family, as well as to Mr G and his family. These are incorporated into the below and are set down in the appendices to this report. The key lines of enquiry are:

1. **Risk assessment:** To review the risk assessments of Mr G completed between 2014 and 2019, considering what was known or what should have been known about him by mental health services and whether his risk assessments were:
   - cognisant of Mr G's known behaviours and history
   - fully completed and compliant with the local and national standards at the time they were completed
   - reconsidered during periods of behavioural change, or past behaviour re-emergence, or any change in his personal circumstances
   - sensitive to any risk of harm Mr G posed to himself or others, be that physical or psychological harm (including controlling behaviour)
   - reasonably formulated in terms of the level of risk to which Mr G was assigned.

2. **Care planning and support:** To determine if Mr G's care plans set out the service and support needs required, assessing the reasonableness of their formulation and whether they were delivered as intended and reconsidered and reformulated as required.

3. **Drug and alcohol misuse:** To consider the extent to which Mr G's substance misuse problems were recognised and considered by his care team and whether this was reflected in his risk assessments and care plans.

4. **Personality disorder:** To consider the extent to which Mr G's diagnosis of personality disorder, between 2014 and 2019, was managed in line with expected standards of practice including those published by the National Institute for Health and Care Excellence.

5. **Carer and/or family involvement and engagement:** To consider the extent to which Mr G's family and/or carers were proactively engaged by mental health services. To consider how Mr G's family and/or carers were supported, and to determine whether they were offered a carer's assessment by the mental health service.

6. **Effective multidisciplinary team working:** To determine the effectiveness of multidisciplinary working across the teams delivering care to Mr G.

7. **Multi-agency working:** To consider the effectiveness of how information was shared with and by mental health services in relation to both Mr G and Beth where there was an identifiable need for this.

8. **Domestic abuse:** To consider the understanding of mental health service staff in relation to domestic abuse pre- and post-incident. To explore with the

mental health team(s) how this may, or may not, have impacted on aspects of their care and management of Mr G prior to the death of Beth.

3 Lessons learnt and improvements already committed to at the mental health trust

There are several areas the trust needs to reflect on, learn from, and improve. For some of these the Trust has already committed to a safety and practice improvement plan, which is underway. The below reflects those areas where the Trust is already undertaking it improvement work and areas for new or additional attention.

5.1 Mr G's diagnosis

The independent team is aware that Mr G's care team have found it difficult to equate the man they provided a service to over four years with the man who was convicted of manslaughter following Beth's death. It is also aware that the team have not agreed with the independent team on the matter of diagnosis.

Developments in the trust since Beth's death are therefore important. A major development has been the implementation of a Trauma Informed Personality Disorder pathway (TIPD pathway). The leaders of this pathway have informed the report author that:

"Anyone referred to secondary mental health services via our Single Point of Access (SPA) who has been assessed as having 'EUPD' or Complex Trauma alongside significant risk would be allocated to an Enhanced Team where the full [multidisciplinary team] will follow the new best practice pathway. The service user would be offered a biopsychosocial model of care including:

- the allocation of a Care Coordinator – with option of initial assessment for Dialectic Behavioural Therapy (DBT) or Structured Clinical Management (SCM)
- access to psychology
- access to OT [occupational therapy], including community rehabilitation OT
- access to psychiatrist."

Technically Mr G met these criteria.

Service users with a lower level of assessed need are referred to the core pathway (that is, the team Mr G was allocated to) with single practitioner support. The range of interventions available is not dissimilar:

- allocation of lead HCP – with option of assessment for DBT or SCM
- psychological therapy
- occupational therapy
- nursing intervention
- access, if required, to a psychiatrist
- recovery college
- Mental Health Act/Carer's assessment where relevant.

In the situation where enhanced care is required but is not available, for whatever reason, or where a service user allocated to the Core team is presenting as having more complex needs than were first assessed, the following safety nets are in place:

1. The Core team is able to make use of the Enhanced team's FACT response – a daily MDT/risk discussion and increased visits
2. Access to the Intensive Home Treatment team to manage short-term crisis

3. Rapid access to medical outpatients' appointments
4. Access to daily duty within the Core team to provide additional visits
5. Complex case discussion forum – MDT forum to formulate and manage complex risk.

Items 1 to 4 were available when Mr G was a service user of the Core team, and all these options were utilised. Item 5 is recently implemented. It is item 5 that brings the principle of multidisciplinary team review into focus and delivers the principle of the Enhanced team. Where necessary, based on the considerations of the complex case discussion forum, a recommendation for transfer to the Enhanced team can occur and/or the recommendation of the lead health professional is further supported.

