An independent investigation into the care and treatment of a mental health service user (X) in Bedfordshire by South Essex Partnership University NHS Foundation Trust

October 2014

Contents

Appendices

1. EXECUTIVE SUMMARY

1.1 NHS England, East region commissioned Niche Patient Safety, (Niche) a consultancy company specialising in patient safety investigations and reviews, to carry out an independent investigation into the care and treatment of a mental health service user (X). The terms of reference are at Appendix A.

1.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27,on the discharge of mentally disordered people, their continuing care in the community and the updated paragraphs 33-36 issued in June 2005.

1.3 The main purpose of an independent investigation is to identify whether there were any aspects of the care which could have altered or prevented the incident. The investigation process will also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.4 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

1.5 We would like to express our sincere condolences to Mr Y's family. It is our sincere wish that this report does not add to their pain and distress.

The Incident

1.6 During the day of 25 February 2011 X went to the house of Mr Y in Hainault, London. At around 18.00, when Mr Y opened the door, X attacked Mr Y with a knife, causing fatal injuries. Mr Y was discovered by his son Z, at around midnight on 25 February 2011.X was arrested on suspicion of the murder of Mr Y on 28 February 2011.

1.7 X had a period of care provided by secondary mental health services between October 2010 and February 2011.

1.8 He was initially referred to primary care 'Talking Therapies' in August 2010, and to mental health services by his GP in September 2010, after a period of time off work with anxiety, panic attacks and depression. He was seen for assessment on 15 October 2010 by a psychiatrist from the Luton Assessment and Single Point of Access (ASPA) team.

1.9 He was assessed as having intermittent thoughts of suicide but no active plans. There is no record of an assessment of risk to others at the time. His antidepressant medication, citalopram,[1] was increased, and he was given a

[1] *Citalopram hydrobromide is used to treat a variety of mental health problems. It is thought that Citalopram hydrobromide increases the activity and levels of certain chemicals in the brain. This can improve symptoms such as depression and anxiety. http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Anxiety&medicine=citalopram*

further out patient appointment in 4 weeks' time, when a referral to psychology would be considered.

1.10 He was seen again on 22 November 2010 and referred to psychology for assessment following disclosing psychological conflicts and anxiety.

1.11 X was next seen by a psychiatrist on 13 December 2010 and disclosed that over the weekend he had left his delivery lorry and taken the train to the house in Borehamwood where his mother used to live with his 'stepfather' Z. He stated he disclosed this because he wanted help.

1.12 He reported that he had bought a baseball bat (and later disclosed he had a knife) and waited outside the house from 14.00 to 23.30, with the intention of killing Z. He went again to the address on the following day but did not find Z.

1.13 The psychiatrist informed the police, and referred X to the Luton and South Beds Crisis Resolution and Home Treatment Team (CRHTT) on 13 December 2010, for more intensive input.

1.14 X was seen and assessed at home on 14 October 2010 by a nurse from the CRHTT. Because the issues were complex, the nurse sought a team discussion, and a decision was made to offer admission to the mental health admission unit (MHAU), after a discussion with the CRHTT consultant.

1.15 X agreed to this and arrived at the MHAU for admission. During the admission process X said he didn't want to stay there, and it was agreed he would attend an appointment with the CRHTT consultant on the following day.

1.16 He was seen and assessed by the consultant on 15 October 2010, and a plan agreed; to be seen daily by the CRHTT, to continue medication, and offer admission if any further concerns arose. It was noted he was not detainable under the Mental Health Act[2] (MHA) at that time.

1.17 Although there were a series of daily phone calls made, some of which he answered, the CRHTT did not actually see him again until a cold call was made on 18 January 2011.

1.18 On this occasion his flat was observed through the letterbox to be in disarray and although X was present, he would not respond to staff.

1.19 Following a team discussion, a Mental Health Act assessment (MHA) was requested; but because of operational issues was not carried out, though police were asked to do a welfare check.

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[2] The Mental Health Act 2007 made several key changes to the 1983 Mental Health Act, which laid down provision for the compulsory detention and treatment of people with mental health problems in England and Wales.http://www.legislation.gov.uk/ukpga/2007/12/contents

1.20 It was reported back to the CRHTT by the approved mental health professional (AMHP)[3] that the police had visited and X was reported to be fine. After team discussion the CRHTT consultant asked for a formal MHA assessment, which was carried out on 21 January 2011 under Section 135 MHA.[4]

1.21 X was assessed as not detainable under the MHA, and a plan of follow up action was proposed, including an appointment with his previous consultant at the ASPA/Community Mental Health Team (CMHT). X did not attend this follow up appointment on 27 January 2011, and it was agreed the CMHT would follow up. He was then discharged from the CRHTT with a diagnosis of Panic Disorder with Depression on 27 January 2011.

1.22 X attended an appointment with the CMHT psychiatrist on 17 February 2011, and was noted to have no evidence of psychosis or affective features, and he denied any thoughts of harm to himself or others. He was given a further appointment for four weeks later.

1.23 The homicide of Mr Y (Z's elderly father), was carried out at Mr Y's home address on 25 February 2011. X had travelled there with the intention of killing Z.

1.24 He had waited outside the house for Z to return, and when Mr Y returned instead, he decided to kill him, knocked on the door and fatally stabbed him.

1.25 X pleaded guilty to the murder of Mr Y and on 20 January 2012 was sentenced to life imprisonment, with a recommendation that he serve 21 years.

1.26 Following this tragic incident South Essex Partnership University NHS Foundation Trust (the Trust) conducted an internal investigation which identified five Service Delivery Problems (SDPs) and no contributory factors.

1.27 The SDPs identified were:

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[3] The role of approved social worker, or ASW, has now been replaced by that of approved mental health professional, or AMHP, in England and Wales. The 2007 amendment of the Mental Health Act 1983 abolished the professional role of the approved social worker and created that of the approved mental health professional. This role is broadly similar to the role of the approved social worker but is distinguished in no longer being the exclusive preserve of social workers. It can be undertaken by other professionals including community psychiatric nurses, occupational therapists and psychologists after receiving appropriate training. http://en.wikipedia.org/wiki/Approved_mental_health_professional

[4] Section 135 MHA 1983 Warrant to search for and remove patients .If it appears to a justice of the peace, on information on oath laid by an approved mental health professional, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder—(a)has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or (b)being unable to care for himself, is living alone in any such place, the justice may issue a warrant authorising any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.

- *Lack of overall coordination of X's care;*
- *No involvement with X's family;*
- *No contingency plan in the case of non-compliance;*
- *Lack of clear responsibility for carrying out actions following the mental health assessment; and*
- *Differing views about level of risk to others at the Mental Health Act assessment.*

1.28 The Trust's investigation also identified a number of findings, and made seven recommendations. The recommendations of the internal investigation are in section 6 of this report and the action plan is at Appendix D.

1.29 The independent investigation team has studied policies, GP notes, clinical records and police reports. We have also interviewed those most closely involved in X's care and met with X and his partner.

1.30 We concur with the recommendations made, and in addition, our independent investigation has developed further findings in the following areas:

- Communication with families after a serious incident;
- Approaches to assessing and managing risk;
- Adherence to adverse incident policy;
- Response to psychology referrals;
- Admission protocols in Luton mental health in patient services;
- Communication with patients about a change in diagnosis; and
- Assurance systems to evidence completion of actions following serious incident investigations.

1.31 In the light of our findings we believe that given his history and current lifestyle, it was likely that X would come to police attention again. He had previously expressed serious intent to kill D, and this was reported to the police. He had reassured Trust staff that this was no longer in his mind, and assessed as not detainable under the Mental Health Act on 21 January 2011. There was never any indication that Mr Y, the father of D, was at risk.

1.32 In our opinion it was not predictable that this tragic event would occur in February 2011.This particular incident was not in our opinion preventable, in the sense of a deliberate action being taken to avoid a predicted or likely event.

1.33 However, the independent investigation team believes there are lessons to be learnt and has made the following recommendations:

Recommendation 1.

The Trust should develop systems that provide assurance regarding the implementation of key policies such as the assessment and management of clinical risk.

Recommendation 2
When organisational structures and policies are changed, there should be a mechanism to ensure that policy and practice changes are aligned, and any relevant forms or documents are updated accordingly

Recommendation 3
The Trust should review the policy for ensuring that service users are kept informed about their care, including copying correspondence to the service user.

Recommendation 4
Where a decision is made to change a service user's diagnosis, this should always be communicated in a face to face discussion with the individual, allowing time for explanation and any concerns and questions. We believe the Trust should ensure this is embedded into practice.

Recommendation 5
The Trust should review the services that are available for assessment and treatment for service users with personality difficulties along with other mental health issues.

Recommendation 6
The Trust should be satisfied that there is clear practice guidance for the management of risk items on admission to Jade Ward, and that any guidance on restrictions is reasonable, proportionate and necessary.

Recommendation 7
The Trust should ensure that communication with families is carried out in line with the Trust's adverse incident policy, and follows guidance in the Memorandum of Understanding[5] and best practice guidance[6] and there are assurance systems that evidence this concordance with policy.

Recommendation 8.
The Trust should review the systems in place to sign off action plans from serious incidents, and ensure that there is an assurance process to evidence implementation and embedded practice changes.

1.23 The following examples of good practice have been highlighted:

[5] *Memorandum of understanding between the NHS counter fraud service and the Association of Chief Police officershttp://www.nhsbsa.nhs.uk/Documents/mou_acpo_cfs.pdf*
[6] *Independent investigation of serious patient safety incidents in mental health services provides best practice guidance on investigations into mental health services http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59836*

- The sharing of information about risk with the Police;
- The instigation of a Mental Health Act assessment following disengagement;
- Learning events have taken place for a range of professionals on learning lessons and understanding the management of serious incidents; and
- External quality reviews are carried out into the investigation of serious incidents.

2. INTRODUCTION

2.1 On 25 February 2011 X spent several hours in the vicinity of Mr Y's home address. At around 18.00 he knocked on the door, and when Mr Y answered, he attacked him with a knife. Mr Y died from his wounds, and he was discovered later that night by his son Z.

