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An independent investigation into the care and treatment of Mr D

January 2022

V3.3

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

Events which may occur outside of the timescale of this review will render our report out-of-date.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

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1 Executive summary

Incident

1.1 Mr D, a 36-year-old man, attacked Miss Y, another resident, in the common room of their supported accommodation on 27 November 2019. Miss Y sadly died later the same day.

Investigation

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 prevent recurrence. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring.

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

Relevant health history

1.5 Mr D had a diagnosis of paranoid schizophrenia and recurrent depressive disorder. He was a recipient of mental health services provided by Cambridgeshire and Peterborough NHS Foundation Trust ('the Trust'). Mr D had used Trust services since he was 19 years old and had been detained under the Mental Health Act[3] (MHA) in the past. His last inpatient admission, a month long, ended in January 2017.

1.6 Mr D had a private flat in supported living accommodation managed by Sanctuary Supported Living ('Sanctuary'). He held an assured tenancy which meant his residency was not dependent on engaging with Sanctuary's services. Mr D had a care package of low-level services e.g., being taken to medical appointments and reminded to take his medication.

[1] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

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

[3] Mental Health Act: https://www.legislation.gov.uk/ukpga/1983/20/contents

1.7 Mr D was under the Trust's Care Programme Approach (CPA) and had an allocated Care Coordinator. He was seen every two weeks by his Care Coordinator, who administered his depot medication and checked on his general wellbeing.

1.8 Mr D had several physical health problems, predominantly related to his stomach and he experienced significant stomach pain. Medical tests indicated Mr D had gastritis and Barrett's oesophagus[4] which could be managed by medication and diet, but Mr D did not always take his medication or eat healthily.

1.9 Mr D continued to experience stomach pains but generally refused to attend medical appointments. However, there were occasions when Mr D would attend the local Emergency Department (ED) to request treatment, although he usually left before being seen or was discharged without follow-up. Mr D often asked to be admitted to the local psychiatric hospital which he believed would be able to address his physical health concerns.

1.10 Mr D was regularly seen by his GP, who often undertook home visits, and sought to encourage Mr D to attend his hospital appointments and to eat a more balanced diet.

1.11 Mr D was found lying outside his flat in early September 2018. His self-care was noted to be poor.

1.12 In November 2018 Mr D's GP was concerned that he might not have capacity to make decisions about his medical treatment. She contacted the Trust mental health locality team (South) who arranged a professionals meeting. The GP, members of the Crisis Resolution and Home Treatment Team (CRHTT) and Sanctuary staff were invited to attend. However, the GP's concerns were misunderstood at this point by Trust staff who believed the GP had concluded Mr D *did* have capacity.

1.13 Mr D made a strangling gesture at a member of Sanctuary staff on 5 November 2018. He later waved a fork at the same individual. Mr D made specific threats to kill a resident, but their name was not documented in the notes. Sanctuary staff called the police, who did not consider their attendance to be warranted and advised that the local mental health team be contacted. Sanctuary staff contacted the Adult Locality team who arranged for the CRHTT to review Mr D.

1.14 Mr D was seen by members of the CRHTT on 6 November 2018. They concluded Mr D did not need an inpatient admission, rather his issues were primarily linked to his physical health concerns which needed addressing.

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[4] Barrett's oesophagus: "*… a medical condition where some of the cells in your oesophagus grow abnormally., it is sometimes called a pre-cancerous condition*" https://www.nhs.uk/conditions/oesophageal-cancer/causes/

1.15 The professionals meeting took place the next day where it was agreed Mr D's GP would continue to monitor his physical health, whilst Sanctuary and Trust staff would seek to encourage Mr D to attend a planned admission to the local acute hospital. Mr D's Consultant Psychiatrist (Consultant 1) agreed to review him in a couple of weeks.

1.16 Consultant 1 reviewed Mr D on 21 November 2018. He told her that "*voices*" were telling him not to eat.

1.17 Mr D continued to refuse to attend medical appointments and the Gastroenterology team informed the GP they were now reluctant to admit him, rather he would need to see a Consultant Gastrologist for which he had an appointment in December 2018. It was subsequently agreed that Mr D did not require further investigative tests but should continue to be monitored.

1.18 Mr D continued to report stomach pain throughout 2019 and was regularly advised by his GP practice, Sanctuary and Trust staff to manage his diet.

1.19 Mr D's Consultant noted during his CPA review in May 2019 that he was "*at a very poor level of mental health*". The Consultant noted that Mr D remained at risk of deterioration which in turn would negatively impact his physical health self-care. Mr D agreed to a trial of increased sertraline dosage.[5]

1.20 Mr D was noted by Sanctuary staff to be sleeping in the corridor outside his flat and complaining of severe pain in his side during the weekend of 6 July 2019. Paramedics attended but no concerns were identified.

1.21 Mr D requested an ambulance on 26 September 2019 because he was experiencing severe stomach pains. He was subsequently taken to hospital where he was discharged the same day.

1.22 Mr D's Care Coordinator saw him on 27 November 2019 to administer his depot medication. Mr D was lying on his sofa, shaking. He told his Care Coordinator "*I need sectioning*". The Care Coordinator asked if this was because of his physical pain, which Mr D confirmed. Mr D then sat up and placed his hands around his Care Coordinator's neck. The Care Coordinator used breakaway[6] techniques to extricate herself and left the flat.

1.23 Mr D followed his Care Coordinator who had found a member of Sanctuary staff. They agreed with Mr D they should all attend the staff office with a view to discussing what had happened. Mr D asked for a hospital admission, saying he needed to be sectioned. He said he would kill the Care Coordinator, Sanctuary staff worker, and Miss Y, another resident who was not present.

[5] Sertraline: an antidepressant https://bnf.nice.org.uk/drug/sertraline.html

[6] "*Physical skills to help separate or break away from an aggressor in a safe manner [that] do not involve the use of restraint.*" The National Institute for Health and Care Excellence (2015).

1.24 Mr D's Care Coordinator contacted the team Consultant who agreed Mr D should be urgently referred to the CRHTT with a view to him being assessed for an informal admission.

1.25 Mr D's Care Coordinator attended the CRHTT office that afternoon to request he be assessed. Following a triage discussion with the Care Coordinator the team concluded, based on the information shared, that Mr D was not an immediate risk and could be reviewed the next morning.

1.26 The CRHTT and locality Consultant were not informed that Mr D had made a specific threat to kill the staff or Miss Y.

1.27 Mr D's Care Coordinator returned to Mr D's accommodation to tell him the CRHTT would attend the next day. Mr D was noted to be happy with this plan and apologised for his earlier behaviour. He told his Care Coordinator he could keep himself and others safe. He was advised to call the emergency services or 111 if he began to feel unwell, after which the Care Coordinator left.

1.28 Mr D committed the homicide shortly after his Care Coordinator left on 27 November 2019.

Findings

Risk assessment

1.29 Mr D's risk was formally assessed by members of the CRHTT on 6 November 2018. Two risk assessments were completed which differed slightly in their detail. Of note, one identified Mr D as a risk to vulnerable adults both historically and in the present.

1.30 The most recent of the two risk assessments (by 20 minutes) and therefore first available to staff, did not clearly identify Mr D as a risk to vulnerable adults (currently or historically) or as having made verbal threats. This was the most recent risk assessment available to staff.

1.31 Mr D did not have an up-to-date, comprehensive formal risk assessment and management plan in place at the time of the incident.

CPA and care planning

1.32 Mr D was under CPA and had an allocated Care Coordinator. His last CPA review took place on 30 May 2019. Mr D's care plan focused on his physical health and ongoing reluctance to attend physical health appointments. This was reasonable based on the nature of his daily concerns, however the care plan set out little in response to addressing these concerns or identifying long-term goals.

1.33 The care plan was not holistic and did not consider Mr D's broader needs which included his lack of social network, his poor personal hygiene and dental care.

1.34 The care plan was predominantly limited to monitoring Mr D's wellbeing and offering him support instead of proactive interventions and future planning.

Mr D's capacity

1.35 In November 2018 Mr D's GP identified that he might not have capacity to consent to treatment and that this warranted a formal mental health assessment by the Adult Locality team. There is evidence the GP contacted the team to raise her concerns about Mr D, and a professionals meeting was arranged, but there is no evidence Trust staff understood that the GP thought Mr D might lack capacity. Instead, the progress notes indicate they thought the GP had said Mr D did have capacity, which was incorrect.

1.36 Mr D was reviewed during his CPA review on 21 November 2018. Consultant 1 concluded Mr D's mental state and capacity appeared to fluctuate and should be monitored. There is no evidence that Mr D's capacity was subject to regular monitoring after the CPA review in November 2018. It was last considered, although the nature of the review was not documented, at a CPA review meeting in June 2019.

Multi-agency involvement

1.37 There is extensive evidence of the Trust, Sanctuary and Mr D's GP practice regularly engaging in relation to managing Mr D's care and treatment. The agencies communicated by phone, email and in person.

1.38 There is evidence of the Trust responding to the concerns of the other agencies (e.g., the Trust arranged a professionals meeting), and equally being willing to challenge when they had concerns (e.g., Care Coordinator 1 spoke to Support Worker 1 about his attitude towards Mr D).

1.39 Trust staff and partner agencies were in regular contact about Mr D. Concerns identified by any party were typically raised promptly, but these were not always productively managed, and a clear plan was not always formulated. Care Coordinator 1 had concerns about the support provided to Mr D by Sanctuary staff and raised these with Sanctuary management, but they were not formally escalated, and no steps were taken to explore whether an alternative package might be better suited to Mr D's needs.

Communication with Mr D and his family

1.40 Historically, Mr D had not had contact with his family and there is no evidence he sought or asked the Adult Locality team to facilitate their involvement in his

care and treatment. The Trust had no contact with Mr D's family between January 2018 and November 2019.

1.41 Trust staff and partner agencies regularly communicated with Mr D throughout the period of care reviewed. Care Coordinator 1 saw Mr D on at least a fortnightly basis, in accordance with his care plan. When unable to attend, she arranged for a colleague to attend in her place.

Safeguarding

1.42 There were three occasions in which safeguarding concerns were raised or warranted consideration.

1.43 Sanctuary staff were concerned in February 2018 that Mr D's building society balance was significantly reduced from the previous year.

1.44 Mr D's Care Coordinator referred him to the Multi-Agency Safeguarding Hub (MASH) in October 2018 for self-neglect. This was in keeping with the Trust safeguarding policy. The referral was not accepted on the ground that the Care Coordinator was already managing Mr D's needs and liaising with other parties (e.g., the GP).

1.45 Care Coordinator 1 identified a sore on Mr D's buttocks in November 2019. She advised him to see his GP. The notes indicate Care Coordinator 1 intended to ask Sanctuary staff to arrange a GP appointment for Mr D, though there is no evidence in the GP notes that this was arranged.

1.46 There is evidence staff identified and responded to concerns in relation to Mr D's finances and self-neglect. However, the outcomes of these enquiries were not consistently documented, and we were unable to establish whether further steps should have been taken.

27 November 2019

1.47 Mr D placed his hands around Care Coordinator 1's neck on the morning of 27 November 2019. She instigated breakaway techniques to extricate herself and left the room. Mr D subsequently followed her, and then agreed to attend the Sanctuary staff office with the Care Coordinator and a Support Worker. Mr D told them he wanted to be sectioned and that he would kill them and Miss Y (who was not present). Care Coordinator 1 called Consultant 1 and informed her what had happened, but she did not tell Consultant 1 that Mr D had made specific threats to kill. They agreed Mr D should be urgently referred to the CRHTT with a view to being assessed for an informal admission. Care Coordinator 1 attended the CRHTT office where a triage was undertaken, and they agreed to see Mr D the next morning.

1.48 The CRHTT decision to see Mr D within 24 hours was in keeping with Trust policy. However, the CRHTT was unaware that Mr D had made a specific

threat against Miss Y. Based on the information provided to it, the CRHTT concluded that Mr D was not an immediate risk and could be seen the next day.

1.49 We were told that the decision to delay seeing Mr D was not driven by caseload pressures and Mr D could have been seen that day had his threat been considered more significant. However, this does not reflect what Care Coordinator 1 told us which was that the CRHTT was at capacity.

1.50 Care Coordinator 1 considered her response to, and management of, Mr D's behaviour to be reasonable based on his actions in November 2018 and the collectively agreed plan.

1.51 Trust policy allows for staff discretion in terms of what they should do if they are physically assaulted. Whilst the policy says physical assaults must be reported to the police, it allows for exceptions if staff consider the service user's clinical condition to be such that their actions were unintentional, and the staff so not wish to report the incident. Care Coordinator 1 did not consider Mr D's actions to be intended to cause her harm and she did not want to report the incident to the police. Current Trust policy allows for staff to exercise their judgement.

1.52 There is no Trust policy about what staff should do when a service user makes a specific threat against another service user. We were advised there is an expectation the service user will be notified but we did not identify any guidance for staff in relation to this point.

Primary care

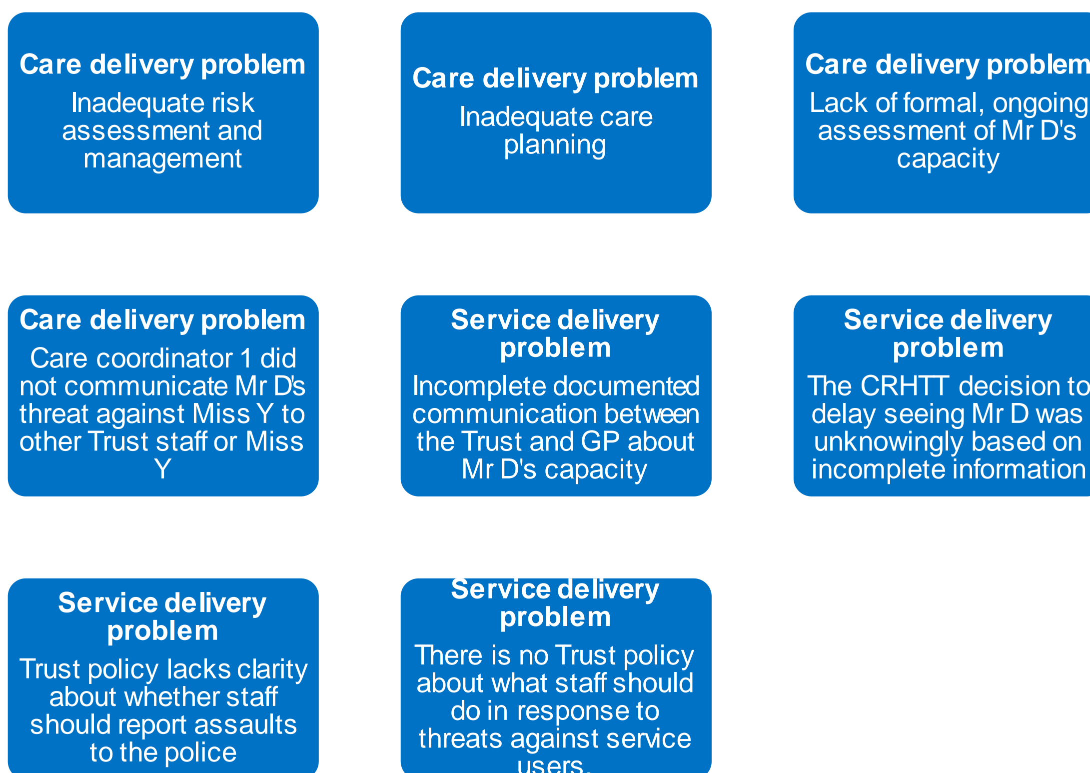
1.53 Mr D's GP proactively engaged with Trust and Sanctuary staff, working with them to develop a plan to manage Mr D's physical health concerns.

1.54 Mr D's GP undertook several home visits, to see him in an environment where he was more at ease, and tried to work with him to facilitate his hospital visits (e.g., request a side room for him).

Care and service delivery problems

1.55 We identified eight care and service delivery problems which are specified in Figure 1.

Figure 1: Care and service delivery problems



1.56 It is our view that the Trust and partner agencies' attempts to manage Mr D's physical health complaints, overshadowed his mental health needs, to the extent that when concerns were identified (e.g., sleeping in the corridor) these were attributed to his physical health. There were several occasions when Mr D's risk assessment should have been updated but Trust staff typically attributed his behaviour to his physical health. Equally his care plan extended little beyond supporting his physical health.

1.57 Mr D's behaviour on the morning of 27 November 2019 was attributed to his physical health. Mr D's Care Coordinator considered his behaviour to be out of character but did not consider him to be a significant threat to herself, the Sanctuary worker or Miss Y. The management of the incident in terms of Mr D's risk was predominantly based on historical knowledge and assumptions made about his behaviour in the past; insufficient consideration was given to his current presentation and the threats he had made. Care Coordinator 1 did not share the detail of his verbal threats (that he had threatened to kill her, a member of Sanctuary staff and Miss Y) with Consultant 1 or the CRHTT and instead focused on what she considered to be the primary issue: managing his physical health. Consequently, the resultant plan was largely based on his behaviour being considered a cry for help as opposed to a significant risk to others.

Recommendations

1.58 This independent investigation has made six recommendations to be addressed in order to improve learning from this event.

Recommendation 1: The Adult Locality team should review the notes of all service users under the Care Programme Approach (CPA) with a view to ensuring all documentation (for example, risk assessments and care plans) has been completed in line with Trust policy, within the required timeframe, and reflect the service user's broader needs and long-term plans. The team should implement a programme of audit to ensure service user documentation continues to be completed in accordance with expected practice.

Recommendation 2: In instances where concerns about a service user's capacity have been raised, capacity must be assessed, reviewed and documented at CPA meetings and, if assessed as requiring ongoing monitoring, documented at agreed intervals.

Recommendation 3: The Trust must review its Managing Violence and Aggression Against Staff Policy to clarify what actions staff should take in response to a physical assault by a service user. The review should address the ambiguity in relation to whether the police should be contacted in response to an assault, the extent to which staff can rely on their own judgement to manage the situation, and what advice and support must be sought at the time.

Recommendation 4: The Trust should develop guidance detailing what staff should do in response to service users making verbal threats against other service users. This should include who should be informed and the documentation of agreed actions.

Recommendation 5: The Crisis Resolution and Home Treatment Team (CRHTT) should review its admission process to ensure urgent referrals can be accepted and managed during handover periods.

Recommendation 6: The Trust should share its internal investigation report with Miss Y's family at the earliest opportunity.

Good practice

1.59 Trust and Sanctuary staff were complimentary about the practice of GP 4 who undertook home visits to see Mr D and sought to work with the other agencies to address his physical health needs.

1.60 We agree that the Trust and GP notes reflect a proactive approach on the part of GP 4. This included liaising with the Adult Locality team, undertaking home visits and seeking to ensure Mr D's hospital visits were adapted to support his needs.

2 Investigation

Incident

2.1 Mr D, a 36-year-old man, attacked Miss Y in the common room of their supported accommodation on 27 November 2019. Miss Y sadly died later the same day.

Approach to the investigation

2.2 The independent investigation follows the NHS England Serious Incident Framework[7] (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[8]. The terms of reference for this investigation are given in full in appendix A.

2.3 The independent investigation was conducted in parallel with a Safeguarding Adult Review (SAR) that examined the provision of care and support given to Miss Y, a vulnerable adult, by different agencies.

2.4 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.

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

2.6 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.

2.7 The report was peer reviewed by Dr Carol Rooney, Associate Director for Niche. Dr Rooney also attended the Safeguarding Adult Review (SAR) panel meetings and provided input and review of the NHS contributions to the SAR.

2.8 We reviewed Mr D's clinical notes from Cambridgeshire and Peterborough NHS Foundation Trust ('the Trust') and his GP practice. We asked the Trust to provide all documents about Mr D covering the period 1 January 2018 until the incident on 27 November 2019. These included any documents completed in retrospect after the incident. During interviews with Trust staff, it became

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[7] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

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

apparent that we did not have all documentation related to the case. These were subsequently supplied by the Trust, but we are concerned we may not have seen all records available. We note the Trust has changed its electronic patient record system since the incident which may account for some of the difficulties in retrieving the older records. Full details of the documents we reviewed can be seen in appendix B.

2.9 We undertook interviews with:

- Consultant 1, South Adult Locality team
- Care Coordinator 1, South Adult Locality team
- Team Manager, South Adult Locality team
- Modern Matron, North and South Crisis Resolution and Home Treatment Team (CRHTT) (former CRHTT Manager) & the 136 Suite[9]
- Service Manager 1, Sanctuary Supported Living
- GP 4

2.10 We would like to thank the interviewees for their time and contribution to the investigation.

2.11 We were unable to interview Support Worker 1 who no longer worked at Sanctuary Supported Living. Sanctuary Supported Living tried to contact Support Worker 1 on our behalf but did not receive a response.