The more focused and robust approach to supporting, assessing and caring for those with personality disorders, and the recognition of the important role of carers/family/friends in this, is a major development since 2019. It is an intervention that should result in the avoidance of the missed opportunities in Mr G's and Beth's narrative.

5.2 The transformation model of the Enhanced and Core teams

The transformation information provided to the independent team was detailed and the business case sets out how the trust envisaged the new service would work. There was a significant amount of data analysis indicating the service demands and resourcing along with a rationale for the new model. However, this review has demonstrated that the model was not as effective in practice as it was in theory. In particular:

1. The core pathway was intended predominantly for low-intensity patients who were graded as meeting the criteria for care cluster three/four. This represented service users who, more likely than not, would not require the services of this team after around 12 months[10]. A care cluster three patient is someone who has moderate problems involving depressed mood, anxiety or another disorder (not including psychosis). Mr G however met the criteria for care cluster eight, which is the highest care cluster for individuals with a non-psychotic diagnosis.[11]

The philosophy of the Core team was that individual need rather than their cluster level informed placement in this team. However, Mr G's case demonstrates that the Core team was dealing with more complex cases than it was designed for. Mr G's issues were permanent and enduring. He never achieved enough consistent stability to warrant a step down in his care cluster, or discharge from the Core team. Aside

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[10] **What are cluster levels:** In this context a cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool (MHCT). The clusters allow for a degree of variation in the combination and severity of rated needs. However, as the clusters are statistically underpinned, definite patterns in the MHCT ratings exist for each of them. These ranges are indicated by the colour-coded grids (Appendix 3) and are supplemented by the contextual information on the left-hand side of each page, which is particularly useful when reviewing the appropriateness of previous cluster allocations.

[11] Reference: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf

from the absence of the diagnosis of psychosis, there is no doubt in the mind of the report author that individuals who knew Mr G for over a decade in the community would have placed him in care cluster 10.

2. In practice, the allocation of resource between Core and Enhanced was not reasonable. Too much burden was placed on the Core team. The few patients allocated to the Enhanced team were getting a good service. This seems to have been at the expense of patients allocated to the Core team. This is especially so for those who met the criteria for enhanced care and needed the structure of an enhanced care pathway.

3. The transition document is clear that part of the intention of the model was to allow easy movement of patients up and down the pathway (that is, flowing between the Enhanced and Core teams). However, this did not happen. Enhanced was invariably at capacity, and therefore the Core team could not pass patients up to them. The impression gleaned was of a reluctance to present cases that required an enhanced model because of the certainty of case rejection. Although this knowledge should not have prevented Core team members from referring service users for consideration by the Enhanced team, the reality of working systems is that a low to no chance of success will result in adjustment behaviour over time, to accommodate the perceived hopelessness of making a referral.

4. The initial analysis in the business case was that there were a sizeable proportion of patients who did not need secondary care. The plan was that these were to be discharged, which would free up capacity. However, this required a significant culture change, and the winning of hearts and minds of the staff, particularly the medical staff who were holding large caseloads in outpatient clinics. We heard there was high resistance from the medical staff, who were not listened to. Further, the way the Core team was formulated brought together professionals whose cultures and established practices were different. This too needed time to evolve to enable optimal effectiveness in the new model.

The impact of the above was an ongoing workload in the Core team that was not envisaged, and service users who required management under enhanced CPA but did not receive this.

Although the Core team model has evolved to enable multidisciplinary review of complex patients, the independent team is uncertain as to the level of awareness at management level regarding:

- how many service users being managed by the Core team meet the criteria for enhanced CPA
- how many of those service users are receiving care, management and multidisciplinary reviews that meet the principles of enhanced CPA
- what the gap analysis reveals, and what the prevailing measurable risk is to:
    - the service users
    - the trust
    - the public.

5.3 The management of individuals who misuse drugs and/or alcohol

In this case, there is no information to support a determination that Mr G was either alcohol or drug dependent. However, there is considerable information to show that he had an unhealthy and damaging relationship with alcohol.

As a matter of course, mental health professionals must be aware of what range of help is available, and they should ensure that service users who have a relationship with drugs and/or alcohol that is negatively impacting on their life are provided with information about groups that are run by recovering addicts.

5.4 Trust-wide risk assessment approach

The risk assessment paperwork in use while Mr G was an adult mental health service user was unwieldy and unhelpfully prescriptive. It also did not address all the risk areas that might be of relevance to someone like Mr G. This observation has been made by other homicide reviews conducted in the trust.