2.2 At the time of the incident X was living in his flat in Luton, and spending time at his partner's flat in Bedfordshire. He had contact with mental health services between October 2010 and February 2011.

2.3 X was seen and assessed by the Luton and South Bedfordshire Assessment and Single Point of Access (ASPA) team on 15 October 2010. He was later referred to the Luton and South Beds Crisis Resolution and Home Treatment team (CRHTT) and offered an admission to the Mental Health Assessment Unit (MHAU). He was referred back to the care of the Community Mental Health Team (CMHT) in January 2011.

2.4 The investigating team would like to express our sincere condolences to Y's family. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of X up to the point of the offence.

2.5 We would like to express our thanks to the families, members of staff of the Trust, and GP practice involved for their contributions.

3. DETAILS OF THE INVESTIGATION

3.1 Approach to the investigation

3.1.1 The independent investigation follows the Department of Health guidance, on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. [7] The terms of reference for this investigation are given in full in Appendix A.

3.1.2 The main purpose of an independent investigation is to discover whether there were any aspects of the care which could have altered or prevented the incident. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

3.1.3 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.

3.1.4 The investigation was carried out by Carol Rooney, Senior Investigation Manager for Niche Patient Safety, with expert advice provided by Dr Ian Davidson. The investigation team will be referred to in the first person plural in the report. The report was peer reviewed by Nick Moor, Niche Director.

3.1.5 The investigation comprised a review and analysis of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[8]

3.1.6 We used information from X's clinical and GP records, evidence gathered from the internal investigation report and police case summary. As part of our investigation we interviewed:

- the author of the internal investigation;
- the Deputy Director of Mental Health and Social Care;
- the Medical Director/Consultant for the Luton CRHTT;
- the Associate Specialist for the Community Mental Health Team (CMHT);
- the CRHTT Manager;
- The Lead Psychologist;
- The Talking Therapies Counsellor;
- the Director of Nursing;
- the Head of Serious Incidents and Quality and
- X's GP.

[7] *Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services*

[8] *National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

3.1.7 These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature. We also conducted telephone interviews with the:

- Approved Mental Health Practitioner (AMHP) who assessed X on 21 January 2011; and
- Assessment and Single Point of Access psychiatrist.

Both were given the opportunity to review transcriptions of the conversation and amend if required.

3.1.8 We had access to the Trust's reports produced at the time of the internal investigation. We met the lead author of the internal investigation in order to understand the Trust's investigation process.

3.1.9 We wrote to X at the start of the investigation, explained the purpose of the investigation and asked to meet him. We then met him on 2 July 2014 in prison. X gave written consent for us to access his medical and other records.

3.1.10 We wrote to the victim's son Z to invite his involvement, but received no response.

3.1.11 We met with X's partner to explain the purpose and process of the investigation.

3.1.12 A full list of all documents referenced is at Appendix E.

3.2 Structure of this report

3.2.1 Section 4 sets out the details of the care and treatment of X. We have included a full chronology of his care at Appendix C in order to provide the context in which he was known to Trust services.

3.2.2 Section 5 examines the arising issues from X's care and treatment, gives details of police involvement and includes comment and analysis.

3.2.3 Section 6 reviews the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

3.2.4 Section 7 sets out our overall analysis and conclusions.

4. THE CARE AND TREATMENT OF X

4.1 Childhood and family background

4.1.1 X was born in 1976 in Lincolnshire and brought up in Hertfordshire. He has one younger brother, who he reported he is not in touch with.

4.1.2 His father left the household when he was three years old. His mother remarried and X has stated that this man sexually abused him. It is not known whether this was reported to the authorities at the time or later, but his mother divorced this man. X reported that this man had subsequently died.

4.1.3 X has reported that his mother asked him to move out of the house when he was 14, and he used to sleep on park benches, visiting the house in the morning to collect his school uniform. Around this time he reported that he started taking drugs and getting into trouble.

4.1.5 X stated that one stepfather was a real father to him, and he adopted his name.

4.1.4 His mother married Z (the victim's son), who was initially her lodger, about a year and a half before she died.

4.1.5 His mother suffered from alcoholism and died in 2009 due to the physical effects of chronic alcohol abuse. Z then inherited the house in Borehamwood where X's mother had lived.

4.1.6 Prior to the incident, X was living in his council flat in Luton, and spending time at his partner's flat in Bedfordshire.

4.2 Education and Employment History

4.2.1 X left school without any qualifications.

4.2.2 He started working as a delivery man after leaving school, and remained in employment.

4.2.3 In 2001 he got a job as a courier which he held for five years. Up to 2010 he worked as a delivery driver for a parcel company, though he was dismissed in late 2010 after a period of absence. It is clear from subsequent events that he was very unsettled after the burns at work in June 2010. His dismissal could be seen to be largely the result of his deteriorating mental health.

4.3 Relationship history

4.3.1 X has one daughter aged 15 from a previous relationship. She used to stay with him at weekends regularly, until a few months before the incident.

4.3.2 He described this relationship as very important to him, and maintained regular contact, admitting that he occasionally had to cancel visits because of his alcohol or drug use.

4.3.3 In the months prior to the incident he reported that his ex-partner had stopped him from seeing his daughter because she was concerned about his mental health. This was known but could not be explored by services, because X would not give contact details.

4.3.4 He has been in a relationship with his current partner since 2010, after meeting through work.

4.4 Substance misuse history

4.4.1 X reported to the assessing psychiatrist in October 2010 that he had used heroin, crack cocaine and cannabis in the past. At this assessment he denied using any illicit drugs for the previous 8 or 9 months, but said he used alcohol occasionally.

4.4.2 At interview in July 2014 X told us that he had been using illicit drugs and had accessed harder drugs such as heroin around the time of his mother's death in 2009. On the night before the homicide in February 2011 he reported staying up most of the night taking drugs.

4.4.3 He also reported to us that he had been drinking alcohol on the day in December 2010 when he waited outside the house with a knife and baseball bat, intending to kill Z.

4.5 Contact with criminal justice system

4.5.1 His first formal contact with police was in his 20s, when he reports he had a drunken 'squabble' with taxi drivers. This occurred after a night of drinking, following breaking up with his then girlfriend, the mother of his daughter. He received a short prison sentence for wounding.

4.5.2 He was sentenced to three years in prison in 1998 for armed robbery, and described robbing petrol stations while brandishing a weapon.

4.5.3 X described leaving prison to live in a bail hostel in 2001 and being determined to change his life.

4.5.4 There were no further convictions after 2001 until the conviction for homicide in 2012.

4.6 Physical health

4.6.1 X had no physical health issues until in June 2010 he had an accident at work. He reports that a parcel spilled open and the fluids caused burns to his legs and arm, and he got some of the fluid in his mouth. He attended A&E where it is recorded he had redness to the skin, but no deep burns. No treatment was necessary, and a dry dressing was applied. X did not attend the follow up appointment.

4.6.2 He began to feel anxious and depressed, found work difficult to cope with, and visited his GP asking for help in June 2010.

4.7 Psychiatric history

4.7.1 X was admitted to Hill End adolescent unit in1991 for a month, after his mother expressed concerns about him stealing, taking drugs and associating with a '*crowd who were in trouble with the law'*. While an in-patient X was described as quiet, and working hard at GCSEs. At a review meeting in March 1991 the discharge summary notes that his mother was pleased at the changes she had seen and, after a successful weekend leave, he did not return. The family did not request any follow up.

4.7.2 In 1999, aged 23, he attended his GP to request help with anger and aggression management, reporting that his verbal and physical aggressive outbursts were causing a great deal of strain on both his relationship and at work. He was referred to psychology at Hillingdon Hospital in April 1999.He did not attend, and after four appointments being offered, he was discharged back to his GP. He reported cutting himself after breaking up with his girlfriend. There were no further contacts with his GP or mental health services until 2010.

4.7.3 X attended his GP after the accident at work in June 2010.He reported taking time off work because of anxiety and depression, and not sleeping well. He was offered counselling, but opted to try medication first to see if that helped. He was prescribed citalopram 20 mg daily.

4.7.4 He was reviewed in July 2010 by his GP and was still getting panic attacks and insomnia, and finding the citalopram was not helping. He was referred to a primary care counselling service 'Talking Therapies'. X saw this counsellor for six sessions for management of anxiety symptoms, which was initially successful in getting him back to work in October 2010. However he returned to his GP after feeling ill and unsafe to drive at work.

4.7.5 The GP increased his citalopram to 40 mg daily in September 2010, and referred him to the community mental health team (CMHT) in Luton for psychiatric assessment.

4.7.6 X was seen for assessment by the speciality doctor in psychiatry, and diagnosed as having panic disorder with depression (F41.0, F32).[9] He was

[9] *International Classification of Mental and Behavioural Disorders http://www.who.int/classifications/icd/en/bluebook.pdf F41 Other anxiety disordersF41.0 Panic disorder [episodic paroxysmal anxiety], F32 Depressive episode*

reported to have had intermittent thoughts of suicide, with no active plans. His daughter was reported to be a strong protective factor against suicidal thoughts. There was no record of whether harm to others was assessed. A letter describing the assessment and plan was sent back to the GP.

4.7.7 The management plan proposed was:

- increased citalopram to 60mg;
- prescribed lorazepam[10] 1mg to take as required for anxiety;
- to see again in 4 weeks' time; and
- consider a referral to psychology after the next appointment depending on the response to Citalopram.

4.7.8 X was seen by a different psychiatrist (K1) on 22 November 2010, where he reported feeling '*depressed and always on edge, and spoke of many psychological conflicts that distress him'*. The notes record that X had not expressed thoughts of harm to self or others, and there is '*no risk at the moment'*. The plan proposed was:

- continue on the same treatment;
- make a referral to psychology; and
- see again in four weeks.