Contact with the victim's family

2.12 We met Miss Y's mother and sister in April 2021 with the Chair of the Safeguarding Adult Review. They described Miss Y as kind, caring and loyal. They said she was thoughtful, very honest and had a number of friends. Miss Y volunteered two and a half days a week at a local café and had several interests which included listening to music, visiting book shops and collecting Beatles memorabilia. Miss Y lived in the same supported accommodation as Mr D.

2.13 Miss Y was close to her family and regularly saw her mother and sister. They described Miss Y as very loved.

2.14 Miss Y's family had several questions pertaining to Mr D's care and treatment which we have sought to address later in the report.

2.15 The draft report was shared with Miss Y's family to review in advance of publication.

[9] 136 Suite: "The 136 Health Based Place of Safety (136 Suite) is a facility for people who are detained by the police under Section 136 of the Mental Health Act." https://www.cpft.nhs.uk/ourservices

Contact with the perpetrator's family

2.16 We wrote to Mr D's family via his housing association. The housing association was unable to share the family contact details due to data protection but forwarded our correspondence. We did not receive a reply. Mr D's notes indicate he had been estranged from his family for several years.

Contact with the perpetrator

2.17 We wrote to Mr D who indicated he would like to be involved in our investigation. We spoke to him via video conferencing in July 2021. However, Mr D was unwell at the time of our call and therefore we were unable to discuss his experience of his care with him. Mr D remained unwell during our investigation.

2.18 We liaised with prison mental health services with a view to sharing the draft report with Mr D. However, we were advised that Mr D was not well enough to review the draft report. Consequently, we were unable to share the draft report with Mr D prior to submitting the final report to NHS England and NHS Improvement.

Structure of the report

2.19 Section 3 provides a narrative chronology of Mr D's care.

2.20 Section 4 examines the issues arising from the care and treatment provided to Mr D and includes comments and analysis related to the terms of reference.

2.21 Section 5 sets out our overall analysis and recommendations.

3 Chronology of Mr D's care and treatment

3.1 Mr D was 36 years old at the time of the incident. He had a diagnosis of paranoid schizophrenia and recurrent depressive disorder. He lived in supported living accommodation where he was a recipient of low-level services. Mr D had been detained under the Mental Health Act (MHA) in the past. His last inpatient admission under Section 2[10] of the MHA was a month long and ended in January 2017.

3.2 Mr D's medication in January 2018 was:

- Flupentixol[11] decanoate[12]
- Colecalciferol[13]
- Docusate[14]
- Mebeverine[15]
- Mirtazapine[16]
- Olanzapine[17]
- Pregabalin[18]
- Prucalopride[19]
- Sertraline.[20]

3.3 We set out below a chronology of Mr D's care and treatment between 1 January 2018 and 28 November 2019. Mr D was generally seen every two weeks by a Care Coordinator to receive his depot medication; we have not documented every appointment, only those of note. The chronology also includes Mr D's contact with primary care and acute services.

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[10] Section 2 of the MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/2

[11] Flupentixol: an antipsychotic https://bnf.nice.org.uk/drug/flupentixol.html

[12] Decanoate: Slow release medication provided intra-muscularly ('depot')

[13] Colecalciferol: Vitamin D tablets

[14] Docusate: A laxative

[15] Mebeverine: medication used to treat gastro-intestinal disorders https://bnf.nice.org.uk/drug/mebeverine-hydrochloride.html

[16] Mirtazapine: an antidepressant https://bnf.nice.org.uk/drug/mirtazapine.html

[17] Olanzapine: an antipsychotic https://bnf.nice.org.uk/drug/olanzapine.html

[18] Pregabalin: an anticonvulsant https://bnf.nice.org.uk/drug/pregabalin.html

[19] Prucalopride: A laxative https://bnf.nice.org.uk/drug/prucalopride.html

[20] Sertraline: an antidepressant https://bnf.nice.org.uk/drug/sertraline.html

3.4 Care Coordinator 1 visited Mr D on 2 January 2018 to give him his depot medication. He was initially uncommunicative but started to appear preoccupied that he had another serious illness, making comments to this effect. Care Coordinator 1 prepared to administer Mr D's depot but Mr D began to scream and refused it. He continued to scream and so Care Coordinator 1 left his flat. She was advised by Sanctuary staff that Mr D did sometimes scream. Care Coordinator 1 planned to visit two days later to administer Mr D his depot medication.

3.5 Mr D was placed in the 'red zone'[21] following the team zoning meeting on 4 January 2018. This was due to concerns he was becoming unwell, and he had screamed in Care Coordinator 1's presence. Care Coordinator 1 saw Mr D later the same day. He was dressed and apologised for screaming earlier in the week. He said he was experiencing a lot of pain in his stomach and bowels. Mr D received his depot as prescribed. Mr D was removed from the 'red zone' the next day.

3.6 Care Coordinator 1 saw Mr D on 9 January 2018. They briefly went out for a coffee, but Mr D was difficult to engage and visibly anxious. They returned to Mr D's accommodation where staff told Care Coordinator 1 that Mr D binge ate which caused him stomach pains and diarrhoea for a number of days afterwards. They told Care Coordinator 1 that when Mr D was not in pain, he was chatty and liked to go out.

3.7 Care Coordinator 1 visited Mr D on 18 January 2018. Staff told her that Mr D had deteriorated ("*taken a downturn*") the day before and was refusing to take his medication and was not communicating with staff. Care Coordinator 1 saw Mr D who said he was too unwell to receive his depot, therefore they agreed Care Coordinator 1 would attend the next day.

3.8 Care Coordinator 1 saw Mr D on 23 January 2018. He was quiet and low in mood. He told Care Coordinator 1 he was experiencing stomach pains because he had eaten two takeaways the day before. They discussed Mr D's eating habits and the impact on his physical health. They made a plan that Mr D should try to decease his use of takeaways.

3.9 Care Coordinator 1 visited Mr D on 5 February 2018. He accepted his depot medication but reported he continued to experience stomach pain. Sanctuary staff told Care Coordinator 1 they intended to speak to Mr D about the volume of books he had in his flat which they considered were becoming a hazard. Care Coordinator 1 advised staff that Mr D may not wish to dispose of his books, and they should discuss buying bookcases with Mr D.

[21] Red zone: "*service users in active state of relapse or at increased risk of relapse due to triggers, anniversaries, non-medication compliance etc*". (Zoning meeting Cambridge Locality Service Agenda – May 2021).

3.10 Mr D attended his GP practice on 13 February 2018. He complained of constipation for the previous weeks and diarrhoea that morning. GP 1 recorded in the notes *"Poor communication (as per previous encounters) capacity".* Mr D was prescribed an additional laxative and was to be reviewed within a couple of weeks if his symptoms did not improve.

3.11 Care Coordinator 1 visited Mr D on 19 February 2018. Staff reported he had attended a GP appointment on his own the week before, but conversely there were days when he would not leave his sofa or see staff. Care Coordinator 1 saw Mr D in his room where he was lying on his sofa and refused to engage. He turned his back when Care Coordinator 1 offered his depot medication. Care Coordinator 1 advised she would attend later in the day to give him his depot medication.

3.12 Care Coordinator 1 did not return to Mr D's accommodation the same day but on 20 February 2018. Mr D accepted his depot. He was monosyllabic and quiet, but said he had a bad stomach. Mr D would not engage and had poor eye contact.

3.13 Care Coordinator 1 spoke to Mr D's Support Worker on 6 March 2018. He reported Mr D had thrown away his dosette box[22] for the week. Care Coordinator 1 saw Mr D on 6 March. He was difficult to engage but said he had thrown the box in the bin. Care Coordinator 1 could not find the medication. Mr D said he had been vomiting in the night which was not unusual for him. He received his depot.

3.14 Care Coordinator 2 (covering for Care Coordinator 1) visited Mr D on 21 March 2018. She first spoke with Support Worker 1 who said Mr D was reporting stomach pain but refusing to take a laxative provided by a pharmacist. Care Coordinator 2 saw Mr D in his flat. He said he was experiencing stomach pain although he was pointing at his lower chest rather than his abdomen. Mr D refused to take a laxative and said, *"I just want to die, I'll starve myself to death"*. Mr D's dosette box contained most of its medication and it was not clear what he had taken. Mr D said he had "*thrown away*" one day's worth of tablets. Mr D accepted his depot medication. Care Coordinator 2 spoke with Support Worker 1 in the staff office, who advised he believed the dosette box was a week old. Care Coordinator 2 informed Support Worker 1 he needed to check Mr D's medication with pharmacy which he agreed to do.

3.15 Care Coordinator 1 visited Mr D on 3 April 2018. She first spoke to Support Worker 1 who said Mr D had not been engaging with staff, did not go out and complained regularly of stomach pain. Support Worker 1 and another member of staff, Support Worker 2, told Care Coordinator 1 they were concerned Mr D

[22] Dosette box: A plastic box with compartments separating medications, and indicating when they should be taken https://www.nhs.uk/conditions/social-care-and-support-guide/practical-tips-if-you-care-for-someone/medicines-tips-for-carers/

was not making use of the staff hours available to him. Care Coordinator 1 saw Mr D in his flat. She noted there was a strong 'ketone'[23] smell in the property. Mr D was quiet and spoke with his hand over his mouth. He accepted his depot medication. Care Coordinator 1 discussed her visits with Mr D and asked whether he would prefer to receive his depot every four weeks (as opposed to two) as the visits seemed to cause him distress (we assume the dosage would have been altered to accommodate any reduction in administration). Mr D declined the offer and said he would try to engage with staff more. Care Coordinator 1 asked Mr D whether he thought there were Sanctuary staff who could support him to which he replied "*no, I don't like them, they don't like me*". Care Coordinator 1 reminded Mr D he was in supported accommodation and if he did not utilise the support he might need to move to a council property. Mr D said he would try to think of something staff could help him with for an hour a week. Mr D said he had been taking his medication regularly. Care Coordinator 1 noted his bad body odour and Mr D admitted he had not washed in over a month. He said he would try to do so within the next two weeks. Mr D told Care Coordinator 1 that he had been out once in the previous week however, another resident later informed Care Coordinator 1 that in addition to this outing, they had met outside Mr D's accommodation (by chance) and had dinner together.

3.16 Mr D attended the Emergency Department (ED) at 10.33pm, 9 April 2018 complaining of abdominal pain. The CT[24] scan was normal, and he was discharged, but Mr D refused to leave stating he "*felt so unwell*". Mr D was escorted off site by security.

3.17 It was documented in Mr D's GP notes on 10 April 2018 that Mr D had received a "*minor head injury*". The information was recorded by administrative staff in the GP notes; no further information was recorded. The ED discharge summary said Mr D had been found on the ground with blood on his head and around his mouth. He said he had been pushed over by security staff when he refused to leave. Mr D was discharged by ED again without follow-up on 10 April 2018. In keeping with GP Practice policy when no action or follow-up is required by a GP, this information was scanned and filed, but not forwarded to Trust or Sanctuary staff, who were unaware of the incident.

3.18 Care Coordinator 1 visited Mr D with a student paramedic on 1 May 2018.[25] Mr D accepted his depot though said he had been suffering from constipation and stomach pain. Support Worker 1 informed Care Coordinator 1 that Mr D had attended Addenbrookes hospital the previous week with stomach pain.

[23] Ketone smell: often described as fruity or similar to nail polish remover, it can be indicative of high levels of ketones in the blood, often associated with diabetes.

[24] CT scan: Computerised tomography https://www.nhs.uk/conditions/ct-scan/

[25] Details of the visit were recorded in the progress notes on 4 May 2018.

Hospital staff told him he was constipated and asked him to leave. Mr D initially refused to leave and was escorted off-site by security.

3.19 Care Coordinator 1 visited Mr D on 15 May 2018. Support Worker 1 reported Mr D had been to the shops with him and Support Worker 2 and purchased a yoghurt. Care Coordinator 1 documented in the notes that this was the first time in many months that Mr D had engaged with staff. Mr D accepted his medication from Care Coordinator 1 but did not engage with her.

3.20 Mr D's GP practice received an invitation on 20 May 2018 for Mr D's next Care Programme Approach (CPA) review, scheduled to take place on 30 May (Care Coordinator 1 subsequently faxed the CPA review outcome to the GP practice on 30 May 2018).

3.21 Care Coordinator 1 visited Mr D on 29 May 2018 with Student Nurse 1. Support Worker 1 reported he had escorted Mr D to a building society, but he had not been to the shops in two weeks. Care Coordinator 1 saw Mr D who accepted his depot medication. He said he had been constipated for two weeks and was unable to drink anything. Care Coordinator 1 noted a 'ketone' smell on Mr D's breath. They discussed the importance of Mr D drinking water regularly.

3.22 Care Coordinator 1 visited Mr D on 12 June 2018.[26] He looked thin and appeared to have lost weight Mr D said he was not eating because of his stomach concerns. Mr D said he wanted a stomach/bowel scan. Care Coordinator 1 advised Mr D to speak to his GP about arranging a scan and to ask about Fortisip[27]/Complan to increase his calorie intake. Care Coordinator 1 told Support Worker 1 who agreed to support Mr D with arranging a GP appointment. Care Coordinator 1 told us she did not weigh Mr D, but her expectation was that this would be undertaken and monitored by his GP. She told us she informed Sanctuary staff that she thought Mr D had lost weight.

3.23 Mr D attended his GP practice with a member of Sanctuary staff (name not recorded) on 14 June 2018. He was seen by GP 2. Mr D complained of constipation which GP 2 noted to be a side effect of clozapine;[28] however, we note Mr D was on depot flupentixol medication, he was not receiving clozapine. Mr D said he had not opened his bowels for three months and had had no appetite in the past five days. The Sanctuary member of staff reported he had lost weight. GP 2 arranged blood tests and prescribed senna. The blood test results were normal with no further action required.

[26] Details of the visit were recorded in the progress notes on 15 June 2018.

[27] Fortisip: Nutritional drink used to supplement poor diets

[28] Clozapine: An oral antipsychotic https://bnf.nice.org.uk/drug/clozapine.html

3.24 Care Coordinator 1 visited Mr D on 26 June 2018. She spoke to Support Worker 1 who advised Mr D had seen the GP about his stomach and no concerns were identified; the GP did not prescribe nutritional drinks and Mr D's blood results were normal. Support Worker 1 made some comments about Mr D's inability to look after himself; Care Coordinator 1 responded that Support Worker 1's attitude would be negatively impacting Mr D. Care Coordinator 1 saw Mr D in his flat. She noted he looked "*very thin*". Mr D said his GP had not weighed him. He asked Care Coordinator 1 if she would speak to his GP about a prescription for nutritional drinks as he was still unable to eat regularly and felt sick. Care Coordinator 1 noted Mr D had a 'ketone' smell on his breath and reminded him of the importance of staying hydrated. Mr D told Care Coordinator 1 he was worried because Support Workers 1 and 2 had told him he would be evicted if he did not engage with them more. Mr D accepted his depot as prescribed. Care Coordinator 1 recorded in the notes that she intended to speak to Mr D's GP about a prescription for nutritional drinks, request they measure his Body mass index (BMI) and do a blood glucose check.

3.25 Care Coordinator 1 returned to Mr D's building later the same day to discuss with Support Worker 1 the "*negative effect his approach was having on Mr D*". She told Support Worker 1 she had previously asked Mr D if he wished to make a complaint, to which he had always said no, and she intended to ask Mr D again. Support Worker 1 said he would take on board Care Coordinator 1's feedback and try to focus on the positives of his relationship with Mr D and seek to rebuild a trusting therapeutic relationship. Care Coordinator 1 raised that Mr D had said he had been threatened with eviction by staff if he did not engage more, to which Support Worker 1 indicated Mr D was not telling the truth. Care Coordinator 1 recorded in the notes that she intended to inform Service Manager 1 about the issue with a view to her investigating further (the notes indicate this happened, but a date is not recorded).

3.26 Care Coordinator 1 spoke to GP 3 on 27 June 2018 who told her Mr D had not referenced his weight, supplement drinks or BMI at his previous appointment on 14 June.[29] A new appointment was made for Mr D on 2 July. Care Coordinator 1 contacted Support Worker 1 and relayed this to him. Support Worker 1 agreed that someone would accompany Mr D to his appointment and provide feedback.

3.27 Mr D was seen by GP 2 on 2 July 2018. Mr D said senna was not helping him; GP 2 advised he increase the dose. Mr D's BMI was 21.6 (healthy weight).

3.28 Care Coordinator 1 saw Mr D on 10 July 2018. She had to be let into his flat by staff because he would not open the door. Mr D was on the sofa with his

[29] Mr D's progress notes do not record a GP appointment on 14 June 2018.

head under a T-shirt. She reminded Mr D he had an impending PIP[30] call with Sanctuary staff, but he did not respond. Care Coordinator 1 asked if he wanted his depot that day which he confirmed. He removed the T-shirt from his face at Care Coordinator 1's request and reported that his stomach and bowel pain was worse and he wanted an Ambulance. Care Coordinator 1 asked Mr D what usually happened when he attended the ED to which he replied he usually had to wait several hours before being told to drink more and eat more healthily. Mr D decided he did not want to attend the ED. Care Coordinator 1 raised her concerns with Mr D that he had said on several occasions that Sanctuary staff were not nice or were threatening him[31]. Care Coordinator 1 advised she had informed the project managers (Sanctuary management) about her concerns, who in turn wanted to speak to Mr D, which he agreed to. Care Coordinator 1 subsequently emailed the project managers to confirm her next visit to see Mr D would be on 24 July and asked that one of them attend.

3.29 Care Coordinator 1 visited Mr D on 24 July 2018 with Sanctuary Housing Manager 1. Mr D was initially uncommunicative, whispering "*phone an ambulance, I need an ambulance*". He told them he was in a lot of pain. Care Coordinator 1 noted he was pale, sweating, had a 'ketone' smell on his breath and looked thin. Housing Manager 1 asked Mr D if he had any concerns about the accommodation to which he replied "[Support Worker 1] *keeps telling me that if I don't engage with staff I will be evicted*". He told Housing Manager 1 and Care Coordinator 1 he found visits difficult and they explained staff were concerned about this physical health and he needed to be seen at least daily. Mr D accepted his depot as prescribed. After the meeting but still on site, Care Coordinator 1 asked Support Worker 1 to arrange a home visit from Mr D's GP (which Mr D had agreed to).

3.30 GP 4 saw Mr D with Support Worker 1 on 25 July 2018. Mr D reported several symptoms which included weight loss, loss of appetite, vomiting and nausea and epigastric pain. GP 4 administered an enema to Mr D. She concluded Mr D needed further assessment due to his weight loss and epigastric tenderness. She referred him to the local hospital for further assessment and imaging (as a two week wait referral). GP 4 left a message for Care Coordinator 1 to provide an update.

3.31 Support Worker 1 subsequently contacted Care Coordinator 1 to advise that GP 4 had administered an enema to Mr D, prescribed lactulose[32] and ordered an urgent CT scan in response to Mr D complaining of stomach pain. Care Coordinator 1 asked Support Worker 1 to liaise with the GP 4 about

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[30] PIP: Personal Independence Payment https://www.gov.uk/pip

[31] There is evidence in the notes that Care Coordinator 1 raised her concerns with Sanctuary management, but our terms of reference do not extend to examining what, if any, action Sanctuary management subsequently took.

[32] Lactulose: A laxative https://bnf.nice.org.uk/drug/lactulose.html

prescribing Mr D a nutritional drink as this was yet to be actioned despite her previous request.

3.32 GP 4 spoke to Support Worker 1 on 27 July 2018 to receive an update on Mr D. He said Mr D reported no bowel movement but was taking lactulose. GP 4 advised they should wait a little longer and she would see Mr D after his scan.

3.33 Support Worker 1 contacted Care Coordinator 1 on 31 July 2018 to advise a CT scan had been booked for Mr D on 2 August, which staff would support him to attend (the GP practice confirmed the details with Support Worker 2 on 31 July). An endoscopy[33] had also been booked for 7 August but Mr D was yet to be told because he would need to be sedated for the procedure.

3.34 Mr D attended the Endoscopy appointment on 7 August 2018. His GP practice was informed the same day he had "*Barrett's segment of Prague C3M3 with hiatus hernia and mild gastritis*".[34]

3.35 Sanctuary staff (names not recorded) contacted Mr D's GP practice on 20 August 2018. They spoke to GP 2 and reported that Mr D was complaining of abdominal pain and constipation. Mr D's carers asked that the GP undertake a home visit but GP 2 recorded in the notes Mr D's recent blood results and bowel CT scan were normal. GP 2 wrote in the GP notes "*Unreliable consumption of laxatives … Investigations by Gastro have shown gastritis and Barrett's oesophagus".* GP 2 recommended that Mr D increased his omeprazole[35] (first prescribed on 10 August) to two tablets a day.

