An independent review of the investigation undertaken by Tees Esk and Wear Valley NHS Foundation Trust into the care and treatment of Mr H

October 2022

Report date: 07/10/2022

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

Our Final Report has been written in line with the terms of reference as set out in the Terms of Reference on the independent review of the investigation undertaken by Tees Esk and Wear Valley NHS Foundation Trust into the care and treatment of Mr H. This is a limited scope review and has been prepared for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date.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

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

Niche Health & Social Care Consulting Ltd.
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Telephone: 0161 785 1000
Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

Authors:

Mary-Ann Bruce, Partner

Kathryn Hyde-Bales, Associate Director

Mary Smith, Senior Investigator.

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1 Introduction and background

1.1 This desktop review examines the internal investigation undertaken by Tees Esk and Wear Valley NHS Foundation Trust (TEWV or 'the Trust') into the care and treatment of Mr H and includes a timeline of events leading up to the death of Mr B.

1.2 The purpose of this review is to determine whether the internal investigation undertaken by the Trust robustly considered and explored the lines of enquiry, and to identify any areas requiring further examination.

1.3 NHS England commissioned Niche Health and Social Care Consulting (Niche) to conduct this review.

1.4 In March 2018, police attended Mr H's flat following the report of the sudden death of a man (referred to in this report as Mr B). Mr H was initially arrested for supplying class A drugs but was subsequently charged with murder. The court later found Mr H guilty of the manslaughter of Mr B.

1.5 Mr H was thirty years old at the time of Mr B's death. One of three children, his parents had separated when he was a child, and he had varied contact with his parents and siblings. Mr H also had a child, although at the time of the homicide, they had not been in contact for over four years.

1.6 Mr H had eight referrals and/or assessment episodes with Trust services between 2010 to 2014, four of which resulted in an offered service. Not all referrals resulted in an assessment.

- Trust alcohol services received referrals for Mr H once in 2010 and three times in 2012. Mr H did not engage following these referrals.
- Mr H engaged with the Trust's alcohol service between June – September 2013 for completion of a court ordered alcohol treatment requirement (ATR).
- The Trust recorded three episodes during 2014 (January, June, and November). These all related to referrals for assessment when Mr H was in crisis following self-harm and/or following offending behaviour in the context of alcohol or substance misuse. Following two of these contacts, Trust services directed Mr H to third sector/community alcohol services.

1.7 The Trust had no recorded contact with Mr H during 2015.

1.8 The Trust recorded three referral and/or assessment episodes during 2016 (January, February, and November), not all referrals resulted in an assessment and none of the completed assessments resulted in treatment. Trust Liaison and Diversion (L&D) services screened referrals but did not assess Mr H in both January and February. The Trust Crisis Resolution Team (CRT) attempted to assess Mr H in November, but he did not remain for the full assessment. Referrals were made in the context of offending behaviour and/or self-harm as well as substance and alcohol misuse and did not result in a service being provided.

1.9 The Trust recorded ten referral and/or assessment episodes during 2017.

1.10 In June 2017, Mr H took an overdose, resulting in admission to the emergency department of a general hospital. When Mr H was medically fit, the hospital referred him to the Trust's psychiatric liaison team for a psychiatric assessment. Mr H remained in the emergency department for the assessment. The Trust psychiatric liaison team assessed Mr H and referred him to the Trust Crisis team. The Crisis team assessed and admitted Mr H informally to an acute adult inpatient ward within the Trust psychiatric hospital based in Middlesbrough.

1.11 Mr H was under the Care Programme Approach (CPA[1]) from June 2017.

1.12 Mr H remained an inpatient from the end of June to early August 2017. During admission, the Trust's Early Intervention in Psychosis Service (EIP) attended the ward and assessed Mr H. EIP accepted Mr H for a 6-month period of community assessment, on the Trust's At-Risk Mental State Pathway (ARMS), with a planned start date following his discharge from hospital. EIP worked with Mr H from early August 2017 and kept him on the caseload until mid-January 2018. However, he was discharged by EIP in his absence at this point.

1.13 Following his discharge from hospital in August 2017, the Trust received eight referrals for Mr H.

1.14 Mr H's last recorded contact with any Trust service before his arrest in March 2018 was mid-November 2017.

1.15 The Trust commenced an internal investigation on 22 March 2018, it was signed off by the Trust Director's Panel on 14 June 2018 and dated as final on 18 June 2018.

1.16 We would like to express our condolences to all the parties affected by this death.

[1] The Care Programme Approach (CPA) is a package of care for people with mental health problems.https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

2 Approach to the review

2.1 This independent review was commissioned in November 2021 and was completed in July 2022. The review was conducted by Mary Smith, Senior Investigator. The report was peer reviewed by Kathryn Hyde-Bales, Associate Director, and Mary-Ann Bruce provided Partner oversight.

2.2 This review falls under the NHS England Serious Incident Framework[2] and Department of Health guidance on Article 2 of the Human Rights Act (1998).

2.3 This is a review of the adequacy of the internal investigation conducted into the care of Mr H following the death of Mr B.

2.4 The review focused on the internal investigation report provided by the Trust alongside a review of all clinical records held on the clinical information system (PARIS) for Mr H, and paper records shared with Niche by the Trust. We also reviewed several Trust policies (see Appendix 2). We only reviewed information generated and provided by the Trust; no other agency records formed any part of this review. Where we have used acronyms and abbreviations, they are expanded in the first instance and a glossary is provided at Appendix 5.

2.5 Working with NHS England, the review aimed to ensure all affected family members were informed and had the opportunity to engage as fully as they wished within this review. NHS England made approaches to Mr H, his family, and the victim's family to offer them the opportunity to inform this review; at the time of preparing this report NHS England had not received a response.

2.6 We have assumed that the Trust's internal serious incident investigation report authors reviewed all relevant documents in detail in drawing their conclusions.

2.7 We shared a draft version of this report, prepared by Niche, with the Trust for review and comment in advance of finalisation. The report was also subject to independent legal review commissioned by NHS England.

[2] https://www.england.nhs.uk/patient-safety/serious-incident-framework/

3 Summary and recommendations

3.1 We reviewed the Trust's internal investigation report against the Niche Investigation Assurance Framework (NIAF), identifying several areas of concern. We describe these in detail within our analysis in Section 5. Overall, we found the Trust's internal investigation met four of the twenty-five assessment standards, partially met seven and did not meet fourteen standards.

Rating	Description	Number	Standards
	Standard met	4	Credibility 4
	Standard partially met	7	Credibility 2 Thoroughness 5
	Standard not met	14	Thoroughness 9 Impact 5

Summary of findings relating to the Trust's internal investigation

The scope and terms of reference for the internal investigation were generic, without specific reference to Mr H and did not identify specific key lines of enquiry to support and guide the investigation.

The report methodology was unclear, without reference to root cause analysis (RCA) and without a contributory factor analysis. There was no evidence of RCA to support the findings.

The investigation did not involve Mr H, his family, or the family of the victim. There was no recorded contact with Mr H, his family or the family of the victim and their views are not in the report.

The investigation met one of its nine stated objectives, did not use the chronology fully and made no attempt to benchmark practice.

The investigation found no care or service delivery problems, no contributory factors or root causes. The investigation made no recommendations and as a result there was no associated action plan.

The panel meetings and sign off processes were at a sufficiently senior level in the Trust; however, we are concerned about the adequacy of this sign off and about the overall independence of the panel process.

Due to the lack of analysis underpinning the report's findings, we were unable to agree with its findings, and it is our view that the report would have no impact on service improvement or change in practice.

3.2 Alongside our review of the Trust's internal investigation report, we also completed a detailed chronology and carried out a high-level review of Mr H's care and treatment from 2010 to the date of the homicide.

3.3 We have identified 12 significant areas that require further exploration to attempt to prevent similar events. We discuss these in detail in our gap analysis in Section 6.

- The interlinks between and access to alcohol and substance misuse.
- The adequacy of housing and any impact on access to treatment.
- Engagement with Mr H and the arrangements and policies for non-engagement.
- Diagnosis – application of diagnoses and onward referral for treatment.
- The use and appropriateness of medication and compliance.
- Forensic Assessment.
- Hospital discharge 2017.
- Adult safeguarding.
- Multi-agency working.
- Care planning and carer assessments.
- Risk management.
- The relationship between the victim's chronology and Mr H.

Narrative summary of gap analysis

Mr H had multiple, complex needs. Poor engagement with services and compliance with medication, unstable housing, complex family relationships, significant offending behaviour and continued alcohol and substance misuse all impacted Mr H's complex presentation.

Multiple Trust services assessed Mr H throughout the time under review. The assessments undertaken repeatedly identified that Mr H's continued substance and alcohol misuse influenced his reported psychotic experiences. We believe this influenced how services responded.

We believe Mr H's needs were all assessed within the context of his alcohol and substance misuse and his associated behaviours were also viewed in this context. As such, Mr H was not considered for referral to alternative, more specialist services, remaining under EIP whose remit did not fit his needs. In addition, Mr H was not assertively followed up when he started to disengage, his non-compliance with medication was not fully explored and several opportunities for adult safeguarding were missed.

Between 2010 and 2017, Mr H had twenty-one referrals to Trust services, only four of which resulted in a service being offered: twice to alcohol services, once for an inpatient admission and once to the EIP service.

Of note, during 2017 and whilst under the care of EIP (August 2017 to January 2018), Mr H was referred eight times to Trust services due to concerns about his mental health contributing to his offending behaviour, self-harm and/or substance and alcohol misuse. These referrals resulted in six assessments, however none of the assessments resulted in services changing his care plan or considering whether he was under an appropriate service.

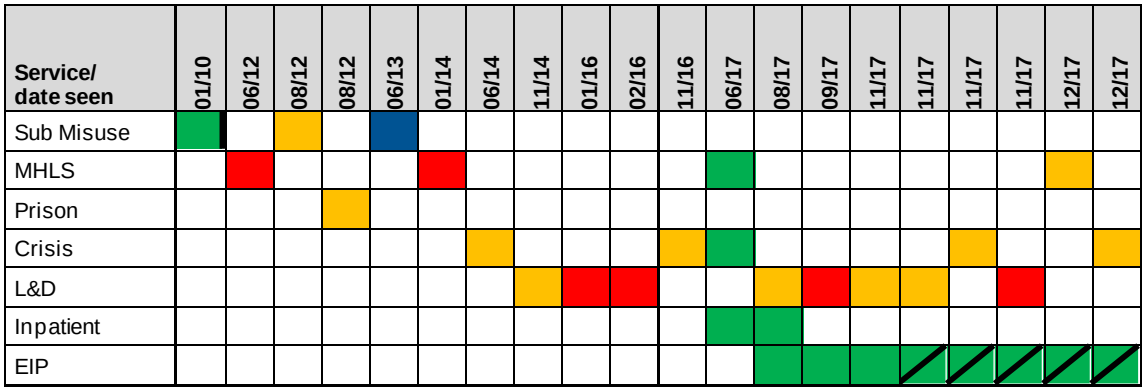
Finally, Mr H was not reviewed by a psychiatrist in the community and his contacts within the criminal justice system were not monitored robustly.

For these reasons, we believe that despite multiple concerns being raised, Mr H hit a "*gatekeeping wall"* regarding access to increased or specialist mental health provision.

We have highlighted this phenomenon in the chart below, showing the pattern of referral and assessment, or referral and no assessment; and the number of times the outcome was 'no change in care planning or service provision.'

