VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent Review of the Trust's internal investigation regarding the care and treatment of Mr X provided by South West London and St George's Mental Health NHS Trust

A report for NHS London

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Author:
Chris Brougham
Peter Killwick
Kieran Seale

Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for regulated organisations.

Verita
338 City Road
London EC1V 2PY

Telephone 020 7494 5670

E-mail enquiries@verita.net
Website www.verita.net

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1. Introduction

1.1 On Monday 19 January 2016, Mr X, a 37-year-old man, who had previously received care and treatment from South West London and St George's Mental Health NHS Trust (from now on known as 'the Trust') carried out an unprovoked stabbing attack on a 23-year-old man (Mr A) in Mitcham, South London. Mr A (not known to Mr X) needed hospital treatment for non-life-threatening injuries and was later discharged.

1.2 Less than an hour later, Mr X carried out another unprovoked attack, stabbing and killing a 30-year-old man (Mr B) in Morden, South London. He was also unknown to Mr X.

1.3 Mr X was arrested by police on 26 January 2016. He pleaded guilty to manslaughter by reason of diminished responsibility. He also admitted a charge of wounding with intent against Mr A. Mr X was given a hospital order under section 45a of the Mental Health Act and was admitted to Broadmoor Hospital.

1.4 The Trust carried out an internal investigation into the care and treatment of Mr X. They wrote a report in which they made a number of recommendations. NHS England London have now asked Verita, a company that specialises in investigations and reviews to carry out a review of the action plan arising from the investigation to find out if the recommendations have been put in place and whether learning has been embedded into practice.

2. Approach to this review

2.1 The terms of reference from NHS England have asked for an independent review of the Trust's internal investigation regarding the care and treatment of Mr X provided by South West London and St George's Mental Health NHS Trust and independently review:

- The Trust's current practice and the implementation of the Trust's internal investigation action plan.
- The embedding of learning across the Trust and identify any other areas of learning for the Trust and/or CCG.

2.2 The outcome of this review will be managed through governance structures in the clinical commissioning group and the provider's formal Board sub-committees. The CCG Care Quality Review Group (CQRG) will provide assurance to NHS England of completion of any actions/outcomes from the completed report.

2.3 The focus is to independently review the following:

- The implementation of the Trust's internal investigation action plan, and in addition:
    - The embedding of learning across the Trust and identify any other areas of learning for the Trust and/or CCG.
    - The processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of Trust services and GP practices.
    - To review any proposed national developments following the HM Coroner regulation 28 report to prevent future deaths, issued to Department of Health and Social Care, following the inquest on 28 and 29 June 2018.
- To make comment on the CCG monitoring of the action plan.
- Make further recommendation for improvement as appropriate.
- To consider making further recommendations locally, regionally and nationally for improvement as appropriate.
- To independently review the challenges that GP face when prescribing patients on antipsychotic or other psychotropic medication (e.g. mood stabilisers & antidepressants) and are at risk of non-compliance and any progress made.

2.4 A full list of the evidence reviewed is outlined in appendix A.

3. Summary of the care and treatment of Mr X

3.1 At the time of the incident, Mr X was 37 years old. He was referred by his GP to the Trust in August 2013 after reporting that he was experiencing voices telling him to harm others. He was assessed by the Merton Assessment Team and referred to the Early Intervention Service (EIS). He started treatment and was assessed by the EIS Consultant and the Community Psychiatric Nurse regularly. In January 2014, he became unwell and attacked a stranger. He was therefore admitted informally to hospital. He settled quickly, was assessed by a psychiatrist and was discharged back to the EIS service at the end of January 2014.

3.2 Following discharge, Mr X remained under the care of the EIS team, with regular, though less frequent, reviews and adjustment of medication until July/August 2014, when he was also seen as an out-patient with the EIS Consultant. Mr X requested discharge from the EIS in May 2014 but was persuaded to remain within the service.

3.3 Mr X remained under the care of the EIS Consultant until June 2015. He was being seen at approximately monthly intervals. At that time, Mr X was seeking discharge back to his GP. He was advised to continue his medication for at least 6 months and that cessation should be gradual and monitored. The EIS Consultant wrote a discharge letter to the GP, and advised the patient and the GP that, as Mr X still had 18 months of EIS time remaining, he could be reviewed within that time through re-referral to the EIS. The EIS consultant indicated to Mr X her willingness to review him prior to any medication reduction.

