An independent investigation into the care and treatment of a person using the services of South Essex Partnership University NHS Foundation Trust

Undertaken by Consequence UK Ltd

JUNE 2013

This is the report of an independent investigation commissioned by the NHS Midlands and East to conform with the statutory requirements outlined in the Department of Health (DH) guidance *"Independent Investigation of Adverse Events in Mental Health Services",* issued in June 2005. The guidance replaces paragraphs 33-36 in HSG (94)27 (LASSL (94)4) concerning the conduct of independent inquiries into mental health services.

The requirement is for an independent investigation of the care and services offered to mental health service users involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services in the six months prior to the event.

The Independent Investigation Team members were:

- Maria Dineen, Director, Consequence UK Ltd;
- Dr Owen Haeney, Consultant Forensic Psychiatrist, and Lead Consultant, The Scott Clinic, Mersey Care NHS Trust;
- Dr Rob Holmes, Consultant Psychiatrist, Crisis and Home Treatment, Coventry; Associate Medical Director, Adult Mental Health, Coventry & Warwickshire Partnership Trust.

Acknowledgements

The Independent Investigation Team wishes to thank:

- The Trust's Head of Serious Incidents;
- The Assistant to the Head of Serious Incidents;

for their co-operation with the Independent Investigation Team.

And:

- The family of Mr H for the information they provided to the South Essex Partnership Foundation NHS Trust investigation team during the conduct of its investigation.

Throughout this report:

- The Independent Investigation Team is referred to as the Independent Team.
- South Essex Partnership University Foundation NHS Trust's internal investigation team is referred to as the SEPT Team.
- South Essex Partnership University Foundation NHS Trust is referred to as The Trust.

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INCIDENT OVERVIEW

On 26 June 2010, Mr H was arrested following a serious assault on his mother, who was admitted to hospital for treatment of her injuries but subsequently died (RIP). At the time of the incident, Mr H was visiting his mother at the home of his brother. He was also a patient of South Essex Partnership University NHS Foundation Trust (The Trust).

The Independent Team expresses its condolences to the family.

Initially, Mr H was unfit to plead and was sentenced to a Hospital Order. Subsequently, in November 2012, Mr H was considered fit to plead and at a sentencing hearing his plea of manslaughter on the grounds of diminished responsibility was accepted by the Crown. He was sentenced to an Indefinite S37/41 Hospital/Restriction Order.

PURPOSE OF THE INVESTIGATION

The purpose of this investigation was to conduct:

- an independent analysis of Mr H's care and treatment as received from The Trust;
- an historical review of Mr H's clinical records prior to his transfer to community forensic services in 2008 and then the community mental health team in 2009;
- an assessment of the internal investigation carried out by The Trust to determine whether or not it was sufficiently complete, fearless and searching, so as to make unnecessary further independent investigation of Mr H's care and treatment;
- an assessment of the recommendations made by The Trust's investigation team and the subsequent actions taken as a consequence of these.

In addition to the above, the Independent Team was tasked with making any additional recommendations considered necessary to ensure that identified lapses in the care and treatment of Mr H were appropriately addressed to reduce the risk of recurrence in the future.

CONCLUSION

Overall, the Independent Team is satisfied that the internal investigation conducted by The Trust was of a reasonable standard and that, in the opinion of the Independent Team, a re-investigation of Mr H's care and treatment will not materially add to the learning and improvement opportunities already identified by The Trust's investigation team and this quality assurance process.

With regards to the predictability of what happened, the Independent Team is of the opinion that, unmedicated, Mr H posed a serious risk of harm to his mother. Although Mr H's first index offence does not suggest intent to kill, the nature of it was such that death could have been a consequence. It was therefore predictable that, unmedicated and/or in relapse, Mr H posed a risk to the life of his mother.

With regards to preventability, this always needs to be considered carefully, avoiding hindsight bias[1] as far as this is possible to achieve.

In this case:

- the Trust's lack of system guiding the transfer of service users from forensic psychiatry to general adult psychiatry;
- the non- delivery of the requirements of CPA by the forensic service at the actual point of transfer;
- the non-assertive follow up of Mr H, following his family's reported efforts to make contact with Mr H's consultant psychiatrist;
- not maintaining as close a medical oversight of Mr H's management within the community as a service user with his history required; and
- lapses in the effective management of the CMHT by the then CMHT manager to ensure that Mr H was properly transferred into the CMHT and assigned an appropriate care coordinator who was able to maintain regular contact with him,

represent lost opportunities in the care and treatment of Mr H.

It is the considered view of the Independent Team that there would have been a range of possible courses of action had the concerns Mr H's family, been heard and acted on. These may have included, but would not have been limited to:

- An urgent review of Mr H could have been conducted by a consultant psychiatrist, preferably with a family member present; or, if not possible, with a clear history being obtained from the family.
- Mr H's Consultant Psychiatrist may have liaised with either the Community Forensic Team, or with Mr H's previous Consultant Forensic Psychiatrist for advice regarding ongoing management.
- If a care co-ordinator was not actively engaged with Mr H then urgent allocation would have been requested.
- If following assessment Mr H's risk(s) were determined as manageable in the community, with the agreement and support of Mr H's family, then this may have been progressed with:
    - Weekly home visits by the care co-ordinator;
    - Supervision of medication by the family;
    - Medical review in a few weeks;
    - All relevant contact numbers being provided to the family, with clear instruction that they were to immediately inform the CMHT if Mr H was not taking his medication or his behaviour deteriorated further;
    - Until stabilised, Mr H to have closely supervised or no contact with his mother.

If Mr H's risk was identified as not manageable in the community by the CMHT, consideration in all likelihood would have been given to:

[1] Hindsight Bias: This occurs when one 'looks back' with knowledge and information that was not available at the time and makes a judgement about what professionals should have done based on this information.

- Community management by the Crisis and Home Treatment Team; or
- Re-referral to the Community Forensic Community Team; or
- Admission of Mr H into hospital for stabilisation, enabled by detention under Section 2 of the Mental Health Act (1983) if necessary.

The key point in the above, is that there would have been assessment of Mr H, and a further course of action based on the outcome of that assessment however it was achieved.

Overall conclusion of the Independent Team

Had any of the options above been delivered, it is the opinion of the Independent Team that the incident which did occur on 25 June 2010 may still have occurred as it did, or (more likely) would have occurred at a later date. However, the risk of it occurring would have been much reduced.

RECOMMENDATIONS

There have been a number of substantial changes in The Trust since 2010 that render recommendations the Independent Team would have made as unnecessary. In brief, these changes are:

- The implementation of a care programme approach policy that requires all service users of working age meeting the CPA policy requirements to be allocated a care co-ordinator from within the appropriate community mental health team, even if the service user is in receipt of care and treatment from forensic services.
- The cessation of a community forensic team. All service users will now be discharged from low secure in-patient services directly to a general adult community mental health team, with a named consultant psychiatrist and a care co-ordinator who is a qualified professional.
- The Forensic Consultant may stay involved with a newly transferred service user for up to 6 months post transfer to the CMHT to ensure a smooth transition of RMO responsibility and clinical care. In these cases the Forensic Consultant and CMHT Consultant will joint work the case until it is agreed that the Forensic Consultant no longer needs to give input. The Care Coordinator will be either a CJMHT Community Mental Health Nurse or Social Worker, dependent on skills, experience, and matching the personality of the Care Coordinator with that of the patient
- A root and branch review of the operational management and clinical leadership of community mental health teams.
- A newly revised policy (currently in draft format) setting out how service users are to be discharged from low secure services to the general adult mental health service.

The Independent Team has a small number of recommendations that it believes will either enhance the effectiveness of the above, or result in improved robustness and completeness of future serious incidents requiring investigation.

Recommendation 1
The Independent Team has been provided with a copy of the proposed new policy document, *"Policy on the Transfer of Clients From Low Secure Services".* Detailed constructive commentary has been provided to the authors of the document via The Trust's Head of Serious Incidents.

Because of the increased risks associated with any transition period (i.e. transferring or discharging a patient from Team A to Team B), The Trust is asked to consider carefully the feedback provided, and to outline a clear rationale to the commissioners of its forensic and general adult mental health services if it decides not to embrace the principles of the commentary and advice provided.

Target Audience: The Trust's Executive Director responsible for Patient Safety, The Executive Director of Forensic Services.

Timescale: Because the *"Policy on the Transfer of Clients From Low Secure Services"* is currently under development, and near to completion, the Independent Team suggests that The Trust should be able to complete its comprehensive working draft within three months of the acceptance of this report.

Recommendation 2
Building on Recommendation 1, The Trust is recommended to conduct a multi-disciplinary Failure Modes and Effects Analysis[2] (FMEA), or Control / Barrier Analysis across the forensic and general adult psychiatric service of its *"Policy on the Transfer of Clients From Low Secure Services"*. Ideally this should occur prior to implementation of the policy document.

In conducting the FMEA, Control/Barrier Analysis, The Trust is encouraged to set out the specific requirements of the new policy document in the order in which the activities are intended to happen, and also to consider setting out a flow diagram of who (or what professional) is expected to do and when. (The use of the principles of Swim Lanes may assist with this.) Once the FMEA chart reflects The Trust's policy (practice standard) requirements, then an appropriate group of professionals can be invited to conduct the identification of known and potential 'risk' points in the process.

For validation purposes, a second group of similarly qualified professionals working in the same areas could also be asked to contribute.

[2] Failure Modes and Effects Analysis (FMEA) is a systematic, proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures, in order to identify the parts of the process that are most in need of change. FMEA includes review of the following:

- Steps in the process
- Failure modes (What could go wrong?)
- Failure causes (Why would the failure happen?)
- Failure effects (What would be the consequences of each failure?).

Once ‘risk’ or hazard points are identified:

- The consequence of the ‘risk/hazard’ occurring in the system as currently designed needs to be realistically and pragmatically worked through, including the ability of existing safety control to contain or mitigate the risk/hazard.
- The robustness of current and proposed safety controls needs to be considered at each risk/hazard point.
- Each of the multi-professional groups needs to consider whether there are any additional steps in the transfer process that, if introduced, would reduce the likelihood of occurrence of the identified risks/hazards, or the consequences of them if they were to occur.
- The work of both groups needs to be ‘brought together’ for comparative analysis and an agreed and cohesive remedial plan implemented.

Note 1: There is a wealth of technical information available about FMEA on ‘the net’ and the NPSA’s RCA e-learning tool kit contains information about Control/Barrier Analysis as do some of the referenced texts on this site. The Health Foundation has also been sponsoring a Safer Clinical Systems project at Warwick Medical School since 2008, and this may be a useful resource for The Trust.

Note 2: The above recommendation is of particular relevance to the Mr H case, as it is recognised that transition periods between teams, services and organisations pose a heightened opportunity for risk. Taking a proactive approach to the identification of these prior to policy launch is one way of reducing this risk.

Target Audience: The Executive Medical Director and Executive Director of Clinical Governance and Quality, the Executive Directors of Integrated Services Bedford and Luton; and Essex, and the Executive Director of Forensic Services.

Timescale: The Independent Team appreciates that to conduct a meaningful FMEA requires careful thought and planning. It is also mindful that it is important that the implementation of the transfer policy, once ratified, is not unnecessarily delayed. Because the policy document is yet to be completed the Independent Team recommends that an FMEA is conducted with input from the locality involved in the Mr H case in the first instance, and during the consultation period before final ratification of the policy.

The Trust is expected to set out for the relevant commissioners of mental health services its timetable for achieving the above.

Recommendation 3

Although the Trust’s investigation utilised nationally available guidance templates during the conduct of its investigation, and in principle met with the then and currently required investigation standards, there were a number of features of the Mr H investigation that could have been improved on if the Trust is to optimise opportunities for effective learning, and the consistent delivery of an effective investigation. The Independent Team recognises that this recommendation represents a ‘gold standard’ in the conduct of adverse event reviews, but it

considers that SEPT has the necessary commitment at Executive and local levels of the organisation to deliver investigations of a higher quality.

