Independent review to follow up care provided for Mr Q at Hertfordshire Partnership University NHS Foundation Trust

Confidential

Independent review of an investigation under HSG (94)27

East of England Collaborative Procurement Hub

Contract reference:	MV/Indiv/2013/6950
Initials of service user:	Mr Q
Incident type:	Homicide
Date of Incident:	2 March 2013

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Date of report:	19 February 2016

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EXPERIENCE, KNOWLEDGE AND EXPERTISE IN MANAGING RISK

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1. EXECUTIVE SUMMARY

1.1. INTRODUCTION

This is the report of a review commissioned by East of England to assess the care provided by Hertfordshire Partnership University NHS Foundation Trust (HPFT) for Mr. Q who was charged with arson and murder of Mr. S in March 2013. It represents a verification of the internal investigation that was completed at that time and an assessment of progress with recommendations to improve the quality of care. Terms of reference for the review can be found in Appendix 3.1 of the main report.

We hope that the report will be of interest to all those who were involved, including the families and friends of the victim and of the perpetrator, and to the staff of the Trust.

1.2. THE INVESTIGATION PROCESS

An initial scoping meeting was held on 16 March 2015 with the commissioner of the investigation (NHS England) and representatives from the Trust. Information was then collected from the electronic care records about the care and treatment provided for Mr. Q. Interviews were held with him; with clinical staff and managers, the Police, providers of substance misuse services and Mr. Q's GP. A random sample of case notes and copies of operational policies were also examined.

1.3. FINDINGS OF THE INITIAL INVESTIGATION

The first report of the investigation that was completed in 2013 describes the events leading up to the death of Mr. S in March of that year.

Mr. Q was first referred to mental health services when he was 23 by his GP in 2006. At that time, he was referred for anger management and for management of his anxiety symptoms. Mr. Q then had intermittent contact with mental health services between 2007 and February 2013. He was seen in Outpatients by a number of psychiatrists. In February 2008, Mr. Q had a brief admission under Section136 of the Mental Health Act and, following a suicide attempt in April of 2008, he received support from the Community Mental Health Team (CMHT). Mr. Q was then seen by a clinical psychologist (CP) for supportive psychotherapy for two years and his medical treatment consisted of antidepressant medication (Venlafaxine) and appointments as an outpatient.

Mr. Q's clinical condition was described as relatively complex. He had symptoms of anxiety and depression including self harm, substance misuse problems, and symptoms of post-traumatic stress disorder (PTSD) following his involvement as a victim in a violent attack in 2007. He was sometimes difficult to engage; he did not always keep his appointments, and he did not voluntarily disclose information about his contact with the Police. The report of the initial investigation also describes how Mr. Q took recreational drugs and periodically drank alcohol to excess.

Whilst Mr. Q made progress in treatment, particularly during the two years when he was receiving psychological therapy, he also had relapses that appear to have been triggered by difficulties in his personal relationships. Information made available to the Court when Mr. Q's case was heard showed a pattern of offending, largely related to relationship breakdowns and to alcohol overuse. In fact, it subsequently became clear that between 2004 and 2010, there were seventeen offences recorded by the Police and eight convictions including common assault, criminal damage to a girlfriend's car, fraud, and for carrying an offensive weapon.

Despite this, Mr. Q did not disclose details of his offending history to his GP. Nor did he readily discuss this with Trust staff. Although some information about his offences is referred to in the notes, his forensic history does not feature in the written assessments of risk. It is clear that Mr. Q was not regarded by either the GP or by Trust staff as presenting a risk of harm to others.

In summarising the circumstances of the case, and in making recommendations, the initial report concludes that the death of Mr. S was neither predictable nor preventable. However, the report highlights some shortcomings in the service and it refers to:

- The importance of strengthening care coordination and of communication across the boundaries between internal and external (to the Trust) teams and services in the management of risk.
- The need to bridge gaps in record keeping and care coordination across the broad domains of clinical, forensic and personal/social circumstances.
- The importance of clarity in relation to Mr. Q's diagnosis;
- The need to manage risk more effectively; and
- The importance of ensuring that all staff (e.g. doctors in training who are on rotation) have effective supervision and support.

