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Investigation, Learning, Improvement

Independent Investigation into the Care and Treatment Received by Mr X at the Lancashire and South Cumbria NHS Foundation Trust

This report was commissioned by NHS England and NHS Improvement – North West Region

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1 Preface

1.1. The Independent Investigation was commissioned by NHS England and NHS Improvement North West Region to review the care and treatment provided to Mr X by the Lancashire and South Cumbria NHS Foundation Trust (The Trust). The Investigation was asked to examine a set of circumstances associated with the death of Ms Y who was found dead in her home in January 2019. The work was commissioned under the auspices of the NHS England National Serious Incident Framework (2015) and the Department of Health HSG (94) 27 guidance. The national ethos for Independent Investigations of this kind is to establish lessons for learning to facilitate service change and improvement in order to promote patient safety.

1.2. The purpose of an Independent Investigation is to review thoroughly the care and treatment received by the patient; this is to minimise the possibility of a reoccurrence of similar events by making recommendations for the future delivery of care incorporating what can be learnt from a robust analysis of the individual case.

1.3. The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals (and others in a position of responsibility working within the Trust and associated agencies) and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong to form a view of what should have happened based on hindsight, and the Independent Investigation Team has based its findings on the information available to relevant individuals and organisations at the time care and treatment was provided.

1.4. The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been investigated by an impartial and independent investigation team.

1.5. At the inception of the work it was agreed that the Independent Investigation would primarily be undertaken as a desktop analysis triangulated by meetings with the Trust, learning events, and high-level supplementary interviews.

1.6. The Independent Investigation terms of reference are provided as appendix 1.

2 Acknowledgements

The Family and Friends of Ms Y (the Victim of the Homicide)

2.1. It was not possible for the commissioners of the Independent Investigation to make contact with the family and friends of Ms Y. Work will continue to ensure they are consulted with and supported should they wish to engage with the Independent Investigation Team at some point in the future. Both the Independent Investigation Team and the commissioners of this report extend their sincere condolences to them.

Mr X and his Family

2.2. The Independent Investigation Team would like to thank Mr X, his family, and those who supported them throughout the investigation process. We are grateful for their honesty and courage – we trust that this investigation report addresses the issues that they raised with us.

The Trust

2.3. The Independent Investigation Team acknowledges the professionalism and courtesy extended throughout the investigation process by the Trust. We are grateful for their support and assistance and appreciate the enquiring minds, transparency and energy of the staff that we worked with.

3 Introduction

Background to the Independent Investigation

Concise Background for Mr X, Incident Description and Consequences

3.1. Mr X has had frequent contact with mental health services for most of his life commencing at a young age. Between 2014 and the autumn of 2018 he received regular and sustained care and treatment from community mental health services at the Lancashire and South Cumbria NHS Foundation Trust (the Trust); in addition he experienced brief contact with the Trust in 2010. Mr X has also spent significant periods of time in prison for serious physical assaults. Consequently, following his release from prison in 2014, he was placed on Multi-Agency Public Protection Arrangements (MAPPA) and was on license with Probation services until the spring of 2016.

3.2. During this time Mr X's care and treatment appears to have been open to some 13 different services and agencies. Between the spring of 2016 and the autumn of 2018 Mr X's care and treatment was provided by the Complex Care and Treatment Team (CCTT) which formed part of the

Trust's community mental health provision. For a number of years Mr X's diagnosis was provisional – that of Paranoid Personality Disorder. In 2016 a second opinion was requested by Mr X and the diagnoses of Paranoid Personality Disorder and Psychosis (not otherwise specified) were given. However the treating team continued with the diagnosis of Paranoid Personality Disorder.

3.3. In January 2019 Mr X went to the house of a female friend who he killed. The following day he was apprehended by the police, arrested and charged with murder. Consequently he was convicted of manslaughter and given a life sentence. He is currently detained in a high secure mental health hospital.

3.4. As part of Mr X's independent assessment for Court proceedings (and as a consequence of his being held in a high secure mental health facility) Mr X was given a diagnosis of Paranoid Schizophrenia. It was thought (by independent psychiatry opinions both for the defence and prosecution) that Mr X had been suffering from this illness for a number of years and that this made a significant contribution to him killing Ms Y.

Investigation Inception

3.5. Between November 2020 and March 2021 scoping meetings for the Independent Investigation took place. Initially consideration was given to the Independent Investigation being multi-agency in nature – but ultimately it was decided the work would focus on NHS inputs alone with the opportunity to share and discuss the findings with multi-agency partners at the end of the process.

3.6. Duncan and Johnstone Consultancy Ltd (D&J) was commissioned to undertake the work which commenced in April 2021.

3.7. Once the work started significant delays were incurred due to difficulties in locating and accessing the required clinical records. NHS (clinical) and Probation records (pertaining to Mr X's sentencing) were provided between May 2021 and March 2022. It is probable that a significant amount of information has still not been located – however the Independent Investigation Team are satisfied that sufficient documentation has been provided in order to yield useful findings, conclusions and recommendations to support improved patient safety and learning for the future. It should be noted that whilst Mr X was open to some 13 services and agencies over a period of four years the principle documentation supplied to the Independent Investigation Team came from the Trust and GP records; this was due to the nature of the Investigation commissioning process.

3.8. It was the decision of the commissioners that full anonymity is given to Mr X, all witnesses to the Investigation, and those who provided clinical care and treatment to him.

Prior Investigation Processes

Trust-Based Internal Serious Incident Report

3.9. In July 2020 the Trust completed an internal serious incident report which reviewed the care and treatment provided to Mr X. This report was shared with the Independent Investigation Team at the inception of the work.

Trust-Based Thematic Review Reports

3.10. During the summer and early autumn of 2020 the Trust commissioned two comprehensive thematic review reports for the Trust's Executive Team; these reports identified organisational learning. The first report considered 14 homicide cases (Mr X's case was included), and the second report considered 92 serious incident reports across the entire Trust service provision.

3.11. A significant number of themes and systemic issues were identified. The reports were shared with the Independent Investigation Team as part of the desktop review documentary analysis process. The two Trust reports identified a significant number of themes.

1. **Thematic Review of Homicides (30 July 2020):** The purpose of the report was to provide an update (and a thematic review) of homicide incidents that had occurred during the past four years involving Individuals known to Trust services. This report examined 14 homicide cases. The themes identified were as follows:

    - lack of engagement;
    - diagnostic issues;
    - poor interagency working (including communication issues);
    - resource issues;
    - inadequate care planning;
    - poor carer assessment, engagement and support.