To achieve this, the areas of investigation practice that the Independent Team considers the Trust may wish to consider are:

- The clear formulation of core competencies for all investigators tasked with the conduct of high impact/ high consequence incidents such as the case of Mr H. These core competencies might include:
  - Knowledge of a range of investigation techniques such as analytical Timelining, Control Analysis, Person / Placement grids
  - Knowledge of how to conduct a repeatable information analysis using tried and tested qualitative research techniques such as Content Analysis and Affinity Mapping
  - Knowing what issues to conduct a contributory factors analysis on
  - Investigative Interviewing, including question formulation such as the "tell all" instruction, reflect back, and effective note taking
  - The quality of interview records made. Attention needs to be given to interview records that are data rich, and reflect the full depth and breadth of the interview content, including evidence of 'reflect back'.
  - The Trust, as a component of the quality assurance standards must include consideration of the fairness with which lapses in practice have been addressed across all professional groups. Although not at all intended the Mr H report did not come across as balanced in its criticisms across the range of professional groups involved.

In addition to the above points, specific and detailed guidance has been provided by the Independent Team to The Trust with regards to:

- The conduct of the investigative interview;
- The formulation and analysis of identified care concerns (significant lapses in practice standards).

Target Audience: The Trust's Executive Director of Clinical Governance and Quality.

Timescale: Realistically, The Trust needs at least six months to address the above.
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Recommendation 4:
As a consequence of the Mr H case, The Trust undertook a root and branch review of the operational management and clinical leadership of community mental health teams. The intention was to achieve a wholesale improvement in clinical and operational functioning. One specific issue of direct relevance to the Mr H case is how service users are reallocated within a community mental health team if their care co-ordinator goes on medium- to long-term sick leave, or leaves the team.

The Trust needs to satisfy itself that the improvements implemented for community mental health teams has resulted in a situation where there is no opportunity for the

circumstances Mr H endured to be repeated. That is, when his care co-ordinator was absent from work, he was allocated to a community support worker (this should not have happened), and when the community support worker left the team in January 2012, Mr H was left as an 'outpatient' follow-up-only patient.

The recommendation of the Independent Team is that the Executive Directors of Integrated Services Bedford and Luton; and Essex, must satisfy themselves that, in comparable circumstances, regardless of whether or not the service user has a forensic history, all of the community mental health teams are consistently attending to the appropriate reallocation of care co-ordination responsibility.

The results of the assessment of this aspect of practice and community team operations must be reported to the Director of Adult Services and the Chair of the Clinical Governance and Quality Committee.

Target Audience: The Executive Director of Integrated Services Bedford and Luton

Timescale: The conduct of this audit will take some careful consideration and planning. It is likely that the community mental health team managers will be the best sources of information regarding the frequency with which a service user's care co-ordinator needs to be re-allocated because of absence from work and/or an individual leaving the team. The Independent Team recommends that The Trust presents the appropriate commissioners with its audit plan, including an achievable timescale for delivery, within eight weeks of the acceptance of this report.

1.0 INTRODUCTION AND TERMS OF REFERENCE

1.1 The Purpose of the Quality Assurance Process

Consequence UK Ltd (CUK) (the Independent Team) was commissioned by NHS Midlands and East to undertake an independent review of the care and treatment of Mr H, who pleaded guilty to the manslaughter on the grounds of diminished responsibility of his mother who died on 26 June 2010.

On 2 November 2012, Mr H was convicted in Court on a charge of Manslaughter on the grounds of diminished responsibility and was ordered by the Court to be detained indefinitely under the Mental Health Act (1983) in a mental health facility.

The Independent Team expresses its condolences to the victim's family.

Because at the time of the incident Mr H was a patient of the mental health service provided by South Essex Partnership University NHS Foundation Trust (The Trust), the incident fell within the health circular guidance HSG (94)27. This guidance requires that in such circumstances there is an independent analysis of the care and treatment provided to the service user by mental health services to determine:

- its reasonableness;
- whether or not the incident as it occurred was predictable by mental health services; and
- whether or not the incident as it occurred was preventable by different care and treatment of the service user.

In addition to the above, it is expected that the retrospective analysis will be proportionate and not unnecessarily repeat elements of The Trust's own internal investigation where the Independent Team assesses this to be of a reasonable standard. This means that the Independent Team considers, following its analysis, that The Trust's report meets local and national expectations of a serious untoward incident investigation, in particular the application of systems analysis where significant lapses in care and/or treatment have been identified.

NHS Midlands and East considered The Trust's investigation report to be sufficiently robust at the time the independent process was commissioned to seek independent validation of the quality of The Trust's investigation. The Independent Team, following its initial perusal of The Trust's report was satisfied that a quality assurance review was the correct approach in the first instance. Subsequent detailed analysis of Mr H's clinical records and the available information used to inform the Trust's findings and conclusions confirmed that the case of Mr H was most appropriately addressed via the quality assurance method.

The terms of reference for the independent process were therefore agreed as:

*"**AIM OF THE INVESTIGATION***

1. *To provide an independent assessment of the quality of the internal investigation into the care and treatment provided to* [*Mr H] by the SEPT Team.*
2. *To review the changes which have been put in place since the date of the incident.*

This investigation is commissioned in accordance with the Department of Health guidance and follows the National Patient Safety Agency Good Practice Guidance for Independent Investigations.

Following the review of clinical notes and other documentary evidence, the Independent Team was asked to:

- *Review The Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.*
- *Review the progress that The Trust has made in implementing the recommendations arising from the internal investigation.*
- *Review the care, treatment and services provided by the NHS, the Local Authority and other relevant agencies from the service user's first contact with services to the time of the offence.*
- *Compile a chronology of events leading up to the homicide.*
- *Review the appropriateness of the treatment of the service user, identifying both areas of good practice and areas of concern.*
- *Review the adequacy of risk assessments and management of known risk to others.*
- *Examine the effectiveness of the service user's care plan, including the involvement of the service user and the family.*
- *Evaluate the extent to which the care provided was in accordance with statutory obligations and relevant national guidance, including local operational policies that were in place at the time of the incident.*
- *Consider and comment on whether this incident was either predictable or preventable.*
- *Provide a written report to the SHA that includes measurable and sustainable recommendations."*

1.2 Incident Overview

On 26 June 2010, Mr H was arrested following a serious assault on his mother, who was admitted to hospital for treatment of her injuries, but subsequently died. At the time of the incident, Mr H was visiting his mother at the home of his brother. He was also a patient of The Trust.

Initially, Mr H was unfit to plead and was sentenced to a Hospital Order by reason of insanity[3]. Subsequently, in November 2012, Mr H was considered fit to plead and at a sentencing hearing his plea of manslaughter on the grounds of diminished responsibility was accepted by the Crown. The patient was sentenced to an Indefinite S37/41 Hospital/Restriction Order.

1.2.1 Relevant Contextual Information

Mr H first came to the attention of specialist mental health services in December 2006, after assaulting his mother, unprovoked. Soon after admission, Mr H assaulted a trainee doctor and was transferred from the open adult ward to a low secure unit on 22 December 2006.

In the three years prior to his admission, it is recorded in Mr H's mental health records that his friends and family had noticed a change in his behaviours. He had, it is reported, been working as a youth worker and left this post without any clear reasons for doing so. It is also reported that he began to dissociate from his friends and that he believed that his friends knew about conversations he had in his home.

Mr H's family reported that he also began to display aggressive behaviour towards his mother. His mother confirmed to Mr H's clinical team a range of unacceptable behaviours by her son towards her. Because of his behaviours, she left her home to live with another of her sons.

1.2.2 Relevant Clinical Information 2007 to 2009

In October 2007 Mr H was transferred to a low secure facility provided by The Trust. Two days after this transfer, Mr H was discharged from Section 37 of the Mental Health Act (1983) by an independent Mental Health Tribunal. Mr H, however, agreed to remain resident in the low secure unit with a plan that he was supported with the continued progression of his Section 17 leave, with the aim of achieving his discharge home. Between the time of his admission to the low secure facility and his transition home, and to the low secure community forensic team, Mr H remained symptom-free; however, his clinical team considered that he was unpredictable and remained a risk, owing to his inability to explain the behaviours leading to his index offence and admission to secure services in 2006. His overall risk, in consideration of risk to others, was assessed as being low. Furthermore, in October 2007 Mr H was supported in meeting with his mother during a supervised visit on the ward. Consequently, in early December 2007 a referral was made to the community forensic team, who undertook an assessment of Mr H on 10 December 2007. The outcome of this assessment was that the community forensic team agreed to accept Mr H onto their caseload. The transfer process between the in-patient and community team was conducted over a period of two months. During this time, the clinical records demonstrate that there were regular reviews and meetings between the in-patient staff, community forensic team and Mr H's relatives.

[3] Insanity and Fitness to Plead Act 1991

In January 2008 there was a multi-disciplinary meeting, including Mr H's relatives, prior to the forensic community team taking over responsibility for Mr H. The clinical records report that:

- Mr H continued not to take responsibility for the events which occurred in 2006.
- Mr H was more interactive with his brothers.
- Mr H was venturing outside of his brother's home, which he had not done prior to the incident in 2006.
- Mr H was maintaining the boundary of not being in contact with his mother and only seeing her in the presence of other family members.
- Mr H's relatives remained concerned about possible future risks.
- Mr H's then forensic consultant psychiatrist highlighted Mr H's persistent denial about what happened in 2006.
- Mr H was to remain on depot medication.
- Mr H's brother was content to provide accommodation for Mr H when he was discharged from the low secure facility.

Discharge from the low secure in-patient facility occurred on 19 February 2008.

Independent Team comment: Up until this point, Mr H's care and treatment was of a good standard. His forensic consultant psychiatrist was appropriately focused on Mr H's residual risks. His case management was appropriate.

19 February 2008 to 2 November 2009

Following Mr H's discharge from the In-patient Services to the community forensic service, he was monitored on a weekly basis by his care co-ordinator. He also attended outpatient appointments with his sector consultant.[4] At the time of his discharge he was on depot medication, which he continued to take until May 2008, when Mr H changed to oral medication. This medication was Aripiprazole 10mg daily, which was increased after three weeks to 15mg a day.

In August 2008, at a CPA meeting, the clinical records reported:

- Mr H showed no signs of psychosis and was medication-compliant.
- Mr H advised that he was now responsible for his medication, and had been since 14 July 2008, and his brother no longer watched him taking his medication. He also reported some side-effects, including a dry mouth and agitation in his legs.
- Mr H had visited his mother in the presence of another adult and that he had also been looking for work.
- Mr H's relatives raised no complaints or worries about him.
- Mr H had re-made contact with old college friends.
- Mr H was working part-time in his brother's restaurant.

[4] Mr H's sector consultant was a Consultant Psychiatrist in general adult psychiatry who covered the locality in which Mr H lived.

The outcome of this meeting was:

- Mr H's medication (Albify) was reduced from 10mg to 5mg.
- A community mental health nurse was to visit twice-weekly.
- The community mental health nurse visits were to be evaluated once a month.
- Mr H was to continue working for his brother.
- Mr H could now visit his mother by himself (providing that she was agreeable).
- Mr H's relatives were to remain vigilant and observe any changes in his behaviour. These were to be reported to the community mental health nurse.

The next CPA meeting was scheduled for 17 November 2008. In the event, it occurred on 6 December 2008.

The December CPA meeting focused on Mr H's discharge from the community forensic team to general adult mental health services. The clinical records noted that Mr H:

- was no longer a risk to his mother;
- was medication compliant; and
- saw his care co-ordinator every two weeks.

In addition, the records showed that:

- Mr H's relatives were actively engaged with him and the community forensic service.
- The transfer to the appropriate community mental health team was to be conducted over a three-month period.

For a variety of reasons unrelated to Mr H's presentation or progress, his discharge from community forensic services to general adult mental health services was delayed.