1.4. FINDINGS OF THE CURRENT INVESTIGATION

In reviewing the care and treatment that Mr. Q received, the team believes, like the authors of the earlier investigation, that this tragic incident could not have been predicted or prevented by staff.

We believe that Mr. Q's primary diagnosis (depression and anxiety) and medication (Venlafaxine) were broadly appropriate. Furthermore, we found evidence of some good quality of care. However, we agree with the authors of the first report that there were some gaps in the way that Mr. Q's care was managed.

Our team therefore explored through interviews with staff and an examination of case records and operational policies the way that risk assessments are now undertaken. In this way, we also explored the way that supervision for doctors in training is provided and the arrangements for inter-agency (for example, between the Trust and Police or Probation services, or between the Trust and social care services) and team communications.

A question had also been raised by the CP about whether a diagnosis of Asperger's should be considered to apply to Mr. Q. However, our team noted the views of the Consultant Forensic Psychiatrist who saw Mr. Q prior to his appearance in Court who did not find any evidence of psychosis or any abnormality of mental functioning within the terms of Section 52 of the Coroners and Justice Act, 2009; he did not think that Mr. Q had a learning disability. We therefore concur with the authors of the first investigation that whilst Mr. Q's care would ideally have been reviewed at an earlier date by the senior team, it is unlikely that such a diagnosis would have made a significant difference to the appraisal of any risk he posed to others.

Revisions to the Risk Assessment Tool used by the Trust were made in 2014 to make it simpler and easier to use. Care Plans have also been revised so that it is easier to identify a chronology of care. Whilst our team found it difficult to define the different or overlapping roles of `care coordinator' `key worker' `care worker' `primary worker' and `contact person' – terms which all appeared at some point in care plans we examined for those on standard care and/or CPA – we were generally satisfied that trained staff understood the terms and that they knew where to find relevant information.

A new system (PARIS) of electronic patient records is now available and staff trained to use it. Space on the first page to record `significant information' is being used and appears to be working effectively.

Our team is therefore content to report that information collected regarding a patient's forensic history or other information relating to risk can now be found

quite easily. A significant level of reorganisation has also taken place in the Trust since the time that the tragic death of Mr. S occurred. For example, policies and procedures with a focus on the importance of inter-agency cooperation and information sharing between police, probation and community mental health services are now in place to support staff to manage risk. The forensic mental health team also now has access to police records, although these are not available to general teams where a telephone call would still be required if a member of staff believed that there would be value in gathering more information. Staff reported that these were working well.

Now, a new service (CRI Spectrum) which was established in April 2012 to support people with substance misuse problems accepts referrals from patients themselves, from GPs and other health providers. All new patients referred to CRI Spectrum are seen within five days and assessed. Furthermore, steps are currently being taken by CRI Spectrum and the Trust to review the dual diagnosis policy. Staff anticipate that this will make communications clearer between the two services.

Now**,** a Single Point of Access (SPA) for patients presenting with mental health problems is operating across the Trust and this appears to be working effectively. Liaison Nurses and `brief intervention' workers are also employed in Accident and Emergency to work with, and liaise with the Trust to ensure that those presenting with physical and mental ill health in A&E are seen and referred on.

Our team concurs with the authors of the internal report that supervision and management, particularly of doctors who saw Mr. Q in outpatients in 2013, was less effective than it should have been. Our team therefore assessed the degree to which support and supervision for junior doctors is currently of a good enough standard. The team understands that every junior doctor has an hour per week of time protected for supervision from their Consultant. This is recorded in the consultant's appraisal portfolio as well as the trainee doctor's training portfolio. In addition, supervision in out-patient settings is now structured around the stage of training and the experience of junior doctors. The team is therefore able to affirm that appropriate written policies are in place, and an appropriate level of supervision and support are provided for junior doctors.

