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PATIENT SAFETY

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

August 2015

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1. EXECUTIVE SUMMARY

1.1 NHS England, East region commissioned Niche Patient Safety, a consultancy company specialising in patient safety investigations and reviews, to undertake an independent investigation into the care and treatment of a mental health service user (Y). 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 We would like to express our sincere condolences to Mr Z'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 Y up to the point of the offence.

The Incident

1.5 On the early evening of 25 June 2011 Y went to the house of Mr Z in Luton. He had met Mr Z previously, when Y had worked on his roof with his father. Y attacked Mr Z with a hammer, allegedly to try to gain the PIN for his cash card. Mr Z was discovered by a neighbour and died in hospital later that evening from his injuries.

1.6 Y had two short periods of contact for assessment with secondary mental health services in April and June 2011.

1.7 He was initially referred to mental health services by his GP on 19 April 2011, after being found by police threatening to jump off a cliff. He was seen for assessment on 24 April 2011 by the Luton & South Bedfordshire Crisis Resolution and Home Treatment Team (CRHTT) and was assessed as not suicidal or a risk to others at the time. He refused to be referred to the community mental health team (CMHT) and was referred back to his GP.

1.8 On 23 June 2011 his GP again referred him to the CRHTT after he had attended Accident and Emergency at Luton and Dunstable Hospital (A&E) having cut his wrists, and presented to his GP with depression and suicidal ideation.

1.9 Y was assessed on 25 June 2011 by a nurse and healthcare worker from the CRHTT, and was offered admission to the short term mental health assessment unit (MHAU). The assessment noted that Y reported he had split from his girlfriend two weeks previously, that he had debts of up to £10,000, and was unable to work because of his physical illness (Crohn's disease[1]). It was also noted that he said he was on police bail for criminal damage to his girlfriend's home, due to return to the police on 28 June 2011. He was offered admission to the MHAU with agitation, restlessness, low mood and fleeting suicidal thoughts; for 'further assessment of his mental health state'. The assessment notes record 'if declined, to be offer [sic] home treatment'. The plan following the assessment was not agreed and documented.

1.10 The CRHTT received a phone call from Y's aunt later on 25 June 2011 stating that she had spoken to Y and he was refusing to come into hospital and was not at home. It was planned to visit Y the following day, and a telephone call was made to him by the CRHTT. There was no voicemail facility. At 10.20 on 26 June 2011 a phone call was made by the CRHTT to Y; he did not answer and there was no voicemail facility. The team then phoned his aunt who told them Y had been picked up by the police the previous night because he was disturbed at home. The family had called the police after Y threatened to harm himself whilst under the influence of alcohol.

1.11 Later that evening Y was arrested on suspicion of the murder of Mr Z.

1.12 A Mental Health Act assessment was carried out in custody and he was judged to be fit to be detained and interviewed.

1.13 On 26 January 2012 Y was found guilty of murder, and sentenced to life imprisonment, with a recommendation that he serve 30 years. It was acknowledged in court that Y's brief contact with mental health services played no part whatsoever in the incident. Y entered a plea of not guilty of murder and there was no plea in relation to manslaughter due to diminished responsibility.

1.14 Following this tragic incident South Essex Partnership University NHS Foundation Trust (the Trust) conducted an internal investigation which identified four Care and Service Delivery Problems (CDPs) and six contributory factors.

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1.15 The CDPs identified were:

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[1] Crohn's disease is a long-term condition that causes inflammation of the lining of the digestive system. Inflammation can affect any part of the digestive system, from the mouth to the back passage, but most commonly occurs in the last section of the small intestine (ileum) or the large intestine (colon). http://www.nhs.uk/Conditions/Crohnsdisease/Pages/Introduction.aspx

- *Not all contacts were recorded on the electronic information systems which may have acted as a trigger or alert to staff that there was historical information available. This information could have been considered as part of the assessment process;*

- *Feedback was not given to the GP following the outcome of the discussion with the service user on the 23rd June 2011 changing the date of the assessment to two days later, which prevented the GP having a view as the referrer on the most appropriate course of action to take in the interim;*

- *Feedback following the interview was ambiguous leading to confusion for the service user and family in relation to outcome of the assessment;*

- *Whilst the overarching process of the team's operational policy were followed in relation to the arrangement and completion of assessments, outcomes of discussion with either the service user or the team were not well documented within the clinical record, including outcomes from MDT's or evidence of the revision of care planning or risk management documents on the basis of a change in the treatment plan for the service user*.

1.16 Care and Service delivery factors identified were:

- ***Patient factors:***
  The service user had a history of non-adherence to medication prescribed by the GP for depression and significant social stressors which contributed to depressive presentation and suicidal ideation. These included chronic illness (Crohn's Disease), financial hardships and relationship difficulties: he was going through a break-up of his relationship with his girlfriend and appeared to be dealing with the news that the man he thought was his father was in fact his step father. He had a history of impulsive para-suicidal gestures and deliberate self-harm and of carrying an offensive weapon, damaging property, of being involved in street fights and gangs and being arrested for drunken behaviour.

- ***Task Factors:***
  The requirement to record patient contacts on the appropriate system was not completed correctly after the first assessment and the "General File" was not routinely checked as a matter of course even in the absence of the patient's name appearing on CIS.

- ***Work environment:***
  In interviews with the assessing clinicians, one mentioned that on 25 June 2011, there were a number of assessments that needed to be done and that this increased the pressure. In the interview with the patient's relative, she stated that the CRHTT had tried to cancel the assessment by telephone call but that they were not at home

and on the way to Lime Trees to attend the appointment. The overall impression formed is that the workload was heavy.

- ***Team Factors:***
  Team Factors - Interviews with the staff members who assessed the service user indicate that the team worked well together and felt clinically and managerially supported through supervision. Joint assessments are the usual practise as is multidisciplinary functioning: an MDT meeting is held on a Monday or Tuesday and led by the consultant psychiatrist. Clinicians recalled that the service user's case was discussed at the handover meetings with other team members however these discussions were not recorded. One staff member said that the team was short staffed with heavy workload in June 2011. The locum consultant suggested that changes to the administration available to the team may have contributed to the communication problems identified in this case (see Communication Factors below).

- ***Communication Factors:***
  The GP referral letter contained information that the service user had been assessed by the CRHTT previously, but this was missed by the assessors. The patient had apparently not been recorded on the CIS computer system with the result that his previous notes were not sought. Administrators would historically check for old notes and previous contacts but clinicians have to do this now. The notes were filed in the so-called "General Folder" for patients who had been seen previously by CRHTT but not taken on by the service. This was not checked prior to the assessment. The clinical assessment was appropriately recorded using the correct "Assessment of Need Form" and the assessment guide prompts were all addressed including a notation about protective factors.

  In interview with the relative, it became apparent that verbal communication about the outcome of the assessment was conveyed differently to the family by the two staff members, which was perceived as confusing. Furthermore, the manner in which the plans for admission were communicated was construed to be "forceful" and lacked "sensitivity".

- ***Education and Training Factors***
  The clinicians who conducted the assessment were experienced and had worked for the Trust for 9 and 7 years. The nurse has worked for the Crisis Team for 2 years and the support worker for 5 years.