4.7.9 The psychiatrist referred X to the psychology department on 3 December 2010, describing him as having a lot of psychological conflicts because of his '*sad and difficult childhood'*. A psychological assessment and further therapy was requested. Letters were all copied to his GP, but not to X.

4.7.10 At his next appointment on 13 December 2010, X disclosed to doctor K1 that when at work on 10 December he had parked his lorry and taken the train to Borehamwood (to the house his mother used to live in). He bought a baseball bat (and later disclosed having a knife) and planned to kill D (the man his mother had married before her death). He disclosed that he believed D had been encouraging her abuse of alcohol, and because of this she died. He reported waiting in bushes in front of the house between 14.00 and 23.30. D did not appear at all, and by 23.30 he reported being cold, and had many texts from his partner, who came to pick him up.

4.7.11 X told doctor K1 he returned to the house the following day but did not find Z. He disclosed that thoughts of killing Z had been present for a while, but deep inside he didn't want to do it. X said he had discussed this with his partner, and he had decided to disclose his thoughts so he could get help. No thoughts of harm to himself or anyone else apart from Z were elicited.

4.7.12 Doctor K1 told X he would need to inform the police, and proceeded to report the disclosure and X's actions over the weekend. This was logged by Bedfordshire police and Dr K1 was given a 'URN' (reference) number.

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[10] *Benzodiazepines like lorazepam are prescribed for short periods of time to ease symptoms of anxiety, or sleeping difficulties caused by anxiety. http://www.patient.co.uk/medicine/lorazepam-a-benzodiazepine*

4.7.13 When X's partner arrived to collect him, Dr K1 spoke to her briefly without X present, asking if she had any concerns, and was told she didn't, X was '*fine with her'*.

4.7.14 Dr K1 then referred X to the crisis resolution home treatment team (CRHTT) on the same day, because he believed X required more intensive input than the CMHT or ASPA could provide. The referral by Dr K1 describes X as "*extremely volatile at the moment, and cannot control his thoughts and emotions...he appears very cold and there is high risk of him harming the person in question".*

4.7.15 The referral was logged by CRHTT at 19.15 on 13 December, and X was phoned at 19.25, to arrange a visit in the morning. X was assessed at his flat by a nurse from the CRHTT on 14 December 2010. The 'First Contact/Crisis assessment of Risk form' used by the CRHT notes his risk of violence or harm to others as '2- medium'. The nurse stopped the assessment due to '*the complexities of the matter'*, to discuss with the team and consultant Dr K2. Dr K2 advised he be offered admission to MHAU for further assessment, to which X agreed.

4.7.16 It was arranged for X to be picked up by taxi, and he arrived with a bag packed. X states that he got as far as a bedroom, when he was asked to give his belt and shoelaces in to staff. He refused, and insisted on leaving. The notes record that he refused to stay because he wasn't allowed to smoke.

4.7.17 It was agreed that he would go home, and return to see Dr K2 the following day. At the time of leaving he denied any thoughts of self-harm but "*continues to have thoughts in the back of his mind".* This statement is not explained, but we believe it is likely that this relates to thoughts of harming others. X agreed to ring CRHTT or attend A&E if thoughts of harming himself or others got worse.

4.7.18 X attended the appointment with the CRHTT doctor K2 on 15 December 2010. He denied any thoughts of harming himself or others, or specifically of harming Z. There were no psychotic features reported, but symptoms of depression were present and it was noted that he had insight. He was assessed as not requiring assessment for detention under the Mental Health Act (MHA),[11] and that "*with CRHTT input/medication, risk can be further minimised. To offer admission if further concerns"*.

4.7.19 The 'Risk Management Plan for CRHT only' was partially completed on 15 December 2010, noting that X has been accepted for CRHT, and categorised as 'RED' that is for a daily visit. The form notes that the service user is involved in the plan, by circling 'yes'. There is space for indicating

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[11] The Mental Health Act 1983 (c.20) is an Act of the Parliament of the United Kingdom which applies to people in England and Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. http://www.legislation.gov.uk/ukpga/1983/20/contents

whether the carer is involved and has agreed, which had not been completed.

4.7.20 A phone call was made to X the following day, and a voicemail was left. CRHTT staff spoke to X on the phone on 17 and 18 December 2010; he initially agreed to meet with CRHTT staff, but later telephoned to say he was staying in his partner's flat and couldn't return because of snow.

4.7.21 There is a subsequent 'Initial summary of risk assessment' form, partially completed, dated 20 December 2010. This form records the risk of violence to others as '1-low'. There is no narrative to this assessment, and no risk management plan. The form is initialled but not signed. This form has the footer 'Bedford & Luton Partnership NHS Trust/Pilot December 2008', so was clearly left over from the previous provider.

4.7.22 The CRHTT continued to try to contact X by phoning daily and cold calling at his flat. There is no record of his partner's address. Between 17 December 2010 and 1 January 2011 the CRHTT staff spoke to X eight times on the phone, and recorded telephone contact only. There is an entry in the notes where he promises to attend on 24 December 2010, but there is no record of whether this took place. His lack of engagement was discussed at a team meeting on 4 January 2011, and it was recorded that as he did not want to work with CRHTT, he would be discharged and an outpatient appointment should be arranged with Dr K1 in the CMHT.

4.7.23 The discharge process was started but the notes record *'phone call to Luton West CMHT to discuss discharge plans but X is open to ASPA so call transferred'*. After discussion with Dr K1 at ASPA/CMHT, it was decided to offer an outpatient appointment with Dr K1 on 17 January 2011 '*in view of past risk'*. At interview it was explained that it was felt X had a positive relationship with Dr K1. X did not attend this, and a cold call was agreed on.

4.7.24 A cold call was made to X's flat, the staff looked through the letterbox and saw that the flat was in disarray. X would not respond to the call although he was in the flat.

4.7.25 Following discussion with Dr K2, it was agreed an assessment under the MHA should be requested. The approved mental health practitioner (AMHP) informed the CRHTT that it was not possible to do an assessment before 17.00, and it was passed to the emergency duty team. It appears from the notes that the duty team asked the police to carry out a welfare check, and it was reported back that the police had seen him and he said he was fine, but did not let the police in his flat.

4.7.26 There was a discussion the following day with the CRHTT consultant Dr K2, and it was agreed that a formal MHA assessment be requested again. The AMHP agreed to apply for a Section 135 warrant.[12] This was good

[12] *Section 135 MHA 1983- Warrant to search for and remove patients.*
(1)If it appears to a justice of the peace, on information on oath laid by an approved mental health professional , that there is reasonable cause to suspect that a person believed to be suffering from mental disorder— (a)has

practice given the risks noted in December, poor engagement, and the reported state of the flat.

4.7.27 The MHA assessment was carried out on 21 January 2011, and it was agreed he was not detainable, but the following recommendations were made:

- Outpatient appointment with Dr K1 at CMHT on 27 January 2011;
- Dr K1 to discuss possible allocation of care coordinator in team meeting;
- Dr K1 to speak to team psychologist regarding psychotherapy;
- X advised of bereavement counselling service;
- consider drug use and any support that may be necessary;
- consideration to notify other agencies of the ongoing potential risk to others, looking at risks to children as his ex-partner is currently prohibiting access to his daughter;
- contact police to ensure 'stepfather' is aware of risk to him and liaise with police regarding an alert on 'stepfather's' (D) address;
- CRHTT to discharge X today;
- citalopram to continue; and
- out of hours contacts given.

4.7.28 A discharge letter was sent to the CMHT from the CRHTT on 27 January 2011 informing them of this, confirming his diagnosis of panic disorder, the appointment on 27 January 2011, and the recommendation from the Mental Health Act assessment that he would benefit from a care coordinator and a referral to a psychologist. This letter was copied to Dr K1, X's GP, but not to X.

4.7.29 X did not attend the appointment on 27 January 2011. On 14 February 2011 Dr K1 wrote to him informing him that his diagnosis had been changed to 'Associated' (sic) Personality Disorder ICD10 F60.2'; that the team did not think he needed a care coordinator, and he had been referred to a psychologist. He was offered a further appointment on 3 March 2011. This letter was copied to X's GP.

4.7.30 Dr K1 wrote to X's GP on 25 February 2011, after a review on 17 February 2011.
Dr K1 reported that X attended on 17 February 2011, and that he had no thoughts of harm to himself or anyone else, was "*compliant and insightful",* to continue on citalopram 60mg, and review in 3 months.
It was noted by Dr K1 that the "*psychology referral was already done"*.

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been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or (b)being unable to care for himself, is living alone in any such place, the justice may issue a warrant authorising any constable . . . to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.

4.7.31 X killed X W on 25 February 2011.

4.8 The homicide

4.8.1 At our interview X described he had been feeling much better, had been staying with his partner in Bedfordshire, and described himself as starting to enjoy life again. He had begun to decorate his Luton flat, and was looking forward to the future. On 24 February 2011 he visited his mother's grave in Borehamwood. He said he then drove past the house she had lived in with Z for 'old time's sake', remembering family life.

Neighbours that he knew were in the nearby gardens so X stopped to chat. He reported being surprised when Z later arrived at the house and offered to show him the changes he had made in the house. X stated it was completely changed from when his mother had lived there.

4.8.2 X said he spent some time with Z, who took him for a drink at a pub nearby. When he was leaving, Z gave him some old papers of his mother's and some money.

4.8.3 X stated that he drove to his flat in Luton and bought drugs and alcohol, and stayed up all night ruminating, reporting that his mind kept dwelling on the unfairness of it. He was angry about the changes that Z had made in the house and felt that Z was responsible for his mother's decline in health. That night he decided that he would kill Z. He came across an address in the papers that Z had given him, and realised it was Z's father's address (Mr Y) in London. He also thought Z must live there, because he wasn't living at the Borehamwood house. He decided to go there the following day to kill him.

4.8.4 X said he still had the baseball bat and knife, and in the afternoon of 25 February 2011 he drove to the address to wait for Z. He noticed Z's car drive away shortly after he arrived and decided to wait. At around 18.00 another car arrived, and he realised that this must be Z's father. X decided he would kill him instead, thinking that Z would then understand how he, X, feels. When Mr Y answered the door, X fatally injured him with the knife and left.