1.5. CONCLUSION

This report, commissioned by East of England under HSG (94) 27 to assess the care provided by Hertfordshire Partnership University NHS Foundation Trust (HPFT) for Mr. Q up to the point on 2 March 2013 (age 30) when he was charged with arson and murder of a 63 year old man (Mr. S), represents a verification of the internal investigation that was completed at that time. It concludes that the tragic death of Mr. S could not have been predicted of prevented. It provides an

assessment of the extent to which recommendations made at that time have been, or are being met. It concludes that appropriate steps have been taken to strengthen Care Planning and Risk Assessment; to communicate effectively across inter-agency boundaries and to provide an appropriate level of support and supervision for staff. Our team does not wish to make further recommendations to strengthen services at this time.

2. REPORT OF THE INDEPENDENT REVIEW

2.1. INTRODUCTION

The importance of a rigorous investigation following a death caused by someone in contact with mental health services is set out clearly in a variety of guidance[1,2,]. Families who are affected and NHS and social care staff agree that processes should be in place to monitor, investigate and learn lessons from such events in order to reduce risk in the future.

This is the report of a review commissioned by East of England under HSG (94) 27 to assess the care provided by Hertfordshire Partnership University NHS Foundation Trust (HPFT). It covers the period of just over five years of care provided for Mr. Q by HPFT up to the point on 2 March 2013 (age 30) when he was charged with arson and murder of a 63 year old man (Mr. S) a former work colleague and the father of his ex-girlfriend.

This report represents a verification of the internal investigation that was completed shortly afterwards in 2013 and it provides an assessment of the extent to which recommendations made at that time to improve the quality of care have been, or are being met. A copy of the Terms of Reference (TOR) for the review may be found in Appendix 3.1.

In addition to the objectives set out in the Terms of Reference, a key feature of this review concerns the degree to which the Trust, families and the public can have confidence that the care being provided by HPFT ("the Trust") is of a good standard and that risks are being managed appropriately. As such, and in addition to a look back at the care provided in the past for Mr. Q, our report has:

1. A focus on the present day;
2. A focus on inter-agency cooperation and information sharing between police, probation and community mental health services so as to manage risk more effectively;
3. An appraisal of the degree to which knowledge and information about forensic histories are now incorporated into routine care.

We hope that the report will be of interest to all those who were involved, including the families and friends of the victim and of the perpetrator, and the staff of the Trust.

[1] `Serious Incident Framework: Supporting learning to prevent recurrence' (March 2015) NHS England Patient Safety Domain. Gateway reference: 03198.
[2] Casey, L., CB, Commissioner for Victims and Witnesses, (July 2011)`Review into the Needs of Families Bereaved by Homicide.' Ministry of Justice.

2.2. ACKNOWLEDGEMENTS

We would like to thank all those who gave their time to talk with the team about the circumstances leading up to the death of Mr. S. We are particularly grateful to members of the Patient Safety Team who helped us to contact staff and make appointments. We are aware that the timing of our visit, coinciding as it did with an inspection by the Care Quality Commission made it an especially busy time for the Trust and we are aware that this investigation took longer than normal as a result. We nonetheless hope that the report will be of interest to all those involved.

2.3. THE INVESTIGATION TEAM

Anne Richardson, BSc MPhil FBPsS is a former Head of Mental Health Policy at the Department of Health and a clinical psychologist by background. She has experience of leadership in mental health policy and policy on mental ill health and offending both at the Department of Health and for the Cabinet Office. She has experience of teaching and training, having formerly worked to develop the DClinPsy programme at University College London, and as regional tutor at UCL and at UEL. Anne has a significant level of experience in managing independent investigations into serious incidents in health and social care at Trust as well as national level. For example, she administered the national investigation commissioned by Secretary of State, chaired by Sir Jonathan Michael, into the deaths of six people with a learning disability (`Healthcare for All', 2008).

Mr. Lawrence Moulin, BSc MSc MBA, is a former clinical psychologist with over thirty years' experience working within the NHS and at the Department of Health in mental health and learning disabilities. Lawrence has worked as a clinician, as a service manager, and strategically at SHA level. His most recent post in the NHS was as the West Midlands Strategic Health Authority Lead for mental health and learning disabilities, with oversight of safety and service performance across the whole area. Prior to this he worked as a commissioner of services for people with mental health problems or with a learning disability. In addition Lawrence has worked on the delivery of national policy with the National Institute for Mental Health in England and in the Department of Health.

