Independent review of mental health treatment and care provided by Leicestershire Partnership NHS Trust

Confidential

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Commissioner:	Ms Mette Vognsen Head of Independent Investigations NHS England and NHS Improvement (Midlands and East of England)

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Contents

EXECUTIVE SUMMARY

1. Introduction 3
2. Methodology..3
3. Background…..4
4. The incident ………..4
5. Findings and conclusions..5
6. Recommendations…..7

MAIN REPORT

7.Introduction 8

8 Methodology…..8

9. The Incident 10

10.Background…..11

11. Findings and conclusions 12

12. Recommendations …..22

APPENDICES

APPENDIX 1: TERMS OR REFERENCE…..25

APPENDIX 2: THE INVESTIGATION TEAM...29

APPENDIX 3: STAFF INTERVIEWED…...30

APPENDIX 4 : RECOMMENDATIONS MADE BY THE TRUST INVESTIGATION…31

APPENDIX 5: CHRONOLOGY OF CARE…..33

Independent review of mental health treatment and care provided by Leicestershire Partnership NHS Trust

Executive Summary

1. Introduction

1.1 This is the report of an independent review commissioned by NHS England of care provided by Leicestershire Partnership NHS Trust (hereinafter called `the Trust') for `Tom' (not his name, nor the names of his family), 46yrs old, who attacked and killed his 92yr old father Frank on 2nd July 2019. Tom subsequently pleaded guilty to manslaughter with diminished responsibility due to mental ill health and he was given an indefinite psychiatric hospital order. We would like to extend our sincere condolences to Tom's mother Elsie and her family for their loss in such tragic circumstances.

2. Methodology

2.2 Our independent review commenced in December 2019 and was completed in the Autumn of 2020, somewhat delayed owing to due Covid-19.

2.3 Our review was commissioned by NHSE and was undertaken separately from any police, legal or Coronial proceedings. However, we were fortunate to be able to work alongside and contribute to a Domestic Homicide Review (DHR) commissioned by the local Community Safety Partnership under guidance issued by the Home Office issued under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). Our team is grateful to the chair and panel appointed to deliver the DHR for the information and support they provided

2.4 Our TOR outlined a requirement to understand the care and treatment provided for Tom from his first contact with specialist mental health services up until the date of the incident (see Appendix 1 in our main report). Information about our team consisted of an experienced consultant psychiatrist, a nurse with dual (general and mental health) qualifications and a clinical psychologist (see Appendix 2).

2.5 Our review was conducted in accordance with NHS guidance which is designed to support the delivery of investigations or reviews to:

- Clarify what, if anything, went wrong with NHS care.
- Minimise the possibility that such an event could recur.
- Make recommendations for the delivery of health services in the future, and

- Support families and the public to understand what happened.

2.6 In conducting our review, we were grateful to the Trust for providing access to their electronic case records about Tom who was their patient at the time when the incident occurred, and other material such as Trust policy documents to help us understand the care that was provided for him and its context. More information is detailed in the main report.

3. Background

3.1 Tom was the middle child of three, with an older sister and a brother with whom he worked periodically; he lived at home with Tom his elderly parents (Elsie, 86 and Frank, 92 years). Tom's parents were his main sources of support and contact since leaving home at the age of 16 to go travelling. Tom had not been in regular paid work for several years.

3.2 Tom was reported in the electronic case notes to have first experienced symptoms of mental ill health in his early twenties in 1995 after a trip to Australia when he began to use illicit substances. He was first admitted to a psychiatric hospital in 1999 (age 29). He remained an inpatient for three months, first on Section 2 (S.2) of the Mental Health Act 1983 (MHA) and then detained under a S3.

3.3 Prior to this, Tom was reported to have been verbally abusive to his mother, Elsie; he had lost his job as a fitter and had been spending considerable amounts of time alone in his room. He thought that spirits were influencing him and that passing cars had control over him; he was guarded and denied mental health problems, but he was also disinhibited: talking about his thoughts and ideas. At that time Tom was given a diagnosis of paranoid schizophrenia and also had symptoms associated with drug misuse.

3.4 Tom had two further admissions to a psychiatric hospital; on the second time, fourteen years later in January 2014, he was admitted as an informal inpatient for a month. On the third occasion, four years later, he was detained for 4 months between February and June 2018 under S.2 and then S.3.

3.5 On each occasion, the pattern of Tom's contact with inpatient services appears to have been characterised by relatively poor compliance with medication, substance misuse, paranoia and occasional aggression. His insight and motivation were recorded as limited. The notes also suggest that Tom occasionally experienced recurrences of his mental ill health around the time that his medication was due, when it may be assumed that the drugs in his system were lower.

3.6 Tom did not like taking medication, even when in the community, and he particularly disliked having injections which were administered owing to Tom's disinclination to take tablets. However, he also disliked having his blood checked – a necessity when taking the medication (Clozapine) which is associated with a risk of a falling white blood cell count.

3.7 The chronology relates (see Appendix 6 for a full account) that Tom was supported latterly in the community through a combination of medication, support from his parents, and visits by the Trust community mental health team with outpatient appointments, home visits by the consultant, non-specific support and advice, and encouragement relating to work, housing and benefits.

4. The Incident

4.1 A Community Psychiatric Nurse (CPN) visited Tom at home at 10.40 AM on 2nd July 2019 to administer his injection. The CPN noted that Tom was showing no obvious signs of thought disorder. Tom asked the CPN if he would need to have injections for the rest of his life and was advised that he would need medication for the foreseeable future. Elsie, Tom's mother, told the CPN she was pleased that Tom had an Outpatient Department (OPD) appointment the following day: she thought he had been more restless and had been pacing and chain-smoking. The CPN administered Tom's medication and left the house.

4.2 At 16.13 hours on the same day a call was made to a Mental Health Practitioner (MHP) from Elsie's house to say that Tom had stabbed his father who died at the scene. Police were called and Tom was arrested. Reviewed by a Mental Health Practitioner (MHP) just after 9pm that evening in detention, Tom was judged as fully orientated to time, place and person and as having capacity. He was not noted to be agitated or irritable.

5. Findings

5.1 Our team has discussed findings in a chronological order, consistent with the history of Tom's NHS care. Prior to the early treatment and care, our team has no reason to doubt that Tom's diagnosis (paranoid schizophrenia) was correct, and that his treatment pathway was appropriate. The MHA was used appropriately to detain Tom when it was clear that he needed a Mental Health Assessment and, possibly, treatment but lacked insight and represented a risk.

5.2 Tom was admitted on S2 of the MHA (13th February 2018) which was later converted to S 3. He was hostile and aggressive during this admission and, on 15th April 2018, he was granted approved (unescorted) day leave to his parents' house. However, he failed to return to the ward later in the day as required. The police were contacted, but they were apparently reluctant to fetch Tom, suggesting that an ambulance should be called instead. There was also some uncertainty as to whether an arrest warrant would be required when a patient is already legally detained.

5.3 It is not uncommon for misunderstandings (about protocols and the scope of the law) to occur in such circumstances. We would urge the Trust and the police to discuss together how they might consider developing knowledge, understanding and improving practice when patients are detained under a Section of the MHA and are threatening or needing help to be returned such as in these circumstances. This might usefully also clarify arrangements for detention under S.136 of the MHA and the arrangements for removal to the Health Based Place of Safety (HBPOS).

5.4 The electronic records show that Tom had a care plan up until the point when he was discharged from hospital on 10th June 2019. The notes also make it clear that Tom's parents (latterly, Elsie, alone in supporting Tom, because Frank was unwell) were involved appropriately in care plan reviews. However, from that point forward, contrary to Trust policy and national guidance Tom was not registered under the Care Programme Approach (CPA) and his family were not recorded as having been formally involved in decisions about Tom's care.

5.5 The risk assessment (the last one recorded in the notes) had been updated on 29th May 2018 whilst Tom was on home leave and this was based upon a full assessment of risk dated 13th February 2018 when Tom was admitted for the third time on S.2 of the MHA. The risk assessment completed at this point appears to have been thorough. It notes Tom's dependence upon Elsie and Frank and their wish that he should be helped to find accommodation. It reports Tom's parents' concern about him, their increasing age and the fact that they were finding him difficult. It describes them as having reported Tom to have been behaving in an aggressive manner (pacing, slamming the kettle, banging doors, smoking continuously and drinking). However, no referral to safeguarding is evident.

5.6 Inpatient safeguarding enquires are completed on behalf of the Local Authority (LA) by the Trust and UHL[1], with the LA retaining oversight via a locally agreed oversight process (see Section 4.2.1 of Leicester, Leicestershire and Rutland Multi-agency Safeguarding Procedures[2]). Systems exist to support the clinical teams working in inpatient services within the Trust and the NHS adult and children's advisers are co-located. There is an advisory helpline for inpatient staff if they have any questions and our team was also informed by one of the Trust team that a SG practitioner will come out to do a home visit, if asked. Despite the availability of effective SG structures, our team was informed that clinical staff are not as aware of their SG responsibilities as they should be, or as ready to refer as they should ideally be. More detail is provided in the main report.