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

1.18 The independent investigation team has studied policies, GP notes and clinical records. We have also interviewed those most closely involved in Y's care and had meetings with the families of Z and Y and with Y.

1.19 We concur with five of the contributory factors identified by the Trust but disagree with the sixth, which notes staff experience and length of service as contributory factors. Noting that staff have extensive experience may be regarded as a mitigating factor, rather than a contributory factor.

In addition, our independent investigation has identified further findings in the following areas:

- Communication with families after a serious incident;
- Approaches to assessing and managing risk in CRHTT;
- Adherence to adverse incident policy;
- Communication between GPs and secondary mental health services; and
- Assurance systems to evidence completion of actions following serious incident investigations.

We agree with the Trust's seven recommendations.

1.20 In the light of our findings we believe that given his history and current lifestyle, it was possible that Y would come to police attention. However there was nothing in his criminal history or mental health presentation that would give rise to concern that he was likely to commit a homicide.

1.21 It is our opinion that this tragic event was not predictable (in the nature and seriousness of the event) by mental health services. However, if Y been admitted to MHAU then the incident in the community resulting in the death of Z would have not have occurred on that day. Therefore 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. If he had been admitted to hospital it would have accidentally disrupted the subsequent chain of events on that day which led to the outcome.

1.22 The independent investigation team believes there are lessons to be learnt and has made the following recommendations:

Recommendation 1.
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 2.
Following a CRHTT assessment, the lead clinician should be responsible for checking with service users and carers that the outcome of the

assessment is clearly understood, and next steps mutually agreed, with a documented note to that effect.

Recommendation 3.
Following a CRHTT referral, the referrer should receive feedback on the outcome of the assessment on the same day, and be informed if there are any changes to the original assessment time or date.

Recommendation 4.
The Trust should ensure there is practice guidance that provides a framework to support risk assessment and decision making about appropriate practical arrangements after an admission to Jade Ward has been agreed.

Recommendation 5.
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[2] and best practice guidance[3] and there are assurance systems that evidence this concordance with policy.

Recommendation 6.
We suggest that NHS England develop an information resource for families who may become involved in an independent investigation.

Recommendation 7.
The Trust should provide guidance regarding feedback mechanisms to staff involved following serious incident investigations.

Recommendation 8.
The Trust should develop systems that provide assurance regarding the implementation of key policies such as adverse incidents.

Recommendation 9.
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:

[2] *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*
[3] *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 CRHTT responded to GP referrals within four hours, and were flexible in their approach to Y's availability;
- 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 June 2011 Y approached Mr Z at his home address and entered the house. He carried out a sustained attack on Mr Z, who was discovered later by a neighbour. Mr Z died later that night from his injuries.

2.2 Y was living with his mother at the time of the offence. He had two contacts with mental health services, in April and June 2011. In April 2011 he had been apprehended by police after threatening to jump of a cliff, and in June 2011 he had cut his wrists and later approached his GP for help.

2.3 Y was seen and assessed by the Luton and South Bedfordshire Crisis Resolution and Home Treatment Team (CRHTT) on June 25 2011. He was offered a short in-patient stay at the medical assessment unit. It is not clear what was agreed at the assessment, but Y did not ultimately take up the offer of a bed.

2.4 The investigation team would like to express our sincere condolences to Mr Z'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 Y 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. THE INVESTIGATION

3.1 The independent investigation follows the Department of Health guidance (94) 27[4], on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in Appendix 1.

[4] *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*

3.2 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.

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

3.4 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.

3.5 The report was peer reviewed by Nick Moor, Director of Niche Patient Safety.

3.6 The investigation comprised of a review and analysis of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance[5].

3.7 We used information from Y's clinical records, GP notes and 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 qualified nurse who carried out the assessment on 25 June 2011
- the healthcare assistant who assisted with the assessment on 25 June 2011
- the Deputy Director of Mental Health and Social Care
- the current Medical Director
- the associate specialist for the CRHTT
- the CRHTT service manager
- the Director of Nursing and
- the Head of Serious Incidents and Quality

3.8 These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature. We had a telephone conversation with Y's GP.

3.9 We reviewed the Trust's immediate, 72 hour and final internal investigation reports produced at the time. We met the lead author of the internal investigation in order to understand the Trust's processes.

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

3.10 We wrote to Y at the start of the investigation to explain the purpose of the investigation and asked to meet him. We then met him in prison. Y gave written consent for us to access his medical and other records. We gave Y the opportunity to comment on the draft investigation report before it was finalised, but he declined.

3.11 We met with the victim's nieces, who represented the victim's family. We explained the purpose and process of our investigation, and gave them an opportunity to contribute to the investigation.

3.12 We met with Y's mother and aunt, explained the purpose and process of the investigation and gave them an opportunity to contribute to the investigation.

3.13 A full list of all documents referenced is at Appendix D.

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

3.15 Section 5 examines the arising issues from Y's care and treatment, and includes comment and analysis.

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

3.17 Section 7 sets out our overall analysis and recommendations.

4. THE CARE AND TREATMENT OF Y

4.1 Childhood and family background

4.1.1 Y was born in 1985 and brought up in the Luton area.

4.1.2 Y was an only child. He lived with his mother and step father until around the age of 10, when his step father left the family home to set up home with another family.

4.1.3 Around this time, he discovered that the man he thought was his father was in fact his step-father, and his family reported he found this very upsetting.

4.1.4 Around the age of 11, he came into contact with his biological father who was reported to be an alcoholic, and the family reported that Y tried to establish and maintain a relationship with him, but with difficulty.

4.1.5 Y was diagnosed with Crohn's disease[6] at aged 16, and was given hospital treatment after losing a large amount of weight.

4.1.6 Prior to the offence he was living with his mother in the family home in Houghton Regis.

4.2 Education and Employment History

4.2.1 Y finished school at age 16 with no qualifications.

4.2.2 He trained to become a butcher, and had several jobs but was unable to maintain work attendance due to his Crohn's disease.

4.2.3 The police statements record that Y was working in 2010 but was laid off, and re-hired for 3-4 weeks in January 2011. After this he is reported to have become depressed.

4.2.4 Y was unemployed but was not claiming benefits at the time of the offence. Y said that he had been trying to get a business together in house repairs. He stated that he was at the time, however, living on the profits of selling on stolen goods for others.

4.3 Relationship history

4.3.1 Y had had a girlfriend, who was a childhood friend he had met up with again in April 2010. Difficulties in the relationship in April 2011 triggered his threatening to jump off a cliff, which required police intervention.

4.3.2 He has no children.

4.3.3 His girlfriend ended the relationship in June 2011, allegedly because Y brought stolen property to her address. Y caused damage to the property in the argument that followed. The police were called and he was bailed for criminal damage.

4.4 Substance misuse history

4.4.1 Y disclosed to CRHTT staff that he had used cannabis in the past, but it didn't agree with him, and he was drinking 10-15 units of alcohol per day in June 2011, which was more than he usually drank. The assessment reports that Y said he had taken cocaine in the past, most recently about two months previously.