4.8.5 X pleaded guilty to murder and was convicted on 20 January 2012, and sentenced to life imprisonment with a recommendation that he serve 21 years. There was no mental health defence presented. The sentencing Judge said X had "*murder on his mind*" when he went to the victim's house armed with a knife.

5. ARISING ISSUES, COMMENT AND ANALYSIS

5.1 In this section we review the interventions offered to X, and policies and procedures in place in the Trust when X was receiving care from mental health services.

5.2 We also looked at the Trust's current policies and procedures and other documentation, to consider adherence to policy and any changes that have been made since the incident in February 2011. We interviewed senior Trust managers who described how policies and procedures have been changed and implemented. A full list of the documents reviewed can be found in Appendix E.

5.3. We have focussed on the points identified in the terms of reference and further areas that have emerged during our investigation. We have reviewed the documents that the Trust has provided as evidence of implementation.

The terms of reference for this investigation asked that we:

- Review the care, treatment and services provided by the NHS from the service user's first contact with services to the time of their offence.
- Review the appropriateness of the treatment of the service user in light of any identified health needs.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming himself or others.
- Examine the effectiveness of the service user care plan including the involvement of the service user and the family.
- Observing the principles of "Being Open" involve the families of both the victim and the perpetrator as fully as is considered appropriate and according to the families wishes.
- Consider if this incident was either predictable or preventable.

5.4 **Comment**

From our investigation we find that X was provided with appropriate treatment by his GP following his presentation with depression and anxiety symptoms in June 2010. He was initially prescribed citalopram 10mg, then later referred to a primary care counselling service, 'Talking Therapies' to assist with his anxiety symptoms. He received six sessions focussed on managing his anxiety about returning to work. X said he found these helpful, and did in fact return to work for a short period.

5.5 Although his anxiety symptoms initially improved with counselling, at interview his GP said he remained concerned about his depression, so decided to refer him to secondary mental health services for diagnosis and possible treatment, on 21 September 2010.

5.6 The referral was received by ASPA on 21 September 2010, and it is noted the outcome of an MDT discussion was that X was offered a medical appointment with a psychiatrist on 12 October 2010. The Luton ASPA referral log notes that he should be due for discharge or transfer to the CMHT by December 2010.

5.7 At this time the ASPA team was seen as the 'front door' of the CMHT, and would assess, provide short term treatment, signpost to other services, or discharge back to the GP. It was acknowledged by Trust senior management that at this time the ASPA service was seen as a separate team, and communication across the three parts of the community acute mental health service was not streamlined. This has since been clarified, with the ASPA function now provided by CMHT staff, rather than a separate team.

5.8 Risk assessment

5.8.1 The assessment by the psychiatrist in October 2010 shows good history taking and positive attempts to understand X's presentation. Risk was explored in relation to self only; it was noted he had no active plans of suicide, though had intermittent thoughts. There is no mention of assessment of risk to others. Although X had not at this stage verbalised thoughts of harm to D, we believe risk to others should have been explored and noted. Significant issues relating to potential risk to others had been disclosed including past history of violence and carrying and using weapons and that his ex-partner had stopped him having visits from his daughter because of her concerns. Not assessing the level of risk to others was despite evidence of real and potential risks in the history.

5.8.2 The plan to see him again in four weeks to assess response to increased clomipramine and then consider referral to psychology was appropriate.

5.8.3 At this point there is an initial diagnosis of Panic Disorder with Depression, ICD 10 diagnostic categories are given, but there is no indication of a HoNOS[13] score, or PbR category.

5.8.4 The Trust 2010 policy 'clinical guidelines for the assessment and management of clinical risk' describes in detail the elements to be considered, for example self-harm, suicide, violence to others. Individual risk assessment tools are ratified by the Clinical Governance committee.

5.8.5 The risk assessment tools to be used in community mental health services are 'CPA risk profile and Key Events Chart', HCR20 and HONOS PbR.

5.8.6 At his second outpatient review with another psychiatrist, Dr K1, there is no mention of risk in the letter back to the GP, nor in the 3 December 2010 referral to psychology.

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[13] HoNOS is the most widely used routine clinical outcome measure used by English mental health services and is an instrument with 12 items measuring behaviour, impairment, symptoms and social functioning. .https://www.rMrCPsych.ac.uk/traininpsychiatry/conferencestraining/courses/honos/whatishonos.aspx. PbR is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. https://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14

5.8.7 There is no reference in the policy to the forms in use in the CRHTT in December 2010. The form 'risk management plan for CRHTT only' is not referenced either.

5.8.8 The CRHTT risk assessment form used for X comprises a form for 'First contact/Crisis Assessment of Risk'. This form has a section for rating severity of risk based on a numerical score, for example 1= low risk. The outcome of this risk assessment was 'risk to self' = 2 (medium), and summary of 'risk to others' = 1(low). This was following X's disclosure of thoughts of killing Z, and Dr K1's referral which emphasised his risk of harm to D.

5.8.9 Comment

We consider that this assessment of risk to others as '1= low' cannot be considered adequate, given the risk events which were described by X previously. X's description of his risks were the key trigger to this CRHTT referral. Known history also included historic evidence of violence and carrying/use of weapons plus still unknown risks to daughter that led to his ex-partner stopping the long established weekend visits.

We consider that the assessment of risk using a simple scoring system does not meet best practice standards.[14] However we have been shown the revised risk assessment document in current use in the CRHTT, which requires the assessing staff member to write a narrative description of the detail of any risks identified. In our opinion this should allow for a more comprehensive description of any risks identified.

5.8.10 The internal report notes that there was no record of exploration of risk to others, although at the internal investigation interview it was stated that it was verbally explored, and given a score of 1=low. We have not repeated the recommendation regarding this, but note that the revised risk assessment forms require a more explicit exploration of risk, and staff are required to document the detail of their assessments and discussions.

5.8.11 Comment

None of the policy risk assessment tools appear to have been used at first assessment, which we believe was an omission, as was the lack of any mention of risk.

There was no allocation of a HoNOS PbR category, which is normally used to indicate a care pathway.

Recommendation 1

The Trust should develop systems that provide assurance regarding the implementation of key policies such as the assessment and management of clinical risk.

5.8.12 The 'Continuing Risk Assessment' document, which appears to be a clinical notes record, has the footer 'Bedfordshire & Luton Partnership

[14] *Department of Health (2009) Best Practice in Managing Risk-Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services.* *http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf*

Trust/September 2008', and was clearly in use by the previous provider of mental health services.

5.8.13 **Comment**
We believe that any new organisation should ensure that policies, procedures and paperwork are aligned.

Recommendation 2

When organisational structures and policies are changed, there should be a mechanism to ensure that policy and practice changes are aligned, and any relevant forms or documents are updated accordingly.

5.9 Communication with X

5.9.1 Within the clinical notes it is clear that none of the correspondence about X was copied to him. He was provided with care from ASPA, the CHRTT, and later the CMHT, (although Dr K1 from the CMHT was also the original ASPA psychiatrist). X himself expressed confusion and frustration about where he was within services, and he was unsure of next steps.

5.9.2 In X's clinical file there is a copy of a letter sent directly to him from the CMHT psychiatrist informing him that his diagnosis has been changed to 'Associated' (sic) Personality Disorder. It is clear from the letter to his GP that the diagnosis intended was Dissocial Personality Disorder. This would have been confusing for X if he had tried to find out more about it.

5.9.3 **Comment**
We consider that informing a service user of a change in diagnosis by letter with no adequate prior discussion, is well below best practice. The introduction of a completely new category such as personality disorder, which was radically different to all diagnostic categories used to that date, is especially concerning.

Recommendation 3

The Trust should review the policy for ensuring that service users are kept informed about their care, including copying correspondence to the service user.

Recommendation 4

Where a decision is made to change a service user's diagnosis, this should always be communicated in a face to face discussion with the individual, allowing time for explanation and addressing any concerns and questions. We believe the Trust should ensure this is embedded into practice.

5.10 The progress of the psychology referral

5.10.1 X was referred to psychology by the ASPA psychiatrist, Dr K1, on 22 November 2010. This was done by written referral and the notes record a discussion with the lead psychologist.

5.10.2 At interview we were informed that a decision about psychology assessing X was delayed because of his referral to the CRHTT, which was in fact on 13 December 2010.
We were told that at that time referrals to psychology would have been discussed within the CMHT multi-disciplinary team meeting, and a decision made. This decision would normally have been recorded in the notes of these meetings. These notes were unavailable to the investigation, so it was not possible to say exactly what the decision had been.

5.10.3 It is clear however from Dr K1's subsequent letters to the GP, and his conversations with X, that Dr K1 believed the referral to psychology was still outstanding, and it was mentioned at the MHA assessment in January 2011. At the time of the homicide X had received no contact from psychology nor any information on how the referral was progressing.

5.10.4 We were shown evidence of a change in psychology referral and assessment practices in place currently, which show that there is a minuted multidisciplinary team discussion and a weekly psychology team discussion about any referrals. A system is in place for communicating to service users about any decisions made.

5.10.5 **Comment**
We have not made a recommendation about the management of psychology referrals because we were assured that the practice has changed considerably, and have seen evidence of referral correspondence.

We do believe however that this aspect of X's care was not well managed, and a psychological assessment would have greatly assisted the services understanding of any risk. It is clear that the system failed as X and at least some key clinicians were unaware that a decision not to proceed/to postpone had allegedly been taken. No evidence to support what actually had been decided has been presented. This system failure was a lost opportunity to further assess and potentially help address his ongoing mental state and any associated risks.

There was however a difference in perspective amongst Luton clinicians on the role of psychology in assessing patients who may have personality difficulties along with other mental health issues.

Recommendation 5

The Trust should review the services that are available for assessment and treatment for service users with personality difficulties along with other mental health issues.