5.7 In April 2019, the CPN asked whether Tom's medication (his depot) could be increased from every three weeks to every two weeks (effectively increasing the dose by a third) because there were signs that he was becoming unwell. Tom was reportedly concerned about whether he had to go to the job centre for a return to work interview and he mentioned that `the eye' was on him – a recurring symptom of his paranoid psychosis. The consultant agreed (without seeing Tom in person) that his medication could be increased, and Tom was reassured concerning the fact that there was no need for him to go to the job centre.

5.8 Our team does not disagree that it was appropriate to increase Tom's medication. However, we were concerned to note how difficult it was reported to secure an outpatient appointment for a patient about whom concerns had been raised. Furthermore, there was a delay of a week in administering Tom's anti-psychotic medication which reportedly would have caused his blood anti-psychotic levels to have fallen.

6. Recommendations

6.1 Our first recommendation is designed to improve knowledge and practice when NHS and police staff overlap and when operational manners and procedures challenge patients. We urge the Trust and the police to discuss together (for example, in a workshop or a series of seminars focused on best practice) how they might consider developing knowledge, understanding and improve practice when patients need to be taken to the Health Based Place of Safety (HBPOS) under S.136 of the MHA and/or who are already detained under Section of the MHA and need help to be returned to hospital.

[1] UHL refers to the University Hospitals of Leicester NHS Trust and covers Leicester Royal Infirmary, Glenfield General and Leicester General and its outlying County hospitals

[2] https://www.llradultsafeguarding.co.uk/contents/#introduction

6.2 Our second recommendation concerns the need for Trust clinical teams and leaders to improve learning, awareness, motivation and responsiveness to safeguarding practice. Whilst safeguarding staff, policy and systems exist in the Trust, operational routine practice is not currently embedded. We recommend that the Trust should take action and demonstrate metrics as well as qualitative feedback within six months

6.3 Our third recommendation concerns the impact of the community transformation. Our team recommends that the Trust should show how basic care processes (e.g., care planning, risk assessment, and access to outpatient appointments, etc.) are being delivered during the transformation. Our team urges particular special attention to the quality and content of risk assessment, an area of concern in Tom's case.

Independent review of mental health treatment and care provided by Leicestershire Partnership NHS Trust

7. Introduction

7.1 This is the report of an independent review commissioned by NHS England (NHSE), Midlands and East region of care provided by Leicestershire Partnership NHS Trust (hereinafter called `the Trust') for `Tom' (not his real name), 46yrs old, who attacked and killed his 92yr old father Frank (also a pseudonym) on 2nd July 2019.

7.2 X subsequently pleaded guilty to manslaughter with diminished responsibility due to mental ill health and he was given an indefinite psychiatric hospital order[3].

7.3 We would like to extend our sincere condolences to Tom's mother, Elsie (a pseudonym) and her family for their loss in such tragic circumstances.

8 Methodology

8.1 Our work was carried out separately from any police, legal or Coronial proceedings. However, we were fortunate to be able to work alongside and contribute to a Domestic Homicide Review (DHR) commissioned by the local Community Safety Partnership under guidance issued by the Home Office[4] issued under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). Our team is grateful to the chair and panel appointed to deliver the DHR for the information and support they provided.

8.2 Full Terms of Reference (TOR) for the DHR are provided in Appendix 1. Those elements of the TOR applying solely to the work of our team can be found at the end.

8.3 Appendix 2 contains information about the team (our team), which was appointed in December 2019 with a representative from NHSE and senior members of the Trust. The team consists of an experienced consultant psychiatrist, a nurse with dual (general and mental health) qualifications (see footnote 9) and a clinical psychologist. The team normally works under contract to NHS England to provide investigations into homicides and suicides by people in contact with NHS mental health services.

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[3] Section 37/41 of the Mental Health Act may be imposed by the Court following a homicide due to mental ill health; patients detained under this Section may not leave hospital; release is subject to review by a Mental Health Review Tribunal and is only permitted following agreement by the Home Office.

[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office, 2011 and 2016.

8.4 Our TOR outlined a requirement to understand the care and treatment provided for Tom from his first contact with specialist mental health services up until the date of the incident. We are grateful to the Trust for providing access to their electronic case records about Tom who was their patient at the time when the incident occurred, and other material such as Trust policy documents to help us understand the care that was provided for him and its context.

8.5 Our review was conducted in accordance with NHS guidance[5] which is designed to support the delivery of investigations or reviews to:

- Clarify what, if anything, went wrong with NHS care.
- Minimise the possibility that such an event could recur.
- Make recommendations for the delivery of health services in the future, and
- Support families and the public to understand what happened.

8.6 An initial face to face scoping meeting with staff from the Trust and our NHSE commissioner was held in December 2019; this provided the opportunity to discuss our methodology, the arrangements to appoint the investigation team and to agree that there were no conflicts of interest or other concerns. It was agreed that the team should conduct a desktop review of documents (electronic case notes, policy documents) to enable us to verify the content of an internal investigation that was commissioned from an independent provider by the Trust immediately after the incident occurred.

8.7 Once our team had reviewed the electronic records and could verify the content of the Trust investigation report, we agreed that we would conduct personal interviews with Trust staff to understand progress with the Action Plan agreed following Trust investigation, and any other changes to and/or improvements in Trust services since the time of the incident. It was agreed that we would not, unless it proved essential, re-interview the direct care staff who had been most closely associated with providing care for Tom owing to the degree of distress for them that this would involve. Staff were shocked and upset to learn what happened and said that they would not have predicted it likely.

8.8 It was agreed that the Chair of the DHR panel would take responsibility for providing a Single Point of Contact (SPOC) for all communications with Tom's family to remove the risk of duplication and reduce sources of potential stress and confusion for them, given that several agencies were reviewing their own histories of contact with Tom. Our team therefore had no direct contact with Tom's family. However, we did have the benefit of information provided through the chair of the DHR.

8.9 All interviews with staff (listed by job title at Appendix 3), given that they took place during the Covid-19 restrictions, were conducted by videoconference and

[5] https://www.england.nhs.uk/patientsafety/serious-incident/ and https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports/

telephone. Adapted Salmon principles were used: all witnesses were given information about the review; its purpose and scope; information about the team, and assurances about confidentiality and its limits. All interviewees were given the opportunity to be accompanied to the interview(s) if they wished and a written account of each conversation was submitted to each interviewee for their comments and corrections before being signed off. We are grateful to staff at the Trust who were able to meet with us and help the team to understand how care was provided at the time when the incident occurred, and the changes that have been introduced since. Our conversations with staff were focused primarily upon progress with the recommendations that were made in the Trust investigation report (see Appendix 4).

8.10 The DHR report and our own report were produced in parallel. The DHR report is more broad ranging than our own which focuses solely upon the care provided by the Trust. The DHR report, by contrast, also contains information about the primary health and social care, police and other contacts made with Tom over the course of his life, as well as information about Frank and Elsie. Readers are urged to look at the two reports together and to be aware that our teams worked in partnership to develop our recommendations to ensure that these were appropriate for all their recipients. Working together helped to ensure that information gathered from different sources about the same events could be triangulated, and it helped to ensure a focus on communication and cross-boundary partnership working – areas that are crucial to the effective management of safety and risk when people, like Tom, with severe mental ill health are supported in the community.

9 The Incident

9.1 This section provides a very brief summary of the events of 2nd July 2019. More detail about the antecedents of the incident and the longer-term history of care provided for Tom by the Trust, and the events that immediately preceded the incident, are provided in Section 4 below.

9.2 A Community Psychiatric Nurse (CPN) visited Tom at home at 10.40 hours on 2nd July 2019 to administer his injection. The CPN noted that Tom was showing no obvious signs of thought disorder. Tom asked the CPN if he would need to have injections for the rest of his life and was advised that he would need medication for the foreseeable future. Elsie told the CPN she was pleased that Tom had an Outpatient Department (OPD) appointment the following day: she thought Tom had been more restless and had been pacing and chain-smoking. The CPN administered Tom's medication and left the house.

9.3 At 16.13 hours a call was made to a Mental Health Practitioner (MHP) from Tom's mother's house Elsie to say that Tom had stabbed Frank, his father, who died at the scene. Police were called and Tom was arrested. Reviewed by a Mental Health Practitioner (MHP) just after 9pm that evening in detention, Tom was judged as

fully orientated to time, place and person and as having capacity. He was not noted to be agitated or irritable.

10 Background

10.1 Tom was the middle child of three, with one older sister and a brother with whom he worked periodically; he lived at home with his elderly parents Elsie and Frank (86 and 92 years at the time of the incident). Tom's parents were his main sources of support and contact ever since he left school at age 16 and went travelling. Tom lived with Elsie and Frank and had not been in regular paid work for several years.

