niche
HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of Ms F in Cumbria, Northumberland, Tyne and Wear Foundation Trust

Executive Summary

August 2022

FINAL REPORT

Investigation Lead Partner: Nick Moor

Investigation team: Sue Denby, Lead Investigator, Dr John McKenna, Clinical Reviewer.

Draft report: May 2022

First published: December 2022

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our Final Report has been written in line with the terms of reference for an independent investigation into the mental health care and treatment of Ms F in Northumberland, Tyne and Wear NHS Foundation Trust (the Trust merged with North Cumbria mental health and learning disability services in October 2019 becoming Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust). This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date.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

This is a confidential report and is for the sole attention of the project sponsor. No other party may place any reliance whatsoever on this report as this report has not been written for their purpose. This report was commissioned by NHS England and NHS Improvement (North East and Yorkshire) and cannot be used or published without their permission. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final version of this report should be regarded as definitive.

Niche Health and Social Care Consulting Ltd
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Telephone: 0161 785 1000
Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

Contents

1 Executive summary 4

The Incident 4

Mental health history 4

Agency involvement 9

Conclusions about Ms F’s care and treatment 12

Serious incident investigation review 16

Recommendations 17

Appendix A – The Independent Investigation 19

1 Executive summary

The Incident

1.1 Ms F was arrested and held in custody for the offence of murder in March 2019. Her partner, Partner 4, had been found at Ms F's home with injuries not compatible with life. Ms F was taken to a local police station and assessed by Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW) Criminal Justice Liaison and Diversion Service. She was subsequently convicted of manslaughter and sentenced to 14 years in prison.

Mental health history

First adult referral - January 2010

1.2 Ms F was referred by her GP to the Northumberland Tyne and Wear NHS Foundation Trust (NTW) East Community Treatment Team (CTT) in January 2010 (NTW became CNTW in 2019). When the CTT contacted Ms F she said she did not require intervention as she had improved.

First admission - April 2010

1.3 Ms F was an informal patient in a local general hospital for 11 days in April 2010 after taking an impulsive overdose of an antidepressant (citalopram).[1] Ms F was discharged into new accommodation, provided with a seven day follow-up visit, and referred to the Home Treatment team (HTT).

1.4 Clinicians diagnosed Ms F as having experienced a moderate depressive episode, with a risk of impulsivity, and was at risk of domestic abuse at the hands of Partner 1.

May 2010 - December 2014

1.5 Ms F received HTT support between April and May 2010 following her discharge from hospital. Ms F told staff she had taken an injunction and restraining order out against Partner 1 due to long-term and ongoing domestic violence. Two Multi-Agency Risk Assessment Conferences (MARAC) during 2013 described Ms F as the perpetrator of high risk domestic violence in relation to her then partner.

1.6 Ms F had contact with Northumbria Police on two occasions in March and June 2013. Ms F was arrested for alleged breach of the peace, possible assault (Assault Occasioning Actual Bodily Harm, AOABH) of her new partner (Partner 2) and for breach of her bail conditions.

---

[1] Citalopram: https://bnf.nice.org.uk/drug/citalopram.html

1.7 Ms F was referred by her GP to the CTT in November 2013 following the break-up of her relationship with Partner 2. Ms F took an overdose of medication (which belonged to Partner 2) in December 2013 and was admitted to the intensive care unit (ICU) requiring intubation. Following discharge from ICU, Ms F was supported by the Crisis Team (CT) for 18 days and referred to the non-psychosis part of the CTT.

1.8 The National Probation Service (NPS) completed an OASys[2] assessment related to Ms F's earlier charge of AOABH three days after her discharge from hospital (see 1.6).

1.9 In April 2014 MARAC were again involved, identifying Ms F as a victim of domestic violence in relation to a family member, and as a perpetrator of domestic violence towards Partner 2.

1.10 Ms F was diagnosed with a moderately severe depressive episode with traits of Emotionally Unstable Personality Disorder (EUPD)[3] in November 2014. A referral was made to the Personality Disorder (PD) Hub and a joint CTT and PD Hub assessment took place in mid-December 2014.

January 2015 - February 2016

1.11 Ms F attended weekly sessions with the PD Hub between January 2015 and the end of February 2016.

1.12 Ms F was referred to the CT and taken on for home-based treatment in May 2015 following reports of her being tearful, irritable and suicidal due to family issues. The CT and PD Hub undertook a joint visit to see Ms F at the end of May 2015, at which she described using taught techniques (such as distress tolerance) to better manage her stress. Ms F was discharged from the CT and continued to be supported by the PD Hub.