3.4 There was no further contact between the patient and the Trust until the incidents on 19 January 2016.

4. South West London and St George's Mental Health NHS Trust internal investigation

4.1 In this section we reviewed the Trust's internal investigation report to show how the Trust investigation panel was set up, how the panel carried out the investigation and the methods use.

4.2 Following the tragic circumstances of the 19 January 2016, the medical director from South West London and St George's Mental Health NHS Trust commissioned an internal investigation to conduct a root cause analysis (RCA) investigation into the incident. This was carried out in line with the Trust's serious incident policy and the principles set out in the NHS England's Serious Incident framework (2015). The purpose of the RCA investigation was to establish the facts and to identify any root causes, contributory factors and key learning from the incident.

4.3 The terms of reference are set out below:

- To establish any care and service delivery problems, contributory factors and possible root cause of the incidents.
- To make recommendations based on the findings to eliminate or to reduce the opportunity for recurrence of further harm to patients or others and to identify opportunities for learning from the review of the incidents.
- To provide support and a forum for the family and relatives to contribute to the investigation and final report.

4.4 A Consultant Forensic Psychiatrist led the investigation and wrote the investigation report. He was supported by the Serious Incident Lead Investigator and Named Nurse for Safeguarding Children, and a Patient Experience Lead, SI Investigator.

4.5 The investigation panel gathered relevant documentary evidence such as the patient's clinical records, policies and procedures and the police case summary file. They interviewed staff from the Early Intervention Services. The panel sought to meet with Mr X, but he declined.

Findings from the internal investigation

4.6 The Trust investigation panel found the following care and service delivery problems:

1. Risk management was insufficiently carried through or integrated and did not lead to a shared and well understood and documented risk and contingency planning, in spite of a good understanding by the clinicians of the risk factors presented by the patient.
2. The care team had not made contact with the patient's mother, in spite of plans to do so.
3. The patient had not been presented to the Merton Risk Panel.
4. Arrangements for rapid review pathways of complex patients discharged from mental health services to primary care are not well developed.

4.7 The Trust investigation found the following contributory factors:

1. The patient (Mr X) appears to have discontinued medication soon after his discharge without contacting services. There is evidence that his mental state had deteriorated, and that he may have used amphetamines in the period before the index incidents took place.
2. Clinical staff did not prioritise formal medium to long term risk management within the patient's overall care planning, taking into account his history of high-risk behaviour.
3. The focus on the recovery and early intervention models of care, set out in guidance documents and underpinned by service delivery expectations, does not sufficiently emphasise risk management of complex and high-risk individuals as part of the care planning.
4. Post-discharge arrangements for review by mental health services depended almost entirely on the patient's judgement and initiative, with no clearly defined role for the GP, and with no understood line of communication with the patient's nearest relative, nor with the police.

4.8 The panel did not have details that would have enabled them to unequivocally determine the root cause of the incidents as the patient had not yet been to trial. It is likely though, that in the period prior to his arrest, Mr X had undergone a relapse or deterioration of his psychotic illness. This was likely to have arisen as a result of his cessation of

medication sometime in the months after his discharge from EIS and was possibly complicated by his use of amphetamines.

4.9 The panel found that Mr X's clinical profile indicated that his involvement in violent and dangerous behaviours which he reported had generally been in the context of, and largely a result of, worsening psychotic symptoms.

4.10 The panel highlighted the following areas for learning:

- High quality clinical care delivery and patient engagement, with a focus on collaborative care and recovery is to be commended but this is not sufficient if risk management of known high and long-term risk is incomplete.
- Risk management and crisis planning documentation and practice as evidenced by this case were not sufficiently robust or consistent. Staff did not effectively review, re-assess and re-formulate the risks based on the patient's history and longitudinal risk and the incidents reported more recently by the patient himself.
- Inpatient crisis admissions are an opportunity for a more detailed review and "stock take" of the risk history, presenting risks and potential risks going forward. This is the case even if the crisis appears to rapidly resolve and the patient is settled, engaged and compliant with treatment.
- Longer term follow-up of complex patients with risk histories that include dangerous behaviour but who are considered clinically stable, is not supported by current commissioning expectations. Rapid review pathways are not straightforward or well established with current arrangements, when a patient chooses to be discharged.
- Post discharge arrangements were very limited, and could have been strengthened by liaison with family, closer engagement with primary care and possibly, through the Merton Risk Panel, the police.