Dr Hugh Griffiths MB BS FRCPsych has a national profile in mental health and over twenty five years experience as a consultant psychiatrist in the North-East of England. He has held roles as NHS Trust Medical Director, Medical Director of the Northern Centre for Mental Health and gained extensive experience conducting inquiries into untoward incidents in mental health services. He was Director of Policy and Knowledge Management for the NHS Clinical Governance Support Team for two years until 2004 and then became Deputy National Clinical Director for Mental Health (England) at the Department of Health. From 2010 until

2013 he was National Clinical Director for Mental Health during which time he led the development of the Government's Mental Health Strategy ("No Health Without Mental Health", HM Government February 2011) and he was instrumental in its subsequent Implementation Framework.

Ms Carol King is a Prince 2 Registered Practitioner with over fifteen years experience in project management, business operational support and event planning within the NHS and private sector. In recent years she has coordinated a mental health programme office, supported the establishment of School Boards for the National School of Healthcare Science and facilitated national NHS recruitment. Carol provided project support and was a point of liaison for all those involved in the present investigation

2.4. METHODOLOGY

The team used an approach based upon Root Cause Analysis to examine the facts of this case, identify ways in which care might have been altered or improved, and understand how systems for delivering care and managing risk are currently working. Salmon Principles[3] were adapted for this non-judicial investigation which meant that all those interviewed were contacted in writing with information about the investigation and they were invited to be accompanied, if they wished.

Clinical case notes relating to the care provided for Mr Q by HPFT were examined. In addition, and to get a clearer picture of Mr Q's needs, the team reviewed notes and files provided by the Police for the Court, including the assessments undertaken at that time by forensic experts.

A random sample of anonymous electronic care records was examined to understand whether the information collected about patients, their care planning and risk assessments was thorough and easy to access.

Copies of current policies used by HPFT were examined, including guidance on Care Planning, Risk Assessment, and information sharing.

Mr. Q was interviewed at Long Lartin Prison.

The Detective Constable involved in Mr. Q's case, the Family Liaison Officer providing support for the victim's family, Mr. Q's GP, a senior member of the Mentally Disordered Offender's Team, a member of CRI Spectrum (the provider

[3] **The Salmon Principles** are six requirements set out under the Tribunals and inquiries Act 1921 designed to ensure fair and appropriate procedures are used in the conduct of investigations.

of drug services) and a commissioner from the Performance & Quality, Integrated Health & Care Commissioning Team were interviewed during this investigation.

Mr Q's family (his mother and half brother) was approached with information about the investigation and an invitation to meet the team, but they did not take this up.

Two members of the victim's family were also approached (by letter and via communication with the Police Family Liaison Officer (FLO) but they too decided not to respond.

These interviews and documents helped the team to form a picture of the way that current teams and services operate, and to understand the way that care is currently provided in the Trust.

2.5. BACKGROUND TO THE CASE

Mr. Q was first referred to mental health services in 2006 at the age of 23. His clinical condition was described as relatively complex; he had symptoms of anxiety and depression, including self harm, substance misuse problems and, later on, symptoms of post-traumatic stress disorder (PTSD). There was also evidence that he took recreational drugs and periodically drank alcohol to excess. His GP had prescribed Citalopram, an antidepressant.

Mr. Q was one of three children. He has an older brother and a younger half brother. His father, with whom Mr. Q had not been close, left the family when he was four years old. As a child, Mr. Q was described as having had some behavioural and learning problems at school. For example - and this is supported by the primary care record - he had hearing problems whilst at primary school and was reported to be dyslexic. He was expelled from school when he was 14.

Although he did not keep the initial appointments offered in 2006, Mr. Q subsequently had contact with secondary mental health services at the Trust in 2007. At this time, he was experiencing anxiety symptoms relating to his having been a victim of a violent attack in his home. This was, according to Mr. Q, a case of mistaken identity and the case was not solved. Mr. Q continued to be seen by staff at the Trust until February 2013, just a month before he was arrested on suspicion of murder.