3.4 The chart below graphically represents this phenomenon, or *"gatekeeping wall"* which shows twenty-one referrals, (eight between August - December 2017), fourteen assessments episodes, and six screening episodes (shown in red), across seven teams over seven years. *(Two referrals in June 2017 resulted in Mr H's assessment and admission to hospital).*

Chart 1 showing referral pattern and outcomes for Mr H (2010-2017)



Key	
	Referred, screened, and not assessed
	Referred and assessed but no service offered and no change in care planning or service provision
	Service offered (and where appropriate length of time Mr H engaged)
	Service offered, but Mr H did not engage, stopped engaging, or service was no longer appropriate
	Referred and assessed and service offered, and Mr H engaged (due to a court order)

3.5 Following our high-level review of the clinical records, we have made twelve recommendations. The Trust should consider these when developing an action plan in response to the care and treatment provided.

3.6 We have made no recommendation regarding the levels of care planning as the national community mental health framework[3] will replace the CPA framework[4]. However, we recommend that the Trust seeks assurance on how it will support individuals with complex presentations and provides guidance to staff to define complex needs and the support available (see Recommendation 7).

3.7 Recommendations 1-4 relate to our review of the standard of the investigation and surrounding sign off. Recommendations 5-12 relate to the care issues identified in our high-level care review.

Recommendation 1 – within twelve months

The Trust should implement an annual audit programme which evaluates the effectiveness of the Trust's investigation processes against best practice and national guidance. This should include:

- a review of the application of RCA methodology; ensure review of medication is a standard part of any investigation.
- the panel review process; family engagement and involvement; and the quality assurance of the final report.

Recommendation 2 – within twelve months

The Trust should ensure that:

- the quality assurance process for signing off serious incidents/homicides is strengthened and the reasons why this was not adequate in this case are understood
- independence from services in investigations is given priority
- the Integrated Care Board (ICB) is given sufficient opportunity to sign off and challenge the findings.

Recommendation 3 – within six months

The Trust should ensure there is appropriate application of Duty of Candour in this case and secure assurance that it is applied correctly in all cases of homicide.

Recommendation 4 – within twelve months

Given the transition to Integrated Care Systems (ICS); NHS England should ensure the North East and North Cumbria ICS and ICB learns from this case to secure robust future sign off processes as part of the new Patient Safety Incident Response Framework[5] (PSIRF)

[3] https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

[4] CPA is due to be replaced over the next three years from April 2021 supported the new NHS Long Term Plan investment. https://www.england.nhs.uk/publication/care-programme-approach-position-statement/

[5] https://www.england.nhs.uk/patient-safety/incident-response-framework/

Recommendation 5 – within six months

It is important that the specific learning from this case is maximised. The Trust should **either** ensure a full care and treatment review is undertaken for Mr H examining each of the gaps identified in this review **or** commit to ensuring the extent of each of the following gaps are clearly quantified for patients across the Trust's services and actions to address them are referenced within the Trust's improvement programme. These include:

a) the impact of substance and alcohol misuse, on Mr H's mental health, diagnosis, or associated behaviour; whether substance misuse impacted on Mr H's engagement with services, and whether his associated behaviours impacted on how services responded to him.

b) the relationship with housing providers to establish if other housing options were available, whether unstable housing impacted Mr H's engagement and his access to services and treatment.

c) all factors that may have impacted upon engagement, particularly focusing on services' responses to see whether they met expected practice. We also recommend that the VCB[6] Guidance is considered to establish what, if any, impact this may have had on his care journey.

d) the diagnostic management and clinical decision-making to establish if practice was in line with expected care and treatment. It would also identify if there were gaps in services or whether the existing models of service, if applied more robustly, would have been sufficient.

e) the use and appropriateness of medication and Mr H's compliance with this.

f) Mr H's forensic history and engagement with the criminal justice system.

g) consideration of his discharge in 2017 to determine whether this was in line with expected practice.

h) adult safeguarding practice to determine whether this was in line with expected practice.

i) multi-agency working to determine whether this was in line with expected practice.

j) care planning to determine whether this was in line with expected practice.

k) risk management and crisis planning to determine whether this was in line with expected practice.

l) exploring any interlinkages between Mr H and Mr B to understand if there is any learning.

Recommendation 6 – within twelve months

The Trust should develop a system to ensure repeat referrals, screenings and assessments across multiple services are monitored effectively to identify potential patient risk and ensure care plans are adequately reviewed.

[6] Trust Core Visual Control Board (VCB) Guidance Version 4.0 May 2021

Recommendation 7 – within six months

The Trust should seek assurance on how it supports individuals with complex presentations, developing and providing guidance for staff on key referral and care planning pathways.

This should include consideration of any additional assessments, any referral to specialist services and specialists (forensic, dual diagnosis) and consideration of increased psychiatric review for individuals with complex presentations.

As part of the guidance for complex cases the Trust guidance should develop a referral pathway for forensic assessments.

Recommendation 8 – within six months

The Trust should provide assurance that staff can access additional clinical advice and support when working with individuals with complex presentations. This should be provided as part of the post-publication assurance review.

Recommendation 9 – within six months

The Trust should provide assurance that current hospital discharges are completed in line with agreed policy.

Recommendation 10 – within six months

The Trust should provide assurance that adult safeguarding practice is in line with agreed policy.

Recommendation 11 – within six months

The Trust should provide guidance regarding recording and oversight for individuals subject to public protection measures such as MARAC and MAPPA.

Recommendation 12 – within six months

The Trust should provide assurance that carers are being offered the opportunity to receive carer assessments as per Trust policy.

4 Summary chronology

4.1 This section provides a summary of the chronology of events leading to the events in March 2018.

4.2 In January 2010, a local substance and alcohol misuse charity referred Mr H to the Trust's Substance Misuse Services (SMS). Mr H did not engage with services at that time, and the Trust closed the referral.

4.3 In early June 2012, the local general hospital referred Mr H to the Trust's Mental Health Liaison Service (MHLS) following an episode of self-harm. We did not find any corresponding record of the outcome of this referral and the Trust closed the episode the following day.

4.4 In early August 2012, SMS assessed Mr H following his admission to hospital from police custody. The Trust provided advice on drop-in access to SMS. On discharge from hospital Mr H did not engage with SMS, and the Trust closed the referral in early September 2012.

4.5 During mid-August 2012, Mr H was detained in prison, and the Trust's prison in-reach mental health service assessed Mr H. This assessment identified Mr H with medium risks to self, and historical risks to others, but stated that he did not require input at that time. The team informed Mr H and closed the referral.

4.6 Probation services referred Mr H to the Trust's SMS in mid-June 2013 for completion of a court ordered six-month alcohol treatment requirement (ATR) programme. The Trust's Alcohol Treatment Service (MATS) received the referral and completed a standard care plan six days later. Mr H attended six of the nine appointments offered to him (between mid-July and mid-September 2013). During this programme (in July), Mr H attended the general hospital on advice from his GP after experiencing withdrawal symptoms. Mr H's last attended appointment was in mid-September 2013. Mr H did not attend his follow-on appointment at the start of October 2013. Mr H did not complete the treatment programme (the notes suggest this was because he was subject to a further custodial sentence although dates are unclear from the records available).

4.7 During the third week of January 2014, a member of the public found Mr H unconscious in the street. Paramedics took Mr H to the acute hospital emergency department who referred him to the Trust's acute liaison mental health team. Mr H discharged himself before liaison staff were able to speak to him and the service closed the referral.

4.8 Mr H's GP referred him to the CRT in June 2014, after he reported suicidal thoughts alongside continued substance abuse. During the assessment, Mr H advised that he wanted admission for detoxification from alcohol; the assessor offered access to community substance misuse services. Mr H refused community support to address alcohol misuse. CRT staff updated Mr H's GP and probation services and closed the referral. At this contact the Trust

identified Mr H as "*green*" under the Trust's traffic light system[7], indicating Mr H did not require admission to hospital at that time.

4.9 The Trust's L&D service assessed Mr H at the end of November 2014 whilst he was in custody for an alleged offence of criminal damage. The assessment identified that Mr H presented a significant risk of violence to others and a risk of accidental self-harm, all in the context of alcohol and substance abuse. The assessor offered to refer Mr H to the Middlesbrough Recovery Together (MRT) and Lifeline community alcohol services, but Mr H stated he would do this himself. The assessment concluded that Mr H displayed *"no evidence of acute mental illness of a nature or severity to warrant diversion,"* and that he was "*fit to be detained and to be dealt with by the criminal justice system."* The team closed the referral.

4.10 We found no recorded contact for Mr H with the Trust during 2015.

4.11 The Trust's L&D service received a referral in mid-January 2016 following Mr H's arrest for a serious offence. The assessment identified Mr H's concerns were all related to substance misuse, not mental ill health, and the team closed the referral.

4.12 The Trust's L&D service received a referral in early February 2016 for Mr H following an arrest for a further serious offence. The team felt Mr H showed no current risks or vulnerabilities that warranted assessment and the team closed the referral.

4.13 The Trust's L&D service completed a court report in February 2016 relating to their assessment of Mr H from January 2016. The report concluded that Mr H was "*able to engage in court proceedings"* and there was *"no requirement for a full psychiatric report."* This court report did not detail the second referral in early February.

4.14 During June 2016, Mr H was subject to a Multi-Agency Risk Assessment Conference (MARAC)[8] protection plan for a serious offence. Trust records later indicate this protection plan ended (no date given), and that Mr H was then subject to a public protection order[9] alone. We found no further details on the status or monitoring of this protection plan in the notes.

4.15 The probation service referred Mr H to the Trust's CRT for assessment in November 2016. The probation officer identified that Mr H was expressing

[7] The Trust patient safety lead informed this review that the Trust uses a traffic light system to determine urgency for admission. We discuss the Trust's traffic light system within our gap analysis in Section 6 (see 6.19 onwards).

[8] A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors: https://www.gov.uk/government/publications/multi-agency-risk-assessment-conference-marac-protection-plans-requests-for-evidence

[9] An order under the Anti-social Behaviour, Crime and Policing Act 2014 https://www.legislation.gov.uk/ukpga/2014/12/part/4/chapter/2/crossheading/public-spaces-protection-orders/enacted

"*suicidal ideation, superficially cutting his wrists"* and was described as *"paranoid, very depressed and anxious."* The referrer indicated Mr H was "*high-risk to others"* and that *"he is not currently on MAPPA[10] but is under a single agency public protection."* There were no further details of this single agency public protection plan in the notes, and the reference to MAPPA does not indicate whether Mr H should have been under this process or indicate if a referral under MAPPA was being, or had been, considered. CRT advised they would not assess Mr H in the community at that time. The reason for this was not recorded. CRT advised that Mr H could however attend the Trust's mental health hospital for a psychiatric assessment, or alternatively probation could seek a GP referral for Mr H to be seen in 2-3 weeks' time by the Trust's Access service. The probation officer felt Mr H should be seen that day and advised they would provide Mr H with a bus pass to attend the Trust's psychiatric hospital for an assessment of his mental state. Mr H did attend but walked out in the middle of assessment stating he did not want to see the crisis team. CRT updated probation, identified Mr H as "*green"* under the traffic light system, and closed the referral.

4.16 Apart from referrals for assessment by the Trust's L&D service and CRT, Mr H was not open to any Trust service during 2016.

4.17 Mr H took an overdose at the end of June 2017. The Trust's Liaison Psychiatry Service assessed Mr H and referred him to CRT. CRT offered Mr H an informal admission.