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[6] *Crohn's disease is a long-term condition that causes inflammation of the lining of the digestive system. Inflammation can affect any part of the digestive system, from the mouth to the back passage, but most commonly occurs in the last section of the small intestine (ileum) or the large intestine (colon). http://www.nhs.uk/Conditions/Crohns-disease/Pages/Introduction.aspx*

4.4.2 The GP notes that at his assessment in April 2011 Y stated he was drinking 24 units a week.

4.4.3 In a statement to the police his ex-girlfriend has claimed that both she and Y were drug users, using speed, cocaine and crack and Y had begun to steal to fund his drug use.

4.4.4 Y was reported to be under the influence of alcohol when he threatened to jump off the cliff in April 2011, when he damaged his girlfriend's flat in June 2011 and on the evening after the homicide when he threatened to kill himself at home.

4.4.5 His family reported finding many empty alcohol bottles in his room after his arrest.

4.4.6 Y reported that he started drinking heavily at about the age of 12, and continued this pattern throughout his teenage years and up to the time of his arrest.

4.4.7 He stated he began to use illicit drugs aged around 17, starting initially with cannabis, but moving on to ecstasy, amphetamines and other 'pills' when he was a part of the clubbing culture. By the time of his arrest he estimated he had spent many thousands of pounds on drugs.

4.5 Contact with criminal justice system

4.5.1 Y has been cautioned several times for pedal cycle offences, and had previously been arrested for possessing a dangerous weapon.

4.5.2 Previous arrests have been for drinking and damage to a police car.

4.6 Physical health

4.6.1 Y was diagnosed with Crohn's disease in 2003, and had an ileo-caecal resection[7], which improved his symptoms and he was able to gain weight.

4.6.2 At follow up in December 2003 his surgeon noted that Y did not take his medication regularly, and continued to smoke, despite advice to stop. He was seen annually until September 2008 by the surgeon for follow up, and at the last review was reported to have had no problems with Crohn's disease for some years and was on no medication. He was again advised to stop smoking, which he was told made him 5 times more likely to relapse. Y is reported to have said he would work on it.

4.6.3 In 2009 he was re-referred to the surgeon by his GP, as he was having pain and other symptoms of Crohn's. He was prescribed medication to relieve

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[7] *The ileocaecal valve is a sphincter muscle valve that separates the small intestine and the large intestine. Its critical function is to limit the reflux of colonic contents into the ileum. http://en.wikipedia.org/wiki/Ileocecal_valve.*

pain and inflammation, and was later described by the surgeon as 'lost to follow up'. Ys family reported ongoing problems with symptoms of Crohn's, which were treated by the GP. Y reported ongoing symptoms of Crohn's disease that are poorly controlled, and he is awaiting further tests.

4.7 Psychiatric history

4.7.1 Y's stepfather left the family home in December 1995, when Y was 10. His mother reported that Y had become withdrawn and would not speak to anyone in the family. His mother asked the GP to refer him for counselling. The GP wrote to Child and Family Services in February 1996, but there is no record of any follow up. Y's family reported that he wasn't ever seen by Child and Family Services.

4.7.2 A GP referral was made to the Community Mental Health Team at Beacon House, Dunstable, following a consultation on 19 April 2011. Y attended his GP's after being found by police attempting to jump off a cliff 2 days previously, and the police had instructed him to see a doctor.

4.7.3 Y reported making a suicide attempt in the past, but had not apparently discussed this with his GP.

4.7.4 He was seen at his home address by the Crisis Resolution and Home Treatment team (CRHTT) on 24 April 2011, and told them this crisis was mainly triggered by splitting up with his girlfriend, and that he also was unemployed and had financial difficulties. He said he had been drinking at the time, and wanted the police to shoot him because he didn't have the courage to kill himself.

4.7.5 Y was offered a referral to the Community Mental Health Team (CMHT) psychiatrist but he declined, saying he didn't want to be locked up, and was not mentally ill. He was advised to seek help for the anger problems he described, but refused, reportedly saying he didn't need any counselling or therapy. He said he would rather be treated by his GP, and the assessment report back to the GP suggested medication to help with sleep and fluctuating moods.

4.7.6 He was again referred to the CRHTT on 23 June 2011 after seeing his GP in the company of his aunt. Y had cut his wrists 2 days earlier and attended A&E for treatment. This GP had just taken Y on as a patient since his previous GP retired, and had met had only met Y once before, some years previously. The GP reported that Y had been prescribed Sertraline[8] 50mg, and had been feeling better, but had stopped taking it about 4 weeks previously.

4.7.7 He was described by the GP as being suicidal and low in mood, but difficult to engage. The GP phoned the CRHTT to arrange an urgent appointment. The GP reported to the internal investigation that the CRHTT agreed to

[8] *Sertraline is prescribed for depression, anxiety disorders, and obsessive-compulsive disorder (OCD). An anxiety disorder is a condition where anxiety is a major symptom. http://www.patient.co.uk/medicine/sertraline-lustral*

offer an assessment within four hours, and he recorded in the GP notes that it was his understanding that Y and his aunt would be together until this assessment occurred.

4.7.8 Y was contacted by the CRHTT on 23 June 2011. Notes record that he said he didn't want to see them at home on the initial date and time offered because he wanted his aunt to be present, and she was not available until 25 June. An appointment was arranged for 25 June 2011. He was seen at the CRHTT office in Lime Trees, Luton with his aunt on 25 June 2011

4.7.9 Y was seen and assessed by a qualified nurse and a healthcare worker, accompanied by his aunt. The assessment recorded that he had suicidal thoughts, had split up with his girlfriend and had debts up to £10,000. Y reported that he had no money and had resorted to selling his property to live. The assessment reported him as being 'non-compliant with medication'. He described poor sleep due to his Crohn's disease symptoms, and was taking painkillers (diclofenac[9]) for pain. At this time Y had been prescribed sertraline 50mg and diazepam[10] 4mg.

4.7.10 The assessment took place with Y's aunt present, though staff also spoke to each of them independently.

4.7.11 Y told these staff that he had no history of contact with mental health services, and it was reported in the assessment notes that this was his first referral. This was not in fact true, as he had been assessed by the CRHTT in April 2011 after a similar GP referral. This assessment was referred to in the GPs faxed referral letter of 23 June 2011.

4.7.12 Y was noted to be restless, anxious and '*very disturbed'*, with low mood. Risk to self was recorded as 2 'medium' on the Trust's 'First contact/crisis assessment of risk' form. This form also recorded his risk to others as 1 'low'.

The recorded plan was to offer admission to the MHAU for '*further assessment and monitoring of his mental health'*. A bed was booked at MHAU, and it was recorded that he should be offered home treatment if he declined. We interviewed the assessing nurse, who reported concern that Y did not know what medication he had been prescribed, or where his tablets were. The result of this assessment was a recommendation that he should be admitted voluntarily to the MHAU, where he could be helped with his agitation, and a thorough assessment carried out. It was reported that Y asked if he could go home with his aunt to collect some belongings, and he was asked to attend the MHAU by 18.00 on that day.

4.7.13 Y told us that he was afraid the staff wanted to '*lock him up and throw away the key'*, and he felt suffocated in the room, so asked to go out for a

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[9] *Diclofenac is used to treat painful conditions such as arthritis, sprains and strains, gout, migraine, dental pain, and pain after surgical operations. It eases pain and reduces inflammation. http://www.patient.co.uk/medicine/diclofenac-for-pain-and-inflammation*
[10] *Diazepam belongs to a class of medicines called benzodiazepines. Diazepam is a medicine which helps to control feelings of anxiety. It makes people feel less agitated and less tense. It also acts as a sedative and an anticonvulsant http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Anxiety&medicine=diazepam.*

cigarette. He said he had not at this stage agreed to come into hospital. After he was let out he ran away and bought a half bottle of vodka to calm himself.