10.2 Tom is reported in the electronic case notes provided by the Trust to have first experienced symptoms of mental ill health in his early twenties in 1995 after a trip to Australia when he began to use illicit substances. He was first admitted to psychiatric hospital in 1999 (age 29) on Section 2 (S.2)[6] of the Mental health Act 1983 (MHA) which was then converted to a S.3 and he remained an inpatient for three months. At this time, Tom was reported to have been verbally abusive to his mother; he had lost his job as a fitter and was spending considerable amounts of time alone in his room. He thought that spirits were influencing him and that passing cars had control over him; he was guarded and denied mental health problems, but he was also disinhibited: talking about his thoughts and ideas. At that time Tom was given a diagnosis of paranoid schizophrenia and had also symptoms associated with drug misuse.

10.3 Tom had two further admissions to psychiatric hospital following recurrences of his psychotic symptoms. One, in January 2014, fourteen years later, for a month as an informal patient and the other for 4 months, four years after that, between February and June 2018, again under S.2 and S.3. of the MHA. On each occasion, the pattern of Tom's contact with services appears to have been characterised by relatively poor compliance with medication, substance misuse, paranoia and occasional aggression. His insight and motivation were recorded as limited. Tom did not like taking medication and he particularly disliked having injections which were administered owing to Tom's disinclination to take tablets. However, he also disliked having his blood checked – a necessity when taking the medication (Clozapine) which is associated with a risk of a falling white blood cell count. The notes also suggest that Tom occasionally experienced `breakthrough' symptoms, especially around the time that his medication was due.

10.4 Following each discharge, Tom was visited regularly by members of the community mental health team and he lived with and continued to be supported by his increasingly elderly parents at the family home. In the next section, our team's findings and opinions are considered in relation to the specific items listed in our NHS TOR (Appendix 1). Where it makes more narrative sense, these items from

[6] Section 2 of the MHA permits detention for assessment in psychiatric hospital for a person who is assessed by trained professionals to be at risk to themselves or others due to mental ill health for up to one month. Section 3 (renewable) permits detention for up to six months.

the TOR are considered in their chronological order and, where they overlap, some of them have been considered together.

11 Findings

Examine the NHS contribution into the care and treatment of the service user from his first contact with specialist mental health services up until the date of the incident.

Review the appropriateness of the treatment of the service user in the light of any identified health needs/treatment pathway.

11.1 An abbreviated tabular chronology of care from the point when Tom first came into contact with specialised mental health services up until the date of the incident is provided in Appendix 5. This summarises the NHS care provided in just over nineteen years between 1999 when X was first admitted to psychiatric hospital and the support provided by the community mental health service after Tom was discharged from his third admission in 2018.

11.2 Our team has no reason to doubt that Tom's diagnosis (paranoid schizophrenia) was correct, and his treatment pathway was appropriate. Descriptions in the notes of Tom's clinical presentation fit the criteria for such a diagnosis very well and the clinical team responded quickly when it became clear that he needed an admission and/or a change of medication.

11.3 The MHA was used appropriately to detain Tom when it was clear that he needed a mental health assessment and, possibly, treatment but lacked insight, was reluctant to take medication, and therefore represented a risk. Tom was detained several times on a Section of the MHA and the notes make it clear that he was very unwell at these times, periodically showing signs of an aggressive manner, including towards Elsie, although he was not actually physically violent towards her.

11.4 The chronology in Appendix 6 relates to how Tom was supported latterly in the community through a combination of medication, support from his Elsie and Frank, and visits by the Trust community mental health team with outpatient appointments, home visits by the consultant, non-specific support and advice, and encouragement relating to work, housing and benefits.

11.5 It is not clear that Tom was formally offered anything other than drug treatment or general support and advice. For example, he was not offered psychological therapy. However, it would not be unusual for someone with the degree of interpersonal challenge that Tom presented to fail to engage with more than the essential elements of mental health care. The notes show that Tom was referred to other appropriate sources of support when he was well enough to engage. It is

also clear that the staff were aware (and offered appropriate advice) in relation to his substance misuse.

11.6 The notes make it clear that Tom's physical health was monitored, and checks were made regularly to ensure that health risks associated with his medication were managed effectively. When it became clear that Tom's white blood cell count had fallen (a risk with the anti-psychotic Clozapine he had been prescribed), his medication was changed appropriately. Tom's CPN also alerted the GP when it became clear that Tom was not visiting for health checks, which was good practice.

11.7 Although Tom was not inclined to make very effective therapeutic relationships with mental health staff (he was often defensive, suspicious and unwilling to communicate – as is frequently observed in people with his diagnosis) it is also recorded that he had a good working relationship with his Community Psychiatric Nurse, particularly in the latter stages of his care prior to the incident.

11.8 In April 2019, the CPN asked whether Tom's medication (his depot) could be increased from every three weeks to every two weeks (effectively increasing the dose by a third) because there were signs that he was becoming unwell. Tom was reportedly concerned about whether he had to go to the job centre for a return to work interview and he mentioned that `the eye' was on him – a recurring symptom of his paranoid psychosis. The consultant agreed (without seeing Tom in person) that his medication could be increased, and Tom was reassured concerning the fact that there was no need for him to go to the job centre.

11.9 Our team does not disagree that it was appropriate to increase Tom's medication. However, we were concerned to note how difficult it was reported to be to secure an OPD appointment for a patient about whom concerns had been raised; this matter is discussed in more detail below.

11.10 Tom received his increased doses of medication in May and June 2019. However, the dose he should have had on 25th June 2019 was delayed by a week until 2nd July because the CPN whom Tom trusted to administer his injection went on holiday. Tom was reluctant to have his drugs administered by someone else and, presumably believing that it would be safe to wait (the notes and informants are not entirely consistent in explaining the reasons), Tom then received his medication a week late. This meant that his overall dose was effectively lowered by a third. As Tom previously (whilst on the ward) had experience of what are known as `breakthrough' symptoms (his psychosis was not always controlled effectively by the drugs) it is possible that, he was somewhat under-medicated at the time when - later that afternoon - the incident occurred.

11.11 Our team noted the helpful report of the pharmacy review commissioned by the author of the Trust investigation report which stated:

‘*This three week gap between doses equates to a daily dose of only one third BNF max and is less than the stated desired dose. Although an injection took place on 2nd July the effects of this would not be expected to be seen for a few days and so there is a strong possibility that X was under medicated at the time of the incident’*.

11.12 Like the authors of the Trust investogation, our team considers that whilst it is not possible to conclude definitively that Tom’s lowered medication was specifically causal in relation to his father’s death, it may have been a contributory factor. Secondly, we believe that the delay would likely have been detrimental to his health and wellbeing. Our team understands that steps are being taken to improve access to outpatient appointments and further discussion of this is provided below. Our team retains some concern that more work may be needed to get assurance on progress with the recommendation relating to this area in the Trust investigation report and this is also discussed below.

Examine the effectiveness of the service user’s Care Plan and Risk Assessment, including the involvement of the service user and his family.

11.13 The electronic records show that Tom had a care plan up until the point when he was discharged from hospital on 10th June 2019. The notes also make it clear that Elsie and Frank (latterly, solely Elsie, because Frank was unwell) were involved appropriately in care plan reviews. However, from that point forward, contrary to Trust policy[7] and national guidance Tom was not registered under the Care Programme Approach (CPA) and his family were not recorded as having been formally involved in decisions about Tom’s care.

11.14 Trust policy states that whilst the use of CPA is focused on those with most complex needs it is applicable to all people who use services. Policy states:

“*All patients accepted into secondary mental health (or learning disability) services care in LPT must receive a full assessment (including risk assessment), a care plan including the name of the person facilitating their care and regular reviews of that care plan and progress. This is a requirement, whether assigned to formal CPA or not.”*

11.15 The risk assessment (the last one recorded in the notes) had been updated on 29th May 2018 whilst Tom was on home leave and this was based upon a full assessment of risk dated 13th February 2018 when Tom was admitted for the third time on S.2 of the MHA, during which time he was recorded to have had a physical altercation with another patient which resulted in him being secluded. The risk assessment completed at that time appears to have been thorough. It notes Tom’s dependence upon Elsie and Frank, and their wish that he should be

[7] Leicestershire Partnership NHS Trust Care Programme Approach Policy and Procedure (adopted 15th November 2015)

helped to find accommodation for Tom. It reports Tom's parents' concern about him, their increasing age and the fact that they were finding him difficult. It describes them as having reported Tom to have been behaving in an aggressive manner (pacing, slamming the kettle, banging doors, smoking continuously and drinking). The notes also record that Tom had reported thoughts that Elsie was poisoning his food and was reluctant to take his medication.

11.16 When our team made inquiries about why Tom had apparently `fallen through the net'; did not have a Care plan or an updated risk assessment almost a year later when the incident occurred; or why the safeguarding team had not been alerted to respond to potential risks to Elsie and Frank's safety, the reasons remained unclear. Reference is made in the Trust investigation report to the fact that caseloads amongst community staff (the consultant psychiatrist and the nurses) were higher than average and that teams were (and are still) exceptionally busy. The CPN had a caseload of around 45 patients who all required a high level of support. The consultant psychiatrist to whom we spoke, who last saw Tom on 26th September 2018, also told us that he had expressed concern to the Trust Clinical Director about caseloads; he thought that demand for services is still currently exceeding capacity.