4.18 Mr H was an inpatient on the Trust's adult acute psychiatric ward from the end of June for five weeks. During this admission, the EIP Team assessed Mr H. This assessment suggested Mr H was experiencing a first episode of psychosis. EIP accepted Mr H for a six-month assessment under the ARMS pathway, to start on discharge from hospital. The Trust's Early Intervention in Psychosis Service Operational Policy (dated March 2014) describes this pathway as suitable for *"those service users aged 14-35 years of age who are deemed to be at high risk of developing psychosis... Decision making regarding ARMS is informed and evidenced by the use of the Comprehensive Assessment of At-Risk Mental States[11] (CAARMS)".*

4.19 EIP worked with Mr H from his discharge in August and kept him on the caseload until mid-January 2018.

4.20 Between his discharge in August 2017 to the time of Mr H's arrest in March 2018, the police referred Mr H to the Trust's L&D service on four occasions. The L&D service screened all four referrals and completed assessments with

[10] Multi-Agency Public Protection Arrangements: designed to protect the public from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

[11] The CAARMS instrument provides a useful platform for monitoring subthreshold psychotic symptoms for worsening into full-threshold psychotic disorder *(Yung AR, Yuen HP, McGorry PD, et al. Mapping the onset of psychosis: the Comprehensive Assessment of At-Risk Mental States. Aust N Z J Psychiatry. 2005;39(11-12):964-971).*

Mr H twice. L&D also saw Mr H on one further occasion when Mr H attended court intoxicated, making threats to kill himself (November 2017). L&D determined that Mr H's main issue related to his housing situation, advised him to see his EIP worker, and to attend a housing review.

4.21 From his discharge in August 2017 to the time of his arrest in March 2018, the CRT also assessed Mr H twice, and the Trust's Liaison Psychiatry Service assessed Mr H once (December 2017).

4.22 Mr H's last contacts with Trust services were with EIP and CRT (separately) in mid-November, with the Liaison Psychiatry Service in early December, and with CRT in mid-December 2017.

4.23 Below is a summary timeline of Mr H's contact with Trust services between discharge in August to mid-December 2017.

Date	Service and nature of contact	Nature of contact
August	L&D	Assessment
August	EIP	Telephone contact (7-day discharge)
End August	EIP	Face to face contact
Mid September	EIP	Face to face contact
Mid September	L&D	Referral screened/not assessed
End September	EIP	Face to face contact
Mid October	EIP	Formulation review
Mid October	EIP	Face to face contact
End October	EIP	Face to face contact
Mid November	EIP & L&D	Joint assessment
Mid November	L&D	Face to face contact
Mid November	EIP	Face to face contact
Mid November	CRT	Assessment
End November	L&D	Referral screened/not assessed
December	Liaison Psychiatry Service	Assessment
Mid December	CRT	Assessment

4.24 EIP attempted but did not contact Mr H just before Christmas 2017 (at his mother's address).

4.25 EIP wrote to Mr H in mid-January 2018 advising him of his discharge from services back to the care of his GP. EIP updated Mr H's care plan on this date.

4.26 EIP sent a discharge summary to Mr H's GP the same day.

5 Analysis of the Trust internal investigation report

5.1 Niche have developed a framework for assessing the quality of investigations based on best practice. It is based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency,[12] NHS England's Serious Incident Framework and the National Quality Board Guidance on Learning from Deaths[13].

5.2 We assess the quality of investigations under three themes – Credibility (6 standards), Thoroughness (14 standards) and Impact (5 standards).

5.3 Our process includes reviewing the Trust's policy for completing serious incident investigations to understand local as well as national guidance to which investigators should refer. We are mindful of the proposed changes to NHS England's Serious Incident Framework (PSIRF). This new framework is due to be issued in Spring 2022; at the time of writing this report the final changes to the PSIRF were not available.

Summary assessment of standards of internal investigation

5.4 Appendix 3 summarises our assessment of the internal investigation against the twenty-five standards within our NIAF. Overall, we found the Trust's internal investigation met four of the twenty-five assessment standards, met seven partially and did not meet fourteen standards.

Rating	Description	Number	Standards
	Standard met	4	Credibility 4
	Standard partially met	7	Credibility 2 Thoroughness 5
	Standard not met	14	Thoroughness 9 Impact 5

We discuss these findings in more detail below.

Internal Investigation Review – Process

5.5 The incident occurred in March 2018. The Trust received notice of Mr B's death on 15 March 2018 and began its investigation on 22 March 2018. The Trust signed off the final report at a director's panel on 14 June 2018; the final report was dated 18 June 2018. This is within Trust policy time frames and the current nationally agreed 60-day timeframe for investigations.

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

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

5.6 The report states that the Trust's internal investigation was a "*Type 2, Comprehensive Investigation"*. The Trust appointed an investigator trained in RCA methodology; the report does not identify their designation, although the Trust later identified they were from the Patient Safety Team which comes under the Nursing and Governance Directorate. The investigator was a band 7 nurse. The Trust's Incident Reporting and Serious Incident Review Policy (2017) states *"serious incident reviews are led by the Patient Safety Team (PST) and are based in the Nursing and Governance Directorate; they are independent of clinical services".*

5.7 The type of investigation and lead investigator appointed were appropriate to the level of incident.

5.8 The Trust's Incident Reporting and Serious Incident Review Policy (2017) states *"all staff involved and identified in the 72 report and those invited by the PST reviewer are expected to attend the Root Cause Analysis (RCA) and feedback meetings".*

5.9 The internal investigation panel convened an RCA meeting on 30 April 2018. In attendance were:

- Advanced Nurse Practitioner, Mental Health Liaison and Diversion Service (L&D).
- Care Coordinator, EIP
- Advanced Practitioner, EIP.
- Team Manager, Mental Health L&D Service; and
- Team Manager, Psychosis service and EIP.

5.10 The Trust's Incident Reporting and Serious Incident Review Policy (2017) states *"on completion of the RCA meeting the PST Reviewer will write up their findings in a draft report and then hold a Feedback meeting with staff from the RCA to confirm their findings (if any) and to check for factual accuracy and learning of lessons. Attendance at the feedback meeting is critical for the Locality Manager (or equivalent) who will lead on any Action Plan, write the SMART objectives and be part of the learning lessons process."*

5.11 The panel had a feedback meeting on 14 May 2018 with the Team Manager for Psychosis and EIP, the Care Coordinator from EIP, and the Advanced Practitioner from EIP.

5.12 The Trust's Incident Reporting and Serious Incident Review Policy (2017) identifies that *"the Service Panel will consist of the Head of Service, Associate/Deputy Medical Director, Modern Matron, and the Consultant Psychiatrist and will ensure there is a full account of the incident and factual accuracy and confirm findings".*

5.13 The Service Panel signed off the internal investigation report on 29 May 2018.

5.14 The Trust's Incident Reporting and Serious Incident Review Policy (2017) identifies that the Director's Panel is the final stage to "*review and sign off the*

report and confirm if Duty of Candour applies." Members of this panel include the Medical Director, an Executive Director, a Non-Executive Director, and the Head of Nursing. The policy also indicates that "*when the Director Panel confirm they accept the report that is the final assurance to the organisation of the full governance process is complete."*

5.15 The Trust Director's Panel signed off the report on 14 June 2018, and the final report was dated 18 June 2018. The Chair of the Director's Panel was the Director of Quality Governance. Also present were the Trust's Executive Director[14], the Head of Nursing, a Non-Executive Director, and the Medical Director.

5.16 Due to leave of absence, we were unable to interview the lead investigator, however, the Trust did provide a senior manager contact who supported this review.

5.17 We found the panel meetings and sign off processes to have been at a sufficiently senior level in the Trust, however we are concerned about the adequacy of this sign off. Given the number of our findings, and the stated challenge role for both the service and director panels, we would have expected these findings to have been identified before the report was completed. We further question the independence of the review process given the large number of services involved in Mr H's care that were also part of the investigation process.

Internal Investigation Report – Credibility (6 standards: 4 met: 2 partially met)

5.18 The internal investigation report indicates the investigation was based on a documentary review of Mr H's electronic care record, telephone discussions, an RCA meeting and email exchanges with external agencies. The Trust's internal report did not provide any details of the emails or telephone discussions. It would have been useful for the investigation to have identified the designations of author/s or participants, and other agencies contacted by email or telephone and the detail of these exchanges.

5.19 The Trust's internal report covered all of Mr H's involvement with the Trust and contact between February 2010 and 9 August 2017 was summarised.

5.20 The Trust's internal report scope states that the chronology ran between 19 September 2017 to 18 March 2018; this is different to the actual date range provided in the tabular chronology to the report. The report does not give a reason for this inconsistency.

5.21 The internal investigation attached a victim chronology as an appendix.

5.22 The report's terms of reference identified one purpose, nine objectives, and one key issue, set out below.

[14] The report did not identify the designation of the attending Executive Director.

5.23 The purpose was described as – *"to identify any root causes and key learning from the incident and use this information to significantly reduce the likelihood of future harm to patients."*

5.24 The objectives were to:

- establish the facts i.e., what happened (effect), to whom, when, where how and why (root causes).
- establish whether failings occurred in care or treatment identifying any care and/or service delivery problems which occurred and what caused them.
- look for improvements rather than to apportion blame.
- establish how recurrence may be reduced or eliminated.
- formulate recommendations and an action plan.
- provide a report and record of the investigation process and outcome.
- identify routes for sharing learning from the incident.
- establish whether appropriate consideration was given to safeguarding processes; and
- identify actions required in line with statutory Duty of Candour regulation.

5.25 The key issue identified – *"did the various agencies involved in supporting the patient, work closely together to provide a coordinated plan of care?*"

5.26 The Trust also completed a 72-hour report. The purpose of a 72-hour report is to identify and provide assurance that necessary immediate action is taken to ensure the safety of individuals, to confirm if the incident meets the criteria as a serious incident, and if it does to recommend the level of investigation required. The Trust's 72-hour incident report met the requirements of the Serious Incident Framework.

5.27 The terms of reference omitted specific reference to the victim other than in the purpose statement that references "*patients*" (plural). The victim chronology, included as an appendix to the investigation report, indicates that the victim was known to Trust services.

5.28 Overall, we found the terms of reference to be generic in format and applicable to all investigations. Whilst recognising that elements of any investigation's terms of reference will by nature be generic, it would also have been useful for the investigation to develop case specific key lines of enquiry to support their investigation. We discuss possible key lines of enquiry as part of our gap analysis in Section 6 of this report.

Internal Investigation Report – Thoroughness (14 standards: 5 partially met: 9 not met)

5.29 The Trust's Incident Reporting and Serious Incident Review Policy (version 8.1, 2017) recommends Root Cause Analysis as a methodology for investigation. The policy identifies the need to complete a "*robust internal*

investigation" in the case of domestic homicides, indicating this will be *"a structured and systematic review of an incident to establish a chronology of all the events leading up to the incident, identifying any root and/or other causal factors that may have contributed to the incident. The aim of which is to understand what happened, identify how future incidents may be prevented and provide a set of conclusions in the final report that are fair, evidenced and reasoned."*

5.30 The Trust's internal report describes the RCA method used as *"Telephone discussions, Information gathering via a root cause analysis meeting, review of the patient's electronic care record, chronological timeline, via email with external agencies and contributory Factors Grid. Identifying contributory factors & root causes Generating solutions."*

5.31 The report does not detail the result of the comparison with the Contributory Factors Grid[15]. The report does not explain the application of RCA methodology or give detail of specific areas of enquiry.

5.32 We found the terms of reference were too generic and did not guide the investigation to consider specific issues or key lines of enquiry. This resulted in a descriptive report that did not offer any analysis of events or any consideration of factors or root causes. We found no evidence of a comprehensive RCA having been undertaken to support the findings.