Over the period of his care by the Trust, Mr. Q was mainly seen in Outpatients by a number of junior doctors on training rotations. His medical treatment consisted of antidepressant medication (Venlafaxine). In February 2008, he had a brief admission under Section136 of the Mental Health Act and, following a suicide attempt in April of 2008, he also received support from the Community Mental

Health Team (CMHT). Mr. Q was subsequently seen by a clinical psychologist for supportive psychotherapy for two years.

It is clear from the notes that Mr. Q was sometimes difficult to engage and he did not always keep his appointments. Whilst Mr. Q made progress in treatment, particularly during the two years when he was receiving psychological therapy, he had relapses that appear to have been triggered by difficulties in his personal relationships. These difficulties also appear to have been associated with a pattern of offending behavior, although very little detail of this is available in the case notes.

Between 2004 and 2010, there were seventeen offences recorded by the Police. Mr. Q's offences include common assault (Feb 2000), possession of a knife (Sep 2004), drink-driving (Mar 2006), ABH/battery (April 2007), fraudulent use of a vehicle and failure to surrender to custody (Aug 2006), criminal damage relating to a domestic (girlfriend) dispute (Feb 2008), criminal damage and ABH relating to another ex-partner (Mar 2008), Disorderly behavior (ditto) (April 2008), damage to property (May 2008), disorderly behavior (May 2008), assault of an ex-girlfriend (Feb 2009) and battery (May 2010).

2.6. FINDINGS OF THE PRESENT INVESTIGATION

The following information is presented so that findings from the investigation can be related more easily to the requirements set out in the Terms of Reference (Appendix 3.1).

2.6.1. The Trust's initial internal review, its conclusion, recommendations and action plan

The report of the investigation completed in 2013 describes events leading up to the death of Mr. S in March of that year. It contains a detailed timeline describing the NHS care provided since Mr. Q was first referred to mental health services. Our team reviewed the case notes in some detail and is content to report that the timeline in the initial investigation report is an accurate account.

On reviewing the case notes and other evidence relating to Mr. Q's case which has only emerged since the case was heard in Court, our team is also content to report that we concur that this tragic incident could not have been predicted or prevented. However, we agree that there were some gaps in the way that his care was managed.

For example, whilst individual team members fulfilled their responsibilities to provide responsive, user-focused care, Mr. Q's treatment was not well coordinated overall. There were care plans relating to work undertaken by different teams, but no integrated overall care plan. There were also concerns about risk assessment and concerns about the supervision of junior doctors (see section 2.6.7 below).

The initial investigation report therefore contains a set of appropriate recommendations for the Trust referring to:

- The importance of strengthening care coordination and of communication across the boundaries between internal and external (to the Trust) teams and services in the management of risk.
- The need to bridge gaps in record keeping and care coordination across the broad domains of clinical, forensic and personal/social circumstances.
- The importance of clarity in relation to Mr. Q's diagnosis;
- The need to manage risk more effectively; and
- The importance of ensuring that all staff (e.g. doctors in specialized training who are on rotation) receive effective supervision and support.

2.6.2. Was Mr. Q treated appropriately?

We believe that Mr. Q's primary diagnosis (depression and anxiety) and medication (Venlafaxine) were broadly appropriate. In this, our team agrees with the opinion expressed in the initial investigation. Like the initial team, we also found evidence of some good quality care and Mr. Q himself reported to the team that he valued his contact with the Clinical Psychologist (CP).

The team considered the continuing uncertainty, mentioned in the first investigation report, regarding whether a diagnosis of Asperger's (Autistic Spectrum Disorder) might have been appropriate for Mr. Q. The CP had formerly suggested this to Mr. Q and had asked for a review, but this was not fully addressed at the time. It therefore remains an issue for Mr. Q who will now need to rely upon the prison in-reach mental health team to follow it up, if they see fit. However, it is relevant that the Consultant Forensic Psychiatrist who saw Mr. Q prior to his appearance in Court did not think he had a learning disability. Nor did he find evidence of psychosis or any abnormality of mental functioning within the terms of Section 52 of the Coroners and Justice

Act, 2009 so Mr. Q was found guilty of murder and he was sentenced accordingly.