1.13 Early in July 2015 Ms F took an impulsive overdose (she later said this was to help her sleep) and declined to be assessed in A&E. She was assessed by a member of the CT who she told she was experiencing relationship difficulties with Partner 2, claiming he had "waved a knife around" during an argument, and she had headbutted him. She was provided with increased support by the CT and enrolment at the Recovery College.[4]

1.14 The PD Hub care coordinator contacted the police and the NTW Safeguarding team for advice about the situation. The police stated that with no complainant

---

[2] http://nomsintranet.org.uk/roh/roh/2-basic_riskassessment/02_02.htm a core structured risk assessment tool used by the National Offender Management Service

[3] https://www.mind.org.uk/information-support/types-of-mental-health-problems/borderline-personality-disorder-bpd/about-bpd/ - those diagnosed with a personality disorder may have difficulties with how they think and feel about themselves and other people and are having problems in their life as a result.

[4] https://www.cntw.nhs.uk/resource-library/recovery-colleges/ - a safe place where people can connect, gain knowledge and develop skills

they were unable to do anything, and it would therefore be inappropriate to log the incident on their system.

1.15 Ms F reported in mid-November 2015 that she and Partner 2 had argued for a couple of days, they had fought (or pushed each other), and Partner 2 had damaged Ms F's property. Ms F contacted the police who advised that one of them should leave the house, which she did. The PD Hub care coordinator contacted the Trust Safeguarding team for advice, although the records do not indicate an outcome.

1.16 A PD Hub discharge date was set for mid-January 2016 and with this in mind, the CTT assessed Ms F the following week. Ms F felt she had made "great progress" with her sessions in the PD Hub. However, Ms F was in crisis at the end of December 2015 and the CT became involved again to offer further support.

1.17 By mid/late January 2016 Ms F was assessed by the CT as being significantly improved and was discharged from the service. Ms F was happy to continue with her care plan via the PD Hub and she was seen by them on a regular basis until her discharge towards the end of February 2016.

September 2016 - April 2017

1.18 Ms F contacted the Initial Response Team (IRT) in mid-September 2016 stating that she had been assaulted the previous night and her bag had been stolen. Three days later Ms F contacted the CT saying that she was having suicidal thoughts, wanting to hurt herself or someone else, shouting, angry, losing her temper and unable to control impulses to harm others. The CT undertook an assessment and made four visits, before discharging Ms F eight days later towards the end of September 2016.

1.19 Ms F's GP referred her to IRT in October 2016. The IRT forwarded the referral to the CTT as she was complaining of feeling more irritable, angry and agitated, citing a stressful relationship. Ms F contacted the IRT herself on two occasions following the referral to say she did not feel ready to have been discharged from the CT.

1.20 As a result, the CT undertook a home visit and Ms F was taken on again for home-based treatment. Ms F received six CT home visits and seven telephone calls (two calls were unsuccessful) between mid-October and mid-November 2016.

1.21 The CT and CTT undertook a joint home visit in the middle of November 2016. Ms F was discharged from CT home-based treatment awaiting confirmation of her suitability for the CTT. The discharge summary noted that Ms F had developed some coping skills (such as mindfulness techniques),

however, when under stress she lost the ability to use these techniques, especially when unwell.

1.22 Ms F contacted services in March 2017 requesting to speak to a clinician, stating that Partner 2 had threatened to stab her in the neck and was worried one of them would be seriously injured. She wanted them to live apart. A CT assessment was undertaken, and Ms F was signposted to Domestic Violence Women's Services (Ms F did not pursue this).

1.23 The CT undertook a home visit in early April 2017 and Ms F was taken on again for a brief period of home-based treatment whilst waiting for CTT allocation. A home-based medical review found Ms F to have prominent generalised anxiety and panic symptoms and was too anxious to leave the house.

1.24 Ms F telephoned the CT a week after the home visit to say she was going to take all her medication to kill herself, repeatedly stating that she was unsafe and would end her life by any means possible.

Second admission – April 2017

1.25 Ms F was admitted informally to a local mental health services ward in the second week of April 2017. The safeguarding care plan stated that Partner 2 was not allowed to visit her on the ward to prevent arguments between them, the NTW Safeguarding team were to be informed of the alleged assault for advice, and Ms F may be asked to complete the victim MARAC checklist.