11.17 In discussion with staff, our team was informed that work has been undertaken to explore staff caseloads – a complicated issue – and a pilot was undertaken of an approach developed in Wales which proved too unwieldy to implement in practice. Other models are being tried. Senior staff reported to our team that they think caseloads (for the nursing staff) are more manageable than they were. The Trust monitors staffing closely with monthly returns identifying vacancies and bank and agency usage; the return includes a narrative aspect meaning that particular pressures such as maternity leave can be identified, and it permits a monthly `RAG' (red, amber, green) rating to be awarded. Staff informed our team that things appear to be improving as there are now no red ratings, however it is difficult to know what impact the pandemic has had.

11.18 We understand that recruitment to vacant medical and nursing posts remains challenging and that workloads for the medical staff currently remain high. Recruitment of doctors has apparently been difficult but, wherever possible, locums have been provided. Joint consultant clinics with nurses and telecom clinics have been used to try and ease the pressure. Booking systems have been changed to try and reduce non-attendances and text messages are sent to remind people of appointments. Senior medical staff told our team that `transformation is the only way to make the changes needed' and the Trust is currently planning a range of significant changes to the way that community teams are configured.

11.19 The transformation programme will amalgamate specialist teams (e.g., Assertive Outreach) into Community Mental Health Teams. This will ensure there are more professionals available to work the team caseloads, but there will also be

specialist skills available. The plan was for a six-month period of consultation starting earlier this year (2020). However, the pandemic has caused delays. In the meantime, a centralised point of access has been developed for patients presenting with issues that are not routine; this provides 24/7 access and is staffed by Band 6/7 clinical staff.

11.20 CPA and Risk assessment training have now been reviewed and Care Plans audited since the time of the incident and our team was assured that systems are now stronger. Our team recommends that staff should continue to be prompted through training and supervision to ensure that families (as appropriate) and partners in primary health, social care and education are always engaged, informed and heard whenever there are potentially vulnerable adults involved (`Think Family '). It will be important for the Trust to continue to work on this area.

11.21 Since the time of the incident that resulted in the death of Frank, work has been undertaken to strengthen collaborative care plans and this has been picked up by the Care Quality Commission (CQC). Patients now get a copy of their discharge summary as well as their care plan. On RIO there is a separate tab for care plans so that they are easier to find, although there are plans to change the electronic records system from RiO to SystmOne. The Trust has consulted with other providers to ensure they can get it right. Steps have been taken to ensure that patients in the community get a care plan with at least a three months' review. Qualitative aspects of the care plan are also considered routinely in clinical supervision, and risk assessments are being be reviewed regularly.

11.22 In clinical supervision, it is usual for two random sets of notes to be considered with the practitioner every 4-6 weeks. A checklist approach is used and if the records are not up to the required standard and escalation process exists that includes a `deeper dive' into other notes of the practitioner. The tool used includes risk assessment. It has recently been reviewed, and consideration is currently being given to using it electronically; once this is done, it will be relaunched

11.23 Our team considers that these developments may help to make a difference although at this point, delayed by restrictions due to Covid-19, it is much too early to tell. We also suspect that there may still be some uncertainty regarding CPA policy for patients who are discharged into the community without a formal care plan. Whilst Trust policy makes it clear that ` Discharge plans are not a substitute for the full CPA Care Plan recorded on the Trust Electronic Patient Record (EPR Primary System)'. We believe that the Trust should clarify and audit arrangements in practice for CPA practice in community teams in view of the following paragraph taken from the Trust CPA policy document which we found unclear:

At the point of discharge from in-patient services, all patients will have either the written Discharge Plan detailing immediate follow up care together with a crisis and

contingency plan and discharge medication or a copy of the updated CPA Care Plan or a copy of an e-discharge letter to the GP. Where the latter is used, the patient must be informed that this copy of the e-discharge letter is their discharge plan. A copy of the agreed Discharge Plan/information must be sent to the relevant GP within 24 hours. Discharge plans are not a substitute for the full CPA Care Plan recorded on the Trust Electronic Patient Record (EPR Primary System). However, where the e-CPA Care Plan cannot be updated and produced at the point of discharge, information provided to the Patient including details for the post discharge period must be recorded in a Discharge Plan. This and any other information relating to the discharge must be sent to the CMHT (or wherever discharged) where the e-CPA Care Plan will be amended accordingly. The Patient (and carer where appropriate) should be involved in, and aware of, any changes to the CPA Care Plan.

11.24 We know that most staff generally do their best for patients and may be affected when things go wrong. Whilst it is clear that the absence of a care plan and risk assessment are very important omissions, it also appears that the CPN supporting Tom in the months before the incident occurred maintained a good relationship with him; administered his medication appropriately; endeavoured to support him to find alternative accommodation, and liaised with his GP. Of course, she should also have completed the relevant paperwork which is essential to the management, communication, review, handover and delivery of effective community mental health care. We understand that personal supervision and further training have now been provided for this member of staff for whom this omission was unusual.

Review and assess compliance with local policies, national guidance and relevant statutory obligations.

11.25 Our team examined documents relating to Trust local policy, national guidance and relevant statutory obligations relating to provision of care for Tom. We did not find that there were material shortcomings in the provision of care for him; his care was broadly appropriate – at least up until the point of discharge from his most recent admission when there were failings in the delivery of policy on care planning and risk assessment. There were also shortcomings in relation to the ease with which a community patient about whom concerns had been raised could obtain an outpatient appointment to see a specialist.

11.26 Our team could see that the appropriate conditions for use of the MHA were met; that relevant forms were completed and leave and other arrangements were made in consultation with X's main carer – his mother – who was also involved in reviews on the ward. However, our team considers that there were shortcomings with regard to the Trust's delivery of its statutory obligations in relation to safeguarding.

Safeguarding

11.27 An Accountability and Assurance Framework for Vulnerable People in the Reformed NHS[8] sets out the safeguarding roles, duties and responsibilities of all organisations in NHS health and social care services; these responsibilities flow from duties under the Care Act 2014. There is (and was at the time of this incident) a section in RiO (the Electronic Patient Record system that will change shortly to SystmOne) for staff who complete a core assessment to record/list family members and then discuss with colleagues any concerns about safeguarding. However, no information was written in this section of the notes and no safeguarding referral was made, despite the fact that Elsie and Frank told staff that Tom had behaved in a threatening manner towards them when he was ill. The electronic notes do show, on more than one occasion, carer's assessments were undertaken (2010, 2012 and 2016) and that a befriender was identified to provide support for Elsie. This was good practice, but a referral to the safeguarding team should have been made.

11.28 There are two foci for safeguarding (SG): one for inpatients overseen by the Trust and one for patients in the community linking directly into the Local Authority. Inpatient safeguarding enquires are completed on behalf of the Local Authority (LA) by the Trust and UHL[9], with the LA retaining oversight via a locally agreed oversight process (see Section 4.2.1 of Leicester, Leicestershire and Rutland Multi-agency Safeguarding Procedures[10]). Systems exist to support the clinical teams working in inpatient services within the Trust and the NHS adult and children's advisers are co-located. There is an advisory helpline for inpatient staff if they have any questions and our team was also informed by one of the Trust team that a SG practitioner will come out to do a home visit, if asked. Despite the availability of effective SG structures, our team was informed that clinical staff are not as aware of their SG responsibilities as they should be, or as ready to refer as they should ideally be. This may be a training issue, and/or an issue that relates to the `culture' of care provision. It is a matter that has been previously addressed by the Trust through training, and our team thought that senior leaders in clinical teams could do more to reinforce by personal example and through more effective supervision of their staff.

11.29 Having said this, use of the SG team has improved and there are many more SG referrals and discussions than before. The Trust has also worked in recent months to make more effective connections between adults and children's services to ensure that joint work can be undertaken when children as well as adults may be vulnerable. It is possible, in this case, had safeguarding concerns been addressed, the unforeseen risk to Elsie and Frank might have been identified so our team urges the Trust to continue to audit and check this important area of care.

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[8] http://www.surreyheathccg.nhs.uk/doc-engagement/nhs-england-safeguarding/470-nhs-england-safeguarding-accountability-assurance-framework/file

[9] UHL refers to the University Hospitals of Leicester NHS Trust and covers Leicester Royal Infirmary, Glenfield General and Leicester General and its outlying County hospitals

[10] https://www.llradultsafeguarding.co.uk/contents/#introduction

Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user

11.30 Our team could see from the notes that Tom was referred appropriately to inpatient services and discharged at what appeared to be appropriate times. Effective communications regarding his care (notwithstanding the omissions described above in regard to care plans and risk assessments) and treatment were sent to the GP. For example, the Core Mental Health Assessment completed on 13th February 2018 when Tom was admitted for the third time for almost four months until 10th June 2019 on S.2 of the MHA is a thorough account of Tom's history, presenting symptoms, personality, and treatment. The consultant responsible for Tom's care in the community last saw him prior to the incident on 26th September 2018. At this point, a comprehensive summary of his care was sent to the GP which described the plan for his care and support in the community by the CPN.