5.11 Involvement of Mr Y's family in the independent investigation

5.11.1 We wrote to Z to invite his participation in this investigation, we received no response to this or any follow up communication. We have no information about whether he was contacted by the Trust.

5.11.2 There were no other family contact details available.

5.12 Involvement of X's family in the investigation

5.12.1 We were unable to make contact with X's brother.

5.12.2. We met with X's partner. She reported that she had no discussion with any mental health service staff about X's care, beyond being seen briefly by the psychiatrist to check her welfare after the disclosure on 13 December 2010. She stated that she had no contact from the Trust after the homicide.

5.13 Involvement of X

5.13.1 X agreed to meet with us in prison, and his account of the events prior to the homicide is detailed above in sections 4.51-4.54.

5.13.2 X reported that he had disclosed the thoughts of killing D to Dr K1 so he could get help. He had already discussed this with his partner. He said he was looking forward to seeing a psychologist, and did not understand why this was taking such a long time.

5.13.3 X said he went to the MHAU with a bag packed, expecting to stay, but when he was shown to his room the staff asked him to give his belt and shoelaces in. He said he didn't want to and had no plans to harm himself. When this was insisted upon, he said he would not stay, and left after agreeing to see the CRHTT consultant the following day. This was a significant event as up to this point he appears to have cooperated with his GP, the counsellor and mental health services but after this, his cooperation significantly reduces.

5.13.4 X said that he never really got involved with the CRHTT, and wasn't sure why he was sent to them instead of seeing Dr K1, because as far as he was concerned he was taking medication, and waiting to see a psychologist to get some treatment that would help him.

5.13.5 He reported being upset when he saw Dr K1 after the MHA assessment, as he was told Dr K1 would see him in 3 months' time. He thought he was still waiting to see a psychologist, and feels he was promised this help at the MHA assessment, and thought things would get back on track for him. He expressed his upset and anger about this interaction. X said that even if he had any thoughts of harm at this stage he would not have told the services about them. He said that he didn't actually have them at that stage until they recurred later when he met Z again.

5.13.6 X did not recall receiving the letter changing his diagnosis, and did not receive copies of any letters sent by mental health services to his GP.

5.13.7 Comment

We were informed at interviews that decisions about what items of property service users may keep when admitted to MHAU (now Jade Ward) would be made as part of an individual risk assessment. It was agreed by several staff that there may be times when laces and or belts may be requested to be given to staff for safe keeping. This does appear to contradict the principle of least restriction. We did not see the admission protocol for MHAU at the time.

Recommendation 6

The Trust should be satisfied that there is clear practice guidance for the management of risk items on admission to Jade Ward, and that any guidance on restrictions is reasonable, proportionate and necessary.

5.14 Police Involvement

5.14.1 Bedfordshire police were informed by Dr K1 about X's disclosure of his plan to kill Z by telephone on 13 December 2010, which was good practice. He made X aware he was doing so and recorded the police 'URN' (reference) number in the clinical notes.

5.14.2 Dr K1 reported that he was informed that the police would ensure that Z was made aware of the threats to kill him, but he wasn't sure exactly how. He stated the police said they would return if they needed any more information. He said the police called three or four times over the next few days, asking for details of GP and relatives, which he provided from the file. Dr K1 said he asked the police if he needed to do anything else and was told they would contact him if needed.

5.14.3 We explored the question of how Z was alerted to the threats from X. This issue has been the subject of an Individual Management Review (IMR) by Bedfordshire police and Hertfordshire constabulary. We have been advised that it was clear that Bedfordshire police, and subsequently Hertfordshire constabulary, were made aware of X's threats on 13 December 2010.

Attempts to locate and speak to Z failed, and at the time of his father's murder Z was unaware of any risk posed by X.

5.14.4 Bedfordshire police were requested to carry out a welfare check on X on 18 January 2011, and assist with a Section 135 Mental Health Act assessment on 21 January 2011. Because the report of concern for Z's safety was logged against Dr K1's work address, and these requests were logged against X's home address, no link was made between the issues.

5.14.5 Any comment with regards to police actions is beyond the scope of this investigation

6. THE INTERNAL REVIEW

6.1 We have detailed the review of the internal investigation under the headings of the Terms of Reference.

6.2 Review the Trust's internal investigation recommendations and any action plan.

The independent investigation has reviewed the internal investigation report guided by the NPSA investigation evaluation checklist.[15] The internal investigation is described as an internal Level 2 comprehensive single incident review (Root Cause Analysis), and was carried out by a panel consisting of the Executive Director of Clinical Governance and Quality, the Executive Director of Social Care and Partnerships, and a consultant psychiatrist from another part of the Trust.

The Care and Service Delivery Problems identified were:

Problem – Team and Social Factors
X was in contact with mental health services between December 2010 (sic)[16] and 25 February 2011. During this period there were a large number of teams involved in his on-going assessment care and treatment and at this time contact was short term resulting in rapid transfer between and across teams. It is not evident from the records where the responsibility for co-ordinating X's care lay. Movement between teams particularly in a short time period increases the risk of critical clinical information not being transferred appropriately.

Problem – Departure from Standard Protocols and Policies
There was no evident engagement with X's family, despite it being noted that his previous partner and the mother of his daughter had concerns about his mental state and was not allowing the daughter to visit him. Involving family members during assessments of care can provide a more

[15] *National Patient Safety Agency. RCA Investigation Evaluation Checklist.*
[16] *- the correct dates are in fact October 2010 to February 2011*

complete picture of the level of risk posed and this information may have provided a more rounded view of his mental state and potential risk.

A contingency plan was not in place in the case of non-compliance.

Problem – Communication

For three of the recommendations that were made following the Mental Health Act Assessment of 21st January 2011, no clear responsibility for carrying out these recommendations was identified. This resulted in a lack of understanding on who would carry out these recommendations.

Problem – Ambiguity

Although the Mental Health Act Assessment carried out on the 21st January 2011 considered that X was not detainable under the Mental Health Act, the professionals involved in the review reported differing views of the level of risk to others.

The recommendations made were:

1. The Associate Director – Luton must review existing processes to ensure that arrangements are in place for care to be safely transferred between teams.

2. The Clinical team leads must ensure that a care co-ordinator is allocated to oversee the effective and safe transfer of the service user between teams.

3. The information sharing protocol should be reviewed to ensure that staff are aware of the need to promptly share details of a threat of significant harm to close family and/or Next of Kin with Police. The protocol should include that the content of any discussion with police is clearly recorded in the clinical notes by the reporting clinician and a follow up call made to police to elicit any actions taken by the police.

4. A directive must be issued to AMPHS undertaking Mental Health Act Assessments to ensure that where recommendations arise from these assessments any subsequent plan must have agreed responsibilities and timescales.

5. The Situation Background Assessment Recommendation (SBAR) tool must be utilised at all times when transferring patients between teams and this tool should form part of the clinical records. An audit to check staff understanding and use of this tool to be undertaken. [17]

Comment

We were informed that the SBAR tool was withdrawn after a pilot, and is no longer in use. The Trust's action plan has rated this action as completed,

[17] *We were informed at interview that this tool had been abandoned after initial pilot.*

and it has not been updated to reflect the fact that this part of the action plan was not implemented. A recommendation is made below about assurance processes regarding serious incident action plans.

6. The Clinical Team Lead must ensure there is a contingency plan in place to address non-compliance with treatment.
7. The Clinical Team Lead must ensure that known risks from all sources are included in the risk assessment and care plan.

6.2.1 Although we have not repeated these recommendations, in our opinion the care and service delivery problems identified did not sufficiently reflect all of the issues. We also note a lack of adherence to the adverse incident policy in the process of locally managing and investigating the incident.

6.2.2 Our independent investigation has developed further findings in the following areas:

- Communication with families after a serious incident;
- Approaches to assessing and managing risk;
- Adherence to adverse incident policy;
- Response to psychology referrals;
- Admission protocols in Luton mental health in patient services;
- Communication with patients about a change in diagnosis; and
- Assurance systems to evidence completion of actions following serious incident investigations.

6.2.3 We interviewed one of the report authors, and found that the investigation had followed due process, but had not adhered fully to the Trusts 'Adverse incident procedural guidelines' (November 2011).

6.2.4 The Trust's 'Adverse incident policy, including serious incidents' (November 2011) and 'Adverse incident procedure' (November 2011) require there to be a Family Liaison Officer (FLO) identified, and a structured process of contacting families and sharing information flows from this.

6.2.5 **Comment**
We were informed of changes that have taken place since this time with regard to Trust Family Liaison Officers and there has been training and identification of people who have the relevant skills to be called upon if needed. The policy requires due consideration to be given to involvement of the service user/ their family and of the victim and alleged perpetrator's family in the review process. We consider the Trust did not involve either family sufficiently in this process.

Recommendation 7

The Trust should ensure that communication with families is carried out in line with the Trust's adverse incident policy, and follows guidance in the Memorandum of Understanding[18] and best practice guidance[19] and there are assurance systems that evidence this concordance with policy.

6.3 Review the progress that the Trust has made in implementing the Internal Report's Action Plan:

6.3.1 We have seen an updated Action Plan from the internal Report that was noted as completed in January 2012 (Appendix D).

6.3.2 We asked the Trust for evidence of any audits that may have taken place or service/policy changes that can give evidence of action plan implementation and/or embedded lessons learnt. We received a copy of the CRHTT care plan audits in September 2012 and March 2013 which showed evidence of improved quality.

6.3.3 We have seen the revised CRHTT triage document which is now in place, which clearly indicates that carers or next of kin details should be collected at first contact.

6.3.4 We were given a copy of the AMHP memo written in October 2011 that requires any recommendations after MHA assessments to have agreed responsibilities and timescales for actions.

6.3.5 The SI action plan states monthly spot checks would be carried out to ensure this learning has been '*implemented into practice'*. We were informed this has not been audited. It is, however, noted as a completed action despite this.

6.3.6 There is a summary of learning from national events and issues on the 'SEPTnet', which is the internal intranet available to all staff.

A learning summary file is compiled for each internal serious incident, and is available on the intranet to download. Managers are expected to cascade this learning, and reported discussing these at team meetings, and cascading learning to staff. Topics are then reviewed in supervision. Examples of learning events and a risk conference were shared, which is commendable as good practice.

6.3.7 There is a system for the Medical Director to ensure these are shared with all medical staff and reflected upon by individual practitioners as part of medical revalidation structures.

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[18] *Memorandum of understanding between the NHS counter fraud service and the Association of Chief Police officershttp://www.nhsbsa.nhs.uk/Documents/mou_acpo_cfs.pdf*

[19] *Independent investigation of serious patient safety incidents in mental health services provides best practice guidance on investigations into mental health services http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59836*

6.3.8 We were provided with agendas and minutes of local meetings referring to serious incidents, and reviews of lessons learnt (discussed bi-monthly at Learning Lessons Review Group) meeting attended by executive and operational directors, quality and governance managers and senior clinical staff.

We have seen the weekly Bedfordshire and Luton 'serious incident position statement' which shows the progress of individual investigations, and outstanding progress and deadlines.

6.3.9 We have seen the Trust-wide tracking log, which summarises all serious incidents within the Trust. These documents are reviewed weekly by the Executive Team.

6.3.10 A serious incident external quality review process has been established for several years, with external professional team invited to take a random sample of SI investigations and conduct a quality audit. In 2014 this is due to be carried out by Professor Appleby's team, which is notable good practice.

6.3.11 Service managers have described changes to the procedures of the CRHTT, and audit and assurance systems that are regularly provided to assure managers of policy implementation and adherence to practice guidance.

The Trust has provided some evidence of implementation of the Action Plan, and assurance regarding the implementation of lessons learned and governance structures that are now in place.

We consider that the completion of the individual action plan from this SI has not been fully evidenced.

Recommendation 8.

The Trust should review the systems in place to sign off action plans from serious incidents, and ensure that there is an assurance process to evidence implementation and embedded practice changes.

7. OVERALL ANALYSIS AND RECOMMENDATIONS

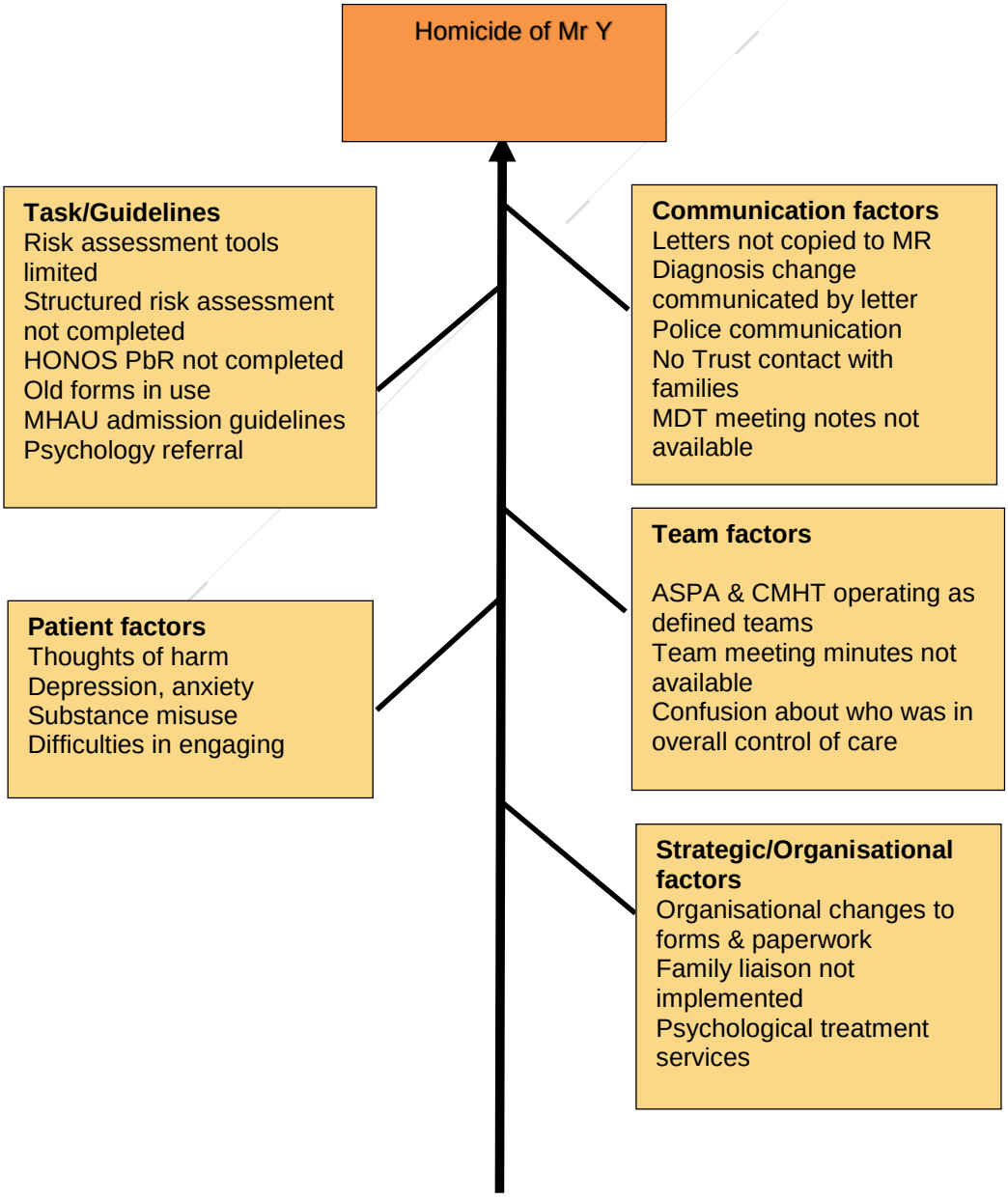
7.1 There are several ways in which the Trust and individual practitioners could have improved their engagement and assessment of X. There was, however, recognition that there were psychological issues which may have benefited from further exploration by either a psychology assessment, or a period of admission for assessment.

7.2 The question of whether X was detainable under the Mental Health Act was well clarified, although as noted the recommendations following the assessment were not carried through.

7.3 The structured risk assessment tools used in the CRHTT were not adequate to make a comprehensive assessment of risk, and have since been updated to a tool which allows for a more qualitative assessment and recording.

7.4 We have illustrated the contributory factors and service delivery factors using a fishbone analysis tool below. We do not consider there to be any causal contributory factors attributable to the actions or omissions of Trust staff.

7.5 Fishbone Analysis



7.6 Good Practice

7.6.1 The following examples of good practice have been highlighted:

- The sharing of information about risk with the Police;
- The instigation of a Mental Health Act assessment following disengagement;
- Learning events have taken place for a range of professionals on learning lessons and understanding the management of serious incidents
- External quality reviews are carried out into the investigation of serious incidents

7.7 Predictability

7.7.1 In our review of the clinical records and in the interviews that we have carried out we believe there were clear presenting concerns that indicated that X may be involved in such an incident in the future.

Whilst it is clear that X had a history of thoughts of killing Z, and was regarded at times as a risk to Z, there were no signs that he may be a risk to Mr Y. In our opinion this particular incident was not predictable.

7.8 Preventability

7.8.1 X was initially co-operating with services offered with the expectation that he would be assessed for psychological help. Co-operation became less than ideal and his intermittent co-operation did complicate assessment and treatment. He reported he became confused about what services were being offered after the referral to the CRHTT, and disappointed that the treatment he expected appeared not to be forthcoming.

7.8.2 The unfortunate timing and circumstances of his meeting with Z on the day before the incident appear to have been a final catalyst in re-igniting his thoughts of killing Z.

7.8.3 Although this independent investigation has highlighted some service delivery problems, these are not felt to be causal or contributory factors to the homicide.

7.8.4 It is our opinion that this tragic event was not preventable, in the sense of a deliberate action being taken to avoid a predicted or likely event. As noted earlier he had posed a risk to others in the past including criminal convictions. X himself said it first occurred to him to harm Mr Y on the day. Z was clearly the previous target of X's homicidal thoughts, and there was never any indication that he was a risk to the victim.

Appendix A:

Terms of Reference

Appendix A: Terms of Reference

- Review the trust's internal investigation recommendations and any action plan.
- Compile a chronology of events leading up to the homicide if not already available or review the existing chronology.
- Review the progress that the trust has made in implementing the recommendations and the learning from their internal investigation.
- Review the care, treatment and services provided by the NHS from the service user's first contact with services to the time of their offence.
- Review the appropriateness of the treatment of the service user in light of any identified health needs.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.
- Examine the effectiveness of the service user care plan including the involvement of the service user and the family.
- Observing the principles of "Being Open" involve the families of both the victim and the perpetrator as fully as is considered appropriate and according to the families wishes
- Consider if this incident was either predictable or preventable.
- Provide a written report to NHS England that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation

Appendix B:

Table of recommendations

Appendix B: Table of recommendations

Recommendation 1.
The Trust should develop systems that provide assurance regarding the implementation of key policies such as the assessment and management of clinical risk.

Recommendation 2
When organisational structures and policies are changed, there should be a mechanism to ensure that policy and practice changes are aligned, and any relevant forms or documents are updated accordingly

Recommendation 3
The Trust should review the policy for ensuring that service users are kept informed about their care, including copying correspondence to the service user.

Recommendation 4
Where a decision is made to change a service user's diagnosis, this should always be communicated in a face to face discussion with the individual, allowing time for explanation and any concerns and questions. We believe the Trust should ensure this is embedded into practice.

Recommendation 5
The Trust should review the services that are available for assessment and treatment for service users with personality difficulties along with other mental health issues.

Recommendation 6
The Trust should be satisfied that there is clear practice guidance for the management of risk items on admission to Jade Ward, and that any guidance on restrictions is reasonable, proportionate and necessary.

Recommendation 7
The Trust should ensure that communication with families is carried out in line with the Trust's adverse incident policy, and follows guidance in the Memorandum of Understanding and best practice guidance and there are assurance systems that evidence this concordance with policy.

Recommendation 8.
The Trust should review the systems in place to sign off action plans from serious incidents, and ensure that there is an assurance process to evidence implementation and embedded practice changes.

Appendix C:

Chronology of X's contacts

Appendix C: Chronology of X's contacts with Secondary Mental Health Services (from September 2010 to February 2011

This chronology has been drawn up from medical records, prison and police records and records from GP

Date	Source	Detail
6/3/91-12/4/91	GP notes	Admitted to Hill End Adolescent unit, behavioural issues, drugs, stealing. Mother did not respond to follow up invite.
1991	GP notes	*'Non-dependent use of drugs, behavioural problems'*
13/6/98	GP notes	Deliberate laceration to L wrist
22/4/99	GP notes	Seeking help with anger and aggression management. Citalopram 10mg prescribed
26/4/99	GP notes	Referred to Clinical Psychology, depressive disorder, relationship breakdown- failed to attend, though was offered 4 appointments
2001	GP notes	Moved out of area, changed GP- no further contact with the GP.
Post 2001	GP notes	**Name change**- H to X
9/6/10	GP notes	Saw GP following burn to arm & leg from leaking parcel
July 2010	GP notes	Prescribed 20mg Citalopram
11/8/10	GP notes	GP Referred to 'Talking Therapies (TT) ' Luton – PCT resource
8/9/10	GP notes	Started 'Talking Therapies' at Liverpool Road Health centre Luton (7 sessions until Jan 11)
21/9/10	GP notes	GP Referred to SEPT - (panicky, anxious, with thoughts of self-harm, not improving with counselling and Citalopram)
21/9/10	SEPT notes	Is offered appointment with Dr S at Calnwood Court 12/10/10 , by letter from administrator at 'Calnwood Court' – doesn't say which dep't
21/9/10	SEPT notes	Letter to X by letter from administrator at 'Calnwood Court' appointment with Dr S 12/10/10
15/10/10	SEPT notes	Seen by Dr R (Speciality Dr)-letter to GP following psychiatric review – diagnosed panic disorder and depression. To see in 4 weeks
22/11/10	SEPT notes	Attended clinic with Dr K1 'no risk to self or others at the moment'. To see in 4 weeks
3/12/10	SEPT notes	Dr K1 referred to Psychology. first referral to Psychology
10/12/10	X interview/SEPT notes	Went to Borehamwood address with knife and baseball bat, waited outside from 2pm to11.30 pm intending to kill DW. Told Dr K1 this on 13/12/10. Referred to CHRTT by Dr K1 because of this.
10/12/10	SEPT notes	Police informed URN 346-131210
13/12/10	Beds & Luton CHRT referral form	Referral to CHRT by Dr K1 (on Beds & Luton Mental health and social care partnership NHS Trust form) - informing them of needs, journey to Borehamwood with intent to kill.
14/12/10	SEPT notes	'Assessment of need form' started, signed by staff nurse

14/12/10	SEPT notes Assessment of need form – CRHT Lime Trees, Luton	'*Assessment unfinished due to the complexities of the matter'*. Discussed with Dr K2 who advised to '*bring him in for further assessment'*
14/12/10	CHRT notes	Arranged collection of X & brought to MAU, initially agreed admission
14/12/10	CHRT notes	X refused to stay, saying the environment doesn't suit him, agreed he would attend 15/12/10 to see Dr K2
15/12/10	CHRT notes	Seen by Dr K as agreed, Plan: to be seen daily by CHRTT, continue Citalopram, offer admission if further concerns, *'not detainable under MHA at present'* last sight by CHRT until cold call on 18/1/11
16/12/10	CHRT notes	Follow up telephone call by CHRTT staff went to voicemail, left message for X to call them
17/12/10 17.50	CHRT notes	Visited at home by CHRTT staff, not there & didn't answer mobile.
17/12/10 19.30	CHRT notes	Follow up telephone call by CHRTT staff, X answered, staying with partner in Beds, planned to return to Luton 18/12 & agreed to be seen in the evening
18/12/10	CHRT notes	Phone call to X by CHRTT staff, he said he can't come back to Luton because of snow, to call again 19/12/10
19/12/10 11.00	CHRT notes	Phone call to X by CHRTT staff, no answer
19/12/10 16.20	CHRT notes	Phone call to X by CHRTT staff, no answer, unable to leave voicemail, only text. Plan to try home visit tomorrow
20/12/10	CHRT notes	Home visit by 2 CHRTT staff, no response, nowhere to leave a note (flats) – to discuss at team meeting
20/10/10	CHRT notes – team meeting	Discussed at team meetings- *'not engaging with CHRTT, contacted NoK, if still no response to inform police'*
20/12/10	CHRT notes	Phone call to X by CHRT staff, he answered, still in Beds with partner, coming back to Luton 21/12 & agreed to attend CHRTT.
21/12/10	CHRT notes	Attended CHRTT Lime Trees (signature illegible) feeling better, agreed to attend 22/1/10
22/1210 10.30	CHRT notes 'nursing' entry	DNA, didn't answer call by CRHTT staff member, not possible to leave message. Plan: phone this pm or day visit 23/12/10 (signature illegible)
22/12/10 17.00	CHRT notes	Phone call to X by CHRTT staff, he answered- said he forgot the appointment, couldn't come on following day, agreed to attend on Friday 24/12/10. Plan to call before to remind him. (signature illegible)
23/12/10	CHRT notes	Phone call to X by CHRTT staff to confirm attendance at 10 on 24/12/10, said he was happy to. (signature illegible)
24/12/10	No entry	No record of attendance or not
26/12/10	CHRT notes 'nursing' entry	Phone call to X by CRHTT staff to see how he is- said had a good Christmas day, plan to see daughter, denied any thoughts of harming anyone- for day visit 27/12/10 (signature illegible)

27/12/10 'am'	CHRT notes 'nursing' entry	Home visit – no response, phone call, no response, message sent by text. Plan- await response, pm phone call
29/12/10 1.30	CHRT notes 'nursing' entry	No response to phone call, went to house to cold call, no response, and left message on phone to call CRHTT. Name in capitals as well as signature.
30/12/10 12.00	CHRT notes	Phone call to X by CHRTT staff, no answer- plan to cold call
31/12/10 15.30	CHRT notes	Phone call to X by CRHTT staff- plan: cold call over weekend
1/1/11	CHRT notes	Phone call made & X spoken to, he was in Bedford, feeling much better, doesn't see any reason to see CRHTT & happy to be discharged. Asked & denied any thoughts of harming DW & wants to get on with life with partner & daughter. Plan*: 'to discuss in team, merits & demerits of discharging X'*
4/1/11	CHRT notes- team meeting	'*Does not want to work with CRHTT, to arrange appointment with Dr K1, no acute MH issues, inform pt. of appointment. Also inform police of discharge, (Police are aware)'*
5/1/11 11.00	CHRT notes- Social Worker	*'Phone call to Luton West CMHT to discuss discharge plans but X is open to ASPA so call transferred. I requested an outpatient appointment with Dr K1 as per discharge plans and a provisional date of 17/1/11 was given. This still to be confirmed with Dr K1- later today?* '
5/1/11 12.15	CHRT notes- Social Worker	'*Phone call to X who sounded very calm and confirmed he no longer has thoughts of harming others, does not need the intensive input from CRHT, but feels he would benefit from some psychological follow up, said Dr K1 had mentioned CBT. He was informed of OPA with Dr K1, and was in full agreement that once a confirmed date was set with Dr K,1 he could be discharged from CHRT to ASPA'*
6/1/11 12.15	CHRT notes- Social Worker	'*Phone call from ASPA team to confirm he is being offered an OPA with Dr I on 11/1/11, ASPA requested copy of CHRT discharge letter prior to this OPA'*
10/1/10 (presumably 2011) 11.58	CHRT notes – student social worker	*'Phone call to X, no response, could not leave a message'*
10/1/10 (presumably 2011) 12.10	CHRT notes – student social worker	*'Phone call to X reminding him of appointment with ASPA at 16.00 on 11/11/11. Case closed to ASPA'*
10/1/11	CHRT notes- team meeting	'*Needs input from CMHT- call Dr K1''*
11/1/11	CHRT notes 'nursing' entry	*'Phone call to Dr K1 who confirmed he had seen X in the ASPA team clinic. Has appointment today at 16.00 with Dr, he can therefore be discharged'.*
11/1/11	SEPT notes	DNA (locum consultant's notes) – '*discussed with Dr S (CHRTT) – X still under their care- tried to call X, no*

		answer- plan: offer one more appointment in view of past risk'
12/1/11	CHRT notes	'Phone call to Dr I to check if X attended his 16.00 appointment- DNA. Plan: to discuss in team meeting'.
12/1/11	CHRT notes 'medical'	'*Met Dr I, DNA yesterday, would offer another appointment in 3 weeks' time, to discuss team and Dr K1"*
14/1/11 19.00	CHRT notes	Home visit, no answer, called phone, couldn't leave a message
15/1/11 10.40	CHRT notes 'nursing' entry	Home visit, phone call, letter dropped at his flat asking him to contact, Plan: call Sunday 16/1/11
17/1/11	CHRT – team meeting	'*Not engaging, missed appointment with ASPA, Plan: formal letter to inform him of discharge'*. (?doctor, signature illegible)
17/1/11	SEPT notes	Dr K1's notes – DNA, to be discussed with the team tomorrow & consider … illegible)
18/1/11	CHRT notes 'nursing' entry	Disengagement policy started
No date or time		Cold call, no answer, saw X through letterbox, wouldn't respond, flat in disarray. Plan*: 'inform Police of our concerns of patient, URN 204,18/01/2011- for MHA assessment'* (signature illegible)
18/1/11 16.00	CHRT notes 'nursing' entry	Referral for MHA assessment made to AMHP, who advised '*the referral will be passed to EDT as they are unable to carry out an assessment today'*.
18/1/11 18.00	CHRT notes	Phone call from Bedfordshire Police, X seen at home and stated his mood was fine, he did not let the police in the door.
19/1/11	CHRT notes	RMN- phone feedback from AMHP, not detainable & suggesting he be referred to ASP/CMHT for follow up once discharged from CRHT- '*discussed with Dr S & Dr K2'* (signature illegible)
20/1//11 10.30	CHRT notes	Phone call to AMHP on duty, CHRT informed he was seen by police for welfare check only & not assessed under MHA. AMHP informed about '*the concerns the team had about X and his not engaging with the team'.* AMHP agreed to get a S135 warrant.
20/1/11 14.20	CHRT notes	AMHP called to say she is at court awaiting the warrant, and hopefully X would be assessed that day
21/1/11 10.21	CHRT notes	Awaiting outcome from MHA assessment, bed booked at Oakley Court, AMHP aware of bed availability
21/1/11 10.45	CHRT notes 'nursing' entry	Phone call from AMHP requesting bed for X as he is to be assessed today
21/1/11 15.30	CHRT notes RMN	Phone call from AMHP regarding his care plans, informed he was given a letter with intention to discharge, not actual discharge.