4.7.14 The assessing nurse stated they did not recommend home treatment at that time, because of Y's level of agitation and distress and because Y appeared unlikely to take prescribed medication. The contingency plan to offer home treatment was described as a "*contingency only*", and the assessing nurse stated they had not discussed alternatives with Y or his aunt, because they believed he had accepted the offer of admission. It was reported that Y was asked to wait in reception while the arrangements were made, and there was further discussion with his aunt. Y left the building and was later seen by his aunt walking away. His aunt reported making telephone calls during the day asking him to attend the hospital, which he occasionally answered, but refused to attend.

4.7.15 At 19.00 a phone call from Y's aunt was received by the CRHTT, informing them that Y was not at home, and was refusing to come into hospital. The notes record that it was agreed with his aunt that the CRHTT would call him the next day and visit him at home.

4.7.16 At 10.20 on 26 June 2011 a phone call was made by the CRHTT to Y; he did not answer and there was no voicemail facility. The team then phoned his aunt who told them Y had been picked up by the police the previous night because he was disturbed at home. The CRHTT phoned the police to inform them he had a bed booked at MHAU, and were informed that he had been arrested for murder.

4.7.17 A mental health act assessment carried out in custody found him fit to be interviewed, with no need for detention under the Act.

5. ARISING ISSUES, COMMENT AND ANALYSIS

5.1.1 In this section we review the interventions offered to Y, and policies and procedures in place when Y was known to the services. Because Y did not progress to the stage of being engaged in treatment, we have concentrated our review on the assessment and plans developed for his care.

5.1.2 We also looked at the Trust's current policies and procedures and other documentation to consider policy adherence and any changes that have been made since the incident in June 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 4.

5.1.3. We have focussed on the points identified in the terms of reference and further areas that have emerged during our investigation. The Trust has provided some evidence of implementation of the action plan, and we have reviewed this.

The terms of reference for this investigation required 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.

5.1.4 **Comment**

We found that Y was provided with a rapid response to the GP's referrals to the CRHTT on both occasions. The practice of the CRHTT in making direct contact with Y, and responding flexibly to his requests for different times and dates is considered good practice. The lack of attention to the previous history has been addressed in the internal investigation recommendations, and we have not repeated this.

5.1.5 He was contacted within an hour of the referral on 23 June 2011 with an assessment time and date, which he delayed for two days because he wanted his aunt to be present.

5.1.6 The assessment on 25 June 2011 was carried out by a Band 6 nurse and a healthcare worker. Y was, according to the Band 6 nurse, offered a 3 day admission to the MHAU, to which it was later reported he agreed. He was not admitted straight away because it was reported that he agreed that he would go home with his aunt to collect belongings, and return to the MHAU by 18.00 that day.

5.1.7 There are different accounts of this interaction. Y's aunt reported that Y had not agreed, and left the building without next steps being clear, but with the strong impression that it was necessary for Y to be admitted. She also stated no alternatives to admission were discussed. Y's account concurs with this.

5.1.8 The healthcare assistant present was interviewed subsequently to explore his recollection of the outcome. This staff member stated that Y had been offered a bed and agreed to be admitted, but said he needed to do some things first. It was not thought unusual at that time to go home first, and as far as he was concerned Y had agreed to the admission and was not sectioned, so could arrive later. The HCA regarded the assessment as completed at this point, and the bed offered. He also stated that his

impression was that Y was not well engaged, and that it was his aunt that was seeking help rather than him.

5.1.9 The Trust 2011 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. There is no reference in the policy to the forms in use in the CRHTT in June 2011. The form 'risk management plan for CRHTT only' is not referenced either.

5.1.10 The 'Continuing Risk Assessment' document, which appears to be a clinical notes record, has the footer 'Bedfordshire & Luton Partnership Trust/September 2008', and was clearly in use by the previous provider of mental health services.

Recommendation 1

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.

5.1.11 The CRHTT risk assessment form used for Y 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). The HoNOS Pbr[11] cluster was recorded as 01 – Non psychotic - low severity with greater need.

5.1.12 We consider that the assessment of risk using a simple scoring system does not meet best practice standards[12]. 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 facilitate a more comprehensive description of any risks identified.

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[11] The Health of the Nation Outcome Scale (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. HoNOS is a rating scale on which service users with severe mental illness are rated by clinical staff.. If the ratings show a difference, then that might mean that the service user's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures. HONOS is not a risk assessment, but relies on the completion of a clinical risk assessment. .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

[12] 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

5.1.13 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.

5.1.14 The assessing nurse reported sufficient concern about Y's agitation and distress to recommend an informal admission to MHAU. There is no record of any discussion about whether a Mental Health Act (MHA) assessment was considered, or whether there was any attempt to ascertain whether Y had capacity to make decisions at this time. The 72 hour report notes that 'He was not considered to need an assessment under the MHA', however we cannot locate any note that evidences that this assessment was made.

5.1.14 **Comment**

We consider that if Y was accepting of the plan to admit informally then de facto a Mental Health Act assessment was not only unnecessary but contraindicated. It would, therefore, be extremely unusual and unnecessary to discuss MHA assessment or document this option. Any reference to use of the Mental Health Act in such circumstances would, at most, be as part of a contingency plan to consider if he didn't attend for admission. Obviously, if at the point of assessment there was clear disagreement by Y to admission then consideration of using the MHA and reason for not using it would have been required to be documented. We note however that Y was seen and assessed under the Mental Health Act in custody, the following day, after the offence, and not considered detainable

There are, however, very different perspectives on the outcome of the assessment. The lack of clear communication about next steps was noted in the internal investigation. Y and his aunt report a difficulty in communication with the staff, and a lack of clarity about what was to happen next. We have revisited this issue at the request of Y's aunt, and have not found any evidence that changes our recommendations. The family requested that we record that they disagree with this finding, and maintain that Y had not actually agreed to accept admission.

5.1.15 It was not clear whether Y did in fact agree to come into MHAU, or was left to consider it and discuss it with his aunt. There is no consensus that Y had agreed, and then requested that he go home with his aunt to collect his belongings. As earlier noted, Y reported to us that he knew the bed was available, and he asked to go out for a cigarette, then ran away.

Recommendation 2

Following a CRHTT assessment, the lead clinician should be responsible for checking with service users and carers that the outcome of the assessment is clearly understood, and next steps mutually agreed, with a documented note to that effect.

5.1.16 Subsequent notes made at 19.00 record Y's aunt phoned to tell the CRHTT that he had refused to come into hospital and was not at home, but that she had spoken to him on the phone. It was noted that it was agreed that CRHTT would visit him at home on the following day.

5.1.17 **Comment**

Given the earlier urgent referral by the GP and later assessment that Y was in need of admission to MHAU, we believe the risk assessment should have been revisited at this point.