11.31 Discharge summaries have recently been subject to an audit and junior doctors who change every 4-6 months have received teaching to support delivery of more effective discharge summaries as part of their induction. The Trust used to undertake an e-audit of discharge summaries as part of the quality schedule, which was reported to the commissioners but, as these were consistently good, the commissioners dropped the requirement to collect them.

11.32 Our team could also see that the consultant had responded effectively and appropriately to the CPN when she raised a concern that Tom might be relapsing and wanted to refer him to outpatients for a consultation. Even though an appointment in outpatients could not be secured for three months, the consultant signed off the request to increase Tom's medication. However, our team could see that other agencies had not been contacted about a potential change in Tom's level of risk and this represents an omission.

11.33 In the weeks immediately prior to the incident, District nurses had attended the house to provide support for Frank who was ill and frail following a hospital admission. Perhaps if Tom had had a care plan and a full current risk assessment, those documents might have provided a prompt to the community staff to consider alerting the general nurses to the fact that Tom had a severe mental illness, and had behaved aggressively to staff in the past when unwell. A review of such documentation might also have prompted consideration of whether it was wise to visit the home alone.

11.34 A risk assessment would also have included attention to mitigating as well as potential environmental triggers for Tom's relapsing mental ill health. The Trust investigation report comments, for example, on the fact that the family had a dog,

which Tom would take out for walks early in the morning; Tom's willingness to walk the dog was normally an indication that his mental health was stable. However, there is no information of how Tom felt about the fact that a few weeks prior to the incident the family dog died, or whether this increased his risk, although the facts were apparently known when the CPN visited on the morning of 2nd July 2019 to administer his injection.

11.35 One other area which our team thought merited attention concerned an event in April 2018. Tom had been admitted on S2 of the MHA (13th February 2018) which was later converted to S 3. He was hostile and aggressive during this admission and on 15th April 2018, he was granted approved (unescorted) day leave to his parents' house. However, he failed to return to the ward later in the day as required. The police were contacted, but they were apparently reluctant to fetch him; they suggested that an ambulance should go. Other notes suggest that there was some uncertainty as to whether an arrest warrant would be required. Two staff from the ward then attended the family home to persuade Tom to return, but left when he refused to engage with them, when he became threatening and aggressive. Elsie and Frank said they did not feel safe; Elsie said she felt too frightened of her son to ring the police herself. Police were informed and they then returned Tom to the ward. On his return to the ward, Tom was angry, verbally aggressive and pacing.

11.36 It is not uncommon for misunderstandings (about protocols and the scope of the law) to occur in such circumstances. We would urge the Trust to work with the police to develop a policy or memorandum of understanding to cover the occasions when a patient detained under Section of the MHA (when a warrant for a S.135 would not be needed) has to be returned and is behaving in a threatening manner. This might usefully also clarify arrangements for detention under S.136[11] of the MHA and the arrangements for removal to the Health Based Place of Safety (HBPOS)[12].

Critically examine and quality assure the NHS contributions to the Domestic Homicide Review.

11.37 Our team agrees with the overall conclusions drawn in the Trust investigation report (and the Individual Management Review (IMR) submitted by the Trust for the DHR Panel which was completed by the same author) says that `although Tom had been verbally aggressive to his parents in the past, the event that took place on the 2nd July 2019 was not predictable'.

11.38 The authors also conclude that it was an accumulation of contributory factors which together had a material impact on the events of that day, making it

[11] S.136 of the MHA permits police to take someone from a public place to a place of safety if they believe that due to mental ill health the person needs 'care or control'.

[12] A health-based place of safety is a location provided by the NHS where a person detained on S. 136 of the MHA can be managed safely while an appropriate assessment is undertaken by a psychiatrist and an approved mental health professional (AMHP).

impossible to have been prevented. Our team, like the author of the Trust investigation, has endeavoured to unpick the contributory factors, which include:

- X's diagnosis.
- His reluctance to engage.
- The likelihood that he was under-medicated.
- The absence of an effective current risk assessment and care plan
- Restrictions upon access to personal oversight by a senior clinician, and
- Environmental triggers about whose impact we can only speculate, including X's father's recent illness and the death of the family pet.

11.39 The Trust investigation commissioned by the Trust from an experienced independent provider is a thorough document. It is, rightly, critical of the care provided by the Trust for Tom. It and makes eleven recommendations for improvement covering the following areas (see Appendix 4):

- Co-production of care plans
- Monitoring and audit of care plans.
- Monitoring and audit of risk assessments.
- Conduct and monitoring of CPA reviews.
- Access to care plans in the electronic patient record.
- Caseloads of community mental health team staff.
- Access to outpatients' appointments.
- Taking a 'whole family' approach (two recommendations).
- Safeguarding.
- Medication management

Our team agrees that these recommendations have been made in the right areas. We note that the Trust has identified specific leads for the work that they have, are currently, or will be taking forward in an Action Plan to ensure that the recommendations are delivered, and this work is described above.

11.40 Our team is aware that the Trust has an Action Plan that is focused on implementing these recommendations, but we believe that it will take at least six months to be able to assess whether this and the service transformation plans are making a positive difference. We note that arrangements made due to the coronavirus pandemic has slowed progress. Furthermore, we know that organisational change is always disruptive, and there may well be a negative impact upon service quality before improvements can be bedded in. Our team therefore recommends a further review of these areas in 6 months' time.

Work alongside the Domestic Homicide Review panel and Chair to complete the review and liaise with the family.

11.41 As indicated above (see Section 2 Methodology), our team had the benefit of working in partnership with the chair of the DHR. The DHR panel gathered information from multiple sources (Police, social care, NHS, policy documents,

reports from the patient and the family, and other material). This was collated and used to construct a single chronology of care not only about Tom the perpetrator, but also for the victim, Frank. This helped our team to triangulate information we obtained from case notes and Trust staff about Tom and develop a more multi-dimensional picture of the care provided for him.

11.42 Agreement was reached with the DHR panel chair that he would provide a Single Point of Contact for Tom's family and our team therefore did not meet them directly. It can be difficult for staff as well as families if they have already participated in an internally commissioned independent investigation and are asked to repeat the process when another investigation team is appointed and again when a DHR investigation is commissioned by the local Community Safety Partnership. We believe that our approach, working alongside the DHR, was the right one for gaining assurance and minimising undue distress for those involved.

11.43 The opportunity to work alongside the DHR also meant that our recommendations – particularly any relating to cross-boundary and inter-agency working could be co-produced (made in partnership); written in language familiar to NHS partners, appropriately contextualised, and more easily understood.

12 **Recommendations**

12.1 Our first recommendation is designed to improve knowledge and practice when NHS and police staff overlap and when operational manners and procedures challenge patients. We urge the Trust and the police to discuss together (for example, in a workshop or a series of seminars focused on best practice) how they might consider developing knowledge, understanding and improve practice when patients need to be taken to the Health Based Place of Safety (HBPOS) under S.136 of the MHA and/or who are already detained under Section of the MHA and need help to be returned to hospital.

12.2 Our second recommendation concerns the need for Trust clinical teams and leaders to improve learning, awareness, motivation and responsiveness to safeguarding practice. Whilst safeguarding staff, policy and systems exist in the Trust, operational routine practice is not currently embedded. We recommend that the Trust should take action and demonstrate metrics as well as qualitative feedback within six months.

12.3 Our third recommendation concerns the impact of the community transformation. Our team recommends that the Trust should show how basic care processes (e.g., care planning, risk assessment, and access to outpatient appointments, etc.) are being delivered during the transformation. Our team urges particular special attention to the quality and content of risk assessment, an area of concern in X's case.

APPENDIX 1

TERMS OF REFERENCE FOR THE DOMESTIC HOMICIDE REVIEW

1. Supporting Framework

1.1. The Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

1.2. In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by

A person to whom he was related or with whom he was or had been in an intimate relationship; or

A member of the same household as himself,

Held with a view to identifying the lessons to be learnt from the death.

1.3. Where the definition, set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

2. Purpose of the DHR

2.1. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

2.2. Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

2.3. Apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;

2.4. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

2.5. Contribute to a better understanding of the nature of domestic violence and abuse; and

2.6. Highlight good practice.

3. Methodology

3.1. This DHR will primarily use an investigative, systems focuses and Individual Management Review (IMR) approach. This will ensure a full analysis by the IMR author to show comprehensive overview and alignment of actions.

3.2. This will ensure that practical and meaningful engagement of key frontline staff and managers will be carried out by the IMR author on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.3. This is more likely to embed learning into practice and support cultural change where required.

4. Scope of the DHR

4.1. Victim: Frank.

4.2. Perpetrator: Tom.

Timeframe

4.3. The scope of the DHR will be from (tbc when the report is completed)

4.4. In addition agencies may be asked to provide a brief background of any significant events and safeguarding issues in respect of this adult and include information around wider practice at the time of the incident as well as the practice in the case.

4.5. The Terms of Reference will be a standing item on the agenda of every panel meeting in order that the team can remain flexible in our approach to identify learning opportunities.