21/1/11 15.40	CHRT notes 'nursing' entry	Phone call from AMHP informing that X is not detainable, and he will attend his next appointment with Dr K1, booked bed cancelled.
21/1/11	SEPT notes	Brief AMHP report - recs: '*Appointment with Dr K1 27/1/11 at 12.15, Dr K to make referral to team psychologist, X would benefit from care coordinator to help with psychosocial issues. Discharge form CHRT '*
21/1/11	CHRT notes 'nursing' entry	Team meeting/Handover: X was discussed in team meeting- Plan: '*discharge to CMHT to be seen by Dr K1".*
21/1/11	GP notes	Discharge letter from Talking Therapies- attended 6 sessions, able to return to work, was offered a further session on 12/1/11 as F/U as he was waiting for appointments to be arranged after having a psychiatric assessment .. DNA & no further contact.
24/1/11	GP notes	Discharge letter from Dr S, (AS to Dr K) informing of discharge from CHRT *'to be followed by Luton West CMHT'* cc to Luton West CMHT appt with Dr K on 27/1/11
27/1/11	GP notes	Dr S letter to GP summarising CHRT home treatment & informing of appointment with Dr K1 on 27/1/11 *'it was also agreed following the Mental Health Act Assessment that he would benefit from a Care – coordinator to help with the psychosocial issues and a referral to psychology'*.cc to Dr K1 .Not cc'd to X
27/1/11	SEPT notes	Identical letter to Dr P, Luton West CMHT from Dr S. Diagnosis at Discharge: Panic Disorder with Depression F40.01, F32)
27/1/11	GP notes	Dr K1's 14/2/11 letter to X following DNA - informing him of diagnosis- "associated" (sic) Personality Disorder , decision that he doesn't need a care coordinator, referral to psychologist, next appointment 3/3/11- cc GP
27/1/11	SEPT notes	Dr K1 letter - sends a second referral to Psychology
2/2/11	SEPT notes- 'People of Working Age Luton West ' Team meeting minutes	*'X- was with the ASPA team then transferred to the Luton West CMHT… New diagnosis should be: Anti-social behaviour – and then will be discharged'*
14/2/11	SEPT notes	Dr K1 sent letter following DNA, advising change of diagnosis to Dissocial Personality Disorder, referral to Psychology, next appointment 3/3/11. 3rd ref to psychology
17/2/11	SEPT notes	Dr K1 sent letter on 25/2/11 from PoWA team to GP, advising X attended & feeling much better, no thoughts of harm to self or others. To continue on Citalopram 60mg,

		next review in 3 months' time. Diagnosis now 'Dissocial Personality Disorder. F60.2
24/2/11	X interview	Went to mother's grave from partner's flat, then past old house in Borehamwood. Saw neighbours and stopped to chat. Z came back – showed him around, went to pub & had a couple of pints, Z gave him £60 when he was leaving
24/2/11 evening	X interview	Went back to Luton flat, bought drugs, and stayed up all night drinking, ruminating. Found Mr Y's address in his mothers' papers & decided to kill Z there.
25/2/11	X interview	Drove to Y's address with knife & baseball bat, saw Z's car leave, waited hours, saw different car arrive & knocked on door- had decided to kill MrY if couldn't kill Z
25/21/1	X interview	Stabbed Mr Y when he answered the door, then left.

Appendix D:

SI 432 Action Plan Completed

Appendix D: SI 432 Action Plan Completed

No	Recommendation	Identified Lead	Target Date	Progress RAG status
1	The Associate Director – Luton must review existing processes to ensure that arrangements are in place for care to be safely transferred between teams. This should include the use of the Situation, Background Assessment and Review (SBAR) tool which should form part of the clinical record.	Associate Director - Luton	30.11.11	COMPLETED Processes reviewed- • verbal handover now essential for every transfer • Joint visits take place when closer joint working required • CRHT do not discharge until handover has taken place and follow up arrangements are agreed.(Evidence - the above principles have been embedded in the reviewed operational policy for the community mental health teams) • SBAR tool re-circulated to community teams for use. (SBR Tool for evidence)
2	A care coordinator must be allocated to oversee the effective and safe transfer of the service user between Luton CRHT and CMHT's.	Clinical Group Manager – Luton Acute and Crisis Clinical Group Manager – Luton Community	13.10.11	Transfer cannot take place without verbal handover to CMHT Care coordinator
3	The information sharing protocol must be reviewed to ensure that staff are aware of the need to promptly share details of a threat of significant harm to close family and/or next of kin with police. The protocol should include a directive for staff that the content of any discussion with police must be clearly recorded in the clinical notes by the reporting clinician and a follow up call made to police to elicit any actions taken by police.	Clinical Group Manager – Luton Community	30.11.11	COMPLETED Current protocol sent to teams with relevant information highlighted. Protocol reviewed October 2011. The protocol is clear regarding when information can be shared and recording processes. Regulatory bodies also direct clinicians regarding the recording of information, actions and outcomes.
4	AMPHS undertaking Mental Health Act assessments must ensure that where recommendations arise from these that any subsequent plan must contain the name of the	Associate Director of Social Care	31.12.11	COMPLETED Memo sent to AMPHS on 11.10.11 from Associate Director of Social Care outlining requirements following assessments:

	person/s responsible and a timescale for completion. A spot audit to be undertaken to check compliance.			-Who recommendations have been discussed and agreed with -Timescales agreed for each action. -Monthly spot checks to be undertaken to ensure learning has been implemented into practice -Evidence of above – Memo.
5	The Clinical Team Lead and the Team Consultant must ensure that there is a contingency plan in place to address non-compliance with treatment. A spot audit to be undertaken to check compliance.	Clinical Group Manager – Luton Community Clinical Director - Luton	31.12.11	Spot check undertaken which demonstrated learning has been embedded Evidence – Trust has overarching disengagement policy Evidence held in SI evidence portfolio
6	The Clinical Team Lead must ensure that known risks from all sources are included in the risk assessment and care plan. A spot audit to be undertaken to check compliance.	Clinical Group Manager – Luton Community Clinical Director - Luton	31.12.11	Spot check undertaken which demonstrated learning has been embedded Evidence held in SI evidence portfolio

Appendix E:

Documents reviewed

Appendix E: Documents reviewed

SEPT policies:

- Clinical Guidelines for clinical handovers dated July 2011
- CPA and Non CPA dated April 2013
- CPA Handbook dated April 2013
- Adverse incident, including serious incidents dated July 2010
- Adverse incident procedural guidelines dated July 2010
- Clinical guidelines for the assessment and management of clinical risk dated August 2010.
- Acute and CRHTT operational policy dated May 2009

Other documents:

- SEPT Serious Incident 432 internal investigation initial incident form, 72 hour report, final report dated 7June 2011 and action plan
- SEPT SI 432 action plan updated-completed January 2012.
- SEPT Serious Incident Action Plan, updated January 2013;
- SEPT 'Initial assessment (CRHTT/Assessment unit only) document dated April 2013
- SEPT 'Assessment of safety and risk issues' document dated July 2013
- SEPT X clinical notes
- X GP notes
- Bedfordshire police case summary
- Bedfordshire & Hertfordshire constabulary Individual Management review (redacted and undated)

In addition to these documents we referred to relevant national publications and guidelines, including:

- Memorandum of understanding between the NHS counter fraud service and the Association of Chief Police officershttp://www.nhsbsa.nhs.uk/Documents/mou_acpo_cfs.pdf
- Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services
- National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services. http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59836
- https://www.MCPsych.ac.uk/traininpsychiatry/conferencestraining/courses/honos/whatishonos.aspx.
- https://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-Payment by results
- Independent investigation of serious patient safety incidents in mental health services provides best practice guidance on

investigations into mental health services http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59836

- Department of Health (2009) Best Practice in Managing Risk- Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services.http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf

Appendix F

Profile of the service

Appendix F: Profile of the service

South Essex Partnership University NHS Foundation Trust (SEPT)

SEPT provides integrated care including mental health, learning disability, social care and community health services from over 200 locations. These services are provided across Bedfordshire, Essex, Luton and Suffolk.

SEPT took over the provision of mental health services from Bedfordshire and Luton Mental Health Partnership Trust in 2010.

Luton West ASPA/CMHT
The ASPA service accepts initial referrals for initial or short term treatment. People would then be signposted to other services, discharged back to their GP, or referred to the CMHT for ongoing treatment.

Luton and South Bedfordshire CRHTT is one of a number of crisis resolution and home treatment teams, who work with a group of clients, who, without this support, would need to be admitted to hospital, or who cannot be discharged from hospital without intensive support. The service operates 365 days a year and enables clients who are in crisis, and not able to function at their normal level, to be supported in their own homes.

There is an assessment unit (was MHAU, now Jade ward) which provides a 72 hour inpatient assessment function for voluntary patients only.