5.33 The report identified three areas of learning which are discussed in the section below on report findings (5.46 onwards).

5.34 The Trust's Incident Reporting and Serious Incident Review Policy states in its introduction "***the needs of staff, patients and the family affected are our primary concern, it is important that all parties are involved and supported*** *throughout the review process."* (Trust bold emphasis)

5.35 The policy states that reviews should ("*unless informed otherwise"*) contact families and carers to clarify actions, offer condolences and offer them the opportunity to be involved in the review process. On completion of the review the family should also have the opportunity of a meeting to consider the findings and lessons for learning, in conjunction with senior staff from the service involved.

5.36 The Trust internal investigation report states *"no involvement has been sought from the patient or relatives, until consent has been received from the police that they are in agreement for the lead reviewer to contact them."* The report does not indicate how, or if, the investigation followed up contact with the police, and does not provide detail of the outcomes of any attempted contacts.

[15] The contributory factors grid is used to guide and organise the analysis of interconnected, contributory, causal and mitigating factors when investigating patient safety incidents (also see https://www.england.nhs.uk/patient-safety/patient-safety-investigation/)

5.37 We found no evidence that contact occurred with Mr H, his family, or the family of the victim at any part of the investigation. There is no evidence that the Trust discussed or shared the report terms of reference or the findings with Mr H or the affected families before, during or after publication.

5.38 The Trust report followed a standard template format. The template provides advice and guidance for completion of the report. The template includes sections for terms of reference, background and context, chronology, a findings section (including incidental findings, care / service delivery problems, root cause, contributory findings, lessons learned) and a conclusion section. We discuss the completed sections below.

Trust Report section on Background and context

5.39 The background and context section gave a narrative summary of Mr H's history and contact with services from 2010 to the date of the homicide. This section also details a discussion between the Trust's lead reviewer and a consultant psychiatrist from the Trust's acute inpatient service. The report does not detail if this consultant was engaged in Mr H's care, however, the wording indicates that the consultant was familiar with Mr H's care and presentation on the ward. The record of this discussion was regarding Mr H's diagnosis and whether he would have been appropriate for an assessment by a forensic psychiatric service.

5.40 At the time of his discharge from hospital Mr H's diagnosis was *"Delusional disorder and Depression, Mild episode."* The report gave details of the relevant ICD:10[16] diagnostic code. The report then indicates that the consultant "*felt this may not have been the outcome, if the patient had been discussed in a multidisciplinary discharge meeting. As no CPA [Care Programme Approach] /discharge meeting had been completed, a unilateral diagnostic decision was made."* The report is unclear why Mr H's diagnosis was under discussion, does not indicate whether this was a key line of enquiry, and does not give any analysis or consideration of this discussion.

5.41 Regarding the discussion and consideration of a referral to a forensic service, this appears to have been a benchmarking exercise to consider best practice against actual practice. The report does not indicate whether, or why, this was a line of enquiry. The consultant was clear in their view that there was *"no indication for inpatient forensic services to be involved."* However, the consultant also indicated they might consider discussing patients with similar presentations with a community forensic service in the future. The report does not include this within either the findings or lessons learned sections and makes no recommendation about this for future practice.

5.42 There was no further discussion or analysis of Mr H's admission and discharge in 2017 and this section of the report does not contain any further comment or analysis on Mr H's background, care, or treatment.

[16] International Classification of Diseases (ICD) codes are the main basis for diagnostic purposes, health recording and statistics on disease https://www.who.int/standards/classifications/classification-of-diseases

Trust Report Chronology

5.43 The report chronology of events starts on 9 August 2017. This is a descriptive timeline of events.

5.44 The report highlighted and commented on three events:

- In September 2017, police arrested Mr H for a serious offence. The report noted from the discussion at the RCA meeting that Mr H had not denied this offence and that the event had occurred in response to a previous event. This was a new risk incident. The Trust report did not detail expected practice in relation to recording of this risk information or examine actual practice in relation to this. There is no further consideration of this event, or indication as to its relevance for the investigation.
- In November 2017, police arrested Mr H for an alleged assault on a relative he was visiting. The report did not comment on this alleged assault or any impact on Mr H's housing situation or continued family relationships. The lead reviewer did however discuss rehousing and risk profiling with Mr H's probation officer. The probation officer confirmed housing services had been aware of Mr H's offending behaviour. There is no further analysis of risk due to housing factors, or any indication as to its relevance for the investigation.
- In January 2018, EIP completed a six-month review in Mr H's absence. The plan was to discharge Mr H. The report notes this plan. The RCA meeting discussed Mr H's discharge from services. Staff informed the lead reviewer that if Mr H had wished to receive help after discharge, he had the resources to do this. The report did not discuss or analyse this further. The report did not indicate whether Mr H's pattern of engagement or his discharge from services informed the investigation's lines of enquiry.

5.45 Aside from these three sections of commentary, the report does not identify any other events in the chronology for further review or analysis. The report does not highlight from the chronology any area of actual practice against expected practice. The internal investigation report does not detail how the chronology informed the analysis stage of the investigation or contributed to the findings.

Trust Report Findings and Recommendations

5.46 The report states there were no contributory factors.

5.47 The report states that there were no root causes and no care or service delivery problems. Whilst not all investigations identify a single root cause, it is unusual that there were no identified care or service delivery problems given the detail of the case.

5.48 However, the report did identify three lessons for learning[17] as follows:

[17] The Trust's Incident Reporting and Serious Incident Review Policy states that *"investigations identify how and why patient safety incidents happen, the analysis identifies areas for change, and make recommendations which*

- *"No evidence of consideration of adult safeguarding processes in relation to Mr H developing a relationship with a female whilst both were inpatients.*
- *No evidence of a multi-agency meeting during or after admission to clarify who would be the lead agency for the care and support offered.*
- *No evidence of a multidisciplinary Care Programme Approach (CPA) meeting taking place prior to his discharge with family who he was going to be living with, or the multiple agencies involved in his care."*

5.49 We consider these to be findings of the investigation rather than learning points. The report did not provide any further detail to support these three learning points, make any comment on actual against expected practice, or establish if there were related care or service delivery problems.

5.50 All three findings indicate potential care and service delivery problems: in safeguarding systems, in discharge planning systems, within care planning processes and within multi-agency working.

5.51 The report made no recommendations.

5.52 We discuss the report's lessons/findings further in Section 6 below.

Trust Report Conclusion

5.53 The report has a concluding section. This section does not provide any evidence of how the investigation reached its conclusions. The conclusion lacks any analysis of the reasons why events happened.

5.54 The conclusion identifies four aspects relating to care and treatment - diagnosis, alcohol and substance misuse, engagement, and hospital discharge in 2017 - but does not indicate why these were of note to the investigation and does not consider them further. We comment on these four areas in our gap analysis in Section 6 below.

5.55 Finally, the report does not compare actual practice against Trust expected practice, Trust policy or national policy and the reader is left without an understanding of whether practice was in line with Trust policy.

5.56 The report concludes that *"based on the outcome of this review that harm was not caused as a result of an act, omission or mistake made during the provision of this persons [sic] care and treatment."*

5.57 Due to the lack of analysis underpinning the report's findings, we are unable to conclude that this investigation was adequate.

5.58 Based on our review of the investigation's terms of reference, the report did not meet the purpose nor eight of the nine objectives. The review met one

deliver safer care for our patients." This process should generate lessons for learning to 'prevent/minimise the same incident occurring elsewhere.'

objective - "*to provide a report and record of the investigation process & outcome.*"

Internal investigation report – Impact (5 standards: 5 not met)

5.59 As previously highlighted, the terms of reference were generic, they did not reference any detail of the incident for consideration and did not identify specific factors for exploration or analysis.

5.60 The report did not examine why events occurred and did not offer any form of analysis, benchmarking of practice, discussion of key events, or consider how to reduce or eliminate recurrence. The investigation did make one attempt to benchmark practice (in relation to the discussion with the consultant psychiatrist about forensic services) but they did not expand on this. This was a missed opportunity to consider whether the consultant's view was a lesson for learning and/or even a recommendation.

5.61 We found no evidence of RCA methodology and no supporting evidence of further analysis as to why events occurred or factors that may have influenced events. The report did not identify any contributory factors, care, or service delivery problems or recommendations. The internal investigation made no recommendations, so an action plan was not developed.

5.62 These findings mean that the report would have no impact on service improvement or change in practice.

Duty of Candour

5.63 One of the objectives of the Trust's internal investigation was *to "identify actions required in line with statutory duty of candour regulation."*

5.64 We found no evidence that the investigation considered whether there were any actions required under the Trust's Duty of Candour Policy or the national regulations[18]. Neither did we find evidence of Duty of Candour considerations in the records provided.

> **Recommendations 1-4**
>
> Relate to our review of the standard of the investigation and surrounding sign off.

[18] https://www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour#duty-of-candour-regulations

6 Gap analysis of care and treatment

6.1 From our review of the Trust's electronic and paper records we developed a chronology.

6.2 In developing this chronology, we have highlighted the following 12 key areas which if explored as lines of enquiry, may have strengthened the internal investigation's analysis and findings. The Trust's internal investigation report does not explore these areas.

6.3 This information was relevant to enable a fuller review of the care and treatment provided to Mr H. We discuss the impact of not considering all relevant and background information within this gap analysis of care and treatment.

- The interlinks between and access to alcohol and substance misuse.
- The adequacy of housing and any impact on access to treatment.
- Engagement with Mr H and the arrangements and policies for non-engagement.
- Diagnosis – application of diagnoses and onward referral for treatment.
- The use and appropriateness of medication and compliance.
- Forensic assessment.
- Hospital discharge 2017
- Adult safeguarding.
- Multi-agency working.
- Care planning and carer assessments.
- Risk management.
- The relationship between the victim's chronology and Mr H.

The interlinks between and access to alcohol and substance

6.4 The Trust's internal investigation identified in the conclusion that Mr H's alcohol and substance misuse, including *"street purchased"* medication such as Zopiclone[19], was a factor throughout his time under the care of the Trust. The Trust's investigation did not analyse or explore this and does not identify whether substance and alcohol misuse had an impact on Mr H's mental health, diagnosis, and associated behaviour, or whether substance misuse impacted on Mr H's engagement with services.

6.5 The Trust's Care and Management of Dual Diagnosis Procedure (2012) identifies dual diagnosis as relevant to an individual with concurrent needs arising out of their mental disorder and/or learning disability and their substance misuse. This document details "*the procedures to be followed*

[19] Zopiclone - used to treat bad bouts of insomnia. https://bnf.nice.org.uk/drug/zopiclone.html

when caring for individuals with concurrent mental health and substance misuse needs." The procedure indicates that where necessary "*dual diagnosis practitioners will provide information and guidance regarding access to service in each locality*." These practitioners are described as "*staff with capabilities in working with dual diagnosis who have a role in supporting and developing other staff in working with this client group.*"

6.6 Mr H may have benefited from a referral to a dual diagnosis practitioner– we found no evidence that his care team considered this.

6.7 The Trust's Care and Management of Dual Diagnosis Policy also notes that Trust services should not discriminate against service users due to their mental health needs perceived as drug or alcohol induced.

6.8 In mid-January 2014, a referral to the Trust described Mr H as a "*known drug and alcohol user*" and probation staff described Mr H at the end of June 2017, as having *"no boundaries… can be "very nasty" and is "one to watch out for".* We suggest these terms indicate personal judgements. The investigation did not consider the impact of such statements on the Trust services that received them. For example, whether they influenced service provision, personal interactions, or services' expectations for engagement.