5.1.18 A reconsideration of the risk may have indicated whether some more urgent action was required. However, we consider this would still have been based on risk to self as no new information of risk to others came to light until after his arrest. On the basis of medium ongoing risk to self and plan to review with home treatment we consider it would it not have been reasonable to expect discussion with the GP out of hours. CRHTT staff are sufficiently senior and should be able to make such risk assessments/reviews within the team on duty.

5.1.19 It is clear from the notes that the GP wanted an urgent assessment, and had been reassured that the CRHTT would offer to see him within 4 hours. The lack of feedback to the GP about the assessment being arranged for two days later has been discussed in the internal investigation but was not subject to a recommendation.

Recommendation 3

Following a CRHTT referral, the GP or referrer should receive feedback on the outcome of the assessment on the same day, and be informed if there are any changes to the original assessment time or date.

5.1.20 In our opinion the failure to admit to MHAU, having decided that it was the appropriate step, was a lost opportunity. As admission was deemed necessary to complete the assessment, the failure to get him into the ward meant the assessment wasn't completed. We have been given no evidence that completing the assessment would have shown an increased risk to others.

Recommendation 4

The Trust should ensure there is practice guidance that provides a framework to support risk assessment and decision making about appropriate practical arrangements after an admission to Jade Ward has been agreed.

5.1.21 If he had been in MHAU then the incident in the community a few hours later resulting in the death of Z would have not have occurred on that day. Therefore this particular incident was not preventable, in the sense of a deliberate action being taken to avoid a predicted or likely event. If he had been admitted to hospital it would have accidentally disrupted the subsequent chain of events on that day which led to the outcome.

5.1.22 It was agreed with Y's aunt that the CRHTT would call him again the following day, and the notes record that they phoned him on 26 June 2011 at 10.20, but got no response and were unable to leave a message.

5.1.23 The CRHTT followed up with a phone call to Y's aunt on 26 June 2011, who informed them he had been picked up by the police because he was threatening to harm himself at home. They then contacted the police to inform them that he had a bed booked at the MHAU, and invited the police to bring him in, and were informed that Y had been arrested on suspicion of murder.

5.1.24 The on call manager was informed, who advised CRHTT staff to offer to assist the police if a Mental Health Act assessment was required. The Trust was later informed by the police that a Mental Health Act assessment had been carried out in custody, and he was found not to be in need of detention under the Act.

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

5.1.26 Both the victim and perpetrator's families in this case report that they had no information or offer of contact from the Trust after the homicide.

5.1.27 Y's aunt was contacted by the review team to enable her to contribute to the review process as part of being open principles as she was the one who attended the assessment appointment with him and was the identified next of kin as provided by Y. We also met with Y's mother. The Trust's own policy regarding making contact with families after a serious incident was not followed in this case. We were informed of changes that have taken place since this time with regard to FLO's, and that there has been training and identification of people who have the relevant skills, to be called upon if needed.

5.2 Involvement in the independent investigation

5.2.1 **Z's family**

5.2.2 Through the Family Liaison Office of Bedfordshire Police Mr Z's nieces were identified as speaking for the family, and agreed to meet with the investigation team. Their overriding concern is now for the health and wellbeing of their parents, as their father is the brother of Z. They reported

feeling very well supported by the Police and Victim Support, but noted that the Trust had had no contact with them, and that they were unaware of an internal Trust investigation, and had not been offered sight of the report. They were also unclear on the process for an independent investigation.

5.2.3 They talked candidly of the distress experienced by the family, in particular by their parents (Z's brother and sister in law) and on reflection would have welcomed an offer of support or signposting to a support service from the Trust. They expressed the hope that more support may be offered to any family in the future in similar tragic circumstances.

5.2.4 **Y's family**

5.2.5 Y's mother and aunt met with the lead investigator, and described Y's difficulties, though they deny that he was seriously in debt. They believe that Y should have been offered help when it was requested as a child, and later by the GP, and that his Crohn's disease had a significant effect on his life, relationships and employment. Regarding the assessment on 25 June 2011, they deny that any discussion about detention under the Mental Health Act took place, and believe Y should not have been given the choice of a voluntary admission, and felt he was in a seriously distressed state.

5.2.6 Y's family stated they did not receive support from the police, and had no approach or offer of support from the Trust. They were not aware of the outcome of the internal investigation, though were interviewed, and had not been offered sight of the report.

Recommendation 5

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[13] and best practice guidance[14] and there are assurance systems that evidence this concordance with policy.

Recommendation 6

We suggest that NHS England develop an information resource for families who may become involved in an independent investigation.

5.3 Y

[13] *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*

[14] *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*

5.3.1 Y was not seen as part of the internal investigation, on the advice of the police at the time. He agreed to meet with us in prison. He recalls the assessment by the CRHTT, and was aware a bed was on offer for him. He also denies that debt was a serious issue. However, he stated he was afraid of being locked away, and started to feel as though he was suffocating in the assessment room. He asked to go out for a cigarette, and then ran away.

5.3.2 Y was aware his aunt went out to look for him, but he would not answer the phone when she rang. He bought and drank a half bottle of vodka after running away.

5.3.3 There was no mental health defence offered at his trial; according to the family this was under Y's instruction. He states he pleaded not guilty because at the time he could not believe he had committed the homicide. He was found guilty of murder on 26 January 2012, and it was recommended that he serve 30 years.

The sentencing Judge said: *"It's quite clear you went there planning to steal from that house and sell items. You tried to extract from him in that house details of his PIN number".*

6. THE INTERNAL REVIEW

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

6.1 Review the trust's internal investigation recommendations and any action plan

6.1.1 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 a Locality Director from another part of the Trust, the Director of Mental Health, and a consultant psychiatrist (clinical director) from another part of the Trust.

The Care and Service Delivery Problems identified were:

- ***Patient factors:***
  The service user had a history of non-adherence to medication prescribed by the GP for depression and significant social stressors which contributed to depressive presentation and suicidal ideation. These included chronic illness (Crohn's Disease), financial hardships and relationship difficulties: he was going through a break-up of his relationship with his girlfriend and appeared to be

[15] *National Patient Safety Agency. RCA Investigation Evaluation Checklist.*

dealing with the news that that the man he thought was his father was in fact his step-father. . He had a history of impulsive parasuicidal gestures and deliberate self-harm and of carrying an offensive weapon, damaging property, of being involved in street fights and gangs and being arrested for drunken behaviour.

- ***Task Factors:***
  The requirement to record patient contacts on the appropriate system was not completed correctly after the first assessment and the "General File" was not routinely checked as a matter of course even in the absence of the patient's name appearing on CIS.

- ***Work environment***
  In interviews with the assessing clinicians, one mentioned that on 25 June 2011, there were a number of assessments that needed to be done and that this increased the pressure. In the interview with the patient's relative, she stated that the CRHTT had tried to cancel the assessment by telephone call but that they were not at home and on the way to Lime Trees to attend the appointment. The overall impression formed is that the workload was heavy.

- ***Team Factors:***
  Interviews with the staff members who assessed the service user indicate that the team worked well together and felt clinically and managerially supported through supervision. Joint assessments are the usual practise as is multidisciplinary functioning: an MDT meeting is held on a Monday or Tuesday and led by the consultant psychiatrist. Clinicians recalled that the service user's case was discussed at the handover meetings with other team members however these discussions were not recorded. One staff member said that the team was short staffed with heavy workload in June 2011. The locum consultant suggested that changes to the administration available to the team may have contributed to the communication problems identified in this case (see Communication Factors below).

- ***Communication Factors***
  The GP referral letter contained information that the service user had been assessed by the CRHTT previously, but this was missed by the assessors. The patient had apparently not been recorded on the CIS computer system with the result that his previous notes were not sought. Administrators would historically check for old notes and previous contacts but clinicians have to do this now. The notes were filed in the so-called "General Folder" for patients who had been seen previously by CRHTT but not taken on by the service. This was not checked prior to the assessment. The clinical assessment was appropriately recorded using the correct "Assessment of Need Form" and the assessment guide prompts were all addressed including a notation about protective factors.

In interview with the relative, it became apparent that verbal communication about the outcome of the assessment was conveyed differently to the family by the two staff members, which was perceived as confusing. Furthermore the manner in which the plans for admission were communicated was construed to be "forceful" and lacked "sensitivity".

- ***Education and Training Factors***
  The clinicians who conducted the assessment were experienced and had worked for the Trust for 9 and 7 years. The nurse has worked for the Crisis Team for 2 years and the support worker for 5 years.

The recommendations made were:

1. The Team Manager must ensure that CRHTT workers are recording all referrals and assessments on CIS regardless of the outcome.
2. Until the introduction of an electronic patient record, the Team Manager must ensure copies of assessment paperwork are filed and accessible even if service user is not taken on for follow up by the CRHT. Assessment of risk to self and others must be documented in the clinical record to inform the outcome of any subsequent assessments. Additionally the CRHT Manager must ensure that there is a robust system in place to check whether those referred to the service have been seen previously prior to assessments being undertaken.
3. The Team Manager must ensure there is a record kept of handover discussions for CRHT service users particularly when there is a change in a management plan or presenting problems.
4. The CRHT Manager and the Team Consultant must ensure that there is a robust process in place which will ensure that where an offer of admission to a MHAU for a period of assessment is made, arrangements must be made for the patient to be conveyed to the available bed at the earliest opportunity. Furthermore the service user must not be left unaccompanied until an appropriate handover between the ward and the CRHT has taken place.
5. The CRHT Manager and Team Consultant must ensure that when service users decline an admission to MHAU an immediate review of the risk assessment is completed and documented. In addition clinicians must demonstrate and document that they have considered the alternatives to an assessment on MHAU including a rationale for the use or not of formal powers for detention.
6. The locality senior management team must ensure that a review of processes and procedures within the CRHT takes place which takes account of resource availability and deployment. This should include a review of the skill mix within the team to ensure that it is fit for purpose and that staff are in possession of the necessary skills and competencies to work in such a specialist area.

7. Given the recent changes in Administrative support services, a review must be undertaken by the operational services to assess whether the administration needs of the CRHT are being met.

6.1.2 Although we concur with these recommendations, and have not repeated them, in our opinion the care and service delivery problems identified did not sufficiently reflect the lack of a thorough risk assessment and communication issues. It was clear however, that there has been a full review of the practices and operating procedures of the CRHTT, and many changes made.

We also note a lack of adherence to the adverse incident policy in the process of locally managing and investigating the incident, in making contact with families, appointing a family liaison officer to maintain contact.

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

- Communication with families after a serious incident;
- Approaches to assessing and managing risk in CRHTT;
- Adherence to adverse incident policy;
- Communication between GPs and secondary mental health services; and
- Assurance systems to evidence completion of actions following serious incident investigations.

6.1.4 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' in maintaining contact with families.(November 2011).

6.1.5 The policy requires due consideration to be given to involvement of the service user/ their family and of the victim and alleged perpetrators' family in the review process. We consider the Trust did not involve either family sufficiently in this process.

6.1.6 The recommendations do not address the lack of communication back to the GP following the change to the assessment date, and the later outcome of the assessment, which has become our Recommendation 3 above.

6.1.7 We were told that communication back to the GP is now mandatory after the CRHTT assessment is completed. A fax of the risk assessment and outcome is sent to the GP the following working day, and a system for checking that the fax had been received is in place. We were assured that regular reports are generated on compliance with this protocol, but these were not provided as evidence.

6.1.8 We requested the interview transcripts, and were informed they were all done by video recording hence there were no transcripts, apart from notes of the meetings with Y's aunt and his GP.

6.1.9 **Comment**
The adverse incident policy does not give guidance on whether these should be transcribed and kept, and we believe guidance to investigators would be helpful.

6.1.10 We have not found any exploration of Y's capacity, or of whether a Mental Health Act assessment was considered. The 72 hour report notes that a Mental Health Act assessment was considered and he was found not detainable, but we have not located evidence of this assessment.

6.1.11 **Comment**
While we acknowledge that the following day, on 26 June 2011, he was found not to be detainable, we believe addressing these areas at risk assessment would support decision making.

6.1.12 We consider that the plan to offer admission to the MHAU was reasonable, given the stated concern that Y was not taking medication already prescribed and his level of distress. However, the risk assessment documented at the time does not in our opinion accurately reflect this level of concern, as risk to self was rated as medium, and risk to others as low.

6.1.13 **Comment**
We consider that the MHAU's threshold for admission at the time must have been sufficiently flexible to accept this referral.

We heard that a staff member interviewed as part of the internal investigation stated they had not seen the final report or had feedback about their involvement. The adverse incidents policy describes arrangements for supporting staff, and references the workforce well-being policy, but does not give any guidance about the structures for feeding back to staff following a serious incident investigation.

Recommendation 7

The Trust should provide guidance regarding feedback mechanisms to staff involved following serious incident investigations.

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

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

6.2.2 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.

6.2.3 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.

6.2.4 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.

6.2.5 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 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.

6.2.6 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.

6.2.7 A serious incident external quality review process has been established for several years, with an 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.

6.2.8 We requested evidence of changes to the management of paper records, and progression of the implementation of electronic records. Senior managers explained that an electronic patient record 'Mobius' has been implemented in the Luton area, and is due for roll out shortly to the CRHTT. This system has an electronic front sheet which shows the patients' previous contacts, and current care needs at a glance.

6.2.9 The issue of clerical support and staff resources in the CRHTT was explored. There has been a structured review of the operations of all of the CHRTTs in the area, led by the Medical Director. Resources for clerical support were described as currently satisfactory. The CRHTT operates a team staffing model, with nursing cover over 24 hours. The clinical WTE described was acknowledged as a well-resourced team.

6.2.10 The caseload for the team is monitored and we were assured if the numbers of patients rise above an identified level, this becomes a trigger to request extra staff resources. The current caseload in August 2014 was

described by staff as manageable, with no current clinical staff or administration resource issues. The caseload is monitored weekly by the Assistant Director.

6.2.11 With regard to the actions for the CRHTT and MHAU on ensuring that '*if an offer of a bed is made, there should be arrangements made for the patient to be accompanied at all times until conveyed to the available bed at the earliest opportunity. An appropriate handover between the ward and the CRHTT must then take place'.*

6.2.12 This implies that all admissions must be accompanied by the CRHTT worker until admission and handover are completed. The completed action plan states '*where admission is offered as a result of assessment in A&E or at home, appropriate transport is arranged'*.

We heard that it would be judged reasonable to allow the patient to go home to collect belongings, accompanied by a family member, then later present themselves at Jade Ward for admission.

6.2.13 **Comment**

While we agree that this may be reasonable in a community setting, this is a contradiction with the recommendations of the action plan. We also consider that when Y failed to return, the CRHTT should have escalated the issue and agreed a firm plan of action about what to do with someone who in their opinion needed to be admitted. (See Recommendation 4 above that addresses this).

6.2.14 There is a recommendation in the internal action plan that when service users decline an admission, an immediate review of the risk assessment must be completed and documented. In addition clinicians '*must demonstrate and document that they have considered the alternatives to assessment (on the MHAU) including a rationale for the use or not of formal powers of detention'*.

6.2.15 **Comment**

Evidence of the implementation of this practice would help to assure the Trust that this has been embedded into practice.

6.2.16 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 some assurance regarding the implementation of lessons learned and governance structures that are now in place. The 2012 audit and the 2013 re-audit of CRHTT care plans showed evidence of improvements in quality of care planning. The revised CMHT Operational Policy dated June 2011 has incorporated the recommended changes, showing a clear care pathway from referral.

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

Recommendation 8.

The Trust should develop systems that provide assurance regarding the implementation of key policies such as adverse incidents.

Recommendation 9.

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

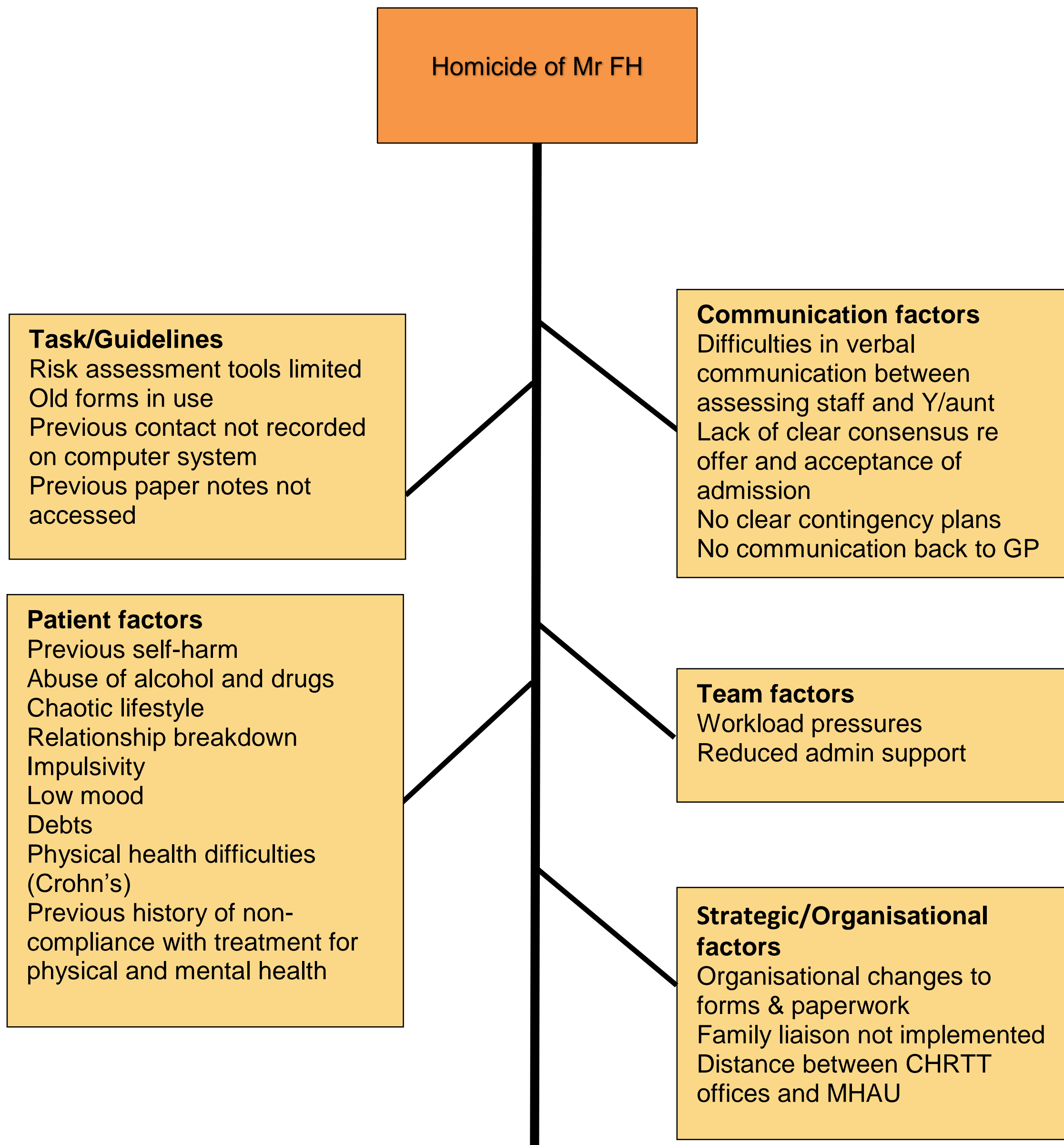
7.1 There are several ways in which the Trust and individual practitioners could have improved their understanding and assessment of Y. In particular, there was recognition that there were psychological issues which may have benefited from further exploration by a period of admission for assessment. The communication and risk assessment issues that prevented a fully documented assessment and clear communication of outcome have been commented on above, with recommendations made. Relevant history could have been gathered by accessing his previous notes. There was no enquiry into the reasons behind his stated debts, although there was recognition that this was a significant stressor. The opportunity to seek corroboration from his aunt at the CRHTT assessment was missed.

7.2 Whilst it is our opinion that there are no indicators in the history that suggest that Y lacked capacity, or was detainable under the Mental Health Act, the absence of recording that these assessments were made leaves a question about the thoroughness of the risk assessment. We accept, however, that neither his GP on 23 June 2011 nor the Forensic Medical Examiner on 26 June 2011 regarded him as detainable under the Act. We found nothing to suggest that this incident was predictable.

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 CRHTT responded to GP referrals within four hours, and were flexible in their approach to Y's availability
- 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 no signs that could have alerted the Trust's staff that an incident of violence such as this would occur. Whilst it is clear that Y had a history of previous contact with the police, and an outstanding charge for damaging his girlfriend's flat, he had not come to the attention of police for any serious violence. There were no presenting concerns that may have indicated that he was likely to be involved in such an incident. In our opinion this incident was not predictable.

7.8 Preventability

7.8.1 Essentially Y did not co-operate with services available that could have helped to complete the assessment and then help him manage any identified mental health issues. The offer of an admission to MHAU for 72 hours was made, at a time when his GP and family were concerned about him, and he was noted to be distressed and agitated.

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

7.8.3 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. If he had been admitted to hospital it would have accidentally disrupted the subsequent chain of events on that day which led to the outcome. The issue of preventability relates to changing circumstances and allowing for further assessment rather than a missed therapeutic intervention for any identifiable mental disorder, as none has subsequently been identified even with knowledge of the incident and its antecedents.

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 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.
- 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

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Recommendation 1.
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 2.
Following a CRHTT assessment, the lead clinician should be responsible for checking with service users and carers that the outcome of the assessment is clearly understood, and next steps mutually agreed, with a documented note to that effect.

Recommendation 3.
Following a CRHTT referral, the referrer should receive feedback on the outcome of the assessment on the same day, and be informed if there are any changes to the original assessment time or date.

Recommendation 4.
The Trust should ensure there is practice guidance that provides a framework to support risk assessment and decision making about appropriate practical arrangements after an admission to Jade Ward has been agreed

Recommendation 5.
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 6.
We suggest that NHS England develop an information resource for families who may become involved in an independent investigation.

Recommendation 7.
The Trust should provide guidance regarding feedback mechanisms to staff involved following serious incident investigations.

Recommendation 8.
The Trust should develop systems that provide assurance regarding the implementation of key policies such as adverse incidents.

Recommendation 9.
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 Y's contacts with Secondary Mental Health Services
(from April 2011 to June 2011)

Appendix C
Chronology of Y's contacts with Secondary Mental Health Services (from April 2011 to June 2011)

This chronology has been drawn up from GP, mental health services notes and interviews, meetings with Y and family, and police records

Date	Source	Detail
16 or17/4/11	GP notes	Caught by police trying to jump off a cliff- was advised to see GP, saw GP 19/4/2011 and talked of suicide
19/4/11	GP notes	Referred to psychiatry, beacon house, Dunstable asking for assessment
24/4/11	GP notes	Seen by CRHT team at home. Refused CMHT input, not suicidal at interview, advised to see GP for medication if needed.
23/6/11	SEPT notes	GP letter asking for Y to be seen again (mentions April assessment) was taking Sertraline but stopped 4 weeks ago. Cut to wrists & suicidal thoughts.
23/6/11 16.30	SEPT notes	CRHT referral/ triage decision making tool (form) notes referral received
23/6/11 17.00	SEPT notes CRHT referral form	Left message on mobile asking Y to contact CRHT
23/6/11 17.30	SEPT notes CRHT referral form	Y called CRHT – would prefer to be seen with Aunt, so declined today's assessment. Said Aunt is working 24/6/11, but available 25/6/11. Arranged for 10am on 25/6/11 with Aunt. CRHT number given to Aunt.
23/6/11	SEPT notes	SEPT service user profile CPA1 started by CHRT, nurse DB – assigned to Dr K.
25/6/11	SEPT notes First contact/Crisis Assessment of Risk form	Assessed by nurse & HCW, note made 14.00- to be admitted to MHAU for further assessment and monitoring of mental state.
25/6/11	SEPT notes Assessment of need form	Seen with 'sister' (in fact Aunt). Offered admission to MHAU for further assessment & monitoring of mental state
25/6/11	SEPT notes	Y leaves Lime Trees, refuses to accept bed offered
25/6/11 17.00 approx	Police case summary	Y approaches Victim Z at rear garden gate of his house, overheard by neighbour talking

25/6/11 Approx. 18.00	Police case summary	Y leaves Z house after attacking him, Z still alive. calls mother later on to collect him from Luton
25/6/11 22.38	Police case summary	Aunt calls police because he is aggressive at home & threatening to kill himself. Y is agitated & threatening to harm himself when police arrived, Taser used and arrested for this. Aunt gives them carrier bag with weapon in, says Y told her he hurt someone. later arrested on suspicion of murder
25/6/11 19.00	SEPT progress notes	First progress note made (after assessment), Aunt phoned to say Y is refusing to come into hospital. Plan: to telephone, and visit tomorrow
26/6/11	SEPT progress notes	T/C to Y, no response, no message facility. T/C to Aunt- she reported that he was picked up by the police after threatening to harm himself at home

Appendix D.
Serious Incident SI 444 Luton CRHT Action Plan Completed January 2012

Appendix D
Serious Incident SI 444 Luton CRHT Action Plan Completed January 2012

No	Recommendation	Identified Lead	Target Date	Progress RAG status
1	The team manager must ensure that CRHT workers are recording all referrals and assessments on CIS regardless of the outcome.	CRHT Manager	30th November 2011	The CRHT Manager has provided assurance that a new form has been introduced and is in use. The form is completed for every referral and is given to the Crisis Team administrator to input onto CIS (electronic patient recording system). Copy of new form in use, held in evidence portfolio. COMPLETED
2	Until the introduction of an electronic patient record, the Team Manager must ensure copies of assessment paperwork are filed and accessible even if service user is not taken on for follow up by the CRHT. Assessment of risk to self and others must be documented in the clinical record to inform the outcome of any subsequent assessments. Additionally, the CRHT Manager must ensure that there is a robust system in place to check whether those referred to the service, have been seen previously prior to assessments being undertaken.	CRHT Manager	28th February 2012	There is now a system in place to ensure historical assessment paperwork is accessible to CRHT staff. In addition all CRHT staff have access to the relevant CMHT cluster folders so that they can check if the service user has been referred previously.
3	The Team Manager must ensure there is a record kept of handover discussions for CRHT service users particularly when there is a change in a management plan or presenting problems.	CRHT Manager	28th February 2012	A record is now kept of handover discussions. This has extended to the regular clinical reviews. The Clinical Group Manager and Shift Leader have responsibility for clinical oversight.
4	The CRHT Manager and the Team Consultant must ensure that there is a robust process in place which will ensure that where an offer of admission to a MHAU for a period of assessment is made, arrangements must be made for the patient to be conveyed to the available bed at the earliest opportunity. Furthermore the service user must not be left	CRHT Manager	31st January 2012	Where admission is offered as a result of assessment in A&E or assessment at home appropriate transport is arranged.

	unaccompanied until an appropriate handover between the ward and the CRHT has taken place.			
5	The CRHT Manager and Team Consultant must ensure that when service users decline an admission to MHAU an immediate review of the risk assessment must be completed and documented. In addition clinicians must demonstrate and document that they have considered the alternatives to assessment on MHAU including a rationale for the use or not of formal powers for detention.	CRHT Manager	30th November 2011	Risk assessments are updated and documented. The consultant and the team discuss and agree on whether a further management plan or MHA assessment should be considered. Record keeping standards are monitored through supervision.
6	The locality senior management team must ensure that a review of processes and procedures within the CRHT takes place which takes account of resource availability and deployment. This should include a review of the skill mix within the team to ensure that it is fit for purpose and that staff are in possession of the necessary skills and competencies to work in such a specialist area. This should include the competency of the assessing clinicians in this case.	Clinical Group Manager	31st March 2012	Comparative skill mix review has been completed which has incorporated demand and capacity parameters. As a result of this review additional psychology resource has been introduced into the team. Review of competency of assessing clinicians completed.
7	Given the recent changes in administrative support services, a review must be undertaken by operational services and admin services to assess whether the administration needs of the CRHT are being met.	Administration Manager Locality Director - Luton	31st March 2012	Extensive review of administration resources has been completed.

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 444 internal investigation initial incident form, 72 hour report, final report (undated) and action plan
- SEPT SI 444 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 Y clinical notes
- Y GP notes
- Bedfordshire police case summary

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. HoNOS
- 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

1 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 Beds and Luton Mental Health Partnership Trust in 2010.

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.