5. Agency Reports

5.1. Agency reports will be commissioned from relevant agencies

5.2. Agencies will be expected to complete a chronology and IMR. Template and guidance attached.

5.3. Any references to the adult, their family or individual members of staff must be in full and later redacted before submission to the Home Office or published.

5.4. Any reasons for non-cooperation must be reports and explained.

5.5. All agency reports must be quality assured and signed off by a senior manager within the agency prior to submission.

5.6. It is requested that any additional information requested from agencies by the DHR Independent Author is submitted on an updated version of the original IMR in red text and dated.

5.7. It is requested that timescales are strictly adhered to and it should be noted that failure to do so may have a direct impact on the content of the DHR and may be referred to in the final Overview Report to the Home Office

5.8. Agencies will be asked to update on any actions identified in the IMR prior to completion of the DHR which will be fed into the final report. Updates will then be requested until all actions are completed.

6. Areas for consideration

Victim:

6.1. Was the victim recognised or considered to be a victim of abuse and did the victim recognise themselves as being an object of abuse?

6.2. Did the victim disclose to anyone and if so, was the response appropriate?

6.3. Was this information recorded and shared where appropriate?

6.4. Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of the victim and their family?

6.5. When, and in what way, were the victim's wishes and feelings ascertained and considered?

6.6. Is it reasonable to assume that the wishes of the victim should have been known?

6.7. Was the victim informed of options/choices to make informed decisions?

6.8. Were they signposted to other agencies?

6.9. Was consideration of vulnerability or disability made by professionals in respect of the victim and perpetrator?

6.10. How accessible were the services for the victim and the perpetrator?

6.11. Was the victim or perpetrator subject to a Multi-agency Risk Assessment Conference (MARAC) or any other multiagency forum?

6.12. Did the victim have any contact with a domestic abuse organisation, charity or helpline?

Perpetrator:

6.13. Was the perpetrator recognised or considered to be a victim of abuse and did the perpetrator recognise themselves as being a perpetrator of abuse.?

6.14. Did the perpetrator disclose to anyone, and if so, was the response appropriate?

6.15. Was this information recorded and shared where appropriate?

6.16. Was anything known about the perpetrator? For example, were they being managed under MAPPA, did they require services, did they have access to services.

6.17. Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of the victim and their family?

6.18. Were services accessible for the perpetrator? And were they signposted to services?

6.19. Was consideration of vulnerability or disability made by professionals in respect of the perpetrator?

6.20. Did the perpetrator have contact with any domestic abuse organisation, charity or helpline?

Practitioners:

6.21. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

6.22. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Policy and Procedure:

6.23. Did the agency have policies and procedures in place for dealing with concerns about safeguarding and domestic abuse?

6.24. Did the agency have policy and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (e.g. DASH) and were those assessments correctly used in the case of this victim/perpetrator?

6.25. Where these assessment tools, procedures and policies professionals accepted as being effective?

7. Engagement with the individual/family

7.1. While the primary purpose of the DHR is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in, and across, agencies and services, it is imperative that the views of the individual/family and details of their involvement with the DHR are included in this.

7.2. Leicestershire and Rutland Safeguarding Boards, through the Independent Chair, are responsible for informing the family that a DHR has been commissioned and an Independent Chair has been appointed. The DHR process means that agency records will be reviewed and reported upon, this includes medical records of both the victim and perpetrator if consent is agreed by the Perpetrator.

7.3. Firstly, this is in recognition of the impact of the death of ….. giving family members the opportunity to meet the review panel if they wish and be given the

opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process focus on the victim's and perpetrator's perspectives rather than just agency views.

7.4. All IMRs are to include details of any family engagement that has taken place, or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the DHR in addition to the Police Family Liaison Officer, FLO, in respect of criminal proceedings.

8. Media Reporting

8.1. In the event of media interest, all agencies are to use a statement approved and provided by Leicestershire and Rutland Safeguarding Boards.

9. Publishing

9.1. It should be noted by all agencies that the DHR Overview Report will be published once completed, unless it would adversely impact on the adult or the family. Publication cannot take place without the permission of the DHR Home Office Quality Assurance Panel.

9.2. The media strategy around publishing will be managed by the DHR Panel in consultation with the chair of Leicestershire and Rutland Safeguarding Boards and communicated to all relevant parties as appropriate.

9.3. Consideration should be given by all agencies involved in regards to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware, in advance, of the intended publishing date.

9.4. Whenever appropriate and 'Easy Read' version of the report will be published.

10. Administration

10.1. The Domestic Homicide Review Officer will act as a conduit for all information moving between the Chair, IMR Authors, Panel Members and the DHR Panel.

SUPPLEMENTARY TERMS OF REFERENCE FOR PROVIDERS OF COLLABORATIVE INVESTIGATIONS COMMISSIONED BY NHS ENGLAND/NHS IMPROVEMENT

To examine the NHS contribution into the care and treatment of the service user from his first contact with specialist mental health services up until the date of the incident, and:

- Critically examine and quality assure the NHS contributions to the Domestic Homicide Review.
- Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user.
- 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.
- Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway.
- Work alongside the Domestic Homicide Review panel and Chair to complete the review and liaise with the family.
- Provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or standalone.

APPENDIX 2

Investigation team

Anne Richardson, BSc, MPhil, FBPsS, Director of ARC, is a clinical psychologist by training. She specialised in clinical work with adults with severe mental ill health and long-term needs. She is an experienced teacher/trainer and communicator, having worked as joint Course Director of the DClinPsy at UCL before moving to take a post at the Department of Health. Subsequently, as Head of mental health policy at the DH, she was instrumental in the development and delivery of the National Service Framework for Mental Health and, with Sir Jonathan Michael, led development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008).

Hugh Griffiths, MBBS FRCPsych, is a former consultant psychiatrist in the North-East of England where he carried responsibility for inpatient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, and liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as National Clinical Director for Mental Health (England) at the Department of Health, he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework. He retired from this post in March 2013 and now works as a non-Exec in a mental health trust in the north of England.

Adrian Childs RMN, RGN, DipN (Lond), MSc, Dip Exec Coaching, trained as a general and mental health nurse. He was director of nursing in Newcastle, Devon, Manchester and Leicester; he holds a diploma in leadership, mentoring and executive coaching. Adrian has contributed to several national working parties including the development and appointment of Consultant Nurses and development packages for nurses working with severe personality disorders. In 2014 Adrian was made Honorary Professor for the Faculty of Health and Life Sciences at De Montfort University, Leicester and in 2019 an Honorary Senior Fellow at Leicester University[13].

[13] Adrian Childs was Chief Nurse in Leicestershire Partnership Trust until six months before the incident to which this investigation related. At the initial scoping meeting with members from the Trust leadership team and a representative from NHSE/ I agreed that there were no conflicts of interest.

APPENDIX 3

Staff consulted

Lead Nurse

Consultant psychiatrist 1

Consultant psychiatrist 2

Deputy of Head of Nursing

Head of community Nursing

Head of Patient Safety

Consultant psychiatrist 3

Safeguarding lead

APPENDIX 4

RECOMMENDATIONS IN THE TRUST INVESTIGATION REPORT

1. It is recommended that care plans are co-produced with the patient and this is monitored at a team level in accordance with the Record Keeping and Care Planning Policy and the outcomes are reported to the Trust Quality systems every three months. This should be in place within three months

2. It is recommended that systems are put in place at a team level to monitor that all patients have a care plan as per the Record Keeping and Care Planning and assurance should be provided to the Trust Quality systems every three months. This should be in place with immediate action.

3. It is recommended that risk assessments are monitored at a team level in accordance with the Clinical Risk and Management policy and the outcomes are reported to the Trust Quality systems every three months.

4. It is recommended that CPA reviews and process should meet the standards of the Clinical Risk Assessment and Management policy and that this should be monitored at a team and strategic level through the Trust Quality systems every three months.

5. It is recommended that a process is agreed to provide access to the care plan in the electronic patient record when they are temporarily not in use, such as an episode of inpatient care. This system should ensure that the full records are available for use in practice, and this should be implemented within three months and monitored through the Information management and technology systems in the trust.

6. It is recommended that caseloads of the multi-professional Community Mental Health Teams be assessed for acuity and limits set to ensure that the clinicians have the capacity to deliver the services to the required standards, this should be achieved within three months, and monitoring systems put in place to enable escalation if caseloads should breach the numbers.

7. It is recommended that there is a review of the systems and processes of the medical provision in outpatients, to deliver a service which provides appointments to patients when required, this process should commence within two months and report through the performance management systems to the Board of Directors.

8. It is recommended that a ‘whole family’ approach is taken to deliver care when more than one clinical service is involved, to provide a systematic approach which includes risk assessment and the mitigation of risks, this should be in place within

six months and monitored through the Caldicott systems of the trust every three months.

9. It is recommended that where there are vulnerable adults living and caring for patients with serious mental illness, safeguarding adult advice should be accessed and if necessary, an assessment and review performed and documented, identification of patients in this situation should be made within three months, and monitored through trust safeguarding systems.

10. It is recommended that there should be an effective system in place between inpatient and community service settings to ensure that medication response and dosage is correct and responsive to the patient's needs. This system should be implemented within two months and monitored at the operational level.