Since Beth's death, the trust has changed its approach to risk assessment from the Sainsbury's model to a model called Formulation Informed Risk Management (FIRM), which was developed in 2013. The main reasons for this are the limitations of the Sainsbury's model.

The original implementation date was postponed because of the Covid pandemic. It is scheduled to go live across adult services on 28 September 2021. Training is underway to achieve this deadline.

The training for the trainers of the new approach underlined the following:

"We never know a person's risk for self-harm or violence; we merely estimate it assuming various conditions, for example:

- In hospital
- Discharge to community
- With or without treatment
- With or without supervision and support
- If abusing substances"

The training for trainers also underlined the risk continuum from 0 per cent to 100 per cent and qualitative descriptors that are often used to describe risk but may not be universally understood or consistently interpreted. For example, a risk might be probable, but what does that mean compared to there being a significant risk, or a severe risk, or a moderate risk, etc. What is made abundantly clear is the uncertain nature of risk assessment in the context of mental health and the fact that a health professional cannot precisely predict the outcome of individual events, or a sequence of events. This is important when reflecting on what happened to Beth and Mr G. The lens of effective risk assessment must be broadly focused, and well informed. A relevant but missing piece of an information jigsaw can have devastating consequences for effective risk assessment and contingency planning. That the trust's revised approach addresses such issues is welcome.

The report author understands that the trust's safeguarding team provided input into the development of the FIRM framework and questionnaire. The Current and

Historical Risks questionnaire was changed because of this to ensure safeguarding and domestic violence risks were highlighted. The report author has seen screenshots of the online forms that trust employees are expected to complete following assessment of risk. They represent a considerable improvement on the more-difficult-to-navigate Sainsbury's model, and domestic violence is now referenced in the section attending to risk of harm to others. Further, professionals also have links to a range of further risk assessment tools including the DASH[12] risk assessment. The report author asked the trust to further consider its wording around domestic abuse and the scope in its risk assessment process to capture domestic abuse behaviours. The Trust responded positively to concerns raised, and the risk document will now include a service users' risk of domestic abuse towards others, not only his/her vulnerability to experiencing abuse.

5.5 Interagency and third-party communication

The independent team appreciates that there are boundaries that must be maintained in terms of confidentiality, and that these considerations can sometimes hamper communications with other agencies. However, in this case, there was enough information provided by Mr G about what was happening regarding his ex-girlfriend (2015) – as well as notes that show awareness of the involvement of probation and its attempts to contact the mental health team – either for mental health services to have been fully informed about Mr G's behaviour towards that ex-girlfriend or for the mental health professionals to have proactively contacted probation so they were more accurately informed about what had happened and the issues they needed to be mindful of regarding risk assessment and risk management. As already highlighted in this report, that lack of interagency communication and information sharing was a significant miss in this case. A more robust approach is necessary, rather than relying on two professionals from two different agencies managing to simultaneously connect on the phone. There was intent to communicate in this case, and there were efforts made to communicate, but they did not deliver a successful communication. A challenge is to design an approach which more reliably delivers the necessary information to the right agency and in a reasonable time frame, and for that information to be assimilated into the overall understanding of the service user's care team and included in their risk assessment and their care management plan.

It is unlikely that one improvement intervention will fully address this challenge. Several interventions will be required. One is the availability of clearly defined and understood communication pathways between agencies, linked to (but not necessarily reliant on) a service user's risk assessment. Core information about a service user could also include a list of all agencies with whom they are in contact or have had recent contact and why. It is understood that the mental health professional is reliant on what the service user is prepared to reveal and what may have been revealed in the original referral to secondary mental health services. Optimising informant history, and making mental health services more accessible for concerned family and friends, may be one way a mental health team can be more situationally aware about the past and present context of a service user in their care.

[12] https://www.dashriskchecklist.co.uk/

5.6 Domestic abuse

The learning to derive from Beth's death in relation to domestic abuse is in part addressed in sections 5.4 and 5.5 This information is not repeated here. An additional avenue that may have resulted in Beth sharing information with Mr G's mental health team about the abuse taking place was via a carer's assessment, which could and should have been offered to Beth. On the balance of probability, it is more likely than not that had Beth been offered a carer's assessment, a connection would have been formed with the service and issues such as information sharing could have been discussed. Considering her contacts with other agencies in the weeks preceding her death, and what has been revealed by her close associates and family, it is conceivable that she would also have contacted mental health services with her concerns had such a connection been in place. This may not have changed the outcome, but it would have provided an opportunity for communication with and further assessment of Mr G by the mental health service.