For his part, Mr. Q considers that he is now receiving a better quality of continuous mental health treatment and care in prison than he received previously. He remains troubled by symptoms of depression, anxiety and self-harm.

Our team thinks it unlikely that a diagnosis of Asperger's would have had salience for arguments about mitigation in regard to the events of 2nd March 2013. It is therefore not directly relevant to our conclusion about whether Mr. S's death could have been predicted or prevented. However, we concur with the authors of the first investigation that Mr. Q's care would ideally have been reviewed at an earlier date by the senior team. Such a review might have led to a clearer decision about whether onward referral, continuing care in outpatients, or discharge was the most appropriate plan.

During the five years that Mr. Q was in contact with the Trust for mental ill health care and treatment, it is important to note that he received support to manage his problem with alcohol. However, as he was found to have cocaine in his blood stream at the point of arrest, the team also examined the way that substance misuse services are currently provided.

A new service (CRI Spectrum) established in April 2012 to support people with substance misuse problems accepts referrals from patients themselves, from GPs and other health providers. All new patients referred to CRI Spectrum are seen within five days and assessed. CRI Spectrum does not provide mental health treatment, so anyone with co-morbid mental ill health is referred on for assessment and onward referral, as appropriate. However, steps are currently being taken by CRI Spectrum and the Trust to review the dual diagnosis policy and staff anticipate that this will make communications clearer between the two services.

Since the events of March 2013, a Single Point of Access (SPA) for patients presenting with mental health problems is now also operating across the Trust. Although the team was informed that not all GPs like the SPA approach because it means that they can't always refer to their preferred Consultant, it appears to be working effectively. Liaison Nurses and `brief intervention' workers are also employed in Accident and Emergency to work with, and liaise with HPFT to ensure that those presenting with physical and mental ill health in A&E are seen and referred on.

2.6.3. Were risk assessments adequate?

There were two alerts in Mr Q's `CareNotes' (as they were called at the time) to indicate that he was known to the Police:

'23.04.2008: Police report that he is registered on their database as carrying weapons on his person, including a handsaw.

`23.04.2008: Personal safety – Q has no convictions for violence or aggression, however Police report that he is known to be both.'

Furthermore, there are entries in the 2010 notes concerning two violent incidents, one of which involved Mr. Q's then girlfriend (Actual Bodily Harm and unlawful imprisonment). However, there are no details of Mr. Q's other convictions and no analysis of any pattern which might have had salience for the assessment of the risk he may have presented in domestic or relationship disputes. Furthermore, this information was not reflected in management or care plans.

The report of the initial investigation makes it clear that Mr. Q did not voluntarily disclose information about his forensic history to the mental health staff; nor did he inform his GP (a fact that he confirmed to our team). However, we concur with the authors of the first investigation that mental health staff could have done more to ensure that all the potential risks (for example, at points when relationships were breaking down or when Mr. Q was intoxicated) were appraised and communicated. This is particularly important when `Alerts' are present on the record and the patient is someone with a record of violence who is known to abuse alcohol and occasionally use drugs.

It is always important for all risks to be assessed as fully as possible. However, as indicated above, we think it is unlikely in this case that Mr. Q's care and treatment would have been affected had full details of his forensic history been known. This is primarily because, and with the benefit of full information after the fact, there is no evidence of a causal link between Mr. Q's mental ill health and his offending behaviour.

A significant level of re-organisation has taken place in the Trust since the time that the tragic death of Mr. S occurred. For example, new policies and procedures with a focus on the importance of inter-agency cooperation and information sharing between police, probation and community mental health services are now in place to support staff to manage risk more effectively. The forensic mental health team also now has access to police records, although these are not available to general teams where a telephone call would still be required if a member of staff believed that there would be value in gathering more information.

2.6.4. Are risks being managed effectively today?

The HPFT Risk Assessment Tool was revised in November 2014 to make it simpler and easier to use. A `crucial information alert' is now available on the front for staff to use if they have any concerns; for example, if a patient is subject to MAPPPA[4] arrangements. Furthermore, a patient's risk history is pulled immediately forward to the current file when a risk assessment is updated.