Key finding

From our high-level review, it is evident that services should have considered Mr H for referral to the dual diagnosis practitioners.

Records also indicate an element of personal judgement relating to Mr H's drug and alcohol misuse. This high-level review cannot determine whether this impacted on how services responded to Mr H. We do however recognise that when staff support individuals with complex needs, they require specialist knowledge and increased levels of personal support and supervision.

See Recommendation 5 – with particular reference to 5a.

See Recommendation 7 – The Trust should seek assurance on how it supports individuals with complex presentations, developing and providing guidance for staff on key referral and care planning pathways.

This should include consideration of any additional assessments, any referral to specialist services and specialists (forensic, dual diagnosis) and consideration of increased psychiatric review for individuals with complex presentations.

See Recommendation 8 – The Trust should provide assurance that staff can access additional clinical advice and support when working with individuals with complex presentations. This should be provided as part of the post-publication assurance review.

The adequacy of housing and any impact on access to treatment

6.9 The Trust's internal investigation discussed housing and accommodation with probation services in relation to risk but did not explore further whether adequacy and provision of housing impacted on Mr H's care or his access to treatment.

6.10 Mr H had a history of unstable accommodation, and he moved between homeless hostels, B&B provision, the family home, and an unfurnished flat. On discharge from hospital in 2017, Mr H had a tenancy. Records indicate that Mr H felt this flat was too far from the family home, and that the flat was unfurnished. The report made no comment on whether staff explored this with Mr H or the housing provider in advance of his discharge from the ward.

6.11 Mr H gave differing accounts regarding whether he still used the flat during November and December 2017, and at the time of the incident, Mr H was using this flat, but he also used temporary (bed and breakfast (B&B) style) accommodation.

6.12 Following his discharge from hospital we identified eleven occasions when Mr H indicated that housing issues were impacting on his ability to engage with services.

Date	Contact
August 2017	Mr H told L&D staff he is anxious as his flat is unfurnished and he does not like being there away from family. He also told staff he had not taken any medication since his discharge two days previously.
August 2017	Mr H told EIP staff he was currently staying at his family home until his flat is ready. His family were away. Mr H said he had not left the house due to anxiety and had not taken his antipsychotic medication (Quetiapine[20]) since discharge due to his GP being too far away.
September 2017	Mr H attended EIP review and told staff his flat was out of area and not near his family. Mr H said he did not want to be there. Mr H also said he had not had any medication since his discharge.
November 2017	EIP and L&D assessed Mr H and noted that he could not return to the family home. Services advised Mr H to seek alternative accommodation.

[20] An anti-psychotic medication used to treat certain mental health conditions (such as schizophrenia, bipolar disorder) https://bnf.nice.org.uk/drug/quetiapine.html

November 2017	EIP and CRT both assess Mr H. CRT record noted "*no report of voices till homeless and without support from family… no shift in his thinking – he is homeless, he feels he is ill and wants to be in hospital."*
End November 2017	EIP completed a 12-week formulation meeting and identified housing issues were contributing to Mr H's hopeless thoughts. They also noted that a lack of mobile phone limited their ability to provide support.
December 2017	EIP spoke to probation officers who told staff Mr H still has the flat but is not going there as he has no furniture. EIP note they are not able to contact Mr H (no phone) and so he is not able to pick up his new prescription.
December 2017	Liaison psychiatry assessed Mr H and identified issues with his housing.
Mid December 2017	Mr H told CRT he was staying at B&B and does not like it due to "*druggies and winos"* and claimed this was making him turn to alcohol and drugs.
Pre-Christmas 2017	EIP attempt to contact Mr H at family address
Mid January 2018	EIP discharged Mr H in his absence and noted that due to missed appointments they were unaware of his current circumstances.

Key Finding

The Trust investigation did not consider whether housing had any impact on Mr H's mental health, his continued alcohol and substance misuse or his engagement with services.

See Recommendation 5 – with particular reference to 5b.

Engagement with Mr H and the arrangements and policies for non-engagement

6.13 The Trust's internal investigation did identify engagement as a factor in Mr H's care, concluding that attempts to engage Mr H achieved "*little or no positive results, and that Mr H focused on wanting an admission to deal with his problems."* The conclusion placed the emphasis on Mr H's responsibility to engage, and, due to the lack of further analysis, could be perceived as directing blame towards Mr H.

6.14 We found no evidence that the investigation considered why Mr H may have struggled to engage with services, whether Mr H was able to effectively engage, or whether there were other services better placed that could have increased Mr H's engagement. In addition, the investigation did not analyse Mr H's disengagement from EIP, explore why he missed appointments or consider whether EIP made appropriate attempts to re-engage Mr H. Mr H's

last contact with EIP was in mid November 2017, eight weeks before his discharge from EIP in January 2018.

6.15 Finally, the Trust's investigation did not examine whether any factors impacted on Mr H's ability to engage with Trust services, and/or consider whether there were actions staff should have undertaken in response to this (e.g., guided by DNA policy).

6.16 The Trust's Did Not Attend (DNA) Policy (2017) identifies that *"When a current service user fails to attend a follow up appointment, the health or social care professional should consider the options and take the most appropriate action, depending upon risk assessment."*

6.17 Our review of the evidence indicates that Trust staff saw Mr H's risks in the context of substance misuse, and this impacted the service's assessment of his mental health. We identified the following factors that may have impacted Mr H's engagement with services:

- we found evidence throughout the notes that Mr H struggled to engage.
- Mr H found keeping appointment times confusing.
- services did not always send out the correct appointment details and did not always arrange follow up appointments at the end of a contact.
- Mr H lacked a permanent address and had limited access to a mobile phone; and
- appointments were on at least one occasion double booked with court dates.

6.18 Throughout the time under review Mr H also requested hospital admission. On at least two of these occasions CRT assessed and *"traffic lighted"* Mr H as *"green"* (June 2014 and November 2016).

6.19 We discussed the process of *"traffic lighting"* individuals with the Trust lead supporting our review, who informed us that this process indicated an assessment for admission. Green means admission is not indicated. Until May 2021 the Trust did not have a written procedure for this system. The Trust have however now published a procedure called 'Core Visual Control Board (VCB) Guidance' Version 4.0 May 2021. We have not reviewed this procedure as it was not in place during the time under review. We do however recommend that this procedure is considered as part of the review into Mr H's care and treatment to establish what if any impact this may have had on his care journey.

Key Finding

Services did not effectively engage with Mr H and due to risk assessment being related to substance misuse and not mental illness, did not follow up robustly when he started to disengage.

See Recommendation 5 – with particular reference to 5c.

Diagnosis – application of diagnoses and onward referral for treatment

6.20 The internal investigation did seek an inpatient consultant's view on diagnosis. The consultant reported that "*as no CPA/discharge meeting had been completed, a unilateral diagnostic decision was made.*"

6.21 We identified that multi-disciplinary team (MDT) meetings occurred prior to Mr H's discharge, including in early August 2017 (on the date of Mr H's discharge). These meetings took place daily on the wards, and whilst not always multidisciplinary, on most occasions at least one doctor was in attendance alongside ward nursing staff. These meetings had standard agenda items including psychosocial presentation, interventions, medication, and risk.

6.22 The Trust's internal investigation made no further comment on diagnosis. It is unclear whether the investigation felt Mr H's diagnosis was a factor, and if so, why.

6.23 Mr H had multiple diagnoses, including mental and behavioural disorder due to the use of opioids, paranoia, post-traumatic stress disorder (PTSD), mild symptoms of dissociation and mild depressive episodes. These differential diagnoses formed part of Mr H's complex presentation.

6.24 One assessment also indicated Mr H had a diagnosis of bipolar disorder (December 2017), however we found no further reference to this diagnosis and at the time of the homicide Mr H had a diagnosis of delusional disorder.

6.25 The following is a summary of Mr H's symptoms and diagnoses. Apart from the assessments completed whilst Mr H was an inpatient (end of June to early August 2017) we found no reference to a formal review by a psychiatrist.

Date	Summary of diagnosis
2010 – 2014	Alcohol and substance misuse, suicidal thoughts, and self-harm
January 2016	Low mood plus alcohol and substance misuse
November 2016	Paranoia plus alcohol and substance misuse
June 2017	Depression, low mood, paranoia, hearing voices, anxiety and alcohol and substance misuse
End June 2017	Depression, psychotic features, first episode psychosis
July 2017	Assessed as paranoid, with voices (telling him to harm others)
Mid July 2017	Assessed as having Post Traumatic Stress Disorder (PTSD) Mild symptoms of dissociative experiences
August 2017	Cluster record noted first episode psychosis
August 2017	Diagnosis on discharge delusional disorder, depression (mild episode)
September 2017	Mr H describes dissociative experiences with voices (telling him to harm others)

November 2017	Delusional disorder
December 2017	One reference by psychiatric liaison service to a diagnosis of bipolar disorder, however we found no further reference to this diagnosis

6.26 From the case notes, Mr H reported hearing voices whilst an inpatient in 2017, including derogatory voices that told him to harm others. In addition, following his discharge in August 2017 Mr H reported:

- increased anxiety later in August.
- hearing mumbling and drums in September.
- hearing voices telling him to harm someone alongside dissociative experiences in September.
- feeling targeted by others *("people out to get him")* in October.
- hearing voices in November 2017.

6.27 Despite multiple diagnoses and his presenting symptoms, no service (MHLS, CRT, SMS, MATS, L&D) determined that Mr H was presenting with a mental illness requiring their intervention (other than during his inpatient admission and subsequent admission to EIP under the ARMS pathway).

6.28 Mr H was under the care of EIP between August 2017 to January 2018.

6.29 The Trust's Early Intervention in Psychosis Service Operational Policy (March 2014) describes this pathway as suitable for "*those service users aged 14-35 years of age who are deemed to be at high risk of developing psychosis. This is termed At-Risk Mental States (ARMS)."* The policy also indicates that for people on the ARMS pathway, *"an assertive engagement approach is not indicated in this client group owing for the necessity of help seeking to part of the presentation. On this basis a lower intensity care package is offered than with first episode psychosis cases. Antipsychotic medication is not indicated in this presentation and will not be prescribed unless clear rationale identified."*

6.30 We found no evidence that services considered whether Mr H should remain on the ARMS/EIP pathway when he started to disengage, or any consideration of whether he was under the care of the correct service.

6.31 The EIP formulation meeting at the end of November 2017 took place in Mr H's absence. This was a thorough and detailed assessment of Mr H's history including his voice hearing experiences. The agreed plan however was for EIP to continue trying to engage Mr H up to the planned discharge date in January 2018, with the final plan that Mr H would be followed up by probation services. The EIP assessment concluded *"there is no indication to indicate he would transfer to the FEP [First Episode Psychosis Pathway] pathway for further involvement."*

6.32 The Trust's internal investigation did not consider whether follow up by probation services alone was an adequate care plan.

6.33 We identified that Mr H was referred twenty-one times to Trust services during the period under review. Following these referrals Mr H was seen and assessed on fourteen occasions (sometimes by more than one service on the same day) and he was not seen or assessed on six occasions. Of the 21 referrals, four resulted in a service being offered. Once for alcohol services, once for a court ordered alcohol treatment plan, once for an inpatient admission and once to EIP for a longer period of assessment.

6.34 Eight of all twenty-one referrals were made whilst Mr H was under the care of EIP (August 2017 – January 2018), five of these referrals followed an arrest for assaultive behaviour. Six of these referrals resulted in an assessment. None of these six assessments resulted in consideration of an alternative service, consideration of the need for a review by a psychiatrist, or consideration of any changes to Mr H's care plan.

