INDEPENDENT ASSURANCE REVIEW

A critical analysis and assessment of a mental health trust's internal investigation of the care and treatment received by JP prior to homicide in 2020

Summary report

May 2024

Contents

Section 1: Introduction

1.1 JP (anonymised initials) was in receipt of services from a local mental health provider (the Trust) intermittently between 2009 and the incident in September 2020.

1.2 In September 2020, the police arrested JP for Grievous Bodily Harm (GBH) with intent. The victim later died of his injuries and JP was arrested and convicted of murder.

1.3 In March 2022, NHS England formally commissioned Facere Melius (FM), a healthcare consultancy with expertise in incident investigations, to undertake an independent quality assurance review of the serious incident investigation undertaken by the Trust and the care and treatment provided to JP prior to the incident of homicide in September 2020. This review was commissioned in line with NHS England's Serious Incident Framework (2015) and the Terms of Reference provided to the FM team (see appendix one).

Section 2: The incident of homicide

2.1 JP had spent a significant amount of his adult life in prison for a range of mainly acquisitive offences including burglary, theft, vehicle crime and possessing illegal drugs. JP's first offence was at age 12 and since then he has had 21 convictions for 69 separate offences. Three of his previous offences were violent, with at least one where he was carrying a weapon. He had a history of mental health problems dating back to 2009, when he was diagnosed with antisocial personality disorder by a predecessor organisation of the Trust. JP also had a history of violence towards others, making threats of harm and carrying weapons.

2.2 JP was released from prison (HMP A) in August 2019. Prior to his release, he had been receiving psychological support in prison. JP was released on licence and, therefore, under the supervision of the probation service. The probation service had assessed him as posing a low level of risk to the public, and his supervision was, therefore, provided under contract by a private company. This arrangement was in line with national guidance in place at the time.

2.3 In late October 2019, following visits to his GP for anxiety and depression, he contacted the mental health helpline provided by the Trust, stating that he was hearing voices telling him to kill himself. He said that he had made two recent suicide attempts. His contact was triaged for an assessment by the Crisis Resolution Home Treatment team (CRHT), which took place later the same day; the team also carried out a clinical risk assessment. JP was then referred to the local Community Treatment Team (CTT) with a recommendation to consider involving Forensic Community Services. The Crisis Team noted that continued input from their team was not clinically indicated at this time.

2.4 4 days later, JP's referral was discussed at a local CTT Single Point of Access (SPA) meeting and several risk factors were discussed including risk to others, history of offending, psychopathic personality, impulsive and volatile behaviours,

substance misuse and lack of remorse. The clinical lead wrote to JP's Probation Officer recommending they refer him to the Forensic Community Personality Disorder Services for further treatment. This was based on an understanding that the probation services provided by the private company would be able to refer JP directly into forensic services. This was however not the case and referral to forensic services was only open to the National Probation Service, and not its contracted services. The recommendation to refer to forensic services was not subsequently followed up by the community treatment team.

2.5 In late January 2020 JP again contacted the mental health helpline and CRHT with ongoing concerns about his increasing thoughts of suicide. In a telephone conversation with him, a member of the mental health helpline team advised JP to discuss referral to the Forensic Personality Disorder Community Service with his Probation Officer. There is no evidence from JP's records that this referral was made.

2.6 In late March 2020 JP's GP referred him directly to the local CTT. The GP chose this pathway because they believed they could not refer directly to the Forensic Personality Disorder Community Service.

2.7 Following a significant administrative delay of six weeks, the GP's referral was recorded onto the CTT's system on 11 May 2020. The CTT then discussed JP's referral at an SPA meeting the next day. Following the team's discussions, JP was offered an assessment appointment for 1 June, when an in-depth assessment was conducted and a risk profile was recorded; this was the last risk profile before the incident.

2.8 On the afternoon of 1 June 2020, following his assessment, JP's case was discussed at a meeting of the local CTT. At this meeting, referrals are placed on the waiting list in priority order (using a Red/Amber/Green or RAG prioritisation system; how the CTT meeting operated is described further in section 9 of this report). JP was rated as an amber priority at the meeting and placed on the waiting list for allocation to a Community Psychiatric Nurse (CPN) to coordinate his care. JP was advised of this decision on 17 June and the interim contact arrangements were explained to him.

2.9 Telephone contact was made by a CPN in late July with another appointment made for the following day due to poor mobile phone signal. The CPN had difficulty contacting JP as planned on the second attempt but was successful on the third attempt. No issues were noted. The last recorded contact by the CTT with JP was 27 August when two abortive attempts at telephone contact were made, with no follow-up action recorded (this point is expanded further in paragraph 6.16).

2.10 The following month, JP was initially arrested for GBH; however, the victim later died of his injuries. JP was then arrested and charged with the homicide. At the time of the homicide, JP's current risk assessment, from the FACE risk profile completed on 1 June 2020, rated him as a serious and apparent risk of violence/harm to others (level 3).

2.11 JP was convicted of murder in early 2021 and sentenced to life imprisonment.

Section 3: Condolences and thanks

3.1 The FM review team would like to express their sincere condolences to the victim's family. The team acknowledges that the events discussed in this report will also have had a significant impact on JP's family and on JP himself.

3.2 The review team would like to thank those staff from the Trust and the probation service who met them and engaged in the assurance review, as well as the managers who supported them and enabled the interviews to take place.

Section 4: Assurance review terms of reference and methodology

Independent assurance review terms of reference

4.1 The draft Terms of Reference were agreed on 21 March 2022 at an initial meeting held by NHS England (see appendix one). The meeting was attended by FM representatives and those agencies involved in the Trust's serious investigation into the care and treatment of JP.

4.2 The purpose of the assurance review was to:

- undertake a desktop review of the internal investigation into the care and treatment of JP undertaken by the Trust.
- determine whether the internal investigation key lines of enquiry into the care and treatment of JP were adequately considered and explored, highlighting any areas requiring further examination
- with a focus on learning, undertake a review of the referral pathway to consider issues relating to delays in the processing of referrals and the impact of delays on assessments and potential interventions
- consider any wider commissioning issues concerning referral processes between the probation service and forensic services.

4.3 FM has carried out a critical analysis of the internal investigation's approach and key lines of enquiry to determine whether these were appropriate at the time it was commissioned, if they were adequately explored during the investigation, and highlighting any areas requiring further investigation.

Facere Melius assurance review methodology

4.4 The FM review team used a range of qualitative and quantitative techniques and methodology to undertake the review. They examined all available records relating to the internal investigation conducted into the care and treatment provided to JP. This process included:

- Review of all (101) submitted documents, including but not limited to:
- internal Trust investigation report
- investigation Terms of Reference
- Trust Action Plan
- clinical notes
- prison clinical notes

- probation notes
- interview notes
- review of national policies, local policies and guidance regarding:
- offender personality disorder pathway
- antisocial personality disorder
- managing attendance
- being open
- learning from incidents
- care programme approach
- risk management and planning
- mental health Single Point of Access
- access to forensic services

4.5 The assurance review team has not been able to meet with either the victim's family or JP's family. The local police family liaison officer advised via NHS England that they have attempted to contact both families with no response.

4.6 The review team interviewed staff, including senior management staff from the Trust community services. The team also met with the probation services and the lead serious incident investigator, who wrote the internal investigation report.

4.7 The FM review team used its own quality and assurance frameworks as tools to assess the approach taken by the Trust in conducting its internal investigation, and their subsequent report, recommendations and action plan.

4.8 The FM quality framework was used to review the Trust's report, focusing on several areas including:

- terms of reference
- engagement with stakeholders
- report authors and experience
- methodology and appropriateness of approach
- alignment and appropriateness of findings and recommendations

4.9 The FM assurance framework was used to assess the action plan developed by the Trust. Further details are provided in appendix two. Each action is assessed against three criteria:

- effectiveness of implementation
- maturity of implementation
- quality of assurance

4.10 Before drafting the report, a team of independent advisors provided FM review team members with additional support, guidance, analysis, and expert opinion. This included giving advice on whether professional practice was in line with national or local guidelines and good practice in their specialism. The draft report was then reviewed, and quality assured by a Facere Melius advisory board,

whose members provided the authors with feedback, having undertaken an objective enquiry and rigorous evaluation of their work.

4.11 On completion of the review, the draft report was shared with the Trust and other stakeholders as part of the factual accuracy process. All stakeholders were consulted on recommendations before publication of the report.

Section 5: Assurance review team

5.1 The assurance review team consisted of a Lead Reviewer, Patient Safety Advisor, Mental Health and Substance Misuse Advisor and Police Advisor.

5.2 The advisory board consisted of Senior Associates, Editorial Standards Advisor and FM Director.

Section 6: Clinical review

6.1 This part of the FM review looks in detail at JP's risk assessment and safety management, the care programme approach and care planning used, and the involvement of other agencies.

Review of JP's risk assessment and safety management

Risk profiles

6.2 The Trust uses an electronic risk profile tool to help assess the risks for their service users facing mental health problems. This risk profile tool is part of a collection of tools to support staff in their evaluation of clinical risk levels. Risk assessment includes consideration of the risk to the service user and their risk to others so that a proactive safety management plan can be considered.

6.3 Two risk assessments were completed for JP in the time leading up to the incident: one on 27 October 2019 by the CRHT and the second on 1 June 2020 by the CTT. No later risk assessments were completed prior to the incident of homicide; a clinical review of his risk assessment was scheduled for 31 July, but this did not happen. It is not referenced in the notes as to why this did not occur.

6.4 There was no evidence of collaborative information gathering to inform the risk assessments; the CTT risk assessment notes that the only sources of information for their assessment is from the case notes and from JP himself. There is no evidence that attempts were made to gain information from his GP, his family or carers, his Probation Officer, or his prison psychologist. The Trust's Care Programme Approach policy (page 25) dated March 2020 states: 'Effective risk assessment should include exploration of any risk with carers and family members who live with and/or provide care to support the service user.'

6.5 The narrative sections in both risk assessments are quite detailed, indicating that comprehensive discussions with JP took place. A clinical review of the two risk assessments, however, highlights some areas of concern, which are set out below.

6.6 A full review of JP's clinical notes showed discrepancies in how JP's risks were identified, recorded and communicated, resulting in inconsistencies as to which risk was deemed to be most significant on different assessment dates. For example, the risk assessment on 27 October 2019 identifies a serious and apparent risk of violence to others, but the crisis team daily review meeting on 28 October 2019 records having looked at risk of suicidal thoughts, and does not acknowledge the risk of violence to others identified the previous evening by the same team. The review team was told that the author of the core assessment from the previous evening, who was aware of the full risk assessment, attended the meeting. In the risk assessment on 27 October 2019, the risks identified were:

- a serious and apparent risk of violence/harm to others (level 3)
- risk of violence to others particularly if he is able to identify and locate his abuser
- risk of impulsive suicidal acts and consequently completed suicide
- risk of deterioration in mental state
- risk of a return to criminality and prison
- risk of a resumption of substance misuse.

6.7 In the crisis team review meeting the next day, however, the only risk documented is 'suicidal thoughts – denies plan or intent.' This omission in recognising the risks identified the day before will have had an impact on JP's risk management plan.

6.8 The risk management form states that 'In the case of any serious apparent risk (level 3) a risk management plan should be/has been drawn up and implemented.' In contradiction to this, there was no risk management plan documented for JP, or evidence of a discussion having taken place together with mitigating actions to address a level 3 risk.

6.9 This assessment lacked crisis, contingency and safety management plans and did not explore strengths and protective factors in any depth. Whilst there were symptoms indicative of risk noted and early warning signs mentioned, there was no plan in place to respond to them.

6.10 The risk assessment on 1 June 2020 was listed for review on 30 July 2020, however, there is no evidence that this was done. The risk assessment on 27 October 2019 was not marked for review at all, resulting in missed opportunities to re-assess JP's risk profile and risk management between October 2019 and June 2020.

6.11 In the June 2020 risk assessment, 41 out of 53 historical risk factor tick boxes were marked 'not selected', and therefore not considered or at least not given a rating in the assessment. NICE guidance states: '*In secondary services, where there may not be the resources to conduct assessments using structured clinical risk management tools, it is important for staff to record detailed histories of previous violence and other risk factors'* (*CG77*).

6.12 Some disparity in the assessment of historical risk factors was observed. Some not rated were then discussed and evidenced in the adjacent narrative. For

example, the rating of JP's history of preparation to harm others, including carrying weapons, is left blank whilst the narrative states that JP was charged with possession of a firearm with intent to cause fear of violence in 2017.

6.13 Throughout the assessment there are multiple references to and evidence of significant current and historical risks of violence. In the risk formulation, however, the following information about JP is not acknowledged:

- history of significant risk/behaviour
- current serious and apparent risk of violence/harm to others
- having been assessed as a potential risk to staff in 2010, with a related risk alert placed on the clinical record
- his historical and current risk of impulsivity/lack of impulse control

6.14 Other opportunities were missed to put in place risk management plans during discussions in SPA meetings on 31 October 2019 and 12 May 2020. A telephone contact was made with JP on 30 July 2020; there is a significant missed opportunity during this call to discuss and review the risks from JP's assessment on 1 June 2020, including his risk of harm to others.

6.15 A further appointment was made for a CPN to make telephone contact with JP for 14:00 hours on 27 August 2020. Progress notes show that JP and his GP were notified of this appointment by letter on 21 August. A CPN member of the Community Treatment Team made two calls to JP at 14:01 and 14:06 as arranged, neither of which were answered. Entries in JP's notes indicate that a voicemail message was left for him. The review team did not locate any evidence to show that attempts were made to follow up the missed appointment with JP or his GP. The Trust's 'Managing Attendance at Appointments' policy, dated November 2019, sets out the actions that teams should consider if a service user does not attend an appointment. Actions include discussion at a Multi-Disciplinary team meeting for a joint decision regarding the next steps to be taken. There is no evidence in JP's notes that such a discussion took place between 27 August and the incident of homicide. The Trust does identify follow-up practice for clients with whom the service has had difficulties in maintaining contact as a significant finding in its Serious Incident report, although as discussed later in this report (section 8), this did not translate into a corresponding improvement action.

Other risk management concerns

6.16 The FM review team noted other concerns related to JP's risk profile and risk management throughout his contact with the Trust's mental health services, which are discussed here.

6.17 JP received a formal diagnosis of antisocial personality disorder (ASPD) in 2009. This diagnosis was made by a Consultant Psychiatrist and was recorded in JP's clinical notes. The first risk assessment by the CMHT on 27 October 2019 acknowledges JP's diagnosis of ASPD as a clinical factor in the risk formulation section at the end of the document. This diagnosis remains on the second risk assessment conducted by the CTT on 1 June 2020.

6.18 In light of a clinical diagnosis of ASPD, there is no evidence that staff considered the NICE guidance for the management of ASPD and the potential impact of this condition on his level of risk of violence or future offending (Antisocial personality disorder: prevention and management. CG77). Neither assessments identify that JP had not received any clinical intervention relating to ASPD. There is no treatment or management plan in recognition of this diagnosis.

6.19 The ASPD clinical guideline states: '*staff working in primary and secondary care services (for example, drug and alcohol services) and community services (for example, the probation service) that include a high proportion of people with antisocial personality disorder should be alert to the possibility of antisocial personality disorder in service users. Where antisocial personality disorder is suspected and the person is seeking help, consider offering a referral to an appropriate forensic mental health service depending on the nature of the presenting complaint. For example, for depression and anxiety this may be to general mental health services; for problems directly relating to the personality disorder it may be to a specialist personality disorder or forensic service.'* (*CG77*). Staff did not appear to use their professional curiosity as described in the guideline to explore the likelihood of JP having a personality disorder, aside from recognising his earlier recorded diagnosis.

6.20 Alongside the risk profile document on the clinical record, there is a separate assessment document that was completed by both the CRHT and the CTT. This assessment document contains a link to an HCR-20 (Historical Clinical Risk management-20) assessment. An HCR-20 assessment is a formal risk assessment that looks at the future likelihood of violence based on historical behaviours, to support the development of a risk management strategy. Whilst historical information and current risk factors around potential violence were noted, there is no evidence that an HCR-20 assessment was considered or carried out. The review team was told that in the Trust, CRHT and CTT staff are not trained to complete this assessment and it is the responsibility of the forensic team.

6.21 Had an HCR-20 assessment been completed, this might have alerted the team to the need for more timely intervention and treatment for JP. NICE guidance (CG77) referred to previously recommends this is used routinely as part of a structured clinical assessment in the case of individuals diagnosed with ASPD. Further, it states that staff involved in the assessment of ASPD in secondary and specialist services should use structured assessment methods whenever possible to increase its validity.

6.22 NICE guidelines note that dropping out of treatment is a particular problem in the treatment of those with a personality disorder and those with ASPD have several characteristics that place them at high risk of doing so. The guideline suggests that special care needs to be taken in the management of those with ASPD to identify indicators of likely drop-out and actively address them. Because the diagnosis of personality disorder was not at the forefront of risk assessment or management for JP, this was not given sufficient attention.

6.23 It is documented that JP and assessing clinicians considered his partner and children as protective factors, albeit, as mentioned earlier, this information was not used to inform JP's clinical care. Children should not be considered as

protective factors for parents with mental ill health. This is not an evidence-based risk theory and places significant responsibility on children who should be being protected by their parents and services. The NSPCC states: '*A child should not be seen as a "protective factor" in the treatment of a parent with a mental health problem, as this does not sufficiently recognise the child's needs or safety' (NSPCC, 2023).*

6.24 There were no safeguarding indications recorded as having been examined, despite a risk of violence to others having been previously noted. JP lived with his partner and children, and another family member, for considerable periods of time. The whereabouts or welfare of JP's child was also not explored. In an interview with the FM team, a member of staff within the local CTT at the time of the incident recognised that the lack of safeguarding consideration was an oversight by the team.

Care Programme Approach (CPA) and care plans.

6.25 At the time of the incident, the Care Programme Approach (CPA) was used in mental healthcare to assess, plan, review and coordinate the range of treatment, care and support needed for people in contact with services who have complex care needs. Using CPA, individualised care plans are developed with service users which describe what support they will need and can expect. Care plans include a crisis plan with instructions for them and their family in the event of an emergency or when they are unwell. Care plans are compiled with the service user by a care coordinator.

6.26 The Trust's CPA policy (page 11) dated March 2020 lists the indicators to identify those service users with enhanced needs who are likely to require care coordination.

These include:

- severe mental disorder (including personality disorder) with a high degree of clinical complexity
- current or potential risk(s), including safety risks, suicide, self-harm, harm to others and history of offending behaviours
- current or significant history of disengagement
- presence of non-physical comorbidity including substance/alcohol misuse.

6.27 All the above indicators were identified for JP in October 2019 but there is no evidence that enhanced CPA was considered between then and September 2020.

6.28 JP's risk assessment in October 2019 indicated complex characteristics and needing support from multiple agencies and so the allocation of a care coordinator should have been considered at this stage, in line with the Trust's CPA policy. The policy available to the FM review team is dated March 2020 and so may not have been in place in October 2019, however CPA has been established practice in mental health trusts since 1991, with enhanced care planning introduced in 2008.

6.29 A management plan for JP from June 2020 focused on his onward referral from the crisis team to the CTT and from them to forensic services. It was identified

on 12 May 2020 that JP needed to have a care coordinator in order to access forensic services and he was therefore placed on the waiting list for care coordination within the CTT. JP was awaiting a care coordinator to be allocated when the incident of homicide occurred in September 2020. He therefore had no CPA status with a corresponding care plan to support him and his family in managing his mental health needs, including in the event of a crisis. There is no evidence that the Trust considered JP's diagnosis of ASPD at this time.

6.30 Had the points previously discussed in the risk management section of this report been adequately addressed, this might also have signalled the need for an enhanced level care plan and the allocation of a care coordinator could have been prioritised.

Involvement of other agencies in JP's care

6.31 On 8 November 2018. JP was sentenced to 21 months in prison, of which he served nine months up to his release on 5 August 2019. He was initially sent to a prison (HMP B) where he spent five days before being transferred to another prison (HMP A). Whilst in prison (HMP B), he was referred to the primary care mental health team (Rethink) for treatment, but he was transferred before this happened. The secondary mental health team also referred him for low intensity cognitive behavioural therapy (CBT) to help with low mood and anxiety, for which he was on a waiting list.

6.32 Whilst in prison (HMP A), JP received care from the primary care mental health team (PCMHT). He attended group work for stress management and when this ended, he was discharged from the PCMHT and referred to the psychology service within the prison.

6.33 The psychology assessment reviewed, which was obtained over several sessions, is comprehensive and gives insight into JP's life, both past and present. These sessions describe very early childhood trauma, being excluded from school for fighting, witnessing physical abuse, drug and alcohol misuse and previous engagement with the Child and Adolescent Mental Health Service (CAMHS).

6.34 JP began working with the psychology service in February 2019 and attended approximately 17 sessions. These sessions focused on managing the impact of flashbacks from traumatic experiences in childhood, learning how to support himself using grounding and distraction techniques, and mindfulness. JP described triggers and symptoms consistent with having experienced trauma, stating that his flashbacks were triggered by people that reminded him of past abusers and when stopping his substance misuse. It was recorded that he was motivated to work on these issues to avoid returning to taking drugs.

6.35 Clinical notes from this period showed that although JP was responding well to this support, he was anxious that on his release, it could take up to six months for him to receive psychological support whilst in the community. Upon his release from prison, JP's concern was realised when he waited many months between his first contact with the Trust in October 2019 and the incident of homicide in September 2020 without adequate psychological support.

6.36 JP described his feelings when encountering individuals who reminded him of his abuser. He described feeling overwhelmed by his emotions when this happened and struggling to stop himself acting out his anger. JP also described periods of dissociation and losing track of time, not feeling any emotions except brief periods of anger, which he would act on. He also discussed his fear of release into the community and that he felt that he said that he would be more likely to 'act on his fight response' when feeling anxious in crowds. He did not want to do something that meant he would return to prison.

6.37 It is recorded that JP engaged in mental health support through a physical activity group and obtained some work in the prison stores. JP attempted to access Through the Gate resettlement services but found that they were not commissioned to operate in his area. He did not therefore receive resettlement support on his release from prison. Following an evaluation of the Through the Gate service in 2021, an enhanced model was launched. The inconsistencies in the commissioning of the resettlement service by private probation company's was noted as part of the evaluation.

6.38 The FM review team heard that there was no information sharing between prison primary care and community-based secondary care mental health services upon a prisoner's release; the quality of communication between the prison psychology service and the Trust was described as 'poor'. Any discharge information from the prison psychology service was instead sent to a service user's GP i.e. primary, rather than secondary care.

6.39 In February 2020, JP attended an appointment with the local Crisis Skylight Crisis Skylight is a voluntary sector organisation that supports people who are experiencing or are at risk of homelessness. In March 2020, JP's GP received a letter from a Mental Health Coordinator from Crisis Skylight stating that he had completed a dissociation questionnaire with him, the results of which suggested that JP had a dissociative disorder not otherwise specified. Long-term trauma informed therapy was suggested to JP but this was not something that Crisis Skylight could offer. Evidence gathered during the review suggests that this letter was shared with the Trust by the GP, but it was not found in JP's CTT notes, and no reference to dissociative disorder was noted. There is no evidence of any direct interaction between Crisis Skylight and the Trust.

Commentary:

C.1 JP's formal diagnosis of ASPD and the lack of treatment and management he received for this is key to accurately determining his risk profile and associated risk management. The Trust's Serious Incident report consistently states that JP did not have a formal diagnosis of ASPD. Appendix 3 to the report however contains a letter from a Consultant Psychiatrist to JP's GP in 2009 containing a formal diagnosis of ASPD. It is not possible to accurately assess what might have been different for JP if his diagnosis of ASPD had been consistently recognised by mental health services. It is clear, however, that at no point was JP placed on an ASPD treatment pathway which meant that some of his needs and associated risks will not have been properly considered over a period of more than ten years. This review has not

been able to establish why this did not happen or why JP's diagnosis was repeatedly overlooked. This is however a serious oversight, and the Trust should reflect on this point that was not highlighted as part of its serious incident investigation, and decide what action is appropriate to avoid this happening again.

C.2 In addition to the missed scheduled risk assessment review on 31 July 2020, further opportunities were missed to put in place risk management plans during discussions in SPA meetings on 31 October 2019 and 12 May 2020. A telephone contact was made with JP on 30 July 2020; there was a significant missed opportunity during this call to discuss and review the risks from JP's risk assessment on 1 June 2020, including his risk of harm to others.

C.3 JP's history of violence and difficulties in moderating his reactions to certain triggers was not fully considered. Mental health services involved in his care and treatment should have conducted a thorough review of his historical risk factors, applied frequent and dynamic risk assessment, and completed an HCR-20 assessment. This approach should have resulted in them applying an enhanced CPA with the prompt allocation of a care coordinator, together with a significantly more robust risk management plan. Recognising his ASPD would have contributed to this. It is possible that a more robust and appropriate response by mental health services, specifically between October 2019 and September 2020, might have altered the course of events during that critical period. This is not fully explored as part of the Trust's serious incident investigation.

C.4 Other challenges that came to light as part of the clinical review that the Trust should consider to maximise learning from this case are set out below (points a, c and d are expanded in section 9 of this report): the significant staffing and capacity pressures within community mental health services in 2019/2020 and their impact on service users' diagnosis, treatment and risk management, including JP

a) the lack of evidence that staff approach clinical risk management in accordance with the latest NICE guidance available
b) the high proportion of service users with a similar clinical and forensic profile to JP meaning that his case did not stand out from others
c) the poor communication between prison and community mental health services and their practitioners, resulting in a lack of continuity in care and treatment for prisons on their release
d) the absence of coordinated rehabilitation services to support JP and other prisoners at the time of his release in 2019, and how mental health services might engage with the enhanced Through the Gate model, launched in 2021.
e) the lack of coordination and consistent recording of and responding to information shared between other organisations involved in supporting service users such as Crisis Skylight

Section 7: Review of the Trust's internal serious incident investigation, and assessment of the adequacy of its findings and recommendations

7.1 The FM review team has assessed the Trust's serious incident investigation report on the care and treatment provided to JP. The team used the FM quality assurance framework as a tool to establish whether the internal independent investigation was robust, appropriate, and complied with best practice and both local and national policy in place at the time of the investigation. A number of areas for improvement were identified, and a detailed assessment of these can be found in appendix three. A summary of the main points from this evaluation is given below.

7.2 The review team also considered the Trust's initial response to the incident and the sharing of learning through an after-action review.

After Action Review (AAR)

7.3 An after-action review (AAR, see glossary and references) is a structured approach for reflecting on the work of a group and identifying strengths, weaknesses, and areas for improvement following an incident. This is held with the team and professionals involved in the care of the service user(s) involved.

7.4 AAR aims to capture learning that is widely disseminated so that good practice can be shared and changes made to reduce the likelihood of recurrence where something has gone wrong. It usually takes the form of a facilitated discussion following an event or activity. It enables understanding of the expectations and perspectives of all those involved, and it captures learning, including any immediate learning, which can then be shared more widely.

7.5 The Trust carried out an AAR on 2 March 2021 to review the incident and identify key actions required to reduce the risk of similar events happening again and agree how learning would be shared.

7.6 A list of staff roles to identify those having participated in the learning session was included in the AAR report:

- Nurse consultant
- Clinical lead
- Community psychiatric nurse
- Incident investigating officer
- Lead clinician

7.7 It is noted that no-one from the private probation company was invited or attended.

7.8 The AAR report states that there was no carer or family involvement after the incident. There is no mention of follow up support post incident being provided to any other members of JP's family.

7.9 The report of the AAR is comprehensive and demonstrates that progress notes relating to the case were examined with learning opportunities explored. Risk assessments, a brief psychiatric and physical history of the patient and

medication prescribed were all considered. A number of key learning points were identified from the AAR which are summarised as follows:

- a significant delay in JP's referral of March 2020 being processed through the SPA
- discrepancies in the referral interface between forensic services and the Forensic Personality Disorder Team, which added delay and confusion to the overall referral process. The report states that there was a plan in place for this issue to be addressed in June 2021.
- lack of follow up of the recommendation, made by the local Community Treatment Team on 30 October 2019, to contact JP's probation worker and advise him to make a referral to the Forensic Community Mental Health Team. This lack of follow up is recognised as delaying a potential assessment for JP
- a further missed opportunity in January 2020 to follow up the referral to forensic services.

7.10 Key actions were also agreed:

- referral process should be streamlined and efficient to prevent delays in the assessment process
- referral actions to be followed up and documented accordingly
- missed contacts to have planned follow ups

7.11 It is not clear from the AAR report how this learning was to be shared with staff or how the actions were to be implemented. No timeframes were attached to the actions and the AAR action plan template had not been populated. The learning points and actions from the AAR process can be recognised in the Serious Incident report findings; however, any delay in disseminating learning from incidents or making improvements potentially puts service users, staff, and others at increased risk.

7.12 The AAR did not seek to address placing patients on the waiting list for care coordination, who as a result, have no CPA status and no interim care plan or safety management plan whilst awaiting allocation, and how this could be successfully improved.

Review of the internal investigation's terms of reference

7.13 The Terms of Reference (ToR) and methodology for the investigation by the Trust were drawn up in accordance with the NHS England Serious Incident Framework (2015) and the Trust's relevant policies (including its incident policy, the management of serious incidents 2016). They did not provide, however, a comprehensive and detailed framework with which to undertake the investigation.

7.14 The ToRs do not specify the timeframe to be considered. They are limited to the chronology, circumstances, and assessment and management of care in the time leading up to the incident. It was conducted as a level two investigation, as reported to the FM review team by a member of the Trust's investigation team, but the level of investigation was not clearly stipulated in the ToR. There is no indication of who approved the serious incident investigation and the ToR, or who drafted them.

7.15 The ToR do not state how they were collated or agreed. They do not state any stakeholders; it would have been expected to list each provider involved in the patient care such as the GP and the probation service.

7.16 The Trust's approach to Terms of Reference is to have specific bespoke lines of enquiry relevant to the case, and general ones that are included in all their serious incident investigations. The latter are more process driven and relate to areas such as developing a chronology, providing a written report, and so on. For this investigation, no specific bespoke ToRs were identified.

7.17 As stated above, the Trust's internal investigation general ToR included the development of a chronology of JP's care and treatment. Appendix 3 includes a tabular timeline of events from 1998 and the care provided by the Trust to JP each time he was released from prison. The summary chronology narrative in the investigation focuses on the demographics of the population being served by the relevant care teams, rather than providing a synopsis of events leading up to the incident of homicide.

7.18 The time frame for completion of a level two investigation at this time was 60 working days from when the incident was reported (as set out in the National Serious Incident Framework, 2015), but the ToR did not address this requirement, or set out how any delays in completing the investigation would be communicated. The Trust's Serious Incident policy does not include reference to the national time frame for completing investigations or set out the local agreed periods for the completion of investigations. The Trust's Incident Policy Practice Guidance Note (dated 2012), which supports investigations, states that a draft report must be submitted for a quality review within 25 days, that the report should be ready for authorisation within 30 days, and that all actions arising from the investigation are to be completed within 60 days. The National Serious Incident Framework (2013) was amended and revised in 2015. The Trust's guidance note is therefore out of date.

7.19 The ToR did not describe any quality assurance or review of the report as part of the Trust's internal governance processes before being submitted to the Clinical Commissioning Group (CCG) for final approval, or for the monitoring of its progress, approval or dissemination of the report's findings, recommendations and actions.

7.20 The ToR request that attempts should be made to obtain the views of the family and significant others to identify learning. No members of JP's family appear to have been contacted. Similarly, there is no evidence that the family of the victim was contacted for their views.

7.21 There is no evidence that there was any collaboration with other stakeholders, such as the police, commissioners, JP's GP, or the probation service about the development of the ToR.

Commentary:

C.5 The use of after action review (AAR) is an example of good practice by the Trust. There was, however, a gap of six months between the incident

and the AAR taking place. The resulting report is comprehensive and demonstrates the thoroughness of the process in identifying both learning points and key actions. Whilst these were recognised in the subsequent serious incident investigation report, it was not clear that they were acted on promptly to reduce the risk to other service users, Trust staff and the wider community.

C.6 Changes in national guidance that affect operational processes should be fully and accurately reflected in organisational policies within a short period. The Trust's serious incident policy and its investigation policy guidance did not include reference to national or local guidelines on timeframes for completing investigations. The guidelines had not been updated since 2012. Policies and guidelines are tools staff use to direct and support their work; it is important that they are kept up to date and clearly reflect national policies.

C.7 The ToR did not state any specific terms of reference for this investigation. Given the length of JP's medical history with the Trust and the nature of the incident, best practice would be to set specific lines of enquiry into the care received by JP, informed by the issues identified in the AAR.

C.8 The ToR did not set out a clear period of time to be considered in the investigation. There is a risk that the importance of care provided to JP by the Trust outside of a short window of time leading up to the incident in September 2020 may have been missed.

C.9 It is the view of the review team that the 25-day internal deadline for investigations would significantly impact the ability of any investigator/investigation team to provide a full and comprehensive review and, therefore, could impact the breadth, depth and scope of any investigation. It is worth noting that in 2020 due to Covid-19 restrictions staff shortages across the NHS resulted in NHS England suspending 60 day targets for investigations.

C.10 The ToR did not set out the governance processes and methods of updating and tracking progress of the delivery of the investigation in a timely and responsive manner. This would have weakened the investigation process. For example, the 60 working days requirement enables commissioners and providers to monitor progress in a consistent way. This also provides clarity to service users and families about the progress and expected completion date of the investigation.

C.11 There was little evidence of the involvement of the families of JP or the victim, or other stakeholders, in the drawing up of the ToR. This meant that there were limited opportunities to develop and agree areas of focus in the collaborative spirit required by the Serious Incident Framework (2015).

C.12 Trusts should comply with the statutory Duty of Candour set out in Regulation 20, Duty of Candour (Health and Social Care Act 2008

[Regulated Activities] Regulations 2014). The aim of this is to ensure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. The Trust should therefore have clarified what efforts it made to contact the families concerned, and the nature of those contacts, to demonstrate that they were complying with the Duty of Candour.

A review of the internal investigation's methodology

7.22 The Serious Incident Framework recommends the use of tools such as Root Cause Analysis (RCA) and human factors methodologies in investigations, and these are cited in the Trust's ToR. The investigation was undertaken by an experienced independent investigator with a mental health practitioner background, and expertise in the use of RCA. The report, however, does not outline his qualifications, skills or experience.

7.23 There is little evidence in the investigation report that these tools (RCA and human factors methodology) were sufficiently and effectively deployed as a means of establishing findings or recommendations. The only reference to human factors is made in a subsection of the report headed 'contributory factors/associated factors', indicating that these are considered of secondary significance.

7.24 The ToR and the investigation report included reference to Trust policies as part of the investigation. This included policies for non-attendance (did not attend – DNA) policy (September 2017) and the Forensic Community Team service information leaflet (December 2019) and referral form (V 13, February 2021 – the review team noted that this is dated five months after the incident in September 2020). A review of the assessment and management of JP's care in the time leading up to the incident was stated in the ToR, including whether due consideration has been given to relevant risk history and the needs of JP.

7.25 Under the section 'Information and evidence gathered' the report states 'n/a' next to the items 'individual staff interviews held' and 'information obtained from non-[Trust] professionals/organisations', suggesting that these were not considered as part of the investigation. JP's GP was asked to produce a report on 1 March 2021, which was received by the Trust on 8 April 2021. This was however after the completion of the Serious Incident report on 22 March 2021 and so would not have been considered as part of the investigation. The report does not refer to an interview with JP.

Commentary:

C.13 The limited evidence of the use of RCA or human factors methodologies in the report weakens the logical basis and analytical framework of how the findings and recommendations were established. Using such tools and techniques ensures that a broad range of factors are considered, leading to a thorough review, and supports the development of recommendations that identify changes and actions likely to produce a greater impact.

C.14 There should be a clear indication of the investigator's qualifications, skills, experience and training in RCA tools and techniques, and human factors. This would provide assurance to those reading the report, of the suitability of those tasked with undertaking serious incident investigations.

C.15 The ToR does not state to review adequacy of risk assessment although this does appear to be explored as part of the investigation.

C.16 The Patient Safety Incident Response Framework (PSIRF) was launched in August 2022. This signalled a fundamental shift in the way the NHS responds to patient safety incidents. It represents a divergence from the use of RCA. Instead, patient safety incident response is to be placed within a wider framework for improvement, prompting a significant cultural shift towards systematic patient safety management. As part of the introduction of PSIRF, organisations will need to ensure that all relevant staff are trained and have developed the expertise to effectively implement the new approach to investigations. With regard to this investigation, best practice would have included examining the support JP received whilst in prison (HMP A), through the probation service, and from other service providers such as Crisis Skylight. It is also noted that time-bound investigations don't feature in PSIRF, and the scope, scale and time frames for investigations are to be considered more flexibly.

Assessment of the adequacy of the findings of the internal investigation

7.26 The internal investigation reviewed the history of JP's care and service from the Trust from 1998, and then focused on the eleven-month period leading up to the offence. JP's contact with the mental health services included contact with the Forensic Adolescent Services as a teenager, and later with the local CTT and the Trust mental health helpline. As previously mentioned, JP was diagnosed with ASPD in 2009, as stated in a letter from the Community Forensic Personality Disorder service to JP's GP, although the internal investigation report states that no formal diagnoses were confirmed.

7.27 As part of the internal investigation, JP's clinical records were reviewed, and these showed that he had intermittent contact with services and periods of nonengagement with mental health services. The review team found that the reasons for JP's non-contact with services between 2010 and when he contacted the IRS team in July 2015, did not seem to have been explored by the Trust. The FM review team believes this was a missed opportunity to discuss with JP what was different for him during this period. This understanding could have enabled services to concentrate on JP's strengths which in turn could have informed a more robust risk and safety management plan and plan of care. This was not explored as part of the investigation.

7.28 The internal investigation found problems and confusion regarding the referral pathway into forensic services, resulting in missed opportunities to provide care and treatment to JP. The report references a plan to rectify this issue in June 2021.

7.29 The conclusion of the internal investigation 'Contributory factors framework/ associated factors' identified predominantly individual patient factors as significant; stating 'no recommendations were required aimed at improvement of the relevant services'. The framework did not identify that Trust policies and procedures were not followed or adhered to and there were 'ineffective interface for communicating with other agencies partnership working'.

7.30 The Trust's Serious Incident report does not explore the issues around JP's risk management and care planning identified earlier in this report.

7.31 The Trust's Serious Incident report does not explore or address the numbers on the CTT's waiting list and the length of waits in the time leading up to the incident (discussed in detail in section 9 of this report) in order to assess the impact this might have had on their capacity to deliver an effective service. This may have identified a contributory factor that required an associated action.

7.32 The incident investigator concluded that Covid-19 measures in place during 2020 had not impacted on the delivery of the service. In contrast, clinicians told the review team that during the Covid pandemic there were no face-to-face contacts with service users and there were staff shortages. This is explored further in section 9 of this report.

Commentary:

C.17 The Trust report identifies some contributory factors/systems and human factors relating to JP's care and treatment. These were not, however, explored in any depth. Factors identified include:

- delays in referrals being processed through the Single Point of Access process
- complication and confusion about the referral pathway into forensic services
- lack of follow-up with the Probation Officer on the recommendation to refer JP into the Forensic Community Personality Disorder Services for further treatment
- no documented follow-ups for unsuccessful contact

C.18 The lack of depth in exploring these important contributory factors has not allowed the issues/problems to be fully understood from a human and system factors perspective. There is a risk that root causes may not have been identified leading to the development of focussed recommendations that result in SMART (specific, measurable, attainable, relevant, timebound) actions and learning to prevent recurrence.

C.19 The review team found that at no time during the time that JP spent out of prison between 2010 and when he contacted the mental health helpline team in July 2015, was his non-contact with the Trust explored. This was also not considered in the investigation. The review team believes this was a missed opportunity to discuss with JP what was different for him during this period. This could have enabled services to concentrate on JP's strengths which in turn could inform a more robust risk and safety management plan and plan of care.

C.20 Having ascertained on 12 May 2020 that JP would need a care coordinator in order to be successfully referred to forensic services, the investigation does not explore whether more proactive care could have been put in place whilst awaiting this allocation.

C.21 The impact of the Covid pandemic measures on service delivery and the effective management of risk should have been examined as part of the Trust's investigation so that learning from this unprecedented period is maximised.

C.22 The Trust's Serious Incident report identifies problems with the referral pathway between probation services and forensic services. The investigation does not, however, appear to have explored why a referral could not have been made from the local CTT directly to forensic services in October 2019. This may have presented a missed opportunity for two teams within the same organisation to work more closely together to find a solution for JP.

C.23 The conclusion section of the internal report focuses on JP's individual factors such as childhood trauma, history of violence and criminal record as well as general demographic details. Whilst these are undoubtedly important factors, the report does not strike a balance between the contribution of JP's individual factors and the contribution of issues with the services and care provided, for example failure to adhere to Trust policy/procedure and ineffective communication with other agencies. Viewing this incident heavily through the lens of JP's individual factors limits the ability of the Trust and the health and care system to identify the full breadth of learning and implement effective improvements.

Assessment of the adequacy of the recommendations of the internal investigation report

7.33 The Trust's internal investigation report makes no recommendations based on significant findings, but does state that additional learning was noted, and this forms the basis of three recommendations and related actions. Some of the investigation's findings were not incorporated into the recommendations and related actions.

7.34 The executive summary of the investigation report, outlines the three recommendations:

- referral process should be streamlined and efficient to prevent delays in the assessment process
- referral actions to be followed up and documented accordingly
- missed contacts to have planned follow up appointments.

7.35 The recommendations section of the report however lacks clarity, and would appear to list four recommendations and/or actions. The narrative also suggests that two of the recommendations (listed in the executive summary) are now to be considered as one recommendation, with an additional fourth recommendation number added regarding access to forensic mental health services via probation services. This lack of consistency with terminology and detail, produces a level of

confusion and could be viewed as demonstrating poor understanding of what a recommendation is. It also fails to demonstrate a clear visible link between key findings and recommendations. This lack of clarity is further demonstrated in the action plan, which is discussed in the next section. It is therefore challenging to provide positive assurance that there is a clear link between findings, recommendations and actions.

7.36 As noted in paragraphs 7.29 and C.22 above the conclusions of the report focus on JP's individual patient/service user contributory factors. In contrast, the recommendations and actions relate to processes and internal practices. The findings note that 'there may have been opportunities for services to intervene in exploring his presentation' and 'highlight possible ways forward to work with services users such as JP' however there were no accompanying recommendations made in relation to the clinical management of complex cases such as JP.

Commentary:

C.24 The recommendations arising from the Serious Incident report are not written in a consistent style. A recommendation is a suggestion or proposal as to the best course of action arising from the findings of an investigation. They should be written in a clear, unambiguous style so that the organisation responsible for implementing them can identify the desired results (objectives/goals) and the action(s) required that will lead to the required outcomes.

C.25 Furthermore, the investigation report's description of the actions required to meet these recommendations do not conform to the SMART approach. This approach provides clear criteria to guide individuals and organisations when setting goals and objectives, leading to effective outcomes and improvements in services and practices. Using this approach means that actions or goals will be characterised and described in line with these criteria: specific, measurable, achievable, realistic, and timely.

C.26 The three recommendations made in the internal report were based mainly on processes, and therefore their impact would be low. They were not focused on outcomes, or sufficiently specific to comprehensively address the issues arising from this incident, and the findings from the investigation.

C.27 Important aspects of the investigation's findings were not incorporated into the recommendations particularly in relation to the management of complex cases. The following are highlighted as important aspects that should have been included in recommendations:

- ensure complex cases are discussed at SPA multi-disciplinary (MDT) meetings for future planning and management
- ensure the crisis teams review and interact with the CTT to ensure information is collated correctly, specifically regarding the forensic services pathways for complex patients.

C.28 There are examples (identified above) where the recommendations and associated actions do not fully capture some of the investigation's significant findings. This would have weakened the validity of the investigation, and reduced opportunities to make improvements or changes in practice.

C.29 There is no evidence of others being involved in the development of the recommendations, such as JP's GP, the CCG, or other agencies that may have come in contact with him. This would have been good practice and provided an opportunity for wider learning beyond the Trust.

C.30 As the investigation was internally focused, the report and recommendations do not consider the impact of the incident and investigation on local or national policy or approach. This should be explored further to ensure the learning from this incident is shared system wide.

C.31 There is no systematic governance process provided to monitor the implementation of the recommendations and their associated actions.

Section 8: Assessment of the adequacy of the implementation of the action plan arising from the internal investigation

8.1 The investigation report sets out both recommendations and actions. We have noted in section 7 above there is a lack of consistency, and some confusion, in the way in which recommendations and actions have been expressed.

8.2 The review team found some discrepancies between the recommendations/actions in the report document and how they are captured in the Trust's Action Plan. The differences are as follows:

8.3 **Report action 1:** *The referral process should be streamlined and efficient to prevent delays in the assessment process.*

The recommendations section of the investigation report states that this action should assist in delivering the following outcomes:

- *formulating a revised procedure for referrals to another service, including complex risk assessments, to be followed by practitioners.*
- *deciding an agreed inter-agency/service plan to reduce the overlap of input between services.*
- *help inform commissioners to identify a more effective care pathway and purchasing plan, for community care provision of a high-risk complex group of service users Community + Secure services*

8.4 The Trust's Action Plan asserts that the issue in this case was not waiting times for assessment and treatment. It explains that the issue was that the referral forwarded to the National Probation Service by the local CTT, to send to the forensic CMHT, was not followed up. The plan states that the single point of referral process has been reviewed. It is noted by the FM review team that the referral was forwarded to the private company, providing probation services, not the National Probation Service.

8.5 **The Trust's Action Plan section 1** responds with two actions:

1.1 The CTT to receive guidance on which referrals may be supported by the Forensic CMHT in order to understand whether a referral may actually reach the criteria for the Forensic Community Mental Health service

1.2 Referral actions to be followed up and documented accordingly and process for monitoring and follow up developed within the service.

8.6 **Report action 2:** *Referral actions to be followed up and documented accordingly and* **Report action 3:** *missed contacts to have planned follow up appointments.* We consider these two recommendations to be interlinked. It is recommended that a review of current processes is undertaken which will assist in identifying areas for further development.

8.7 **The Trust's Action Plan section 1.2** (as above) corresponds with the report action 2. **The Trust's Action Plan section 2** states: *'the review highlighted some internal processes to be corrected'* and the corresponding Trust action is:

2.1 CTT to ensure all letter correspondence is date stamped on receipt into the service.

8.8 The Trust's Action Plan therefore does not include an action aligned to the report action 3, regarding missed contacts needing to have planned follow-up appointments. The action plan refers to the team having been reminded about following the DNA policy for any disengagement to evidence completion of the action.

8.9 **Report action 4**: *[The Trust investigation] Department to share learning point around probation referrals into forensic services with the Justice Health Commissioners.*

8.10 **The Trust's Action Plan section 3** corresponds with this action.

Commentary:

C.32 The report action: 'The referral process should be streamlined and efficient to prevent delays in the assessment process', has not been captured in the Trust's Action Plan. There is, however, a reference, under the heading of evidence of completion, to a review of the Single Point of Access (SPA) referral process having been completed. The Trust should seek assurance that their SPA referral process review has delivered the investigation report's recommended outcomes as described in paragraph 8.3 above.

C.33 The Trust's interpretation of the report recommendation 3: 'Referral actions to be followed up and documented accordingly and missed contacts to have planned follow up appointments', was too narrow. No reference is made in the action plan to the wider recommended review of the current process used to follow up and document missed contacts, and also identify service users who might disengage from treatment.

C.34 The Trust should ensure that the necessary changes to systems and protocols are implemented so that referral actions are consistently

followed up and documented accordingly. Planned follow-up appointments should be arranged in response to a missed contact with a service user who may be starting to disengage. The Trust should also consider how it will be assured that this change is embedded, resulting in better outcomes for service users.

Review of progress against actions arising from the investigation

8.11 The FM review team has assessed the quality and impact of the implementation of the action plan produced by the Trust in response to the investigation report recommendations. To achieve a comprehensive assessment, the review team used an analytical framework that enables a systematic assessment of its findings. The team considered the evidence provided by the Trust, and information from staff interviews to make an assessment against the following three measures:

1. effectiveness of intervention or action (in terms of having effected positive change)
2. maturity of the implementation of the actions
3. quality of assurance

8.12 The first measure has been adapted from the Hierarchy of effectiveness of risk reduction strategies (Institute for Safe Medication Practices, June 2020). This approach assesses the human and systems reliability of each action, and how effective they are likely to be in addressing the identified issue.

8.13 The second measure takes account of the evidence that the Trust has given the review team to demonstrate the achievement of the action. From this evidence, an assessment is reached on how well the action plan has been implemented.

8.14 The third measure is based on the four lines of defence framework. This framework is designed to help organisations analyse the overall strength of their internal control, supervision and review processes (Institute of Chartered Accountants in England and Wales (ICAEW): four lines of defence). It helps to identify and understand the different contributions from the various sources of information and evidence that are used, and how each one helps support the overall level of assurance. Examples of the four lines of defence are as follows:

First line: the way risks are managed and controlled day-to-day. Assurance comes directly from those responsible for delivering specific objectives or processes.
Second line: the way an organisation oversees the control framework so that it operates effectively. The assurance provided is separate from those responsible for delivery, but not independent of the management chain, such as risk and compliance functions.
Third line: objective and independent assurance, for example internal audit, providing reasonable (not absolute) assurance of the overall effectiveness of governance, risk management and controls.
Fourth line: assurance from external independent bodies such as the external auditors or other external bodies

8.15 FM has used this model to assess the quality of the assurance evidence the Trust has provided to demonstrate the implementation of its action plan.

8.16 The differences between the investigation recommended actions and the Trust's response are explored in paragraphs 8.1 - 8.10 above. For the purposes of the review of progress and to save confusion, FM has evaluated the Trust's performance against its Action Plan rather than the recommended actions captured in the Serious Incident investigation report.

8.17 Using the FM assessment framework, a summary of the review team's findings of the progress that has been made is set out below, along with areas where further work and progress are needed. A more detailed assessment can be found in appendix four.

Figure 1: Summary table using FM assurance framework

Recommendation / Action(s)	Effectiveness of Intervention	Maturity of implementation	Quality of assurance
1			
2			
3			

8.18 This assessment is intended to be useful and evaluative so that the Trust can focus on the further steps it should take in order that they can be assured that the actions they have taken are complete, embedded, impactful and sustained.

Narrative summary of the FM assessment

8.19 Two of the three actions described in the Trust's Action Plan have been assessed by the FM review team as likely to be the easiest to implement, but the least effective in terms of reducing the risk of recurrence. This is because the actions described rely mainly on changes in human behaviour, rather than in systems. Potential actions that are more effective, although harder to implement, are those that include introducing an element of task automation in a system. Barriers and forcing functions within systems to help prevent human error can also prove effective. Such factors can ensure consistency in the quality of tasks carried out, particularly in situations where there is a high probability of variation or error in the ways in which people might carry out those tasks. For example, the use of the electronic patient record could include prompts or barriers that require the user to populate a certain intervention or action before moving to the next stage.

Action 1: Referral process

8.20 **Action 1.1 -** *The CTT to receive guidance on which referrals may be supported by the Forensic CMHT in order to understand whether a referral may actually reach the criteria for the Forensic Community Mental Health service.*

8.21 **Action 1.2 -** *Referral actions to be followed up and documented accordingly and process for monitoring and follow up developed within the service*

8.22 The Trust's Action Plan included the following narrative alongside the actions:

> *There was some delay in this person accessing support from the [local] CTT. This was not about waiting times to assessment and treatment as these are not excessive (wait times to assessment – circa 5 weeks and wait times to treatment are circa 8-9 weeks). In October 2019 his referral was forwarded onto the National Probations Service to send to forensic CMHT – this was an inappropriate action as the service is ONLY commissioned to accept referrals from the National Probation Service and not, as was the case for this gentleman, where someone is open to the contracted offender monitoring provider (contracted for those who are considered at lesser risk of offending within Justice community services). The team did not follow up on the referral to the NPS and so were not aware of outcome of that onward referral.*

8.23 **FM assessment:** The first part of this action is written as an intention rather than an action. An intention is an aim or plan that someone means to carry out; an action is a task that is done to achieve an aim or a goal. The Trust cited the establishment of a forensic forum/clinic to support the completion of its intention. The ToR and the date for the first forum were described as supporting evidence. The review team was told that the forensic forum was initially launched with very limited attendance and no evidence was provided to confirm if it had continued and to what extent it had made an impact on services. The effectiveness of this action was therefore considered to have low potential impact, with no progress having been achieved.

8.24 Regarding the second part of the action, although again written as an aim or plan, the Trust was able to demonstrate that some steps had taken place to address the issue. This included the review of the SPA referral process in the community treatment team (CTT) and a change of review methodology within the local CTT. Assessment of the SPA referral process is examined in detail in section 9 (9.11 – 9.18) of this report. The completion of a form for staff to record reviews to ensure all tasks are completed was described, prompting clinicians to instigate a welfare check and MDT discussion, was referred to. A copy of the template and one set of team meeting minutes was accepted by the Trust as sufficient evidence that this change had been satisfactorily implemented.

8.25 The FM review team considered this to have low potential impact in terms of changing behaviours and practice. It does not take into consideration any review of the current process or independent assurance of the effectiveness of the changes. The review did assess the Trust however as having made early progress towards achieving its plan, based on limited evidence.

Action 2: Referral action follow up and missed contacts

8.26 **Action 2 -** *CTT to ensure all letter correspondence is date stamped on receipt into the service.*

8.27 The Trust's Action Plan included the following narrative:

The review highlighted some internal processes to be corrected. There was some delay evident in the team considering the next referral to the CTT from the GP in March 2020, this may have been due to the context of Covid ways of working that Primary care had to adopt. The referral letter was not date stamped for when the CTT received it but was actioned immediately, as the GP had dated the letter

8.28 **FM assessment:** The action plan states that the pathway manager has confirmed by email that the action was communicated by email to the admin lead, and that admin staff had been reminded of the need to date stamp all correspondence.

8.29 The FM review team considered this action to have low potential impact in terms of changing behaviours and practice, leading to limited effectiveness in reducing the risk of recurrence. The Trust did not provide evidence that the action had been implemented by admin staff and the review therefore concludes that no progress has been made. The review team did not see any evidence to validate the impact of the intended change.

8.30 Because the Trust did not follow the investigator's recommended action, the matter of missed contacts needing to have planned follow up appointments was missed. No action to respond to this was captured in the Trust's Action Plan. The Trust did not provide any evidence of a review of the referral or pathway processes, or documented follow up for unsuccessful contact with patients.

Action 3: Referrals to forensic services

8.31 **Action 3** – *[The Trusts investigations] Department to share learning point around probation referrals into forensic services with the Justice Health Commissioners.*

8.32 **FM assessment:** Although the action was considered as having medium potential impact in terms of its effectiveness in reducing risk, it was assessed as complete. Information and learning had been shared with the Health and Justice commissioners in November 2021, although a follow up response was not completed until September 2022. At this point it was noted that the action was no longer relevant because the HM Probation Service is now the sole provider.

8.33 FM agrees this issue has been resolved as the private company no longer provides probation services; the probation service took over the full service from May 2021, which was confirmed in email correspondence on 27 September 2022.

Commentary:

C.35 This assessment has established that overall, the Trust has made limited progress in delivering the actions arising from this homicide. More work will be needed to ensure that the improvements arising from the actions in its action plan are complete, have become embedded and are being sustained. The Trust should consider the potential impact of actions designed to result in change. Reminding staff to follow guidelines and pathways such as the DNA policy relies solely on changes in human behaviour. Whilst actions such as this are the easiest to implement, they are equally the least effective. Actions that involve the strengthening of

systems' controls that enforce changes in human behaviour, and introduce forcing functions and fail-safes, are the hardest to implement but the most effective in terms of reducing the risk of recurrence.

C.36 The review team identified that the Trust's actions did not consistently match the contributing factors highlighted by the investigating officer. It would be considered good practice that recommendations are developed and articulated in the investigation report, and that actions are co-produced between the investigator and the clinical and operational teams tasked with their delivery. This is to ensure consistency between the investigator's findings and the Trust's response. This did not happen in this instance and consequently, the Trust's Action Plan is not fully aligned with the report findings, recommendations and suggested actions.

C.37 Earlier commentary in section 7 of this report (C.23 and C.24) equally apply to the Trust's Action Plan. The FM review team's comments relate to the need for clarity when forming actions. Further, not using the SMART approach to action planning makes the measurement of improvement difficult to gauge.

C.38 Providing the CTT with clear guidance on the acceptance criteria for referring service users to the community forensic services, was identified as a key Trust action. The Trust's outcome or evidence of completion of this action was the establishment of a forensic forum/clinic. The review found that this was launched with very limited attendance and no evidence was provided to confirm if it was ongoing and effective. This is a significant gap in delivering learning and change from the homicide investigation and the Trust should revisit this action to ensure that the CTT have the necessary guidance on which referrals may be supported by the Forensic CMHT.

C.39 The Trust has not provided evidence to show how it is assured that the changes put in place are having an impact on the quality of the care that is provided to service users. For example, the changes in the referral process by the CTT should be validated using the Trust's internal scrutiny or performance reporting arrangements. The Trust may also wish to consider how it triangulates its improvement using surveillance mechanisms such as incident themes and trends, complaints, and service user and carer engagement.

C.40 The Trust's response through its action plan was limited because it concluded that the predominant factors in this case, highlighted from the investigation, were related to the service user. Assigning fault to individuals limits the opportunities for meaningful reflection and a deeper understanding of how to improve. The FM review team heard that a significant proportion of those using CTT services have a similar profile to JP, i.e. with a forensic history and presenting with changing and complex needs. It is important therefore to guard against complacency in the management of these service users, each of whom will have their own individual needs and circumstances.

Section 9: Systems, safeguarding, governance and compliance

9.1 The FM review team referred to relevant NICE guidance, local and national policies relating to the care and treatment of ASPD, the establishment and operation of SPA services, and the management of service users whilst on a waiting list and others listed in the references (section 14).

Referral pathways

9.2 It was not possible for the FM team to map the pathway that JP followed between August 2019 and September 2020. This is because JP appears not to have been put onto a recognisable pathway for assessment and treatment. This section of the review therefore focuses on JP's journey during this time period and the issues that arose, such as:

- the ability to access forensic services
- the triage of service users by the CTT
- management of service users whilst awaiting a named care coordinator
- issues affecting waiting times for the CTT, including the impact of the Covid pandemic on access
- inter-agency working between the trust and probation services.

9.3 The first attempt to refer JP to forensic services was recommended in October 2019. A period of 45 weeks passed between this point and the incident of homicide in September 2020. No successful referral was made to forensics during this time, with no meaningful plan for how JP's care should be managed whilst he was waiting.

9.4 Interviews with staff confirmed that JP's GP made a referral to the CTT on 27 March 2020, which was not actioned until six weeks later on 11 May 2020. On 12 May 2020, the clinical lead for the CTT spoke to the clinical lead for the forensic personality disorder service who confirmed that the referral could only be accepted if JP had been allocated a care coordinator.

9.5 JP was assessed and recommended for trauma support and treatment from the forensic service on 1 June 2020. He was placed on a waiting list for the allocation of a named care coordinator. The plan was for JP to have four-weekly telephone contacts with a CPN whilst awaiting this allocation. Successful contacts were made on 3 June and 30 July 2020, but he did not respond to two attempted calls on 27 August, and this was not followed up by the CPN (as discussed in section 6 of this report under the heading 'Risk Management'). JP was therefore not receiving any treatment at the time of the incident as he was still without a named care coordinator. JP was on this waiting list for over 14 weeks between 1 June 2020 and the incident of homicide on 11 September 2020, in addition to the six weeks delay in the response to his first referral in March 2020 – a total of 23 weeks.

9.6 The FM review team noted that JP's contact with his GP appears to end in March 2020, following his referral to the Trust's CTT. This correlates with the start of the Covid pandemic. Before the pandemic, the Trust's lack of response to a referral may have prompted the GP to follow this up. The emergence of the pandemic in 2020 had a significant impact on both primary and secondary

healthcare services and this might explain why the GP did not enquire after the Trust's delayed response to her referral.

Access to forensic services

9.7 As discussed earlier in this report, the private probation company was unable to make a direct referral into the Trust's forensic services. Changes to the commissioning arrangements whereby forensic services were not able to accept referrals from a privately contracted service only became clear when the clinical lead for the CTT had a conversation with the Forensic Personality Disorder clinical lead on 12 May 2020. By this time almost seven months had elapsed since the original recommendation on 31 October 2019 for forensic services to be involved in JP's care.

9.8 Although all the forensic services listed on the Trusts website outline a referral mechanism from specialist mental health services, or joint working with national probation services, the clinical lead for the local CTT explained in an interview that it was unclear where patients such as JP should be seen. A lack of consistency in multidisciplinary team discussion around complex cases such as JP's was also commented on.

9.9 NICE guidance for the prevention and management of ASPD states '*Clearly agreed local criteria should also be established to facilitate the transfer of people with antisocial personality disorder between services. As far as is possible, shared objective criteria should be developed relating to comprehensive assessment of need and risk' (CG77).* It is likely from our clinical review of JP's care and treatment that his diagnosis of ASPD was not considered as part of the decision-making when a referral to one of the Trust's forensic services was recommended. It has not been possible to establish what difference this might have made to JP's access to forensic services, such as the Community Forensic Personality Disorder Service at this time.

9.10 The Trust's Serious Incident investigation correctly identifies complication and confusion around access to forensic services as a contributory factor in this incident, however the report does not explore this in sufficient depth. As discussed in section 8 of this report, the actions in the Trust's Action Plan that relate to referral into forensic services are considered to have low potential impact. The evidence seen by the review team showed there has been little progress with their implementation

Commentary:

C.41 There was no successful referral of JP into one of the Trust's forensic services between October 2019 and September 2020, although some professionals involved in his care believed that this would have been an appropriate pathway for him. This review concludes that access to forensic services proved difficult, even for other mental health teams within the Trust. Access for professionals such as GP's and at the time, contracted probation service providers, was impossible. It is important that access to appropriate care and treatment pathways is clear to all professionals and service users. It is important that the correct diagnosis is recognised, in this case ASPD, when selecting an appropriate pathway.

C.42 As discussed earlier in this report, HM Probation Service no longer contracts out offender monitoring to independent providers. The FM review team understands that this has removed the barrier to direct referrals to forensic mental health and/or personality disorder services by Probation Officers. The Trust should however consider what further work is required to ensure that the remaining barriers to access noted in this review are resolved.

C.43 Commissioners should ensure that services are operating in line with NICE guidance: Antisocial personality disorder: prevention and management (CG77).

C.44 The Trust should also consider how it provides assurance to its board and senior management that its services are operating in line with the latest national guidance and regulatory requirements.

Single Point of Access (SPA) meetings and Post Assessment Meetings (PAM)

9.11 Commonly, a mental health Single Point of Access or SPA provides a single-entry point for referrals to secondary mental health services and support in a mental health crisis. The mental health SPA is generally open 24 hours a day, 7 days a week, and 365 days a year, with all calls routed through one freephone number. Those in a mental health crisis can speak to a member of the SPA team without needing to be referred. The service is open to everyone, including existing service users, referrals from GPs and other social care professionals as well as those working in the housing, voluntary and charity sectors.

9.12 A mental health SPA team will screen all referrals and, if required, carry out assessments over the phone. The information from this initial assessment is then used to signpost the caller to a service who can best meet their needs. All assessments are conducted to establish the level of need and risk profile of the individual.

9.13 In the Trust in 2019-20, the term SPA was used to describe a meeting held within the CTT, and not a single referral point as previously described. The clinical lead for the local CTT at this time explained how their SPA meetings operated in 2019-20. SPA meetings took place daily on Monday to Thursday each week. Decisions would be taken at these meetings on whether to accept new referrals into the CTT, or signpost them to a more appropriate service or team. If a referral was accepted at the SPA meeting, then the individual was offered an assessment by the CTT. Following assessment, their case would be discussed at a post-assessment meeting (PAM), which took place weekly in order to place referrals in priority order.

9.14 Between October 2019 and June 2020, JP's case was reviewed twice at a CTT SPA meetings.

9.15 JP contacted the Initial Response Service (IRS) on 27 October 2019 due to hearing voices telling him to kill himself. Following a crisis assessment and FACE risk profile, he was referred on to the local CTT. JP's case was scheduled for discussion at their SPA meeting on 31 October 2019. Following this meeting,

a member of the CTT wrote to JP's Probation Officer asking him to refer JP to forensic services.

9.16 JP's GP referred him to the CTT on 27 March 2020. The issues around this referral not being processed until 11 May 2020 are discussed earlier in this report. JP's case was again discussed at a SPA meeting on 12 May 2020. At this stage it was confirmed that JP required a care coordinator in order to be referred to forensic services. Following the assessment by a CPN and the CTT clinical lead on 1 June 2020, JP's case was discussed at a PAM meeting on the same day. The review team heard that this is usually a MDT team meeting, but it is noted that on 1 June, it was attended by nursing staff only. No Consultant Psychiatrist was present at this time.

9.17 There is evidence that the local CTT carried out work in September 2020 to refine how its SPA meetings should operate. This work focuses on the processes and procedures of the meeting, including the administration arrangements for handling referrals and the SPA and PAM rota for staff attendance at meetings. There are some useful prompts for the panel to consider in its decision making; an assessment template is to be completed and uploaded to the RiO patient record system for each case.

9.18 In terms of possible outcomes, an onward referral to a specialist service, such as a forensic or personality disorder service, is not explicitly listed. This may however be implicit within the term 'signpost'. The document includes a draft of how the SPA should handle urgent allocations to a CPN, which could in principle reduce waiting times for people in JP's position requiring a care coordinator before onward referral to forensic service. The document however describes how cases will be assessed at the subsequent PAM meeting, where all cases are given a RAG (red, amber or green) rating. It is not clear what criteria are used to allocate these ratings and JP was given an amber rating when his case was discussed at a PAM meeting in 2020. On this basis, he would not have been assessed as urgent and therefore escalated for allocation of a CPN.

Commentary:

C.45 The Trust was not operating a recognisable SPA service or system that could have benefited JP and others during the period he was in contact with Trust mental health services between October 2019 and September 2020. The application of the term 'SPA' in this case, by the CTT, is misleading, albeit some of the elements of SPA were contained in this process. For example, individual assessments of need were completed and recorded on the RiO system and various options for signposting service users were considered. RAG ratings were allocated at the weekly PAM meeting with RAG ratings allocated to each service user that lacked clarity, in terms of the level of risk and the next appropriate steps in their care or treatment.

C.46 The document provided to the FM review team showed that work was underway to streamline and strengthen the CTT's SPA process but this was incomplete. For example, in the version seen, the DNA protocol needed to be written and agreed by the team. The document referred to

the local CTT only. Guidance on referrals to forensic services was not explicit in this document. The status of the document was unclear i.e. whether, once completed, it was to be formally approved and incorporated into a Trust policy or protocol, or whether it would be limited to providing guidance to staff in the local CTT team.

C.47 The review team did not find sufficient evidence to demonstrate that substantial improvements had been made to strengthen and clarify its referral processes for service users, and address the barriers to accessing forensic and personality disorder services.

C.48 The Community Mental Health Framework for Adults and Older Adults, published in 2021, describes in section 3.1 the principles that should apply to mental health services for people with more complex needs, including people leaving the criminal justice system. These principles include:

- Stepping up and stepping down people's level of care being straightforward and seamless
- A 'no wrong door' approach to accessing care
- People with the full range of mental health problems being able to access support, care and treatment in a timely manner and from wherever they seek it, whether from their GP, from a community service, through online self-referral, other digital means or another route
- In all care for complex needs, the principle of continuity remains critical.

C.49 The Trust should reflect on how it delivers the principles of this framework as described above. This should include the establishment of an effective SPA service that provides one access point for those in need of, or professionals needing to refer to, adult mental health services for those between 18 and 65 years of age.

Management of service users while on the waiting list for allocation to a named care coordinator

9.19 An interview with a member of Trust staff confirmed that on the first waiting list call, JP was identified as a cluster 7 patient, i.e. categorised as *'Enduring Non-Psychotic Disorders (High Disability)'* (NHS Data Model and Dictionary). This was updated to cluster 8 following his assessment (*'Non-psychotic chaotic and challenging disorders')* and placed on the waiting list for a care coordinator.

9.20 It is understood that the allocated RAG rating, described earlier in this report, was used to assist in the management of the CTT waiting list. JP was categorised as amber priority on 1 June 2020. His management involved having an initial conversation with a CPN within eight weeks of being placed on the waiting list, and subsequently a call every four weeks to check his welfare. The review team has been unable to locate the waiting list policy and as previously commented, the criteria of assessment and risk that supports the RAG classification of service users.

9.21 It was explained to the FM review team that it was not uncommon for the team to have a high caseload of forensic patients, managed by a care coordinator from the CTT, with advice and guidance from a forensic service (known as scaffolding). It was explained that, of the forensic patients on their caseload at the time, a high proportion included a diagnosis of a personality disorder. CTT staff considered that JP's profile did not stand out as being exceptional in the context of this caseload.

9.22 Following JP's assessment on 1 June 2020, the CTT wrote to JP and provided information regarding the plan for his next contact within eight weeks, who to contact if he felt his mental health was declining, and a number of website resources should JP wish to find out more about mental health issues.

9.23 JP was then on the waiting list for a care coordinator for over 14 weeks between this assessment on 1 June 2020 and the incident of homicide on 11 September 2020. During this time, he had only one telephone contact (30 July 2020 – 7 weeks and 3 days after his assessment) and did not respond to two attempted calls on 27 August 2020; this could have indicated a change in his presentation and risk level. As reported in the clinical review section (paragraph 6.16), there is no evidence that this unsuccessful contact was followed-up in accordance with the Trust's policy for service users not attending planned appointments. For example, no evidence was provided to show that JP's lack of response was discussed at an MDT meeting, which would have been good practice.

9.24 It was explained to the FM review team that a weekly meeting took place between June and September 2020 to discuss people awaiting allocation to a care coordinator. People who had been waiting for a long time or were categorised as urgent were discussed and prioritised for allocation to an available case coordinator. As JP had been rated amber, his length of time on the waiting list does not appear to have triggered a discussion at this allocation meeting.

Commentary:

C.50 Once JP had been categorised as amber on the RAG scale on 1 June 2020, a delay of eight weeks before he was first contacted is considered too long. Similarly, four weekly subsequent contacts may not be adequate to monitor and escalate any changes in risk and clinical presentation. The review team has seen other Trusts operate more frequent contact with those on waiting lists such as daily check-in calls, calls three times a week, and weekly.

C.51 The impact of the Covid pandemic on healthcare services at the time of JP's contact with Trust mental health services in 2019 and 2020 are recognised and explored in this report. The Trust should however review its protocol for monitoring and keeping in touch with people on waiting lists for care and treatment across all its community services, ensuring that waiting list check-in calls are made at a frequency relative to their individual needs and current level of risk.

C.52 The Trust's Serious Incident report does not explore the issues around caseload, profiling of the waiting list, or the lack of forensic team input into managing the community team waiting list despite the high numbers with a forensic profile. The FM review team notes that the clinical lead for the local CTT was not interviewed as part of the Trust's investigation. In reviewing its waiting list management, the Trust should consider how those with a significant forensic history, and a history of violent behaviour, are managed for their own safety and for the safety of others.

C.53 The FM review team noted that when JP was put onto the waiting list for the CTT, he was provided information about what to do should his mental health decline and given further sources of information about mental health issues to explore. Other Trusts have worked on improving how they can support people waiting for mental health treatment. One example from Derbyshire Healthcare NHS Foundation Trust involves providing an information leaflet to people, signposting them to GPs and other NHS services, voluntary sector organisations (with contact numbers included), encouraging people to think about accessing peer support or faith support where appropriate, and advice on living and staying well while waiting for treatment.

C.54 The review team also noted a piece of work by the Trust's community treatment teams, working with the voluntary sector.

Issues affecting waiting times for the community treatment team

9.25 In July 2021, NHS England set out plans for five waiting times guarantees, including stating that '*Adults and older adults presenting to community-based mental health services should start to receive help within four weeks from referral. This may involve the start of a therapeutic intervention or a social intervention, or agreement about a patient care plan'.* Whilst this was not the guidance in place during JP's care in 2019-20, it is notable that he waited for just over seventeen weeks between his referral being accepted by the CTT on 13 May 2020 and the incident occurring on 11 September 2020. There was an additional six weeks between the GP referring JP to the CTT on 27 March 2020 and his case being discussed at a SPA meeting on 12 May 2020.

9.26 The review team has not been able to ascertain how many people were on the waiting list or staffing levels in the CTT in May and June 2020. The review team however heard from Trust staff that there were significant pressures on the service with staff shortages at this time, and so referrals needed to be allocated within the resource available. A waiting list of over 350 people was referred to before the start of the Covid pandemic. It was said that this was significantly reduced to around 30 and had then started to rise again to around 70 people by September 2020.

9.27 The number of people on the CTT's waiting list, and the high proportion with a forensic profile, highlights the importance of an effective multidisciplinary team working between CTT staff and forensic services at that time.

9.28 The FM review team was advised that measures in place during the Covid pandemic impacted on waiting times for the CTT, as well as more general issues around the recruitment and retention of staff. Although it has not been possible within the scope of this review to verify this point, it does correlate with the national picture regarding staffing pressures in mental health services. The British Medical Association (BMA) outlines in their article 'Mental health pressures in England' (August 2022, updated August 2023) the challenges to mental health services due to such factors as population growth and the impact of the pandemic.

9.29 The review team understands that issues regarding waiting times (as also described in section 6 of this report) have been looked at through the Trust's access and waiting times group and the corporate services business intelligence group.

9.30 The review team understands that a waiting list dashboard has been developed to support waiting list management. This is a Trust-wide system, which means it is likely that standard requirements in relation to how it will be used will be incorporated. It would however be useful for those who manage waiting lists to be involved in the development of information dashboards. This would ensure that the threshold criteria of functions such as RAG ratings are clearly defined and consistently applied, so that capacity and demand is managed effectively and safely.

9.31 This picture of increased demand and operational capacity and staffing issues is replicated across the NHS, with the Royal College of Psychiatrists outlining that: '*Analysis of new NHS Digital data shows there were 3.3 million referrals to adult services …. in England between January and December 2021'* (Royal College of Psychiatrists, March 2022). The Royal College also states that 642,303 adults (19 to 64 years) were in contact with mental health services in December 2021 compared to 612,222 in December 2019, showing a 4.9% increase.

Commentary:

C.55 The Trust's Serious Incident report states (page 19) 'With reference to COVID-19 measures during 2020, no factors were identified which compounded delivery of the service'. This is contrary to reports from staff, who describe Covid measures affecting waiting times for treatment., which would be more in line with the national picture of healthcare services at this time.

C.56 The Trust may wish to consider, if they have not done so already, utilising demand and capacity modelling to better understand how its services operate. NHS England provides a range of guidance and tools to support this quality improvement and service redesign work, including modelling for community and/or mental health (see references). An NHS England published document Demand and capacity – a comprehensive guide (2022) describes the following initial steps:

- engage stakeholders and process map the steps involved in their services (the patient journey)
- identify any bottlenecks and their causes

- better understand their constraints
- use RCA techniques to establish the real reasons for delays
- measure and map demand, capacity, backlog and activity in units of time

C.57 Other organisations such as The Strategy Unit, have created mental health surge models following the learning from the Covid pandemic, following national analytical collaboration. This modelling work has estimated the increase of referrals to mental health services, each year for the next three years, with associated costs and the impact on annual expenditure.

C.58 Embarking on quality improvement work such as this gives the Trust the opportunity to prepare for the impact of any surges or increase in referrals through a Single Point of Access (SPA) model and enable plans to be put in place to support those referred, from whatever source, and the impact on onward signposting to its various services.

C.59 The Trust should also review its processes and procedures around waiting list management to ensure that:

- robust caseload management is made possible within CTTs, with clear senior leadership oversight, governance and escalation where required to address concerns around caseloads, waiting times and waiting lists
- clear processes for discharge planning, clinical supervision and peer review of caseloads are in place.

C.60 In addition, it may be helpful to review the criteria for service eligibility and validation of the lists. This is to ensure that all patients, especially those RAG rated as green, need adult mental health services rather than signposting to alternatives such as non-statutory support services.

Inter-agency working between the Trust and probation services

9.32 On his release from prison in 2019, JP was on licence and under the supervision of the private probation company. This was in line with national guidance at that time as JP's Probation Officer assessed him as medium risk of serious harm to the public at the time of his release. This is documented in an assessment on the Offender Assessment System (OASys) on 21 August 2019. OASys is an assessment tool used by the HM prison and probation services in England and Wales. It provides a standardised assessment of the needs and risks of service users which, once identified, can be used to develop and deliver sentence plans. As part of the assessment process, the individual risks of further offending and the risks of harm posed to the public by an offender are analysed. The system captures all previous and current offences together with sentencing and risk assessment information relating to an individual in one place.

9.33 Review of this record showed that the self-assessment section of the OASys document was not completed by JP at the time of his release. The terms of his licence were:

- weekly contact with his RO (responsible officer)

- two-weekly home visits by the HOST team (homeless offenders strategy team)

9.34 It would appear from JP's probation records that these terms were not rigorously adhered to; for example, there were significant gaps in JP's appointments with his RO between August and November 2019 and again between November 2019 and January 2020. There appears to have been only one appointment with the HOST team between August 2019 and September 2020; this appointment took place on 4 December 2019.

9.35 JP's contingency plan whilst released under licence included triggers for robust enforcement action in the event of non-compliance with any requirements of his order.

9.36 A senior probation service officer noted in interview with the FM review team that not having access to the mental health issues affecting JP was a missed opportunity; he stated that had the probation service been aware of the additional information concerning JP's mental health issues, it may have significantly impacted on the risk assessment and subsequent risk management plan. Although the assessment in 2019 did not highlight concerning mental health issues, the OASys record reviewed by the FM team showed earlier mental health concerns such as a risk of suicide and self-harm on his release from prison, 23 November 2016. The 2019 assessment therefore conflicted in this regard with JP's earlier OASys records.

9.37 From the same interview, it appears that the probation service also did not have access to mental health information from JP's time in prison (HMP A), during which he received support from a psychologist within the primary care mental health team. Neither did the probation service have access to mental healthcare information after JP's release from prison in August 2019, even though he was meeting frequently with his Probation Officer (RO).

9.38 The FM review team also heard that the quality of communication between prison psychology services and the community treatment team was poor and that they would receive no handover or assessment information before a prisoner's release. The prison psychology service was in this case operated by primary care teams, and therefore any discharge or assessment information was sent to the GP, with no formal information sharing between primary and secondary care services.

9.39 The CTT wrote to JP's Probation Officer on 31 October 2019 to ask him to refer JP to forensic services. This letter did not include any clinical information as to why this referral was considered necessary. Similarly, there is no evidence that the probation service acted on this letter from the Trust and no additional information regarding JP's mental health presentation was sought by them. Appreciating the need for NHS services to maintain patient confidentiality, had an appropriate level of information been shared between the Trust and the probation service, it may have prompted the probation service to review JP's risk rating on their OASys system. Probation officers are expected to re-assess an offender's risk of harm as appropriate, according to JP's licence conditions.

9.40 Whilst the chronology developed by FM does identify some limited sharing of information between agencies, primarily the NHS and the probation service, this was on an ad-hoc basis. The review did not find any evidence of formal multi-agency information sharing, risk assessment or risk management planning relating to JP.

Commentary:

C.61 Although the review team have been unable to interview one of the supervising probation service staff, it is considered that the lack of effective information sharing between the private probation company and mental health services meant that JP's risk assessment on release, classifying him as medium risk of serious harm to the public, was not revised. He may otherwise have been assessed at a higher risk with his supervision switched from the private company to the national probation service, who would have had better access to forensic services to support JP's needs.

C.62 The review questions whether the assessment carried out in August 2019 was sufficient. Clinical notes from JP's time in prison (HMP A) showed that although JP was responding well to psychological support, he was anxious that on his release, it could take up to six months for him to receive psychology support whilst in the community. If JP had been asked to complete the self-assessment section of this assessment he might have shared these anxieties. Further, it did not appear to have taken full account of JP's offending and mental health history from earlier OASys records.

C.63 The review team also notes a lack of formal information sharing between three agencies involved in JP's care: the probation service, the prison psychology service provided by primary care, and the secondary mental health services provided by the Trust. There is an opportunity from this review that these agencies work together to establish processes for sharing appropriate information that can inform better informed risk management and care planning for someone with JP's risk profile.

C.64 Whilst probation services are no longer provided by private companies as from May 2021, the local probation service should assure itself that staff are able to obtain relevant mental health information to support their risk assessment and offender management process. This should include a review of existing information sharing protocols with the relevant mental health providers, and thorough review of all previous records held by the HM Prison and Probation service.

Investigation and learning from incidents

9.41 The review considered the Trust's Incident Policy (Including the Management of Serious Incidents), 2016 in place at the time of the investigation. The Trust policy is supported by a series of what are termed: Incident Policy Practice Guidance Notes. Relevant to this review are:

- Investigation of Incidents – V02, Issue 4 – January 2012

- Learning Lessons from Incidents and Near Misses – V04, Issue 3 – April 2019.

9.42 The policy contains the definition of homicide by a person in receipt of mental health care within the recent past, in line with the 2015 National Serious Incident Framework. Reviewers noted that it does not however define the three levels of investigation as described in the framework. This should include a definition of when an independent or externally led investigation might be considered.

9.43 Providing practice guidance notes for staff to support them in the application of Trust policy is seen as good practice. Providing information in this way can help busy members of staff focus on the practical elements of delivering an investigation and reduce the risk of misinterpretation of more lengthy policy documents.

9.44 The policy states that investigations are communicated to the Trust Board of Directors via monthly reports relating to safer care, which outline the activity for the last period, acknowledging the systems and processes in place within the Trust, and an update around increases or decreases to specific Serious Incident activity over the last quarter. The policy contains the definition of homicide by a person in receipt of mental health care within the recent past, in line with the 2015 Serious Incident Framework. It does not however define the three levels of investigation as described in the framework. This should include a definition of when an independent or externally led investigation might be considered.

9.45 The review team found some inconsistency between the Trust's incident policy and its guidance documents regarding the timeframes for investigating and reporting on serious incidents, which could lead to misunderstanding. The Trust's policy does not include reference to timeframes for the completion of serious incident investigations.

9.46 The Learning Lessons from Incidents and Near Misses guidance note (2019) states:

> 'Within 60 working days of serious incidents being investigated they are presented to the serious incident panel and any learning, reflection is shared with the Locality Care Group Directors, senior clinicians and the service involved. The Associate Director will action any improvements and share with the team or wider within Clinical Services through their established learning systems.'

9.47 The Investigation of Incidents Guidance Note (2012) used by the investigating officer, and referenced in the report, states however that a final draft of the investigation report is to be submitted for quality check within 25 working days, with the final version signed off at 30 working days. According to this note, all actions should be completed within 60 working days, which is contrary to the National Framework, 2015. It states the Associate Director will action any improvements and share with the team or wider within clinical services through their established learning systems.

9.48 The Learning Lessons from Incidents and Near Misses Guidance Note (2019) states that it is designed to support an effective organisational learning culture through a robust reporting and investigating process that supports staff. It captures the processes in place to aid this at all levels within the Trust. It provides a visual representation that explains the processes for sharing, reporting and learning activity associated with incidents and complaints. It includes reporting to the board of directors as part of the cycle of Board Safety Reports.

Commentary:

C.65 The use of supporting practice guidance notes is seen as good practice in terms of supporting staff to enact Trust policy in a practical manner, and reducing the risk of it being misinterpreted. The Trust should ensure however that its policy and supporting practice guidance notes are aligned, consistent, reflect up-to-date national guidance, and include the following:

- Clear instructions for the reporting and investigation of homicides by a person in receipt of mental health care within the recent past.
- Consistent timeframes for the conclusion of investigations following Serious Incidents i.e., currently 60 working days as set out in the 2015 Serious Incident Framework.
- Explanation of the three levels of Serious Incident investigation, and the criteria to be used in selecting the level most appropriate.
- A clear definition of when an independent or externally led investigation might be considered.
- How it plans to utilise external contractors to undertake Serious Incident investigations, and what their status is in terms of independence.
- Ensure that all those undertaking investigations have access to clear, up to date and consistent guidance.

Section 10: Conclusion

10.1 This review has examined the key lines of enquiry required from FM's ToR which can be summarised as follows:

- undertake a desktop review of the internal investigation into the care and treatment of JP undertaken by the Trust
- determine whether the internal investigation key lines of enquiry into the care and treatment of JP were adequately considered and explored, highlighting any areas requiring further examination
- undertake a review of the referral pathway, with a focus on learning, to consider issues pertaining to delays in the processing of referrals and the impact of delays on assessments and potential interventions
- consider any wider commissioning issues concerning referral processes between the probation service and the forensic service.

10.2 This report explores each of these lines of enquiry, analysing the review findings and capturing opportunities for learning and improvement throughout

in its commentary at the conclusion of each section. In conclusion, this section summarises those findings and learning points. Sustainable and measurable recommendations will be developed in consultation with key stakeholders.

10.3 The purpose of a good Serious Incident investigation is to enable an organisation to understand where it has gaps or weaknesses within its delivery of services so that they can be rectified. It is important that Trusts update their operational approach to Serious Incident investigation when the national approach changes.

10.4 The review found a number of issues with the approach the Trust had taken to investigate the homicide. For example, how the ToR were developed and the approvals process was unclear. The review noted that families and key stakeholders such as JP's GP, the probation service, and commissioners did not contribute to this process.

10.5 The recommendations and actions from the Trust's investigation lacked clarity and did not address some of the investigation findings. The potential impact of actions was assessed as being low. Recommendations were not developed in collaboration with key stakeholders and actions were not SMART. It was unclear how the completion of actions would be validated.

10.6 Clinical review showed that the quality of risk assessments and contingency plans for JP did not reflect his presenting risks or long history with mental health services, regardless of the intermittent nature of this history. The increased risk to JP and others during his long wait for forensic referral and treatment from the community team from October 2019 to June 2020 did not trigger care plans or risk management plans.

10.7 Further, risk assessments did not consider JP's formal diagnosis of ASPD in 2009. At no point was an ASPD treatment pathway considered for JP, meaning that some of his needs and associated risks will not have been properly considered over a period of more than ten years. Recognition of this diagnosis could have had a significant impact on the Trust's response to and management of JP. For example, staff should have considered the NICE guidance for the management of ASPD (NICE clinical guideline CG77) and the potential impact of this on JP's risk of violence or future offending.

10.8 The absence of appropriate information sharing between the agencies working with JP was a contributing factor in this incident. For example, the community team following up on the recommendation to JP's Probation Officer for a referral to forensic services may have resulted in quicker care and treatment for JP.

10.9 The lack of clarity regarding the referral process between community and forensic services and the delay in processing JP's referral to the CMHT, made by his GP in March 2020, were concerning. Both issues resulted in significant delays to care planning, risk management and treatment.

10.10 The objective of strengthening the Trust's quality assurance is to generate improvement in all of these areas. Learning from this case demonstrates that the assessment of patients' risk to self and others, and patterns of violent

behaviour, need to be comprehensively understood and well documented. The wider interagency sharing of information across public services such as the prison service, probation, social care, housing, mental health and NHS physical healthcare will support the development of well-informed and holistic risk assessments and ensure risk management can be enacted across all service user touch points with public services.

Section 11: Recommendations

The commissioners of this investigation, NHS England, will ensure that each of the individual and statutory agencies involved in the care and treatment of JP will develop (a) robust action plan(s) to address the recommendations outlined below.

Clinical risk management

R. 1 The Trust to assure itself that the approach to risk management of challenging patients is robust, and ensures that the use of genograms is considered on a case-by-case basis. The Trust to assess the quality of risk assessments, and to confirm if issues in relation to lack of crisis, contingency and safety management plans are isolated or systemic.

Clinical practice (Mental Health Act & Care Planning)

R. 2 The Trust to review how waiting lists can be more robustly managed and those services users who are identified with complex enhanced needs are allocated a care coordinator immediately, including review of access to forensic support and MDT working.

Safeguarding

R. 3 The Trust should ensure that all staff know how to identify and report safeguarding concerns when a patient has a forensic history and a potential for violence. This is so that the risks to family, carers and children with whom they live are properly considered and acted on to help keep them safe.

Cross-agency information sharing

R. 4 The Trust should ensure the robust application of existing mechanisms for sharing relevant information with known system partners to support the effective management of risks of harm to self and/or others across organisational boundaries.

System-wide MOU / Post incident Information sharing and cross agency working

R. 5 A system-wide information sharing agreement or memorandum of understanding to be put in place, to ensure that all agencies involved in the care, treatment or management of a service user are given the opportunity to contribute, and investigators have access to all relevant records.

Quality governance framework

R. 6 The Trust should consider developing a quality governance framework so that actions and learning arising from Serious Incidents and other adverse events result in measurable quality improvements. Quality governance frameworks capture how patient safety and patient experience intelligence from sources such as: serious incident investigation, incident themes and trends, complaints,

inquests, claims and quality improvement mechanisms including clinical audit connect with the wider Trust governance framework.

Section 12: Appendices

- Appendix one – Assurance review terms of reference (ToR)
- Appendix two - FM quality and assurance frameworks
- Appendix three - FM quality framework – investigation report
- Appendix four - FM assurance framework – action plan

Appendix one – Investigation Terms of Reference (ToR)

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

The Terms of Reference for independent review 2020/17295 are set by NHS England with input from the CCG and may be developed further in collaboration with the investigation company and family members however, the following terms of reference will apply.

Purpose

To determine whether the key lines of enquiry within the Trust's internal investigation into the care and treatment of JP, have been adequately considered and explored, highlighting any areas requiring further examination.

With a focus on learning undertake a review of the referral pathway, to consider issues pertaining to delays in the processing of referrals and the impact of delays on assessments and potential interventions.

Consider any wider commissioning issues concerning referral processes between the probation service and the forensic service.

Involvement of the affected family members and the perpetrator

In partnership with NHS England ensure that affected families understand the purpose of the review, its scope and process and are offered an opportunity to contribute, including developing the terms of reference.

Involve the families of both the victim and the service user as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations

Offer JP a minimum of two meetings, one to explain and contribute to the investigation process and the second to receive the report findings.

Scope of the desktop and pathway review

The independent review team will determine the historical context and identify significant periods of care provision relevant to the incident.

Taking into account the Trust's chronology of events, source and review relevant documents to develop a comprehensive chronology by which to review the internal investigation's findings against.

Critical analysis of the internal investigation's key lines of enquiry and whether these were relevant, adequately considered and explored, highlighting any areas requiring further investigation. The expectation of NHS England and NHS Improvement is that the following considerations will be included:

The gathering of additional information from appropriate personnel, where necessary.

The extent to which the Trust's internal investigation report recommendations were appropriate.

The review and assessment of compliance with local policies, national guidance, and where relevant statutory obligations.

Through review of the clinical records, assess the care and treatment received by JP including review of the adequacy of risk assessment, risk management and care planning.

Review of the appropriateness of the planned interventions of JP in light of identified health and or social care needs, identifying areas of good practice and opportunities for learning and areas where improvements to services are required.

Identify any gaps or omissions in care not adequately addressed within the investigation.

Constructively review the referral pathway for service users such as JP who have changing and complex needs, including the follow up arrangements, identifying gaps and potential opportunities for improvement and make appropriate recommendations for commissioners.

Deliverables

Provide an anonymised written report to NHS England that includes specific, measurable, achievable and realistic recommendations anchored within a delivery time frame. Explicitly identify expected outcomes required, to achieve a risk reduction.

The report should follow both the NHS England style and accessible information standards guide.

Provide a concise case summary and identify appropriate mechanisms to share the learning opportunities.

Support an NHS England facilitated action planning workshop to refine report recommendations, to ensure stakeholder engagement and ownership of actions required to deliver sustainable change.

Provide NHS England with a monthly update on progress, detailing actions taken, actions planned, family contact and any barriers to progressing the review.

Appendix two – Facere Melius Quality and Assurance Frameworks

Facere Melius Quality Framework

This framework is used to assess and RAG rate (Red, Amber, Green) the Trust's internal investigation report. The framework guides the reviewer to consider key points around the terms of reference, methodologies, findings and recommendations.

Facere Melius Assurance Framework

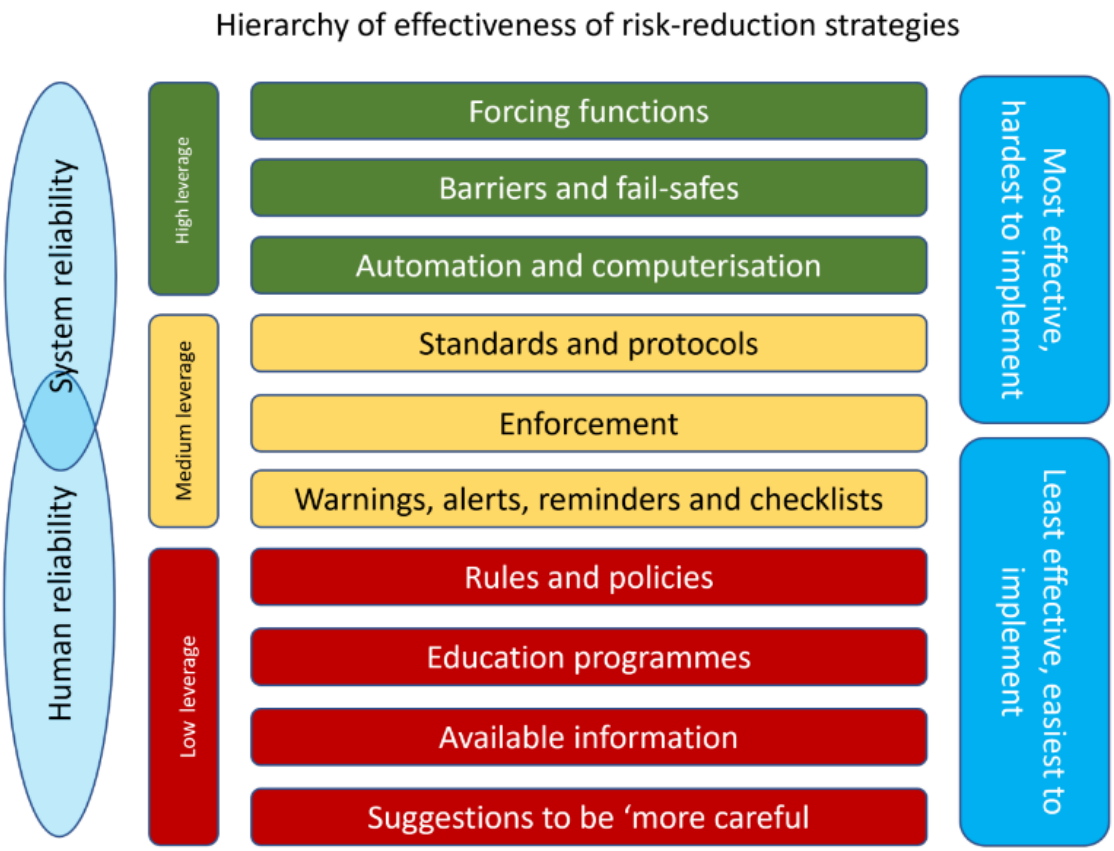
The FM assurance framework is used to review the quality and robustness of the action plan developed, focussing on establishing the adequacy of the findings, recommendations and the implementation of the action plan.

- Effectiveness of intervention
- Maturity of implementation
- Quality of assurance

This framework is based on the recognised international models of assurance

- Hierarchy of Effectiveness
- 4 Lines of Defence model

Effectiveness of Intervention	Maturity of implementation	Quality of assurance
Suggestions to be 'more careful'	No progress	No assurance
Available information	Basic level	Self control
Education programmes	Early progress	Management control
Rules and policies	Firm progress	Internal self-assessment, audit or review
Warnings, alerts, reminders and checklists	Results being achieved	Internal independent control
Enforcement	Maturity	Internal audit
Standards and protocols	Exemplar	External independent audit
Automation and computerisation		
Barriers and fail-safes		
Forcing functions		



[Adapted from the Institute for safe medication practices June 2020]

Appendix three – Facere Melius, Quality Assurance framework (investigation report)

Quality Assurance Framework– investigation report

Review of investigation report written by a mental health trust

Terms of reference	Rating	Narrative
Do they:		
• include time frames of treatment and care to be considered?	Red	The terms of reference (ToR) provided as part of the investigation report do not specify the timeframe for the care and treatment to be considered other than the circumstances surrounding and leading up to the incident. Without a clear time frame, the scope of the investigation required is unclear.
• list out all the stakeholders?	Red	The ToR do not state any stakeholders to be involved in the investigation. It would be good practice to name each provider service involved in the service user's care during the time frame for the investigation. In this case for example, the GP and the probation service. The review notes that the tabular timeline in appendix 3 of the report does give details of outside agencies involved in JP's care.
• state to identify missed opportunities and identify care or treatment issues?	Amber	The ToR request that the investigation comments on and considers the treatment and care of JP, but are not specific regarding the identification of missed opportunities or treatment issues. It does state to consider any learning for the Trust. Using clear wording in terms of reference that clearly describes what is required from an investigation can ensure that

		it is comprehensive, and in line with the national guidance in place at the time it was commissioned.
• analyse if policies, procedures, guidelines (local and national) have been applied	Amber	The ToR do ask to consider compliance with Trust policies and procedures. They do not refer to national policies, procedures and guidelines. The body of the report lists national guidance and research accessed by the investigator.
• include details of the governance process for the report	Red	The ToR do not refer to any governance process or monitoring for the completed investigation report, or how it will be quality reviewed, approved and learning shared. The report was reviewed by a senior member of the investigation team and an associate director from the Trust. The incident policy does not include a governance process for the monitoring, scrutiny and assurance of investigation reports, although within the policy is a list of responsibilities which includes the groups for sharing and monitoring.
• describe how the report will be shared with the family?	Red	The ToR do include the need to attempt to obtain the views of the family and significant others in order to identify learning, although within the report the authors explains other arrests made and that there were no other identified carers/relatives. This is incorrect as JP spent time with his parent, who was considered a protective factor, as stated in his clinical notes on 1 June 2020. It is not stated how the investigation report or findings will be shared with the family. The Trust's policy ([The

		Trust] Being Open – Fulfilling our Duty of Candour – V04) sets out the expectation that families will be told how the incident is to be investigated and how they can expect to be kept informed.
Have they been co-produced with		
• the family?	Red	The family were not contacted for the reasons above which is not in line with the expectations of the National NHS Serious Incident Framework 2015.
• the commissioners of the service?	Red	The ToR do not state if they were constructed in collaboration with the Trust's commissioners.
• key stakeholders?	Red	The ToR do not state if they were constructed in collaboration with any other stakeholders.

Report Authors	Rating	Narrative
• Do the authors have the right qualifications?	Red	The report does not state any information or biography of either of the report authors therefore it is not possible to understand what qualifications they possessed. The NHS Serious Incident Framework 2015 states the importance that investigators have the appropriate skills and competencies required to undertake each investigation.
• Have the authors been trained in investigation techniques?	Red	The report does not give information as to the investigators' training. The NHS Serious Incident Framework 2015 states for investigating teams to have relevant skills and competencies. See previous comment.
• Have conflicts of interest been considered or registered?	Red	There is no mention within the report of any conflicts registered by the investigators.

• Do they have the right clinical experience required to make the judgements required?	Red	The report does not state the clinical experience of the investigators. NHS Serious Incident Framework 2015 states for investigating teams to have relevant skills and competencies.

Methodology	Rating	Narrative
Do they:		
• consider a full chronology of events from all stakeholders?	Amber	The ToR are specific in stating the need to compile a chronology of events. The report has a limited tabular timeline as appendix 3 giving a brief outline of events from 1998 of the care given from the Trust to JP each time he was released from prison. There are referrals from the GP mentioned and discussions with his Probation Officer who are stakeholders. The timeline is brief in detail and is not considered a full chronology of care and contact with the service user.
• give due consideration to stakeholders who have not engaged?	Red	The ToR do not give the investigators the guidance or lead to access information from other stakeholders, such as the probation team.
• the tools and techniques that have been used during the investigation?	Amber	The report gives a list of evidence and information gathered and lists the contributory factors framework applied to the investigation completed. It does not state whether a specific method was used, for example fishbone diagram. The report does describe some of the tools/techniques used for the investigation: • interviews • reviewing clinical records • investigation review meetings

		There is however no explicit reference to the following: • evidence gathering • service mapping • using standard root cause analysis tools and techniques such as fishbone analysis to identify service and care delivery problems, lapses, acts and omissions in care • tools to analyse contributory factors/root causes and fundamental issues
• engage with the families of both victim and perpetrator?	Red	The family of both victim or perpetrator were not contacted to engage with the investigation process due to 'no other family being identified', although within the records it is clear from the clinical notes, his parent was involved in his care. There is no mention of the victim's family within the report. CQC regulation 20: Duty of Candour does state that family/carers of both victim and perpetrators should be offered the opportunity to engage in the investigation process. NHS Serious Incident Framework 2015 requires investigating teams to ensure that families/carers/patient/service users should be involved.

Findings	Rating	Narrative
Do the findings:		
• identify any contributory or human factors and from both missed opportunities?	Amber	The Trust report identifies a number of contributory factors/systems and human factors with the care and treatment of the patient, however these were not explored in any depth. Namely: delays in referrals being processed within SPA, referral into the forensic/probation service, no follow up with Probation Officers for referral into forensic psychological services, no documented follow-ups for unsuccessful contact. The author does indicate that there were missed opportunities in 2019 when the patient would have benefited from a forensic referral being made, also requested by his GP in March 2020, along with the difficulties in accessing forensic services. The probation service was not approached by the investigating team. Although the above points were identified, there was no clear analysis or description of contributory or human factors stated clearly within the report. The report does not refer to the missed opportunity to consider JP's personality disorder diagnosis when making decisions on the appropriateness of his treatment and management.
• Identify governance issues?	Red	The report does state there are a number of additional findings that predominantly relate to general recording in the clinical notes, updating assessments, management plans, and not following Trust policy.

		There is no mention of monitoring of systems and processes within the Trust and no indication of audit plans.

Recommendations and the report	Rating	Narrative
Do the recommendations:		
• align to the findings?	Red	The report author identified four recommendations and then identifies additional learning which are not incorporated within those four. In reading the additional learning section of the report, it is clear that there are six more areas of learning that could have been incorporated into the action plan: 1. Managing attendance of clients who do not engage 2. Reviewing the referral process within the SPA system/process to ensure referrals are managed swiftly and appropriately. To incorporate a monitoring system to ensure referrals are not missed 3. Ensure referrals to the CTT's are reviewed, assessed and actioned appropriately 4. Ensure complex cases are discussed at SPA multi-disciplinary meetings for future planning and management 5. Ensure the crisis teams review and link in with CTT to ensure information is collated correctly, specifically regarding the forensic services pathways for complex patients

		6. Ensure all information of contact or attempted/no contact is recorded within clinical notes
• have high impact and proportionate actions?	Red	The recommendations were considered low impact within the report, although they have highlighted the need for a more streamlined referral process to access community mental health teams and to promote joint team working among practitioners, which would give more robust assessment and management plans specifically for complex patients. However, having not included the learning points identified above has limited the Trust's opportunities to effect comprehensive transformation and change. The Trust did not accept all of the report recommendations and therefore the actions developed by them and captured in their action plan did not fully align to and address the report findings.
• where appropriate, consider local and national changes from both a commissioner and provider perspective?	Red	The report and recommendations do not consider the impact of the incident and investigation on the need to consider the need for changes to local or national policy or approach; this needs to be explored further to ensure the learning from this incident is exploited system-wide. The report recommendations highlighted the need for probation referrals to be streamlined and clearer pathways for teams to access for their forensic patients. This service was being provided by a private provider and could not be accessed by them. The author has requested this to be shared with the Justice Health Commissioners. The probation service were not

		approached to be involved in the investigation as a key stakeholder.
• describe the desired impact?	Red	The recommendations made do not sufficiently describe their desired impact in a way that could be effectively measured, monitored, or lead to effective ongoing assurance of their implementation.
• Have the recommendations been co-produced with the target audience?	Red	The report does not state that the recommendations have been produced in collaboration with the mental health service teams expected to deliver the changes. As commented earlier, the Trust did not accept the recommendations in their entirety when developing their action plan.
• Does the report describe how learning will be shared and how the impact will be assessed?	Red	The report does not explain how learning will be achieved or how it will be assessed as having been embedded into clinical practice. There is no method of future monitoring to assess the impact of the changes arising from the actions implemented. The report does not comment on how the learning will be shared across the Trust or other services other than in recommendation 4, requesting that the findings are shared with Justice Health Commissioners. The Trust policy (Learning Lessons from Incidents and Near Misses– V.04) clearly states the sharing or learning process, although it does not state how the changes to practice will be monitored to ensure they are embedded.

Appendix four – Facere Melius, Assurance framework (action plan)

Assurance Framework – Action Plan

Review of Action Plan produced by a mental health trust

Recommendation one	**Report recommendation one:** The referral process should be streamlined and efficient to prevent delays in the assessment process. **Trust action 1.1**: The CTT to receive guidance on which referrals may be supported by the Forensic CMHT in order to understand whether a referral may actually reach the criteria for the Forensic Community Mental Health service. To be achieved through the establishment of a forensic forum/clinic. **Trust action 1.2**: Referral actions to be followed up and documented accordingly and process for monitoring and follow up developed within the service. To be achieved through the review of the Single Point of Referral process.		
	RAG rating	**Narrative**	**Evidence submitted**
Effectiveness of intervention	No Progress	The Trust did not provide evidence to confirm that the forensic forum had been established and has been effective in delivering this guidance. The SPA pathway document provided sets out the arrangements as at September 2020, and was annotated to show proposed changes. The version of the document seen was incomplete and therefore it was not possible to assess its effectiveness. It was not possible for the review team to establish the effectiveness of these actions from the evidence provided.	• Forensic Forum - terms of reference - undated • Local CTT single point of access (SPA)pathway as at September 2020 - incomplete draft document Evidence gaps: • Forensic forum minutes and actions • Referral meeting minutes and template

Maturity of implementation	Basic Level	Based on the difference between the report and the action plan the Trust did not agree with the recommendations made and felt the actions related to referrals to the forensic services within probation and needed clear guidelines on how to manage that. The Trust therefore changed the actions as described above. The forensic forum was initially launched with very limited attendance and no evidence was provided to the review team to show that it had been properly established and its work had continued. As previously explained, the SPA pathway document provided as evidence was incomplete.	• Interview with Clinical Lead on 27 September 2022 • Forensic Forum - terms of reference - undated • Forensic Community Team referral form • The Trust Offender Personality Disorder Pathway Community Intervention Service information leaflet • Local CTT SPA pathway as at September 2020 - incomplete draft document • Managing Attendance at Appointments Evidence gaps: • Forensic forum minutes and actions • Referral meeting minutes and template
Quality of assurance	No Progress	No assurance evidence was obtained to understand how any actions taken by the Trust have impacted on the quality of service provision or how this is scrutinised through the Trust's assurance systems and processes	Evidence gaps: • Forensic forum minutes • Local CTT SPA pathway as at September 2020 - incomplete draft document • Referral meeting minutes and template
Recommendation two	**Report recommendations two and three:** Referral actions to be followed up and documented accordingly and missed contacts to have planned follow up appointments. The investigation report considers these two recommendations to be interlinked and should result in a review of current processes is undertaken which will assist in identifying areas for further development. **The Trust's action 1.2** (above) corresponds with the report recommendation two The Trust's action plan does not include a response to the recommendation for missed contacts to have planned follow up appointments		
	RAG rating	**Narrative**	**Evidence submitted**

Effectiveness of intervention	No Progress	The Trust has not followed the investigator's recommendations and has taken one action for referrals to be date stamped with no mention of the disengagement being reflected upon and addressed. The only relevant evidence provided was notes of the local CTT business meeting where staff have been reminded to follow the Trust DNA policy when service users fail to attend two consecutive appointments. This would not have changed the response to JP's scheduled telephone appointment as this was the first time he had failed to respond to a call.	• Interview with Head of Clinical Risk & Investigations on 13 September 2022 • Community Treatment team Business meeting minutes • Email from Pathway Manager confirming email to administration staff to remind them to date stamp all correspondence. Evidence gaps: • No review of disengagement and follow up • No evidence of how the referrals are monitored when received, placed into the system RIO etc. • No staff feedback • No patient feedback
Maturity of implementation	No progress	The Trust either interpreted incorrectly or re-wrote the recommendations made, and felt the actions related to referrals to the Community Treatment Team (CTT). They stated in their action plan: 'The review highlighted some internal processes to be corrected. The referral letter was not date stamped for when the CTT received it but was actioned immediately, as the GP had dated the letter'. The report states: significant delay in the referral being processed from date of GP referral 27/03/2020 to 11/05/2020 when the referral was uploaded onto Single Point of Access system.	• Interview with Head of Clinical Risk & Investigations on 13 September 2022 • Community Treatment team Business meeting minutes • Email from Pathway Manager confirming email to administration staff to remind them to date stamp all correspondence. • CTT SPA pathway as at September 2020 - incomplete draft document Evidence gaps: • No clear review of pathways/referrals into the Single Point of Access process • No review of disengagement and follow up • No evidence of how the referrals are monitored when received, placed into the system RIO etc. • No staff feedback • No patient or carer feedback

		The report states 'no documented follow up contacts for the unsuccessful contacts from the CTT after 27 August 2020'. The Trust has not provided adequate evidence of a review of referral/pathway processes or documented follow-up contacts for unsuccessful contact with patients.	
Quality of assurance	No Progress	The Trust has not provided evidence to understand how the effectiveness of the changes to the services for referrals into the service or the process of disengagement review is having on the services or how the group is scrutinised through the Trust's assurance systems.	Evidence gaps: • No review of disengagement and follow up • No evidence of how the referrals are monitored when received, placed into the system RIO etc. • No staff feedback • No patient or carer feedback
Recommendation four	**Recommendation four:** The review highlighted that only certain parts of the Community Justice services, namely the National Probation Service, may currently refer into Forensic Community Mental Health Services **Trust action 3:** Clinical Risk and Investigations Department to share learning from this review with Justice Health Commissioners		
	RAG rating	**Narrative**	**Evidence submitted**
Effectiveness of intervention	Automation & computerisation	The Trust gave evidence that fulfilled the role of sharing the learning with the Health and Justice commissioners.	• Interview with Head of Clinical Risk & Investigations on 13 September 2022
Maturity of implementation	Maturity	The Trust provided the email from the Head of Clinical Risk & Investigations to the Health and Justice Commissioners, dated 1 November 2021. The investigation report is dated 22 March 2021. Issue now irrelevant as the CRC do not provide probation services, HMP Probation took over the full service from May 2021	• Interview with Head of Clinical Risk & Investigations on 13 September 2022 • Email to Health & Justice commissioners dated 1 November 2021 • Response from Health & justice offering a call, dated 10 November 2021. • Email correspondence in September 2022, following up previous emails.

Quality of assurance	Internal independent control	The Trust gave evidence that fulfilled the role of sharing the learning with the Health and Justice commissioners, although follow up response was not completed.	• Interview with Head of Clinical Risk & Investigations on 13 September 2022

Section 13: Glossary

Acquisitive offending / crime
Acquisitive crime is defined as an offence where the offender derives material gain from the crime. Examples include shoplifting, burglary, theft, and robbery.

After Action Review (AAR)
An After Action Review (AAR) is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future *(see references).*

Community Treatment Team (CTT)
This team provides assessment and treatment by a multi-disciplinary team. The team provides a specialist service for men and women between the ages of 18 and 65 years who experience severe complex mental health difficulties and require a period of assessment and treatment. Referrals are accepted from care coordinators, GPs, primary care mental health teams, local authorities or specialist mental health services. Referrals are made through the single point of access.

Crisis Revolution and Home Treatment Team
The Crisis Resolution and Home Treatment Team is a multidisciplinary team that offers assessment and home treatment for people over 16 experiencing a mental health crisis as an alternative to hospital admission. The team operates across a set geographical area 24 hours per day, 7 days per week. Referrals are accepted from care coordinators, GPs, Primary Care Mental Health Teams, specialist Mental Health Services, and self-referrals.

Forensic Community Services
The Forensic Community Team operates as a community-based mental health service. The service has the ability to utilise the expertise of Forensic Psychology when needed. The primary objective of the team is to minimise the risks posed to the public by individuals suffering from significant mental illnesses. This encompasses individuals who have been evaluated and identified as potentially harmful, requiring further assessment, ongoing psychiatric evaluation, formulation, and treatment.

The team endeavours to enhance the mental well-being of these individuals and enhance their overall quality of life. Furthermore, the service aims to educate other professionals on assessing and managing the risk of harm to others.

In accordance with government policy, the Forensic Community Team also offers a care pathway for offenders with mental illnesses.

HM Probation Services
The probation services provide resettlement services to offenders whilst they are in prison, (anticipating their release into the community), they supervise individuals serving community orders imposed by a court and supervise those released from prison under license. In order to effectively protect the public, the Probation Service would be responsible for assessing the risk that offenders pose to the community and developing risk management plans to mitigate that risk.

Low Intensity Cognitive Behavioural Therapy
Low Intensity - Cognitive Behaviour Therapy (LI-CBT) is a form of self-guided help for those experiencing mild to moderate symptoms of depression and or anxiety, delivered by a Psychological Wellbeing Practitioner

Protective factors
Protective factors are often the converse of risk factors and include individual resilience; control and security (financial, housing etc.); meaningful activity including quality employment; participation and social networks. They may include individuals, families or communities that support resilience, help people more effectively manage stressful events, and strengthen other characteristics that minimise the risk of mental health *(see references).*

Single point of access (SPA)
Single point of access (SPA) is a process whereby referrals are received from professionals and discussed within individual CTTs, who in turn provide screening and triage, allocating referrals to appropriate trust care pathways or signposting onward to non-trust services.

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