2. **Contributory Factors Analysis from Serious Incident Investigations Conducted in 2019/20 & a Review of Homicide SI Recommendations from Four Years of SI Investigations (15 September 2020):** The purpose of the report was to provide information to the Trust Executive Team and to support organisational learning and improvement. This report examined a total of 92 serious incident investigations across the entire Trust provision (NB: approximately 60% of the incidents occurred within Mental Health Services). The themes identified were as follows:

    - impact of substance misuse;
    - care coordination;
    - referral and waiting times;

- recognition of deteriorating mental health;
- risk assessment and care planning;
- medication management;
- isolated/vulnerable service users;
- lack of crisis management planning;
- waits for Mental Health placement;
- access to IT to complete assessments;
- process for cancelling appointments;
- disengagement from service;
- not recognising or treating first episode psychosis;
- lack of Mental Health input.

Court-Based Reports

3.12. Two reports were prepared for the Court proceedings pertaining to Mr X's trial and sentencing. These reports detailed Mr X's full psychiatric history, mental health issues and diagnostic profile (past and present). These reports were shared with the Independent Investigation Team in February and March 2022.

Selection of the Independent Investigation Team

3.13. Duncan & Johnstone Consultancy Ltd appointed an investigation team to conduct the work. The team comprised individuals with the requisite knowledge and experience and who were (and continue to be) entirely independent of the Trust and all other services within the locality under review.

Independent Investigation Team

Dr Androulla Johnstone — Mental Health Nursing, Systems and Governance

Experience: Androulla Johnstone has 40 years of experience in mental health care and has a background in NHS clinical and operational service delivery as well as in strategic planning and commissioning. She has held two Executive Director of Nursing Board level positions in the NHS and retains her nurse registration. Androulla held the position of CEO of the Health and Social Care Advisory Service (an investigation body set up by the Secretary of State for Health and Social Care in 1969), and has been Chair of many independent investigation panels.

Androulla has:

- chaired and/or quality reviewed a total of 80 independent homicide (HSG (94)27) and unexpected death investigations;

- chaired the Jimmy Savile Stoke Mandeville Investigation (2015) into historic sexual abuse;
- chaired the Tawel Fan Investigation in North Wales (2018) which reviewed allegations of abuse and neglect in relation to 108 patients (overseen by Welsh Government);
- led/taken part in some 45 service reviews;
- led/taken part in several hundred internal investigation processes;
- led thematic reviews into mental health service user homicides and suicides.

Gillian Duncan — Safeguarding and Multi-Agency Working

Experience: Gill Duncan has 40 years experience of working in health and social care, with 20 years in senior management posts. Most recently, from 2008-2015, she was Director of Adult Services at Hampshire County Council prior to this she was Assistant Director for Older People in Hampshire and her first post with the council was Director of Residential and Nursing Services.
As part of her work Gill established a robust care governance framework for the service including incident reporting and links to safeguarding processes.

Prior to moving into social care, Gill was a Primary Care Trust Chief Executive and had been a Director of Nursing in a Mental Health and Community Trust. Alongside her extensive management and leadership experience she has a clinical background as a nurse, midwife and district nurse. Gill has extensive experience of service transformation, integration of health and social care and understands the challenges of leading and managing large and complex organisations. She was a member of the Prime Minster's Nursing and Care Quality Forum 2013-2014 and was an investigation panel member of the Tawel Fan Investigation in North Wales (2018) which reviewed allegations of abuse and neglect in relation to 108 patients.

Dr Peter Wood — Consultant Psychiatrist Advisor

Experience: Dr Wood is the Deputy Medical Director at the Avon and Wiltshire Partnership NHS Trust (AWP). He is a consultant forensic psychiatrist and has over twenty years of experience as a

consultant. He was Clinical Director for Secure Services at AWP between 2013 and 2017, is a Medical Member of the First Tier Tribunal Service (HESC) and is Health Examiner and Medical Supervisor for the General Medical Council. He is approved under the provisions of Section 12 (2) Mental Health Act (1983) and is a Member of the Royal College of Psychiatrists.

Dr Wood also has considerable knowledge and experience of all aspects of general psychiatry for adults of working age.

4 Investigation Method and Methodology

Method

Duty of Candour - Family Communication: Ms Y

4.1. Senior officers from NHS England and NHS Improvement North West Region were unable to make contact with the family of Ms Y. Efforts to make contact with them will continue.

Duty of Candour - Family Communication: Mr X

4.2. The family of Mr X was invited to take part in the investigation process. They were written to at the inception of the work by NHS England and NHS Improvement North West Region. Four virtual Microsoft Teams meetings were held with the family. The first meeting was chaired by the commissioners with members of the Independent Investigation Team present. The second and third meetings were held between members of the Independent Investigation Team and the family – these meetings provided the opportunity for the family to reflect on their experiences as carers, to provide information and to set questions for the Investigation Team to consider. The fourth meeting presented the family with the findings and conclusions of the Independent Investigation. This meeting was chaired by NHS England and NHS Improvement North West Region as part of its Duty of Candour responsibilities.

Duty of Candour - Communication with Mr X

4.3. NHS England and NHS Improvement North West Region wrote to Mr X informing him that an independent investigation had been commissioned to review his care and treatment with the Trust's mental health services.

4.4. Communication was established with Mr X with the support of his current treating team and solicitor. The Independent Investigation Team conducted three virtual meetings via Microsoft Teams with him. The first two meetings were to provide Mr X the opportunity to engage with the investigation process (which he was willing and able to do).On these occasions he was able to recount his experiences and to set questions for the Investigation Team to consider. The third meeting was to provide him with the findings and conclusions of the Independent Investigation. This meeting was chaired by NHS England and NHS Improvement North West Region as part of its Duty of Candour responsibilities.

Triangulation and Establishing the Evidence Base

4.5. The commissioners required the Independent Investigation be conducted as a desktop review. Whilst there can be significant limitations with this kind of approach the Independent Investigation Team is satisfied that a fair and transparent process was deployed which has yielded useful findings, conclusions and recommendations. However a desktop review is limited in scope and can only address the specific clinical issues relating to an individual as set out in the available documentation.

4.6. This Investigation was run in parallel with a detailed Care Pathway Review (also conducted by the D&J Independent Investigation Team). The Investigation and Review process was supported by a workshop (set up to examine the systemic issues relating to the care and treatment of five Service Users of which Mr X was one – each of the selected Service Users had similar case profiles and incident outcomes where members of the public were assaulted by them). Both the Independent Investigation and the Care Pathway Review were supported by high-level corporate interviews (examining the systemic issues across the aforementioned five cases) and clarification meetings. By interweaving the two processes (the Independent Investigation and the Care Pathway Review) it was possible to explore underlying systems issues and gain relevant insights about how the services that provided Mr X's care and treatment were managed and where areas for improvement needed to focus. This kind of process is in keeping with the new NHS England *Patient Safety Incident Response Framework* (2022). This Framework encourages an in-depth analysis to be taken that *"embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management".* It should be noted that the new framework moves away from the assignation of blame and the assignation of blame to individuals and focuses on how systems need to work better to provide safe and quality services.

4.7. The Independent Investigation Team worked with the Trust to identify workshop participants who represented a robust cross-section of the organisation from both a management and clinical perspective; of note several of the workshop and interview participants had either led (or worked on) the Trust-based Thematic Review work as mentioned in paragraphs 3.9, 3.10, 3.11); consequently they were well aware of the

issues requiring attention. The Trust also worked with the Independent Investigation Team to prepare the participants and to organise the topics for discussion. The post holders for the workshop and high-level interviews comprised the following:

1. Executive Director of Improvement & Compliance (interviews and planning meetings);
2. Deputy Medical Director - Consultant Forensic Psychiatrist (workshop and planning meetings)
3. Associate Director of Operations No 1 (interview only);
4. Associate Director of Operations No 2 (workshop only);
5. Associate Director of Operations No 3 (workshop only);
6. Service Manager Community Mental Health Teams and Home Treatment Teams (workshop only);
7. Consultant Psychiatrists of Adult Mental Health Services x4 (workshop only)
8. Consultant Psychiatrist of Forensic Services (workshop only);
9. Clinical Psychologist Adult Mental Health Services (workshop only);
10. Nurse Consultant Community (workshop only);
11. Nurse Consultant Inpatients (workshop only);
12. Head of Allied Health Professionals/Freedom to Speak Up Guardian (Workshop, interviews and planning meetings);
13. Occupational Therapy Consultant (workshop only);
14. Community Team Leaders x 2 (workshop only);
15. Registered Mental Nurses Community and Inpatient x 7 (workshop only)
16. Forensic Speciality Nurse (workshop only);
17. Head of Patient Safety (workshop, interviews and planning meetings);
18. Governance Manager (workshop only);
19. Governance Leads x 2 (workshop only);

4.8. Following the workshop the transcript of the event was made available and each participant was invited to reflect on the day and send any clarifications and further information to the Independent Investigation Team should they think it useful.

4.9. In the interests of fairness the Independent Investigation Team developed a reflective statement template for key witnesses to complete. However capacity pressures on Trust services due to COVID made this approach untenable. The Independent Investigation Team continued to work with the Trust to establish a fair and inclusive process that could yield triangulated evidence to develop robust findings and conclusions.

4.10. To this end a standards proforma was developed based on both local and national best practice policy guidance – the standards proforma was also used for the Care Pathway Review. This proforma was developed to provide an objective assessment of the care and treatment Mr X received from the Trust in a comprehensive and evidence-based manner. The use of the proforma provided a triangulation method to validate and support the workshop findings together with those from the analysis of the clinical

records. Triangulation was further supported by high-level corporate interviews. A blank standards proforma can be found as appendix 2.

4.11. In addition the Independent Investigation Team considered the findings of the Trust's serious incident report (see paragraph 3.8) together with the two thematic review reports commissioned internally for the Trust's Executive Team (see paragraphs 3.9, 3.10 and 3.11). There was a high degree of synergy between the Trust's thematic review reports and the findings of the Independent Investigation Team – this served to provide mutual validation and triangulation and supported an in-depth systems-review approach.

4.12. To summarise: the Independent Investigation Team worked in a traditional manner at the outset; reading the available records and developing a detailed chronology. As interviews and reflective statements were not possible means to explore and test emerging issues with Mr X's treating team, the standards proforma was developed and a workshop opportunity provided to verify and test findings, and to gain deeper insights into how community services worked. A systems approach was taken in keeping with the new NHS England *Patient Safety Incident Response Framework* (2022).

Factual Accuracy - Scott and Salmon Processes

4.13. A desktop review is limited to the documentation available. When witnesses from a service user's treating team/s cannot be called to interview, discretion has to be taken when writing a report for the public domain. To this end the report focuses on relatively high-level findings and cannot examine in any detail the decisions and rationale behind the inputs of individual practitioners – instead a systems stance has to be taken.

4.14. The findings within this report are factual and evidence-based with the assessment of care and treatment set against national and local best practice expectations. The Independent Investigation Team produced 100 pages of evidence during the examination of this case. This evidence is not published with this report to protect the privacy of Mr X – but was made available to the Trust, the commissioners and for legal review. This evidence comprised:

- a paginated and referenced clinical chronology based upon the careful examination the clinical record; and
- a completed standards proforma against which Mr X's care and treatment was assessed.

4.15. Prior to the completion of the Independent Investigation the draft report was sent to the Trust for a factual accuracy evaluation. The Independent Investigation Team worked with the Trust to ensure that the findings and conclusions were triangulated and deemed to be a fair representation of the identified facts. Scott and Salmon compliance refers to national legal requirements when conducting investigations and inquiries (with particular

reference to when reports are destined to enter the public domain). Scott and Salmon compliant processes require that a fair, reasonable and transparent process is provided by an investigation or inquiry team. It should be noted here that this Independent Investigation Team was not commissioned to interview (or otherwise engage with) members of Mr X's treating teams. This means that any criticisms of specific practice could not be made in this report, instead (and in keeping with the new NHS England Framework) any areas of concern relating to individual practice were raised with the Trust directly for further examination and the commissioners duly notified.

Methodology

4.16. This investigation was commissioned under the previous NHS England Patient Safety Framework which required a Root Cause Analyses (RCA) approach to be taken. The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility. RCA is a four-stage process. This process is as follows:

1. **Data Collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, and evidence from other sources (e.g. workshops, high-level interviews and meetings in this case). A detailed chronology and evidence table is constructed.

2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected and a sequence of events is established. From this, causal factors, or (as in this case) critical issues and lessons for learning can be identified.

3. **Root Cause Identification.** The National Patient Safety Agency (as was) advocated the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the 'Decision Tree', the 'Five Whys' and the 'Fish Bone'. The Independent Investigation also used a detailed, evidence-based standards proforma to both examine and test findings.

4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

4.17. To complement the root cause analyses stance, a quality audit/evidence-based standards approach was taken in order to explore how Trust clinical systems operated; this to identify if any underlying issues were present. To this end a Quality Standards Proforma was developed. The proforma was developed using both local and national best practice policy guidance and focused upon the thematic areas of concern the Trust (and commissioners of this Investigation) had already identified. It also addressed key themes that the Independent Investigation Team found in addition.

Part Two

Background and Context Information

5 Lancashire and South Cumbria NHS Foundation Trust

Information about the Trust

5.1. The Trust was established in April 2002 as a mental health and learning disability provider and authorised as a Foundation Trust on 1 December 2007. On 1 June 2011 the Trust incorporated a range of community health and wellbeing services from neighbouring provider organisations, extending its portfolio to include a range of community-based services. On 1 October 2019 the Trust expanded its services. The Trust has an active Council of Governors comprising elected staff and public Governors and nominated partner Governors. The Council of Governors represents the views of the Trust's 7,000 public and staff members.

5.2. The Trust provides health and wellbeing services for a population of around 1.8 million people. The services provided include community nursing, health visiting and a range of therapy services. Wellbeing services include smoking cessation and healthy lifestyle services. The Trust specialises in secure, perinatal, inpatient and community mental health services, including services for children and young people and patients with learning disabilities. The Trust serves the whole of the Integrated Care System footprint and as of 31 March 2021 employed 6956 staff, with 1112 Bank staff, across more than 400 sites, working with a multitude of partners. Care and support is provided in a range of settings. Service provision is delivered to meet the physical and mental health needs of the local population. The Trust has 26 Care Quality Commission (CQC) registered locations.

Service Configuration

5.3. The Trust's Community Mental Health Team Standard Operating Procedure (2021) states that:

"This Procedure is based upon the following Values Based Model:

- *Quality care in the right place at the right time, every time. Robust assessment and triage*
- *One service, different functions – caring for the neighbourhood*
- *Recovery focused and enabling*
- *Responsive to service user and carer needs, in the least restrictive environment*
- *Consistency of care for service users and carers in line with the carers' strategy – not to put an undue burden on carers*
- *Based on good relationships of trust, respect and team working*
- *Strong GP relationships*

- *Safe*
- *Effective and efficient*
- *Caring and compassionate.*

We aim to follow these key principles:

- *To collaborate with service users in planning their care*
- *To involve families and carers in planning and delivery of care where appropriate*
- *To deliver high quality treatment and care which is known to be effective*
- *To be non-discriminatory*
- *To be accessible so that appropriate treatment can be obtained when and where it is needed; To promote the safety of service users and that of their carers and staff*
- *To offer choices which promote independence; and*
- *To empower and support our staff".*

5.4. The procedure also states that the community mental health team is an umbrella term for a range of adult mental health community-based functions and interventions that are delivered by a multi-professional team, consisting of nurses, occupational therapists, clinical psychologists, psychological therapists, psychiatrists, and health care support workers. The role of the community mental health team (CMHT) is to provide assessment and community-based interventions, which is undertaken in partnership with referred individuals and focusses on individual needs, self-determination and recovery.

5.5. The community mental health team supports and coordinates individual care planning that may involve the following services:

- access to accommodation and benefits advice;
- biological interventions;
- cognitive assessment (psychology and psychiatry);
- community care coordination and support;
- occupational therapy;
- peer support;
- psychiatry review and intervention;
- psychological intervention (individual or group or family or consultation) intensive psychological interventions for Borderline Personality Disorder;
- recovery group (occupational therapy) residential rehabilitation social care interventions;
- specialist assessments (e.g. Autism);
- support for families and carers (including carer support and/or contingency planning):
- vocational and employment advisors.

5.6. Mr X was eligible for CMHT services throughout the entire period of his care and treatment with the Trust.

6 Accounts and Experiences from Mr X and his Family

Account from Mr X

6.1. Mr X met with members of the Independent Investigation Team on two occasions to provide his contribution to the work. He approached the task in hand with dignity and courage. Quite simply he wanted the following questions to be addressed:

1. *"Who were all of the people and services involved in my care?"* Mr X found the service provision complicated and confusing – to this day he is not certain who everyone was and which services/agencies they worked for.

2. *"Why wasn't I given the correct diagnosis?"* Over the years Mr X is on record as repeatedly trying to get a diagnosis and to understand what this meant for him and his mental health state.

3. *"Why wasn't I listened to when I repeatedly tried to get help?"* Over the years Mr X is on record as repeatedly trying to access help and support – especially when paranoid and psychotic. On frequent occasions Mr X retained enough insight to know he was becoming a danger to those around him and promptly sought help which was often not forthcoming. Consequently he isolated himself at home necessitating a disengagement from mental health services.

Account from Mr X's Family

6.2. In addition to meeting with the Independent Investigation Team Mr X's family provided a written statement. The family experienced significant and sustained online 'trolling' following the homicide. They wanted to explain the impact of this combined with their frustration at what they perceived to be the poor standards of mental health care and treatment provided to Mr X between 2014 and the autumn of 2018.

6.3. The statement begins: *"Afraid is something we have felt for such a long time… long before that fateful day".* The family had not been able to see Mr X for approximately one year before the homicide due to his growing paranoia and fears for their safety; the whole family lived in fear. At this stage the family had lost their trust in mental health services – however they wrote an anonymous letter detailing their concerns (the Independent Investigation Team found a copy of the letter in Mr X's clinical record). The communication was written anonymously because the family was afraid of Mr X and what he would do to them should he be told by mental health

services who had sent the letter; at this stage the family had no confidence in services being able to keep them safe and so maintained their distance from him.

6.4. The family remained silent throughout the Court case out of respect for the Victim's family; they are acutely aware that the victim's family suffered and continues to suffer deeply *"there is a family out there that is suffering more than us as a consequence of … [Mr X's] actions".* However after careful reflection the family decided to engage with the Independent Investigation process because they had questions they wanted to have addressed. They are as follows:

1. *"Why was there such poor support when Mr X came out of prison?"* The family is of the view that a great deal was promised but in reality Probation and mental health services did not work well together.

2. *"Why was there no consideration for detention under the Mental Health Act (1983)?"* Mr X's partner and the family all felt afraid and helpless – there were many occasions when they thought his paranoia would lead to violence. It is on record that a Mental Health Act assessment was requested by Mr X's partner – but services declined to conduct one.

3. *"Why did it take so long for Mr X to get a valid diagnosis? Why did it take for him to commit a homicide before getting the diagnosis of Paranoid Schizophrenia?"*

4. *"As Mr X was not diagnosed appropriately over the years (prior to the homicide) did he receive the 'correct' care and treatment (including medication)?"* The family noted that now Mr X is being treated appropriately for this illness he has undergone a significant change for the better with his mental state and paranoia stabilising.

5. *"Could the 'correct' care and treatment have prevented the incident – or at least made it less likely to happen?"*

6. *"Why did the family receive no support?"* The family was at pains to say they do not want sympathy – but that they would *"like understanding and empathy of our plight in getting answers. Not only for us but for other families who may go through something similar… if the care that should have been provided to my brother is also not given to their loved one then history will unfortunately repeat itself – and that cannot and should not happen".*

6.5. The family reflected that Mr X was *"alone in the world"* and *"trapped in his own mind"*. They recalled the gentle and loving person that he was before his mental illness took him over – they are aware that two families have been devastated and will never recover fully. They want questions to be addressed and lessons to be learned.

Part Three
Internal Report Findings and Conclusions

7 Summary of the Trust's Internal Investigation Findings and Conclusions

Findings and Conclusions

Findings

7.1. There are few findings and conclusions considering the seriousness of the incident. They are as follows:

1. The care and treatment the Service User received was at or above the expected standard as defined by Trust policies and procedures at the time.

2. It was noted that the Service User *"had a long history of disengagement"* from mental health services. In view of this the quality of services received was considered together with the *"quality, safety and appropriateness of services attempts to engage the service user in accessing these services and maintaining and developing this engagement once it was achieved".* The investigation found there were no deficiencies in the care and treatment provided and that there were examples of good practice identified which were *"above that which was mandated by the policies and procedures in place at the time".*

3. Comprehensive psychiatric assessment reviews were completed when the Service User attended appointments *"… it was important that these were thorough. The review has found that the assessments were particularly thorough and comprehensive and informed and guided subsequent care planning, risk assessment and risk management. This was maintained in the face of antagonistic, hostile presentations by the service user during some of these reviews".* The report states that practice was consistent with the Care Programme Approach policy in place at the time care and treatment was delivered.

4. The Service User was provided with an evidence-based psychological therapy treatment – Cognitive Analytic Therapy (CAT) by a therapist from the Forensic In-reach Team. This was considered to be good practice.

5. Dynamic risk assessment, formulation and management were clear priorities in all practice and was consistently completed and recorded in keeping with policy expectation at the time. This was used to inform care planning.

7.2. No findings were identified where care and treatment fell below the standards required.

Conclusions

7.3. The care delivered to the Service User was found to be compliant with policies and procedures for *"the teams involved, based on a thorough review of all care records from March 2014 until the incident in January 2019".*

7.4. *"There were no care and service delivery problems identified. It was identified that services involved made assertive effort to engage and re-engage the service user in mental health services in the years leading up to the incident; nevertheless, the service user did not re-engage in the four months between his discharge from services and the incident".*

7.5. An area of good practice was identified regarding assertive attempts to engage with the Service User.

Feedback from the Independent Investigation

Feedback on the Internal Investigation Findings

7.6. The Independent Investigation Team could not determine how the Trust Lead Investigator developed the findings in the report – a great deal of the information provided is not correct; the Independent Investigation Team could not replicate the findings. Key information (such as Mr X's prison history and release on license) was presented in a confusing manner and did not appear to have been based on a factual and up-to-date chronology. Significant information written in the summer of 2018 referral documentation from the GP was left out – this created a misleading picture of Mr X's needs, presentation and risk at a pivotal time.

7.7. The report cites key reasons for Mr X's discharge from Trust services in September 2018 was due to disengagement and non-attendance. The report states that practice in relation to managing disengagement was above the standard to be expected – however the Independent Investigation Team notes that Trust policy states this is not a reason to discharge an individual who is eligible for CPA. Consequently the report appears to 'victim blame' the Service User for disengagement without exploring and understanding the significant reasons why this was an ongoing issue. It is also important to note that no assertive approach was taken to engage with Mr X during the summer and autumn of 2018 – despite his history being known to the treating team and despite advisory 'warnings' from the GP that Mr X would disengage without careful management.

7.8. It is possible that the Trust Lead Investigator had access to more detailed records than were made available to the Independent Investigation Team

– however from the records made available to us it is not possible to see how attempts to engage Mr X were made between late July 2018 and his discharge from services on 19 September 2018.

7.9. A close examination of the clinical record shows that reviews were neither comprehensive nor accurate over time. It is a fact that the clinical records were overly concise and risk assessment and care planning were often 'cut and paste' bearing little relation to Mr X's dynamic presentation and levels of risk. The internal investigation states that assessments were thorough – however the Independent Investigation Team could find little evidence to support this finding.

7.10. The internal investigation report states that Mr X received an evidence-based therapy (CAT). This was indeed the therapy of choice for a person with a diagnosed Personality Disorder; however Mr X did not appear to have received a robust diagnostic process over time – and he in fact had Paranoid Schizophrenia. This was something two independent experts stated in Court; they were of the view that Mr X had been suffering from this illness for a period of some years prior to the homicide taking place. So whilst the finding of CAT therapy was in itself correct (had Mr X had a Personality Disorder) the internal investigation did not appreciate the ongoing diagnostic ambiguity (as detailed in the clinical record) and the fact that Mr X did not receive an evidence-based care and treatment approach for Paranoid Schizophrenia.

7.11. The internal investigation made the finding that risk assessment, formulation and management were conducted in keeping with Trust policy expectation. The Independent Investigation Team could not replicate this finding. Risk management processes were not triggered when Mr X's presentation and/or risk changed. Most of the available documentation was 'cut and paste' and bore little relation to changes in Mr X's presentation. Risk assessments largely appear to have been based on an original assessment made in 2014 – and this was not updated in a meaningful way over time. Risk planning was virtually non-existent and did not address child safeguarding issues. Considering Mr X was subject to MAPPA (and on license with Probation services) risk assessments do not appear to have been multi-agency and neither did they address Mr X's dynamic and ongoing risk to others.

Feedback on the Internal Investigation Conclusions

7.12. The Independent Investigation Team could not replicate the evidence-base upon which the internal investigation conclusions were based.

Feedback on the Internal Investigation Process

7.13. The incident (the homicide of Ms Y) took place in January 2019. The report was completed 18 months after the incident – the Trust has not been able to explain why this was – however it would seem that the Service User was not receiving care and treatment from the Trust at the

time of the incident and it apparently took several months before the Trust was made aware of the homicide. This is unsatisfactory as Trust personnel assessed the Service User in a prison cell directly after the homicide – therefore the Trust should have been alerted to the homicide at this stage. The Trust explained the subsequent events as to why the internal investigation finally took place 18 months later; this was due to a significant backlog of Serious Incidents and this incident being triaged incorrectly. It is of note that the incident was reported to commissioners some 11 months after it took place – well outside of the required timeframe.

7.14. It would appear that the investigation was managed by a single practitioner with support from a Safety and Learning Review Specialist – this was not in keeping with Trust Policy for a serious incident of this kind.

7.15. A mental health related homicide is of the utmost seriousness; it would be usual for a Multidisciplinary Team to be constituted to undertake the investigation and it would also be usual for clinical witnesses to be called. This was not achieved. The Terms of Reference are of a poor standard and fall short of what would usually be expected for a case of this kind.

7.16. The Independent Investigation Team notes that the body of the internal investigation report focused on the last four months of Mr X's care and treatment with the Trust – this was a period during which he was not seen. Whilst the report states that the clinical record developed between March 2014 and September 2018 were considered *"carefully"* the Independent Investigation Team could see no evidence of this as numerous incorrect assumptions about Mr X (and his care and treatment) were made in the report which were factually incorrect. This was a lost opportunity for the Trust to identify significant learning in relation to its practice.

7.17. The internal investigation process in relation to Duty of Candour is not known as nothing was recorded in the report. It is of note that there was no investigation archive developed and no notes made of decisions taken. Members of the Independent Investigation Team discussed this with senior officers from the Trust. The Trust acknowledged that it did not discharge its Duty of Candour responsibilities and that the investigation process did not reach the standard to which it aspires.

Feedback on the Trust's Internal Investigation Process

7.18. The Independent Investigation Team found the Trust's Incident Policy to be well written and fit for purpose; the Trust has been implementing significant changes and improvements to its investigation process over the past three years. At the time the internal investigation report relating to Mr X's care and treatment was developed the new processes were still being embedded. It should also be taken into account that COVID challenges and restrictions were at their height during this time.

7.19. Across England internal investigation reports tend to focus on the six-month period prior to the incident occurring; in many cases only the few weeks directly prior to the incident are considered in depth. Often this is sufficient to identify key casual and contributory factors and areas for learning and service improvement. However the 60 day timeframe and the limits to the protected time for lead investigators means that (at times) a relatively superficial set of findings and conclusions are made; the risk of this occurring is heightened when a serious incident is investigated by a lone individual without the benefit of multidisciplinary inputs. Whilst this was the case for Mr X the Trust states that it looks at the 'relevant time period' in all complex cases with no *"cut off".*

7.20. The Independent Investigation Team recognises that Trust Lead Investigators can only spend a limited amount of time on each case and that the subsequent findings (and any consequent thematic reviews which are now an increasing requirement of NHS England/Improvement) will also be limited. Key points for the Trust to consider are as follows:

- the need for more robust and detailed Terms of Reference that address basic building blocks of care (this to support systems learning);
- the need for internal investigation processes to be supported by appropriate investigation teams and not lone individuals (in keeping with Trust policy);
- that detailed internal investigation archives are kept detailing method (a sensible requirement for Inquests and future Independent Investigation processes);
- serious cases (such as service user-perpetrated assault and homicide), should involve clinical witnesses from treating teams to aid clarity and to increase learning;
- internal investigation reports should detail how the treating teams under investigation have investigation findings fed back to them (the Independent Investigation Team could not understand how this was achieved);
- investigation reports should detail how recommendations have been developed and with whom.

7.21. The Trust should have an agreed and consistent approach to Duty of Candour in relation to the involvement and support of service users, families and the victims of any assault/homicide. The Independent Investigation Team was able to ascertain that at present there is no such approach and that investigation practice does not always take into account national best practice guidance.

Part Four

Independent Investigation: Findings and Conclusions

8 Concise Chronology

Background for Mr X

8.1. Mr X was born in 1979 and adopted at six days. He was of mixed ethnic origin and placed with a white family. Mr X had a troubled childhood despite his loving home; this required inputs from mental health services and led to him being placed in care for a number of years. Mr X had a brief period of time in the army which culminated in a dishonourable discharge and time in prison for assault. Moving forward Mr X made many attempts to establish himself in the community but went on to spend a number of years in prison (on and off), once again for serious assault and wounding. He was released from prison on license in 2014 and was subject to Multi-Agency Public Protection Arrangements (MAPPA) level 2. Mr X has only lived in the community for approximately five years of his adult life. He is now aged 43.

8.2. Following Mr X's release from prison in 2014 he received care and treatment from the Trust. Mr X's time with the Trust was marked by a degree of diagnostic ambiguity (his provisional diagnosis was Paranoid Personality Disorder) which led him to losing trust and confidence in the services provided.

8.3. Ultimately Mr X's mental health deteriorated. He made attempts to seek help but his paranoia and lack of trust led him to ultimately disengage from services. In January 2019 Mr X went to Ms Y's house (who was a friend of his) with a hammer and killed her. He was found guilty of manslaughter by virtue of his deteriorated mental health. Following the homicide of Ms Y Mr X was found to have Paranoid Schizophrenia; an illness he was estimated to have been suffering from (undiagnosed) for a number of years.

Issues Regarding the Development of the Chronology

8.4. This is a complex case. It should be noted that from the clinical records available Mr X was open to the following services between 2014 and September 2018 (the degree of overlap remains unclear):

1. Revolution Service (Lancashire Integration Offender Management Programme).
2. Burnley and Pendle Crisis Resolution and Home Treatment Team.
3. Burnley and Pendle Complex Care and Treatment Team (CMHT).
4. Probation Services.
5. General Practice.
6. Social Services.
7. Floating Support Services (Calico).

8. Forensic Offender Personality Disorder Services.
9. Housing.
10. Inspire (alcohol and substance misuse service).
11. Burnley and Pendle Assessment and Treatment Team.
12. Pendle Primary Mental health Team.
13. East Lancs Recovery Team.
14. Multi-Agency Public Protection Arrangements (whilst MAPPA is not a service it is listed here to illustrate the complexity of inputs Mr X was subject to /received).

8.5. The Independent Investigation Team was able to access clinical records from the Trust and General Practice; however it would appear that these records were not complete. It was not possible to access records from external agencies (such as Housing, Social Services and the Police-led Revolution Service). Limited information (in the form of Court reports) were made available from the Probation Service – but it should be noted that Trust-generated Forensic Services records could not be accessed due to them having been sent to Probation Services at some point in the past – now rendering them inaccessible to the Trust for the purposes of this Investigation.

8.6. The Independent Investigation Team is aware that the following chronology may not capture a complete picture of the care and treatment Mr X received and how the disparate services and agencies worked together to support this complex individual. It should be noted that Mr X was a recipient of the Care Programme Approach (CPA) from his acceptance on to the Complex Care and Treatment Team caseload in July 2015.

Date	Event
1979	Mr X was born.
1986 - 1995	Mr X received inputs for behavioural disturbance and was placed in care for the majority of this period of time.
1997	Mr X joined the army.
2000?	Mr X committed a violent assault and was sent to prison – he was dishonourably discharged from the army.
2001	A psychiatric report was prepared for the Court. No mental illness was diagnosed; neither was it thought Mr X had a Personality Disorder; it was noted he had anger control issues. The recommendation was that Mr X received psychotherapy in prison.
2002	Mr X was due to be released from prison. He had not received psychotherapy; and was referred by Probation Services to the Burnley Community Mental Health Team

	(CMHT) for an assessment and support to reduce the likelihood of him reoffending. It was recognised Mr X probably needed forensic service input but there was none available (the records available do not explain why).
2003/2004?	Mr X returned to prison.
May 2010	Mr X was released from prison on license. Prior to his release Probation Services had referred him to the Trust's forensic mental health team; he was placed on a waiting list. At this time Mr X had a diagnosis of Emotionally Unstable Personality Disorder. Mr X's GP referred him to the Pendle CMHT. Following assessment it was considered that he could be a significant risk to others with minimal provocation. The CMHT did not think they could offer him any support at this stage; however a referral to psychological services was made. It was noted that a safeguarding assessment had been undertaken due to Mr X having two young children; Social Services were involved.
December 2010	Mr X failed to respond to psychology services – unbeknownst to them Mr X had been returned to prison; there is nothing on record to explain the circumstances. No therapy was offered to Mr X whilst in prison.
24 February 2014	Mr X was released from prison on license (for a two-year period). It would appear Mr X was subject to Multi-Agency Pubic Protection Arrangements level 2 (MAPPA); there are scant records for this period.
June 2014	Mr X was referred to Community Personality Disorder Services (forensic service) by Probation; it was thought Mr X had an Anti-Social Personality Disorder. Mr X was subject to MAPPA and was also open to the Police Revolution Team. Ongoing child safeguarding issues were noted; Mr X was *"forbidden"* from seeing his two children. NB: it is not clear where his diagnosis originated from as it appears Mr X had no further psychiatric assessments since the 2001 report prepared for the Court.
July 2014	A risk assessment was undertaken by the Trust's forensic service. It was noted that Mr X found it difficult to form and maintain relationships with professionals as he had significant trust issues. It was noted Mr X could reoffend if he felt *"mocked or wronged"* and that he needed to develop coping strategies, anger management and structure to his

	day. It was suggested that Mr X received Cognitive Analytic Therapy (CAT).
August – December 2014	Mr X continued to receive support from various services. Anger management work continued (it was not specified from where). It was noted that Mr X's new partner was ten weeks pregnant. Mr X was advised to notify Social Services of this himself when the pregnancy was between 24-28 weeks.
January – July 2015	Mr X continued to be supported by Probation, the Police Revolution Service, and Criminal Justice Liaison. The Community Personality Disorder Service (run by the Trust Forensic Service) was involved and started to provide CAT. Mr X was commenced on anti-anxiety medication. In **July** Mr X had been experiencing violent and intrusive thoughts and reported hearing voices. Concerns were expressed for professional workers and Mr X's partner and baby. 1:1 therapy was not thought to be helpful at this stage until his mental state stabilised.
July – October 2015	At the end of **July** Mr X was referred to the Burnley and Pendle Crisis Resolution and Home Treatment Team (CRHTT). Mr X was assessed with his partner and a friend present. Mr X's behaviour was described as changeable – he had been hearing voices both inside and outside of his head. He knew his friends were afraid of him. At this stage Mr X was not on any medication; his new baby was seven weeks old. The plan was to offer support on Trust premises as staff felt they could not visit him at his home due to the levels risk he presented with. It is unclear what (if any) arrangements were made in relation to his baby. In **August** a consultant psychiatrist assessment stated that Mr X's provisional diagnosis was *"Psychotic episode precipitated/perpetuated by a use of Spice on a background of antisocial personality disorder (or traits of the disorder)".* Mr X continued to report hearing voices and experiencing intrusive thoughts; he was also paranoid. Mr X was told to stop drinking alcohol and smoking Spice. The plan was to communicate with Probation, the Police and the forensic-service therapist. Olanzapine 10mg was prescribed. By the end of **August** Mr X had stopped attending the CRHTT as someone there had upset him (apparently calling him a *"baby".* Probation and Police services continued to support him. The plan was for Mr X to continue with the Olanzapine and CAT therapy. During **September** and **October** Mr X appeared to be responding to his antipsychotic medication and the voices

	grew less intrusive (they did not entirely disappear) – however he continued to have violent thoughts. Mr X was referred to the Burnley and Pendle Complex Care and Treatment Team (CCTT). The plan was for a care coordinator to be allocated and for Police support services to *"step back".* A Care Programme Approach (CPA) review meeting was held; the Police Revolution Team Lead was present. Mr X was visibly paranoid during the meeting – he was also *"patting his friends down"* for weapons and acting on the voices he was hearing. It was noted that Mr X was yet to receive a diagnosis (this was apparently still being worked on) – this was something Mr X was pressing for. The plan was for Mr X to be seen at Pendle House by his care coordinator every *"2-4 weeks".* The decision had been taken not to visit Mr X at his home due to the fears of staff for their own safety.
November – December 2015	Mr X was arrested for wounding with intent – the services involved with Mr X did not intervene – in the event Mr X was found to be the victim and no charges were brought. Mr X's Olanzapine was raised to 15mg; Mr X found the Olanzapine to be helpful *"to an extent".* Mr X was still pressing for a diagnosis.
January – March 2016	In **January** a CPA review took place – Mr X's partner and seven-month old baby were present. The meeting did not go well. Mr X became angry as he felt he was being *"fobbed off"* – he no longer wanted to engage with services. The staff present felt too intimidated to talk with him further – consequently a referral was made to Social Services in relation to the potential safety of his child – and a letter was sent to Mr X informing him that any further angry outbursts would not be tolerated. It was noted that staff were not to see Mr X on their own. Social Services did not pursue the referral beyond the initial assessment process. Mr X continued to feel frustrated – he wanted a definite diagnosis. Mr X's partner and friend continued to be worried about his increasing paranoia and aggressive presentation. Forensic therapy and Probation Services continued to work with him – Mr X would frequently become agitated and angry with them.
April – August 2016	In **April** a *"second opinion"* was sought regarding diagnosis. A meeting was held where Mr X was told the diagnoses were Paranoid Personality Disorder and Psychosis (not otherwise

specified). Mr X struggled to understand what was being said; he was encouraged to look it up online.
Mr X was discharged from Probation on **7 May** and his license came to an end. Mr X continued to struggle with aggression and paranoia. Between **1** and **3 June** he reached a crisis and (after speaking with his care coordinator) was happy to accept a hospital admission. However this option was not agreed by the whole multidisciplinary team and Mr X was invited to continue to take his medication with a review in *"a couple of weeks"* if he remained complaint with the Olanzapine (Mr X had been experiencing side-effects and was uncertain whether to continue taking it or not).

Mr X was compliant with his medication but continued to be paranoid with *"mad thoughts"* – he was preoccupied with eating human flesh and decapitating people. He was particularly paranoid that his partner was cheating on him.

September – December 2016

During **September** and **October** Mr X withdrew from service. During a follow up call at the end of **October** Mr X told the CCTT that he was struggling with his thoughts and he had stopped taking his medication.

On **1 November** the care coordinator visited Mr X at his home. He was visibly agitated with rapid hand gestures, sweating and pressure of speech. He was not going out and was troubled by thoughts of wanting to eat human flesh. Both Mr X and his partner asked about his diagnosis – it was explained that the current diagnosis was psychosis not otherwise specified. Mr X also talked about the illuminati and aliens and other conspiracy theories – he had been watching YouTube videos. Mr X's conspiracy theories were thought to be bizarre. Risk: deemed to be of low risk to himself and a moderate risk of harm to others. The plan was for him to be seen by the consultant psychiatrist. Mr X continued to disengage throughout the rest of November.