Recommendations arising from the investigation

1. The Trust's current risk management training should be reviewed to ensure that it is suitable to the service and individual clinical roles. The Trust, through its service and professional leads should ensure that this forms part of individual clinicians' professional development.

2. The Trust should take any necessary steps to ensure that Care Planning includes detailed and methodical risk management planning, tailored to the individual patient's risk factors, using available supporting services and tools as necessary. It is crucial that such plans are supported by a suitable, coordinated document set, updated and understood by those involved in the patient's care including the patient.

3. The Trust and CCGs need to develop a shared protocol for the oversight and escalation of medication collection and compliance for patients assessed to be at increased risk.

4. The Trust and the Commissioning bodies should consider what arrangements, involving primary and secondary services may be put in place to ensure effective pathways for rapid clinical review for those patients whose clinical profile, including risk, indicates the need for this.

Arrangements for sharing learning

4.11 The panel recommended that the investigation report should be presented and discussed with the clinicians and team involved with the patient's care. The panel considered that it could usefully form part of a thematic presentation to a wider group of clinicians from general adult services at a suitable half day event.

Finding

F1 The Trust investigation panel carried out the investigation in line with NHS serious incident policies and procedures and RCA principles. They developed logical and evidence-based key learning points, conclusions and recommendations. The report was clear, well written and comprehensive.

5. Action plan

5.1 In this section we assess the Trust's current practice and the implementation of their internal investigation action plan (see appendix B) to find out whether learning has been embedded across the Trust and identify any other areas of learning for the Trust and/or CCG as outlined in the terms of reference. To do this we:

- Reviewed the internal investigation action plan
- Interviewed senior members of staff
- Undertook a review of new policies and procedures
- Received copies of training programmes

Trust internal investigation recommendation one

5.2 The first recommendation in the action plan states that the Trust's current risk management training should be reviewed to ensure that it is suitable to the service and individual clinical roles. We heard in our interviews that that the Quality Governance Department within the Trust took the responsibility for the review and since then the Trust has developed a risk management training programme called RATE: Risk Assessment Training and Education. The training is mandatory for all clinical staff. All new staff receive the training as part of the induction process and undergo refresher training every 3 years.

5.3 We have received a copy of the RATE training programme and course content. This contains an educational e-learning part which is carried out by delegates before the training. After this, a full day face to face training takes place. RATE trainers have been identified within each speciality service to ensure that delegates receive individualised training for their specialist area. For example, delegates attending from the community focus on risk management in the community and the challenges faced. Simulation is used to make the training interesting and accessible.

5.4 The content of the training is evidence based, meaning that it draws on national risk management good practice and data from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Suicide for England (2004-2016).

5.5 The course includes risk assessment, the formulation of risk management plans and monitoring and managing risk for homicides, suicides and fire setting. The training helpfully includes sessions on how risk management can be undermined and the safest approach to risk assessment and management.

5.6 Finally, we have noted that the content of the RATE training programme includes information for delegates to share with services users. This includes details of crisis hotlines and apps which have an outline of the service user's safety plan and provide a quick access to national crisis support helplines or contact details for identified relatives or friends who can provide support.

Finding

F2 The Trust has successfully demonstrated that risk management training has been reviewed and that a new mandatory programme has been implemented to ensure that it is suitable to the service and individual clinical roles. We found the course to be comprehensive and in line with guidance and best practice. The course materials are good, and the lead trainer (in interview) demonstrated a strong understanding of its content and goals.