The next substantial CPA meeting was in April 2009, the notes of which demonstrated that:

- Mr H was to be gradually introduced to his new care co-ordinator in the community mental health team.
- His current 'sector consultant' will continue to look after Mr H.
- There was no plan for any sudden changes, but to move forward gradually over the next 4 months, on Mr H's return from holiday.
- Mr H was to agree not to purposely put himself into high-end anxiety-provoking situations.
- Mr H's forensic care co-ordinator was to discuss his case in any Thursday morning team meeting over the following 2-3 months.
- A letter of referral was to be sent to the appropriate community mental health team manager.
- The next CPA review would be in 4 months' time.

A risk assessment dated 14 April 2009 (which mirrored one written in December 2008) also noted:

- Any concerns from the family were to be taken seriously and

    - the care co-ordinator and consultant psychiatrist were to be notified immediately;
    - an outpatient appointment was to be made urgently;
    - consideration of an urgent planned admission to a suitable environment, preferably a secure environment;
    - to consider a full mental health assessment under the Mental Health Act (1983).
- The family were to be kept "in the loop".
- All staff were to visit Mr H in pairs.

On 17 April 2009 Mr H's community forensic care co-ordinator wrote to the team leader of the CMHT with the purpose of referring Mr H to that team. In this letter, the forensic care co-ordinator informed his colleague that *"*[*Mr H*] *no longer presents a risk to himself or others".*

On 1 June 2009 Mr H attended his first outpatient appointment with his new community consultant psychiatrist. The outpatient letter generated as a consequence of this and sent to Mr H's previous 'sector consultant' indicated that Mr H was very low risk and that it was appropriate for him to be discharged from forensic services to general adult services. The letter also noted Mr H to be symptom-free, and that he accepted his diagnosis of paranoid schizophrenia. Mr H was noted as requesting to stay under the medical care of his pre-existing 'sector consultant', and the CMHT consultant advised that he would discuss this with his team and also the allocation of a care co-ordinator for Mr H.

10 July 2009: Mr H was re-referred to general adult mental health services. The referral in April was made erroneously to the wrong community mental health team.

2 November 2009: Mr H and his forensic care co-ordinator attended for an outpatient's appointment. The record of this reported that Mr H was *"doing well"*, there were no signs of psychosis, and that Mr H was to be discharged from the community forensic team to the general adult community mental health team on 12 November. Mr H's relatives were noted to be supportive.

A community support worker made contact with Mr H by telephone on 17 November and met with Mr H at his place of residence on 18 November. Mr H's care co-ordinator was absent from work at this time.

1 December 2009: Mr H attended for an outpatient appointment. On this occasion he was seen by an ST3 doctor (this is a doctor who has completed training at medical school, and has completed his/her post-qualification foundation years and is now on a specialist training scheme in psychiatry).

The records of this appointment show that:

- The lead professionals for Mr H were identified as the CMHT consultant psychiatrist and the community support worker.
- Mr H remained on Aripiprazole 10mg daily.
- Mr H's risks were well contained.
- Mr H was well presented, his talk was relevant and coherent, and his mood was euthymic.

- No formal thought disorder was identified.
- No psychotic symptoms were identified.
- Risk of self-harm was considered to be low.
- Risk of harm to others on 1 December 2009 was considered to be low.

The documented plan was:

- To continue with the current medication.
- To review Mr H in three to four months.

Between 2 December 2009 and 14 January 2010 the community support worker met with Mr H on two occasions: once in a local department store (December) and the second at the house of Mr H's brother (13 January 2010). Text and telephone contact had also occurred during this period, as Mr H requested the re-arrangement of planned meetings owing to unfavourable weather conditions.

14 January 2010: The community support worker set out a closing summary on Mr H's file as he was leaving the community mental health team. The record the community support worker made communicated clearly that Mr H required meetings every other week at the department store and that monitoring of Mr H was required.

18 February 2010: Mr H attended an outpatient appointment with his CMHT consultant psychiatrist. No concerns were identified and a review was planned for three to four months' time.

7 June 2010: Mr H attended an outpatient appointment with his CMHT consultant psychiatrist. The record made suggested that Mr H presented as well. However, it was also noted that he could no longer work at his brother's restaurant.

25 June 2010: Mr H assaulted his mother who subsequently died of her injuries.

1.3 Contact With the Family

In keeping with good practice, the SEPT Team met with Mr H's brothers, following the incident, on 14 September 2010. The minutes of the meeting show clearly that Mr H's brothers were concerned about Mr H in the period of time immediately preceding the death of their mother, and that his brothers did try and raise their concerns with The Trust at the time. However, the family did not receive any response from Mr H's team at the time. The Independent Team notes that the record made of the meeting by the SEPT Team was of a good quality, and clearly set out the experiences of Mr H's family.

NHS Midlands and East also made contact with Mr H's family when it was clear that an independent review was required. Further correspondence was sent to Mr H's family in July, September and October 2010; however, they received no response to their correspondence.

The Independent Team wrote to Mr H's family on 5 February 2013 setting out the purpose of the independent review, the progress of the process at the time of writing, and offering to meet with Mr H's family to take them through the outcome of the quality assurance process. No response was received to this correspondence.

On 21 March a letter was sent to Mr H's Consultant Forensic Psychiatrist. A component of this letter sought the assistance of Mr H's current clinical team in either establishing contact with Mr H's family or of establishing what their wishes were with regards to meeting with the Independent Team and/or having the opportunity to offer an input into the independent process.

On 22 April Mr H's current consultant psychiatrist spoke with the Independent Team. He confirmed to the Independent Team that Mr H did not want to meet with the team. With regards to making contact with the family it was agreed that the consultant would ask the ward staff caring for Mr H, to speak with his family about the report should they call the ward. It was agreed between the Independent Team and the consultant that it was not appropriate for him or his team to contact Mr H's family directly.

2.0 THE TRUST'S INVESTIGATION

NHS Midlands and East commissioned Consequence UK (the Independent Team) to conduct a quality assurance review of The Trust's investigation to determine whether:

- a reasonable process had been followed;
- the issues identified by the investigation were appropriate;
- the issues were explored sufficiently;
- reasonable recommendations were made; and
- relevant actions had been taken as a consequence of The Trust's investigation.

The Independent Team was also tasked with making any further recommendations it considered necessary to ensure that the maximum opportunity for learning and safety and quality improvements was achieved.

As has already been stated, the reason why a Quality Assurance Review was commissioned was because of the requirement of Health Circular Guidance 94(72), which requires as mandatory the independent analysis of a mental health service user's care and treatment if he/she is convicted of manslaughter or murder.

2.1 Overall Impression of the Independent Team of the investigation conducted by The Trust

The investigation undertaken by the SEPT Team, as demonstrated by their investigation report, was assessed by the Independent Team as a detailed and considered investigation. The internal report is well laid out, with a clear structure which makes it easy to read. The narrative chronology is particularly well structured and the SEPT Team's decision to present this in accordance with the distinct phases of Mr H's care and treatment under specialist mental health services assisted this. The SEPT Team also included a more succinct timeline in Appendix 1 of its report, which was helpful.

Based on the Independent Team's own review of Mr H's clinical records and compilation of their own chronological timeline, the Independent Team can confirm that the SEPT Team's chronology was complete and accurate.

The SEPT Team identified one aspect of practice that they considered to be *"notable"* following its meeting with Mr H's family, and four aspects of Mr H's care management that fell below the required standard. These are elucidated later on in this report.

The SEPT Team presented in its report an analysis of what it considered to be the contributory factors to the identified care lapses and then identified what it considered to be the 'root causes' of these. The presentation of this type of information complies with national expectations regarding the conduct of serious untoward incident investigations. Furthermore, the presentation of the information suggests that the principles espoused in the National Patient Safety Agency's 'RCA E-Learning Tool Kit' were applied, as were the standards set out and NPSA's and the Department of Health's national guidance on the conduct of mental health

investigations published on 15 June 2005.[5] Although the Independent Team considers that the conduct and presentation of the contributory factors analysis could have been improved, The Trust's effort to undertake and present a comprehensive investigation process remains commendable.

The SEPT Team made two recommendations as a consequence of its investigation, and these are set out below. The Independent Team considers that other recommendations could and should have been made, and these are set out in section 6.0 (page 49) of this report.

Although, the National Patient Agency's (NPSA) *"Guide to Investigation Report Writing*" does not specify that NHS internal review teams should identify whether a serious incident was preventable or predictable the Independent Team is of the opinion that, in this particular case, the findings of the SEPT Team were sufficiently robust that it could have commented judiciously on both points. However, this is not something the Independent Team would encourage as a matter of routine, because of the complexity of consideration often required and the depth of investigation required to facilitate this safely.

The Independent Team's opinion with regards to predictability and preventability is set out in section 5.0 (page 47).

2.2 The Aspects of Care the SEPT Team identified as *"notable"* and those it identified as falling below the required standards

2.2.1 Notable practice

The SEPT Team identified one aspect of practice that it considered *"notable"*. This was following the meeting with Mr H's family, who considered that the care co-ordinator for Mr H in the community forensic service had worked well with Mr H and with his family.

Independent Comment

The Independent Team considers that, overall, Mr H's forensic management was of a good standard up to the time of his transfer to the community forensic team and then general adult services. The Independent Forensic Psychiatrist noted that, following a change in Mr H's consultant psychiatrist from forensic services to general adult services in August 2008,[6] there did appear to be a loss of risk awareness. This is why the Independent Team places a caveat on Mr H's care and treatment as being of a very good standard up until his transfer in 2009 to general adult services. The Independent Team, however, does concur with the SEPT Team that the community forensic team, which was a nursing-led team, provided a good service to Mr H, visiting frequently, and maintaining good communications with his family, seeking and valuing their input at all times.

[5] P:\Shared Access Folder\External Inquiries\USEFUL PAPERS\Independent investigation of adverse events in mental health services Department of Health − Publications.mht

[6] This occurred in advance of his transfer from the forensic community team to the general adult services community mental health team.

2.2.2 Areas where Mr H's care and treatment fell below the required standards

The SEPT Team identified the inadequacy of the transfer process for Mr H as the main area of clinical concern and a significant contributor to the loss of risk awareness and also the loss of contact and relationship with Mr H's family, who, up until the time of his transfer to general adult services, had been a key source of information for the forensic service and provided an invaluable gauge as to Mr H's well-being.

The specific range of care concerns identified by the SEPT Team in its report was:

"It was noted that there was not a timely response from the CMHT[7] *for the transfer of the care of the service user from the Community Forensic Team. It was further noted that, even once the correct Community Consultant Psychiatrist had accepted the patient and requested the allocation of a care co-ordinator, this was still not responded to by the CMHT.*

The panel noted that the transfer of care took place in a 30-minute appointment slot allocated to a junior medical member of the team. The doctor did not know that this appointment was for the transfer CPA.[8] *This accounts for his rationale that the service user was not subject to CPA.*

The care co-ordinator responsible for taking over the service user's care was not present at this meeting. The panel would expect that team management arrangements are such that an appropriate professional would attend a CPA transfer meeting in these circumstances and ensure that the correct and appropriate care arrangements were put in place.

The hand-over of care was not co-ordinated in accordance with the CPA policy and procedures.

Whilst the service user was under the care of the Community Forensic Team, his compliance with taking prescribed oral medication was monitored by his care co-ordinator, who stated during interview that he checked the medication boxes and also spoke to the family. In addition, the family closely monitored the service user taking his medication[9] *while living with his brother and other family members. It was acknowledged by the Community Forensic Care Co-ordinator during interview that the service user's family was an important part of his improved mental state. However, after transfer to* [*Mr H's*] *CMHT, this close monitoring did not continue in the same way.*

[7] CMHT – Community Mental Health Team.
[8] CPA – Care Programme Approach.
[9] The Independent Team noted that the family of the service user stopped monitoring his medication in 2008, prior to the hand-over from forensic services to the community mental health team.