5.7 Carers

The trust's senior management team agrees that Beth should have been offered an assessment, and it should have been recognised that she fulfilled a care and support role for Mr G. The trust's 'Family, Friends and Carers Commitment' makes the following three commitments:

- We will work with you as a partner.
- We will support you to get help and assistance when you need it.
- We will train our staff to be aware of carers' needs.

These commitments were not delivered to Beth. Furthermore, the trust knows it has further internal education work to undertake with its staff to ensure these principles are consistently delivered. Because of the Covid pandemic, the face-to-face training was placed on hold; however, an e-learning package, which was designed by Carers UK, is available to staff.

The trust is also promoting the Carer Passport, which was launched at the end of 2020. The purpose of the passport is to enable people in a caring role to keep close at hand a record of contact details for them and the person they care for, details of local help and support groups, and useful information. The passport was co-produced and co-designed with carers working alongside trust staff.

Carers' champions have also been recruited, and carers' groups are linked in with Carers Count[13].

Accepting that accuracy in record keeping is always challenging, the trust informed the report author that its record-keeping guidance already promotes recording the needs and views of identified carers, formal or informal, and how these have been taken into account. The reliability of how professionals incorporate such information is assessed via peer-review record-keeping audit. The report author has also been informed that the modern matrons and practice governance coaches also conduct dip-sample record-keeping audits as part of ongoing quality and assurance checks.

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[13] https://carerscount.org.uk/kirklees-mental-health-carers-forum.php

There is also a quantitative annual audit, which seeks to identify the reliability with which information about carers and their contributions is captured.

The trust has committed to including engagement with carers in its next service line learning event, which is scheduled for October 2021 with the Core team, and in a trust-wide learning event in November 2021.

4 Full list of recommendations

A question raised by Beth's friends and family, related to sanctions to be imposed on the mental health professionals involved in this case, because of the significant omission in the risk assessment of Mr G relating to domestic abuse.

The NHS has a strong commitment to a Just Culture, and not a blame culture. It is now recognised and accepted, that punishing staff for mistakes does not positively impact on the overall safety of patient care and does little to enhance clinical practice. Punishing staff for unintended mistake tends to inhibit learning and acts as a barrier to open reporting of mistakes.

However, it is reasonable to expect a culture of justifiable accountability, and to know that the employing organisation is doing the right things when it has been identified that there have been mistakes in care delivery and/or systems and processes supporting that care are not as robust, or complete as they could be.

To achieve consistent application of these principles the NHS has a Just Culture guide.[14]

The principles of this guide were applied to the omission in risk assessment practice in this case by the Trust, and by the author of this report. Because of this the Trust has already committed to a program of professional development and improvement, for the Core Team to which Mr G was allocated. The improvement programme focuses on domestic abuse and the Trust's new approach to risk assessment and team supervision.

Regarding the independent recommendations there are no individual professional performance monitoring or disciplinary recommendations. The:

- complexities of this case,
- the omission of domestic abuse as part of the Trust's risk assessment process (2014 – 2019)
- fact that more than one Trust professional omitted to identify and capture domestic abuse as a risk management issue
- excessive caseloads the Core Team were operating under
- lack of opportunity for multi-professional review of complex service users allocated to the Core Team, but who had more complex needs than the team was designed for
- lack of domestic abuse training
- unwieldiness of the Trust's risk management documentation (2014 – 2019),

means that singling out one or more individual practitioners is not the right thing to do. Neither is it in keeping with the NHS commitment to a safe learning and improvement culture.

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14 https://www.england.nhs.uk/wpcontent/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf

The independent team is encouraged that the trust has already embarked on a substantial redesign of its approach to risk assessment. Its new approach has been piloted and has received significant support from senior clinicians across the trust. The new approach will help the trust overcome weaknesses in its historical approach, which has attracted criticism in previous independent reports. The trust is also committed to its development of a high-quality personality disorder pathway. Such a pathway would have applied to Mr G. The changes implemented and underway will reduce the likelihood of the modifiable factors in this case being repeated.

The recommendations by the independent team are intended to support the trust in the continuance of these activities and to ensure that they are complete so far as is reasonably practicable.

Recommendation 1: Learning event
Directed to: The Director of Nursing and Quality at the trust

What is required:
To organise and facilitate an Oxford Model learning event[15] to ensure that the widest reflection and learning is achieved across adult services from this case. Key points to be drawn out are:

- management of complex service users with personality disorder(s), including psychosis, outside of the CPA framework
- domestic abuse
- multi-agency communication, information exchange and engagement
- carer engagement and support.