Trust internal investigation recommendation two

5.7 The second recommendation from the Trust internal investigation report states that the Trust should take any necessary steps to ensure that care planning includes detailed and methodical risk management planning, tailored to the individual patient's risk factors, using available supporting services and tools as necessary. We heard that a task and finish group was established to further integrate clinical risk management. There is now an amended Clinical Risk Assessment and Management Policy which we have received a copy of. This policy highlights the importance of ensuring that care planning is thorough and tailored to individual patient's risk factors. These principles are also included in the RATE training which we have described above. We have received a copy of the Trust's amended Trust care planning standards. This makes it clear that the patient's care plan should demonstrate that the person's risk assessment and management plan has been addressed.

5.8 In order to ensure that care plans are up to date and take due account of any significant change for individual patients, the Trust has initiated a monthly audit of care plans which includes an assurance that any change in patient circumstances is reflected in their plan.

Finding

F3 We are satisfied that the Trust has put steps in place to further integrate risk management and care planning. The monthly audit of individual patient plans is an example of exemplary practice.

Recommendation

R1 The Trust should continue with their regular monthly audits to measure whether care plans are tailored to the patient's individual risk profile.

Trust internal investigation recommendation three

5.9 The third recommendation states that Trust and CCGs need to develop a shared protocol for the oversight and escalation of medication collection and compliance for patients assessed to be at increased risk.

5.10 We heard that a task and finish group was established to take this recommendation. Several actions have been taken, firstly, the Medicines Code Policy was amended and now it states that GPs should raise issues of non-compliance back to specialist mental health services. The policy also states that specialist mental health services will monitor compliance and initiate actions to support adherence with medicines.

5.11 A further significant action taken by the Trust is to embed mental health specialists within primary care – the Primary Care Liaison Teams. These are specifically designed to offer support both to GP's in managing complex mental health cases and to monitor patients on the Serious Mental Illness register. Within the terms of shared care agreements between the Trust and primary providers, a key function of these teams is to monitor compliance of

patients on specified medication and to feed back to the Trust where non-compliance is observed or suspected.

5.12 We were told by a representative of Merton CCG that these embedded teams are highly valued by the GP community, and provide very useful support to GP's, particularly in complex cases requiring specialist skills and knowledge.

5.13 We were told that the GP's have a mechanism by which they can feed back to the Trust areas of concern through their CCG's – "Quality Elapse". While this is effective for the GP's, we were also told that there is not a reciprocal arrangement for the Trust to suggest improvements for primary care practice – "Reverse Quality Elapse". We believe that this would be of systemic benefit.

Finding

F4 We are satisfied that the Trust has made good progress in ensuring that there are better shared processes in place for overseeing and monitoring patient's at increased risk.

Recommendation

R2 The Trust should make every effort to roll out Primary Care Liaison Teams in collaboration with all of their five CCG's. If possible, the system of 'Reverse Quality Elapse' should be formally adopted in order to provide 360-degree communication and accountability for quality monitoring and improvement.
Note – since the drafting of this report, we are told that the Reverse Quality Elapse' has now been renamed as the "Make a Difference Alert" (MKAD) and is now a reciprocal process. This is to be commended.

Trust internal investigation recommendation four

5.14 The fourth recommendation states that the Trust and the commissioning bodies should consider what arrangements, involving primary and secondary services, could be put in place to ensure effective pathways for rapid clinical review, for those patients whose clinical profile, including risk, indicates the need for this. In April 2017, a quality standards

document was launched. This states that a client who has been discharged from services can rapidly re-engage directly with the Community team within 6 months of discharge without having to be re-assessed by the Single Point of Access Team.

5.15 Merton uplift was launched in April 2019, to make sure primary care professionals have access specialist mental health expertise, so that primary care professionals are better placed to support people with common and severe mental illnesses, without the need for a referral to secondary care. It is an integrated primary care mental health service accessible to anyone living in the borough of Merton or registered with a Merton GP who are 18 years and over. They support anyone who has a mental health or wellbeing need, whether this is due to emotional difficulties or life stressors. They also offer a service for people with a stable mental health diagnosis such as psychosis and bipolar affective disorder. Merton uplift is a partnership between the NHS and local voluntary sector organisations. The service utilises the principles of integration, partnership working and co-production to support individuals with complex and severe and enduring mental illness. The service is not an alternative to the early intervention service.