Comment by Independent Team

The Independent Team agrees with the above in principle; however, it is the perspective of the Independent Team that the SEPT Team did not in its investigation identify or sufficiently address the full range of 'care concerns' that the independent review of Mr H's clinical records identified. These were:

- *The conflicts in the medical recommendations made to the magistrates court when the decision was made not to put a restriction order in place.* The consultant level report was perhaps not as forthright in its recommendations as it might have been. Furthermore, the subsequent addendum to this presented a degree of ambiguity about whether or not a restriction order was required. The independent Consultant Forensic Psychiatrist considers that it was reasonable for Mr H's Forensic Consultant not to have been too forthright. However, he is concerned that the addendum Mr H's then forensic consultant wrote was done only two weeks after his initial report and placed too much emphasis on Mr H's signs of improvement, which at that time were short-lived. It is this change in perspective and the premise on which it was made that the Independent Team considers should have been explored more robustly by the SEPT Team.
- *The reasonableness of transferring a client such as Mr H to a busy community mental health team.* His initial index offence was in 2006; as late as February 2008, Mr H was still unable to provide an explanation as to why he assaulted his mother and denied that it was as a consequence of his paranoia. The Consultant Psychiatrist on the open ward at this time noted that, until such time as he was able to do this, Mr H remained a risk.
- *The speed at which Mr H moved through the forensic system when the forensic team managing him was acutely aware that Mr H still denied many of the risk behaviours that pre-dated the initial assault, and had little insight*.

  The reasonableness of this should have been explored and addressed within the SEPT Team's report.

  The Independent Team's consultant forensic psychiatrist reports that, at the time Mr H was a patient, the speed of progress did reflect that which was occurring in his own unit at the time. However, in a case such as this one, when it is clear that the risk cannot be fully addressed (because the service user does not accept a large part of what happened leading to his/her admission), there needs to be explicit consideration of whether the person can safely be discharged. Although, in this case, Mr H was discharged by Mental Health Act managers[10], the SEPT Team's investigation report and interviews should have demonstrated exploration of this. This could and should have been reflected on in light of the incident that occurred.

[10] "*The use of the word "managers" can be confusing because it does not mean the people responsible for the day-to-day management of the hospital. Mental Health Act Managers are members of the community who act as non-executive directors of a hospital - a bit like the function of school governors. The Mental Health Act managers are responsible for ensuring that the Mental Health Act is used properly. Among their powers is the ability to discharge someone from detention under a section of the Mental Health Act, to consider reports for the renewal of sections and to refer certain cases to a Tribunal. A detained patient can request a review of their detention by the Mental Health Act managers".* (Ref: http://www.rethink.org/living-with-mental-illness/mental-health-laws/discharge-from-detention/mha-managers-review)

- *The lack of detailed structured risk assessment.* There is no evidence that recognised tools regularly used within a forensic service were used in the conduct of Mr H's risk assessments, such as HCR20. The clinical records refer to a system called TAG, which both Independent Consultant Psychiatrists consider to be a risk assessment tool that might be used to triage a crisis patient and provide a 'day-to-day' indicator of risk. It is not a tool that either of the Independent Consultant Psychiatrists would consider suitable as the sole risk assessment in a forensic service.

  The purpose of TAG

  TAG is a brief assessment of the severity of an individual's mental health problems. Instructions for completing it are contained on the Score Sheet, and this page provides further guidance. TAG is very easy to complete, requiring seven ticks on the Score Sheet. It is rated by staff for people who have (or who are believed to have) mental health problems. Information on diagnosis should be recorded separately, if required.

  TAG can be used in different ways, including:

  - By GPs and other agencies (e.g. social services) who think someone has mental health problems and want to refer to a specialist mental health team − by appending a TAG to their referral letter, specialist mental health services will be helped to prioritise those most in need of help.
  - To give a means of agreeing between agencies at what point in the care system people should receive help − this might be done by locally agreeing thresholds for referral.
  - As a routine outcome measure for patients on the caseload of a mental health team.
  - To give commissioners a means of specifying the way in which community mental health teams are to focus on the severely mentally ill.

- The lapse in medical responsibilities when Mr H was transferred from community forensic services to general adult services, including:
  - The lack of enquiry regarding the allocation of an appropriate care coordinator.
  - The lack of enquiry regarding Mr H's CPA status.
  - The lack of enquiry regarding risk.
  - The lack of assertive response to Mr H's family when they reportedly tried to contact Mr H's consultant psychiatrist in the weeks leading to the incident. **Note:** Mr H's Consultant Psychiatrist reported to the Independent Team that he was unaware of the repeated attempts by Mr H's family to make contact with him. Had he been aware, the Consultant Psychiatrist told the Independent Team that he would have seen Mr H as a matter of urgency.
- The SEPT Team identified that *"The hand-over of care was not co-ordinated in accordance with the CPA policy and procedures".* The Independent Team

considers that this should have been more clearly stated, or addressed in relation to each of the following:

- There was no information seen by the Independent Team that demonstrated effective joint working between the outgoing forensic community care co-ordinator and the in-coming adult services care co-ordinator. Accepted good practice in the transfer of a forensic patient to general adult services means that this should have occurred over a three- to six-month period, with the adult service care co-ordinator attending initially in an observational capacity with a gradual change-over of roles. Towards the end of the hand-over period, the adult service care co-ordinator should have been visiting on his/her own and briefing the outgoing community forensic care co-ordinator over the telephone.
- The Community Forensic Service was not, as far as can be deduced from the investigation report or internal interview records, required by the SEPT Team to explain why it released a patient with a forensic history to adult services when it was clear, despite the best efforts of the Forensic Service, that there had been an insufficient hand-over of care. This exploration should have occurred within the SEPT Team's investigation.
- The lack of effective and formalised consultant-to-consultant hand-over from the open forensic ward to the first general adult consultant, and then the first general adult consultant to the consultant psychiatrist attached to the community mental health team to which Mr H was allocated, was not explored as thoroughly as it should have been.
- The transfer letters sent from the Community Forensic Service to the general adult service were not set out in a way that sufficiently made clear the patient's:
    - History
    - 2006 index offence
    - Current risk profile, including clear descriptions of the outstanding areas of concern, such as his ongoing denial of many of the initial risk behaviours, his inadequate explanation of the index offence (stabbing), his poor insight and the absolute need for external mechanisms to ensure compliance with medication
    - Insight
    - Risk detractors/containers
    - The central importance of the family to the risk management plan
    - The fundamental components of the care plan and the importance of its continuance.

  The letters sent actually stated that Mr H no longer presented a risk. This was, however, factually incorrect and contradicted what the previous clinical teams and consultants had explicitly said. Consequently, the content of these letters, and any guidance provided

to the authors of such correspondence, should have been explored by the SEPT Team, and the findings of this enquiry clearly presented.

2.3 Recommendations Made by the SEPT Team

As a consequence of its investigation, The SEPT Team made two recommendations. These are reproduced here:

"Prior to the incident in June 2010, there was no protocol in place to provide guidance to staff about actions to be taken when transferring service users from the Community Forensic Team to a Community Mental Health Team. It is, however, noted by the panel that a protocol was developed and put in place with immediate effect following the Desk-Top Review undertaken by the Medical Director and the Executive Director of Strategy & Business Development. This was to ensure that appropriate action was taken to address a possible patient safety concern prior to the completion of the internal review.

Recommendation 1

The panel recommends that a full review of the effective implementation of the protocol takes place.

Throughout this report, reference has been made to deficiencies in the operational and clinical management of the CMHT. This particularly applied to the management of referrals and work load and the management and oversight of caseload complexity. The panel could not satisfy itself that decision-making arrangements and protocols were of sufficient rigour to guarantee the seamless management of clinical presentation and risk. Team Management arrangements at the time were not sufficiently robust to provide assurances that day-to-day operational functionality was at its optimum.

Recommendation 2

The panel recommends that an urgent review of operational and professional lead arrangements across all community services is initiated which must take into account the following issues:

Traditionally, the model of service delivery and management was structured in a way which did not allow services to deliver care in the most effective manner. Services were managed in either large geographical patches or as stand-alone specialist teams.

An internal Consultation process is currently underway which proposes integrated Locality-based operational management arrangements. These remodelling proposals will enable the delivery of more effective care pathways across aligned groups of clinical services, both on a single- and supra-locality basis. Inherent in these proposals is the need to ensure that services meet local need and that clinical safety is paramount.

With the introduction of dedicated clinical leadership and managerial overview, specific attention can be devoted to ensuring that both Managerial and Clinical Supervision are conducted on a regular basis and that it is of sufficient quality and rigour to ensure the delivery of high quality care.

It will also ensure that the application and implementation of Trust Policy around the management of risk and CPA is appropriately implemented. Additionally, the requirement to ensure robust caseload management systems are implemented will

provide an assurance that both complexity and volume of activity are being sufficiently addressed going forward."

Independent Team Comment

The recommendations formulated above, although reasonable and appropriately targeted, do not address the full range of issues that the Independent Team considers required addressing as a consequence of this case, and as the 'care concerns' it has highlighted might indicate.

3.0 Actions taken by The Trust as a consequence of the recommendations it made

Since the completion of its own investigation, The Trust has:

- Implemented a “Protocol for the Transfer from Community Forensic Service to CMHT”.
- Tested out staff’s understanding of the transfer process and that staff demonstrated this.
- Re-launched the transfer of forensic to CMHT protocol after the conclusion of the internal investigation.
- Added to the standing multi-disciplinary team-meeting agenda within CMHT’s “case transfers from forensic services”. This agenda was checked on 22 April 2013 and still reflects discussions on all transfers not just forensic cases
- Implemented a new structure throughout the Trust, the organisational map of which was made available to the Independent Team.
- Appointed Clinical Team Managers, and one of their key roles is in the delivery and assurance of a high-quality safe service.
- Made more clear the lines of accountability for clinical leads within CMHTs. The Trust considers that moving away from ‘profession’-specific lead roles and having one clinical lead for each CMHT has been pivotal in achieving this.
- Introduced robust caseload management systems to provide assurance that both complexity and volume of activity are being sufficiently addressed.

In addition to the above, The Trust’s Care Programme Approach Policy now requires that a service user’s care co-ordinator remains involved with any patient requiring a period of care and treatment within the forensic service. The Trust believes that this will *“ensure throughout the patient pathway that the community mental health team will have a thorough understanding of the case, and any associated risks”*. As a consequence of the more directive guidance, The Trust considers that the *“hand-over and risks of transferring to a new service will no longer be an issue”.*

The commissioners of mental health services in the locality in which the incident involving Mr H occurred signed off The Trust’s action plan as fully implemented on 11 October 2011.

3.1 Robustness of the Trust's Recommendations in assuring incident prevention or the prevention of similar lapses in care standards in the future

The actions taken to date by The Trust are reasonable and one could not criticise them. The more robust clinical leadership structure, the Independent Team believes, should improve the consistency of procedural compliance, as well as delivering a more effective day-to-day leadership approach within the community mental health teams. It is, however, for the commissioners of mental health services in South Essex to require quantitative data that shows that improvements have not only been achieved but that they are sustained.

With regards to the implementation of a revised operational policy for the community mental health teams, as above, providing that The Trust can demonstrate that the protocol is being delivered, then this too will support the delivery of a consistent standard of practice within each community mental health team.

With regards to the transfer policy developed specifically as a consequence of the Mr H case, the Independent Team is less confident that this will result in the degree of risk reduction hoped for. This document, entitled *"Protocol for Transfer From Community Forensic Services to CMHT"*, does contain a number of robust features; for example:

> Point 6, which says: *"This care co-ordinator, or their representative, should attend all CPA meetings for the patient until the actual date of transfer".*
>
> And point 8: *"For the first six months from the date of transfer, the Community Forensic Team Care Co-ordinator, or representative, will provide a monthly quality review to the CMHT in relation to the agreed care plan, compliance with treatment and appropriate management of risk."*
>
> And point 9: *"This care plan must include minimum standards of care which, if breached, will act as a flag to initiate urgent reviews. The aim is to ensure that the care does not fall below the minimum standard that would be set by the forensic service in terms of appropriately managing the risk that has been transferred to mainstream services."*

However, the Independent Team considers that the policy document could be made significantly more robust.

For example, the first point of the current policy says:

"All relevant information should be made available by the care co-ordinator in the community forensic mental health team to the appropriate CMHT manager."

This wording is ambiguous and diminishes the opportunity for the policy to deliver its intent. It would be strengthened if the policy said something to the effect of:

"When preparing to achieve the transfer of a forensic patient back to the day-to-day management of an adult mental health service community mental health team (CMHT), it is essential that the relevant CMHT manager is involved, and is sufficiently informed about the patient.

At minimum, the following must take place:

- *An initial telephone meeting to discuss the case with the CMHT manager and to achieve tacit agreement to the proposal.*
- *The provision to the CMHT manager of the following documents:*
  - *A historical summary of the service user, setting out in brief:*
    - *The index offence for the service user and the length of time he/she have been in forensic services (secure ward, open ward and community forensic)*
    - *The key points of the patient's care needs*
    - *A summary of the patient's risk profile and current risk status*
    - *Family engagement and involvement*
    - *Medication and compliance with this*
    - *Key points that the forensic team does not want the CMHT to lose sight of*
  - *The up-to-date CPA documentation*
  - *An up-to-date risk assessment that meets minimum standard requirements, such as HCR20*[11] *and a crisis and contingency plan*
  - *An up-to-date Carer's assessment."*

Point 10 of The Trust's policy states:

"The Team Manager of the Community Mental Health Team should quality check the records of patients transferred from the Community Forensic Service to ensure that the level of care does not drop below the agreed standard. This should be done with the care co-ordinator during supervision."

Although the Independent Team agrees that it is the role and responsibility of the Team Manager to satisfy himself or herself regarding compliance with protocol requirements, the Independent Team recommends that there are also more robust audit mechanisms that need to be instituted so that each locality, and thus The Trust, can quantifiably demonstrate a high quality and safe service.

To improve the prospects of the *"Protocol for Transfer From Community Forensic Services to CMHT"* delivering the intent of its authors, the Independent Team recommends the following inclusions to the protocol, or its successor:

- Conduct regular audits of the transfer (or discharge) process. The Independent Team suggests that a formal case note review of at least 20% of all service users whose care has been transferred from forensic services

[11] The HCR20 is a structured professional judgement tool to assess for risk of violence and to help develop a management plan. It provides a list of twenty factors that are known to correlate with increased risk of violence in mentally disordered people, organised into ten 'past' (historical) factors, five 'present' (clinical) variables and five 'future' (risk management) items. Consideration of these factors will help predict likelihood of future violence and should help elucidate risk factors that are potentially modifiable. It is widely used within forensic psychiatry settings. The current version, version2, was released in 1997 and version 3 is being released this year.

to a general adult community team in the last twelve months would be a reasonable litmus test to determine whether or not the documentation standard demonstrates current policy and procedural compliance. The review would need a dedicated audit tool designed for this purpose so that the results of the audit can be aggregated and presented in a formalised audit report, with findings, conclusions and recommendations included.

- Survey the same 20% of families and carers for the service user to find out their views on the transfer, or discharge, process. For example, how comfortable were they to contact the care co-ordinator? What was their experience of the forensic team in terms of being able to share information and having it listened to? What is their current experience with the community mental health team?

  The Trust ought to stipulate the minimum frequency with which the audits are conducted in the short, medium and long term.

- To consider splitting the protocol, or its successor document, into clear phases. For example:
  - Guidance on when a forensic service user could be considered for discharge to a community mental health team.
  - Activities required of the Forensic Service once a decision has been reached that a service user is suitable for care and treatment within a general adult CMHT.
  - Activities required of the CMHT Team Leader taking receipt of the request for discharge to the community mental health team, but before the discharge request is accepted.
  - Activities required once the request for discharge to the community mental health team has been accepted.
  - Activities required once the Forensic Service has transferred complete responsibility for case management to the community mental health team.

  Structuring the protocol around clear headings may enable the inclusion of relevant quality standards in addition to clear direction and guidance to the activities that must be conducted, etc. For example, it would not be unreasonable for the CMHT Manager to be required to acknowledge receipt of the transfer/discharge request and any appended documents in writing (e-mail or letter) within seven working days.

The Independent Team is informed (March 2013) that a new policy for the discharge of service users from the forensic service to general adult psychiatric services is to be implemented. The Associate Director of Secure Services (SEPT) is confident that, now service users are automatically provided with a care co-ordinator from general adult services, the transition issues that arose in the care and treatment of Mr H can no longer occur. This is to be applauded.

However, because the key issue arising from the Mr H case related to 'transition' − and 'transition' between teams, services and agencies is not infrequently identified as problematic during independent homicide reviews and serious case reviews − when The Trust has re-formulated its protocol along the principles outlined above, it is the recommendation of this Independent Team that an appropriate group of individuals who are likely to be actively involved in the care and management of service users who require forensic and general adult psychiatric services are

brought together to conduct a Failure Modes and Effects Analysis[12] of the process before the revised policy document is launched. This will enable the services to pre-determine where any existing weaknesses in the system lie, and look to strengthen them.

The above being recommended, the Independent Team believes that the reported enhanced robustness of the management of service users between forensic and general adult services will be a good development and represents another safety intervention that should make a positive and consistent contribution to the minimisation of risk when a service user is discharged from the forensic service to general adult psychiatry.

The Independent Team also emphasises that if:

- The new policy document includes greater attention to detail, where the detail can reasonably be prescribed;
- The new policy document is subject to a Failure Modes and Effects Analysis, and The Trust acts appropriately on the findings of this;
- Regular (periodic) audits of protocol compliance are undertaken, using case-note review methodology and other methods such as non-participant observer reviews as appropriate, and the findings are presented to the appropriate healthcare governance and safety groups and are acted on;

then the Independent Team considers that The Trust will have implemented actions that are more likely to deliver the consistency in practice that is required to reduce as far as possible the loss of risk awareness.

[12] Failure Modes and Effects Analysis (FMEA) is a systematic, proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures, in order to identify the parts of the process that are most in need of change. FMEA includes review of the following:

- Steps in the process
- Failure modes (What could go wrong?)
- Failure causes (Why would the failure happen?)
- Failure effects (What would be the consequences of each failure?)

Reference: Institute for Healthcare Improvement, Cambridge, Massachusetts, USA (http://www.ihi.org/knowledge/Pages/Tools/FailureModesandEffectsAnalysisTool.aspx)

4.0 THE DETAILED ASSESSMENT OF THE OVERALL QUALITY OF THE INTERNAL INVESTIGATION CONDUCTED BY THE TRUST

4.1 The Trust's Terms of Reference

Following the completion of the 'desk-top review' conducted by the Trust's Medical Director, the internal investigation was commissioned by The Trust's Executive Team on 20 July 2010. The terms of reference were to:

1. *"Review The Trust's internal investigation processes to date.*
2. *Review the care and treatment provided by the NHS and any other relevant agencies from the first contact to the time of the alleged offence.*
3. *Compile a complete chronology of events leading up to the alleged offence.*
4. *Review the appropriateness of the treatment, care and supervision of the mental health service user in the light of his assessed needs.*
5. *Review the adequacy of risk assessments and risk management.*
6. *Examine the effectiveness of the service user's care plan, to include the views of the service user's family.*
7. *Examine and comment on the effectiveness of the transfer of care between the Community Forensic Service and the Community Mental Health Team.*
8. *Review compliance with local and national guides and relevant statutory obligations.*
9. *Consider any other matters arising during the course of the investigation which are relevant to the incident or might prevent a recurrence.*
10. *In the process of conducting the review, the Panel is asked to give due consideration to the need to liaise with relevant stakeholders and other agencies, including the Police, the Crown Prosecution Service, and the service user's family."*

Technically, for the seriousness of the incident that occurred, the terms of reference were reasonable. However, the Independent Team considers that the terms of reference could have been more specifically targeted to the needs of this case, as a consequence of the desk-top review already conducted.

The desk-top review conducted in July 2010 included a detailed review of Mr H's clinical records between:

- 12 December and 20 December 2006;
- 27 November 2007 and 19 February 2008;
- 19 February 2008 and 2 November 2009;
- 2 November 2009 and 10 June 2010.

It is the contention of the Independent Team that it should have been possible to have identified more specific aspects of Mr H's circumstances that required detailed analysis than the formulated terms of reference achieved. Specifically, the following should have been questions that were achievable as a consequence of the robust approach to the commissioning of serious untoward incident investigations that was undertaken:

- To examine the medical reports provided to the courts prior to the conclusion that Mr H did not require a restriction order to determine:
  - their completeness;
  - the reasonableness of formulation of the reports; and
  - whether they provided sufficient clarity and direction for the courts to come to an informed decision regarding the service user.
- To examine the circumstances of Mr H's clinical progress in the forensic service, the understanding of any prevailing risk features and to determine the reasonableness of the planned transfer of him to a general adult CMHT at the time this decision was made.

  To be included in this section is the analysis of:
  - Mr H's risk assessments, including usage of relevant tools and the clarity of his crisis and contingency plan;
  - Mr H's care plan;
  - The appropriateness of his step-down from a secure to an open ward and then to the community forensic team;
  - Medical oversight of his management and decisions made.

With regards to terms of reference 7:

"Examine and comment on the effectiveness of the transfer of care between the Community Forensic Service and the Community Mental Health Team."

This term of reference would have been enhanced if it had given specific direction as to the issues the Executive Team expected the SEPT Team to address in depth in its report. For example:

"Examine and comment on the effectiveness of the transfer of care between the Community Forensic Service and the Community Mental Health Team, paying specific attention to:

- *the quality of CPA and risk information provided to the CMHT;*
- *information about Mr H's index offence;*
- *information about Mr H's level of insight;*
- *information about the engagement of Mr H's family and their level of engagement and support;*
- *the frequency of face-to-face meetings conducted with Mr H with both the forensic care co-ordinator and the appointed CMHT care co-ordinator present;*
- *the conduct and content of the discharge CPA from forensic to CMHT service;*
- *the level of medical engagement in the process."*

Building on this, the terms of reference for the internal investigation required a specific reference to Mr H's medical management during and after transfer. The independent review of Mr H's records highlights concerns with regards to Mr H's medical management following his transfer into general adult services. An appropriate and balanced term of reference could have been:

"To examine the appropriateness of Mr H's medical management between:

- *27 November 2007 and 19 February 2008;*

- *19 February 2008 and 2 November 2009;*
- *2 November 2009 and 10 June 2010;*

including:

- *involvement in care planning;*
- *involvement and oversight of the risk assessment and risk management plan;*
- *involvement with the CPA process;*
- *involvement with Mr H and his family;*
- *supervision of trainee doctors involved in the care and management of Mr H."*

Had more specific detail of direct relevance to the retrospective analysis of Mr H's care and treatment been set out in the terms of reference by The Trust's Executive Team, the Independent Team is confident that some of the omissions it has identified in The Trust's investigation would have been less likely to occur.

Independent Comment

There may be occasions where it is not possible to formulate case-specific terms of reference at an early point in the investigation process. In such cases, the Independent Team recommends that either:

- The construction of a detailed and analytical timeline becomes a core component of the desk-top review process; or
- Once the internal investigation team has been appointed, the terms of reference are revisited on completion of the timeline, so that The Trust can be confident that the depth of exploration across the right antecedent period is undertaken.

4.2 The Appropriate Usage of investigation tools and techniques

The SEPT Team's investigation report is narrative in style, and this is common for this type of report.

The Trust's investigation report on page 12 states:

"A comprehensive panel review was undertaken in accordance with The Trust's Policy and Procedure for Reporting Adverse Incidents (including Serious Incidents), which complies with guidance outlined in the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation. The panel also considered the Memorandum of Understanding, which is a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and Health and Safety Executive when investigating patient safety incidents involving unexpected death or serious untoward harm.

In accordance with the principles of the Memorandum of Understanding, initial contact was made with the Detective Inspector leading the police investigation, who indicated that Bedfordshire Police had no concerns about The Trust undertaking its own internal investigation, as it would not conflict with the ongoing legal proceedings."

The report also says:

"The panel met initially to scope the incident on 12 August 2010 and again on 12 October 2010 to analyse the findings. Staff interviews, and an interview with the family, were undertaken during September 2010. Further detailed analysis of the information gathered was undertaken to identify the Contributory Factors and Root Causes identified within this report."

It would have been useful if the SEPT Team had set out clearly the actual investigation tools it used. The Independent Team's analysis of the SEPT investigation leads it to suggest that at least the following tools were used:

- Simple Timelining;
- The NPSA's contributory factors framework.

The simple timeline was used to set out the chronology in Appendix 1 of the report, and this was an appropriate use of this tool. The NPSA's contributory factors framework was used to set out the SEPT Team's analysis of the care concerns identified. In this case, the SEPT Team chose the right tool to support its analysis. However, the way it appears to have been used[13] did not best suit the purpose of a contributory factors analysis.

[13] There appears to have been no detailed content analysis of the interview records against each of the stated care and service delivery concerns listed on page 25 of The Trust's report. Furthermore, the quality of the internal interview records was such that no meaningful content analysis could have taken place, even had the internal team wanted to undertake this.

4.2.1 The analysis of information gathered by the SEPT Team

The Independent Team believes that a well-intended but somewhat informal information analysis process was utilised and that the SEPT Team did not, at all times, work with the 'hard evidence' it had collected. Hard evidence is the information set out in the interview record that has been validated with the interviewee. In this case, the interview notes did not contain the full depth and breadth of the information exchanged between the SEPT Team and its interviewees. Furthermore, the interviews were not recorded, so the Independent Team was not able to double-check the information that was gathered, or reported on in the SEPT Team's investigation report.

To meet good practice standards in the conduct of a serious incident investigation, the SEPT Team should have conducted its information analysis on a 'care concern' by 'care concern' basis against the issues it listed on page 25 of its report. However, it did not separate out its analysis in this way. The analysis conducted was set out against related but different care concerns to those which the SEPT Team used at an earlier stage of its final report. This introduced inconsistency into the SEPT report. The lack of robustness and consistency at this stage of the investigation process is not all that unusual in the experience of the Independent Team's team leader.[14] A grounded understanding of qualitative research techniques such as content analysis is helpful to achieve the necessary degree of robustness in a report of this gravitas.

In this case, the lack of an effective information analysis was not critical to the identification of root causes. The 'root cause' to the lapse in expected practice standards around Mr H's case transfer was readily apparent − there was no system or process guiding the transfer of service users from forensic to general adult services. However, should The Trust need to conduct a retrospective investigation of a case with greater complexity and its in-house investigators do not understand how to robustly analyse the information gathered, then The Trust will be at risk of identifying and addressing the wrong issues, which will adversely affect the quality and safety improvements it might hope to achieve.

4.2.2 The investigative interviews

As has already been noted, the quality of the interview records taken in the Mr H investigation were below the standard that is required and did not demonstrate:

- What questions were asked of interviewees.
- That the SEPT Team had conducted a sufficiently inquisitive enquiry of the systems and processes underpinning the care and treatment of Mr H.
- That the SEPT Team had undertaken a sufficiently questioning approach to exploring individual practice concerns with the professionals involved in Mr H's care and treatment in the immediate antecedent period to Mr H's transfer to general adult services and thereafter.

[14] Maria Dineen has 19 years' experience in the field of serious untoward incident investigations. She was an advisor to the NPSA in the formulation of their root-cause analysis and training workshops, and RCA e-learning tool kit. She has also written a popular investigators' manual for NHS and Social Care staff which is now in its third edition. Maria has conducted in excess of 45 independent mental health investigations, and has provided root-cause analysis and investigation training across the NHS in England and Scotland since 2002.

- Use of reflect-back, so that the SEPT Team could test out its interpretation of what the interviewee had said.
- The depth and breadth of the information covered on the interview day.

The Independent Team has reviewed a more contemporary interview record that The Trust's Head of Serious Incidents reported is representative of the current standard of interview record.

It is the opinion of the Independent Team that the contemporary record was of significantly better quality than the interview records obtained in 2010.

4.2.3 Other investigation tools that the SEPT Team could have utilised

In a case such as this, the Independent Team suggests that the SEPT Team could have used the following tools in the conduct of its investigation:

- Tabular or analytical timeline.
- Investigative or cognitive interviewing (this requires the use of the broad, open 'tell all' instruction, the use of reflecting back to the interviewee what the interviewer believes he or she has heard, and a balanced range of open questions with closed questions used for clarification purposes).
- Control analysis (this is a process where an investigator sets out the appropriate process map, in this case the transfer of a service user from forensic to general adult services, and determines to what extent each step and sub-step in the process has been followed, and whether there are any missing steps).
- An interview validation map (this is a simple x-y grid that enables an investigator to ensure that he/she is interviewing a sufficient range of staff to ensure best opportunity for the collection of validated and triangulated information).

4.3 Did the SEPT Investigation identify a reasonable range of issues?

This question has already been addressed on pages 5 and 6, section 2.2.2, and also in the Independent Team's reflection on the terms of reference on pages 15-17, section 4.1.

4.4 Did the Information Gathered by the SEPT Team demonstrate an acceptable depth of exploration of the identified care and service delivery concerns?

The Independent Team is satisfied that the SEPT Team conducted an analysis of Mr H's care and treatment over an appropriate antecedent period leading to the incident that occurred. This was from December 2006 to June 2010.

As has already been stated, the Independent Team considers that the range of care and service delivery concerns could and should have been more expansive. The Independent Team did consider the need to re-interview the Consultant Psychiatrist for Mr H in the months leading to the death of his mother. However, the Independent Team is informed that this individual has since retired. After careful consideration, and having reviewed the summary of his original internal interview, the Independent Team is not convinced that any additional information would emerge from such an interview that cannot be gained from the already completed internal investigation and this reflective quality assurance process.

However, the Independent Team considers that it is essential that those members of the SEPT Team who remain in the employment of The Trust reflect on the content of this quality assurance process with The Trust's Executive Director of Clinical Governance and Quality and the Head of Serious Incidents. It is essential in delivering a balanced and credible investigation that, where professional standards have lapsed, as they appear to have done in this case, these lapses are explored with the same degree of rigour as system lapses.

4.4.1 The analysis of the care concerns the SEPT Team identified and set out in its report

The SEPT Team clearly had the NPSA's framework in its mind when it conducted its analysis. From the middle of page 25 to page 31 of The Trust's report, the SEPT Team identified a range of care concerns that were related to, but distinct from, those set out under the heading *"Care Delivery Problems".* This is not usual. However, there was a degree of overlap between the two and the Independent Team could see that the influencing factors set out below also related to the care concerns presented in the first half of page 25:

"Task Factors
The service user had been mentally stable for about eighteen months prior to the incident in June 2010. However, this was with protective factors including living with his family, who were monitoring his compliance with taking medication and monitoring his mental state, an identified care co-ordinator, who saw him very regularly and maintained contact with his family, and monitoring of compliance with taking medication by his care co-ordinator. These factors were no longer present after transfer[15] *to the CMHT.* **[1. The Independent Team Agrees]**

The panel noted that there was a significant delay in transferring the service user from the care of the Community Forensic Team to the care of the CMHT. The panel

[15] The Independent Team notes that some of these protective factors (such as supervision of medication by the family) had already lapsed prior to transfer. This situation should have been made clear in the SEPT Team's report.

is of the view that the difficulties in transferring the service user from the Community Forensic Team to CMHT were a major contributory factor in the sequence of events that followed. **[2. The Independent Team partially Agrees. However, there was also a delay in the Forensic Service chasing it up because of Mr H's holiday]**

Prior to the service user's transfer from the Community Forensic Team, a Care Programme Approach meeting took place on 6 December 2008. In the notes made by the Community Forensic Care Co-ordinator, there is reference to 'considerate discharge to the CMHT over a three-month period'. **[This is not a contributory factor to any of the lapses identified by the SEPT Team]**

Panel (SEPT) Comment
The panel noted that it was almost eleven months from the decision being taken that the service user was ready to be transferred to the CMHT that the actual transfer took place."

Independent Team Comment
If a SEPT Team is going to make a comment as above, it must ensure that it is contextually correct. There were some valid reasons why the decision to transfer took such a long period of time, not least a holiday for Mr H, and a conscious decision by the Forensic Service to revisit the transfer on his return. Furthermore, there is no information to demonstrate that the Forensic Service had any system or process to chase up a transfer request for which they had received no response.

"Influencing Factors
Section 41 of the Mental Health Act 1983 (a Restriction Order) provides that, where the Crown Court makes a Hospital Order, it may also consider a Restriction Order that restricts the patient's discharge, transfer or leave of absence from hospital without the consent of the Secretary of State.

The Crown Court can make a restriction order if:

1. *At least one of the doctors whose evidence is taken into account by the Court before deciding to make the Hospital Order has given evidence,*

   And

2. *It is necessary for the protection of the public from serious harm for the person to be subject to special restrictions, having regard to:*
   - *The nature of the offence*
   - *The antecedence of the offender and*
   - *The risk of the offender committing further offences.*

The service user's treating consultant at the time of his sentencing provided several reports for the Magistrates Court. In these reports he went to great lengths to explain to the Court:

'… I find it difficult to be convinced that he will keep to any of these promises and it is, of course, a matter for the court to decide whether an additional restriction is justified.'

He went on to say in his report of 13 March 2007 that the service user had been more communicative, less hostile and for the first time had acknowledged the

possibility that he may have been suffering with a mental illness when he committed the assaults. He said, however, that, at that time, it was not clear in his mind whether a Restriction Order should be made and, when he asked the Court to allow more time to consider this specific issue, he requested a further four weeks' adjournment.

In a second recommendation for a Hospital Order, the Section 12 Approved Doctor was more direct, saying:

'… I would also request the Court to consider further the possibility of a Section 41 Restriction Order, since it would be very difficult to assure the Court that such acts of violence would not recur.'

Panel Comment

The panel was unable to obtain any information suggesting why the Court had made the service user subject to a Hospital Order only, without the additional safeguards of a Restriction Order, in the light of the written evidence that the Court received. The panel acknowledges that commenting about the decision of the sentencing court is outside the scope of investigation or expertise; but it was felt that the Magistrates Court might have considered committing the matter to the Crown Court for further consideration of a Restriction Order. Such a course of action might have provided additional safeguards through the statutory monitoring processes, which in turn might have mitigated further risk of violence.

The panel notes that the community forensic team care co-ordinator adopted a robust and consistent assessment of risk throughout the period that the service user was under his care. Unfortunately, during the interviews of the CMHT Consultant and other members of the CMHT, there appeared to be a total reliance on the forensic care co-ordinator's assessment of risk, rather than conducting their own appraisal of the risk once he was under their care. Risk assessment is a dynamic process which needs to be considered within the resources of a treating team. As such, the assessment of the community forensic team with a relatively small caseload, and the ability to see clients very frequently, might be different to the assessment of risk by a busy CMHT, which ostensibly can see service users significantly less frequently. A reappraisal of risk in that context should therefore have been undertaken and this might have informed a more appropriate management of the service user."

Independent Team Comment

The Independent Team observed that, in its analysis, The Trust's report suggests that the decision of the Court could have been made differently. However, this is not the role of The Trust's team. Its job was to analyse what The Trust and its staff did with regards to Mr H.

The SEPT Team sets out quotations taken from Mr H's records, but does not set out what its opinion was of the quality or content of the reports provided to the Courts. This is the role and responsibility of an investigation team – to give an opinion, testing this out with other similarly qualified professionals where necessary, before committing to it.

It was the opinion of the Independent Consultant Forensic Psychiatrist that the addendum made by Mr H's then consultant psychiatrist may have unwittingly given

the impression that a restriction order was not required, and that the reasoning for the opinion was flawed and made on the basis of a very limited period of improvement.