To achieve: Whole service learning following this independent process.

To reduce the risk of: The modifiable factors in the care and management of Mr G recurring.

Recommendation 2: The Care Programme Approach and care pathways
Directed to: The Director of Operations at the trust
This review has highlighted the fact that there are service users allocated to the Core team who meet the criteria for CPA and thus enhanced care. This was a contributory factor in Mr G not receiving longitudinal assessments and there thus being missed opportunities for reconsideration of his diagnosis.

What is required:
1: The trust must determine the extent to which there is a gap in service provision for those service users meeting Care Programme Approach criteria, to ensure that it is

[15] This is an organisation-wide learning event where services are invited to a presentation about what happened in this case, the key learning points and what must change because of it. Representatives from the attending services are asked to reflect and identify what elements are of specific relevance to their service and how they can take and implement the learning. This type of event can include representatives of the staff involved and advocates for the families involved, as well as representation from the team who undertook the learning investigation. Bringing all these elements together provides a powerful learning event.

aware of its risk management position in relation to this gap, and to have a clear plan for mitigating its impact.

2: For all service users identified as meeting Care Programme Approach criteria, the trust must ensure that there is an auditable and defendable approach to determining which of them are accepted onto the Care Programme Approach as a matter of priority once capacity is released.

3: The trust has implemented a complex case forum, and other initiatives, for service users who may meet the threshold for enhanced care but cannot be accommodated on the enhanced care pathway, as well as service users who are presenting as more complex than the Core team can accommodate. The trust must audit the usage and effectiveness of the safety nets provided and provide assurance that the avenues to achieve a more enhanced and intensive package of support are being used as intended and to identify those service users for whom an enhanced care package must be achieved.

4: Where it is identified clinically that enhanced care must be delivered to a service user and the range of safety nets is not sufficient to deliver an effective or safe package of care, there must be tangible and measurable steps in the care pathway design to enable this to be escalated via the trust's risk/patient safety committees and brought to the attention of the commissioners.

5: The trust board should receive quarterly reports detailing the number of adult service users who meet the threshold for the Care Programme Approach but are not receiving this intensity of care package and explaining why not. Assurance regarding the delivery of safe and effective care will also be required.

To achieve: A safe system of care.

To reduce the risk of: Not achieving:

- the full depth and breadth of diagnostic consideration
- effective multidisciplinary care management consideration and planning
- an appropriate level of case management supervision for a complex case such as Mr G's.

Recommendation 3: Risk assessment

Although the independent team was impressed by what it has seen of the trust's revised approach to risk assessment, it identified several possible omissions in the design of the form and the training content. These related to domestic abuse and safeguarding where the service user may pose a risk to others.

Directed to: The FIRM (risk assessment and management) development team

What is required 1: The revised FIRM model must facilitate the consistent capture and consideration of information relating to the spectrum of domestic abuse (emotional, psychological, financial, physical). This must encompass risk posed by the service user to others, not only risks to the service user. Reasonable expectations are that assessed risk will include known episodes of police and/or probation involvement in relation to such behaviours. A reasonable expectation is

that the risk assessment process will triangulate what a service user reveals with these agencies where it is clear that the service user has had contact/involvement with them.

What is required 2: Information captured via FIRM that highlights safeguarding concerns for vulnerable adults, such as domestic abuse, should trigger a force-field alert for the assessing professional to consider whether a referral to adult safeguarding, or a domestic abuse agency, is necessary. If it is determined that no action is required, the system must require the professional to record their rationale for this.

To achieve: The standard of situational awareness and professional response expected for harm minimisation in situations of domestic abuse both in terms of risk to a service user and risk posed by a service user, be that physical harm or psychological harm.

To reduce the risk of: The missed opportunities for harm minimisation and/or harm avoidance that occurred in the care and management of Mr G.

Recommendation 4: Carer's assessments
Directed to: Manager (Public Engagements Lead) Partnerships Team

What is required: A situation must be achieved where working/informal carers providing emotional, physical, or day-to-day living support to a service user are routinely offered a carer's assessment and are provided with a carer's passport, in line with the trust's Family, Friends and Carers Commitment.

To achieve: An avoidance of the situation Beth and others providing support to Mr G found themselves in – that is, not perceived as providing care support, not having their needs established, having no clear line of communication with the responsible care team, and having a lack of understanding about what it was reasonable to contact the care team about.

To reduce the risk of: The service user's care team being unaware of the depth and breadth of support being provided, as well as to reduce the risk of a care team not being aware of risk behaviours, escalation of these in the community and concerns held about the service user by non-professionals in the community.