Finding

F5 We are satisfied that effective pathways have been put in place so that patients whose clinical profile, including risk, receive a rapid clinical review if necessary.

The outcome of the inquest and preventing future deaths

5.16 On 5 February 2016, an inquest was opened into the death of Mr. A, then aged 30 years. The inquest concluded on 29 June 2018. The medical cause of death was shock and haemorrhage due to stab wound to the abdomen. The coroner issued a regulation 28 report (report to prevent future deaths). This set out concerns and requested that action should be taken. The concerns were as follows:

- When Mr X was discharged to the care of his GP by the Community Mental Health team, he was warned not to stop his medication because of the risk of relapse.
- GP surgeries do not routinely monitor that psychiatric patients are collecting their antipsychotic medication. Evidence revealed that it is not uncommon for

such patients stop their medication and relapse. Relapse puts them at a risk of harm to themselves and, sometimes, they pose a risk to others.

- Following the death of Mr A, the GP responsible for the care of him has implemented a system within the practice to monitor the collection of antipsychotic medication of their patients which was funded by the practice.

5.17 The Trust has under a duty to respond within 56 days of the date of the report. We have reviewed the response to see what action was taken to prevent future deaths of a similar basis.

5.18 We now review any proposed National developments following the HM Coroner regulation 28 report to prevent future deaths, issued to Department of Health and Social Care, following the inquest on 28 and 29 June 2018.

The role of the CCG in monitoring Trust internal investigations

5.19 NHS Wandsworth CCG, and NHS Merton CCG are the commissioners of the Trust. Merton CCG has lead commissioning responsibilities for SI management. There is an internal governance structure in place which allows for oversight and scrutiny of the action plan at several levels. There are two meetings, the joint primary care quality review group and the serious incident panel for Merton CCG. Multi-disciplinary team of medical, nursing and managerial personnel and representatives from the CCG and the Trust attended these meetings. The purpose of these meetings is to review and monitor the action plan progress for so that the CCG are assured that improvements have been made.

5.20 Once the report and action plan were considered fit for purpose, it was monitored via the monthly serious incident meetings held with the CCGs and the Trust. Once there was consensus between the Trust and commissioners that actions are embedded into practice, the action plan is closed.

5.21 In addition to the above arrangements the CCG also use an action plan tracker so that any progress or problems can be proactively managed.

5.22 We were told by the head of MH and LD commissioning at Merton Council that the working relationship with the Trust is open and effective. He stated that there are both

formal and informal forums for two-way communication, both of which work well. As a standing element of quality and safety, progress made against action plans are routinely monitored.

Patient medication compliance

5.23 In this section we review the challenges that GP face when prescribing patients on antipsychotic or other psychotropic medication (e.g. mood stabilisers & antidepressants) and are at risk of non-compliance and any progress made.

5.24 The primary body for setting policy and ensuring adherence to these policies is the quarterly Mental Health Interface Prescribing Forum. This is attended by the Trust and the medicines management teams from all CCG's. In this forum, instances of where medicines compliance issues have arisen (and the risks associated with this) are highlighted and corrective actions agreed.

5.25 It was agreed that all patients registered on the Serious Mental Illness (SMI) register will be monitored to ensure that medication is collected from the pharmacy or that patients have attended for depot medication. For patients still under the care of the Trust, there is now an electronic prescribing system that will ensure non-attendance for depot injections is flagged.

5.26 It is recognised, however, that simply ensuring that medication is collected does not guarantee that it is being taken.

5.27 The Primary Care Liaison teams play a significant role in monitoring patients on the SMI register through direct contact with these patients and using their personal support networks (family, clubs etc) to monitor their state of wellbeing. On this basis, we commend the Trust for this valuable initiative.

Finding

F6 We are satisfied that the Trust, in consultation with GPs, have taken all practical steps to ensure that patients comply with their medication regime.

6. Overall summary

6.1 This external quality assurance review comprised of a review of documents and policies provided by the South West London and St George's NHS Foundation Trust, coupled with interviews with key personnel from the Trust and CCG's.