11. It is recommended that a 'whole family' approach is taken to the involvement of family and carers in the delivery of care to patients with severe mental illness and assessment and engagement of their needs and the rationale for these decisions is documented, and this is monitored through the trust quality systems every three months

APPENDIX 5

TABULAR CHRONOLOGY OF CARE

1995	After travelling to India and Nepal in his early twenties, Tom became withdrawn, was seen to talk to himself and was low in mood. He reported `using his mind to enter other worlds', which gave him new insights and helped him to see the world differently. He had apparently been using illicit substances.
1999 Admission #1	He said that a spirit was trying to control him, and that he influenced others by a certain smile or vacant look. He believed the spirit brother was trying to destroy him and was powerful and tried to change his sex. He was diagnosed with paranoid schizophrenia and drug induced phenomena. He was treated with a depot (intramuscular) anti-psychotic.
2004	In March Tom was seen in outpatients and his depot was increased. He had stopped using cannabis and had reduced his alcohol to 2-3 pints of lager a week. He was interested in sports and football. A care plan and contingency plan were completed, and risks were identified. It was noted that he smashed some of his parents' belongings and could sometimes become aggressive. He reported that his mental state had deteriorated, and that he heard derogatory voices, had thought-blocking and was preoccupied.
2005	In Feb Elsie contacted the mental health services to advise that Tom had had gone on holiday to Australia. Due to this, his depot was delayed and given two weeks later than prescribed. On his return, Tom was noted to be hearing voices, which he did not want to discuss. Three weeks later Elsie contacted services again; she thought Tom needed urgent help. He was seen the following day and his depot medication was administered. Elsie reported that he was not sleeping and had increased his alcohol intake.
2006	In February, Tom contacted his CPN and admitted smoking cannabis. His brother also contacted services. Tom requested an increase in his depot medication. Notes record that he heard voices, had ideas of reference, and consumed alcohol; his medication was reviewed. Between May and July Tom continued to experience auditory

	phenomena and paranoid hallucinations. He reported struggling with crowds and his motivation was identified as a problem. His medication was increased.
2007	In August Tom reported that his psychotic symptoms were under control and he was managing to work between two and four days a week, he continued to have his depot and remained well for the next 18 months; he helped his brother at work, and went on holiday with his parents. At a CPA review in August, the risk screening tool did not indicate any risk to others.
2009	In August Tom's psychotic symptoms reoccurred, and the voices, led to an increase in his consumption of alcohol. Tom's sleep was impaired; he believed his life was restricted. He avoided social contact and was reported to be depressed and lacking motivation, but by November he had improved again.
2010	In March, Tom was recorded as not feeling well; he thought that people were talking about him, which resulted in anxiety when out. He was drinking alcohol. A referral was made for a carer's assessment for Elsie and it was suggested that a befriender might help her. Between April and August Tom attended outpatients and reported that his mental health symptoms were `breaking through'. This tended to happen when his when his depot was due, and he used alcohol to cope. He advised that he might not attend psychiatric appointments as he didn't believe they changed anything.
2011	Tom was seen in OPD in January. He reported that he would not attend his next outpatients' appointment in May due to `a woman in the next room being abusive'. His parents had been away; he felt someone was watching him, and he had re-commenced drinking nightly. His CPN referred Tom to Rethink for additional support. In September Tom reported feeling stressed by recent `return to work' interviews. In October he missed an outpatient's (OPD) appointment. Elsie contacted the service in December to ask for help. Tom's medication was increased (his depot medication was given early). It is noted that Tom's Consultant Psychiatrist and CPN visited him at home and that he was

	not washing; was staying in his bedroom with the blinds pulled; that he lacked insight and refused all interventions. He accused his parents of plotting and requested a lock on his door to stop them from entering. Tom's CPN whom he had known for 7-8 years reported that Tom was becoming curt and suspicious. A risk assessment indicated a risk for fire setting/arson, although this is not recorded in any other records. There was no indication of risks in relationship to others at this time.
2012	In Jan-Feb Tom was noted to be isolating himself and refusing to enter his garden at home due to his paranoia. He took extra medication as he was not sleeping well. His medication was changed. In March he was noted to have a tooth infection and refused to go to the dentist. He consumed additional alcohol and his medication was increased. His risk to himself or others was described as `low'. A carers' assessment was performed for Elsie and Frank in May. In September, Elsie requested a second medical opinion for Tom, who reported feeling that was `stuck'. In September Tom's medication was changed from Risperidone to Quetiapine. Elsie asked again for a second opinion but it is not clear from the notes if this was provided.
2013	In May the CPN wrote to the Consultant Psychiatrist because Tom had run out of the house into the street saying that people were talking about him. He ran to Elsie, said that Frank was being attacked outside, and that his face was yellow. Notes report Tom to have said he believed that his parents were against him and that he had been unwell for about fourteen months. Tom's medication was increased. In May, he had a medical review at home when it appeared that he had improved. In July Tom had a befriender assessment, but he turned down the offer. In August he was reviewed with his parents, brother and sister present. It was noted that Tom did not want this visit. By October, Tom had improved again and was walking the dog. He worked half a day a week in a warehouse and his parents were pleased with his progress. Tom's independence and a potential move to a flat in the local area were discussed; Tom's medication was Quetiapine 650mg. A professional's meeting took place to consider Tom's mental

	state and the ability of his parents to manage because Tom had been verbally abusive to his CPN and Elsie, and he believed that neighbours had called him a paedophile. A referral to Assertive Outreach was considered but it was noted that he would not meet the criteria.
2014 Admission # 2 (for just under one month)	On 3rd January, Tom was visited at home by his Consultant Psychiatrist. His medication was increased. On the 16th January 2014 Tom was admitted informally to Thornton ward. His risk assessment included a history of verbally abusive behaviours specifically to his family when he was unwell. He denied substance misuse. An initial drug screen indicated he was positive to cannabis (this was his last positive drug screen). Tom believed that his change in medication had precipitated his increased aggressive tendencies. He was discharged from the ward on the 12th February 2014. Whilst on the ward he was prescribed Clozapine. As the year progressed Tom's blood test results began to show a low White Blood cell Count. Staff continued to try to help him to find a flat although notes record that Tom's parents were not keen for him to live alone. A risk assessment acknowledged the increased level of risk due to the fact that his parents were now quite old and were becoming less able to support him.
2015	Early in 2015, social services were reported to have closed their search for accommodation owing to Tom's lack of engagement. At Tom's CPA review in May it was noted that he was staying at home, although he walked the dog, and he had coped alone whilst his parents were away. However, during a home visit in September Tom reported hearing voices. Elsie had been unwell, Frank was in poor health, and this made Tom anxious. Tom was also visited at home in October and found to be isolating himself; he was reported to be hearing derogatory male and female voices and as refusing to mix with his extended family; he had been out walking at t 5.00 am to avoid other people. A medical assessment at home in November, with his parents present, highlighted that Tom was continuing to hear voices and that his medication had not helped. Just prior to Christmas Tom was seen at home again; he was less troubled, and although he remained paranoid, he could rationalise

	this. He continued to spend most of his time in his bedroom. The risk assessment did not indicate any risk to others
2016	Tom continued to attend the clozapine clinic and to receive home visits. In February he was found to have a raised blood pressure and a raised pulse. At a home visit, he reported that he continued to hear voices, but felt better. He remained isolated. His mother had recently had a fall and had was getting help with the cleaning. In May Tom's Clozapine was increased; he was asked to attend his GP for an ECG but did not attend. In July Tom was visited at home. He continued to hear voices and reported no improvement since his medication increase. Tom commented that his high heart rate was due to his anxiety about attending clinic. His CPN continued to see him monthly, and Elsie was receiving some support. In August and September, Tom attended the clozapine clinic and was found again to have a raised heart rate. In October he had a cardio metabolic health screen, and a social worker visit was arranged.
2017	Tom continued to attend the Clozapine clinic and have home visits. In April he continued to look for flats, and he decorated his parents' home. He refused to attend Frank's 90th birthday. In May it was noted that Tom was stressed, paranoid and panicky when attending clinic; he had been accompanied by Elsie who was unwell. He was allocated a new CPN. In September Tom was recorded as having an Amber blood test result for his Clozapine and at the end of September 2017, he ceased taking it due to a 'red' result. He commenced Olanzapine and was required to attend clinic daily, though he did not want to. At an `allocations' meeting on the 3rd October 2017, Tom was noted to be of particular concern to the staff. On the 6th October 2017 Elsie called to report that Tom did not want to go to the clinic; he was verbally hostile and refused. Tom spoke to LPT staff on the telephone; was angry and terminated the call. Later that day he was visited at home by the Consultant Psychiatrist. He was abrupt and angry, and distracted by auditory hallucinations. Medication was provided. The following day Tom

was visited by the Crisis team, a Mental Health Practitioner but he refused to stay for the whole assessment.