1.26 The records indicate that police disclosure had been requested and that no further safeguarding action was required as Ms F no longer had contact with Partner 2, who had moved out of the area.

1.27 Ms F was discharged from hospital in April 2017 after nine days. Her risks were identified as being low and associated with relationship breakdown and difficulties with Partner 2.

April 2017 - January 2018

1.28 Following discharge from hospital Ms F was supported at home by the CTT. The PD Hub confirmed it would also provide refresher sessions for Ms F.

1.29 According to health records, in three separate telephone calls between 16 and 17 May 2017, Ms F reported the following: that she had been drinking more regularly; that she had left home with a knife to challenge a male who was looking for a family member; that neighbours were listening to her, laughing at her, and making recordings of her; and, that at some point she had assaulted her former partner (Partner 2) and that he had hit her back.

1.30 A joint PD Hub and CTT home visit in June 2017 identified Ms F's risks as being harm to self with some suicidal ideation, but no plans or intent to act upon these. The records indicate she had been issued with a 12-month short tenancy.

1.31 Between July and September 2017 Ms F stated she was in a new relationship which was going well (Partner 3), was found to be engaging well with good insight, had developed skills in emotional regulation and distress tolerance, and had a good understanding of her diagnosis. She did not disclose any suicidal ideation or self-harm.

January 2018 – February 2019

1.32 Ms F stated in January 2018 that her relationship with Partner 3 had ended. Ms F had thoughts of self-ligature, was overusing her prescribed medication and using other people's medication.

1.33 The CT undertook a home visit and Ms F was taken on for home-based treatment. The plan included working towards discharge from the CT, contact with the CTT and a possible joint visit to plan handover of care.

1.34 The CT undertook home visits in February 2018. Ms F told them she was being victimised by a neighbour (she thought the neighbour had voice-controlled CCTV). According to health records, Ms F also told the CT that she had armed herself with knives and approached drug dealers in order to protect her family.

1.35 In June 2018, Ms F reported that her relationship with Partner 3 had ended. In July, she told staff that Partner 4 (who she referred to as a friend) had been staying at her address.

1.36 Ms F struggled with physical and mental health issues during November 2018. She agreed to a medical review with a view to having her medication increased. However, Ms F missed the two planned appointments with the CTT for this in January 2019. She had been struggling to get out of the house as she was feeling low in mood and suicidal. She stated she had been reported to the council by a neighbour for raised voices after having an argument over the phone. Partner 4 had moved house, making it difficult for Ms F to see him, he was not allowed to visit her at her address (as part of a Good Neighbour Agreement, GNA) [5] and she was not using public transport due to increased anxiety. Ms F reported that she had accessed illicit drugs to help with her anxiety.

[5] https://www.lawinsider.com/dictionary/good-neighbour-agreement - an agreement between the Licensee and the Licensor, that addresses specific issues that could impact the local residential community.

1.37 The CTT found Ms F to be low in mood in February 2019. It is recorded that she said she had ended her relationship with Partner 4. During a further home visit in late February, Ms F reported that Partner 4 had been staying with her on occasions, and that she wanted to have contact with him. The GNA had ended, and he was not causing problems when he visited.

1.38 The CTT visited Ms F at home in the third week of March 2019. She answered the door in her nightwear and said she was feeling unwell. The records made at the time have no further detail, but the internal Trust report states that Ms F told the staff member that on the previous night she had asked Partner 4 to leave her address following an argument. This reflects what Ms F told the independent investigation. She also told the independent investigation that Partner 4 had hit himself on the head with a hammer, and that she had told the staff member at the time. The home visit was rescheduled for 13 days later.

1.39 Ms F attended a suitability assessment for an anxiety management group towards the end of March 2019. She said it had been a difficult day due to an argument with Partner 4.

1.40 Five days later Ms F was arrested and held in custody after being charged with the offence of murder at the end of March 2019. Partner 4 had been found at Ms F's home with injuries not compatible with life. Ms F was convicted of manslaughter in October 2019 and sentenced to 14 years in prison.

Agency involvement

1.41 We reviewed information provided by South Tyneside Adult Social Services, NPS North East Region (South Tyneside) and South Tyneside Homes (STH). We requested, but were not provided with, the police records.