3.36 Care Coordinator 1 visited Mr D on 21 August 2018 and was told by Support Worker 1 that Mr D's GP (name not recorded) had been in touch to advise Mr D had a hiatus hernia. A GP was to visit Mr D on 24 August to discuss treatment options. Mr D's prescription for omeprazole had been increased. Support Worker 1 informed Care Coordinator 1 that Mr D had poor body odour and he would not be willing to take him in his car for future appointments unless he washed; Mr D would need to take a taxi instead. Care Coordinator 1 spoke with Mr D about this and he said he felt he could manage a bath before the GP visit. Mr D indicated to Care Coordinator 1 that he was pleased he had a diagnosis and possible treatment plan. He said he continued to experience a lot of pain. He received his depot as prescribed.

[33] Endoscopy: https://www.nhs.uk/conditions/endoscopy/

[34] Barrett's oesophagus: https://www.nhs.uk/conditions/oesophageal-cancer/causes/

[35] Omeprazole: medication used to reduce stomach acid https://www.nhs.uk/medicines/omeprazole/

3.37 GP 4 saw Mr D in his flat on 24 August 2018. She explained his hospital results and advised he eat regular small meals and avoid fizzy drinks. GP 4 prescribed Mr D lansoprazole.[36]

3.38 Care Coordinator 1 saw Mr D on 4 September 2018. Support Worker 1 had left a note for Care Coordinator 1 advising that the GP had changed Mr D's prescription to lansoprazole from omeprazole because Mr D had said omeprazole had not made a difference to his health.[37] Care Coordinator 1 wrote in the notes that she was 'very concerned' that Mr D appeared to have lost more weight since she last saw him. Mr D said he had not eaten or slept for two weeks. Care Coordinator 1 encouraged Mr D to try to eat sandwiches, which he said he enjoyed. Care Coordinator 1 noted Mr D had a 'ketone' smell on his breath and his skin appeared dry.

3.39 Care Coordinator 1 was concerned Mr D might need extra support including a hospital admission for dehydration, poor diet and a possible eating disorder. She raised these concerns in the team meeting on 5 September 2018 and spoke to Mr D's GP that evening, saying she thought Mr D needed a medical review and possible admission and that he might have developed an eating disorder. GP 4 queried in the notes whether Mr D was developing an eating disorder or if his Barrett's oesophagus was contributing to his discomfort and deterioration. GP 4 agreed to undertake a home visit the next day.

3.40 GP 4 reviewed Mr D on 6 September 2018 and subsequently arranged for Mr D to be taken to the ED by ambulance. Support Worker 1 contacted Care Coordinator 1 to advise Mr D had gone to hospital and that he had given paramedics his and the GP's contact details.[38] Care Coordinator 1 advised Support Worker 1 she would escort Mr D to his next scheduled medical appointment on 12 September 2018 if it went ahead.

3.41 The Emergency Department sent a notification to the GP practice on 6 September 2018 to report Mr D had left the department without being seen for treatment.

3.42 Sanctuary staff contacted Mr D's GP practice on 7 September 2018 to advise he had left the ED without being seen on 6 September because the wait was too long. They advised Mr D had an appointment with gastroenterology on 12 September 2018 to discuss his CT and endoscopy results.

3.43 Care Coordinator 1 was unable to attend the gastroenterology appointment on 12 September 2018 (reasons not documented). A member of the team

[36] Lansoprazole: medication used to reduce stomach acid https://www.nhs.uk/medicines/lansoprazole/

[37] GP4 told us Mr D found omeprazole was unhelpful for his stomach pain.

[38] The progress notes provide no further information about Mr D's ED attendance or the outcome.

contacted Support Worker 1 who advised it would be difficult for staff to escort Mr D to his appointment, but they would try.

3.44 Mr D attended his gastroenterology appointment with Support Worker 1 on 12 September 2018. It was planned that Mr D would have an oesophago-gastro-duodenoscopy (OGD)[39], start taking ranitidine[40] in addition to lansoprazole, have a follow-up in two months and, if necessary, have oesophageal physiology tests.

3.45 Social Worker 1 (a member of the Adult Locality team) spoke to Support Worker 2 on 13 September 2018 to request an update about Mr D's medical appointment the previous day. Support Worker 2 advised she was unclear of the detail, but Support Worker 1 had taken Mr D to his appointment and he had been given advice about his eating habits. Social Worker 1 asked that Support Worker 1 call her to give a full update.

3.46 Support Worker 1 called Social Worker 1 later the same day to confirm Mr D had attended his medical appointment on 12 September 2018. The doctor advised that Mr D might have Barrett's oesophagus[41] and another endoscopy would be needed to investigate this.[42] The doctor advised Mr D to sleep with more pillows under his back, to drink water, eat small portions of food and avoid fizzy drinks or spicy food. It was documented Mr D's weight had increased from 52kg on 2 July to 53.6kg (Mr D's height was 1.55m). Support Worker 1 advised he would share his notes about the visit with Care Coordinator 1.

3.47 Mr D was removed from the red zone on 18 September 2018.[43] The rationale was documented in the notes as "*Went to Addenbrookes appt, may have cancer, [Care Coordinator 1] visiting today*". Care Coordinator 1 visited Mr D the same day. She saw Support Worker 1 who advised Mr D was taking his medication but there had been no change in his condition. Care Coordinator 1 saw Mr D who was uncommunicative. Mr D said he had not eaten for three weeks and was in pain. Care Coordinator 1 asked Mr D whether he understood what he had been told at his medical appointment on 12 September 2018 to which he shook his head. Care Coordinator 1 explained the new medication should help and that, if necessary, surgery was an option to repair his hernia. She asked Mr D if he wanted her to leave which he

[39] OGD (also known as gastroscopy): https://www.nhs.uk/conditions/gastroscopy/

[40] Ranitidine: Medication used to reduce stomach acid.

[41] Barrett's oesophagus: "*… a medical condition where some of the cells in your oesophagus grow abnormally.., it is sometimes called a pre-cancerous condition*" https://www.nhs.uk/conditions/oesophageal-cancer/causes/

[42] The clinic letter sent to the GP on 20 September said another endoscopic assessment was needed, with more biopsies, in keeping with surveillance protocol.

[43] We have been unable to establish from the notes when Mr D was placed on the red zone. The last occasion documented in the notes was 4 January 2018, which lasted for one day.

confirmed. She was advised by Support Worker 1 that Mr D should be given another Endoscopy appointment within four weeks and that he had another clinic appointment in December.

3.48 Care Coordinator 1 saw Mr D on 16 October 2018. He was very thin but said he had been taking his medication and drinking calorie drinks (Mr D was not weighed). He said he was not eating or sleeping. Mr D said he was very worried about the endoscopy that was scheduled to take place the following week. Care Coordinator 1 said she would ask his GP if he could be given some diazepam prior to the procedure.

3.49 The GP practice subsequently issued a prescription for Mr D, but they were unable to contact Care Coordinator 1 to agree getting the prescription to Mr D. The prescription was subsequently sent to Mr D's local pharmacy. The practice tried to call Mr D but he did not answer.

3.50 Support Worker 1 contacted Care Coordinator 1 on 23 October 2018 to advise that Mr D had refused to attend his Endoscopy appointment despite his GP prescribing diazepam. Mr D declined to be sedated for the procedure. Support Worker 1 said he would try to reschedule the appointment.

3.51 Mr D did not attend his endoscopy on 23 October 2018.

3.52 Care Coordinator 1 visited Mr D on 30 October 2018. She spoke to Support Workers 1 and 2 who were frustrated that Mr D had not attended his Endoscopy appointment. The appointment had been rescheduled but they were concerned he would refuse to attend. They were also concerned Mr D had not collected his Fortisip. Care Coordinator 1 asked that they collect it, given Mr D was not eating or drinking properly. Staff let Care Coordinator 1 into Mr D's flat. He was in bed and would not speak. Care Coordinator 1 explained she would leave if he did not communicate to which he started to speak quietly, explaining he felt physically unwell. He said, "*I need to be sectioned*" and admitted to Fulbourn. He said, "*I am in pain. I am constipated. I am dying*". Mr D's breath had a strong 'ketone' smell and he had bad body odour. He could not recall when he had last washed. Care Coordinator 1 told Mr D she was concerned he was physically unwell, and he needed to attend his Endoscopy appointment. Mr D said "*I am too ill to go anywhere*" but indicated he would try.

3.53 Care Coordinator 1 recorded in the notes that she was worried about Mr D's physical health and would open a safeguarding alert on the grounds of self-neglect. Care Coordinator 1 documented her intention to speak to the team psychiatrist. She contacted Mr D's GP to discuss him being admitted to hospital for physical health checks. Mr D's GP agreed to visit him at home the next day and, if necessary, would advise him to attend the ED, although she noted there was little she could do if he refused. Care Coordinator 1 emailed the Addenbrookes link worker to ask that they support Mr D if he attended.

3.54 Care Coordinator 1 called GP 4 on 30 October 2018. She said she was concerned Mr D had not been eating and drinking much, was at risk of self-neglect and had repeatedly refused to attend his Endoscopy appointment. Care Coordinator 1 said she was concerned about Mr D's physical health and wanted him admitted to general hospital for assessment. GP 4 recorded in the notes that she discussed the previous attempt to have Mr D assessed when he left without being seen. GP 4 queried whether Mr D needed a mental capacity assessment. She agreed to see Mr D the next day.

3.55 Care Coordinator 1 referred Mr D to the local Multi-Agency Safeguarding Hub (MASH) on 31 October 2018. She exchanged a number of emails with the team who said Mr D would need a capacity assessment if they were to proceed but concluded he did not meet the team threshold for involving the team, noting *"Currently you appear to be working with all the agencies involved around* [Mr D] *successfully and working bringing them all together as a multi-agency team, He also appears to be accepting of both you and his GP and is engaging with you around his care needs … As this is the case I cannot currently see what extra a safeguarding enquiry would bring to* [Mr D's] *current case".* The email author concluded the email saying Care Coordinator 1 should re-refer Mr D if the situation changed or his self-neglect worsened.

3.56 GP 4 saw Mr D on 31 October 2018. She spoke to Support Worker 1, then Mr D. GP 4 wrote in the notes that she spent a lot of time talking to Mr D about his health, which she had reviewed, and concluded that he needed a physical assessment given his poor intake of food/drink and need for pain management. Mr D indicated he was unsure what he wanted to do; GP 4 advised he could be supported by Support Worker 1 to attend a hospital appointment. Mr D agreed to think about his options with a view to discussing them with GP 4 the next day.

3.57 GP 4 left a voicemail on Care Coordinator 1's phone to advise she had reviewed Mr D who had lost 3kg in the previous six weeks and his BMI was now 20.[44] She said she intended to see Mr D that day at home and informed Care Coordinator 1 she would undertake a capacity assessment if he refused to go to hospital. GP 4 intended to ask Mr D if he would agree to blood tests. Care Coordinator 1 recorded in the notes (on 1 November) that a professionals meeting might need to be arranged depending on how Mr D engaged with GP 4 and if he went to his upcoming Endoscopy appointment.

3.58 It was agreed at the morning multidisciplinary team (MDT) meeting on 1 November that Mr D should remain in the red zone due to ongoing concerns about his physical health. Mr D had previously been removed from the red zone on 18 September 2018 – the notes do not say when he was added back in the red zone.

[44] A BMI within the range of 18.5-24.9 is considered normal.

3.59 GP 4 saw Mr D with Support Worker 1 on the morning of 1 November 2018. Mr D told her "*I want to die here*" and said he did not want to go to hospital. He told GP 4 he experienced pain in waves and that at times it was "*very severe*". GP 4 talked through the nature of Mr D's conditions (hiatus hernia and Barrett's oesophagus) with him and advised they could be better managed with the right medication and monitoring. GP 4 explained a hospital assessment was key to this and she could make arrangements for Mr D and seek to make the process as easy as possible, e.g., Support Worker 1 would drive Mr D and they would seek to have a private room for him. Mr D said he still would not attend hospital and would not attend his forthcoming Endoscopy appointment. GP 4 told Mr D that if his physical health continued to decline, he could be putting himself at risk. Mr D said he understood, and he did not want to "*starve to death*". Mr D agreed to blood tests.

3.60 Mr D went on to say he wanted to be "*sectioned*" and said his "*thoughts were mixed up*", "*I cannot think clearly because of my head*" and "*I cannot make up my mind*". GP 4 concluded in the notes:

> *"Given with the assessment above, I don't think [Mr D] can demonstrate capacity regarding the decision of his physical health, in particular, going to hospital for his physical assessment and management … I think a joint meeting is needed and a formal psychiatry assessment/mental capacity assessment is needed"*

3.61 GP 4 recorded in the notes that she intended to speak to Care Coordinator 1 and her team. A professionals meeting was arranged for 7 November 2018.

3.62 A nurse from the GP practice visited Mr D on 2 November 2018 to take bloods. She documented that he was dehydrated and his veins were not easily visible. She encouraged Mr D to keep drinking even if he did not want to eat.

3.63 Support Worker 1 contacted Care Coordinator 1 on 2 November 2018 to advise that Mr D had told him he would not attend his Endoscopy appointment therefore Support Worker 1 was going to cancel it. Support Worker 1 said he had bought some nutritional drinks for Mr D whilst he waited for Fortisip to be available at his pharmacy.

3.64 Care Coordinator 1 contacted the Crisis Resolution and Home Treatment Team (CRHTT) about Mr D's physical health on 2 November 2018. She advised CRHTT Worker 1 that the GP deemed Mr D, who had refused to be admitted to Addenbrookes or attend further medical appointments, had capacity at that time to make this decision. She said that Mr D had been asking to be admitted to Fulbourn for many months and asked to be "*sectioned*", but he was not displaying psychotic symptoms and had been accepting his depot. CRHTT Worker 1 said he did not think an admission to Fulbourn would benefit Mr D, rather he needed to be admitted to

Addenbrookes. Care Coordinator 1 asked if the CRHTT would like to attend a professionals meeting on 7 November, to which CRHTT Worker 1 advised he did not see a role for the team in Mr D's care at that time. Care Coordinator 1 said she would keep the team updated.

3.65 Mr D was removed from the red zone after a zoning meeting on 2 November because the Adult Locality team (incorrectly) understood his GP to have confirmed he had capacity to make decisions about his physical health.

3.66 Mr D entered the Sanctuary staff office on 5 November 2018 and made a strangling gesture towards Support Worker 1. Support Worker 2 contacted the police Integrated Mental Health Team (IMHT)[45] on 5 November. She said Mr D had been aggressive, making threats to kill people and had put his hands around a member of staff's neck. He calmed down and went back to his flat but later returned and tried to get into the office. He made threats to kill a specific resident (name not recorded) and then said he wanted to kill anyone.[46] She advised that they had called the local mental health team but not received a call back within 50 minutes, they had therefore called the police, but during that time Mr D had returned to his flat. Support Worker 2 spoke to Care Coordinator 1 who said they were putting together a plan for Mr D given that his mental health had deteriorated recently.

3.67 IMHT staff contacted Care Coordinator 1 and advised they were unsure if police attendance would be helpful at that time because the police would only be able to assess whether Mr D should be arrested. They agreed with Care Coordinator 1 that the mental health team should put a plan in place to manage Mr D, and that they would advise the police against attending because there was no immediate risk of harm to self or others being reported.

3.68 Support Worker 1 contacted Care Coordinator 1 during the afternoon on 5 November 2018 to provide more information about what had happened. He said Mr D had attempted to put his hands around Support Worker 1's throat, tried to stab a member of staff with a fork and threatened to kill another resident.[47] Care Coordinator 1 spoke to Consultant 1 who said the CRHTT should attend with a view to Mr D being admitted to Fulbourn. Care Coordinator 1 contacted the CRHTT who said they did not have staff to attend that afternoon and asked that Care Coordinator 1 attend and assess whether Mr D needed to be admitted to Fulbourn.

[45] Trust employed mental health staff are based in the local police control room with a view to triaging mental health related calls. The Trust staff have access to service user Trust records.

[46] Miss Y's name was not recorded in the progress notes, but the Trust Individual Management Review (IMR) submitted to the Safeguarding Adult Review says that she was named by Mr D on 5 November 2018.

[47] The risk assessment for this incident says Mr D was 1–2 feet away from staff throughout the incidents and did not make physical contact.

3.69 Care Coordinator 1 visited Mr D with Social Worker 2 (the time of the visit is not recorded in the notes).[48] They saw Mr D in his room who was in bed shaking and facing the wall. He kept saying "*I am going to hurt people, I am going to attack people, I am going to kill people*". Mr D said he wanted to be admitted to Fulbourn. Care Coordinator 1 told Mr D that his behaviour was unlikely to get him admitted but he would likely be arrested by the police if he continued to threaten people (it was documented he had threatened other residents). She told Mr D that it would be best if he went to Addenbrookes for his physical health checks, but Mr D continued to repeat he was going to kill people. Care Coordinator 1 said she would refer Mr D to the CRHTT.

3.70 Care Coordinator 1 called the CRHTT on the evening of 5 November 2018 to request that the team assess Mr D in the morning. The team sent an email to her that night asking her to call the CRHTT in the morning to refer Mr D.

3.71 Social Worker 3 referred Mr D to the CRHTT on 6 November 2018.[49] She advised that a member of the team who knew Mr D was available and could support a joint visit of the CRHTT, however, this was felt unnecessary as Mr D was known to the CRHTT.

3.72 Social Worker 4 and Senior Mental Health Practitioner (SMHP) 1 from the CRHTT assessed Mr D on 6 November 2018. They concluded that Mr D did not need an inpatient admission, rather his issues were primarily linked to his physical health which needed addressing. Mr D was remorseful and no longer voicing an intention to hurt others. They concluded CRHTT was not needed but Mr D agreed they should contact his GP with a view to possibly arranging an enema and the Adult Locality team about supporting him to attend physical health appointments. The outcome of the assessment was shared with the wider CRHTT, the Adult Locality team, Support Worker 1, Mr D and his GP.

3.73 A professionals meeting took place on 7 November 2018. It was attended by Consultant 1, Support Worker 1, GP 4 and a GP in training. Consultant 1 documented the meeting. It was noted Mr D's weight had dropped from roughly 70kg to 49kg in 12 months, although his blood pressure (BP), blood tests and kidney function remained in the normal limits. Mr D was refusing to eat but took his Fortisip. Mr D had previously refused an endoscopy and was deemed to have capacity to make this decision[50]. Mr D's next Gastroenterology Clinic appointment was on 19 December 2018. Mr D's GP and Support Worker 1 indicated they were not sure of the extent to which Mr D was compliant with his medication. Mr D did not appear psychotic, but he was highly anxious. It was noted Mr D frequently complained of stomach pain

[48] Details of the visit are recorded in the risk assessment it is not in the progress notes.

[49] Care coordinator 1 was off sick on 6 November (source: GP notes).

[50] This is in contrast to the concern of GP 4 on 1 November 2018 that Mr D did not have capacity to make decisions about his care.

and wanted to be admitted to Fulbourn, although he had recently agreed to consider an admission to Addenbrooke's under Gastroenterology, which his GP was to support and facilitate. The professionals meeting agreed:

- Mr D's GP would continue to undertake weekly health monitoring;
- Sanctuary and Trust staff would support Mr D to accept a planned admission to Addenbrooke's;
- Care Coordinator 1 would follow-up with Mr D (depending on her availability);
- Consultant 1 would undertake a medical review on 21 November 2018; and,
- the team would submit a request to Psychology to help Mr D manage his anxiety.

3.74 GP 4 spoke to Support Worker 1 on 9 November 2018 who advised Mr D was up and about (no further detail was recorded in the notes). He had told Mr D that GP 4 would continue to monitor his health, which he had agreed to. Support Worker 1 agreed to keep GP 4 updated on any developments.

3.75 Mr D's GP practice was sent the CRHTT assessment on 9 November 2018.

3.76 The GP practice referred Mr D to the district nurse on 12 November 2018 for weekly physical health monitoring at home (e.g., blood tests, heart rate, blood pressure and weight). The Community Nursing team subsequently accepted the referral and liaised with Sanctuary staff to make arrangements to see Mr D.

3.77 Care Coordinator 1 saw Mr D on 13 November 2018. He engaged well although said he remained very unwell physically. Care Coordinator 1 told Mr D that his GP could arrange for him to have an appointment with Gastroenterology without him needing to attend the ED. Care Coordinator 1 also reminded Mr D that he could rearrange his Endoscopy outpatient appointment and steps could be taken to support him to attend. Mr D said he would think about this. Care Coordinator 1 queried when Mr D had last washed, to which he replied that he could not remember. She encouraged him to have a bath which she said might help him relax. Mr D accepted his depot medication as prescribed.

3.78 Consultant 1 saw Mr D for medical/CPA review on 21 November 2018. Consultant 1 met with Care Coordinator 1, Support Worker 1 and Sanctuary Housing Manager 1 in advance of his review. Mr D presented as low in mood and anxious. He expressed a death wish and reported auditory hallucinations commanding him not to be admitted to Addenbrooke's. Consultant 1 noted Mr D's mental state and capacity appeared to fluctuate. The agreed treatment plan was to continue monitoring Mr D's physical and mental health and to

ensure he continued to have capacity to make decisions about his care. The Adult Locality team and Sanctuary staff would remind Mr D of the option of a Gastroenterology admission. Consultant 1 recorded in the notes *"We will need to consider treatment in his best interest if his health deteriorates and an intervention is immediately necessary"*. Consultant 1 shared her CPA notes with the GP whom she asked to continue to monitor Mr D's physical health on a weekly basis and continue Mr D with his current psychotropic medication.

3.79 Support Worker 1 contacted Care Coordinator 1 on 22 November 2018 to report he and Support Worker 2 were concerned about Mr D who was complaining of pain and wanted to be "*sectioned*". Support Worker 1 said Mr D's GP was on leave (and consequently unavailable to support a GP admission to hospital) therefore he might need to attend Addenbrooke's via the ED. Care Coordinator 1 explained a Duty GP should be available and he should liaise with this individual in the first instance to see if Mr D could be admitted to Gastroenterology.

3.80 Care Coordinator 2 saw Mr D on 28 November 2018. He told her he did not feel up to attending his outpatient appointment at Addenbrooke's and was waiting to hear if it would be rescheduled. Mr D was chatting and engaging despite his physical health issues. He accepted his depot medication. Care Coordinator 2 intended to speak to Sanctuary staff about rearranging Mr D's outpatient appointment.

3.81 Mr D's GP practice received the outcome of Consultant 1's review on 30 November 2018.

3.82 GP 4 spoke to Support Worker 1 on 4 December to confirm a visit to see Mr D the next day. She documented in the notes that the District Nurse team had not carried out weekly blood tests or physical health monitoring and it was not clear why.

3.83 Consultant 1 spoke with Mr D's GP on 7 December 2018 who advised the Gastroenterology team were now reluctant to admit Mr D and recommended that he attend his review with the Consultant on 19 December 2018. The GP said she would see Mr D the next week and discuss with him the plan to change his medication from sertraline to venlafaxine[51] (initially 75mg then 150mg after two weeks) for better management of his depression and anxiety. It was also thought it might help his physical pain – the Gastroenterology team had suggested prescribing amitriptyline[52]. Mr D was not prescribed amitriptyline; however, we note it unlikely Mr D would have been prescribed a

[51] Venlafaxine: an antidepressant https://bnf.nice.org.uk/drug/venlafaxine.html

[52] Amitriptyline: an antidepressant which is also used in low doses for pain management https://bnf.nice.org.uk/drug/amitriptyline-hydrochloride.html

second antidepressant, and Mr D would have to have been weaned off the latter before commencing amitriptyline.

3.84 GP 4 saw Mr D with a Support Worker on 5 December (name not recorded – Support Worker 1 was away). They had a long discussion about whether Mr D would consider a hospital assessment. Mr D said he needed more time to think and that he was unable to make a decision. He did not want to go to the ED because the department and sick people made his anxiety worse. GP 4 wrote in the notes she intended to speak to the Gastroenterology team about what options were available for Mr D.

3.85 GP 4 saw Mr D on 7 December 2018. She told him she had spoken to the on-call Gastroenterologist who advised that Mr D be given amitriptyline to help with his pain management, which Mr D agreed to. She left a message with Consultant 1 (there is no evidence in the notes to indicate this was discussed further and Mr D's medication did not change).

3.86 Care Coordinator 1 saw Mr D on 12 December 2018. She reminded him of his upcoming gastroscopy appointment which he said he was too ill to attend. Care Coordinator 1 told Mr D that Sanctuary staff would support him to attend the appointment, but he continued to say he was too ill to attend. Mr D's personal care was poor and Care Coordinator 1 tried to address this with him, but he said he was too ill to wash. Care Coordinator 1 said Sanctuary staff could help Mr D with his laundry which he declined. She asked Mr D if he needed more supportive accommodation to which he replied "*you are evicting me*". Care Coordinator 1 assured Mr D he was not being evicted but said he might benefit from a placement where more support was available. GP 4 and the District Nurse arrived; Mr D turned his back and refused his depot medication. Mr D's GP informed Mr D that she had spoken to Consultant 1 and they would be making some changes to his physical and mental health medication. She encouraged Mr D to attend his gastroscopy appointment. Mr D accepted his depot medication.

3.87 Mr D did not attend his Gastroenterology appointment on 19 December 2018. Support Worker 1 informed the GP practice the next day.

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3.88 Care Coordinator 1 visited Mr D on 22 January 2019. Support Worker 1 informed her that Mr D appeared to be taking some of his medication in one dose as opposed to four times across the day. He advised that Mr D had an upcoming appointment with the Gastroenterology Department, but Mr D had repeatedly said he was not going to attend. Care Coordinator 1 saw Mr D who was up and dressed. He said he was no better physically and felt he was "*going to die*". Care Coordinator 1 asked Mr D why he was not taking his medication as prescribed to which he replied he could not be bothered to remember. She advised him it was important the medication was spread out

across the day to help with his stomach pain. Care Coordinator 1 asked Mr D about his Fortisip consumption, which was prescribed twice a day. He said he sometimes took more than prescribed and would run out. Mr D accepted his depot medication.

3.89 Mr D missed his Trust physical health clinical appointment on 31 January 2019. It was rescheduled for 26 February 2019.

3.90 Care Coordinator 1 visited Mr D on 5 February 2019. She spoke with staff beforehand who advised he had seemed slightly better in the past couple of weeks, was going out a little more and allowed staff to help him do laundry. They continued to work with Mr D to get him to take his medication as prescribed. The Housing Officer had recently viewed Mr D's flat and asked him to move some of his books from the kitchen area because they were a fire/safety hazard. Staff reported Mr D threw his books in the bin. They also advised he had very little money in his building society account and were concerned where his money had gone, given he had significantly more money in his account about a year before. They offered to support Mr D to attend the building society to review his statement and check his benefits were being received as intended.

3.91 Care Coordinator 1 spoke to Mr D who said he had lost his building society books six months previously and thought the money had been stolen. He said he would try to go to the building society with Sanctuary staff but thought he would be too unwell to manage the trip. Care Coordinator 1 told Mr D that Sanctuary staff could not attend without him. Mr D accepted his depot as prescribed.

3.92 Care Coordinator 1 saw Mr D on 19 February 2019. He was up and dressed when she arrived. He said he had run out of money but was ok to wait until his next benefits were available. Mr D asked Care Coordinator 1 to inform the physical health team that he would not attend for a physical health check because he was too unwell. Mr D accepted his depot as prescribed.

3.93 GP 4 undertook a home visit to see Mr D with Support Worker 1 on 20 February 2019. Mr D said he continued to experience intermittent abdominal pain and was prone to constipation. He said he sometimes binged on food and then felt sick afterwards. Support Worker 1 said there had been some confusion over Mr D taking his medication but that this was not his fault because he does not have a calendar or phone. Staff intended to get Mr D an alarm to remind him to take his medication. Mr D's BMI was 21 (healthy). GP 4 intended to increase Mr D's venlafaxine and update the mental health team. She queried in the notes whether Mr D would benefit from cognitive behavioural therapy (CBT).

3.94 Care Coordinator 1 saw Mr D on 16 April 2019. He had noticeable body odour and was wearing dirty clothes. His flat was untidy with books all over the floor.

Mr D was chatty and easy to engage. They reported that Mr D's breath had a ketone smell. He said his stomach remained painful, but he could not decide whether he wanted to have an endoscopy. Mr D complained of constipation for which Care Coordinator 1 advised that he drink more water and eat fruit. She suggested he contact his GP if he remained concerned. Mr D said his Fortisip has been reduced to one a day. Care Coordinator 1 spoke to Support Worker 1 about this and asked that he check with Mr D's GP whether the prescription had been reduced or if it was a mistake. She also informed Support Worker 1 about Mr D's constipation complaint and that he might need to see his GP.

3.95 GP 4 saw Mr D with Support Worker 1 at home on 26 April 2019[53]. Mr D was reported to have been to the shops recently and his mood was stable. Mr D complained of stomach pain and said he had not eaten much. GP 4 noted 16+ cans of cola in Mr D's fridge – she reminded Mr D that fizzy drinks would cause stomach bloating and discomfort. She noted Support Worker 1 had put a list of foods Mr D should avoid (e.g., spicy) on his cupboard door. GP 4 noted Mr D was maintaining his weight. GP 4 advised him to avoid fizzy drinks and advised that Fortisip should not be used as a substitute for meals, rather he should have regular meals.

3.96 Care Coordinator 1 visited Mr D on 30 April 2019. Support Worker 1 advised that Mr D's GP had checked his weight, which, although low, remained stable. She had increased his Fortisip drinks to two a day. Care Coordinator 1 saw Mr D who she noted had very poor personal hygiene. Mr D told Care Coordinator 1 he had experienced a lot of stomach pain the night before. He accepted his depot as prescribed.

3.97 Mr D's CPA review with Consultant 1 and Care Coordinator 1 took place on 30 May 2019. They also met with Support Worker 1 to discuss Mr D's progress. Mr D said he continued to experience poor physical health. He described Sanctuary staff as "*unsympathetic*" and "*unhelpful*" and said, "*they bully me and say I will be evicted*". Consultant 1 recorded in the notes that Mr D appeared stable although "*at a very poor level of mental health*". Consultant 1 noted Mr D remained at risk of deterioration which in turn would negatively impact his physical health and self-care. Mr D agreed to a trial of increased sertraline and that his Fortisip be prescribed weekly rather than monthly to ensure he took it as prescribed. GP 4 would be asked by Sanctuary staff to continue to monitor his physical health.

3.98 GP 4 called Sanctuary Supported Living on 3 June 2019 but was unable to leave a message for Support Worker 1.

[53] The visit was documented in the GP notes on 29 April 2019.

3.99 Mr D's GP practice received Consultant 1's clinic letter on 5 June, detailing the CPA review on 30 May 2019. The letter included a request that the practice continue to undertake regular health checks

3.100 Mr D was seen at home by GP 5 on 7 June 2019. GP 5 noted "[Mr D's flat was] *covered in comics and books … sense of self-neglect … hot choc [sic] powder all over kitchen counter. Coca cola cans – full in fridge and taking up space. Two ready meals in fridge*". Mr D told GP 5 his physical health problems were bad, but he was not keen on the solutions because they were unpleasant to him. GP 5 diagnosed constipation. Mr D was told to drink more and given advice about healthy eating and regular exercise. GP 5 wrote in the notes, "*note he lacks a proactive attitude and I am sceptical about whether he will follow the plan given*".

3.101 GP 4 undertook a home visit to see Mr D on 28 June 2019. She also spoke to Support Worker 1. She noted Mr D's prescription for venlafaxine had been stopped and he was now on mirtazapine only. GP 4 documented that Mr D's diet was "*still poor*" and that he continued to eat at infrequent times and drank lots of fizzy drinks. Mr D's weight had increased (his BMI was 23); Mr D was advised to decrease his intake of Fortisip and eat more food.

3.102 GP 4 contacted Consultant 1 on 28 June 2019 to advise there had been a misunderstanding about Mr D's medication. She reminded Consultant 1 that Mr D's antidepressant had been changed on 7 December 2018 from sertraline to venlafaxine. GP 4 was on leave when Consultant 1 submitted his request to increase Mr D's sertraline, which was subsequently prescribed by another GP at the practice who did not realise Mr D was on venlafaxine. Consultant 1 and GP 4 agreed that Mr D should be restarted on venlafaxine, which should gradually be increased to 300mg. His mirtazapine was to be reduced to 30mg.

3.103 East of England Ambulance Service faxed a referral to Mr D's GP practice on 7 July 2019. The ambulance service had treated Mr D after he had fainted and was complaining of abdominal pain. Mr D told ambulance staff he had ongoing medical problems, but the pain had got worse, so he had lowered himself on to the floor to avoid losing consciousness (the notes do not say whether this was before or after he had fainted). The ambulance service noted Mr D suffered from mental health problems and had a hiatus hernia. They requested that Mr D be reviewed for pain relief and be given information on eating and drinking properly.

3.104 The Adult Locality team received a call from Sanctuary staff on 8 July 2019 to report that Mr D was lying in the corridor in his sleeping bag and had reportedly been doing so all weekend. Mr D told staff it was because he had severe pain in his side. Paramedics attended but upon review said there was nothing medically wrong with Mr D who was likely to be experiencing constipation. Mr D told staff he had not drunk for four days though they felt this unlikely given he appeared to be reasonably well. The information was

passed on to Care Coordinator 2 who was Mr D's acting Community Psychiatric Nurse (CPN) in Care Coordinator 1's absence.

3.105 GP 4 saw Mr D on her way to visit him on 9 July 2019. He was going to the shops. Mr D reported his pain was much better. GP 4 wrote in the notes that Mr D should continue to be monitored in the community.

3.106 Care Coordinator 2 saw Mr D on 10 July 2019. Mr D was no longer sleeping in the corridor and said he felt slightly better but was still in pain. Mr D said he had eaten a takeaway before experiencing the pain and acknowledged this might have been a contributing factor. Care Coordinator 2 reminded him he should be careful of what he eats in case it aggravated his hernia. Mr D accepted his depot as prescribed.

3.107 Care Coordinator 1 saw Mr D on 6 August 2019. Sanctuary staff told her Mr D kept turning off his fridge because the noise kept him awake at night. She spoke to Mr D and advised him to keep his fridge on to ensure his food remained fresh (and less likely to exacerbate his stomach). She suggested he invest in ear plugs. Care Coordinator 1 noted Mr D appeared better than when she had last seen him. He said he intended to buy new clothes and trainers.

3.108 GP 4 saw Mr D at home on 9 August 2019. He appeared cheerful and was talkative. She noted he had recently been seen socialising with other residents. Mr D reported pain in his lower rib. GP 4 examined him and explained it was likely to be muscle sprain and that he should use topical pain relief if needed. Mr D said he would be happy to be referred to Gastroenterology for follow-up. GP 4 reminded Mr D to eat a healthy diet and to avoid fizzy drinks. Mr D's BMI was 24.

3.109 Care Coordinator 1 visited Mr D on 20 August 2019. Support Workers 1 and 2 told her Mr D had taken a "*dip in mood and activities*" in the previous few days. Mr D would not answer the door to his flat so Support Worker 1 let them both in. Mr D was lying on the sofa shaking and jerking as if he were having a fit. Care Coordinator 1 sat with him for a few minutes, holding his hand and he stopped. Support Worker 1 then left. Mr D told Care Coordinator 1 he had eaten a kebab with onions and chilli sauce the previous Friday which had caused a severe reaction in his stomach. He said he had not eaten or drunk anything since Sunday. Mr D agreed to receive his depot medication but as Care Coordinator 1 was drawing it up he began coughing and "*choking*". Care Coordinator 1 helped calm Mr D and his breathing returned to normal, but he was worried it could happen again when he was alone. Mr D accepted his depot. Upon leaving, Care Coordinator 1 asked Sanctuary staff to inform Mr D's GP about his coughing episode and asked that they check on him later in the day.

3.110 GP 5 saw Mr D at home on 20 August 2019. Mr D reported long standing constipation and abdominal pains which had worsened in recent days. Mr D

was not eating well, had eaten a takeaway a few days before, and was using a number of 'build up' shakes. Mr D was advised to use four sachets of Fybogel[54] until he was able to use the toilet, at which point he should reduce to one a day. However, Mr D was not keen on this approach.

3.111 GP 5 saw Mr D on 2 September 2019. He had been experiencing epigastric pain since eating a sandwich the day before. Mr D also complained of ongoing constipation despite using Fybogel. Mr D was advised his pain should settle. GP 5 reminded Mr D of the plan agreed on 7 June which involved him exercising and eating more healthily.

3.112 Care Coordinator 1 visited Mr D on 3 September 2019. Support Worker 1 stated that Mr D had spent a few days lying in the corridor outside his flat. Mr D had told Support Worker 1 he had eaten a takeaway which had caused him extreme stomach pain. Support Worker 1 persuaded Mr D to return to his flat. Care Coordinator 1 noted when she saw Mr D that his self-care was bad, but he appeared in good spirits and accepted his depot as prescribed.

3.113 Mr D asked support staff to call an ambulance for him due to severe stomach pains on 26 September 2019. Paramedics arrived just before 3.00pm. Mr D was uncommunicative and resisted their requests for him to sit up. One of the paramedics found a number of Mr D's tablets under the sink. She asked why he had thrown them away to which he replied, "*I don't know*". Mr D was taken to hospital shortly before 4.00pm.

3.114 Mr D told the assessing ED staff that he had been experiencing "*burning*" upper abdominal pain for three days. He had no other physical complaints. The ED notes said, "*His main concern is that 'he wants to be sectioned', but won't say why. Says he was sectioned two years ago and was an inpatient at Fulbourn, but won't say why".* The assessing staff documented in the notes that they told Mr D they did not consider he needed sectioning, but he would likely benefit from input from social services. However, Mr D declined, and it was documented he had the capacity to refuse treatment. The discharge summary indicates psychiatric liaison services were not involved in the assessment or discharge.

3.115 Mr D was discharged from the ED without follow-up. The discharge summary was sent to his GP practice the same day.

3.116 Sanctuary staff did not see him again that day but Support Worker 1 saw him the following morning and Mr D advised he had returned the night before about 11.00pm.

3.117 Support Worker 1 emailed Care Coordinator 1 on 27 September 2019 to let her know what had happened. In his email he said Mr D seemed to be

[54] Fybogel: A laxative https://www.nhs.uk/medicines/fybogel-ispaghula-husk/

exaggerating his illness. Support Worker 1 informed Care Coordinator 1 he had asked Mr D's GP to contact him so he could update her on recent events.

3.118 GP 4 spoke to Support Worker 1 on 27 September 2019. He explained what had happened the day before and that Mr D had been taken to hospital by ambulance. Support Worker 1 advised tablets had been found near Mr D's vomit and it was concluded he had not been taking his medication.[55] GP 4 noted that Mr D has an appointment with Gastroenterology on 4 November. GP 4 planned to visit the following week.[56]

3.119 Support Worker 1 emailed GP 4 on 2 October 2019. His email contained a copy of the email he had sent to Care Coordinator 1 on 27 September 2019.

3.120 GP 4 saw Mr D and Support Worker 1 on 8 October 2019. Mr D's weight was stable. They discussed Mr D's medication; Mr D admitted he sometimes did not take tablets because he felt too "*sedated*". He said he was still drinking cola daily. GP 4 noted Mr D was losing teeth (three front upper and two at the back) because he was not brushing often. Mr D appeared calm and more reactive than usual. Support Worker 1 also noted Mr D seemed more interactive when he skipped his medication. It was noted Mr D had an appointment with the Gastroenterology team at the beginning of November. GP 4 planned to review Mr D in a month.

3.121 Support Worker 1 emailed the GP practice and Care Coordinator 1 on 11 October 2019 to advise that Mr D's Gastroenterology appointment had been brought forward from 4 November to 23 October 2019. He noted it was solely a consultation and Mr D was aware no procedures would be carried out.

3.122 Care Coordinator 1 saw Mr D on 15 October 2019. He had poor self-care and body odour. Mr D was chatty and pleasant but said he had not slept in over a week and experienced stabbing pains when he lay down. Mr D told Care Coordinator 1 that he had decided against having an endoscopy and was unsure if he would attend his appointment with the Gastroenterology team the following week because he felt they would be unable to help him. Care Coordinator 1 encouraged Mr D to attend the appointment. Mr D accepted his depot as prescribed. Care Coordinator 1 asked Support Worker 1 to let her know if Mr D attended his appointment with the Gastroenterology team.

3.123 Support Worker 1 emailed Care Coordinator 1 and GP 4 on 21 October to advise he continued to encourage Mr D to attend his upcoming appointment with Gastroenterology, but Mr D was very reluctant to attend and had been saying he did not feel up to it. Support Worker 1 had asked Mr D to give

[55] The notes do not say if Support Worker 1 said which medication had not been taken.

[56] 27 September was a Friday.

serious thought to attending the appointment and intended to discuss this with him again the next day.

3.124 Mr D attended his appointment with the Gastroenterology team on 23 October 2019. He was informed he did not need an endoscopy but was advised he needed to take his medication as prescribed at the correct times. Mr D did not require further monitoring by the Gastroenterology team and another appointment was not made, rather he was deemed suitable for follow-up with his GP every six to eight weeks. Mr D's GP practice was sent the clinic letter the same day. It included the request that Mr D remain on lansoprazole but stop taking ranitidine at lunchtime and only have it in the evening.

3.125 Support Worker 1 emailed Care Coordinator 1 and GP 4, on 24 October 2019, copying members of the Sanctuary Supported Living Housing team into the email (including Support Worker 2 and Housing Manager 1). Support Worker 1 gave details of the Gastroenterology appointment that had taken place the day before. He provided details of the assessment and advised no follow-up was required.

3.126 Care Coordinator 1 saw Mr D on 29 October 2019. He was warm and welcoming though a little low in mood about his stomach problems. He felt the Gastroenterology team had given up on him. Care Coordinator 1 assured Mr D that he could request an endoscopy if he changed his mind which he responded well to. He accepted his depot and thanked Care Coordinator 1 for attending.

3.127 Care Coordinator 1 saw Mr D on 11 November 2019. He was chatty and easy to engage. Care Coordinator 1 gave Mr D his depot medication as prescribed. She noted "… *the area between his bottom cheeks was very red, sore and nearing broken*". She suggested he speak to his GP about having some antibiotic cream or treatment before the skin broke and became infected. Care Coordinator 1 advised Mr D to have a bath or strip wash because there were "*faeces on his bottom*". No other concerns were identified.

3.128 A member of the Adult Locality team tried to call Mr D on 26 November 2019 to let him know Care Coordinator 1 was unwell. Mr D did not answer his phone therefore they called Sanctuary staff to advise that Care Coordinator 1 or another member of staff would attend the next day to administer Mr D's depot.

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3.129 Care Coordinator 1 was back at work and visited Mr D the morning of 27 November 2019 to administer his depot. Mr D was lying on the sofa, shaking and not talking. Mr D told Care Coordinator 1 "*I need sectioning*". Care Coordinator 1 asked Mr D if this was because he was in physical pain, to which he replied "*yes*". Mr D then sat up and placed both hands around Care

Coordinator 1's neck[57]. Care Coordinator 1 used breakaway techniques and went from Mr D's flat to the building office. Mr D followed Care Coordinator 1 who, with Support Worker 3, asked Mr D to accompany them into the office to discuss what had happened[58]. Mr D asked for a hospital admission, saying he needed to be sectioned. He said he would kill Care Coordinator 1, Support Worker 3[59] and Miss Y (who was not present).

3.130 Care Coordinator 1 contacted Consultant 1 to report Mr D had attempted to strangle her and said he needed to be in hospital. Care Coordinator 1 did not tell Consultant 1 that Mr D had threatened to kill staff and Miss Y; she told us this was because she was in shock at the time and forgotten he had said it because he had spoken very quietly. It was later, when speaking to the Police that she remembered.

3.131 They decided Mr D did not warrant a MHA assessment because he had requested a hospital admission. They agreed that Mr D should be urgently referred to the CRHTT.

3.132 Care Coordinator 1 tried to contact the CRHTT by phone but was told by the person she spoke to that the team was undertaking handover between 1.00pm and 2.00pm and no one was available to speak to. Care Coordinator 1 told the person she was speaking to that the matter was urgent but received the same response.

3.133 Care Coordinator 1 decided to attend the CRHTT office in person to request Mr D be assessed for an admission. She informed Mr D of her intentions, who agreed with the plan. Care Coordinator 1 and Support Worker 3 agreed that if Mr D's behaviour escalated, Sanctuary staff would call the police.

3.134 Care Coordinator 1 attended the CRHTT office where they undertook an assessment (for more detail please refer to section '27 November 2019', paragraphs 4.130-4.160) and agreed two members of the team would review Mr D the next day between 9.30 to 10.00am.

3.135 Care Coordinator 1 returned to Mr D's accommodation to tell Mr D that the CRHTT would visit him the next day. He was lying on the sofa in the communal area. Mr D apologised for "*lashing out*" and said he felt he could keep himself and others safe until the CRHTT appointment. She asked Mr D if he would return to his flat, to which he replied "*no*". Care Coordinator 1 told Mr D to call 111 or the emergency services if he felt unwell after Sanctuary staff

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[57] Care coordinator 1 told us Mr D placed his hands around her neck but applied no pressure. The Trust notes completed by a member of the CRHTT record Mr D's "*attempt to strangle her*". The Datix report completed by Care Coordinator 1 on 27 November 2019 says he put his hands round her throat "*quite forcefully*".

[58] Care coordinator 1 told us Mr D initially followed her out of his flat therefore they and Sanctuary staff asked him to accompany them to the office. This is in contrast to the notes completed by a member of the CRHTT which say Mr D "*has to be told to go back to his room 3 times*".

[59] Support worker 3 later stated in Court that he had not heard Mr D make a verbal threat towards the staff or Miss Y.

left for the day. She asked if knew where to get a phone if he needed one, to which he confirmed he did.

3.136 Mr D committed the homicide later the same day.

4 Discussion and analysis of Mr D's care and treatment

4.1 In this section of the report we consider Mr D's care and treatment and whether it was provided in line with Trust policy and best practice.

Risk assessments and risk management plans

4.2 The Healthcare Quality Improvement Partnership (HQIP, 2018) says 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*"[60].

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

4.4 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.

4.5 The Department of Health (2009)[61] 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 to 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."

4.6 Best practice in managing risk 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.

[60] https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-70-Mental-Health-CORP-Risk-Assessment-Study-v0.2.docx.pdf

[61] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

4.7 The Trust Clinical Risk Assessment and Management Policy (2015)[62] sets out several aims of risk assessment and management which include:

- *"Service users, staff and others are safeguarded.*
- *Wherever possible, the service user is involved in the planning and delivery of their care related to their personal level of risk.*
- *Indicators of possible increased risk, for example non-compliance with treatment or non-attendance at appointments are identified and addressed.*
- *Risks to service users, staff and others are communicated appropriately and in a timely fashion.*
- *Care plans reflect and address assessed levels of risk".*

4.8 The policy says risk assessment and management should be an ongoing, dynamic process subject to "*constant*" review. Further to this, certain events should prompt a formal review of a service user's risk assessment and management plan. These include *"a significant change in clinical, mental and or physical health condition, following a serious event or incident involving a near miss or actual incident … or any review of care provision e.g., CPA".* The policy references the Trust Care Plan Policy that states care plans should be reviewed, as a minimum, every six months.

4.9 The policy describes a number of information sources that should be referred to during the risk assessment process and the nature of information that should be recorded e.g., historic risk factors.

"An integrated treatment/care plan will identify the risks the service user presents, through their behaviours, cognitions, physical state, and disability as well as in which situations and organisational contexts the risks present. The plan will identify all the actions/interventions that are to be implemented to address those risks, the goal/aim of those actions/interventions and who will act/intervene and when. The type of action/intervention will be congruent with the clinical risk identified and consistent in the intensity with the level of clinical risk".

4.10 The service user's risk assessment and management plan should be recorded on RiO[63].

4.11 The policy says Trust staff should consider if other agencies should be informed when risk factors have been identified, but in the first instance this must be agreed with the Consultant Psychiatrist (Consultant 1) and the multidisciplinary team (MDT).

[62] The Trust reviewed and issued a revised policy in June 2019. The changes documented predominantly relate to children therefore we have referred to the policy that was in place for most of the period of care in this review. However, the 2019 policy does also include further reference to family engagement which we refer to later in this report.

[63] RiO: Electronic patient records system for healthcare providers.

4.12 The Trust Clinical Risk Assessment and Management in Mental Health Policy (June 2019) provides guidance in relation to risk of harm to another person:

"Where a serious risk of harm to the physical or mental health of another person is identified (e.g., to a relative or carer living with the service user) careful consideration must be given to taking action to alleviate that risk. Such action may involve discussion with the person at risk or with the police or other appropriate authority. Each case will be considered on the basis of its circumstances and will involve the balancing of the duty of confidentiality to the service user with the public interest in the protection of others. Such decisions are often difficult, and advice is available from the Safeguarding Team and through line management and clinical supervision structures".

4.13 The Trust gave us Mr D's risk assessment documentation completed between January 2018 and November 2019. Mr D's risk assessment was last updated on 7 November 2018. However, this was a crisis assessment therefore we also asked for the last risk assessment completed by Mr D's Care Coordinator; this was dated 12 October 2017.

October 2017

4.14 Mr D's risk assessment was completed by a locum Care Coordinator on 12 October 2017. Mr D's risks in the previous six months were:

- Act with suicidal intent (historic)
- Self-injury or harm (historic)
- Suicidal ideation (last six months and historic)
- Self-neglect (historic)
- Risk of neglect (last six months and historic)
- Risk of emotional/psychological abuse including bullying (historic)
- Risk caused by medication/service/treatment (last six months and historic)
- Violence/aggression/abuse to other clients (last six months)
- Violence/aggression/abuse to family (historic)
- Weapons (historic)

4.15 No new risks to others were identified on 12 October 2017. It was documented that Mr D had talked of assaulting staff and other patients in July 2016.

4.16 Factors affecting Mr D's risk were:

- Major life event (historic)
- Current mental state (last six months and historic)
- Discontinuation of medication (last six months)

- Housing status (historic)

4.17 The risk summary concluded that Mr D did not present with any risks to himself or others at that time.

4.18 It is difficult to comment on the October 2017 risk assessment because the time it was completed is out of scope for this review. Consequently, we have no information against which to assess whether the risk assessment was comprehensive or accurately reflected Mr D's risk at the time.

4.19 Mr D's risk assessment was not updated within the expected 12-month period; we would have expected a risk assessment to have been completed in October 2018.

November 2018

4.20 Mr D was referred to the Crisis Resolution and Home Treatment Team (CRHTT) in response to his behaviour on 5 November 2018. The progress notes completed by Social Worker 2 documented that Mr D expressed a desire to kill people, although he had not indicated how he intended to do this. Social Worker 2 wrote in the notes:

"… there is a risk that his behaviours may escalate if [Mr D] continues to feel this way. [Mr D] is very unpredictable and seems very anxious about what the future holds … [Mr D] has attempted to strangle [Support Worker 1] and made threats towards other residents which potentially puts his tenancy at risk".

4.21 The CRHTT assessed Mr D's risk on 6 November 2018 in response to his actions on 5 November 2018. It was documented that Mr D approached Support Worker 1 in the main office and made a strangling gesture towards him. Support Worker 1 was roughly 1–2 feet away from Mr D and they did not make contact. Mr D later attended the office with a fork in his hand and made a similar strangling gesture but was not close to staff at the time.

4.22 It is recorded in Mr D's progress notes that Support Worker 1 informed Care Coordinator 1 later the same day that Mr D had reported thoughts of killing others and named another service user. The service user's name was not recorded in the notes or risk assessment. Mr D was documented (in the progress notes) as later saying his comments were in relation to ongoing difficulties he had with this individual because they were loud in their flat. Again, the service user's name was not recorded in the notes.[64]

4.23 Two risk assessments were completed after the incident on 5 November 2018; one by Social Worker 4 and one by Senior Mental Health Practitioner

[64] The Safeguarding Adult Review examining Miss Y's care, indicates that she was named during this incident, but we have not been able to evidence this in the records we have seen.

(SMHP) 1, who undertook the CRHTT assessment on 6 November 2018. Both risk assessments were updated 7 November.

4.24 The two risk assessments are similar, in that they contain the same concluding narrative summary and plan, but are written by different authors and the individual supporting narratives, under each area of risk, are slightly different. We note the risk history differs between the two assessments. We set out the differences in the table below.

Table 2: Risk assessments conducted on 6 November 2018

	Risk assessment 1[65] – completed by Social Worker 4	**Risk assessment 2[66] – completed by SMHP 1**
Date of assessment[67]	7.46am on 7 November 2018	9.00pm on 6 November 2018
Updated	7.54am on 7 November 2018	8.10am on 7 November 2018
Harm to self	Self-neglect in last six months – yes	Self-neglect in last six months – no
Harm from others	Risk of neglect in last six months – no	Risk of neglect in last six months – yes
Harm to others	Violence/aggression to other clients ever – yes	Violence aggression to other clients ever – no
	Verbal threats in last six months – yes	Verbal threats in last six months – no
	Verbal threats ever – yes	Verbal threats ever – no[68]
	Violence/aggression/abuse to staff in last six months – no	Violence/aggression/abuse to staff in last six months – yes
	Violence/aggression/abuse to staff ever – no	Violence/aggression/abuse to staff ever – yes
	Risk to vulnerable adults in last six months – yes	Risk to vulnerable adults in last six months – no
	Risk to vulnerable adults ever – yes	Risk to vulnerable adults ever – no
Factors affecting risk	Current mental state in last six months – yes	Current mental state in last six month – no
	Discontinuation of medication in last six months – yes	Discontinuation of medication in last six months – no

4.25 The concluding summary – the CRHTT assessment – is the same in both risk assessments (see paragraphs 4.41-4.42).

4.26 Risk assessment 1, updated by Social Worker 4 at 7.54am, identifies eight different risk factors that risk assessment 2, updated by SMHP 1 at 8.10am does not identify. In addition, risk assessment 2 identifies three further risk factors that risk assessment 1 does not capture.

[65] This file was named Risk assessment 2 in the records provided to us by the Trust.

[66] This file was named Risk assessment 3 in the records provided to us by the Trust.

[67] The assessment took place on 6 November 2018. We use 'date of assessment' to mean when it was first recorded on RiO.

[68] The corresponding narrative in risk assessment 2, "*harm to others*", references verbal threats made by Mr D in July 2016 which preceded him assaulting another service user.

4.27 The Trust Patient Safety Manager told us that risk assessment 2, updated at 8.10am on 7 November 2018, would be the risk assessment first available to staff on RiO, but risk assessment 1 would be in the history (and available to staff). We were told the Trust expectation is that only one member of staff will update a risk assessment. The Trust was unable to account for the duplication.

Risk assessment 2

4.28 Below is further detail of risk assessment 2, the version first available to staff accessing Mr D's notes.

4.29 Under the category of "*harm to self*", no risk factors were identified in the last six months, but all were identified as historic factors[69]. However, risk of self-neglect is identified as an ongoing risk in the corresponding narrative. Mr D was noted to binge eat and then not eat for three days after.

4.30 Under the category of "*harm to others*" Mr D was identified as a risk of (in the last six months):

- violence/aggression abuse to other clients
- violence/aggression/abuse to staff

4.31 "*Violence/aggression/abuse to staff*" was documented as a historical risk (abuse to other clients was not), alongside "*violence/aggression/abuse to family*" and "*weapons*".

4.32 Mr D's risk assessment documented four incidents in 2016 when he was verbally abusive towards staff or other service users. Historic incidents of physical violence documented were:

- Mr D assaulted a service user in 2016;
- Mr D was violent towards his brother and "*went for him*" with a knife in 2002; and
- Mr D attempted to strangle his mother when she visited him as an inpatient in 2002.

4.33 One risk factor was identified as affecting Mr D's risk in the previous six months: 'refusal of services'. This is in conflict to the summary narrative which says Mr D had requested an inpatient admission roughly a week before (see paragraph 4.36).

4.34 This was also documented as a historical factor, in addition to Mr D's mental state, housing status and major life events.

[69] Act with suicidal intent, self-injury or harm, suicidal ideation, and self-neglect.

4.35 The summary in Mr D's risk assessment noted that he had been complaining of stomach pain for the previous six months and had not been eating or drinking properly or attending to his personal care. The assessment narrative described self-neglect as "*ongoing*"; however, "*self-neglect*" within the last six months was not documented under "*harm to self*". Mr D had declined to attend hospital appointments arranged to investigate his physical health concerns. It was recorded that Mr D's GP had assessed he had capacity to decline these interventions (the risk assessment does not provide further detail of the capacity assessment).

4.36 It was noted that Mr D requested an inpatient admission to Fulbourn roughly a week before he made the strangling gesture at Support Worker 1, but staff considered this was because he wanted treatment for his physical health concerns, and a psychiatric inpatient admission was inappropriate. Mr D reiterated his request for an inpatient stay during the assessment saying, *"I want to be sectioned"*. Mr D said this was because his physical health was impacting his mental health and quality of life. The assessing staff asked Mr D why he had not attended the medical appointments that had been arranged for him, to which he replied the hospital always sent him home.

4.37 Mr D told the assessing staff that the last time he had attended hospital (in April 2018) he had refused to leave and was escorted out by security, which had led to him falling and hitting his head. The assessing staff asked Mr D if it would be helpful if he was accompanied to his appointments which he agreed.

4.38 Mr D indicated that he was sorry for his behaviour towards Support Worker 1 the previous day and had since apologised to him. Mr D said there were "*many*" things he was dissatisfied with in his life and that he had no social networks. The assessing staff noted he had low self-esteem.

4.39 The assessing staff discussed with Mr D what he thought would be helpful for him. He initially indicated he wanted an inpatient psychiatric admission although later said this was for his physical health and/or chronic difficulties in his life. The assessing staff concluded these would not be addressed by such an admission. Mr D said he would like an enema and agreed he would liaise with his GP about this. The assessing staff advised Mr D that if he made further hospital appointments for his physical health, he should inform them of his mental health, with a view to them offering appointments less likely to have long wait times (e.g., first thing) or to arrange for someone to accompany him to the appointments.

4.40 The assessing staff offered to take Mr D to the local Emergency Department (ED) but told him it would likely be more appropriate if he arranged an outpatient appointment which Mr D agreed to.

4.41 The CRHTT identified three options in response to Mr D's behaviour:

- *"Informal admission to hospital*
- *Brief CRHTT support*
- *Continued existing support"*

4.42 They concluded Mr D should continue to receive their support with additional input from the CRHTT which should be fed back to the Adult Locality team and GP. The assessing staff noted:

"Ultimately, the majority of [Mr D's] reported issues are linked with his physical health and an inpatient admission would not alter this. [Mr D] is no longer voicing intent to harm others, he was remorseful of the recent events. CRHTT input is also not indicated at this juncture, again due to the chronicity of his complaints, although [Mr D] did confirm he would like us to contact both his GP and the Adult Locality Team to discuss the possibility of setting up an enema and to see if it is possible for professionals to assist him to attend physical health appointments".

4.43 The risk assessment was to be shared with the CRHTT, Mr D, Support Worker 1, his GP and the Adult Locality team.

4.44 Mr D's risk assessment was not updated again. We asked to see the last risk assessment completed before the crisis team assessment in November 2018, but this was not provided.

Ongoing assessment of risk

4.45 Prior to the incident on 5 November 2018, Mr D's risk assessment had not been formally updated since October 2017, although there are entries in the progress notes (e.g., after the incident on 5 November 2018). As we have noted, our review scope does not extend to 2017, therefore we have no knowledge of whether any significant events occurred which should have prompted a review of Mr D's risk assessment. However, in keeping with Trust policy, Mr D's risk assessment should have been formally reviewed every six months as part of the Care Programme Approach (CPA) process. There is no evidence in the risk assessment notes to reflect this happened. In accordance with Trust policy, the risk assessment should have been reviewed and updated in May and October 2018.

4.46 Equally, Mr D's risk assessment was not updated after the CRHTT assessment in November 2018. Care coordinator 1 told us she completed a risk assessment on 7 November 2018, which she shared with us, but said the record was overwritten by another member of staff. The Trust provided us with one risk assessment completed on 7 November 2018 – which we have previously referred to as risk assessment 1 (please see above). It is the same as that shared with us by Care Coordinator 1. We asked the Trust to review the record history to see if the risk assessment had been overwritten. We were advised there is no documentary evidence a risk assessment was started or amended by Care Coordinator 1 on 7 November 2018. The records

indicate a risk assessment was completed by Social Worker 4 from the CRHTT. Care Coordinator 1 was clear in her contact with us that she completed a risk assessment on 7 November 2018. We have been unable to resolve this discrepancy.

4.47 Mr D's risk assessment was not updated after his CPA review on 30 May 2019. Consultant 1's clinic letter to Mr D's GP practice in June 2019 described Mr D as:

"… stable, though at a very poor level of mental health. He remains at risk of deterioration, which would likely cause further deterioration in his physical health and self-care, with self-neglect, malnutrition and non-engagement with medical care being his main risks currently".

4.48 However, Mr D's risk assessment was not updated, nor a management plan put in place, to reflect Consultant 1's assessment.

4.49 We have identified further occasions, which in keeping with Trust policy that risk assessment and management plans should be updated in response to "*a significant change in clinical, mental and or physical health condition…*", should have prompted a review of his risk assessment and management plan. These include:

- Sleeping in the corridor over the weekend of 6 and 7 July 2018 (paramedics attended and identified no concerns).
- Laying in the corridor outside his flat and noted to have bad self-care in early September 2018.
- Concerns raised by support staff and GP 4 at the professionals meeting on 7 November 2018 that Mr D was not compliant with medication.
- Mr D told Consultant 1 during his CPA review on 21 November 2018 that voices were telling him not to eat.
- There were six occasions in 2018 and one in 2019 when Care Coordinator 1 noted Mr D had a 'ketone' smell to his breath.
- Mr D requested an ambulance on 26 September 2019. He was subsequently assessed and taken to the local hospital. He was discharged the same day.

4.50 Prior to the incident in November 2018, Mr D's risk assessment had not been updated for over a year. This was not in keeping with Trust policy.

4.51 Mr D's risk assessment was updated in response to his behaviour on 5 November 2018. This was in keeping with Trust policy. However, the fact that two risk assessments were completed for the same incident is confusing. The Trust was unable to give an explanation as to why two risk assessments were completed following Mr D's assessment. Risk assessment 1 identified more risk factors, including "*risk to vulnerable adults*" and "*verbal threats*". Risk

assessment 1 says Mr D was "*reporting having thoughts to kill others. He named another service user… he later explained he has ongoing difficulties with this service user due to how loud they are…".* Risk assessment 2 says Mr D had "*… voiced wanting to kill people*". Risk assessment 2's corresponding narrative does provide more information, including detail of verbal threats in 2016 and historical physical violence, but neither assessment clearly sets out that Mr D had said he wanted to kill another resident or who this was. It is recorded in the progress notes on 5 November 2018 that Mr D threatened to "*kill another resident*". The CRHTT assessment (not the risk assessment) dated 6 November 2018 says, *"He continues to have problems with one other resident [misspelling of Miss Y's name], and this is due to the amount of noise she makes, and she lives in the flat above [Mr D] …".* It is reasonable to assume these notes collectively are referring to Miss Y, but we do not consider Mr D's risk assessments clearly captured that he had made a verbal threat against her, and the detail was not recorded in the progress notes. Risk assessment 2 – the version first available to staff - made no reference to other residents and/or Miss Y being threatened.

4.52 Mr D's risk assessment was not updated again in the next 12 months, prior to the incident, despite there being several occasions which should, under Trust policy, have prompted a review. Care Coordinator 1 told us she regularly updated Mr D's risk assessment and was surprised the records we were given suggested otherwise. She told us that she was unable to access Mr D's historic records therefore could not check the records. Care Coordinator 1 told us she completed a risk assessment in 2018 but it had been overwritten by staff completing the risk assessment in November 2019. We asked the Patient Safety team to check the records again in relation to this point. They advised that the risk assessments given to us were the only ones available.

4.53 Mr D's care plan, completed in June 2019, contained a risk screening section. It identified that Mr D could be a risk to himself in terms of poor self-care and dietary habits. Under "*risk to others*" no contemporary risks were identified but the following was recorded, and it was noted Mr D "*… had no plan or intent to harm anyone*".

4.54 Service Manager 1 for Sanctuary told us that Mr D's risk assessment and management documentation did not change, despite Mr D's problems not being resolved. Consequently, Sanctuary staff found it difficult to formulate a plan to manage Mr D's problems. There is no evidence in the notes this was raised with the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Adult Locality team.

Finding: Mr D did not have an up-to-date, comprehensive formal risk assessment and management plan at the time of the incident.

Finding: Mr D's most recent risk assessment did not clearly identify him as a risk to vulnerable adults (currently or historically) or having made

verbal threats, despite his actions on 5 November 2018. This is in contrast to the risk assessment completed at the same time by another assessing member of the CRHTT, which identified Mr D as a current and historic risk to vulnerable adults.

Recommendation 1: The Adult Locality team should review the notes of all service users under the Care Programme Approach (CPA) with a view to ensuring all documentation (for example, risk assessments and care plans) has been completed in line with Trust policy, within the required timeframe, and reflect the service user's broader needs and long-term plans. The team should implement a programme of audit to ensure service user documentation continues to be completed in accordance with expected practice.

Care planning and CPA

4.55 The Care Programme Approach (CPA) is a package of care offered to support mental health service users. It is intended to act as a framework to identify individual needs and a goals, with a view to providing support, and is underpinned by a care plan. Care plans can cover a broad number of areas including physical health, medication, housing and social support.[70]

4.56 NHS England's personalised care and support planning handbook (2016)[71] defines personalised care and support planning as:

"… *a process in which the person with a long-term condition is an active and equal partner. The process should normally be recorded in a personalised care and support plan: but this plan is only of value if the process has taken place effectively.*"

4.57 The Care Coordination Association (CCA)[72] defines a care plan as:

"*A plan that describes in an easy, accessible way the needs of the person, their views, preferences and choices, the resources available, and actions by members of the care team, (including the service user and carer) to meet those needs. It should be put together and agreed with the person through the process of care planning and review.*"[73]

4.58 The CCA says a care plan is:

- A written record of a plan of action negotiated with the person to meet their health and social needs.
- Something which sets out who is doing what, when and why.

[70] CPA and care planning: https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

[71] Personalised care and support planning handbook: https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf

[72] Care coordination association: http://www.cpaa.org.uk/

[73] CCA handbook: http://www.cpaa.org.uk/writing-good-care-plans-handbook.html

- A tool to support the safety of the service user and others.
- Based on a thorough assessment of need.
- Produced in partnership with all those concerned.
- Coordinated by the most appropriate person, such as the Care Coordinator or lead professional.

4.59 The Trust CPA policy (2014)[74] sets out a number of criteria to identify whether a service user should be under CPA, although it stresses the list should not be considered exhaustive. Criteria include:

- *"The service user has a severe mental disorder (including personality disorder with a high degree of clinical complexity/complex needs …*
- *There are current or potential risk(s) to themselves or others including:*
    - *… self-neglect/non-concordance with treatment plan.*
- *The service user is experiencing significant disadvantage or difficulty as a result of:*
    - *… physical health problems/disability".*

4.60 The policy describes assessment as a holistic, ongoing person-centred process:

"… an initial assessment of the individual is likely to focus on immediate concerns as well as the assessment and management of risk, and then the on-going assessment process will focus on a more holistic exploration of longer term concerns and goal, and the assessment will be reviewed and updated accordingly".

4.61 The care plan should explore:

- *"Mental health needs and physical health needs, including medication and substance misuse.*
- *Social care needs, including employment, education/training, housing and living arrangements and finances (where appropriate).*
- *Personal relationships and emotional needs including social inclusion/social contacts.*
- *Other needs such as spiritual, religious or cultural needs.*
- *Those needs arising from the statutory requirements of the Mental Health Act … ".*

4.62 Care Coordinators have the primary responsibility of managing service user's care, allocating resources and coordinating the delivery of care.

[74] The CPA policy was due for review in 2017; the Trust confirmed it was the policy in place 2018-2019.

4.63 The policy says reasonable attempts should be made to involve the service user, their family and/or carer. The policy sets out that risk assessment may need to be more a more detailed clinical risk assessment, but any risks and their management should be recorded in the care plan.

4.64 A care plan should be the primary means of communicating the plan to the service user and other parties involved in delivering the care. Services users under CPA will have a "*formal, comprehensive*" care plan. It should be clearly written and user friendly. The service user should be provided with a copy of their care plan, which should also be shared with the service user's GP and other relevant agencies. The care plan should set out:

- "*The assessment and identified needs of the individual.*
- *The goals and desired outcomes of the plan.*
- *The interventions and action required to meet the identified needs, linked to specific goals.*
- *How risks will be managed and reviewed (where this is appropriate).*
- *The responsibilities of the people involved in delivering the interventions.*
- *The dates these will be reviewed.*"

4.65 Services users under CPA should also have a contingency or crisis plan. Care plans should be reviewed, as a minimum, every six months. Care plans should also be reviewed in response to changes in the service user's conditions, circumstances or risk.

Mr D's care plan

4.66 Mr D was under CPA and his last CPA review took place with Care Coordinator 1 and Consultant 1 on 30 May 2019. The notes indicate they subsequently spoke to Support Worker 1 as part of the review process. The copy of the care plan we were given was undated[75] but the Trust confirmed it was updated on 4 June 2019.

4.67 Mr D's care plan was divided into four areas: managing risk; physical, medical and smoking; social circumstances; and compliance with medication (though the associated goal is not included). The care plan sets out the involvement of Sanctuary staff and the GP practice in monitoring Mr D's wellbeing and physical health. Mr D had a crisis and contingency plan. The plan detailed Mr D' relapse indicators/warning signs - panic attacks, persecutory delusion and expression of suicidal ideas - and set out the contact details of agencies he should contact should be become unwell (e.g., the Adult Locality team and his GP). The care plan recorded that Mr D continued to experience daily stomach pains and that he was thinking about attending his Endoscopy appointment,

[75] The date on the care plan automatically updated to the date when it was downloaded for our investigation (2021). The scheduled review date listed in the care plan (December 2019) correlates with a June 2019 review.

which he had previously refused to do. The plan also recorded that Mr D found Sanctuary staff were unsympathetic and unhelpful.

4.68 Mr D's care plan focuses on his physical health and acknowledges his ongoing reluctance to attend his Endoscopy appointment. Mr D consistently refused to attend medical appointments, but the care plan sets out little intervention in response to this. Nor is there evidence of exploring Mr D's refusal with him, for example, discussing with Mr D what might help him to attend the hospital. The progress notes indicate discussions were ongoing with Mr D and that his GP in particular had discussed various options with him, but these were not reflected in his care plan. There is no guarantee interventions would have worked, but by documenting and testing them, staff would have been working methodically with Mr D to achieve his hospital attendance.

4.69 Similarly, Mr D's eating habits significantly contributed to his stomach problems but there is no evidence of a plan to address his eating habits, other than checking once a day that he was eating. There is no evidence Trust or Sanctuary staff developed a healthy eating plan with Mr D, explored whether he could cook, or if he was confident shopping for groceries. Again, there is evidence healthy eating was discussed with him by his Care Coordinator and GP, but there is no evidence a plan was agreed with Mr D.

4.70 Interventions in response to the care plan goals are limited in scope e.g., "*Staff at* [provider] *to offer support to* [Mr D] *to attend any appointments at the* [*GP/clinic/*local hospital] *appointments and liaise with Care Coordinator … staff to check on* [Mr D] *at least once a day, if he has not been seen, to ensure he is eating/drinking/taking meds, managing his pain etc.*"

4.71 As noted, Mr D's care plan mainly focused on his physical health, specifically his stomach complaints and pain. Given the ongoing nature of his complaints, this was not unreasonable. However, there were other areas which should also have been taken into consideration, with a view to developing a holistic care plan with Mr D. These include:

- Mr D's lack of social engagement or social network – he rarely left his flat.
- Mr D's dental care (the GP notes indicate he was losing teeth due to poor dental care).
- Mr D's poor personal hygiene.
- Mr D's placement at Sanctuary Supported Living (and whether it was appropriate).
- Mr D's engagement with Sanctuary services.
- Mr D's complaint that his schizophrenia was worse (this was recorded in the care plan under "*client view*" but no interventions identified).

- Long-term plans for Mr D (e.g., employment, education, activities).

4.72 Care Coordinator 1 received regular supervision, as per Trust policy, and this would have been a key opportunity to develop Mr D's care plan (and review Mr D's risk assessment and management plan). However, the notes do not indicate concerns were raised in relation to managing Mr D or developing a plan for him; the Adult Locality Team Manager told us anecdotally that concerns about Mr D were primarily related to his physical health. Care Coordinator 1 told us she did not feel the need to discuss Mr D during clinical supervision because she discussed his care with Consultant 1, Support Worker 1 and GP 4 on many occasions.

4.73 Mr D's care package included funded social care hours/support from Sanctuary staff which he did not utilise. This was a source of frustration to Sanctuary staff, and Mr D's care plan reflected he found staff "*unsympathetic* [and] *unhelpful*", and that they had reportedly threatened him with eviction. Mr D's placement was conditional on him utilising his care package yet there is no evidence this was factored into his care plan or formally reviewed, particularly in relation to addressing some of the points above (e.g., taking Mr D to the dentist). Equally, there is evidence in the notes of Care Coordinator 1 challenging Sanctuary staff about their attitude towards Mr D, but his relationship with Sanctuary staff is not included in the care plan – either in terms of improving the relationship or utilising staff to help him address basic care needs (e.g., personal hygiene).

4.74 The care plan does reflect some element of the role of Sanctuary staff in implementing Mr D's care plan, but as set out above, they could have been more broadly involved in developing a holistic care plan with Mr D. If Mr D's relationship with Sanctuary staff and their attitude towards him was an inhibiting factor this in turn should have been addressed in the care plan.

4.75 There is evidence that the Trust sought to involve Mr D's GP in his care planning and physical health management. The Adult Locality team invited the GP practice to attend Mr D's CPA review in May 2019. The CPA invitation asked the GP practice to provide feedback about Mr D's medication and a patient summary, including physical health information, if no one from the practice was able to attend the review. The team subsequently sent the practice the outcome of the assessment and the accompanying clinic letter.

4.76 Mr D's family were not involved in his care plan; however, the notes indicate that he was estranged from them.

Finding: Mr D's care plan was limited in scope and did not reflect a holistic approach to his care needs. Interventions were largely limited to monitoring and offering support to Mr D, as opposed to proactive interventions and future planning.

4.77 We have previously made a recommendation in relation to service user documentation and audit. Please refer to recommendation 1.

Mr D's capacity

4.78 Guidance regarding the assessment of capacity is provided in the Mental Capacity Act (MCA) 2005 Code of Practice (2007)[76] which gives information and guidance about how the Act works in practice.

4.79 People may lack capacity to make some decisions for themselves but will have capacity to make other decisions. It is also the case that a person who lacks capacity to make a decision for themselves at a certain time may be able to make that decision at a later date. A person's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it needs to be made.

4.80 When assessing capacity to make more complex or serious decisions there may be a need for a more thorough assessment (perhaps by involving a doctor or other professional expert). Significant, one-off decisions (such as moving house) will require different considerations from day-to-day decisions about a person's care and welfare. However, the same general principals should apply to each decision.

4.81 Capacity should be assessed when:

1. "*the person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision*
2. *somebody else says they are concerned about the person's capacity, or*
3. *the person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works, and it has already been show they lack capacity to make other decisions in their life.*"

4.82 It is good practice for professionals to carry out a proper assessment of a person's capacity to make a particular decision and to record the findings in the relevant professional record.

4.83 An assessment of a person's capacity to consent or agree to the provision of services will be part of the care planning process and should be included in the relevant documentation.

[76] MCA code of practice: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Mr D's capacity

4.84 We specify below points during Mr D's care when his capacity was referenced in his notes.

31 October 2018

4.85 Care Coordinator 1 referred Mr D to the local Safeguarding team. The team queried whether Mr D's capacity had been assessed, to which Care Coordinator 1 replied:

"*I have not done a capacity assessment formally at this stage, but I think he does have capacity to make decisions around his health*".

4.86 Care Coordinator 1 indicated she would discuss Mr D's capacity with his GP, and the Safeguarding team asked to be informed of any outcomes. No formal assessment of capacity was documented in the notes.

1 November 2018

4.87 GP 4 recorded in the notes that she had spoken to Care Coordinator 1 who had advised that the GP should assess Mr D's capacity during a home visit that day.

4.88 GP 4 concluded that Mr D needed a capacity assessment in relation to his indecision to have an endoscopy. GP 4 wrote in the notes:

"*… I don't think [Mr D] can demonstrate capacity regarding the decision of his physical health, in particular going to hospital for physical assessment and management … I think a joint meeting is needed and a formal psychiatrist assessment/mental capacity assessment is needed*".

4.89 GP 4 wrote in the notes that they had passed this message back to Care Coordinator 1 and the Adult Locality team. The progress notes reflect Care Coordinator 1 received a voicemail from GP 4 on the morning of 1 November 2018 which indicated GP 4 would do a capacity assessment that day. However, any subsequent contact from GP 4 that day is not recorded. It is not recorded in the progress notes that GP 4 made contact again after the home visit on 1 November to advise she did not think Mr D could demonstrate capacity and warranted a formal capacity assessment from his mental health team. The GP notes indicate contact was made less than two hours later the same day, saying a Professionals meeting had been arranged to take place at the GP Practice the next week (this is referred to in the progress notes on 2 November 2018).

2 November 2018 (morning)

4.90 Mr D was removed from the 'red zone' on 2 November 2018. It was recorded in the notes:

"*GP did capacity assessment. Confirmed he does have capacity*".

4.91 We have been unable to ascertain how or when this was communicated to the Adult Locality team. Care Coordinator 1 told us she received a voicemail from GP4 which said Mr D had capacity. We set out more detail in paragraph 4.96, but GP 4 told us she did not undertake a capacity assessment on 1 November 2018.

2 November 2018 (afternoon)

4.92 Care Coordinator 1 spoke to a member of staff from the CRHTT and advised that GP 4 deemed Mr D to have capacity to refuse an admission or attend appointments:

"*I updated [CRHTT staff] with the current situation regarding [Mr D's] physical health and the concerns we have about him and let him know that [GP 4] has deemed [Mr D] to have capacity at this current time, to refuse admission to Addenbrookes or to attend further appointments there, with support*".

7 November 2018

4.93 Social Worker 4 wrote in the notes:

"*The GP has very recently done a Mental Capacity Assessment and assessed that [Mr D] has capacity to decline interventions*".

7[77] November 2018

4.94 Consultant 1 wrote in the notes after the professionals meeting:

"*He [Mr D] appears to have capacity to make treatment decisions*".

21 November 2018

4.95 Consultant 1 wrote in their clinic letter (dated 23 November 2018) to GP 4 after Mr D's medical review:

"*He was assessed to have capacity to decline investigations and inpatient admission when discussing this with you as well as with [Care Coordinator 1] in recent weeks … his mental state appears to fluctuate and in my view, his capacity does as well. He appears to have a reasonable understanding of the consequences of refusing to eat and further investigations and thoughts about wishing to end his life appear to fluctuate … Our agreed treatment plan is therefore to continue monitoring his physical and mental health as well as his capacity to make decisions about his treatment*".

4.96 We spoke to GP 4 about the assessment she undertook on 1 November 2018. GP 4 told us she did not undertake a full capacity assessment, rather her focus was on whether Mr D had capacity at that time to make a decision

[77] The notes were updated on 16 November, but it is not obvious what is new information.

about his immediate hospital treatment. GP 4 relayed her concerns to the Adult Locality team, with a view to it undertaking a full psychiatric assessment; consequently, the team arranged and held a professionals meeting on 7 November 2018.

4.97 We have been unable to ascertain why GP 4's conclusion that Mr D warranted a formal capacity assessment was not noted and actioned by the team. There is clear evidence the two agencies were in regular contact and were working together in relation to Mr D's physical health and wellbeing, for example at the professionals meeting on 7 November 2018. However, there is no entry in the notes to reflect GP 4's concern that he did not have capacity to make decisions about his physical health in early November 2018, rather the reverse: it was recorded at least three times in the notes by Adult Locality team staff that Mr D's GP considered he had capacity. However, there is no documentary evidence to substantiate this view (e.g., a documented assessment process).

4.98 Mr D's capacity is not referenced again in the progress notes after November 2018 until June 2019 as part of a CPA review. Consultant 1 wrote in the notes that Mr D "*… showed good insight into his fears that he had* [an additional serious illness] *being part of his illness and retained capacity to make decisions about his treatment*". His care plan said "[Mr D] *has capacity to make decisions relating to his care and treatment*".

4.99 We would have expected Mr D's capacity to have been subject to regular review in addition to being part of his CPA review.

22 February 2019

4.100 A member of the Multi-Agency Safeguarding Hub (MASH) emailed Care Coordinator 1 about a safeguarding referral she raised in October 2018. The author wrote "*it appears as* [Mr D] *has capacity …* ". There is no detail of what evidence was reviewed to make this assessment.

Finding: Mr D's GP concluded in early November 2018 that he might not have capacity to consent to treatment and warranted a capacity assessment from his mental health team.

Finding: There is evidence that GP 4 contacted the team after the home visit and a professionals meeting was arranged. However, there is no evidence in the progress notes that the team received GP 4's concern that Mr D might not have capacity and needed to be assessed further, rather it was documented at least three times in the days that followed that GP 4 considered Mr D did have capacity.

Finding: There is no evidence in the notes that Mr D's capacity was subject to regular monitoring after the professionals meeting in November 2018. It was reviewed at a CPA meeting in June 2019.

Recommendation 2: In instances where concerns about a service user's capacity have been raised, capacity must be assessed, reviewed and documented at CPA meetings and, if assessed as requiring ongoing monitoring, documented at agreed intervals.

Multi-agency engagement

4.101 The terms of reference extend to considering referral arrangements, communication and inter-agency working within the NHS and with partners who had contact with Mr D.

Sanctuary Supported Living[78]

4.102 Sanctuary Supported Living is commissioned by the local authority to provide support across a range of accommodation as part of the Mental Health Supported Accommodation Pathway. Personalised support hours delivered by Sanctuary are commissioned via a delegated budget from the local authority to the Trust. Any significant changes in support must be agreed by Sanctuary staff, the Care Coordinator and a Social Worker Manager. Service user support packages should be reviewed, at a minimum, once a year by the Trust as part of the Section 75 partnership agreement[79] with the local authority.

4.103 The nature of support Sanctuary offers varies from intensive to low level. Intensive services are up to 13 hours a week per client, although not necessarily all face to face. Mid-level services are six to seven hours support, low-level are one to three hours.

4.104 Mr D had a self-contained flat with support provided by Sanctuary. He was on an assured tenancy (which meant his residence was not dependent on engaging with Sanctuary services) and was a recipient of low-level services.

4.105 We spoke to a Service Manager for Sanctuary who told us Mr D's support package was minimal and largely focused on encouraging him to take his medication. The team also supported Mr D to attend medical appointments and manage his budget.

Escalating concerns

4.106 We were told by the Trust and Sanctuary that any concerns the latter might have in relation to a resident/service user would first be escalated to the Care Coordinator. Equally, if members of the Adult Locality team had concerns the expectation was that these would be raised directly with Sanctuary staff.

[78] Sanctuary supported living: https://www.sanctuary-supported-living.co.uk/

[79] Section 75 Agreement: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/better-care-fund-support-offer/

4.107 There is evidence in the notes of Care Coordinator 1 raising concerns with the Sanctuary staff about Mr D's wellbeing, but also about how staff engaged with Mr D. Equally there is evidence Sanctuary staff raised concerns with Care Coordinator 1, particularly about Mr D's unwillingness to engage with support services. However, we have not seen evidence of further steps being taken in relation to these concerns. For example, there is no evidence in the notes to indicate the Adult Locality team or Sanctuary staff discussed Mr D's care package in terms of whether it was best suited to his needs or if there were alternative options, which could be expected given his lack of engagement with Sanctuary services.

4.108 Service Manager 1 told us that any concerns raised by Care Coordinator 1 about Sanctuary staff were fully investigated and discussed with the relevant individuals during supervision.

4.109 Sanctuary and Trust staff escalated concerns about Mr D's physical health with his GP practice. However, we note there were exceptions to this. In particular there were six[80] occasions in 2018 and one on 16 April 2019 when Care Coordinator 1 identified a 'ketone' smell to Mr D's breath, but there is no evidence she raised this with is GP. A 'ketone' smell can be indicative of diabetes, and we would have expected this to have been raised by Care Coordinator 1 with Mr D's GP (and documented in the notes).

4.110 Additionally, Care Coordinator 1 told us she repeatedly raised concerns about Mr D's weight with Sanctuary staff, asking that they liaise with his GP to prescribe nutritional drinks, but this did not happen for several months.

Referral arrangements

4.111 It is extensively documented in Mr D's progress and GP notes that he experienced significant physical health problems which required input from acute services.

4.112 There is evidence in the notes of Care Coordinator 1 and Support Worker 1 liaising with the GP practice when they had concerns about Mr D's physical health. GP 4 made a number of referrals to acute services for Mr D. The notes indicate such referrals were submitted promptly following contact from Trust or Sanctuary staff.

Communication

4.113 There is evidence in the notes that Trust staff, Mr D's GP and Sanctuary staff routinely communicated by email, phone and in person. Service Manager 1 told us there were regular emails and meetings with Care Coordinator 1. The

[80] 3 April 2018, 29 May 2018, 26 June 2018, 24 July 2018, 4 September 2018 and 30 October 2018.

Adult Locality team shared documents (e.g., the CRHTT risk assessment and clinic letters) with the GP practice.

4.114 There is also evidence of the agencies working collaboratively. For example, in November 2018, when GP 4 raised concerns about Mr D's capacity, it was agreed with the Adult Locality team that a professionals meeting should take place, which was attended by GP 4 and Sanctuary staff. However, we note that the Adult Locality team misunderstood an element of GP 4's concerns – going on to record in the notes that GP 4 considered Mr D had capacity which was not the case, rather she wanted the team to formally assess his capacity.

4.115 Similarly, Consultant 1 and GP 4 liaised together when they identified discrepancies in Mr D's prescription.

4.116 The notes indicate that Care Coordinator 1 was willing to raise concerns with Sanctuary staff about their practice. For example, in June 2018, Care Coordinator 1 challenged Support Worker 1 about his approach with Mr D. Support Worker 1 in turn said he would reflect on the feedback. Care Coordinator 1 also raised her concerns with Sanctuary management, but we have not seen evidence in the notes that the matter was discussed within the Adult Locality team. Service Manager 1 told us she did not think Care Coordinator 1 and Support Worker 1 always saw eye to eye, but they dealt with their differences professionally.

4.117 Support Worker 1 usually accompanied GP 4 to see Mr D in his flat.

Inter-agency working

4.118 There is extensive evidence in the notes of Trust staff, Sanctuary staff and Mr D's GP practice liaising about his wellbeing and physical health. Sanctuary staff attended Mr D's CPA meetings and his GP practice submitted information for the reviews.

4.119 Service Manager 1 was complimentary about the Adult Locality team's engagement and availability but noted that Mr D's risk assessment and management documentation did not change. They told us the documents were not updated in response to incidents which meant it was difficult for the Sanctuary team to formulate a support plan with Mr D because his mental health treatment plan did not change (despite his behaviour not improving). However, there is no evidence in the notes that this was raised by Sanctuary staff with Trust staff, despite the volume of ongoing communication between both parties.

4.120 Trust and Sanctuary staff we spoke to were complimentary about GP 4, noting her responsiveness, regular attendance to see Mr D at home, and engagement with other services. We agree the GP notes indicate GP 4 was proactively trying to work with Mr D to ensure he received treatment for his physical health issues. These included liaising directly with the hospital

gastroenterology team and offering to Mr D that they could request a private room on his behalf with a view to reducing his stress when attending hospital. We have discussed GP engagement in more depth under 'Primary care' (paragraphs 4.173-4.184).

Finding: Trust staff and third partner agencies were in regular contact about Mr D. However, whilst concerns identified by any agency were usually raised promptly, these were not always productively managed, or a clear plan formulated. There is evidence Care Coordinator 1 had concerns about the support provided to Mr D by Sanctuary staff, but these concerns were not formally escalated and managed. Equally, there is no evidence to suggest the Adult Locality team explored Mr D's care package with Sanctuary staff and whether it was suited to his needs, given his reluctance to engage with services.

Communication with Mr D and his family

4.121 In the 'Risk assessment and risk management' section of this report we referred to the 2015 Risk Assessment Policy because it covered most of Mr D's period of care under review. The policy says that where possible, and appropriate, staff should seek to involve families in a service user's care.

4.122 The 2019 version of the policy (Clinical Risk Assessment and Management in Mental Health Services) includes a section called 'Communication and working with families'. The policy says staff must:

"*… collaborate with and involve the service user, their family and carers in the risk assessment process, risk management, and any safety planning unless there are clear reasons this is not possible or not clinically indicated (in which case these must be documented)*".

Staff must also:

"*… carefully consider the role of family members and other close relationships in the well-being of service users. Close relationships can be protective factors or can be risk factors … staff will therefore need to think carefully and deliberately on a case to case basis about how best to collaborate with the service user and involve family and carers in the assessment and management of risk for the service user … ".*

Mr D's family

4.123 Mr D's risk assessment recorded that his father died in 2004 and his mother died in 2009. Mr D's older care plan (2012) indicated he regularly saw his aunt and grandfather, and was in telephone contact with his brother, but his most recent care plan (June 2019) indicated no contact with his family. Anecdotally, we understand Mr D was estranged from his brother.

4.124 There is no evidence in Mr D's notes that he was in contact with his family or asked the Adult Locality team to contact them on his behalf.

4.125 We wrote to Mr D's family via Sanctuary Supported Living. Sanctuary was unable to share the family details because of data protection but agreed to pass on our correspondence. We did not receive a response.

Finding: Historically, Mr D had not had contact with his family and there is no evidence he either sought or asked the Adult Locality team to facilitate their involvement in his care and treatment. The Trust had no contact with Mr D's family between January 2018 and the incident in November 2019.

Communication with Mr D

4.126 Mr D's care plan included fortnightly review by Care Coordinator 1. Care Coordinator 1 saw Mr D at least every couple of weeks, to administer his depot and check his wellbeing. In instances when Care Coordinator 1 was not able to see Mr D, he was informed and given another date, or another member of the team visited. The notes reflect regular contact with Mr D.

4.127 Care Coordinator 1 saw Mr D as planned in the weeks preceding the incident:

- 15 October 2019
- 29 October 2019
- 11 November 2019
- 27 November 2019

4.128 We have previously detailed GP 4's engagement with Mr D under primary care, and that this was viewed positively by other agencies.

4.129 The notes indicate that Care Coordinator 1 sometimes had concerns about how Sanctuary staff engaged with Mr D, and that on at least one occasion she had asked Mr D if he wished to make a complaint (he did not).

Finding: Trust staff and partner agencies regularly communicated with Mr D throughout the period of care reviewed. Care Coordinator 1 met Mr D fortnightly, in accordance with his care plan.

27 November 2019

4.130 We have previously set out in the chronology the events of 27 November 2019 which began with Mr D placing his hands around Care Coordinator 1's neck.

Care Coordinator 1's response to Mr D's assault

4.131 Care Coordinator 1 phoned Consultant 1 after Mr D had placed his hands around her neck to discuss what action they needed to take in response to his behaviour. Consultant 1 provided us with a statement she wrote shortly after

the index offence. It set out the rationale behind the decision to refer Mr D to the CRHTT, specifically:

- A similar event had occurred on 5 November 2018 when Sanctuary staff contacted the police who did not attend (Mr D did not make physical contact on this occasion). Mr D was subsequently referred to the CRHTT the outcome of which was that he was discharged to the Adult Locality team for regular follow-up.
- A Mental Health Act (MHA) assessment was considered inappropriate because Mr D had requested a hospital admission.
- They did not think it was necessary to involve the police because they inferred from their previous experience of him, that his behaviour was "… *driven by psychosis and distress*".
- They judged the risk of Mr D harming anyone to be low based on his previous history.

4.132 Consultant 1 and Care Coordinator 1 agreed Mr D should be urgently referred to the CRHTT with a view to him being considered for an admission. Consultant 1 advised that the call was less than five minutes. There is no evidence in the statement to indicate Care Coordinator 1 told Consultant 1 that Mr D had make threats to kill her, Support Worker 3 or Miss Y. Care Coordinator 1 told us that she did not tell Consultant 1 that Mr D had made threats to kill because she was in shock, and had forgotten what he had said. It was later, when speaking to the police, that Care Coordinator 1 remembered what Mr D had said. She told us she had not considered what Mr D had said to be a threat because he had whispered and been difficult to hear.

4.133 Care Coordinator 1 told us she had tried to urgently refer Mr D to the CRHTT by telephone, describing the matter as urgent, but was told by the individual taking the call that the team was overseeing its handover and was unavailable[81]. As a result, she decided to attend the office, which was relatively close to Mr D's accommodation, in person.

4.134 Care Coordinator 1 told us she considered the plan that the CRHTT see Mr D in the morning to be reasonable based on the following:

- Mr D's behaviour was out of character.
- Mr D had calmed down by the time she saw him in the common room (we do not know what time Care Coordinator 1 returned to the property, other than it was before 4.00pm because she asked Mr D if he would be able to

[81] It was documented in the Datix report for the incident that Care Coordinator 1 had been told when she rang the CRHTT that the team was in handover and could not be disturbed.

keep himself and others safe after this time, when Sanctuary staff would go home).

- Mr D was remorseful and apologised for his actions.
- Mr D responded to questions and advised he was able to keep himself and others safe until the assessment[82].
- Mr D was happy to wait for the assessment the next day.

4.135 Care Coordinator 1 told us the plan had been collectively agreed with the CRHTT and Consultant 1, and that Mr D's behaviour no longer gave cause for concern. Consultant 1 also told us the decision to see Mr D the next day was routine and not something she was concerned by.

4.136 Care Coordinator 1 did not report Mr D's actions to the police. She told us she was not frightened by Mr D's actions and although he placed his hands around her neck, it was without pressure. However, we note the Datix report she completed described him placing his hands around her throat "*quite forcefully*" and that she had to implement breakaway techniques.

4.137 Modern Matron 1 (in his role as CRHTT Manager at the time) told us he asked Care Coordinator 1 at the CRHTT office why she had not reported Mr D to the police, to which she said she had discussed the incident with Consultant 1 and had not felt threatened. Care Coordinator 1 told us she was asked if she had contacted the police, but no one from the CRHTT told her she should call the police. CRHTT staff did not contact the police themselves in response to the Care Coordinator's decision.

4.138 We note that the Trust Managing Violence and Aggression Against Staff Policy (2018), on what staff should do in response to an assault by service users, is conflicting. The policy says:

*"Any staff member who has been subject to violence and/or aggression resulting in physical assault **has the right to report** [our emphasis] the incident to the police and will be supported by the police to do so".*

4.139 However, the policy also says:

*"Physical assaults by patients **must be reported** [our emphasis] to the police unless the assailant's clinical condition is such that the assault was clearly unintentional, and the member of staff affected does not wish to report the incident".*

4.140 A flow chart in the policy (appendix 4) also indicates staff should call the police in the event of a physical assault, and that all incidents should be reported on Datix.

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[82] The notes do not say if Miss Y was referred to during the discussion.

4.141 We consider the Trust policy could be interpreted by Trust staff that it is at their discretion as to whether they wish to report an assault to the police. We note an assault is a criminal offence and, as such, consider it should generally not be at the discretion of staff to decide whether they wish to report the incident. Equally, in terms of identifying an assault as "*unintentional*", the policy does not say who should make this judgement or against what criteria. We also question the use of the word "*unintentional*" in this policy, which leaves it open to interpretation. There are three basic types of assault offence set out in law[83] – common assault, actual bodily harm (ABH) and wounding/grievous bodily harm (GBH). They are primarily defined by the harm caused to the victim – with common assault at the lower end of harm and GBH at the upper end. The law describes "*intentional*" and "*reckless*" acts of assault, with no provision for "*unintentional*" assaults. It could be said that the consequences of an assault may be unintentional, but we question whether an assault should be viewed as unintentional.

Finding: Care Coordinator 1 acted proactively, attending the CRHTT office when the CRHTT would not accept her referral by telephone because handover was taking place.

Finding: Care Coordinator 1 considered her response and management of Mr D's action to be reasonable based on his previous behaviour, the collectively agreed plan, and Mr D's subsequent remorse for his earlier actions.

Finding: Trust policy is open to interpretation by Trust staff as to whether physical assaults committed by service users against them must be reported to the police, or at the discretion of Trust staff. Care Coordinator 1 did not consider Mr D's actions to be "*intentional*" and she did not wish to report it to the police – as permitted by the Trust policy.

Recommendation 3: The Trust must review its Managing Violence and Aggression Against Staff Policy to clarify what actions staff should take in response to a physical assault by a service user. The review should address the ambiguity in relation to whether the police should be contacted in response to an assault, the extent to which staff can rely on their own judgement to manage the situation, and what advice and support must be sought at the time.

Specific threat to Miss Y

4.142 We have not identified a Trust policy that sets out what staff should do in the event of one service user threatening another. The Trust's Positive and Proactive Care: The Recognition, Prevention and Therapeutic Management of Violence and Aggression Policy (2018) says that staff should report any

[83] https://www.sentencingcouncil.org.uk/news/item/assault-offences-explained/

physical assault or threats by "*members of the public*" to the police. It also says threats against staff should be reported to the police, whether considered credible or not. However, the policy does not extend to service users. Modern Matron 1 told us staff would refer to the Trust safeguarding policy, and that there would be an expectation on staff to notify the potential victim at the earliest opportunity, but we note this is not supported by Trust policy.

4.143 Mr D said, in the presence of Care Coordinator 1 and Support Worker 3, that he would kill Care Coordinator 1, Support Worker 3 and Miss Y. It later came to light that Support Worker 3 had not heard Mr D make the threat.[84] Care Coordinator 1 advised that Mr D spoke very quietly and she had not considered him to be making a threat.

4.144 However, there is no evidence Care Coordinator 1 told anyone that Mr D had made a specific threat against Miss Y. Consultant 1 was unaware and the CRHTT Manager (Modern Matron 1) told us the CRHTT were unaware that Mr D had made specific threats (they were informed he expressed he might kill "*someone*"). He told us had they known, they would have advised Care Coordinator 1 to notify Miss Y.

4.145 We asked Care Coordinator 1 whether they considered telling Miss Y that Mr D had made a specific threat towards her. Care Coordinator 1 told us that they decided the best course of action was to go directly to the CRHTT office to ask that Mr D be referred.

4.146 We accept that Support Worker 3 had not heard the threat, which would likely have contributed to the reason why it was not discussed with Care Coordinator 1. Care Coordinator 1 did not view the threat as significant and she considered agreeing a plan with Mr D, in which he returned to his room, as reasonable. However, we note when Care Coordinator 1 went back to see Mr D to tell him the CRHTT would see him the next morning, he remained in the common room and declined to return to his room.

4.147 Anecdotally there was some history of antagonism between the two residents and Mr D had reportedly made a threat towards Miss Y on 5 November 2018 (though this was not clearly reflected in the CRHTT risk assessment or recorded in the progress notes); both factors which should have been taken into consideration at the time of his threat on 27 November 2019.

4.148 The Trust has a Breaching Confidentiality Quick Guide' for staff to refer to in instances when they believe there is a need to breach patient confidentiality.

[84] Support worker 3 said during Mr D's criminal trial that they are deaf in one ear and had not heard Mr D make the threat against the staff or Miss Y.

However, there is no clear guidance about what staff should do in response to a service user making verbal threats about or towards another service user.

4.149 It is our view that it would have been prudent to have informed Miss Y that another resident had made a specific threat against her. Further to this, consideration should have been given to informing Sanctuary management and Miss Y's Care Coordinator about the threat, with a view to formulating a plan to ensure Miss Y's safety and wellbeing.

Finding: Consultant 1 and members of the CRHTT were unaware that Mr D had made specific threats against Care Coordinator 1, Support Worker 3 or Miss Y.

Finding: There is no Trust policy about what staff should do in response to a service user making a verbal threat against another service user.

Recommendation 4: The Trust should develop guidance detailing what staff should do in response to service users making verbal threats against other service users. This should include who should be informed and documentation of agreed actions.

Timeliness of CRHTT response

4.150 The CRHTT operational policy (July 2019 – draft)[85] sets out the aims of the CRHTT as providing:

- "*A 24-hour service … for people presenting with a serious mental illness who are believed to require an acute hospital admission …*
- *Rapid assessment and treatment service, usually within 12[86]–24 hours, 24 hours a days, 365 days a year …*
- *Treatment in the least restrictive environment, taking into account service user choice and issues of safety …* ".

4.151 The policy says the service is for service users who need to be considered for an admission due to being in crisis. The policy definition of crisis states:

"According to the assessment of secondary mental health service practitioners, a substantial deterioration has occurred in the mental health and/or social functioning either of a service user who has an existing mental disorder or in someone not previously known to Services, … ".

4.152 The policy lists a number of criteria largely focused on the risk to the service user (not others). The policy says internal referrals will be accepted subject to a progress entry being completed in advance of the referral, detailing the presenting complaint, mental state examination and current risks, alongside

[85] The 2015 version of the policy is also marked 'draft'.

[86] The 2018 version of the policy says assessments will take place usually within four hours.

the risk assessment being updated. We accept the pace at which events unfolded on 27 November 2019 meant Care Coordinator 1 was not in a position to complete paperwork in advance of the referral to the CRHTT.

4.153 We asked Modern Matron 1 about Care Coordinator 1's experience of trying to telephone the team and being told no one was available. Modern Matron 1 told us that CRHTT does try to avoid receiving referrals between 1.00pm and 2.00pm because it is overseeing handover, but it would accept urgent referrals. We note this does not reflect Care Coordinator 1's experience.

4.154 The CRHTT agreed to assess Mr D nearly 24 hours after he had laid hands on Care Coordinator 1 and threatened to kill two members of staff and Miss Y. Adult Locality staff told us that the CRHTT generally does not have a same-day response (due to being booked up) and, in instances where an immediate response is required, the CRHTT will advise Adult Locality staff to contact the emergency services. Adult Locality staff indicated that assessment usually took place the day after submitting a referral. This is in line with Trust policy which says assessments will take place within 12–24 hours.

4.155 We spoke to Modern Matron 1 about the CRHTT's response to Care Coordinator 1's referral. He told us in the first instance he asked her why the police had not been contacted after Mr D had put his hands around her neck, to which Care Coordinator 1 advised this had been discussed with Consultant 1 and Support Worker 3 and agreed it was not warranted.

4.156 Members of the CRHTT undertook a 30–40-minute assessment with Care Coordinator 1, reviewing Mr D's notes as part of the process. Care Coordinator 1 told them Mr D did not warrant an inpatient admission, rather the purpose of a CRHTT assessment was to validate Mr D's physical health needs. This contradicts the discussion between Care Coordinator 1 and Consultant 1 who agreed Mr D should be referred to the CRHTT with a view to him being admitted. The CRHTT triage notes do not set out detail of the assessment therefore we have been unable to resolve this discrepancy (we were advised the form is designed to serve as a conversation prompt rather than as a record of the discussion).

4.157 The CRHTT asked Care Coordinator 1 whether Mr D's preoccupation with his physical health was delusional in nature, to which she replied that Mr D was not mentally unwell. Care Coordinator 1 provided details of Mr D's self-neglect and said he had lost weight.

4.158 The team agreed they would review Mr D but would wait until the next day because:

- Mr D was not an immediate risk that required police intervention.
- Mr D did not need an admission.

- Mr D was not mentally unwell.
- Mr D's depot was not overdue.
- Care Coordinator 1 advised she was returning to see Mr D after the meeting with the CRHTT.
- Care Coordinator 1 was not pressing for a more urgent response.
- There was no sense of urgency or that Mr D was an immediate threat.

4.159 Modern Matron 1 told us the decision to see Mr D nearly 24 hours after the incident was not driven by caseload pressure. The team was relatively busy, but the timeframe for review seemed reasonable based on the intelligence available. The team could have gone out the same day had they been needed.

4.160 Modern Matron 1 and Care Coordinator 1's recollections of the events on 27 November 2019 differ in terms of the level of urgency communicated and expectations of what an assessment would achieve. There are few notes pertaining to that day, therefore we have largely relied on individual recollections. Care Coordinator 1 told us that whilst she advised the CRHTT that the referral was not specifically about Mr D's mental health (e.g., he was not hearing voices or suicidal), he had done something completely out of character and she felt she needed to do "*something*" to appease Mr D (e.g., refer him to the CRHTT). She told us the only way Mr D would be informally admitted would be via the CRHTT assessment process. Care Coordinator 1 told us she understood that the CRHTT did not have the resource to see Mr D that day, but equally, she, the CRHTT, and Consultant 1[87] agreed it could wait until the next day.

Finding: Mr D's referral to the CRHTT in November 2019 was in keeping with Trust policy.

Finding: The CRHTT informed us it had enough resource to assess Mr D on 27 November 2019 but concluded, based on the information provided by Care Coordinator 1, that the assessment could wait until the next day.

Finding: The CRHTT decision to undertake the assessment the next day was in keeping with Trust policy based on the information shared with the team.

Recommendation 5: The Crisis Resolution and Home Treatment Team (CRHTT) should review its admission process to ensure urgent referrals can be accepted and managed during handover periods.

[87] The statement provided by Consultant 1 does not set out her expectations in relation to when the CRHTT would see Mr D, only that he should be urgently referred to the team.

Safeguarding

4.161 The Trust gave us three versions of its Safeguarding Policy, one of which was dated 24 January 2018, the other two (version 6.1 and 6.2) were dated 9 April 2019 and were due for review in November 2020. We have referred to the January 2018 and 6.2 versions as the policies in place at the time of the incidents detailed below.

4.162 The Safeguarding Policy says all Trust staff have a responsibility to recognise, report and refer concerns of abuse or substandard practice.

4.163 There were three occasions when safeguarding for Mr D was raised or warranted consideration: February 2018, October 2018 and November 2019.

February 2018

4.164 The Trust Safeguarding Policy identifies financial abuse as a type of abuse, indicators for which include:

- *Inability to pay bills/unexplained shortage of money*
- *Unexplained withdrawals from an account*

4.165 Sanctuary staff raised concerns in February 2018 that the amount of money in Mr D's building society account had reduced significantly from the previous year. Mr D said he had lost his building society book six months before and believed the money had been stolen.

4.166 Sanctuary staff agreed to attend the building society with Mr D with a view to acquiring an account statement and reviewing it with Mr D.

4.167 The notes do not say whether Sanctuary staff were able to establish what had happened to Mr D's money, but there is no evidence they raised the matter again with Care Coordinator 1, or either agency reported it to the local Multi-Agency Safeguarding Hub (MASH).

October 2018

4.168 Care Coordinator 1 sent a safeguarding form to the MASH on the basis of self-neglect on 30 October 2018. She identified that Mr D meet the three criteria required for the referral, specifically:

"a) The adult has needs for care AND support (whether or not the authority is meeting any of those needs)

AND

b) The adult is experiencing, or is at risk of, abuse or neglect

AND

c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."

4.169 The safeguarding team advised that they did not consider Mr D to meet the threshold for safeguarding because Care Coordinator 1 was working with other agencies to manage Mr D's health concerns. Care Coordinator 1 was asked to assess Mr D's capacity and to let the MASH know if he attended his scheduled medical appointments. Care Coordinator 1 was advised to re-refer Mr D if his self-neglect worsened.

4.170 Trust policy says a Datix report should be completed as part of the safeguarding process ('record'), but we have not been provided with a completed form or evidence it was reported on Datix.

4.171 Care Coordinator 1 emailed the MASH on 21 February 2019 to advise they had dealt with Mr D's physical health concerns under CPA, but the concerns remained. It is not clear what prompted the update, but we assume the MASH was seeking an update as to whether the original enquiry should be closed. The MASH replied that Mr D did not meet the criteria for a safeguarding enquiry.

November 2019

4.172 Care Coordinator 1 identified a sore in the area between Mr D's buttock cheeks, which was "*very red, sore and nearing broken skin"* on 11 November 2019. Care Coordinator 1 documented she had not seen his skin look that bad before. The notes say she intended to speak to Sanctuary staff about this with a view to them arranging a GP appointment for Mr D. Care Coordinator 1 told us she did ask Sanctuary staff to arrange a GP appointment for Mr D. However, there is no evidence in the GP notes that an appointment was made prior to the incident. We would have anticipated that Care Coordinator 1 would have taken steps to check the GP appointment had been made and continued to monitor the sore with a view to escalating if required. We would have anticipated such monitoring to have occurred before the next scheduled depot appointment, two weeks later. Care Coordinator 1 told us that usually Sanctuary staff would contact her between her visits if they had concerns, therefore she felt it was reasonable to wait to follow-up at her next visit on 27 November 2019.

Finding: There is evidence staff identified and responded to concerns in relation to Mr D's finances and self-neglect. However, the outcomes of these enquiries were not consistently documented, therefore we cannot conclude whether further steps were warranted and/or should have been escalated. There is no evidence Mr D's missing money was reported to the MASH.

Finding: The referral to the Multi-Agency Safeguarding Hub (MASH) in October 2018 was in keeping with the Trust safeguarding policy.

Primary Care

4.173 Mr D had been registered at Mill Road Surgery since November 2012. Mr D had a number of physical health complaints which centred on gastric and abdominal pain.

4.174 Mr D's medication documented at his CPA review in May 2019 was:

- Flupentixol decanoate
- Sertraline[88]
- Pregabalin
- Mirtazapine
- Mebeverine
- Docusate
- Colecalciferol
- Qvar (beclomethasone)[89]
- Salbutamol[90]
- Prucalopride
- Lansoprazole
- Ranitidine
- Fortisip

4.175 Mr D attended the GP practice seven times between 2018 and 2019. He also received 13 home visits during the same period.

Working with other agencies

4.176 Mr D's GP practice responded to other agencies requests to see Mr D. For example, GP 4 undertook a home visit on 31 October 2018 at the request of Care Coordinator 1, shortly after Mr D refused to attend an Endoscopy appointment (26 October 2018). GP 4 and Mr D discussed his need for a physical assessment, but Mr D said he could not decide what to do, therefore GP 4 visited again the next day to discuss further. GP 4 concluded a joint meeting was needed with the mental health team and that Mr D needed a mental capacity assessment. GP 4 liaised with Care Coordinator 1 in parallel with these visits, and a professionals meeting was arranged by Care Coordinator 1, which GP 4 attended on 7 November 2018. One of the actions

[88] It was incorrectly assumed by Consultant 1 that Mr D was taking sertraline. He had been switched to venlafaxine in December 2020.

[89] Qvar: An asthma inhaler

[90] Salbutamol: An asthma inhaler

from the professionals meeting was that GP 4 and practice colleagues would regularly monitor Mr D's physical health (weight, blood pressure and blood tests), which GP 4 subsequently arranged with the Community Nursing team.

4.177 It is documented in the progress notes that Mr D's GP practice contributed to his CPA review in May 2019. Staff were aware GP 4 saw Mr D at home and continued to monitor his weight, blood pressure and blood test results.

4.178 GP 4 contacted Consultant 1 in June 2018 when she noticed Mr D's venlafaxine prescription had been stopped. They identified this was a mistake[91] and Mr D's prescription was restarted.

4.179 There is evidence in the notes of GP 4 liaising with Sanctuary staff and equally, Sanctuary staff contacting the practice/GP 4, to discuss concerns about Mr D.

4.180 The Trust and Sanctuary staff we spoke to were complimentary about GP 4 and their attempts to engage Mr D and support his physical health. In particular they noted GP 4's willingness to accommodate Mr D's reluctance to attend the GP practice, undertaking home visits to see him in his own environment.

Finding: There is evidence of Mr D's GP proactively engaging with Trust and Sanctuary staff, working with them to develop a plan to manage Mr D's physical health complaints.

Engagement with Mr D

4.181 As noted above, there is evidence GP 4 sought to proactively engage Mr D in his health care – returning on 1 November 2018 to discuss options with him. Similarly, GP 4 saw Mr D at home three times in December 2018[92] to encourage him to attend an appointment with the Gastroenterology team on 19 December.

Finding: Mr D's GP sought to proactively engage with him, undertaking home visits to monitor Mr D's physical health and in response to concerns raised by Trust and/or Sanctuary staff.

Incident in April 2018

4.182 Mr D sustained a minor head injury when attending the ED in April 2018. Care Coordinator 1 was not informed of the incident.

4.183 Mr D had attended the hospital complaining of abdominal pain, but an examination and tests revealed nothing of concern and he was discharged

[91] Please refer to the 'Chronology of Mr D's care and treatment' (Section 3) for further detail.

[92] 5 December, 7 December and 12 December 2018

from the hospital. However, the notes indicate that Mr D "*refused to leave*" because he felt so unwell, and was escorted off the premises by hospital security. He was subsequently found outside on the ground with blood on his head and mouth. Mr D informed ED staff that he had been assaulted by the security staff who had pushed him to the ground when he refused to leave. Mr D was assessed and discharged with no follow-up.

4.184 GP 4 told us that the practice would take no further action in relation to any ED letter marked "*no follow-up*".

Finding: Mr D was discharged from the Emergency Department (ED) on 10 April 2018 after sustaining a head injury on site, with "*no further action*" required. Consequently, in keeping with expected practice, the GP practice did not share the information with Care Coordinator 1 who remained unaware of the incident.

Questions from Miss Y's family

4.185 We met Miss Y's mother and sister in April 2021. They raised a number of questions about Mr D's care and treatment which we set out below. We have included our response directly after each question.

4.186 **Who originally made the decision to discharge Mr D from an inpatient setting to low-level support (i.e., Sanctuary Supported Living managed accommodation)?**

The terms of reference for this review cover the timeframe 1 January 2018 until 27 November 2019. We have not reviewed Mr D's transfer from inpatient care to a community setting because this occurred outside the review period.

4.187 **What protocol should have been followed by Mr D's Care Coordinator when he attempted to strangle her and allegedly made a specific threat about harming Miss Y?**

We have set out the detail of the events of 27 November 2019 in the report section called '27 November 2019' (paragraphs 4.130-4.160). However, we note that Trust policy is unclear on what staff should do if a service user assaults them. The wording of the policy is such that staff may decide whether they should report an assault to the police. Equally, there is no guidance available to staff about what they should do when a service user makes a threat about another service user, although the CRHTT were clear there was an expectation on their part that any potential victims be notified.

4.188 **What did Care Coordinator 1 report to the crisis team after the incident, and what was agreed; was this in keeping with Trust policy and practice?**

We have set out the detail of the events of 27 November 2019, including engagement and information shared with the CRHTT, in the report section called '27 November 2019' (paragraphs 4.130-4.160).

The CRHTT decision to review Mr D the next day, based on the information available to them at the time, was in keeping with Trust policy and response timeframes.

4.189 **What is the status of the Trust internal investigation?**

The terms of reference for the Trust internal investigation were approved in November 2020. It was a desktop exercise; staff were not interviewed by the Trust investigators. The police asked Trust investigators not to interview staff whilst the criminal investigation was ongoing.

The internal investigation was completed in January 2021. The Trust submitted its internal investigation to the CCG in September 2021.

The terms of reference for this independent investigation do not extend to the Trust internal investigation.

Recommendation 6: The Trust should share its internal investigation report with Miss Y's family at the earliest opportunity.

5 Conclusions and recommendations

5.1 Mr D was a 36-year-old man with a diagnosis of paranoid schizophrenia and recurrent depressive disorder. He suffered from with extensive gastrointestinal problems, frequently complaining of stomach pain and requesting admission to the local psychiatric hospital to address his physical ailments. However, although Mr D requested his physical health complaints be addressed, he usually refused to attend acute health appointments typically advising staff in advance that he would not attend the appointment.

5.2 Staff, particularly his GP, at times questioned his mental capacity in relation to making decisions about his physical health. His Consultant noted at a Care Programme Approach (CPA) review in November 2018 that his mental state and capacity tended to fluctuate and should be subject to regular monitoring. However, there is no evidence Mr D's capacity was regularly monitored except during his CPA reviews, most recently at the end of May 2019. We cannot comment as to whether hospital services would have changed their approach towards Mr D had he been assessed to lack capacity, but it would have prompted a dialogue between the services about what might encourage and help Mr D to engage with hospital services.

5.3 Trust, Sanctuary staff, and particularly his GP tried to help Mr D address his physical health concerns, supporting him to attend appointments, rescheduling those he did not attend, and encouraging him to engage with acute services.

5.4 However, Mr D's physical health at times detracted from his mental health needs such was the focus of all those involved, including his Care Coordinator, in addressing these concerns. As a result, whilst Mr D was seen regularly by his Care Coordinator, who worked hard to support his physical health and maintained detailed progress notes of her contact with him and partner agencies, his risk assessment and management plan were not up to date, and his care plan extended little beyond his physical health. However, we note the care plan did not respond to concerns that Mr D's breath had a 'ketone' smell at times, and there was a lack of action to work with Mr D to address his inadequate diet other than monitoring by his GP and staff encouraging him to drink his nutritional drinks as prescribed.

5.5 There was no holistic long-term plan for Mr D. Trust and Sanctuary staff were aware he was not required to engage with support services, and we were left with a sense of frustration, particularly on the part of Sanctuary staff, that Mr D would not utilise services. Similarly, Mr D routinely ignored advice from his GP about managing his diet and refused to attend medical appointments. As such, those we spoke to told us the long-term plan for Mr D was to encourage him to attend his medical appointments. Mr D accepted his medication, and whilst Care Coordinator 1 was not happy about aspects of his placement,

there were few alternatives available. Equally, Mr D could not be admitted for assessment without a clear catalyst e.g., acute risks or acute deterioration.

5.6 We identified episodes which should have prompted a review of Mr D's risk assessment and mental capacity, but instead these were predominantly attributed to his physical health needs. Equally his threatening gestures towards Support Worker 1 in November 2018 were not viewed as significant, rather the Crisis Resolution and Home Treatment Team (CRHTT) placed emphasis on his physical health concluding in their assessment:

"Ultimately, the majority of [Mr D's] reported issues are linked with his physical health and an inpatient admission would not alter this."

5.7 It is our view that Care Coordinator 1's management of the incident on 27 November 2019 was influenced by her historical knowledge of Mr D and assumptions based on his previous behaviour, rather than his current risk and the threats he was making. Care Coordinator 1's focus on Mr D's physical health influenced her decision-making after the incident when she told the CRHTT that Mr D was not acutely mentally unwell, rather he needed his physical health concerns validated. We cannot comment as to whether Mr D was acutely mentally unwell or not, but it is our view that emphasis was placed on Mr D's physical health.

5.8 Trust policy does not extend to what staff should do if a service user makes a threat against another service user, therefore it is down to individual judgement. Care Coordinator 1 told us she did not inform other staff of Mr D's whispered threat, because she was in shock and briefly forgot about it. However, she did not perceive Mr D to be a threat to her, Support Worker 3 or Miss Y. Rather Mr D's concerns were about himself, and his actions were seen as largely a way of getting attention.

5.9 We cannot comment as to whether the agreed plan with Consultant 1 would have been different had she been aware that Mr D had threatened another service user. Care Coordinator 1 and Consultant 1 noted in their brief discussion that Mr D's behaviour echoed that of the previous year when he gestured at Support Worker 1 and the police did not attend the property, asking that Sanctuary staff liaise with the mental health team. Equally, whilst the CRHTT indicated it would have attended the same day, they had previously attributed Mr D's concerns to his physical health and Adult Locality staff we spoke to commented that assessments usually took place the next day.

5.10 The lack of clarity on the part of the Trust as to when staff should report a staff assault to the police or how threats towards service users should be managed, meant Care Coordinator 1 took what she considered to be reasonable actions based on Mr D's history, her experience of him and what she agreed with Support Worker 3, Consultant 1 and Mr D.

5.11 However, it is our view that whilst Trust policy meant it was at Care Coordinator 1's discretion as to whether the police should be contacted, Miss Y should have been told that Mr D had made a direct threat against her. Accordingly, Consultant 1, the CRHTT team, Miss Y's Care Coordinator and Sanctuary management should have been informed of the threat to Miss Y, with a view to a plan being formulated to ensure Miss Y's safety and wellbeing.

Recommendations

Recommendation 1: The Adult Locality team should review the notes of all service users under the Care Programme Approach (CPA) with a view to ensuring all documentation (for example risk assessments and care plans) has been completed in line with Trust policy, within the required timeframe, and reflect the service user's broader needs and long-term plans. The team should implement a programme of audit to ensure service user documentation continues to be completed in accordance with expected practice.

Recommendation 2: In instances where concerns about a service user's capacity have been raised, capacity must be assessed, reviewed and documented at CPA meetings and, if assessed as requiring ongoing monitoring, documented at agreed intervals.

Recommendation 3: The Trust must review its Managing Violence and Aggression Against Staff Policy to clarify what actions staff should take in response to a physical assault by a service user. The review should address the ambiguity in relation to whether the police should be contacted in response to an assault, the extent to which staff can rely on their own judgement to manage the situation, and what advice and support must be sought at the time.

Recommendation 4: The Trust should develop guidance detailing what staff should do in response to service users making verbal threats against other service users. This should include who should be informed and the documentation of agreed actions.

Recommendation 5: The Crisis Resolution and Home Treatment Team (CRHTT) should review its admission process to ensure urgent referrals can be accepted and managed during handover periods.

Recommendation 6: The Trust should share its internal investigation report with Miss Y's family at the earliest opportunity.

Good practice

5.12 Trust and Sanctuary staff were complimentary about the practice of GP 4 who undertook home visits to see Mr D and sought to work with the other agencies

to address his physical health needs. Trust and Sanctuary staff described her as "*brilliant*".

5.13 We agree that the Trust and GP notes reflect a proactive approach on the part of GP 4. This included liaising with the Adult Locality team, undertaking home visits and seeking to ensure Mr D's hospital visits were adapted to support his needs.

Appendix A - Terms of reference

The investigation is to be conducted in partnership with the Adult's Serious Case Review into the death of [Miss Y] terms of reference.

- The investigation will examine the NHS contribution into the care and treatment of Mr D from January 2018, in line with the Adult Serious Case Review, with specialist mental health services.
- Critically examine and quality assure the NHS contributions to the Adult Serious Case Review.
- Examine the referral arrangements, communication and inter-agency workings of the different parts of the NHS and partners that had contact with Mr D.
- Review and assess compliance with local policies, national guidance and relevant statutory obligation.
- Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family.
- Examine the communication with the service user and his family in the lead up to the homicide and the responsiveness of services.
- Review the appropriateness of the treatment of the service user considering any identified health needs/treatment pathway.
- To work alongside the Adult Serious Case Review and Chair to complete the review and liaise with affected families.
- To provide a written report with the Adult Serious Case Review to the Safeguarding Board and NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or stand-alone.
- To produce a learning document for sharing with the wider NHS outlining the major learning points from the investigation.

Appendix B – Documents reviewed

- Mr D's clinical records and notes
- Mr D's risk assessments and care plans
- Datix report (27 November 2019)
- Trust policies and procedures
- Correspondence between the Trust, Sanctuary Supported Living and the GP practice
- Information about links between the Trust, local authority and Sanctuary Supported Living
- GP records and correspondence
- Statement from Consultant 1
- Mr D section history
- Safeguarding referral (October 2018)
- Crisis Resolution and Home Treatment Team (CRHTT) triage form (November 2019)

Appendix C – Glossary of acronyms

ABH	Actual bodily harm
BMI	Body mass index
BP	Blood pressure
CBT	Cognitive behavioural therapy
CCA	Care Coordination Association
CPA	Care Programme Approach
CPFT	Cambridgeshire and Peterborough NHS Foundation Trust
CPN	Community Psychiatric Nurse
CRHTT	Crisis Resolution Home Treatment Team
CT	Computerised tomography
ED	Emergency Department
GBH	Grievous bodily harm
HQIP	Healthcare Quality Improvement Partnership
IMHT	Integrated Mental Health Team
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multidisciplinary team
MHA	Mental Health Act
PIP	Personal Independence Payment
SAR	Safeguarding Adult Review
SMHP	Senior Mental Health Practitioner