6.2 It was very clear over the course of the investigation that the Trust has treated this case with the degree of seriousness merited by the events and has taken practical, actionable steps to minimise the likelihood of a similar incident occurring in future.

6.3 The case is clearly a very tragic one. Risk can never be entirely removed from the management of serious mental illness, but we are assured that the Trust has developed new protocols and services that will contribute to the minimisation of these risks.

Appendix A

Documentary Evidence

- Trust root cause analysis investigation report
- Trust internal action plan
- CCG action plan tracker
- CCG Serious Incident Review Group ToR's
- Trust clinical risk assessment and risk management policy
- Risk assessment training and education (RATE) course materials
- Risk assessment and safety alert SBAR (Situation, background, Assessment, recommendation) documentation
- Quality Governance Group minutes
- Quality audit survey report
- Merton Uplift specification
- Trust monthly learning bulletin
- GP locality meeting minutes
- Joint Primary Care Quality Review Group Wednesday 25th July 2018
- Learning from Incidents in Primary Care review minutes
- Care planning standards poster
- Regulation 28 – Report to prevent future deaths
- Department of Health and Social Care response to Regulation 28 report

Appendix B

The Trust's internal action plan

Action Plan – 2016/2877

	Action 1	Action 2	Action 3	Action 4
Recommendation	The Trust's current Risk Management training should be reviewed to ensure that it is suitable to the range of services and individual clinical roles.	The Trust to develop integration of Risk Management and Care Planning	Improve Trust and primary care shared risk management and re-referral of higher risk cases following discharge.	The Trust and CCGs need to develop a shared protocol for the oversight and escalation of medication collection and compliance for patients assessed to be at increased risk.
Action to Address Root Cause	Quality Governance Department to coordinate review of Risk Management Training.	Task and Finish group to be established to provide a plan for further integration.	Trust and Lead CCG to develop a Task and Finish group to develop shared arrangements.	To be included in the Terms of Reference for Action 3
Level for Action (Org, Direct, Team)	Organisation	Organisation	Organisation and CCG	Organisation and CCG
Implementation by:	Quality Governance overseen by Head of Risk	Quality Governance with Rio change group	CCG Care Quality Review Group (CQRG)	CCG Care Quality Review Group (CQRG)
Target Date for Implementation	December 31st 2016	January 31st 2017	January 31st 2017	January 31st 2017
Additional Resources Required (Time, money, other)	Time	Time	Time	Time

	Action 1	Action 2	Action 3	Action 4
Evidence of Progress and Completion	Minutes of review group	Terms of Reference and minutes of Task and Finish group	Terms of Reference and minutes of Task and Finish group	Terms of Reference and minutes of Task and Finish group
Monitoring & Evaluation Arrangements	Monitored through the Monthly Learning Group	Monitored through the Monthly Learning Group	Monitored through CQRG	Monitored through CQRG
Sign off - action completed date:	Sign off at Quality Assurance Sub Committee (QSAC)	Sign off at Information Governance Group (IGG)	Sign off at CQRG	Sign off at CQRG
Sign off by:	Chair of QSAC	Chair of IGG	Chair of CQRG	Chair of CQRG
Update 22nd November 2017	The Trust has reviewed and re-launched the Risk Assessment Training and Education (RATE) programme. The training is now mandatory for all clinical staff. This consists of an e-learning package and assessment followed by a full day face to face training which includes theatrical and practical training. From November 2017, Through the new Trust Service Line Reporting structure more RATE trainers are being trained. This will provide service specific and more individualised training for particular specialist areas and services.	The Trust RATE training now integrates Risk Management and Care Planning through the application of *Risk Formulation and Risk Management Plans*.	Quality Standards document launched in April 2017. The Community Quality Standards highlight that a client who has been discharged from services can rapidly re-engage directly with the Community team within 6 months of discharge without having to be re-assessed by the Single Point of Access Team.	The Medicines Code Policy (TWC20) highlights the internal document for raising issues about compliance. The general shared care says: • GPs should raise issues of non-compliance back to specialist services. • Specialist services will monitor compliance and initiate actions to support adherence with medicines. • Changes to the clinical picture will be communicated to GPs. This is to be re-issued via the MLB in January 2018.