On the 9th October 2017 Tom was calm when interviewed, monosyllabic and minimal in speech. He had stopped taking the dog out. A Crisis team keyworker was allocated, and the risk assessment was reviewed. A core mental health assessment was faxed to his GP. Tom was visited at home daily and on the 11th October 2017, he was noted to be better, less agitated and restless; he was then visited on alternate days. On the 16th October 2017 Tom was recorded to be pacing and drinking lots of tea and coffee, an indication of his deteriorating mental health. On the 18th October 2017 at a home visit, his sleep had improved. He talked about the ‘eye’ and asked what ‘ponce’ meant. He had disturbed thoughts and stopped watching television. Over the next two weeks Tom was seen every two days, but no notable improvement was shown. He was irritable and intimidating, and Elsie reported on the 29th October 2017 that she and Frank were frightened and had nearly had to barricade themselves into their bedroom the previous night. This incident was not included on his risk assessment.

A Mental Health Act assessment was performed on the 30th October 2017 but Tom was deemed not detainable. He continued to be visited daily by the crisis team. On the 6th November 2017, the visits were decreased to every two days. Tom had commenced walking the dog, although he seemed distracted. On the 22nd November 2017 it was noted that he was warmer towards staff, and he displayed unusual mannerisms, rubbing his teeth and covering his mouth. Two days later, a joint visit took place with his CPN and a member of the Crisis team; they found Tom to be guarded, suspicious and angry towards his parents; he was restless and fidgeting, and Elsie was upset, as Tom’s behaviour had become worse. Tom could not confirm that he was concordant with his medication. These risks were not noted on his risk assessment.

	On the 27th November 2017, Elsie raised concerns about his concordance with medication, as Tom was irritable and aggressive towards her. A Mental Health Act Assessment was initiated. Although a medical recommendation for Section 3 was provided, this was not agreed by the Approved Mental Health Practitioner. A medical review took place and Tom was discussed within the MDT. On the 3rd December 2017 during a home visit, Tom engaged in conversation and reported taking the dog out. He had fewer outbursts and was keen for the clinicians to leave. However, 2 days later, he was difficult to engage; had not slept and was hyperactive. Elsie felt his mental state was deteriorating and that he may need admission. Over the next two weeks Tom was noted to be calmer and more settled. He was less hostile, although he continued to respond to unseen stimuli. Tom was discharged from Crisis team on the 15th December 2017 after a joint visit with his CPN
2018	During January Tom was visited at home weekly, but his parents reported that he was not doing well. Tom believed someone had stolen his laptop and mobile phone; he was pacing, hostile and agitated. On the 22nd January 2018 Tom was hostile during the home visit; he paced frequently and drank large amounts of tea and coffee; he shouted and was swearing. A medical review on the 29th January 2018, found Tom defensive, and difficult to engage in conversation; his risk assessment was not updated in light of this presentation. Elsie contacted the team on the 12th February 2018 to report that she and Frank could not deal with him any longer as he was verbally aggressive. Tom was referred to the crisis team and a joint visit took place the following day. He was referred for a Mental Health Act Assessment. Risks were identified as a danger to self from neglect and a possible danger to his parents.
13th February	Tom was admitted on S2 of the MHA which was later converted to S 3. He was hostile and aggressive during this admission. A risk assessment

2018 – 10th June 2018 Admission # 3 (for 16 months)	(the last one noted in the electronic records) was recorded on 29th May 2018 whilst he was on home leave. On the 15th April 2018, Tom went on unescorted day leave to his parents but failed to return to the ward as required. The police were contacted, but it is noted that they were reluctant to fetch him and suggested that an ambulance should go. Two staff from the ward attended the family home but left when refused to engage with and became threatening and aggressive. Elsie and Frank said they did not feel safe. Tom refused to return, and Elsie was too frightened of him to ring the police. Police were informed and they returned Tom to the ward at 14.00 hours. On his return to the ward, Tom was angry, verbally aggressive and pacing. On the 19th April 2018 Zuclopenthixol decanoate 500 mgs was administered after nine days rather than fourteen. On the 23rd April 2018 it is recorded at the ward round, Tom believed that he did not need treatment as he wasn't ill. On the 26th April 2018 Zuclopenthixol decanoate 600 mgs was given.
September 2018	After Tom's discharge from hospital, a letter to Tom's GP following an outpatient's appointment included an assessment of the risk he presented and the plan for his care, although neither was recorded in the risk assessment tool or care planning domains of the electronic patient record. Tom was not recorded as being registered under the Care Programme Approach (CPA) as policy dictates he should have been.
Jan-Mar 2019	Between January and March 2019, the CPN visited Tom at home to provide support and to administer his medication. In January, Tom missed his outpatient appointment; he was reported as uncommunicative, and reluctant to continue his depot medication and another appointment was made for March which he did attend. It was also noted that Tom had not attended his GP for over a year. The CPN visited the GP due to problems with a prescription and reminded the GP of the shared care arrangement for Tom's physical health needs.
April 2019	Frank went into hospital. The CPN who came to administer Tom's depot noted his speech to be mainly delusional in content and that he was agitated and not sleeping well. In May 2019, Frank came out of hospital.

June 2019	On or around 15th June, the family dog had had to be put down. On 26th June 2019 Tom called the police with allegations that his neighbours were being abusive to him although it is recorded in the electronic records that he was not able to answer specific questions by the call taker. Police were advised that the Trust staff would make contact with Tom the following day, although there is no additional documentation about this. Tom had received regular doses of his medication up to and including the dose on 11th June. However, Tom's CPN then went on leave and the dose that he should have had on 25th June 2019 was delayed by a week to 2nd July. Tom therefore received his medication after 19 days rather than 14. According to the pharmacy report this equated to a minimal dose increase" which meant that prior to the incident which occurred on 2nd July 2019, Tom was under-medicated.
2nd July 2019 a.m	The CPN who visited Tom at home at 10.40 hours on 2nd July 2019 to administer his medication reported that he had helped Elsie to take shopping from the car into the house. It was recorded in the notes that Tom maintained some eye contact with the CPN but that he had been monosyllabic, as usual. Tom told the CPN that he had not been sleeping well but had had a good night the previous night. He looked as if he had lost weight and said his appetite had decreased. The CPN recorded that there were no obvious signs of thought disorder. Tom asked the CPN if he would need to have injections for the rest of his life and was advised that he would need medication for the foreseeable future. Tom was due to have an OPD appt the following day. Tom's mother was pleased about this as she thought he had seemed more restless: pacing and chain-smoking.
2nd July 2019p.m	At 16.13 hours a call was made to a Mental Health Practitioner (MHP) from Tom's mother's house to say that Tom had stabbed Frank, who died at the scene. Police had been called and Tom had been arrested. A MHP reviewed Tom at 21.01 hours at the police station and assessed him as fully orientated to time, place and person and as having capacity; he was not noted to be agitated or irritable.

Addendum

Recommendations identified and accepted by the health IMR

1. It is recommended that care plans are co-produced with the patient and this is monitored at a team level in accordance with the Record Keeping and Care Planning Policy and the outcomes are reported to the Trust Quality systems every three months. This should be in place within three months.

2. It is recommended that systems are put in place at a team level to monitor that all patients have a Care Plan as per the Record Keeping and Care Planning and assurance should be provided to the Trust Quality systems every three months. This should be in place with immediate action.

3. It is recommended that risk assessments are monitored at a team level in accordance with the Clinical Risk and Management policy and the outcomes are reported to the Trust Quality systems every three months.

4. It is recommended that CPA reviews and process should meet the standards of the Clinical Risk Assessment and Management policy and that this should be monitored at a team and strategic level through the Trust Quality systems every three months.

5. It is recommended that a process is agreed to provide access to the Care Plan in the electronic patient record when they are temporarily not in use, such as an episode of inpatient care. This system should ensure that the full records are available for use in practice, and this should be implemented within three months and monitored through the information management and technology systems in the Trust.

6. It is recommended that caseloads of the multi-professional Community Mental Health Teams be assessed for acuity and limits set to ensure that the clinicians have the capacity to deliver the services to the required standards. This should be achieved within three months, and monitoring systems put in place to enable escalation if caseloads should breach the numbers.

7. It is recommended that there is a review of the systems and processes of the medical provision in outpatients, to deliver a service which provides appointments to patients when required. This process should commence within two months and report through the performance management systems to the Board of Directors

8. It is recommended that a ‘whole family’ approach is taken to deliver care when more than one clinical service is involved, to provide a systematic approach which includes risk assessment and the mitigation of risks. This should be in place within six months and monitored through the Caldicott systems of the Trust every three months.

9. It is recommended that, where there are vulnerable adults living and caring for patients with serious mental illness, safeguarding adult advice should be accessed and, if necessary, an assessment and review performed and documented. Identification of patients in this situation should be made within three months and monitored through Trust safeguarding systems.

10. It is recommended that there should be an effective system in place between inpatient and community service settings to ensure that medication response and dosage is correct and responsive to the patient’s needs. This system should be implemented within two months and monitored at the operational level.

11. It is recommended that a ‘whole family’ approach is taken to the involvement of family and carers in the delivery of care to patients with severe mental illness and assessment and engagement of their needs and the rationale for these decisions is documented, and this is monitored through the Trust quality systems every three months.