"Influencing Factors/Family Perspective on Delivery of Care
Two members of the panel met with Mr C, the service user's brother, as part of the internal review process. He commented on the poor involvement of the Community Mental Health Team with the family. During interview, the Community Forensic Team Care Co-ordinator described the service user's family as being 'always involved in care plans' and stated that concern from the family was regarded as 'a significant indicator of deterioration in the service user's mental state'. The Community Forensic Team Care Co-ordinator also described meeting up with the family before seeing the service user, practice that is commended by the panel; but this was not continued after the Community Mental Health Team took over his care. The panel noted that the Community Forensic Team Care Co-ordinator informed the CMHT Care Co-ordinator that the family was very involved in the service user's care in a collaborative way. A meeting to introduce the new Care Co-ordinator was arranged by the Community Forensic Team Care Co-ordinator before the transfer of care took place.

During the meeting with Mr C, the service user's brother, he made reference to telephoning the service user's CMHT Consultant on several occasions when the family had become concerned about the service user's mental state in the period leading up to the incident in June 2010. After this information was shared with the panel, arrangements were made to scrutinise the message book in use by the [*CMHT*] *Consultant. One hand-written entry was found in March 2010 when the Consultant was asked to contact Mr C, the service user's brother.*

The Consultant was asked to comment on this aspect, and stated that he could not specifically recall the details, but, from the way in which the message was marked in the message book, it indicated that he had received the message but was not able to speak to Mr C. The Consultant could not recall the specific reason, but said this may suggest he had tried to make contact but had not been successful.

Mr C further stated during the meeting with two of the panel members that, after his attempt to contact the Consultant, the length of time between the service user's appointments was increased. This viewpoint was put to the [*CMHT*] *Consultant Psychiatrist, who explained that he had not spoken to Mr H and had continued to care for the service user as before.*

Panel Comment
The panel recognises the significant burden placed on family and carers of individuals with severe and enduring mental health problems. The family's support was pivotal to the successful management of this service user in the community. A feature of the original risk management plan from the time of discharge from [*forensic in-patient services*] *was based on the family reporting changes or abnormalities in his presentation. The family were not aware that the transfer that took place on 1 December 2009 had any impact on this risk management plan. The Consultant involved was aware of these factors and, upon being contacted by the*

family, should have given the attempted contact from the family in the time leading up to the incident far greater significance."

Independent Team Comment
The Independent Team appreciates that, if a member of staff professes to have little to no memory recall of a specific situation, as occurred in this investigation, it makes unravelling the root of the problem very difficult.

However, the SEPT Team could have asked the relevant consultant to have described how he normally engaged with families, and what his normal procedure was in responding to family requests for a meeting, or a telephone-based discussion, and what his normal approach would be if he tried to make contact and was unsuccessful. It is the opinion of the Independent Consultant Psychiatrist that Mr H's consultant psychiatrist, the care co-ordinator and the CMHT team manager could also have been asked how CMHT intended to provide support to Mr H's family and how their concerns should have been communicated and addressed. The lack of an acceptable response to Mr H's family was a missed opportunity for revisiting Mr H's risk assessment, which in the opinion of the Independent Team had effectively broken down prior to transfer from the forensic service to the CMHT.

"Communication Factors
It would seem that the transfer of care took place at an outpatient appointment. An appointment was set up seemingly for this purpose on 2 November 2009. It is not clear why the transfer was made to a junior doctor member of the [*community mental health*] *team rather than the* [*CMHT*] *consultant who had been seeing the service user.*

Panel Comment
The investigation identified some confusion as to which community mental health team was to have been responsible for the patient after discharge from the community forensic team. It is concerning that, having eventually decided to take the service user onto the books of the CMHT, it was felt that he could be managed on an outpatient basis. The panel could not establish what decision-making processes were employed in deciding to manage the service user on an outpatient basis. In the interview with the [*CMHT*] *Consultant, he stated that the recording of 'non-CPA' in the letter to the GP after transfer of the service user was an error. The panel is of the view that whether this is an error or an oversight, this should not have happened. The Community Forensic Team Care Co-ordinator and the Consultant were both copied into this letter and should have noted this recording error. Given the complex history that was evident, this was clearly the wrong decision, and, had more robust mechanisms been in place for the management of referrals, caseload volume and complexity, it is unlikely that the same decision would have been taken.*

The Staff Grade Psychiatrist[16] *who saw the service user on 1 December 2009 said that he was unaware that the appointment was a transfer Care Programme*

[16] The Independent Team draws attention to the fact that it was not a staff-grade psychiatrist who saw Mr H on 1 December 2009 but an ST3 junior requiring supervision. This actually occurred on 2 November 2009 and not 1 December 2009, as stated in the SEPT Team's report.

Approach meeting and believed it to be a standard outpatient review. This view was supported by the fact that only half an hour was allocated for the appointment. The Staff Grade Psychiatrist recalled during interview that approximately ten to fifteen minutes of this appointment were taken up discussing the service user with the Community Forensic Team Care Co-ordinator before he came in, leaving only fifteen minutes for assessment and review with the service user. The panel noted very poorly recorded details of the information transferred over to the CMHT and noted that no care programme approach documentation was completed following this meeting.

Panel Comment

The Staff Grade Psychiatrist recorded that the service user was not subject to the Care Programme Approach in the follow-up letter to the GP. In the panel's view, this is a significant causative factor [*that*] *compromised the ongoing care that the service user received with the Community Mental Health Team from that time."*

Independent Team Comment

As previously stated, The Trust's investigators should state clearly what 'care concern' they are analysing.

With regards to the conduct of Mr H's transfer CPA being conducted in a standard outpatient appointment and that he was placed on non-CPA, the Independent Team agrees completely with the SEPT Team that this lapse in standards was significant, but not that it was the most critical in terms of the subsequent negative impact it had on Mr H's care and treatment. The Independent Team considers that of utmost importance was the hand-over of risk, prevailing concerns and the essential components of Mr H's management plan, all of which could still have been done well, even if Mr H was erroneously placed on non-CPA.

Accepting that the SEPT Team identified a lack of effective systems and processes and team leadership, the Independent Team would have expected a more substantial analysis of this specific issue to have been presented in the internal report; specifically:

- The conflict in interview information gathered from the Consultant and Specialist Trainee (year 3) with regards to Mr H's CPA status should have been explored further.
- A non-participation observer assessment of the referral and allocation meetings for Mr H's CMHT, and perhaps at least one other CMHT for comparative purposes, could have been undertaken.
- A non-participation observer assessment of a multi-professional team meeting of Mr H's CMHT and inclusion of a comparative CMHT could have been undertaken.
- To have interviewed a broader range of CMHT staff not involved in the Mr H case, and asked them to describe the usual referral and allocation process, their experience of team leadership, how case transfers are usually managed between teams. (This list is not exhaustive.)
- To have asked the Community Forensic Team Leader why he was content to accept such an inadequate process.

These would have provided a much richer source of information for the SEPT Team and may have enabled them to have a better perspective of 'how' the lapses in Mr H's care and treatment occurred as they did.

This being said, the Independent Team considers that the information presented in The Trust's report was sufficient for The Trust to recognise that it had significant systems and practice issues that it needed to address. The Independent Team is also satisfied that the root and branch review of the leadership arrangements across all CMHTs has negated the need for further analysis of this issue. To revisit the situation as it was in 2009-2010, when it is so vastly different now, would be of no beneficial value to enhancing the quality and safety of the service being delivered by The Trust.

"Team and Social Factors
A number of shortfalls around the Clinical management of Community Services in the location Mr H was being treated had been identified both in the period leading up to, and at the time of the incident. The substantive Team Manager had been seconded into the post of Clinical Group Manager, which had been created specifically to manage a cluster of community services and to provide enhanced clinical and managerial support to Team Managers and Acting Team Managers. Central to this was a need to manage the workload of the respective teams in a more focussed manner with an emphasis on managing caseload volume and complexity. To backfill this arrangement, the Professional Lead for Nursing within the Team was asked to act into the role of Interim Team Manager whilst receiving support from the Acting Group Manager.

It has transpired that, rather than establish tighter operational control and enhancing managerial effectiveness, no improvements were brought to bear in this CMHT around the management of caseload complexity and care co-ordinator workloads.

The failure to employ rigorous caseload monitoring systems, compounded by the decision to manage the individual on an outpatient /non-CPA basis, meant that, supported only by a Clinical Support Worker, the service user would not receive the level of care and support that circumstances warranted. This resulted in the care regime being scaled down from a sustained level of frequency whilst with the Community Forensic Team to one of occasional social support. By virtue of this arrangement, the CMHT did not have the ability to detect potential deterioration in mental state or indeed to detect any change in risk profile. This meant that any protective and proactive therapeutic interventions that were available whilst under the care of the Community Forensic Team were not forthcoming when care was transferred to the CMHT.

[*During the period under review*] *the Professional Lead for Social Care within* [*Mr H's CMHT*] *was asked to provide* [*acting leadership cover while the usual Team Leader was absent from work*]*. This process was conducted without any form of hand-over between the two leads and meant that an opportunity to review the caseload was missed. The manager* [*who initiated the temporary cover for CMHT team leadership*] *should have ensured that the incoming acting manager was given the requisite levels of support to assume the responsibilities of the role.*

From an operational and delivery perspective, the panel has identified a number of system deficiencies. These have ranged from weak caseload management arrangements to poor management of workload. Notwithstanding these, the centrality of the CPA process in this context was totally overlooked upon transfer to the CMHT. It would seem that the focus was on the process of securing a transfer rather than ensuring that legitimate care arrangements were being put in place to manage the client in a seamless manner. In this respect, the procedural requirements of the Trust CPA Policies were not followed."

Independent Team Comment

Notwithstanding the range of comments already made regarding the formulation of clear 'care concern statements' and ensuring consistency with these throughout the report, the SEPT Team has presented a succinct but informative analysis of how the basic standards of CMHT management were allowed to lapse as they did. The Independent Team suggests that the following information would have enhanced the analysis presented by the SEPT Team:

- Staff's perspective of the CMHT's functionality.
- Staff's perspective regarding the safety of their working practices.
- The frequency of supervision (management and clinical) across the team.
- Whether staff had any professional concerns about the safety of their service between 2009 and 2010 and what they did to raise these, and what response did they experience?

Where a Trust's investigation team identifies significant lapses in systems and processes, this Independent Team considers that there is always merit in trying to understand the whole team culture.

The main reason for this is, even though there has been a wholesale root and branch review of the leadership framework, if the culture remains the same, or damaging cultural issues remain unidentified and unaddressed, then there is a hidden threat to the success of the developmental work already undertaken.

The Independent Team emphasises that it has no reason to consider that there are cultural issues that need to be identified and addressed; its reflection above is specifically intended to inform the future conduct of serious untoward incident investigations and influence the breadth of enquiry undertaken.

5.0 CONCLUSION

Overall, the Independent Team is satisfied that the internal investigation conducted by The Trust was of a reasonable standard and that, in the opinion of the Independent Team, a re-investigation of Mr H's care and treatment will not materially add to the learning and improvement opportunities already identified by The Trust's SEPT Team and this quality assurance process.

With regards to the predictability of what happened, the Independent Team is of the opinion that, unmedicated, Mr H posed a serious risk of harm to his mother. Although Mr H's first index offence does not suggest intent to kill, the nature of it was such that death could have been a consequence. It was therefore predictable that, unmedicated and/or in relapse, Mr H posed a risk to the life of his mother.

With regards to preventability, this always needs to be considered carefully, avoiding hindsight bias[17] as far as this is possible to achieve.
In this case, a consequence of:

- the Trust's lack of system guiding the transfer of service users from forensic psychiatry to general adult psychiatry;
- the non- delivery of the requirements of CPA by the forensic service at the actual point of transfer;
- the non-assertive follow up of Mr H, following his family's reported efforts to make contact with Mr H's consultant psychiatrist;
- not maintaining as close a medical oversight of Mr H's management within the community as a service user with his history required; and
- lapses in the effective management of the CMHT by the then CMHT manager to ensure that Mr H was properly transferred into the CMHT and assigned an appropriate care coordinator who was able to maintain regular contact with him,

represent lost opportunities in the care and treatment of Mr H.
.