Key finding

Services assessing Mr H repeatedly identified that his continued substance and alcohol misuse influenced psychotic experiences. We found no evidence that Mr H's diagnosis or presentation triggered a psychiatrist review or that staff explored these experiences with Mr H.

See Recommendation 5 – with particular reference to 5d.

See Recommendation 6 – The Trust should develop a system to ensure repeat referrals, screenings and assessments across multiple services are monitored effectively to identify potential patient risk and ensure care plans are adequately reviewed.

See Recommendations 7 & 8 – Whilst this high-level review cannot determine why services responded in this way, we would request that the Trust considers the implications of this finding. In particular, the implications for increased monitoring, support, and assessment when individuals present with similar multiple, complex needs. In addition, we would request that the Trust consider the implications for supporting staff who work with service users with similar complex needs.

The use and appropriateness of medication and compliance

6.35 The investigation did not consider medication prescribed, or Mr H's compliance with medication.

6.36 Following discharge from hospital in August 2017, Mr H quickly became non-compliant with medication. Mr H informed services of this at the assessment

in early August, his 7-day follow up telephone call four days later, and at review visits in late August and mid-September. EIP reviewed medication with Mr H at the end of September. At this and other meetings, Mr H requested an anti-psychotic medication as he reported they had helped with his symptoms.

6.37 Following the assessment at the end of September, EIP prescribed an anti-depressant, rather than an anti-psychotic medication. Mr H had stopped this medication by the time of his EIP review in mid-October. Mr H repeatedly reported that the anti-psychotic medication had helped him and there was evidence from his stay on the ward that this medication did reduce his reported symptoms. It would have been helpful if the investigation had explored the EIP decision not to prescribe anti-psychotic medication and the underpinning rationale, with a view to assessing whether this decision was in line with expected practice.

Key finding

Following his discharge from hospital Mr H quickly became non-compliant with medication. Mr H repeatedly requested anti-psychotic medication, reporting this helped with his voices. The Trust internal investigation did not explore the use and appropriateness of medication and compliance issues.

See Recommendation 1 – as part of the quality assurance for internal investigations the Trust should ensure review of medication is a standard part of any investigation.

See Recommendation 5 – with particular reference to 5e.

Forensic assessment

6.38 The investigation sought the view of an inpatient consultant regarding whether Mr H would have met the criteria for a forensic assessment. We felt this was an attempt to benchmark practice, however the investigation did not comment on the consultant view that in future similar cases they may consider referral for forensic assessment; the report made no comment regarding referral criteria for forensic assessments and no further analysis of the impact of Mr H's forensic history on his care and treatment.

6.39 Mr H had an extensive history of contact with criminal justice services for violent offences and criminal activity, often relating to misuse of alcohol, substances, and associated risk behaviours.

6.40 Police arrested Mr H five times between his discharge from hospital in early August 2017 to the date of his arrest. We set out details below:

- August 2017, for an alleged serious offence. This was two days after his discharge from hospital.
- September 2017, for an alleged serious offence.

- November 2017, following an alleged serious offence against a relative he was visiting.
- November 2017, for an alleged serious offence.
- December 2017, for an alleged offence.

Key finding

The forensic history and Mr H's engagement with the criminal justice system were significant events that may have impacted on this case. The internal investigation did not analyse any impact of Mr H's forensic history on his care and treatment, and despite the inpatient consultant view that they would consider referral for a forensic assessment in similar cases the investigation made no recommendation regarding this.

See Recommendation 5 – with particular reference to 5f.

See Recommendation 7 – as part of the guidance for complex cases the Trust guidance should consider developing a referral pathway for forensic assessments.

Hospital discharge 2017

6.41 Mr H was an inpatient from the end of June to early August 2017. At the point of discharge from hospital Mr H had a tenancy and moved under the care of EIP. The internal investigation report detailed the hospital discharge process in its conclusion stating there were issues with discharge planning, multidisciplinary working and the engagement of Mr H and his family in care planning. The investigation however did not analyse whether these factors impacted Mr H's hospital discharge, did not explore why certain processes did not happen, and did not explore actual compared to expected Trust practice.

6.42 The Trust's Admission, Transfer and Discharge of Service Users within Hospital and Residential Settings Policy (2016) indicates that discharge should be a planned collaborative process involving the service user, their family and any other relevant services people are engaged with.

6.43 The ward planned Mr H's discharge early in his admission. Ward staff informed Mr H of his planned discharge at the end of July (4 days before his planned discharge date). When told, Mr H became distressed and agitated. In addition, the ward held a pre-discharge meeting in mid-July, but did not inform Mr H or his family.

Key Finding

The internal investigation report did not comment on Mr H's delayed discharge from hospital. Mr H did not have a collaborative discharge from the ward in 2017.

See Recommendation 5 – with particular reference to 5g.

See Recommendation 9 – The Trust should provide assurance that current hospital discharges are in line with agreed policy.

Adult safeguarding

6.44 The Trust investigation identified as a lesson learned, the lack of adult safeguarding processes applied in response to Mr H developing a relationship with another patient on the ward. This is a finding rather than a learning point as the finding itself would not prevent recurrence.

6.45 The investigation identified Trust services should have considered Mr H's relationship with another patient under the safeguarding framework. We found no evidence that the investigation explored or analysed why this did not happen and no evidence that the investigation considered whether actual practice met the standard expected by Trust policy. The Trust internal report had no actions or recommendations relating to this finding.

6.46 From the chronology we identified five opportunities for ward staff to consider concerns under the adult safeguarding framework relating to Mr H's growing relationship with another inpatient; these are set out below:

- Mid-July 2017, Occupational Therapy (OT) staff noted that Mr H told a female patient he "*had a crush on her*". This is the first recorded instance when Mr H talks about a female patient in this way. This was an opportunity for nursing staff to discuss with Mr H the appropriateness of his behaviour and to consider under the safeguarding framework, whether the female patient could be at risk of abuse due to her mental health or other vulnerabilities.
- End of July 2017, OT staff noticed that Mr H gave a heart shaped box to a female patient. We found no record of further actions taken. This was a further opportunity for nursing staff to review this growing relationship under the safeguarding framework.
- End of July 2017, OT staff noticed that Mr H "*focused his attention on a female patient*". Other patients told staff they were "*in a relationship that had started over the weekend."* The records do indicate that the OT informed nursing staff on the ward, highlighting potential risks as they believed Mr H was under the MARAC framework. This was in line with policy and expected practice. However, we found no evidence that nursing staff took any action in response to this or considered whether this was a concern under the adult safeguarding framework.
- Early August 2017, OT staff observed Mr H "*kissing and hugging a female patient*". Records indicate that Trust nursing staff completed an incident form (on the Datix system) and recorded that *"both were spoken to."* There is no record of the outcome of this discussion, and we found no evidence

that staff referred this as a concern under the adult safeguarding framework.

- Early August 2017, the multidisciplinary ward meeting noted *"report of kissing female patient*". We again found no evidence that staff considered this or referred this as a concern under the adult safeguarding framework.

6.47 In addition to concerns about this growing relationship we also noted that in early August 2017 the multidisciplinary ward meeting recorded Mr H had "*attempted to restrain a peer."* We found no evidence that staff considered this as a concern or made a referral for the other inpatient under the adult safeguarding framework.

6.48 Finally, in early August (two days after his discharge from hospital), police arrested Mr H on suspicion of a serious offence. The referral identified that the alleged victim had been an inpatient under Trust services at the same time as Mr H. The risk assessment completed whilst Mr H was in custody noted under adult safeguarding, "*no issues evident and nothing from alleged offence to indicate safeguarding concerns*." We found no evidence that staff considered this as a concern under adult safeguarding.

6.49 Throughout the period preceding the event in March 2018 (from January 2010) we found no records of referrals made for Mr H under the adult safeguarding framework.

6.50 This is a significant area of practice that requires further examination.

Key finding

We identified seveal occasions when Trust adult safeguarding practice for Mr H and individuals he was associated with, fell below expected standards.

See Recommendation 5 – with particular reference to 5h.

See Recommendation 10 – The Trust should provide assurance that adult safeguarding practice is in line with agreed policy.

Multi-agency working

6.51 The Trust internal investigation identified missed opportunities for effective multi-agency working within the discharge processes. We found no evidence that the investigation considered or explored why services missed these opportunities.

6.52 Within the section on notable practice, the report does identify that probation services felt communication and information sharing had been "*a positive venture, with both parties being proactive and sharing information relevant to care decisions*."

6.53 Sharing information is in line with policy and expected practice, however the Trust internal investigation did not explore whether the communication and information shared was adequate and effective. From the case notes we identified confusion around the recording of multi-agency public protection systems and processes in relation to whether Mr H was under MARAC and/or MAPPA. This is of concern. Individuals subject to public protection measures require an increased level of support and monitoring and mental health services, where involved, should play a key partnership role.

6.54 We found no evidence of multi-agency working beyond contact with probation services.

Key Finding

The Trust's internal investigation did not explore or consider how the Trust interacted with the public protection processes or explore the effectiveness of any joint working with the criminal justice system.

See Recommendation 5 – with particular reference to 5i.

See Recommendation 11 – The Trust should provide guidance regarding recording and oversight for individuals subject to public protection measures such as MARAC and MAPPA.

Care planning and carer assessments

6.55 The Trust internal investigation made no comment on the use, recording or effectiveness of the care planning process, did not benchmark actual and expected Trust practice against policy, and did not explore whether Mr H was under the correct level of care.

6.56 The Trust Care Programme Approach and Standard Care Policy (2016) lists characteristics to consider when deciding whether an individual should be under standard care or under the Care Programme Approach. These include a view on complex needs, numbers of agencies involved, levels of risk, level of engagement and levels of support.

6.57 Mr H was under the Trust's standard care from early June 2012 to the end of June 2017. Mr H had a standard care plan dated mid-June 2013. This covered Mr H's relationships, support, substance and alcohol misuse, risks, accommodation, and his short-term goals.

6.58 On admission to hospital Mr H was supported under the CPA. The ward completed daily care plans during his admission in 2017. Mr H was discharged from the ward under CPA. We did not find a discharge CPA care plan related to that date.

6.59 Mr H did have a CPA care plan started by EIP in mid-September 2017, and finalised and dated mid-January 2018. This care plan detailed the purpose of the ARMS assessment. The care plan aims included engaging in interventions covering recovery focused work, assessment of physical health needs, family appointment, vocational needs, psychiatric and psychological assessment. The care plan does not detail outcomes, was not signed by Mr

H and there is no record that he received a copy of the plan.

6.60 The Trust internal investigation made no comment on the involvement of Mr H's family, or provision (or not) of carer assessments to support them in their caring role.

6.61 The Trust's Care Programme Approach and Standard Care Policy (2016) states *"Carers, families and other supporters are seen as partners and a vital support to the person in their recovery and wellbeing. There is evidence that outcomes are improved when they are appropriately informed, consulted and involved in decisions about the care and treatment of the person they support."* The policy also provides guidance on referrals for carer assessments, stressing the importance of providing appropriate information and support.

6.62 Throughout Mr H's contact with the Trust, case notes indicate that Mr H had contact with his family, and that their relationship was being impacted upon by his continued use of alcohol and substances. In addition, following his admission in 2017, Mr H was discharged to his family home, and it was to this address EIP wrote offering Mr H appointments.

6.63 Mid-June 2014, during an assessment by CRT, a family member was offered but declined carer support. We found no other record that Trust services offered Mr H's family support through provision of a carer assessment.