1.42 We have included this information for context and understanding, particularly in relation to multi-agency engagement, however the investigation has not considered the actions, practices, policies or systems of South Tyneside Adult Social Services, NPS North East Region (South Tyneside), or STH as these do not form part of the terms of reference. Equally, we make no comment as to the veracity of the records.

South Tyneside Adult Social Services

1.43 The North East Ambulance Service (NEAS) raised a safeguarding alert with Adult Social Services in April 2010 after Ms F was taken to the local hospital emergency admissions unit (EAU) and admitted informally to a local general hospital following an overdose. Adult Social Services noted that all appropriate agencies were involved. They were unable to contact Ms F, and

no further attempts were made due to appropriate mental health services, including crisis services, being involved.

1.44 The police contacted South Tyneside Adult Social Services in December 2017 with concerns that Ms F had no money for food for herself and was in rent arrears. South Tyneside Adult Social Services attempted to contact Ms F on five occasions all of which were unsuccessful and recorded nine failed attempts to contact the police officer involved via email and telephone for a joint welfare check.

National Probation Services (NPS) North East Region (South Tyneside)

1.45 In November 2013, the NPS North East Region (South Tyneside) assessed Ms F at Newcastle Crown Court following charges of making a threat to kill, criminal damage and assault of her partner at the time. Ms F was subject to a community probation order with supervision (commencing January 2014, ending February 2015) following the Newcastle Crown Court sentence start date.

Northumbria Police

1.46 We have not received access to Northumbria Police records as part of this investigation. We found the following information in the CNTW records relating to Ms F's contact with Northumbria Police for violent offences:

Date	Forensic information
July 2010	Charged with criminal damage. Ms F smashed an ex-partner's window and was ordered to pay compensation.
March 2013	Arrested for alleged breach of the peace and possible assault (AOABH) of her new partner (Partner 2). No charges were pursued by Partner 2.
June 2013	Arrested for threat to kill and criminal damage following an argument with Partner 2. It was also noted that she had obtained a kitchen knife and was "waving it" at her partner. The charge was changed to affray as Partner 2 would not press charges. Ms F received a National Probation Service (NPS) community supervision order for one year.
Twice in June 2013	Arrested and charged for breach of bail conditions and resisting an officer in the execution of his duty. Records refer to Ms F as still being under curfew and recently coming out of prison, however, there is no further information documented.

Multi Agency Risk Assessment Conference (MARAC)

1.47 There were eight occasions on which MARAC was involved with Ms F, describing her as either, or both, a victim and a perpetrator of high-risk domestic violence:

- January 2010
- May 2010
- July 2010
- October 2010
- April 2013
- July 2013
- April 2014 (two separate MARAC meetings were held on this date).

South Tyneside Homes (STH)

1.48 STH were involved with Ms F between 2017 and 2019 following an initial anonymous call saying that Ms F was unstable because of mental health problems and was setting fires in the garden. STH received numerous calls thereafter from neighbours reporting harassment, threats and abuse from Ms F. They also received reports of fights and Ms F shouting in the family home.

1.49 STH liaised with mental health services, the police, the Anti-Social Behaviour (ASB)[6] unit, the Welfare Support team and undertook joint visits with the Community Safety and Tenancy Enforcement team. STH identified Ms F as a potential perpetrator as well as a victim of domestic abuse. Ms F said she was staying with Partner 3, had recently declined a women's refuge place offer, and was looking to move accommodation.

1.50 STH records indicate that STH and Northumbria Police undertook a joint visit in May 2017 following an incident two weeks before when Ms F had allegedly threatened youths with knives. STH contacted Ms F the next day to inform her a notice of seeking possession (NOSP)[7] would be served. However, a direct let for rehousing was subsequently agreed rather than continuing to pursue possession proceedings.

1.51 During 2018 STH received information from the police reporting several incidents between Ms F and Partner 4, including allegations of assault. Neighbours reported abuse from Ms F, constant domestic noise and arguments, and fighting in the street with Partner 4. Ms F was offered alternative accommodation, subjected to a GNA as a condition of having the

[6] https://www.sunderland.gov.uk/antisocialbehaviour#cookie-consents-updated
- aggressive, noisy or abusive behaviour to neighbourhood disturbances involving drugs or animals which should be reported to the police.