We are therefore pleased to report that Care Plans and Risk Assessments do now appear to be thorough and they are easy to find. A new system (PARIS) of electronic patient records is now available and staff trained to use it. A space on the first page to record `significant information' is being used and appears to be working effectively..

Care Plans have also been revised so that it is easier to identify a chronology of care. They are quite easy to find, as are current case summaries and letters to the GP although, inevitably, there are some current patients who still have both paper and electronic records. Our team nonetheless found it difficult to define the different or overlapping roles of `care coordinator' `key worker' `care worker' `primary worker' and `contact person' – terms which all appeared at some point in care plans for those on standard care and/or CPA. However, the team was generally satisfied that trained staff understood the terms and that they knew where to find the Care Plan for a patient in contact, for example, with the CMHT, the outpatients department, the MDO team and the psychology department.

2.6.5. Is there an appropriate level of support and supervision for junior doctors?

It is quite common for patients who have been seen in mental health services to be followed up in outpatients for a period. Such patients may sometimes be seen by `junior' doctors. These are qualified staff, but, as they progress towards more senior positions, they rotate through different clinical placements. This means that some outpatients may be seen by a number of different people in the course of a year.

[4] MAPPA refers to the Multi-agency public protection arrangements that are in place to ensure effective management of violent and sexual offenders. MAPPA guidance sets out the responsibilities of the police, probation trusts and prison service. It also touches on how other agencies may become involved, for example the Youth Justice Board which is responsible for the care of young offenders

Our team concurs with the authors of the internal report that supervision and management, particularly of junior doctors who saw Mr. Q in outpatients in 2013, was less effective than it should have been. For example, over twelve different doctors – some of whom saw Mr. Q only once – were involved in his care and there is little evidence that their input was coordinated effectively.

Our team assessed the degree to which support and supervision for junior doctors is currently of a good enough standard by meeting a junior doctor who formerly worked in general adult mental health care currently working in care for older adults and a Consultant also currently working in this area. The Consultant medical member of our team was also able to speak with the Trust Medical Director. The team understands that every junior doctor has an hour per week of time protected for supervision from their Consultant. This is recorded in the consultant's appraisal portfolio as well as the trainee doctor's training portfolio. In addition, supervision in out-patient settings is now structured around the stage of training and the experience of junior doctors The team is therefore able to affirm that appropriate written policies are in place, and an appropriate level of supervision and support are provided for junior doctors.

2.7. CONCLUSION

This report, commissioned by East of England under HSG (94) 27 to assess the care provided by Hertfordshire Partnership University NHS Foundation Trust (HPFT) for Mr. Q up to the point on 2 March 2013 (age 30) when he was charged with arson and murder of a 63 year old man (Mr. S), represents a verification of the internal investigation that was completed at that time. It concludes that the tragic death of Mr. S could not have been predicted of prevented. It provides an assessment of the extent to which recommendations made at that time have been, or are being met. It concludes that appropriate steps have been taken to strengthen Care Planning and Risk Assessment; to communicate effectively across inter-agency boundaries and to provide an appropriate level of support and supervision for staff. Our team does not wish to make further recommendations to strengthen services at this time.

3. APPENDICES

3.1. TERMS OF REFERENCE

An external verification and quality assurance review is intended to be a verification of the internal investigation with limited further investigation to enable the review team to fulfil the terms of reference. This may be undertaken via a desktop review.

- Quality assure the trust's internal investigation, recommendations and any action plan.
- Review the appropriateness of the treatment of the service user in light of any identified health needs.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.
- Focus the investigation on the present day services and current processes.
- Review the progress that the trust has made in implementing the recommendations and the learning from their internal investigation and other investigations.
- Consider how interagency co-operation between police, probation services and community mental health service clinical teams could be enhanced by allowing sharing of information between services.
- Consider if the CMHT/CMHS had been able to access the forensic history of this patient would the care and treatment had been different.
- Consider what changes are necessary to allow the routine sharing of forensic information with community and more generic mental health services
- Consider if similar incident/circumstances occurred today would the current Trust policies and procedures prevent a reoccurrence.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate.
- Consider if this incident was either predictable or preventable.
- Provide a written report to NHS England that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation.