An independent investigation into the care and treatment of Mr Z

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V3.6

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

Our Draft Report has been written in line with the terms of reference set out in the independent investigation into the care and treatment of Mr Z. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. However, where there is evidence that the information is not accurate, this has been made clear in the Report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

This is a confidential Report and has been written for the purposes of NHS England alone under agreed framework terms. No other party may place any reliability whatsoever on this Report as this Report has not been written for their purpose. Different versions of this Draft Report may exist in both hard copy and electronic formats and therefore only the final, approved version of this Report, the 'Final Report' should be regarded as definitive.

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Contents

1. Executive Summary and Recommendations

1.1 NHS England Midlands and East of England commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user, Mr Z. The requirement was also to assess the implementation of recommendations which resulted from the Trust's internal investigation. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services[2]. The terms of reference for this investigation are given in full in Appendix A.

1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to reduce the chance of recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

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

1.5 This independent investigation concerns the care and treatment of Mr Z (which is a pseudonym) by South Essex Partnership University NHS Foundation Trust (known as Essex Partnership University NHS Foundation Trust since April 2017).

The homicide

1.6 Mr Z started a fire at his block of flats on 7 May 2016. Sadly, Ms A, who was eight months pregnant, was in the building and though found by emergency services, died two days later in hospital.

1.7 Mr Z was arrested on 10 May 2016 for murder and criminal damage – arson and endangering life. He plead guilty to manslaughter and arson in March 2017 and was detained under Section 37[3] of the Mental Health Act 1983 (MHA) and subject to a Section 41 MHA restriction order[4].

Mental health history

1.8 Mr Z had been under the care of mental health services since 1991. Mr Z has a diagnosis of paranoid schizophrenia for which he had received depot

[1] *NHS England Serious Incident Framework March 2015. Https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*
[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*
[3] *https://www.legislation.gov.uk/ukpga/1983/20/section/37*
[4] *https://www.legislation.gov.uk/ukpga/1983/20/section/41*

medication,[5] slow-release medication given by injection, for over 20 years. Historically, Mr Z had been detained three times under the MHA and had spent a number of months as an inpatient following an arrest in 2010 for which charges were later dropped.

1.9 Mr Z was 47 years old when he moved to Essex from London in January 2015. He registered with a GP shortly after moving but was told the GP practice did not administer depot medication. His medication was changed to oral anti-psychotic medication and he was referred to South Essex Partnership University NHS Foundation Trust[6] mental health services for depot medication. Mental health services subsequently rejected the referral, citing that Mr Z was stable, and that his GP should provide his depot medication. The matter was unresolved when Mr Z changed to another GP practice in early February 2015. He remained on oral anti-psychotic medication.

1.10 Mr Z's family became concerned that his mental health was deteriorating and contacted the Trust mental health services and his GP later in 2015 and into 2016 asking that he be assessed by mental health services.

1.11 Mr Z was assessed by the First Response Team (FRT) on 22 April 2016. He was accompanied by his father who spoke to the assessing consultant, but his father did not attend Mr Z's assessment at the request of Mr Z. The FRT did not accept Mr Z onto its caseload but asked Mr Z's GP to recommence him on depot medication. The GP practice did not receive the outcome of the assessment until 5 May 2016 because it was initially sent to Mr Z's previous GP.

1.12 Mr Z was assessed by the Criminal Justice Liaison and Diversion Team (CJLDT) on 9 May 2016 following his arrest for an unrelated matter. His actions on 7 May 2016 were unknown to the team. The team concluded he was stable and discharged him with no follow-up at his request.

1.13 Mr Z was arrested again on 10 May 2016 for murder and criminal damage – arson and endangering life.

Findings

Risk assessment and risk management

1.14 Mr Z was subject to two risk assessments in April and May 2016:

April 2016

1.15 Mr Z was assessed by a consultant psychiatrist and community psychiatric nurse (CPN) on 22 April 2016. They undertook a mental state examination

[5] https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/depot-medication

[6] *South Essex Partnership University NHS Foundation Trust merged with North Essex Partnership University NHS Foundation Trust to form Essex Partnership University NHS Foundation Trust (EPUT) on 1 April 2017.*

which did not identify concerns. They undertook a risk assessment that did not record any risks to Mr Z or others. They recorded that Mr Z did not have a past risk history.

1.16 Mr Z's risk assessment did not fully reflect the knowledge and concerns his family had previously shared with the team and his GP (e.g., by phone and in writing). Their concerns included his deteriorating mental health, that he was not taking medication and that he could become a risk to others or himself. The assessment was not holistic, and his recent behaviour was not captured (e.g., two incidents of being abusive to members of the public). Had the assessing clinicians taken these factors into consideration, it could have facilitated a comprehensive risk assessment and, in turn, a responsive risk management plan that might have gone beyond asking Mr Z's GP to recommence his depot medication.

May 2016

1.17 Mr Z was assessed by the CJLDT on 9 May 2016 following an arrest for making threats to kill. The team was unaware that Mr Z had started a fire at his block of flats two days previously.

1.18 The CJLDT completed a risk assessment documenting that Mr Z had no thoughts of self-harm or intention to harm others. Mr Z showed no sign of thought disorder, clinical depression, acute psychosis or paranoia. The team concluded Mr Z did not require a hospital admission, though identified seven risk factors which included 'possible risk to others' and 'possible risk of deterioration in mental state due to change in medication (from depot to tablet)'. The team did not share their findings with Mr Z's GP at his request, and he was discharged from the service because no further interventions were identified.

1.19 Mr Z did not have a risk management plan in place at the time of the incident when he started the fire at his flat.

Care planning

1.20 Mr Z was not under the care of Trust mental health services and consequently did not have a care plan.

Primary care and medication

Depot medication

1.21 Mr Z had taken depot medication for 20 years. It was documented in his notes that he preferred to receive it from his GP and did not wish to engage with secondary mental health services. Mr Z told us he did not like taking oral medication because he could sometimes forget to take it.

1.22 Mr Z's transfer from London to his Essex GP in January 2015 was completed in line with the GP practice policy. He was told during his first GP appointment

that the practice did not administer depot medication and he was referred to Trust services who subsequently rejected the referral.

1.23 Mr Z told us he changed GP practice again in early February 2015 with a view to receiving depot medication, although he remained on oral medication until he stopped collecting the prescription in April 2015.

1.24 There is no shared care agreement between the Trust and primary care in relation to depot medication. Some GP practices do administer depot medication whereas others direct patients to depot clinics or secondary mental health services. The Trust introduced senior primary care mental health care practitioners in the south east Essex area in December 2019 with a view to supporting GP practices and, although it would not be a routine scenario, they can administer depot medication on the premises.

Contact with primary care services

1.25 We identified three occasions when Trust services contacted Mr Z's previous GP practice rather than the practice he was registered with. The Trust had the correct details for Mr Z's GP. We have been unable to establish why, despite this, his previous GP was sent information three times, including the request in April 2016 that his depot medication be recommenced.

Family engagement

1.26 Mr Z's sister and parents began to raise concerns about his mental health in June 2015. There are several occasions documented in the notes when they contacted the FRT or Mr Z's GP. These included Mr Z's parents attending the adult mental health services office in January 2016, and his sister submitting a letter detailing her concerns to his GP in April 2016, which went on to form part of his referral to mental health services.

1.27 There is no evidence the family's requests were subject to a formal assessment or their input was sought in relation to Mr Z's risk management, or as part of a care plan, despite their attempts to engage the FRT.

1.28 The failure by the FRT to act on the concerns of Mr Z's family, particularly the letter from his sister submitted as part of the GP referral in April 2016, was a missed opportunity to undertake a thorough assessment of his mental health and explore treatment options.

Internal investigation and action plan

1.29 The Trust internal investigation was undertaken in line with Trust and national policy.

1.30 The findings of the Trust internal investigation were reasonable, but the scope should have been expanded to consider the management of Mr Z's depot requirements and the Trust's documenting and sharing of FRT decisions with primary care. The report would have benefited from the investigators setting out the detail of their analysis and benchmarking of practice. Steps should

also have been taken to share the report findings with the families of Mr Z and Ms A.

1.31 The internal investigation recommendations did not sufficiently address the key issues pertaining to Mr Z's care and treatment.

Recommendations

1.32 This independent investigation has made five recommendations for the Trust to address and to improve learning from the incident. We suggest these are completed within six months of publication of this report.

Recommendation 1: The Trust should evaluate the senior primary care mental health nurse practitioner role in south east Essex to establish whether it has facilitated the management of depot medication and mitigated the risk of patients not receiving it.

Recommendation 2: The Trust, Local Medical Committee and relevant Clinical Commissioning Groups should develop and agree a shared protocol for the administration of depot medication in the community. This should include agreement as to which party is responsible for undertaking the initial patient assessment, and for the initial and ongoing administration of depot medication.

Recommendation 3: The Trust should assure itself that electronic patient records only give staff access to the patient's current GP contact details and that all other out-of-date contact details are archived.

Recommendation 4: The Trust should assure itself that concerns submitted by families or members of the public regarding a patient are documented, subject to assessment and review, and where appropriate proactively acted on. In instances where action is not taken, the rationale should be documented.

Recommendation 5: The Trust should put a system in place to ensure that internal investigation report findings are shared with service users, their families, and that other affected parties are taken into account.

2. Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full at appendix A.

2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring.

2.3 The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

2.4 The investigation was carried out by Kathryn Hyde-Bales, Associate Director for Niche. Expert clinical advice was provided by Dr Mark Potter. The investigation team will be referred to in the first-person plural in the report.

2.5 The report was peer reviewed by Dr Carol Rooney, Associate Director for Niche.

2.6 We reviewed Mr Z's clinical notes from the Trust and all three GP practices with whom Mr Z had been registered between January 2015 and May 2016. We asked for copies of his notes and detail of some practice policies. GP Practice C closed in July 2018, and despite liaison with Castle Point and Rochford Clinical Commissioning Group (CCG), it was not possible to access the practice legacy documentation (e.g., policies) or locate the lead GP.

2.7 Full details of the documents we reviewed can be seen in Appendix B.

2.8 We undertook interviews with the following Trust officers:

- the Service Manager for South East Essex Community Mental Health Services; and
- the Executive Chief Operating Officer/Deputy Chief Executive (and member of the Trust internal investigation team).

2.9 We would like to thank the interviewees for their time and input to the investigation.

2.10 The investigation began in January 2020 but was subject to delays due to difficulties in obtaining information from the GP practices and Castlepoint and Rochford CCG. The investigation was put on hold for two months over the summer due to the COVID-19 pandemic.

Contact with the victim's family

2.11 We wrote to Ms A's husband to inform him of our investigation and to offer to meet. He initially indicated he wanted to be involved, but later decided he would prefer to speak once the investigation was reaching its conclusion. We spoke to Mr A at the end of our investigation to share our draft report and to seek his views on the findings.

2.12 Ms A was a 30-year-old woman who was eight months pregnant at the time of her death. Mr A described her as loving, sweet and very thoughtful. He said she was a gentle and innocent person who was 'sunshine' in the lives of everyone she knew. He told us they had chosen a name for their unborn child.

2.13 Mr A said the death of his wife and unborn child had destroyed his life and caused him constant pain. He told us '*What has been lost is more precious than even I can imagine, much less describe*'.

2.14 We would like to offer our sincere condolences to Ms A's family for their tragic loss.

Contact with the perpetrator's family

2.15 We spoke to Mr Z's sister (referred to as Ms J in the report) who kindly provided additional information pertaining to his care. She submitted questions to the investigation team which we have sought to address in the report. We offered to involve Ms J and Mr Z's parents in the investigation, but Ms J advised she would act on their behalf. We would like to thank Ms J for her time and input into the investigation.

Contact with the perpetrator

2.16 We spoke with Mr Z whom we were unable to meet in person due to COVID-19 restrictions; but we were able to hold a meeting via videoconference.

2.17 On completion of the investigation, we shared the draft report with Mr Z (via his Responsible Clinician) and Ms J for their comment. We received no feedback from Mr Z.

Structure of the report

2.18 Section 3 provides a narrative chronology of Mr Z's care and treatment.

2.19 Sections 4 to 7 examine the issues arising from the care and treatment provided to Mr Z and include comment and analysis related to the terms of reference.

2.20 Section 8 provides a review of the Trust's internal investigation.

2.21 Section 9 sets out our overall analysis and recommendations.

3. Chronology of care and treatment

3.1 At the time of the homicide, Mr Z was a 47-year-old man with a diagnosis of paranoid schizophrenia. He had been in receipt of mental health services since 1991. He had been detained three times under the MHA and had spent several months as an inpatient at Chase Farm hospital,[7] London in 2010, following an arrest for which charges were later dropped.

3.2 Mr Z moved to Essex in early 2015, to be closer to his family. Prior to the move he had lived in North London for several years. He was a patient at GP Practice A[8] in Enfield and received a monthly depot at the GP practice.

2015

3.3 Mr Z moved to Essex in January 2015. He registered with GP Practice B on 9 January 2015.

3.4 GP1, at GP Practice B, saw Mr Z on 12 January. GP1 recorded in the notes that Mr Z had a 20-year diagnosis of schizophrenia and received clopixol[9] depot medication from his GP.[10] Mr Z was noted to be calm, indicated no suicidal ideation and said clopixol helped him 'a lot'. GP1 changed Mr Z's medication to a trial of zuclopenthixol[11] tablets to be taken up to three times daily and recommended Mr Z be referred to psychiatric services for review, which he agreed to.

3.5 GP1 referred Mr Z to the Trust FRT on 15 January 2015. The referral set out that Mr Z was a new patient who had a long-standing diagnosis of schizophrenia and was a recipient of monthly clopixol injections. The referral said Mr Z received his injections from his GP practice (but did not specify it was his previous GP practice). It added that he was not comfortable engaging with mental health services and was last seen by a psychiatrist ten years previously. GP1 asked the team to review and assess Mr Z with a view to offering him further care. Mr Z was noted to be prescribed zuclopenthixol up to three times daily.

3.6 A letter was sent to Mr Z from the Trust Routine Booking Appointment Centre on 16 January 2015 to inform him that Trust services were not suited to his current needs and that he should contact his GP about further management.

3.7 The FRT, in addition to the above, wrote to GP Practice B on 20 January 2015 declining the referral. The response said Mr Z did not meet the criteria for input from the service and, given he was stable, it was best he continue with his medication. It was recorded in the GP notes that Mr Z was not keen to take zuclopenthixol tablets and that he wished to revert to depot medication.

[7] *Part of the Royal Free London NHS Foundation Trust*
[8] *Mr Z was a patient at GP Practice A from 9 July 2014 until 15 January 2015.*
[9] *An antipsychotic. Clopixol is the brand name for zuclopenthixol. The terms can be used interchangeably, as is the case in Mr Z's notes.*
[10] *Mr Z received his last depot medication at GP Practice A on 10 December 2014.*
[11] *An antipsychotic used to treat schizophrenia and other psychoses.*

3.8 GP Practice B contacted the FRT on 20[12] January 2015 in response to its rejection of the referral, saying that they did not administer depots and wanted the FRT to assume management of this. They explained that Mr Z was currently being given oral medication, but he wanted to go back onto a depot. The FRT Team Leader and a doctor (role not specified) discussed the GP response, concluding that the practice should give Mr Z his depot medication given he was not unwell. The notes do not indicate how and when this was relayed to the practice and it is not documented in the GP notes, though the Team Leader noted the practice would *'not be happy with this outcome'*.[13]

3.9 GP Practice B issued Mr Z with a repeat prescription for zuclopenthixol tablets on 28 January 2015.

3.10 Mr Z registered with GP Practice C on 2 February 2015. It issued him with a prescription for 100 tablets of zuclopenthixol on the same day.[14]

3.11 Ms J contacted the FRT on 8 June 2015 to raise concerns about Mr Z's mental health. She spoke to CPN1. She said she felt her brother was becoming unwell since he had switched from depot medication to oral medication. She said he had lost three stone in weight, looked unkempt, and had displayed unusual behaviour at a family BBQ the day before. She added that he kept altering the brightness and contrast on his television which he had done when previously unwell. Ms J told the FRT that the family were unable to contact his GP because Mr Z would not share the details.

3.12 CPN1 contacted the GP practice the same day, asking that Mr Z's GP contact her when he was available. The FRT initially contacted GP Practice B, Mr Z's previous practice, it was only on further inspection of the system they found the correct GP details (GP Practice C). CPN1 called Ms J to let her know she had contacted Mr Z's GP and was waiting for a call back.

3.13 GP2 from GP Practice C called CPN1 later[15] on 8 June 2015. He said he had not met Mr Z[16], but would follow-up the family concerns. GP2 asked for details of the FRT referral pathway which CPN1 provided. CPN1 contacted Ms J to let her know that Mr Z's GP would contact him; she did not give GP2's name due to patient confidentiality[17].

3.14 GP2 saw Mr Z at the practice in the afternoon on 8 June 2015. He was noted to look well, maintained eye contact and was in a 'good mood'. GP2 noted that Mr Z had a long history of mental health issues for which he said he was taking tablets regularly. Mr Z said he felt well on the tablets and was generally happy. Mr Z said he was not experiencing negative thoughts or hearing voices. He said he was not taking recreational drugs and only drinking a small amount of alcohol. Mr Z declined a mental health referral saying he felt well,

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[12] *The contact was logged by the FRT Team Leader on 21 January 2015.*
[13] *Continuation/progress outcome form dated 21 January 2015.*
[14] *The practice issued further prescriptions on 19 March, 27 April, 9 June and 6 July (56 tablets as opposed to 100 in July).*
[15] *The call was recorded in the notes at 1525hrs.*
[16] *Mr Z had attended the practice once to see a nurse and his latest prescription had not been collected (we assume this was the April prescription because Mr Z's next prescription was issued on 9 June 2015, the day after his appointment with GP2).*
[17] *In keeping with the Data Protection Act (1998).*

though agreed to continue taking his medication and that he would attend the GP practice if he felt unwell.

3.15 Ms J contacted the FRT on 12 October 2015. She was concerned that Mr Z had lost a lot of weight and was not visiting the family. Ms J said she was also concerned that he was refusing to access mental health services and added that historically he had been arrested for sexual assault, though was found not guilty.[18] Ms J did not think Mr Z was acutely unwell therefore the FRT told her to direct him to his GP. The FRT contacted GP Practice C on 12 October[19] to relay the concerns of Ms J. GP2 took the call. The FRT later called Ms J to tell her they had spoken to Mr Z's GP and he would refer Mr Z to the FRT if necessary.

3.16 GP2 wrote in the notes that he had tried to call Mr Z, but there had been no reply and he would try again the next day.

3.17 GP2 tried calling Mr Z on 13 October 2015 but received no response. A letter was sent to Mr Z the same day asking him to attend the practice for a health check.

2016

3.18 Mr Z's parents attended the adult mental health services office on 8 January 2016 to raise concerns about his wellbeing. They spoke to CPN2. They said Mr Z had a history of schizophrenia and had been 'sectioned' ten years previously. They were aware he had stopped receiving his depot medication and were concerned his mental health was relapsing. They said he had started to walk around the garden talking to himself and would not tell them who his GP was. CPN2 told them that Mr Z could attend the FRT or be referred by his GP or, if he was in crisis, attend A&E. Mr Z's parents said he would not engage with them when they suggested to him that they attend a GP appointment with him or take him to hospital. CPN2 gave Mr Z's parents the FRT address and phone number if they needed further information.

3.19 Mr Z attended GP Practice C on 5 February 2016 after GP2 telephoned him that morning.[20] Mr Z appeared well. He had a calm demeanour, maintained eye contact and spoke coherently. Mr Z indicated he was not happy that his family kept contacting him and he did not want a mental health referral. GP2 noted that Mr Z had capacity[21] and, despite his attempts, could not be persuaded to be referred to mental health services. GP2 and Mr Z agreed he should attend the practice regularly for review. Mr Z agreed to attend in a few weeks' time.

3.20 Ms J telephoned GP2 on 6 April 2016. She said she thought Mr Z's mental health was deteriorating and detailed an incident in which he had got into

[18] *The Trust internal investigation says the charges were dropped. We have not sought to confirm the outcome of the charges because it is beyond the scope of our terms of reference.*
[19] *The FRT initially contacted GP Practice B, Mr Z's previous practice, it was only on further inspection of the system they found the correct GP details.*
[20] *It is likely that this contact was prompted by Ms J contacting GP Practice C on the morning of 5 February 2016, but the notes only say 'History [Ms J's name] [phone number]'.*
[21] *GP 2 did not write in the notes how he reached this assessment.*

arguments at a bank and became angry with people. GP2 called Mr Z who agreed to attend an appointment on Monday 11 April.

3.21 GP2 contacted Rochford hospital[22] after speaking to Mr Z on 6 April. He was told he should review Mr Z then refer him to the crisis team for a mental health assessment.

3.22 GP2 contacted Ms J the same day asking that she provide a letter to the practice setting out the family concerns and details of Mr Z's mental health history.

3.23 Ms J wrote to GP2 on 7 April 2016. In her letter she set out her concerns about Mr Z's mental health, noting his behaviour had deteriorated on a monthly basis over the past year. She detailed he had recently been abusive towards bank staff, had engaged in a confrontation in a car show room, and when at their parents' home, constantly adjusted the television without watching it and walked around the garden talking to himself. She added that she had been trying to have him assessed since he had stopped receiving his depot following his move to Essex at the beginning of 2015. She further outlined that Mr Z:

- had lost roughly seven stone[23] in the previous 12 months;
- showed a disregard for personal hygiene;
- refused to let his parents see his flat;
- did not accept that he had a psychiatric illness or was unwell; and
- had been in a car accident[24] and she did not think he was a safe driver.

3.24 Ms J wrote she was at a loss as to what to do for Mr Z. She had contacted the local mental health team who advised her brother should attend A&E. She concluded that his condition would continue to deteriorate and would culminate in an incident, which she hoped would not affect him or a member of the public.

3.25 GP2 referred Mr Z to mental health services on 8 April 2016 (the form was faxed to the FRT on 11 April 2016, see below). GP2's referral set out that Mr Z had moved to the Essex area at the beginning of the previous year. He had a history of paranoid schizophrenia but was not on any medication, although GP2 noted Mr Z had received monthly depot injections when he lived in London. GP2 outlined that Mr Z did not attend the GP Practice often, but his family had recently raised repeated concerns about his mental health. GP2 included what he described as the 'detailed' letter from Ms J dated 7 April 2016 in his referral. GP2 highlighted that she had described Mr Z to be self-neglecting, had been getting into arguments in public, and had previously crashed his car (which Mr Z denied although he later told us he crashed his car when he swerved to avoid a dog in the road). GP2 asked the FRT to formally assess Mr Z's mental health.

[22] *Rochford community hospital provides community based mental health support, including crisis resolution services.*
[23] *There is no detail in Mr Z's notes to indicate that GP2 discussed his substantial weight loss.*
[24] *The car accident happened in early February 2016.*

3.26 GP2 saw Mr Z on 11 April. He looked well, had a good rapport and maintained eye contact. Mr Z indicated that he thought he was doing well. He said he was not experiencing negative thoughts or hearing voices. He said he understood his family's concerns and agreed he would see mental health services for depot injections. GP2 told Mr Z he intended to refer him to mental health services, and they agreed that he should attend the practice if he experienced a crisis. The Trust Central Appointments Office received the faxed referral from GP2 on 11 April 2016.

3.27 The FRT received GP2's referral on 12 April 2016. An FRT screening outcome was completed on 13 April 2016. Mr Z was to be offered a routine FRT assessment appointment within 14 days.

3.28 Mr Z, accompanied by his father, attended an outpatient appointment with the FRT on 22 April 2016. Mr Z's father did not sit in on the assessment but spoke to the team with Mr Z beforehand. Mr Z's father said Mr Z did not want to take his medication, though Mr Z said it was because his GP would not administer the medication.

3.29 Mr Z was seen by Consultant Psychiatrist 1 and CPN3. CPN3 completed an FRT Adult and Older People assessment form. It was recorded that Mr Z had a 15-year history of paranoid schizophrenia and had been treated with depot medication, but this had stopped since his move to the Essex area. Mr Z's risk assessment recorded no current suicidal or homicidal thoughts, and he denied symptoms of psychosis. The risk assessment recorded no historical risk incidents. The team noted Mr Z appeared to have sufficient insight into his condition, his rapport was adequate, and he maintained eye contact. Mr Z denied taking any illicit substances and said he drank alcohol in moderation. He was noted to have lost weight. Mr Z signed a consent form agreeing the team could share information with his parents.

3.30 Mr Z declined to be referred to a depot clinic or involved with secondary mental health services (e.g., the wellbeing clinic). He agreed to start monthly clopixol 400mg injections to be administered at his GP practice. Mr Z was discharged from the service.

3.31 The FRT faxed its outpatient clinical report on 27 April 2016 to GP Practice B, Mr Z's previous practice[25]. The clinical report asked the GP to confirm Mr Z's depot medication with his former London GP before starting him on the depot.

3.32 GP2 spoke to Mr Z and his sister by telephone on 4 May 2016. They told him Mr Z had attended Rochford hospital (mental health services) two weeks previously and had agreed to start depot medication. GP2 wrote in the notes that he had not received a letter from the FRT and would ask a colleague to follow-up.

3.33 A member of GP practice C's administration team contacted the FRT on 5 May 2016 about Mr Z's medication. The FRT later the same day faxed GP

[25] *Details of Mr Z's current GP were recorded in the assessment paperwork.*

Practice C details of Mr Z's assessment and medication from the 22 April appointment. The outpatient clinical report had previously been sent (incorrectly) to GP Practice B on 27 April.

3.34 Ms J spoke to GP2 on 6[26] May 2016.

3.35 It was recorded in Mr Z's GP notes on 6 May 2016 that his previous depot medication had been confirmed and arrangements should be made to see Mr Z at the practice.

3.36 Nurse 1 recorded in Mr Z's notes on 6 May 2016 that GP2 had agreed the practice would administer Mr Z's monthly depot medication. Mr Z's prescription was printed, and it was agreed Mr Z should be asked to attend the practice 'asap'.

3.37 Mr Z started a fire at his block of flats on 7 May 2016. His actions were unknown to the police at the time. Trust staff and GP Practice C were also unaware of the incident. Mr Z was arrested on 9 May 2016 on suspicion of indicating a 'threat to kill'. The arrest was unrelated to the fire on 7 May 2016 for which Mr Z's culpability was yet to be established. The police referred him to the CJLDT due to '*markers of schizophrenia*'.

3.38 The team saw Mr Z the same day, the assessment was logged at 2200hrs. He was noted to be polite, cooperative, and oriented to time and place. He exhibited a good rapport and maintained eye contact throughout the assessment. Mr Z told the team that £2000 had been stolen from his bank account and he had said '*things*' to a member of staff in the spur of the moment which he did not mean. The CJLDT recorded in the notes that Mr Z showed *'no evidence of thought disorder, paranoia, acute psychosis or severe depression'*. Mr Z told the team about his previous long-term use of depot, which had changed to oral medication following his move to Essex. He added that following a recent assessment he was waiting to hear from his GP about arrangements to provide him with a depot. Mr Z described himself as stable. The team completed a risk assessment, noting Mr Z denied any thoughts of self-harm or harm to others. The team identified seven risk factors:

- *"Risk of deterioration in mental state due to ongoing drug use (legal high).*
- *Deterioration in physical health due to ongoing drug use (legal high).*
- *Lack of insight with regards to use of legal high which he refers [to] as 'herbal'.*
- *Possible risk to others (alleged offence).*
- *Possible increase of impulsivity due to use of legal high.*
- *Possible risk of deterioration in mental state due to change in medication (from depot to tablet).*
- *Possible risk of reoffending due to all the above-mentioned factors".*

[26] *There is no record of this call in the GP notes, but a letter faxed by Mr Z's sister to the GP Practice on 10 May 2016 references a discussion taking place 'last Friday' which would have been 6 May 2016. The letter is dated 7 April, but Mr Z's sister told us this was a mistake. The fax timestamp on the letter is 10 May 2016.*

3.39 Mr Z declined a referral to drug and alcohol services and did not give consent for information to be shared with his GP. The CJLDT closed his case and no other interventions for Mr Z were indicated.

3.40 Mr Z's father attended the mental health service office on 9 May 2016. He told the team that Mr Z's GP had not received a letter from the team. The team asked that he double check this with Mr Z's GP as they were sure they had sent a letter but would fax another copy to the practice.

3.41 The FRT sent the initial assessment outcome letter dated 9 May to GP2 on 10[27] May 2016. The letter repeated the detail of the assessment letter sent to the practice on 5 May 2016. It reiterated the request that the practice confirm Mr Z's historic depot use before starting him on monthly clopixol (400mg). We discuss this further under risk management and risk assessment (Section 4).

3.42 Ms J faxed a letter to GP2 on 10[28] May 2016. Her letter referenced a conversation she had had with GP2 the week before and said that Mr Z had agreed to go back onto monthly depot medication. She noted that GP2 had said he had not received the FRT assessment, which the family had followed up with the Trust who had agreed to send the assessment again. Ms J referenced Mr Z's previous behaviour in a bank and that he was now potentially facing a charge of making threatening behaviour. Ms J reiterated her concerns that it was a matter of time before another incident happened. She urged that GP2 give Mr Z his medication as a priority "*before anything else happens"*. She asked to be told when an appointment had been made for Mr Z and concluded her letter, noting the family were very concerned about his continuing deterioration and weight loss.

3.43 GP Practice C attempted to contact Mr Z on 10 May, but he did not respond. The practice then contacted Ms J to let her know that they had been unable to contact Mr Z but wanted him to attend the practice the next day for his depot medication.

3.44 Mr Z was arrested on 10 May 2016 for the fire he started on 7 May 2016. He was arrested for murder and criminal damage (arson endangering life). He was assessed by the CJLDT on the morning of 11 May. Mr Z appeared polite and oriented to place and time. He had a good rapport, maintained eye contact and spoke coherently. Mr Z told the team he was due to have depot medication at his GP practice the next day. The team noted Mr Z's history and undertook a risk assessment. It was recorded in the notes that he presented with insight and understanding of the situation. Mr Z declined that his family and GP be informed of the CJLDT assessment and declined a referral for substance misuse; the CJLDT closed his case.

3.45 Mr Z's brother-in-law contacted GP Practice C on 11 May 2016 to report that Mr Z was at a local police station. The police contacted the practice the same

[27] *A further copy of the Initial Outcomes letter was posted on 12 May 2016.*
[28] *The letter is dated 7 April 2016, but a fax cover sheet indicates the letter was sent on 10 May 2016. Mr Z's sister told us the letter had been incorrectly dated and confirmed it was sent on 10 May 2016.*

day to advise Mr Z was in custody. They asked for the details of his depot medication which was administered to him that day.

3.46 HMP Chelmsford contacted GP Practice C on 19 May 2016 to request Mr Z's medical history and detail of his medication.

3.47 Mr Z pleaded guilty to manslaughter and arson in March 2017. He was detained under Section 37 under the MHA and subject to a Section 41 restriction order.

4. Risk assessment and risk management

4.1 The Healthcare Quality Improvement Partnership (HQIP, 2018) states that a good risk assessment combines *"consideration of psychological (e.g., current mental health) and social factors (e.g., relationship problems, employment status) as part of a comprehensive review of the patient to capture their care needs and assess their risk of harm to themselves or other people".*[29]

4.2 A comprehensive risk assessment will take into consideration the patient's needs, history, social and psychological factors, and any negative behaviours (e.g., drug use).

4.3 Risk management planning is defined as a cycle that begins with risk assessment and risk formulation, which in turn leads to a risk management plan subject to monitoring and review.

4.4 The Department of Health (2009)[30] identifies 16 best practice points for effective risk management which include:

"… a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions be taken by practitioners and the service user in response to crisis"; and

"Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach."

4.5 Best practice risk management is based upon clinical information and structured clinical judgement. It involves the practitioner making a judgement about risk based on combining:

- an assessment of clearly defined factors derived from research (historical risk factors);
- clinical experience and knowledge of the service user, including any carer's experience; and
- the service user's own view of their experience.

4.6 The Trust 'clinical guidelines for the assessment and management of clinical risk' (2010, reviewed in 2014)[31] describe risk assessment as a process of estimating an individual's harmful or beneficial outcomes based on gathering historical and current information. The guidelines say:

"A risk assessment seeks to answer for [sic] *simple related questions:*
- *How bad?*
- *Is there a need for action?*

[29] https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-70-Mental-Health-CORP-Risk-Assessment-Study-v0.2.docx.pdf
[30] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf
[31] The policy was 'superseded in May 2016 – reviewed as part of CQC action'. We have referred to the legacy policy because it was the guidance in place and available to staff during the time of Mr Z's care and treatment.

- *How often?*
- *What can go wrong?"*

4.7 The guidelines set out clinical factors to consider including the risk of self-harm, self-neglect, violence towards others, and other types of risk to other people, that include arson. Clinical staff are directed to consider behaviours that include evidence of:

- *"recent discontinuation of medication, change in medication or non-compliance;*
- *actual or potential substance misuse;*
- *physical health risks e.g., refusing to eat; and*
- *threatening behaviour and delusions."*

4.8 The guidelines define risk management as:

"… the practice of identifying potential risks in advance, analysing them and taking precautionary steps to reduce/curb the risk. It involves making decisions based on knowledge of research evidence, knowledge of [the] *patient's own experiences and clinical judgement"; and*

"The management of clinical risk is a multi-disciplinary process that should include the service user and/or their careers. It involves making decisions based on knowledge of research evidence, knowledge of the service user and their social context, knowledge of the service user's own experience, and their clinical judgement. All those concerned should collaborate in identifying potential clinical risks and the implementation of an agreed plan to manage risks and make best use of the service user's own strengths to promote their recovery."

Mr Z's risk assessment on 22 April 2016

4.9 Consultant Psychiatrist 1 and CPN3 from the FRT saw Mr Z on 22 April 2016. They undertook a mental state examination which did not identify concerns. They undertook a risk assessment that did not record any risks to Mr Z or others. They recorded that Mr Z did not have a past risk history. It was noted that Mr Z's father accompanied him to the appointment but was not part of the assessment.

4.10 It is documented in the notes that Ms J had concerns about her brother's mental health, so much so that she had written to his GP in early April 2016 to raise her concerns about his deteriorating mental health which she feared would culminate in an incident affecting either him or a member of the public. Her letter highlighted several points in relation to Mr Z's risk:

- he had not received depot medication in over a year;
- he had been detained three times under the MHA;
- he had been arrested (detail omitted) and subsequently spent 'months' at Chase Farm Hospital waiting for his case to be heard - charges were later dropped;

- Mr Z's behaviour had continued to deteriorate over the previous 12 months;
- Mr Z had lost a significant amount of weight and demonstrated little personal hygiene;
- his behaviour had become 'very volatile', leading to two abusive/ confrontational incidents with members of the public in recent days;
- he walked around the garden talking to himself;
- he kept adjusting the television; and
- he had purchased a car and the family did not consider him a safe driver (he had been involved in a car accident in February 2016).

4.11 Ms J had also contacted the FRT in the past to raise concerns. She had phoned the FRT in October 2015 and said that Mr Z had previously had an allegation of sexual assault against him and had been an inpatient at Chase Farm.

4.12 GP2 shared Ms J's letter as part of Mr Z's referral to the FRT. However, Consultant Psychiatrist 1 told the Trust internal investigation that he did not see Ms J's letter before the assessment. The Trust were unable to ask CPN3 whether he had seen Ms J's letter because he had left the Trust.

4.13 It is recorded in the Trust internal investigation that Consultant Psychiatrist 1 spoke with Mr Z's father alone, before Mr Z's assessment, and subsequently explored his concerns in the assessment, but the detail of the discussion is not documented in the notes. It is not clear whether Mr Z's father outlined the nature of Mr Z's behaviour, his history, and why the family were concerned about his mental health.

4.14 However, Consultant Psychiatrist 1 told the Trust internal investigation that had he been sighted on the letter from Ms J he would have explored this with Mr Z, but it would not have changed the outcome of the assessment. While Mr Z did not want to engage with secondary mental health services, he was willing to restart depot medication which had previously kept him stable.

4.15 The risk assessment did not fully reflect the knowledge and concerns his family had previously shared with the team. His social and psychological factors and recent behaviour were not captured (e.g., two incidents of being abusive to members of the public). The team did not document a risk management plan in their assessment although identified that Mr Z should start taking clopixol and asked his GP to facilitate this.

4.16 The Trust investigation does not say why Consultant Psychiatrist 1 did not see the letter from Ms J, particularly given it was highlighted in the GP referral; but we consider, had the letter been reviewed it may have changed the outcome of the assessment. The letter would have served as a prompt to discuss Mr Z's history, previous inpatient admissions, his unusual behaviour, significant weight loss, and his recent car accident. In the case of the latter, given Ms J had said the family did not consider him to be a safe driver, Consultant

Psychiatrist 1 would have had a professional responsibility to consider whether to contact the Driver and Vehicle Licensing Agency (DVLA) about Mr Z's ongoing intention to drive.

4.17 Had the assessing clinicians taken these factors into consideration, it could have facilitated a comprehensive risk assessment and, in turn, a responsive risk management plan that might have gone beyond asking Mr Z's GP to recommence his medication. We consider this was not an appropriately assertive approach given the risk information that was detailed in Ms J's letter. Had the team reviewed the letter they may have considered taking him into secondary care services, although he may have declined. The team should have considered contacting GP2 directly to ensure the plan for Mr Z's medication was put in place rather than relying on a fax.

4.18 The FRT should have sought and documented the answers to the four questions set out in the Trust clinical guidelines for the assessment and management of clinical risk:

Trust risk assessment questions	***Evidence from Mr Z's sister and the assessment on 22 April 2016***
How bad?	Mr Z's mental health was deteriorating, he was displaying unusual behaviour, had argued with members of the public, had been in car accident and his family considered him to be an unsafe driver.
Is there a need for action?	Yes. Historically, a lack of intervention had resulted in Mr Z being detained under the MHA three times.
How often?	Historically, Mr Z had responded well to monthly depot medication but, given Mr Z was not known to the Trust, a holistic risk assessment should have been undertaken which considered whether there were alternative means of working with him.
What can go wrong?	Ms J stated that she thought an incident would occur that would result in harm to either Mr Z or a member of the public. The family considered him to be an unsafe driver, therefore a car accident was a possibility.

Mr Z's risk assessment on the evening/night of 9 May 2016

4.19 The CJLDT was unaware on 9 May 2016 that Mr Z had started a fire on 7 May 2016, or that Ms A and her unborn child had died. There is no evidence that anyone (e.g., Trust staff or the police) was aware that Mr Z had started the fire until his arrest on 10 May 2016.

4.20 Mr Z was arrested on 9 May 2016 for threats to kill.[32] Mr Z told the team the incident had occurred a month previously and related to £2000 being stolen from his account. He said when he called his bank, he was made to wait a long time and the member of staff was rude to him which resulted in him saying 'things' which he did not mean.

4.21 The CJLDT completed a risk assessment documenting that Mr Z had no thoughts of self-harm or intention to harm others. Mr Z showed no sign of thought disorder, clinical depression, acute psychosis or paranoia. The team concluded Mr Z did not require a hospital admission. The team identified seven risk factors:

- *"Risk of deterioration in mental state due to ongoing drug use (legal high).*
- *Deterioration in physical health due to ongoing drug use (legal high).*
- *Lack* [of] *insight with regards to use of legal high which he refers to as 'herbal'.*
- *Possible risk to others (alleged offence).*
- *Possible increase of impulsivity due to use of legal high.*
- *Possible risk of deterioration in mental state due to change in medication (from depot to tablet).*
- *Possible risk of re-offending due to all of the above-mentioned factors".*

4.22 The team did not devise a risk management plan with Mr Z to mitigate the risks they had identified.

4.23 It was recorded in the notes that Mr Z was known to Trust services (e.g., he had been assessed in April 2016) and that his last contact had been when the FRT referred him back to his GP. The team noted that Mr Z had been assessed on 22 April 2016 in relation to his medication and that he had been referred back to his GP because he did not want to attend a depot clinic. The team also noted that Mr Z's mother and sister had been in contact with the FRT to express concerns about his behaviour, although did not set out the detail.

4.24 There is no evidence in the notes that the team tested Mr Z's assertion that £2000 has been stolen from his account. If it was untrue, then it possibly indicated evidence of paranoia or, if it was true, it suggested a safeguarding intervention might need to be considered.

4.25 The team did not inform Mr Z's GP of his arrest or assessment as per Mr Z's request for confidentiality. It was recorded in the notes *"*[Mr Z] *gave his consent to share information by signing all the relevant forms however explained that he did not want the information to be sent to* [the] *GP."*

[32] *We do not have information about this incident though note the letter from Mr Z's sister to GP2 in April 2016 which said that Mr Z had been in arguments with members of the public in a car show room and at a bank.*

4.26 The Royal College of Psychiatrists[33] says that to share confidential patient information *"… patients should have capacity to decide whether to consent to disclosure and should give their consent to it."*

4.27 NHS services can share information about a service user with other providers/services involved in his/her care. Typically, this is done under 'implied' consent[34] in which it is assumed the service user would consider it reasonable to share information. However, a service user can object to their information being shared. In such circumstances, healthcare providers must adhere to the service user's request not to share their information unless:

- it is in the public interest because the service user presents a risk to themself or others; and/or
- the service user lacks capacity to decide whether their information should be shared, but it is considered in their best interests to do so.

4.28 Although there is no evidence in the notes to suggest Mr Z's presentation was such that the team had cause to breach this confidentiality, seven risk factors were identified, and it is normal practice to share information with a patient's GP. Mr Z was entitled to ask that the team not share information with his GP, but discussion around this request and the reason for it should have been documented in the notes. As it was, although the team identified a number of significant risk factors, it did not make a plan to mitigate these and they subsequently discharged Mr Z without follow-up or adequately exploring the issue of sharing information with his GP, which we do not consider to be in line with best practice.

4.29 We discussed this with the Trust Service Manager for South East Essex Community Services, who told us she would have anticipated a safeguarding alert to have been raised and considered in relation to Mr Z's money, although it would not necessarily have led to an investigation. In instances where an investigation is not instigated, and the alert closed, she would expect the rationale to be documented. She also said that in a scenario where the patient does not want information shared with the GP, she would anticipate that steps would have be taken to stress the central role of the GP to the patient and the importance of their involvement, with a view to them agreeing to share information.

4.30 The Trust Deputy Chief Executive told us he thought information sharing had improved, and it would be more likely now that the team would share such information, although patient confidentiality remained a challenge.

Finding 1: Mr Z's risk was not comprehensively assessed by the FRT in April 2016 or by the CJLDT in May 2016. Neither assessment reflected Mr Z's mental health history, recent events, behaviour, or detailed the concerns of his family. Crucially, those assessing Mr Z did not appear to

[33] *https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr209.pdf?sfvrsn=23858153_2*
[34] *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality_-_NHS_Code_of_practice.pdf*

grasp the risk Mr Z could pose to himself and others, despite the documented concerns of his sister.

Finding 2: The CJLDT did not share the outcome of their assessment with Mr Z's GP at Mr Z's request. This was in line with national guidance pertaining to patient confidentiality.

Finding 3: Mr Z did not have a risk management plan in place at the time of the incident.

5. Care plan

5.1 The Trust Care Programme Approach (CPA) handbook (2015) describes a care plan as follows:

"The care plan is the patient's own record of who is supporting them with their recovery needs. The care plan must be person centred and focus on the patient's own strengths and aspirations. It is expected that care plans will address the principles of social inclusion, recovery, dignity, respect, and be mindful of ethnicity and diversity."

5.2 The Trust clinical guidelines for the assessment and management of clinical risk say:

"… a good quality plan of care is individual and personalised and is developed by staff and the patient in partnership, reflecting their discussions and agreements and also discussions held with family/carers."

5.3 The FRT did not accept Mr Z onto its caseload therefore he did not have a care plan.

Finding 4: Mr Z did not have a Trust CPA care plan in place at the time of the incident, because he was not on the FRT caseload.

6. Primary care and medication

Transfer of care

6.1 Mr Z moved from London to Essex in January 2015, registering with GP Practice B on 9 January 2015. The surgery has a new patient registration process which sets out a number of steps that include:

- inviting the patient to attend the surgery for a 'new patient check';
- arranging an appointment with the GP if they take regular medication; and
- referring any patient with a diagnosis of schizophrenia – but is unknown in the area - to secondary mental health services.

6.2 There is evidence in the notes that the above steps were taken in Mr Z's case. He was subject to a 'new patient check' shortly after registering and saw GP1 on 12 January 2015. GP1 referred Mr Z to the FRT on 15 January 2015.

6.3 There is nothing in the notes to suggest Mr Z's transfer of care to GP Practice B was unusual. There are no documented concerns in relation to gaining information about Mr Z from his previous practice. Mr Z's London based, GP Practice A, told us his registration with them ended on 15 January 2015.

6.4 Mr Z was seen by GP1 at GP Practice B shortly after registering and steps were taken promptly to refer him to secondary mental health services.

Finding 5: Mr Z's transfer to GP Practice B was completed in accordance with the surgery's registration process.

Depot medication

6.5 The Royal College of Psychiatrists[35] describes depot medication as that given by injection which is slowly released in the body over a number of weeks. The Royal College says there are positives and negatives to depot, most notably the positives being depot medication is taken monthly as opposed to daily oral medication. Depot medication and oral medication can be the same medication, it is the method of administration that is different. However, achieving an equivalent dose is not always straight forward.

6.6 NHS England describes Shared Care Prescribing Guidelines as *'… local policies to enable General Practitioners to accept responsibility for the prescribing and monitoring of medicines/treatments in primary care, in agreement with the initiating specialist service'.*[36]

6.7 Mr Z had received depot medication for 20 years. He preferred to receive it from his GP and did not wish to engage with secondary mental health services. When Mr Z moved to Essex, GP Practice B did not offer a depot

[35] https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/depot-medication
[36] https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf

service, and he was switched to oral medication. However, when the FRT rejected Mr Z's referral in January 2015, it was clear that it considered GP Practice B to be responsible for administering depot medication. In turn, GP Practice B reiterated that it did not offer a depot service. GP Practice B told us that it does not administer depot medication, rather a local clinic is provided, managed by a Trust mental health team.

6.8 There is no evidence in the notes to indicate that resolution was sought between the FRT and GP Practice B about this issue. Mr Z changed to GP Practice C a few weeks later. There is also no evidence in the notes to indicate that he discussed depot medication with the new practice, rather his prescription for oral zuclopenthixol was reissued a few days after registering with the surgery (five days after GP Practice B had issued a prescription for oral zuclopenthixol). Further to this, there is no evidence that any healthcare professionals involved in Mr Z's care checked he was taking his oral medication.

6.9 GP Practice C closed in June 2018 therefore we have been unable to explore these issues with them; nor have we been able to access the policies/ procedures in place at the surgery in relation to medication monitoring (e.g., zuclopenthixol) or administering depot.

6.10 We contacted Castle Point and Rochford CCG who advised that there is no shared care protocol in place for prescribing depot medication in the area.

6.11 We spoke to the Trust Service Manager for South East Essex Community Mental Health Services, who confirmed that there were no shared care agreements in the area for depot medication. She told us most patients attend resource centres for their medication or it is administered to them at home. We asked whether a scenario similar to Mr Z's, in which neither party took responsibility for administering his depot, could arise under the current process. We were told that since December 2019 the Trust has senior primary care mental health care practitioners linked to GP Practices, and though a scenario like Mr Z's would not be routine, the practitioner role could undertake the administration of depot within a GP Practice. We were told the introduction of senior primary care mental health care practitioners had been deemed a success and that steps were being taken to recruit to further posts, taking the total to nine senior practitioners in south east Essex.

Finding 6: There is not a shared care agreement in Essex between primary and secondary care in relation to depot medication. Some GP practices do administer depot medication whereas others direct patients to depot clinics or secondary mental health services. Senior primary care mental health care practitioners were introduced in south east Essex in December 2019 with a view to supporting GP practices and, although not a routine scenario, they could administer depot medication on site.

Recommendation 1: The Trust should evaluate the senior primary care mental health nurse practitioner role in south east Essex to establish whether it has facilitated the management of depot medication and mitigated the risk of patients not receiving it.

Recommendation 2: The Trust, Local Medical Committee and relevant Clinical Commissioning Groups should develop and agree a shared protocol for the administration of depot medication in the community. This should include agreement as to which party is responsible for undertaking the initial patient assessment, and for the initial and ongoing administration of depot medication.

Trust contact with primary care services

6.12 There were three occasions during Mr Z's care on which the FRT contacted the wrong GP practice despite having the correct details on record:

- 8 June 2015;
- 12 October 2015; and
- 22 April 2016.

6.13 On the first two occasions, the mistake was identified and remedied on the same day[37] by the FRT or GP Practice B. However, on the third occasion, two weeks passed before it was identified and corrected (following a conversation between GP2, Mr Z and his sister). Crucially, this was the outcome of the FRT assessment, asking that Mr Z's depot medication be recommenced. GP2 received the FRT request on 5 May 2016 two days before the arson incident occurred on 7 May 2016. Steps had been taken by GP Practice C to arrange for Mr Z to be given his depot upon receipt of the FRT request, but he did not attend the surgery before the incident.

6.14 We note that the two GP surgeries were physically situated next to each other, had similar names, and the same postal address. Consequently, it is not unreasonable to anticipate that an administrative error could occur on occasion; but we would have expected the FRT to have taken steps to mitigate the mistake from recurring. The mistake should have been corrected when it first occurred in June 2015. The Trust had the correct details for Mr Z on record, but kept referring to the old contact details, the reason for which we have found no explanation. There is no evidence in the notes that GP Practice B contacted the FRT in April 2016 to say it had received a request pertaining to an individual who was no longer a patient.

6.15 We asked the Service Manager for South Essex Community Mental Health Services to explain the Trust expectations in relation to ensuring patient information is correct and, on occasions where errors are identified, remedied. She told us that Trust staff are aware of their responsibilities under

[37] *It is not documented in the notes whether the FRT staff submitted Datix reports in response*

information governance and would be expected to check they have the right patient information. In instances where a member of staff has made a mistake, they would be expected to report it on Datix and undertake further information governance training if required. She added that email is increasingly the prevailing method of contact between the Trust and GP practices which has helped to mitigate some of the risks encountered when using a fax machine.

Finding 7: The Trust has an information governance policy, but it would not mitigate against the administrative mistakes in Mr Z's care, which were the result of human error.

Recommendation 3: The Trust should assure itself that electronic patient records only give staff access to the patient's current GP contact details and that all other out-of-date contact details are archived.

7. Family engagement

7.1 It is best practice, where appropriate, to involve families in mental health care. They are well placed to provide a unique insight into their relative's wellbeing and can have a significant role in care planning and providing support. The National Confidential Inquiry into Suicide and Homicide (2015)[38] highlighted that service users maintaining closer contact with family members was thought to reduce the risk of suicide and homicide.

7.2 As noted above, the Trust clinical guidelines for the assessment and management of clinical risk identify the importance of involving families and carers in care planning.

7.3 Our chronology detailed that Mr Z's parents and sister contacted his GP and mental health services to raise concerns about his wellbeing. Ms J told us she had contacted the GP practice and Trust services many times, and on more occasions than are documented in the notes. She felt she needed to telephone every couple of months to try and get help for her brother. She added that initially, she did not have Mr Z's GP details, Mr Z would not share them, which created difficulties when the FRT directed her to his GP because she did not know who this was. We note the FRT did try to work around this, contacting GP2 on behalf of Ms J, asking that he contact Mr Z.

7.4 Ms J felt that GP2 was initially reluctant to receive her concerns in writing, but it was only when she did this that health care professionals started to respond to her concerns. We have set out below contact made by Mr Z's sister and parents that was recorded in the medical notes:

- Ms J called the FRT on 8 June 2105.
- Ms J called the FRT on 12 October 2015.
- Mr Z's parents attended the adult mental health services office on 8 January 2016.
- Ms J called GP2 on 6[39] April 2016.
- Ms J faxed a letter to GP2 on 7 April 2016, at his request.
- Mr Z's father accompanied him to his FRT assessment on 22 April 2016.
- Ms J called GP2 on 4 or 6 May 2016 (the notes and Ms J give different dates but confirm a call took place).
- Ms J faxed a letter to GP2 on 10 May 2016.

7.5 The Trust internal investigation acknowledged that staff had not always listened fully to the family's concerns, noting that staff did not respond to Ms J's request to assess him, but rather they directed her to Mr Z's GP:

[38] https://www.hqip.org.uk/wp-content/uploads/2018/02/national-confidential-inquiry-into-suicide-and-homicide-ncish-annual-report-2015.pdf

[39] *It is likely Ms J also called GP Practice C on 5 February 2016 but there is no detail recorded in the notes other than her name and telephone number.*

"Best practice would be to listen to family and respond appropriately, the Trust staff whilst discussing the concerns raised with the GP did not appear to listen enough… The Trust can only apologise for this lack of concerted response."

The Trust: *"… apologise unreservedly for not listening such that the families* [sic] *concerns were not heard or acted upon."*

7.6 The Trust investigation did not set out why the FRT did not seek to assess Mr Z in response to the family's concerns. The Trust investigation noted that the FRT did not have acceptance/rejection criteria for new patients but there is no evidence in the notes to indicate that the family request to assess Mr Z was subject to consideration or review, rather they were directed to Mr Z's GP. There is no evidence of professional curiosity. Patient confidentiality does limit the extent to which health care professionals can engage with third parties about a patient, but this does not limit their scope to act on any information shared.

7.7 Consultant Psychiatrist 1 told Trust investigators that he would not have changed his assessment of Mr Z had he seen Ms J's letter in April 2016. We have previously commented that we consider the information could have facilitated a more effective risk assessment and resultant action plan that might have gone beyond asking Mr Z's GP to recommence depot medication.

7.8 Ms J told us that trying to get help for him had been exhausting, frustrating and at times very distressing. She felt she was 'passed round the houses', repeatedly being told by Trust services and the GP that the other agency was best placed to help Mr Z. She told us that in the autumn of 2015 she had asked the FRT to provide a list of GPs in the area that did offer depot services but instead was directed to a website. She also said that initially during her conversations with GP2 he told her that the surgery did not offer depot, but later said it did.

7.9 Ms J said that trying to engage with services had had a significant impact on her parents too. Her parents' first language is Italian, but the Trust never offered them a translator. She also felt that the Trust response that she should take her brother to A&E was impractical and unhelpful given he did not consider himself to be unwell and would therefore be unwilling to attend hospital.

7.10 She became increasingly concerned that either Mr Z or a member of the public would come to harm, something she set out in her letters to GP2 in April and May 2016.

7.11 The Service Manager for South East Essex Community Mental Health Services told us that families and patients can now use '111' to access mental health services when they are in crisis; they do not need to attend A&E. This aspect of the service is managed by mental health practitioners.

7.12 The Trust Deputy Chief Executive told us the Trust had undertaken a lot of work with staff (e.g., suicide prevention training) around family engagement and the importance of actively engaging families in care.

7.13 The Trust internal investigation included a recommendation about working with families which we discuss below under 'Trust internal report recommendations'.

Finding 8: The Trust acknowledges that it did not take adequate steps to engage with Mr Z's family despite their regular attempts to raise concerns about his mental health and wellbeing. There is no evidence the family's requests were subject to a formal assessment, but rather they were referred by default to Mr Z's GP, despite the family initially advising they did not have the GP's details. There is no evidence their input was sought in relation to Mr Z's risk management or as part of a care plan, despite their attempts to engage the FRT.

Finding 9: The failure by the FRT to act on the concerns of Mr Z's family, particularly the letter from his sister submitted as part of the GP referral in April 2016, was a missed opportunity to undertake a thorough assessment of his mental health and explore treatment options.

Recommendation 4: The Trust should assure itself that concerns submitted by families or members of the public regarding a patient are documented, subject to assessment and review, and where appropriate proactively acted on. In instances where action is not taken, the rationale should be documented.

8. The Trust internal investigation

8.1 The NHS England Serious Incident (SI) Framework (2015) does not give an explicit definition of a serious incident, rather, it says the classification should be judgement based. It gives examples which include:

"[a] *homicide by a person in receipt of mental health care within the recent past"*

8.2 There are seven principles to SI management which include being open and transparent, objective, proportionate, timely and responsive. The SI framework says:

"Investigations of serious incidents are undertaken to ensure that weaknesses in a system and/or process are identified and analysed to understand what went wrong, how it went wrong and what can be done to prevent similar incidents occurring again".

8.3 The framework says a systems-based methodology – typically known as Root Cause Analysis (RCA) - should be adopted to identify:

- *"the problems (what?);*
- *the contributory factors that led to the problems (the how?) taking into account the environmental and human factors; and*
- *the fundamental issues/root causes (the why?) that need to be addressed".*

8.4 The SI Framework says that when more than one organisation has been involved in a patient's care all parties should, where possible, take steps to undertake a single investigation.

8.5 The Trust current 'Adverse Incident Policy, including serious incidents' was implemented in 2017.[40] We have therefore referred to the 2010 Policy (reviewed in May 2016) that was in place at the time of the Trust internal investigation. The policy references national guidelines draws on NHS England's SI Framework (2015) and uses its definition of a serious incident. The policy provides detail on incident classification and reporting.

8.6 The reader is advised to use the Trust Policy in conjunction the Trust Adverse Incident Procedural Guidelines (2010)[41] which provide information on undertaking investigations. The guidelines include NHS England's SI management flow chart which sets out the tasks and timelines required in order to complete a Serious Incident investigation. Trust SI investigations must be completed using RCA and submitted to the CCG within 60 working days of the incident being reported.

[40] Reviewed in 2019.
[41] Reviewed in 2016.

Internal investigation approach

8.7 The internal investigation team was the Deputy Chief Executive and Executive Director for Mental Health Services, a consultant psychiatrist (specialism not stated) and the Consultant Nurse for Suicide Prevention and Serious Incident Investigation. The investigation was chaired by a Non-Executive Director (NED).

8.8 The team undertook a documentary review of Mr Z's notes, met Mr Z, and undertook interviews with:

- Consultant Psychiatrist 1;
- Duty staff nurses (individuals not specified);
- FRT staff (individuals not specified); and
- CJLDT staff (individuals not specified).

8.9 The Trust report does not say how many staff were interviewed and whether these took place on an individual or group basis. Trust investigators did not interview either of Mr Z's Essex GPs as part of their investigation, though did submit an information request to the first GP (GP Practice B) which was not answered.

8.10 The investigation referred to the Trust clinical guidelines for the assessment and management of clinical risk, and Department of Health guidelines (2016) '*Safer Services, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness'* although the detail is not set out in the Trust report. It would have been helpful to provide the reader with clarity on the guidance (what *should* have happened), and whether it was adhered to (what *did* happen).

8.11 The Trust investigation report said the police had initially refused its request to contact Mr A (Ms A's husband) and any of his family until court proceedings were completed. It does not say whether this request extended to Mr Z's family.

8.12 Trust investigators wrote to Ms J on 19 January 2017, eight months after the incident. This was the first contact Mr Z's family had received from the Trust. Ms J subsequently spoke by telephone with the Consultant Nurse from the investigation team on 23 January 2017 and met her on 31 January 2017.

8.13 The Trust involved Mr Z and Ms A's families in its investigation, meeting them and providing them with an opportunity to ask questions in keeping with expected practice.

8.14 Ms J sent a letter to the Trust on 23 January 2017 detailing a chronology of Mr Z's care since his move to Essex in 2015, and her attempts to engage Trust and GP services for him. However, Ms J told us that after her meeting with the Trust at the end of January 2017 she had heard nothing further and

was not provided with written answers to her questions. She did not see the final Trust report.

8.15 We were unable to speak to Mr A during our investigation (he did not reply to our contact), therefore do not know if he received a copy of the Trust internal investigation report. We asked the Trust Deputy Chief Executive in his capacity as a member of the internal investigation team about this, but he could not remember if the draft report had been shared with Mr A.

8.16 The Trust report was finalised in February 2017.

8.17 The Trust report states that an RCA investigation was undertaken. However, apart from a chronology and timeline, we did not find evidence that RCA methodology was applied to the investigation e.g., fishbone diagram, the contributory factor framework to identify contributory factors, or the five 'whys'. RCA tools would have facilitated the analysis and understanding of any fundamental system issues associated with the findings.

Internal investigation report findings

8.18 The Trust investigation identified seven care and service delivery problems. We concur with the report findings but consider the investigation should have provided further comment about the lack of clarity between the Trust and primary care services in relation to the administration of depot. The investigation report did not confirm whether the following points were appropriate:

- GP Practice B's refusal to administer depot medication;
- the FRT's refusal to administer depot to Mr Z in response to the GP Practice refusal; and
- Consultant Psychiatrist's 1's view that he would not have changed his assessment of Mr Z had he seen the letter from Ms J as part of the referral.

8.19 The investigation report does not clarify who ultimately had responsibility for administering Mr Z's depot medication and what, if anything, the FRT should have done given GP Practice B would not administer a depot to Mr Z. The report makes no comment about the lack of shared care agreement with primary care in relation to depot administration. As it was, Mr Z was switched to oral medication, and it was not until April 2016 that the decision was taken to recommence Mr Z on depot medication.

8.20 The report makes no comment about the Trust administration systems; specifically, that the FRT incorrectly sent its April 2016 assessment to Mr Z's first Essex GP, as opposed to his actual GP whose details were on file. Equally there is no evidence that GP Practice B alerted the FRT to this mistake. As such, GP Practice C did not receive the FRT's request to recommence Mr Z's depot until 5 May 2016, nearly two weeks after the assessment.

8.21 The report makes no comment as to whether the FRT and CJLDT acted appropriately in relation to patient confidentiality, for example, not sharing the name of Mr Z's GP with Ms J, or when Mr Z did not want information shared with his GP.

8.22 The report describes three changes to the FRT system in terms of how patient information is compiled, reviewed in advance of an assessment, and subject to multi-disciplinary team (MDT) review. However, the report notes that a patient would not be subject to an MDT review if the consultant had concluded, as was the case for Mr Z, that they did not need mental health services.

8.23 We spoke to the Trust Deputy Chief Executive in his capacity as a member of the internal investigation team. We asked whether he considered if there was appropriate challenge of Consultant Psychiatrist 1's view that he would not have changed his assessment of Mr Z, had he seen Ms J's letter. We were told that ultimately it was Consultant Psychiatrist 1's opinion, but it had been tested by the Trust investigation team, in particular, by the consultant psychiatrist.

Finding 10: The Trust internal investigation was undertaken in line with Trust and national policy, but the findings were not shared with Ms A or Mr Z's families.

Finding 11: The findings of the Trust internal investigation were reasonable, but the investigation scope should have been expanded to consider the management of Mr Z's depot requirements and the Trust's documenting and sharing of FRT decisions with primary care. The report would have benefitted from the investigators setting out the detail of their analysis and benchmarking of practice.

Recommendation 5: The Trust should put a system in place to ensure that internal investigation report findings are shared with service users, their families, and that other affected parties are taken into account.

Internal report recommendations

8.24 The Trust report made four recommendations. We have set out our comments under each one.

1. The consultant and the clinical team must always review appropriate clinical information and obtain collateral information (where possible) prior to making a clinical decision about management of the patient. In situations where time does not permit the review of relevant information, the information should be obtained/reviewed after the clinical assessment in order to assist the decision making.

8.25 It is best practice, in keeping with GMC[42] and NMC[43] guidelines, to review appropriate clinical information prior to making a clinical decision. As such, whilst we agree there is merit in reminding staff of this, the recommendation does not say how the Trust can ensure clinical information is always reviewed and what safeguards should be put in place to monitor practice going forward.

8.26 We note that Consultant Psychiatrist 1 told Trust investigators that had he seen the letter from Ms J in April 2016, it would not have changed the outcome of his assessment. The Trust investigation does not say *why* Consultant Psychiatrist 1 did not see the letter. Equally there is no documented testing of Consultant Psychiatrist 1's statement that had he seen the letter it would not have changed the outcome of his assessment. It would have been helpful for the Trust investigators to have detailed the nature of their discussion with Consultant Psychiatrist 1 and possibly sought an independent opinion to test this view further.

2. The Trust to review the operational guidelines for the FRT and decide whether it is possible to incorporate inclusion and exclusion criteria.

8.27 We agree the Trust should review its operational guidelines in response to the findings of its internal investigation. The Trust also needs to provide guidance about what staff should do if a patient is not deemed appropriate for the service. The Trust needs to ensure staff are assuming responsibility for helping patients and directing them to the correct services, as opposed to simply rejecting the referral.

8.28 The above is not a 'SMART'[44] recommendation. It does not set out who should be responsible for the review, when it should take place, and requires no outcome.

3. The Trust to identify how concerns expressed by families of patients who have been referred to the services can be responded to in a supportive way thus enabling a fully informed assessment and minimise the identified risks.

8.29 We agree it is important to incorporate the concerns of families in patient care and treatment. However, this is not a 'SMART' recommendation. It does not set out who should be responsible for undertaking the task, how it will be completed and does not give a timeframe for completion. Equally it is unclear what is meant by *a 'supportive way'*. We assume the recommendation is aimed at ensuring family input is incorporated into a risk assessment, but the use of the term '*supportive'* is misleading.

4. Executive Medical Director to remind all Consultants/clinicians about the possibility of relapse in patients stopping depot anti-psychotic medications and the need to monitor these patients.

[42] *https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-1---knowledge-skills-and-performance#paragraph-14*
[43] *https://www.nmc.org.uk/standards/code/*
[44] *SMART: Specific, Measurable, Achievable, Relevant, and Time-specific.*

8.30 The above is best practice, rather than a recommendation, that may have mitigated the risk of the incident occurring on 7 May 2016. We agree that a recommendation in relation to depot management is appropriate. However, we consider the dialogue between the FRT and Mr Z's first GP (GP Practice B) about his medication in January 2015 to be of greater significance. GP Practice B asked the Trust to administer depot medication to Mr Z. It would later be learnt that Mr Z only wanted to receive depot medication from primary care services, but at the time the Trust declined the referral, saying depot administration was the responsibility of the GP. The introduction of senior primary care mental health care practitioners should mitigate the risk of a similar scenario arising; but as we have set out above, the Trust needs to evaluate the effectiveness of the new role with a view to ensuring it has the correct safeguards in place to prevent patients from missing depot medication. Equally, as previously recommended, we consider it appropriate that a shared care agreement for depot administration be put in place between the Trust and primary care.

The Trust recommendations do not sufficiently address what we consider to be key issues pertaining to Mr Z's care and treatment:

- The Trust/GP communication pathways in January 2015 about the administration and management of depot medication.
- The Trust advising Mr Z's sister and his parents to send him to his GP or A&E as opposed to the FRT seeing him, when the family raised concerns in June 2015, October 2015, and January 2016.
- The clinical team not reviewing the information available to them about Mr Z (e.g., the letter from his sister) in advance of his assessment on 22 April 2016.
- The FRT incorrectly sending information to Mr Z's former GP on three occasions, including the outcome of the assessment on 22 April 2016, despite the correct GP details being on file.
- The lack of clarity about communication and confidentiality between Trust services, primary care and Mr Z's family.

8.31 We spoke to the Trust Deputy Chief Executive about the Trust internal recommendations and he agreed they could have been more responsive to the internal investigation findings.

Analysis of the internal investigation report – Niche Investigation and Assurance Framework (NIAF)

8.32 Niche have developed a robust framework for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency,[45] NHS England Serious Incident Framework and the National Quality Board Guidance on Learning from

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

Deaths[46]. We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

8.33 In developing our framework, we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA (or Root Cause Analysis and Action, hence 'RCA Squared')[47]. This discusses how to get the best out of RCA investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

8.34 We also considered the proposals for the new NHS Improvement Patient Safety Incident Response Framework on how to improve learning from investigations. This has identified five key problems with the current application of the process:

- defensive culture/lack of trust e.g., lack of patient/staff involvement;
- inappropriate use of the serious incident process e.g., doing too many, overly superficial investigations;
- misaligned oversight/assurance process e.g., too much focus on process related statistics rather than quality;
- lack of time/expertise e.g., clinicians with little training in investigations trying to do them in their spare time; and
- inconsistent use of evidence-based investigation methodology e.g., too much focus on fact finding, but not enough on analysing why it happened.

8.35 We evaluated the guidance available and constructed 25 standards for assessing the quality of serious incident reports based around the three key themes of credibility, thoroughness and whether the report was likely to lead to change in practice. We have developed these into our own '**credibility, thoroughness and impact**' framework.

8.36 We found the Trust internal investigation met nearly half (10) of the assessment standards. Similarly, nearly half (12) of the standards were partially met. Three standards were not met; these pertained to the timeliness of the investigation, areas of incongruence in the report, and the recommendations not being SMART.

8.37 As set out above, the Trust investigation was undertaken in line with Trust and national policy, but we consider there were areas in which further exploration and inquiry was warranted. In particular, the internal investigation recommendations would not mitigate the risk of recurrence of a situation similar to that of Mr Z's.

8.38 Full details of our assessment can be seen in Appendix C.

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

[47] *National Patient Safety Foundation (2016) - RCA2- Improving Root Cause Analyses and Actions to Prevent Harm – published by Institute of Healthcare Improvement, United States of America*

9. Overall findings and recommendations

9.1 Mr Z moved to Essex in January 2015. He changed GP Practice within the first month of moving to the area with a view to being given depot medication in primary care, which did not happen. Otherwise, he had limited contact with primary care services. He also had little engagement with Trust services. His first referral in January 2015 was rejected and his assessment in April 2016 concluded that his GP should recommence his depot medication.

9.2 His family were increasingly concerned about his mental health during 2015 and 2016, taking steps to engage mental health services on his behalf. They were mindful that his depot medication had stopped in January 2015 and that this coincided with a deterioration in his mental state. This culminated in his sister writing to his GP in April 2016 to say she was concerned that harm could come to Mr Z or a member of the public if action was not taken to help him. Despite raising concerns in writing, in person and by telephone, the family were usually told by one service to speak to the other. Neither the FRT nor primary care demonstrated professional curiosity into Mr Z's mental health, sought to proactively engage with him, or act on the risk information provided by his family; rather they referred the family elsewhere.

9.3 We found little evidence that a scenario like Mr Z's would not arise today. The Trust told us that engaging with families can be difficult in the context of preserving patient confidentiality, although steps have been taken to improve access to mental health services (e.g., families can now call 'NHS 111' on behalf of a relative). However, this does not provide assurance that families are now able to successfully engage with the Trust if they have concerns about a relative.

9.4 There is no shared care agreement between the Trust and primary care services for the administration of depot medication; it is at the discretion of GPs as to whether they will administer a depot. The introduction of senior primary care mental health care practitioners by the Trust into GP practices may serve to mitigate this risk, but the programme remains in its infancy and is yet to be evaluated. As such, there is no formal assurance that patients who prefer to receive depot medication via primary care have ready access to it in instances where their GP does not administer it.

9.5 We have set out five recommendations in response to our findings, designed to help the Trust address the gaps in practice we identified.

Recommendation 1: The Trust should evaluate the senior primary care mental health nurse practitioner role in south east Essex to establish whether it has facilitated the management of depot medication and mitigated the risk of patients not receiving it.

Recommendation 2: The Trust, Local Medical Committee and relevant Clinical Commissioning Groups should develop and agree a shared protocol for the administration of depot medication in the community. This should include agreement as to which party is responsible for undertaking the initial patient assessment, and for the initial and ongoing administration of depot medication.

Recommendation 3: The Trust should assure itself that electronic patient records only give staff access to the patient's current GP contact details and that all other out-of-date contact details are archived.

Recommendation 4: The Trust should assure itself that concerns submitted by families or members of the public regarding a patient are documented, subject to assessment and review, and where appropriate proactively acted on. In instances where action is not taken, the rationale should be documented.

Recommendation 5: The Trust should put a system in place to ensure that internal investigation report findings are shared with service users, their families, and that other affected parties are taken into account.

10. Appendices

Appendix A – Terms of Reference

The terms of reference, set by NHS England, were:

To identify whether there were any gaps or omissions in the care and treatment of [Mr Z] *which could have helped avoid the homicide from happening. The investigation process should also identify areas of good practice, opportunities for learning and areas where improvements to services may be required. Specifically,*

- *Review the trust internal investigation and assess the adequacy of its findings, recommendations and action plan.*
- *Review and verify the trusts chronology of events leading up to the homicide.*
- *Review the appropriateness of the care, treatment and services provided by the NHS, local authority and other relevant agencies from the service user's first contact with services to the time of their offence, focusing on the period leading up to the homicide, identifying both areas of good practice and areas of concern.*
- *Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming them self or others.*
- *Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.*
- *Involve the families of both the victim and the service user as fully as is considered appropriate, in liaison with advocacy organisations and in accordance with the families wishes.*
- *Review the transfer of the service user primary care services from Enfield to Essex, in particular his medicine management and the availability of depot medication within primary care in Essex.*
- *Review the support provided in the community to the service user and the response to the concerns raised by the relatives.*
- *Review and assess compliance with local policies, national guidance and relevant statutory obligations.*
- *Provide a written report to NHS England that includes agreed, measurable and sustainable recommendations.*
- *Produce a learning document, suitable for sharing with other providers, on the learning from the investigation.*
- *Undertake an assurance follow up review 6/12 months after the report has been published to assure the report's recommendations have been fully implemented.*

Appendix B – Documents reviewed

- Mr Z's clinical records
- Mr Z's GP records from January 2015 to the incident
- The Trust internal investigation
- Trust internal investigation action plan
- Correspondence between Mr Z's sister and his GP
- Correspondence between the Trust and Mr Z's GPs
- Trust guidelines, policies and procedures
- Correspondence with Castle Point and Rochford CCG
- GP Practice B policies and procedures
- National guidelines and protocols

Appendix C – Trust internal SI report NIAF

Standard		Niche commentary
Theme 1: Credibility		
1.1	The level of investigation is appropriate to the incident	The Trust 'Adverse Incident Procedural Guidelines' (2010) draw on NHS England's SI Framework for definitions, process management, and investigation methodology. It sets out three levels of SI investigation – (1) concise, (2) comprehensive and (3) independent. The Trust report does not say which level of investigation is being undertaken but the nature of the team indicates it was RCA *Level 2*. The Trust investigation was chaired by a Non-Executive Director and undertaken by a team composed of the Executive Director for Mental Health Services, a consultant psychiatrist (specialism not stated) and the Consultant Nurse for Suicide Prevention and Serious Incident Investigation. The guidelines say homicide investigations will have a review panel chaired by an Executive Director and that the terms of reference will be agreed by the Executive Operational subcommittee. The scope and level of investigation was appropriate for the incident. Standard met
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	The Trust investigation scope was from Mr Z's first referral to the FRT in January 2015 until the incident in May 2016. The investigation said it would also 'touch' on his care since May 2016. The terms of reference were tailored to the incident and included questions from Mr Z's family and Mr A, the victim's husband. However, the terms of reference do not include engagement with primary care. Again, the investigation is not expressly labelled a *Level 2* RCA (i.e., the level is not specified) but does adhere to NHS England criteria. Standard met

1.3	The person leading the investigation has skills and training in investigations	The investigation does not set out the investigative experience or training of the internal team, although we note the seniority of those involved. The Consultant Nurse was a lead for suicide prevention and serious incident investigation. Standard met
1.4	Investigations are completed within 60 working days	The investigation report is dated February **2016**. We assume this is a typographical error and in fact the report was completed in February 2017 – nine months after the incident. However, the report says that the investigation was not allowed to start until the police had agreed which family members could be approached (the report does not say whether Mr Z's family or that of Ms A). The Trust was given permission to speak to any family members after Mr Z had plead guilty. The Trust report does not say whether this delayed the investigation. However, we note Mr Z pleaded guilty to arson in March 2017 - one month after the Trust report was completed. Standard not met
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The report is written in plain English and provides a clear description of the investigation. However, the report front cover is incorrectly dated February 2016 as opposed to 2017, the contents page has not been completed, and there are typographical errors and mistakes in the main report. For example, the chronology says Mr Z's parents attended Warrior House on 8 February 2016 – the clinical notes say they attended on 8 January 2016. Standard partially met
1.6	Staff have been supported following the incident	The report says staff were supported through their line management structure and supervision, with access to the Occupational department and the Employee Assistance Programme as required. Standard met
Theme 2: Thoroughness		
2.1	A summary of the incident is included, that details the	The report provides a summary of the incident that culminated in the death of Ms A.

	outcome and severity of the incident	Standard met
2.2	The terms of reference for the investigation should be included	The terms of reference are in the main report. Standard met
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people	The report is headed a 'root cause analysis investigation report'. It says the investigation used a variety of methods which included tabular timelines, interviews and witness statements. It sets out what information and evidence was reviewed. A chronology is available, but the report does not set out the nature of its analysis to support its findings e.g., fish bone diagram or the five whys. Standard partially met
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	The Trust report is unclear when it engaged with Mr Z's family and Ms A's family. No dates are documented although there is evidence both were involved in the investigation and Ms J has advised she was contacted in January 2017. The report says the police refused permission to contact Mr A or any family member until Court proceedings were complete. It does not distinguish between Mr Z's family and Ms A's family. It is therefore not clear in reading the report alone when either family was informed of the Trust investigation. Standard partially met
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	The Trust report includes information and questions (which it has answered) from Ms J and Ms A's husband. However, Mr Z's family was not provided with the answers to their questions or a final copy of the Trust report. We were unable to confirm whether Mr A received a copy of the report. Standard partially met
2.6	A summary of the patient's relevant history and the process of care should be included	The scope of the Trust investigation did not predate Mr Z's move to Essex in January 2015. The report does provide a summary of Mr Z's mental health history and that he was previously admitted to Chase Farm, but the detail is not provided. It would have been helpful for the reader to have been given detail about Mr Z's mental health history and previous inpatient admissions.

		Standard partially met
2.7	A chronology or tabular timeline of the event is included	Appendix 1 contains a tabular chronology of Mr Z's care from 15 January 2015 until 1 June 2016.
		Standard met
2.8	The report describes how RCA tools have been used to arrive at the findings	The report does not describe its methods but says the investigation *"used a variety of methods to establish the facts surrounding the incident; these included tabular timelines, witness interviews and witness statements from the staff involved, establishing a chronology of events and identifying any care and service delivery issues".* The report lacks clarity as to the nature of its analysis to reach its findings.
		Standard partially met
2.9	Care and Service Delivery problems (CSDP) are identified (including whether what were identified were actually care delivery or service delivery problems)	Seven CSDPs are identified. The first CSDP is that the Trust and GP did not have all the relevant information pertaining to Mr Z in January 2015. However, the Trust report says that the GP did not respond to its request for information and that it is assumed the GP did not have access to the information. This is therefore an untested assumption as opposed to a care and service delivery problem.
		Standard met
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	The report identifies: • patient factors • communication factors • task factors • working environmental factors
		Standard met
2.11	Root cause or root causes are described	The investigation team did not identify a root cause for the incident. It can be the case that a single root cause will not be identified but we consider the report lacks detail as to how it reached this conclusion.
		Standard partially met
2.12	Lessons learned are described	Three lessons were identified although we consider the first (*"all available information needs to be reviewed by the clinician prior to any assessment"*) to be good practice. It is not a lesson that can be attributed solely to Mr Z's case.

		The report makes no comment about the Trust's engagement with primary care and whether there was an opportunity for learning about engagement, sharing information and agreeing an approach to help Mr Z. The Trust report makes no comment about the FRT faxing information on three occasions to Mr Z's former GP after he had changed GPs, the new details for whom were recorded in his records and available to staff.
		Standard partially met
2.13	There should be no obvious areas of incongruence	The Trust identifies a CSDP as Mr Z's (first) GP, GP Practice B, not having access to all of his records. The Trust did try to contact Mr Z's GP but did not receive a response to its request for information; therefore, the CSDP is an untested assumption.
		Standard not met
2.14	The way the terms of reference have been met is described, including any areas that have not been explored	The report provides a chronology of care leading to the incident and identifies CSDP and contributory factors. However, we do not consider the terms of reference have been fully answered. The report makes little comment on: *"Consider and comment on the handover of care from the previous care provider"* It says information should have been provided by the Enfield GP, but the Enfield GP was not involved in the Trust investigation, and Mr Z's first Essex GP did not respond to the Trust request for information; therefore, the investigation did not verify what information had been shared across primary services. This also pertains to the term of reference: *"Seek to obtain and include the views of significant others as decided by the panel in accordance with Being Open principles and the Memorandum of Understanding.* We consider it would have been helpful to have contacted GP Practice A and GP Practice C as part of the investigation. The investigation report does comment on the care and treatment of Mr Z, but does not make specific reference to his proposed risk management plans, as identified in the terms of reference. The investigation lists the 'clinical guidelines for the assessment and management of clinical risk' but there is no

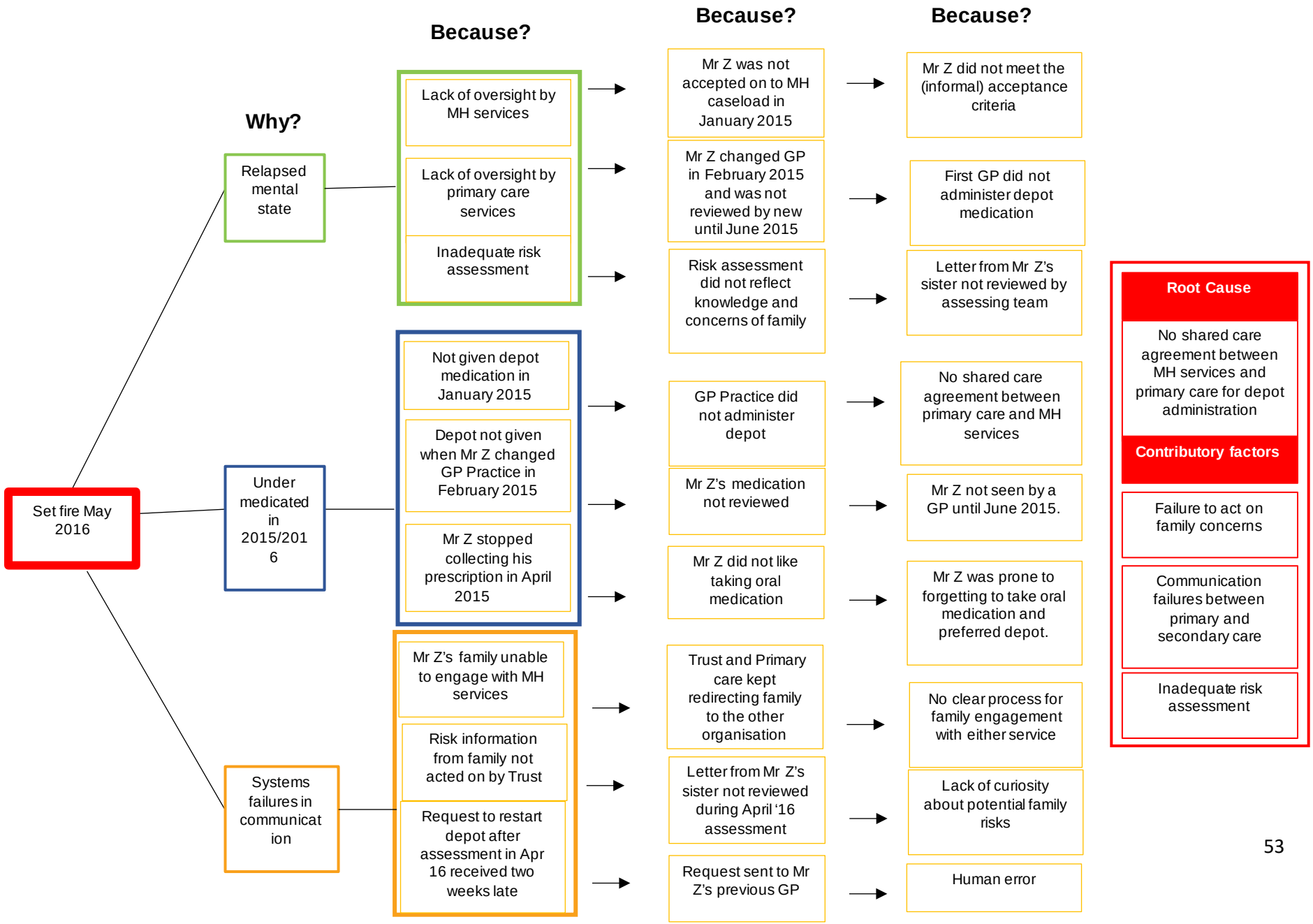
		detail of how these were applied in the investigation analysis. We do not consider the investigation tested whether a similar incident could reoccur – "*Consider any other matters arising during the course of the investigation which are relevant to the incident or might prevent a reoccurrence*" - and if there has been any agreement with primary services as to who is responsible for administering depot medication. We note the Trust did seek information from GP Practice B, but it has not indicated whether this extended to exploring depot arrangements. There is no evidence the investigation team attended Mr Z's court case, as set out in the terms of reference.
		Standard partially met
Theme 3: Lead to a change in practice – impact		
3.1	The terms of reference covered the right issues	The terms of reference did cover the right issues but should also have considered the events of January 2015 when GP Practice B indicated it was not willing to give Mr Z depot medication, despite the FRT view that this should remain the responsibility of primary care. There is no evidence in the notes to indicate whether any agreement was reached between the FRT and GP Practice B, and if the matter should have been escalated (e.g., if other patients wanted to receive depot medication at the GP Practice). Similarly, it would have been helpful if the investigation had assessed whether the risk assessment undertaken by the CJLDT on 9 May 2016 – without the knowledge that the incident had occurred - and the resultant plan were appropriate.
		Standard partially met
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	The Trust report includes a chronology of events but there is limited supporting analysis to underpin conclusions. The report does not consistently set out what *should* have happened against what *did* happen. For example, there is no clarity as to Mr Z's depot medication and if anything was agreed between the FRT and the first GP practice in January 2015.

		Standard partially met
3.3	Recommendations relate to the findings and those that led to a change in practice are set out	The Trust report made four recommendations, two of which are about undertaking good practice as opposed to being SMART recommendations.
		Standard partially met
3.4	Recommendations are written in full, so they can be read alone	Yes
		Standard met
3.5	Recommendations are measurable and outcome focused	No
		Standard not met

Appendix D – Glossary

CCG	Clinical Commissioning Group
CJLDT	Criminal Justice Liaison Diversion Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CSDP	Care and Service Delivery Problem
DoC	Duty of Candour
DVLA	Driver and Vehicle Licensing Agency
FRT	First Response Team
GMC	General Medical Council
GP	General Practitioner
HQIP	Healthcare Quality Improvement Partnership
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
NED	Non-Executive Director
NHSE	National Health Service England
NIAF	Niche Investigation and Assurance Framework
NICE	National Institute of Clinical Excellence
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NQB	National Quality Board
RCA	Root Cause Analysis
SI	Serious Incident
SMART	Specific, Measurable, Achievable, Relevant, and Time-specific

Appendix E – The Why diagram



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