Key finding

The Trust internal investigation made no comment on the use, recording or effectiveness of the care planning process, did not benchmark actual and expected Trust practice against policy, and did not explore whether Mr H was under the correct level of care. The Trust internal investigation also made no comment on the involvement of Mr H's family, or provision (or not) of carer assessments to support them in their caring role.

See Recommendation 5 – with particular reference to 5j.

See Recommendation 12 – The Trust should provide assurance that carers are being offered the opportunity to receive carer assessments as per Trust policy.

Risk management

6.64 The Trust's internal investigation discussed risk assessment with probation services in relation to Mr H's housing needs but did not explore further whether assessment of risk impacted on Mr H's care and treatment. The internal investigation made no further comment on the use, recording or effectiveness of risk management processes and did not benchmark actual practice against expected Trust practice and policy.

6.65 The Trust Clinical Risk Assessment and Management Policy (2014, amended 2015) states that management of risk should be an ongoing, dynamic process, kept under constant review with assessments updated after significant events. These events include amongst others any incident during contact with Trust services, after discharge or change of service, or following

any significant change to the service user's presentation, physical or mental state.

6.66 Services did complete risk assessments on multiple occasions, adding information to past risk assessments, however we found no evidence that services routinely updated these assessments following Mr H's contact with the criminal justice system, particularly when informed of incidents but then did not assess. In addition, we found no evidence that Mr H had an updated risk assessment on his discharge from hospital.

6.67 As previously identified, following his discharge from hospital in August 2017, services assessed Mr H six times. All resulted in updated risk assessments, some very detailed; however, all the assessments also concluded that Mr H's issues related primarily to his continued alcohol and substance misuse. None of the assessments resulted in consideration of a change in service, consideration of his engagement pattern, consideration of the level of increased referrals and his risk-taking behaviours, and none considered any changes to his care plan.

6.68 The Trust Clinical Risk Assessment and Management Policy also identifies that service users should have active crisis plans. We found no evidence of crisis planning within Mr H's care records.

Key finding

Mr H had a lengthy forensic history, sometimes resulting in custodial sentences. The investigation did not explore risk or consider whether compliance with risk management systems impacted on Mr H's care and treatment.

See Recommendation 5 – with particular reference to 5k.

The relationship between the victim's chronology and Mr H

6.69 The Trust's serious incident report provides a chronology as an appendix for the victim, Mr B. The report does not reference or discuss this chronology.

6.70 The Trust's serious incident report provided no information as to the nature of Mr H's relationship with the victim, Mr B, nor did the report detail how they knew each other, or how the fatal contact occurred. The investigation did not offer any assurance that there had been no known contributory factors relating to this relationship prior to the homicide.

Key finding

The Trust's serious incident report included a victim (Mr B) chronology as an appendix, but the investigation made no reference to this, and its purpose for inclusion was unclear.

See Recommendation 5 – with particular reference to 5l.

7 Conclusion

7.1 The Trust commissioned a suitable level and type of investigation. We have identified areas of concern however, regarding their investigation and therefore, are unable to agree with the report's conclusion. Further, we do not believe the current investigation and report would have any impact on future practice or prevention of future re-occurrences.

7.2 Using the Niche assurance framework, the Trust internal investigation met four of the twenty-five assessment standards, partially met seven and did not meet fourteen standards.

7.3 As part of our review against the twenty-five standards we identified the following areas of missed opportunities for the Trust investigation to provide assurance:

- The investigation required clear lines of enquiry to guide the terms of reference.
- The investigation panel and sign off processes should have provided challenge and oversight.
- The report should have been clear about the investigation methods used.
- The report required a more comprehensive chronology.
- The investigation should have explored Mr H's interactions with the Trust and detailed any known interactions with the victim.
- The investigation should have involved both Mr H and any relevant family members.
- The investigation should have explored whether Mr H's care and treatment met expected standards.
- The investigation should have explored what happened against expected practice, and using a clear method of analysis, established whether there were any contributory factors. Using these factors, the investigation should then have identified whether changes in practice could prevent reoccurrence.

7.4 We also completed a detailed chronology, a high-level care and treatment review and a gap analysis. From these we identified twelve areas that we believe require further investigation to determine whether Trust practice was at the expected level for Mr H before drawing any conclusions about care and/or any service delivery issues and/or root causes.

7.5 We have therefore recommended that the Trust arrange a review of Mr H's care and treatment covering these twelve areas.

7.6 We have also made a further eleven recommendations relating to both the Trust investigation processes and oversight, and around specific practice issues that we feel require immediate attention and assurance that cannot wait the completion of the fuller review.

Appendix 1 – Terms of reference

Terms of Reference for Independent Review under NHS England's Serious Incident Framework 2015 (Appendix 1)

The Terms of Reference for an independent review of case 2018/7083 have been set by NHS England and NHS Improvement North East and Yorkshire region. The Terms of Reference will be developed further in collaboration with the investigative supplier and family members however the following will apply in the first instance:

Purpose of the Review

To undertake a desktop review of the internal investigation into the care and treatment of Mr H undertaken by Tees Esk and Wear Valley NHS Foundation Trust, to determine whether the internal investigation lines of enquiry were robustly considered and explored, highlighting any areas requiring further examination.

Based on review findings, formulate recommendations which would lead to sustainable and measurable improvements.

Involvement of the affected family members and the perpetrator

In collaboration with NHS England, ensure that all affected family members are informed of the review, the review process and are offered the opportunity to contribute including developing the terms of reference and agree how updates on progress will be communicated including timescales and format.

Involve affected family members throughout the review as fully as is considered appropriate, in liaison with Victim Support and/or other support or advocacy organisations.

Share the report in an agreed format with the affected family, seek their comments and ensure that appropriate support is in place ahead of publication.

Offer Mr H a minimum of two meetings, one to explain and contribute to the review process and the second to receive the report findings.

Scope of the Independent Review

To undertake a critical analysis of the internal investigation's approach and key lines of enquiry, to determine whether these were appropriate at that time, adequately considered and explored, highlighting any areas requiring further investigation.

It is NHS England's expectation that this will incorporate the following considerations:

- Review of the clinical records, to determine the relevant historical context, identify the significant periods of care delivered of relevance to the incident which occurred.
- Development of a comprehensive chronology of events, against which the internal investigations' findings will be considered.

- With a focus on learning, identify any gaps, deficiencies or omissions in care and treatment of the service user not adequately addressed within the investigation undertaken by Tees Esk and Wear Valley NHS Foundation Trust.
- Assessment of the care and treatment received by Mr H including review of the adequacy of risk assessments and risk management including the risk of harm to others.
- Exploration of whether Mr H's family had alerted professionals to any mental health concerns and if so, how was this acted upon.
- Review the appropriateness of the treatment of the service user in the light of identified health and social care needs, identifying both areas of good practice and areas of concern.
- Assessment of compliance with local policies, national guidance and statutory obligations including safeguarding.
- Based on overall review findings, constructively review any gaps in inter-agency working and identify opportunities for improvement including making recommendations for expected standards and modes of communication between organisations.
- Identify any notable areas of good practice and further opportunities for learning determined throughout the review activities and outline what is expected to change as a result.

Deliverables

Based on review findings make organisational or service specific recommendations which are outcome focused with a priority rating and expected timescale for completion.

Provide a written report to NHS England and NHS Improvement that includes findings recommendations for further action where necessary. The report should follow both the NHS England style and accessible information standards guide.

Provide a concise case summary clearly indicating learning points and opportunities, to enable wider sharing of learning.

Provide an opportunity for the families to receive supported feedback related to findings.

Provide NHS England with a monthly update on progress, template to be provided by NHS England, detailing actions taken, actions planned, family contact and any barriers to progressing the investigation.

Attend an action planning meeting to deliver the key findings and any recommendations to the Trust and Stakeholders.

Where recommendations are made, conduct an evidenced based Assurance Review within 6-12 months following publication of the report to assess implementation and monitoring of associated action plans.

Provide a short-written report for NHS England outlining the findings of the Assurance Review.

Appendix 2 – Policies reviewed

Policy name and version	Approved / Ratified	Last amended
Incident reporting and serious incident review policy v8.1	18 January 2017	28 April 2017
Early Intervention in Psychosis Service Operational Policy	March 2014	Replaced 19/09/19
Early Intervention in Psychosis Process pathways v2	No date	No date
Comprehensive Assessment of At-Risk Mental States (CAARMS)	2015	No date
Care Programme Approach and standard care policy framework V6	6 April 2016	6 April 2016
Did Not Attend (DNA) Policy	5 April 2017	05 April 2017
Care and Management of Dual Diagnosis Policy V4	February 2011	01 October 2012
Clinical Risk Assessment and Management Policy V6	6 February 2014	24 January 2015
Safeguarding Adults Procedure V6	5 September 2016	27 November 2019
Safeguarding Children Policy V6	6 April 2016	10 May 2019

Appendix 3 – NIAF: internal investigation report

Rating	Description	Number
	Standard met	**4**
	Standard partially met	**7**
	Standard not met	**14**

Standard		Niche commentary	
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident	The Trust's Incident Reporting and Serious Incident Review policy[21] states that following confirmation of a Serious Incident the Trust will submit a completed 72-hour report to the commissioners. The incident will then be allocated to a Patient Safety Team (PST) reviewer for a *'full review of the care and treatment'* provided. The report identified all staff involved within the review, in the 72-hour report, and those invited by the PST reviewer to attend the Root Cause Analysis (RCA) and feedback meetings, which the PST reviewer leads on. The policy also states that reporting and reviewing processes will be *"in line with the NHS England Serious Incident Framework of 2015 and NHS Improvement FAQ's (April 2016)".* The terms of reference (ToR) for the Trust internal investigation indicate this was a '*Type 2, Comprehensive Investigation'*, and the lead reviewer identified was a	Partially met

[21] CORP-0043-v8.1 dated approved 18/01/17; last amended 28/04/17. Version 8.1 was replaced with version 8.2 on 13 June 2018 three days before the internal report was finalised. For this review, we have used version 8.1 throughout.

Standard		Niche commentary	
		'*Serious Incident Investigator, trained in Root Cause Analysis (RCA) Methodology*'. The investigation involved clinicians from the Liaison and Diversion (L&D) Service and the Early Intervention in Psychosis (EIP) Service and included both the care coordinator and the advanced practitioner from EIP. The lead investigator spoke to staff from probation. The investigator did not have contact with any family involved and the report stated that "*no involvement has been sought from the patient or relatives, until consent has been received from the police...*" The report did not indicate if this consent had been received or if contact was followed up further. The six policies reviewed as part of the process were: 1. Admission, Transfer and Discharge Framework 2. The Care Programme Approach and Standard Care Policy 3. Did Not Attend Policy 4. Dual Diagnosis, Care and Management Policy 5. Lone Working Procedure 6. Minimum Standards for Clinical Record Keeping Policies available but not considered included: • EIP Service Operational Policy • Safeguarding Adult Procedures and Protocols • Clinical Risk Assessment and Management Policies	
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	The Terms of Reference for the investigation were generic for a Trust Level 2 Serious Incident (SI) Root Cause Analysis (RCA) Report and were not adapted to the specifics of this incident.	Partially met

Standard		Niche commentary	
		The report identified the key issue as *"did the various agencies involved in supporting the patient, work closely together to provide a coordinated plan of care?"* The generic nature of the terms of reference omitted specific reference to the victim other than the general-purpose statement that references patients (plural). The overall objectives were generic, for example one objective of the investigation was to *"establish whether appropriate consideration was given to safeguarding processes*." The investigation was not therefore, guided to specifically consider: • Mr H or the victim as either victim or perpetrator within the adult safeguarding framework. • the role of the Trust in external safeguarding processes such as Multi-Agency Risk Assessment conferences (MARAC); and • the effectiveness of any joint working with the criminal justice system. The scope of the review considered all of Mr H's involvement with the Trust, although the period February 2010 to March 2018 was summarised and the detailed chronology covered 19 September 2017 to the 12 March 2018 (six months). There was a victim chronology included as an appendix, but the scope of the review did not include any consideration of the victim's care or treatment.	

Standard		Niche commentary	
1.3	The person leading the investigation has skills and training in investigations	The Trust's Incident Reporting and Serious Incident Review Policy states *"'Within the NHS, the recognised approach is commonly termed Root Cause Analysis (RCA) investigation. The investigation must be undertaken by those with appropriate skills, training, and capacity, which in TEWV is the PST reviewers.'"* The lead reviewer was a "'*Serious Incident Investigator, trained in Root Cause Analysis (RCA) Methodology.'"*	Met
1.4	Investigations completed within sixty working days	The Trust's Incident Reporting and Serious Incident Review Policy *states "'the review process must be completed within 60 days of the incident being reported on STEIS in line with the guidance in the NHS England Serious Incident Framework (NHS England 2015). The commissioners may in exceptional circumstances agree an extension to the 60-day deadline'".* The incident occurred in March 2018. The Trust received notice of Mr B's death on 15 March 2018 and began its investigation on 22 March 2018. The Trust completed its report on 18 June 2018. This is within the Trust policy and the current nationally agreed 60-day timeframe for investigations.	Met
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The report is in clear English, and the narrative is easy to understand. The report contains grammatical errors (inaccurate or inconsistent use of commas, and an inconsistency when referring to the patient, with the T being capitalised in some instances and not in others) but this does not impact on the overall readability of the report.	Met

Standard		Niche commentary	
1.6	Staff support following the incident	The Trust's Incident Reporting and Serious Incident Review Policy states the Trust complete investigations within a "Just Culture;" provided information on how staff can access support services available within the Trust; and there was a discussion about using reflective practice and clinical supervision.	Met
Improvement opportunities to provide assurance – credibility 1 The investigation should have identified clear lines of enquiry to guide the terms of reference. 2 The investigation panel and sign off processes should have provided challenge and oversight.			
Theme 2: Thoroughness			
2.1	A summary of the incident included that details the outcome and severity of the incident	The report contained a brief description of the incident and outcome. The incident type was categorised as 'alleged homicide.' The report does not provide any detail of the victim or identify that the victim was known to Trust services.	Partially met
2.2	The terms of reference for the investigation included	The report includes terms of reference. These are generic and non-specific.	Partially met
2.3	The methodology for the investigation is described, that includes use of systems based PSII of root cause analysis analytical tools, review of all appropriate documentation and interviews with all relevant people conducted.	The methodology is briefly described within the report as "*'Telephone discussions, Information gathering via a root cause analysis meeting, review of the patient's electronic care record, chronological timeline, via email with external agencies and contributory Factors Grid. Identifying contributory factors & root causes Generating solutions."* The report records detail of the documentation viewed, and designation of people interviewed. The report includes a chronology for both Mr H and the victim.	Partially met

Standard		Niche commentary	
		There is no evidence of root cause analysis methodology in the report, and no analysis provided to support the findings.	
2.4	Bereaved/affected patients, families and carers informed about the incident and of the investigation process	The report states "*'No involvement has been sought from the patient or relatives, until consent has been received from the police…'".* The report later states *'A contact in the police force has been identified and contact is being arranged.'* There is no evidence in the report that this contact happened.	Not Met
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	There is no evidence of any contact with the family prior to setting the terms of reference, that interviews took place with the family, or of any sharing of the terms of reference. There is no evidence that the Trust discussed or shared the report with the affected families before, during or after publication.	Not Met
2.6	A summary of the patient's relevant history and the process of care included	The report held a summary of Mr H and his mental health history and care. There is a victim chronology attached to the report but no reference to this within the body of the report and no summary of the victim's mental health history and care.	Partially met
2.7	A chronology or tabular timeline of the event included	There is a chronology included for Mr H within the report. Three events from the chronology and one from the background have supplementary commentary relating to staff views of events. There is no analysis of this commentary. There is a victim chronology (as an appendix), in the report. There is no commentary or analysis of any events from the victim chronology and no evidence this formed part of the investigation.	Partially met

Standard		Niche commentary	
2.8	The report describes how RCA tools have been used to arrive at the findings	The report does not describe any root cause analysis methodology or use of other tools. There is no separate analysis section. There is supplementary commentary detailing staff views and discussions held in the RCA meeting as indicated in italics in four areas of the background and chronology. There was no analysis of these sections. The concluding section does not refer to the findings or lessons learned and is a summary of events rather than an analysis. The report did not reference the victim or victim chronology.	Not Met
2.9	Care and service delivery problems are identified (including whether what were identified were actually care delivery problems (CDPs) or service delivery problems (SDPs))	There were no care or service delivery problems identified in the report, despite evidence of missed opportunities to address issues such as safeguarding, lack of a CPA review and multi-agency meeting. There was no evidence of analysis of care or service delivery factors for either the victim or Mr H. The report identified three lessons learned (see section 2.12).	Not Met
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	There were no contributory factors identified within the report despite the victim and Mr H both having long histories of contact with mental health services, histories of poor engagement and identified social and interpersonal risk factors. There was no evidence of analysis of contributory factors for either the victim or Mr H.	Not Met
2.11	Root cause or root causes described	The investigator identified no root cause for the incident. There was no evidence that the report used RCA methodology to reach this conclusion.	Not Met

Standard		Niche commentary	
2.12	Lessons learned are described	Despite concluding that there were no care or service delivery problems, and no contributory factors identified, the report described three lessons learned. These three lessons identified care and / or service delivery problems. (See section 2.13).	Not Met
2.13	There should be no obvious areas of incongruence	There are areas of incongruence within the report: • The investigation, described as a *'Type 2, Comprehensive Investigation'*, provided no evidence of RCA methodology. • The investigation concludes that there were no care or service delivery problems despite identifying missed opportunities. These included opportunities to engage with a multi-agency approach, to use the framework of CPA and to address adult safeguarding issues. • The investigation concludes that there were no contributory factors despite identifying that Mr H had a long history of contact with mental health services, poor engagement with services and complex social and interpersonal risk factors. • Despite the inclusion of the victim chronology, there is no reference to this within the body of the report. • The report omits the victim throughout, and does not analyse their circumstances, mental health, or any risk factors. • There is no reference to any known prior interaction with the victim in the report.	Not Met
2.14	The way the terms of reference have been met is described, including any areas that have not been explored	The terms of reference were generic and did not identify any key lines of enquiry pertinent to the case. The investigation established facts relating to Mr H but did not analyse any interactions, care, or treatment, and	Not Met

Standard		Niche commentary	
		provided a description of events rather than an exploration of factors. The report also did not explore factors relating to Mr H's living circumstances or any known interaction/s with the victim.	

Improvement opportunities to provide assurance - Thoroughness

1 The report should have been clear about the investigation methods used.

2 The report required a more comprehensive chronology

3 The investigation should have explored Mr H's interactions with the Trust and detailed any known interactions with the victim.

4 The investigation should have involved both Mr H and any relevant family members.

Standard		Niche commentary	
Theme 3: Lead to a change in practice – Impact			
3.1	The terms of reference covered the right issues	As above, the terms of reference were generic, they did not reference any detail of the incident and did not identify factors for exploration or analysis. There was no evidence of RCA methodology other than provision of chronologies (for both Mr H and the victim).	Not Met
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	The report detailed what happened and provides a chronology for Mr H with a separate appendix chronology for the victim. There was no supporting evidence of further analysis or RCA methodology as to why events occurred or factors that may have influenced events. The report made no comment on supporting why or how to prevent a recurrence	Not Met
3.3	Recommendations relate to the findings and that lead to a change in practice are set out	The report did not identify any recommendations.	Not Met
3.4	Recommendations are written in full, so they can be read alone	The report did not identify any recommendations.	Not Met
3.5	Recommendations are measurable and outcome focused	The report did not identify any recommendations.	Not Met

Improvement opportunities to provide assurance – Impact

1. The investigation should have explored whether Mr H's care and treatment met expected standards.
2. The investigation should have explored what happened against expected practice, and using a clear method of analysis, established whether there were any contributory factors.
3. Using these factors, the investigation should then have identified whether changes in practice could prevent reoccurrence.

Appendix 4 – Summary of Trust Services and Aims

Service	Purpose or aim of service	Source
Alcohol and Substance Misuse Services (SUBM)	To provide substance misuse services for young people and adults aged 18 years and above.	TEWV Annual Report 2010/11
Acute Mental Health Liaison Service (MHLS)	To reduce 'repeat' self-harm presentations to A&E and urgent care centres and subsequent admissions. To reduce re-admissions to acute hospitals for those with a mental health disorder and to reduce the overall cost to the local health economy ascribed to service users with mental health and substance misuse needs currently accessing acute hospital	Trust Annual Report 2012/13
HMP Holme House Mental Health Team	To provide timely and accessible mental health assessment and treatment to prisoners	Trust Website Current
Middlesborough Alcohol Treatment Service (MATS)	To provide community substance misuse assessment and treatment services for people aged 18 years and above.	Trust Annual Report 2012/13
Psychiatric Liaison specialises in the interface between medicine and psychiatry often taking place in acute hospital settings	To provide qualified mental health practitioners to support local acute Trust staff to assess patients effectively and to ensure that they receive treatment in a timely manner.	Trust Report 2014/15
Crisis Resolution Team (CRT)	To provide community specialist assessment for people aged over 16 years who need urgent mental health care across the Trust area.	Trust Website Current
Liaison and Diversion Service	To provide assessment and advice for people of all ages, who are in contact with the Criminal Justice System and experience mental health problems, learning disabilities, or other vulnerabilities	Trust Website Current
IP (name redacted)	A mental health hospital in Middlesbrough for older, adult, and young people.	Trust Website Current
Early Intervention in Psychosis Service (EIP)	To provide a recovery-based model of care working to reduce hospital admissions and time in hospital, help individuals maintain or achieve education and employment, reduce suicides, improve engagement with services, reduce distress, increase social inclusion, and build personal resilience.	Trust Policy 2014

Appendix 5 – Glossary

ARMS	At-Risk Mental State Pathway
ATR	Alcohol Treatment Requirement
ATS	Alcohol Treatment Service
CAARMS	Comprehensive Assessment of At-Risk Mental States
CPA	Care Programme Approach
CRT	Crisis Resolution Team
EIP	Early Intervention in Psychosis Service
ICS	Integrated Care System
IDVA	Independent Domestic Violence Advisor
L&D	Liaison and Diversion
MAPPA	Multi-Agency Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MATS	Middlesborough Alcohol Treatment Service
MHLS	Mental Health Liaison Service
MRT	Middlesbrough Recovery Together
NIAF	Niche Investigation Assurance Framework
OT	Occupational Therapy
PARIS	Clinical information system
PSIRF	Patient Safety Incident Response Framework
PST	Patient Safety Team
PTSD	Post-Traumatic Stress Disorder
RCA	Root Cause Analysis
SMS	Substance Misuse Services

Niche Health & Social Care Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Tel: 0161 785 1000

Read more about us at: **www.nicheconsult.co.uk**

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