It is the considered view of the Independent Team that there would have been a range of possible courses of action had the concerns Mr H's family, been heard and acted on. These may have included, but would not have been limited to:

- An urgent review of Mr H could have been conducted by a consultant psychiatrist, preferably with a family member present; or, if not possible, with a clear history being obtained from the family.
- Mr H's Consultant Psychiatrist may have liaised with either the Community Forensic Team, or with Mr H's previous Consultant Forensic Psychiatrist for advice regarding ongoing management.
- If a care co-ordinator was not actively engaged with Mr H then urgent allocation would have been requested.
- If following assessment Mr H's risk(s) were determined as manageable in the community, with the agreement and support of Mr H's family, then this may have been progressed with:
    - Weekly home visits by the care co-ordinator;

[17] Hindsight Bias: This occurs when one 'looks back' with knowledge and information that was not available at the time and makes a judgement about what professionals should have done based on this information.

- Supervision of medication by the family;
- Medical review in a few weeks;
- All relevant contact numbers being provided to the family, with clear instruction that they were to immediately inform the CMHT if Mr H was not taking his medication or his behaviour deteriorated further;
- Until stabilised, Mr H to have closely supervised or no contact with his mother.

If Mr H's risk was identified as not manageable in the community by the CMHT, consideration in all likelihood would have been given to:

- Community management by the Crisis and Home Treatment Team; or
- Re-referral to the Community Forensic Community Team; or
- Admission of Mr H into hospital for stabilisation, enabled by detention under Section 2 of the Mental Health Act (1983) if necessary.

The key point in the above, is that there would have been assessment of Mr H, and a further course of action based on the outcome of that assessment however it was achieved.

5.1 Overall conclusion of the Independent Team

Had either of the options above been delivered, it is the opinion of the Independent Team that the incident which did occur on 25 June 2010 may still have occurred as it did, or (more likely) would have occurred at a later date. However, the risk of it occurring would have been much reduced.

6.0 RECOMMENDATIONS

There have been a number of substantial changes in The Trust since 2010 that render recommendations the Independent Team would have made as unnecessary. In brief, these changes are:

- The implementation of a care programme approach policy that requires all service users of working age meeting the CPA policy requirements to be allocated a care co-ordinator from within the appropriate community mental health team, even if the service user is in receipt of care and treatment from forensic services.
- The cessation of a community forensic team. All service users will now be discharged from low secure in-patient services directly to a general adult community mental health team, with a named consultant psychiatrist and a care co-ordinator who is a qualified professional.
- The Forensic Consultant may stay involved with a newly transferred service user for up to 6 months post transfer to the CMHT to ensure a smooth transition of RMO responsibility and clinical care. In these cases the Forensic Consultant and CMHT Consultant will joint work the case until it is agreed that the Forensic Consultant no longer needs to give input. The Care Coordinator will be either a CJMHT Community Mental Health Nurse or Social Worker, dependent on skills, experience, and matching the personality of the Care Coordinator with that of the patient
- A root and branch review of the operational management and clinical leadership of community mental health teams.
- A newly revised policy (currently in draft format) setting out how service users are to be discharged from low secure services to the general adult mental health service.

The Independent Team has a small number of recommendations that it believes will either enhance the effectiveness of the above, or result in improved robustness and completeness of future serious incidents requiring investigation.

Recommendation 1
The Independent Team has been provided with a copy of the proposed new policy document, *"Policy on the Transfer of Clients From Low Secure Services".* Detailed constructive commentary has been provided to the authors of the document via The Trust's Head of Serious Incidents.

Because of the increased risks associated with any transition period (i.e. transferring or discharging a patient from Team A to Team B), The Trust is asked to consider carefully the feedback provided, and to outline a clear rationale to the commissioners of its forensic and general adult mental health services if it decides not to embrace the principles of the commentary and advice provided.

Target Audience: The Trust's Executive Director responsible for Patient Safety, The Executive Director of Forensic Services.

Timescale: Because the *"Policy on the Transfer of Clients From Low Secure Services"* is currently under development, and near to completion, the Independent

Team suggests that The Trust should be able to complete its comprehensive working draft within three months of the acceptance of this report.

Recommendation 2
Building on Recommendation 1, The Trust is recommended to conduct a multi-disciplinary Failure Modes and Effects Analysis[18] (FMEA), or Control / Barrier Analysis across the forensic and general adult psychiatric service of its *"Policy on the Transfer of Clients From Low Secure Services"*. Ideally this should occur prior to implementation of the policy document.

In conducting the FMEA, Control/Barrier Analysis, The Trust is encouraged to set out the specific requirements of the new policy document in the order in which the activities are intended to happen, and also to consider setting out a flow diagram of who (or what professional) is expected to do and when. (The use of the principles of Swim Lanes may assist with this.) Once the FMEA chart reflects The Trust's policy (practice standard) requirements, then an appropriate group of professionals can be invited to conduct the identification of known and potential 'risk' points in the process.

For validation purposes, a second group of similarly qualified professionals working in the same areas could also be asked to contribute.

Once 'risk' or hazard points are identified:

- The consequence of the 'risk/hazard' occurring in the system as currently designed needs to be realistically and pragmatically worked through, including the ability of existing safety control to contain or mitigate the risk/hazard.
- The robustness of current and proposed safety controls needs to be considered at each risk/hazard point.
- Each of the multi-professional groups needs to consider whether there are any additional steps in the transfer process that, if introduced, would reduce the likelihood of occurrence of the identified risks/hazards, or the consequences of them if they were to occur.
- The work of both groups needs to be 'brought together' for comparative analysis and an agreed and cohesive remedial plan implemented.

Note 1: There is a wealth of technical information available about FMEA on 'the net' and the NPSA's RCA e-learning tool kit contains information about Control/Barrier

[18] Failure Modes and Effects Analysis (FMEA) is a systematic, proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures, in order to identify the parts of the process that are most in need of change. FMEA includes review of the following:

- Steps in the process
- Failure modes (What could go wrong?)
- Failure causes (Why would the failure happen?)
- Failure effects (What would be the consequences of each failure?).

Analysis as do some of the referenced texts on this site. The Health Foundation has also been sponsoring a Safer Clinical Systems project at Warwick Medical School since 2008, and this may be a useful resource for The Trust.

Note 2: The above recommendation is of particular relevance to the Mr H case, as it is recognised that transition periods between teams, services and organisations pose a heightened opportunity for risk. Taking a proactive approach to the identification of these prior to policy launch is one way of reducing this risk.

Target Audience: The Executive Medical Director and Executive Director of Clinical Governance and Quality, the Executive Directors of Integrated Services Bedford and Luton; and Essex, and the Executive Director of Forensic Services.

Timescale: The Independent Team appreciates that to conduct a meaningful FMEA requires careful thought and planning. It is also mindful that it is important that the implementation of the transfer policy, once ratified, is not unnecessarily delayed. Because the policy document is yet to be completed the Independent Team recommends that an FMEA is conducted with input from the locality involved in the Mr H case in the first instance, and during the consultation period before final ratification of the policy.

The Trust is expected to set out for the relevant commissioners of mental health services its timetable for achieving the above.

Recommendation 3

Although the Trust's investigation utilised nationally available guidance templates during the conduct of its investigation, and in principle met with the then and currently required investigation standards, there were a number of features of the Mr H investigation that could have been improved on if the Trust is to optimise opportunities for effective learning, and the consistent delivery of an effective investigation. The Independent Team recognises that this recommendation represents a 'gold standard' in the conduct of adverse event reviews, but it considers that SEPT has the necessary commitment at Executive and local levels of the organisation to deliver investigations of a higher quality.

To achieve this, the areas of investigation practice that the Independent Team considers the Trust may wish to consider are:

- The clear formulation of core competencies for all investigators tasked with the conduct of high impact/ high consequence incidents such as the case of Mr H. These core competencies might include:
  - Knowledge of a range of investigation techniques such as analytical Timelining, Control Analysis, Person / Placement grids
  - Knowledge of how to conduct a repeatable information analysis using tried and tested qualitative research techniques such as Content Analysis and Affinity Mapping
  - Knowing what issues to conduct a contributory factors analysis on
  - Investigative Interviewing, including question formulation such as the "tell all" instruction, reflect back, and effective note taking

- The quality of interview records made. Attention needs to be given to interview records that are data rich, and reflect the full depth and breadth of the interview content, including evidence of 'reflect back'.
- The Trust, as a component of the quality assurance standards must include consideration of the fairness with which lapses in practice have been addressed across all professional groups. Although not at all intended the Mr H report did not come across as balanced in its criticisms across the range of professional groups involved.

In addition to the above points, specific and detailed guidance has been provided by the Independent Team to The Trust with regards to:

- The conduct of the investigative interview;
- The formulation and analysis of identified care concerns (significant lapses in practice standards).

Target Audience: The Trust's Executive Director of Clinical Governance and Quality.

Timescale: Realistically, The Trust needs at least six months to address the above.
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Recommendation 4:
As a consequence of the Mr H case, The Trust undertook a root and branch review of the operational management and clinical leadership of community mental health teams. The intention was to achieve a wholesale improvement in clinical and operational functioning. One specific issue of direct relevance to the Mr H case is how service users are reallocated within a community mental health team if their care co-ordinator goes on medium- to long-term sick leave, or leaves the team.

The Trust needs to satisfy itself that the improvements implemented for community mental health teams has resulted in a situation where there is no opportunity for the circumstances Mr H endured to be repeated. That is, when his care co-ordinator was absent from work, he was allocated to a community support worker (this should not have happened), and when the community support worker left the team in January 2012, Mr H was left as an 'outpatient' follow-up-only patient.

The recommendation of the Independent Team is that the Executive Directors of Integrated Services Bedford and Luton; and Essex, must satisfy themselves that, in comparable circumstances, regardless of whether or not the service user has a forensic history, all of the community mental health teams are consistently attending to the appropriate reallocation of care co-ordination responsibility.

The results of the assessment of this aspect of practice and community team operations must be reported to the Director of Adult Services and the Chair of the Clinical Governance and Quality Committee.

Target Audience: The Executive Director of Integrated Services Bedford and Luton

Timescale: The conduct of this audit will take some careful consideration and planning. It is likely that the community mental health team managers will be the best sources of information regarding the frequency with which a service user's care co-ordinator needs to be re-allocated because of absence from work and/or an individual leaving the team. The Independent Team recommends that The Trust presents the appropriate commissioners with its audit plan, including an achievable timescale for delivery, within eight weeks of the acceptance of this report.

APPENDIX 1 INDEPENDENT INVESTIGATION METHODOLOGIES

The independent investigation commissioned by NHS Midlands and East constituted a quality assurance review and therefore required modification of the more traditional investigation process that has historically been applied to delivering the principles of Health Circular Guidance (HSG 94 27).

A qualitative process was adhered to, with data analysis robustness being achieved as far as it was possible to do so with the usage of the recognised qualitative research techniques of content analysis and affinity mapping.

Specifically, the Independent Team conducted the following:

- The construct of a detailed analytical timeline drawing information from Mr H's clinical records, appropriate policies and procedures, and The Trust's interview records.
- Mr H's records were independently analysed by Dr Holmes and Dr Haeney.
- A team meeting of all three Independent Team members enabled clarity regarding areas where the Independent Team was in agreement with the SEPT Team and areas where the Independent Team considered there could and should have been more inquisitive enquiry.
- The team meeting also provided the vehicle for the Independent Team to come to a decision regarding the need for further independent investigation.

The Independent Team did not specifically utilise any human factors analysis tool such as the NPSA's human factors framework and the fishbone, because it was not necessary for the conduct of the quality assurance review.