[7] https://www.gov.uk/government/publications/understanding-the-possession-action-process-guidance-for-landlords-and-tenants/understanding-the-possession-action-process-a-guide-for-private-residential-tenants-in-england-and-wales - a notice provided by a landlord specifying a date by which you are being asked to leave your home and after which possession proceedings may be started in the county court.

property, in addition to agreeing that Partner 4 would not visit the property for six months. The GNA ceased in February 2019.

1.52 Between January and March 2019, the STH Community Safety and Tenancy Enforcement Officer received an increased number of telephone calls from Ms F's neighbours. They reported the noise at night was "horrendous" with shouting, foul language, banging and punching the wall. Ms F was heard shouting at Partner 4. STH contacted Northumbria Police about a joint visit to the property but the neighbour did not want the Community Engagement and Enforcement Officer to visit Ms F.

Conclusions about Ms F's care and treatment

1.53 We identified 15 findings (seven key and eight additional) as either care or service delivery problems. We have separated out the key and additional findings to provide clarity on the findings that directly relate to the priority recommendations.

1.54 The key findings relate to Care Programme Approach (CPA - now superseded by the Community Mental Health Framework)[8] risk assessment and management, safeguarding and MARAC. We analysed the key findings using root cause analysis (RCA)[9] tools (fishbone[10] and 5 why's)[11] to identify the key underlying factor(s) contributing to the incident.

1.55 In terms of the finding on CPA risk assessment and management, we identified the current Functional Analysis of Care Environments (FACE)[12] risk system as a key underlying factor. This is because it pulls through the last risk assessment which the clinician then amends, changes or updates accordingly. This can lead to such documents becoming very lengthy and chronologically non-sequential, especially in complex and longstanding cases with significant events dating back over several years.

1.56 In terms of both the findings on CPA risk assessment and management, and on safeguarding and MARAC, we found that key underlying factors were:

- CTT service demand,

[8] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

[9] https://www.scie-socialcareonline.org.uk/six-steps-to-root--cause-analysis/r/a11G00000017xjaIAA

[10] https://www.england.nhs.uk/wp-content/uploads/2021/12/qsir-cause-and-effect-fishbone.pdf

[11] https://www.england.nhs.uk/wp-content/uploads/2022/02/qsir-using-five-whys-to-review-a-simple-problem.pdf

[12] https://www.cntw.nhs.uk/content/uploads/2018/07/FACE-Frequently-Asked-Questiions-V01-Mar-19.pdf - FACE is a risk assessment tool.

- care coordinator (CCO) caseloads with high levels of complex clients,
- a lack of professional curiosity, and
- inadequate clinical supervision practice.

1.57 Staff were more attuned to Ms F's risk of self-harm (including fatal self-harm) than her risk to others. Given the pattern of her behaviours over many years, particularly at times of psychosocial stress, this appears to have been an understandable and justified position.

1.58 It is the case that repeated but sporadic or infrequent episodes of interpersonal conflict with intimate partners (including verbal threats, brandishing of knives and physical assault), and at times with neighbours and professionals, had been a recurrent feature of her presentation for nearly thirty years up to the time of the incident.

1.59 However, in the months leading up to the incident, Ms F was regarded as engaging with services, functioning well, and relatively stable, compared to the historical context. Our view is therefore, that there does not appear to have been any clinically relevant risk factors or circumstances that would, or should, have led staff to anticipate an increased risk of imminent and serious violence to others.

Key findings – CPA risk assessment and management		
1	(a) The quality of the Functional Analysis of Care Environments (FACE) risk assessments and care coordination care and risk management plans (CCC/RMPs) were inadequate (not up to date, edited, nor comprehensive with relevant up to date risk information) and there were missed opportunities to update these. (b) The relapse and risk management plans were generic and not person-centred. (c) There was no evidence of risk management strategies to address Ms F's alcohol misuse despite this having been highlighted as a potential trigger for self-harm or harm to others.	Care
Key findings – multi-agency working, safeguarding and MARAC		
2	There was a lack of professional curiosity in terms of Trust staff contact with other agencies particularly given the background of MARAC involvement. In addition, there was a lack of a multi-agency approach to support Ms F particularly regarding her risks, and with specific reference to adhering to the GNA to sustain her tenancy. There were two occasions when the Community Safety and Tenancy Enforcement Officer contacted the Trust however this resulted in singular action on the part of the Trust and did not progress to a joint working approach.	Care
3	There were several opportunities for Trust staff to safeguard Ms F and, as a result, missed opportunities to develop an in-depth understanding of the risks to Ms F and to formulate a risk management plan with other agencies. This suggests a lack of professional curiosity. We found eight occasions in the Trust records, between July 2015 and March 2017, where Ms F was identified as a victim of domestic violence. On three occasions safeguarding concerns were raised, and on five occasions safeguarding concerns were not raised, although other action was recorded. All had either inadequate or incomplete outcomes.	Care

4	There were missed opportunities to complete the MARAC Safelives Dash risk checklist, which would have automatically notified the police and alerted them to the fact that Ms F was a victim, allowing an Independent Domestic Violence Advocate (IDVA) to engage with her. The sharing of information between agencies at a MARAC meeting would have aided the development of a multi-agency safety plan for Ms F as a victim and potentially as a perpetrator of domestic violence. Specialist advice was not sought in response to information that Ms F was also a perpetrator of domestic abuse.	Care
5	We found FACE risk assessment quality issues and inadequate safeguarding or MARAC response.	Care
6	The Trust provided Ms F with acknowledgement and support in relation to her children, and the associated difficult circumstances, rather than actively considering the safeguarding implications for them.	Care
7	Adequate clinical safeguarding supervision practice was not in place in the Community Treatment team (CTT) due to service demand and care coordinators (CCOs) having high and complex client caseloads.	Care

Additional findings – CPA risk assessment and management		
8	Although staff thought holistically about Ms F's care and treatment, this was not always reflected in her care plan. Family engagement was limited due to the difficult relationships and circumstances at the time. There are some references to Ms F undertaking voluntary work and her relationships with her partners and adult children, but there was little reference to her living arrangements.	Care
9	After being discharged from the CT, Ms F waited for CTT CCO allocation for four months, between mid-November 2017 and the end of March 2018, due to service demand. Ms F would have benefited from the continuation of CT support during the waiting period and was not offered the usual practice of waiting list phone calls for support.	Care

Additional findings – diagnosis, medication management and compliance		
10	There were some missed opportunities to undertake formal reviews of medication when Ms F was experiencing a crisis, with an increased risk of serious harm to herself.	Care
11	A psychologically informed formulation was not used for Ms F. This would have been helpful to complement, summarise and make sense of complex risk assessments.	Care

Additional findings – forensic care		
12	Ms F did not meet the Trust forensic mental health community team service specification criteria for a forensic service referral due to her diagnosis, as individuals whose primary problems are within the domain of PD form part of the service exclusion criteria.	Service
13	The forensic service specification PD exclusion criteria is inappropriate and inconsistent both with national guidance and the Trust PD Hub team Operational Policy.	Service

Serious incident investigation review

1.60 We undertook a detailed review of the Trust's serious incident investigation internal report using the Niche Investigation Assurance Framework (NIAF). In summary, we assessed the 25 standards as follows:

- Standards met: 10
- Standards partially met: 8
- Standards not met: 7

1.61 We were provided with information about the implementation of the Trust's action plan and assessed the progress made, with recommendations for further assurance where required. We graded our findings using the following criteria:

Score	Assessment category
0	Insufficient evidence to support action progress/action incomplete/not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement

1.62 In summary we found actions had commenced for each of the findings and learning identified in the Trust's action plan.

Additional findings – analysis of Trust serious incident investigation		
14	The Trust Incident Policy Practice Guidance on the application of Duty of Candour does not provide staff with adequate guidance or examples to illustrate where the criminal justice services are involved.	Service
15	National guidance on the standards for serious incident (SI) reports were not applied: • The root cause inappropriately identified patient factors. • No care or service delivery problems were identified, or recommendations made to address the significant findings (due to the fact that the Trust already had outstanding recommendations to address these). • The identified areas of learning were not derived from the findings. • The recommendations made to address additional areas of learning were not outcome focussed or measurable.	Service

Recommendations

1.63 We have made the following recommendations to address the key findings and underlying factors:

Recommendation 1: The Trust must review the utility of the Functional Analysis of Care Environments (FACE) risk assessment tool, and the care coordination care and risk management plan (CCC/RMP) systems and processes to ensure that (a) they are fit for purpose (comprehensive, up to date and edited with relevant risk information) within the clinical setting, (b) able to be practically applied, and (c) embedded in practice ensuring ready access to key clinical background and developments.

Recommendation 2: The Trust must ensure that the Safeguarding Adults at Risk Policy is embedded, with training compliance identified, in local procedures and practice ensuring that (a) risk is considered in relation to adult safeguarding criteria (b) that opportunities to refer to MARAC and domestic violence services are considered (c) adult safeguarding concerns are accurately documented with advice, referrals and outcomes captured within clinical records and (d) that victim safety planning includes family members as part of the risk management plan.

Recommendation 3: The Trust must ensure that the principles of the Community Mental Health Framework[13] are embedded in practice and supported by relevant training to address the quality of risk assessment,

[13] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

holistic care and management plans, professional curiosity, multiagency working and family engagement.

Recommendation 4: The Trust must ensure that the Clinical Supervision Policy is embedded in practice.

1.64 The following recommendations are intended to address the additional findings:

Recommendation 5: The Trust must implement systems to ensure that patients waiting for treatment and care coordinator allocation in the Community Treatment team are adequately supported whilst they do so.

Recommendation 6: Specialist substance misuse services or staff must be requested to advise on, or to assess and contribute to, care and treatment plans where there are substance misuse issues and associated risk to others.

Recommendation 7: Care coordinators must initiate a discussion with the Consultant Psychiatrist to assess whether a formal medication review is required when there is a crisis and serious risk of harm to self.

Recommendation 8: The Trust must ensure that the forensic service specification follows the National Institute for Mental Health in England guidance *Personality disorder: No longer a diagnosis of exclusion* (2003).

Recommendation 9: The Trust should ensure that the Duty of Candour Policy provides staff with guidance where criminal justice services are involved.

Recommendation 10: The Trust should ensure that standards for serious incident reports comply with national guidance.

Recommendation 11: The Trust should implement the use of psychologically informed formulations to complement, summarise and make sense of complex risk assessments.

Appendix A – The Independent Investigation

1.65 This investigation was commissioned by NHS England and NHS Improvement (North East and Yorkshire) in order to:

- Identify any gaps, deficiencies or omissions in the care and treatment received by Ms F provided by CNTW and to undertake an assurance review of investigative recommendation implementation by the Trust, post-publication.

- Identify any areas of best practice, opportunities for learning and areas where improvements to services are required, with a focus on the care and treatment period from Ms F's first admission in 2010, to the date of the incident.

1.66 The scope of the investigation commences from Ms F's first mental health services admission in 2010 up to the incident on 31 March 2019 to provide a longitudinal view of her care, treatment and risk.

1.67 The independent investigation follows the NHS England Serious Incident framework (March 2015)[14] and Department of Health guidance[15] Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.

1.68 Additionally, the NHS England and NHS Improvement Regional team, with the agreement of South Tyneside Community Safety Partnership and the Independent Domestic Homicide Review (DHR) Chair, set terms of engagement for this independent investigation allowing for the provision of a mental health expert to support a DHR.

1.69 For context and understanding, particularly in relation to multi-agency engagement, we have reviewed Individual Management Review (IMR) information provided to the DHR by South Tyneside Adult Social Services and South Tyneside Homes (STH). We have also reviewed the National Probation Service (NPS) North East Region (South Tyneside) records. This information, unless otherwise stated, was not available at the time to CNTW staff.

1.70 We have not considered the actions, practices, policies or systems of South Tyneside Adult Social Services, NPS North East Region (South Tyneside), or STH as these do not form part of the ToR for this independent investigation.

1.71 The Trust internal report has been reviewed using a framework for assessing the quality of investigations based on international best practice. We grade

[14] NHS England Serious Incident Framework March 2015 https://www.england.nhs.uk/patient-safety/serious-incident-framework/

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

our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency, NHS England Serious Incident framework (SIF) and the National Quality Board Guidance on Learning from Deaths.[16] We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

1.72 The investigation was carried out by:

Sue Denby	Senior Investigator and Report Author, Niche.
Dr John McKenna	Retired Consultant Forensic Psychiatrist, Clinical Lead, Niche and mental health expert to support the DHR.

1.73 The draft report was shared with Ms F who largely disagreed with the detail and findings of the investigation. In particular, she refuted the extent of arguments with her neighbours, and challenged the accuracy of records referenced.

[16] National Quality Board: National Guidance on Learning from Deaths. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Niche Health & Social Care Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Tel: 0161 785 1000

Read more about us at: **www.nicheconsult.co.uk**

Niche Health and Social Care Consulting Ltd is a company registered in England and Wales with company number 08133492.

niche
HEALTH & SOCIAL CARE CONSULTING