On **15 December** Mr X attended a CPA meeting; a consultant psychiatrist was present. The diagnosis was noted as being: *"psychosis not otherwise specified v paranoid personality disorder".* Mr X had stopped taking his Olanzapine due to side effects (swollen hands and feet). He was prescribed Quetiapine 150mg to be titrated up. Mr X reported that since stopping the Olanzapine his thoughts of cannibalism had increased – whilst he had no plans to eat anyone he was *"preoccupied"* with the thoughts of the death of other people in which he *"might have some role".* He felt the voices that he heard had increased slightly.

	A safeguarding assessment was conducted – it was noted that Social Services were not involved with the family and that there were no child protection plans in place.
January – end April 2017	Mr X continued to be agitated and paranoid; he was still hearing voices and not taking his medication properly. Mr X's friend was concerned that he was relapsing and growing more paranoid. Mr X's medication was increased to Quetiapine 300mg *nocte* and 100mg *mane*.
May – August 2017	In **May** Mr X's partner contacted the CCTT because she was worried; she thought Mr X might need to be *"sectioned".* Mr X was paranoid and not taking his medication properly. Family and friends were concerned that he would become violent in response to his paranoia; they felt too scared to challenge him. On **25 May** an emergency CPA review took place. The consultant psychiatrist raised Mr X's medication – however Mr X and his friends (who accompanied him) were not happy with this and wanted more to be done. The meeting was brought to a close. Mr X's risk was recorded as being *"moderate".* The diagnosis was now stated to be Paranoid Personality Disorder. Throughout **June, July** and **August** Mr X continued to be paranoid and his self care was variable. He was deemed to be a low risk to himself and a moderate risk to others.
September – December 2017	Mr X continued to be paranoid and was not always compliant with his medication. Weekly visits were instituted to monitor Mr X and to ensure he took his medication. However Mr X did not receive this level of support and he became frustrated and wanted to be treated by a different psychiatrist.
January – June 2018	Mr X refused to see his consultant psychiatrist and wanted to be reviewed by someone else (this was not facilitated). Mr X was visited by his care coordinator at his home but he would not answer the door; he also did not attend clinical appointments. On **8 May** it was decided that Mr X would be discharged back to the care of his GP. On the **24 May** Mr X contacted the Crisis Resolution and Home Treatment Team (CRHTT). He had been trying to speak with his care coordinator but had not been able to speak to her. He was struggling with his mental health and was hearing voices. The CRHTT recorded Mr X's concerns and contacted the care coordinator. The care coordinator was sent an email. On **7 June** a CPA

review was held. Mr X did not attend – a different consultant had been found (it is not certain whether Mr X had been made aware of this). Mr X was discharged from the service in his absence.

At the point of discharge Mr X was receiving 400mg Quetiapine twice a day.

July – September 2018

On **27 July** Mr X was referred to the Burnley and Pendle Single Point of Access Team (SPAT) by his GP. The GP set out that Mr X had a diagnosis of **Paranoid Personality Disorder** and took Quetiapine 400mg BD. He had previously been discharged due to a lack of engagement with service. But Mr X told the GP this was because he did not know the person who had contacted him and his telephone came up with 'withheld numbers' which he would not answer due to his paranoia. The referral stated *"He reports that his mental health is difficult at the moment. He describes increased anxiety and stress and much of this related to threatened eviction from his accommodation due to non-rental payments and his own damaging of the property. He is also due in court next month for assault. He complains of hearing voices of other people who he cannot identify. He finds these voices threatening and causes him anxiety. He has no suicidal ideation and no thoughts of harming others and states he is compliant with medication. When I have spoken to him there was some pressure of speech but he had congruent thought processes and did not appear agitated. He has previously admitted to elicit substance misuse but states that he has been clean for more than 4 months. Mr X is keen to be followed up in your service to get some further support with his mental health. Thank you for seeing him".*

The SPAT declined the referral and suggested that Mr X be referred to the CCTT. It was noted that Mr X had prior relationship difficulties with his previous consultant psychiatrist at the CCTT.

The GP contacted the CCTT to say that all contact should be made via the GP Practice as Mr X would not answer his telephone to any unknown numbers due to his paranoia.

In **August** Mr X's case was discussed at the CCTT – his diagnosis was given as Paranoid Personality Disorder; an assessment care coordinator was allocated. It was decided that Mr X would retain his previous consultant psychiatrist despite his known reservations.

On **6 September** it was recorded that Mr X did not attend his appointment with the CCTT. The GP was written to advising

	him that Mr X was to be discharged back to the care of General Practice. Another letter was written to the GP on **11 September** stating that Mr X would be offered another appointment. On **19 September** Mr X was discharged from service due to non-attendance.
14 January 2019	Mr X killed his friend Ms Y at her home *"This later resulted in him being convicted of manslaughter with account being taken in sentencing of diminished responsibility for this crime due to the presence of mental disorder. This plea and the diminished responsibility grounds were accepted by the prosecution and the court following the submission of comprehensive psychiatric evidence".*

8.7. Following the homicide Mr X was assessed and detained in a high secure mental health hospital. Following assessment it was determined that Mr X was suffering from Paranoid Schizophrenia and that it was highly probable that he had been suffering from this illness for many years prior to the killing of Ms Y.

9 Personality Disorder Guidance

9.1. Prior to the killing of Ms Y Mr X was consistently recorded as having a Paranoid Personality Disorder. It is important that Independent Investigation Teams consider the appropriateness of the care and treatment an individual receives based on any given diagnosis at the time – regardless of whether this is amended to a different illness or disorder post incident. The notion of Personality Disorder was the lens through which Mr X received his care and treatment. The following guidance sets out the national context and expectation for the care and treatment of individuals with Personality Disorders.

National Picture

9.2. The general principles for the management of a service user with a Personality Disorder are outlined in *Personality Disorder: No longer a Diagnosis of Exclusion* NIMH (E) (January 2003). It states:

"Good practice indicates that service provision for personality disorder can most appropriately be provided by means of:

- *The development of a specialist multi-disciplinary personality disorder team to target those with significant distress or difficulty who present with complex problems.*
- *The development of specialist day patient services in areas with high concentrations of morbidity".*

It also states:

> *"What is clear is that people with personality disorders make heavy demands on local services, which are often ill equipped to deal with these. One of the characteristics of this group is that they often evoke high levels of anxiety in carers, relatives and professionals. They tend to have relatively frequent, often escalating, contact across a spectrum of services including mental health, social services, A&E, GPs and the criminal justice system. They may present to mental health services with recurrent deliberate self harm, substance abuse, interpersonal problems that may include violence, various symptoms of anxiety and depression, brief psychotic episodes, and eating disturbances".*

9.3. The National Institute for Health and Care Guidance (NICE) published *Borderline Personality Disorder: The NICE Guideline on Treatment and Management* in 2009 – it underwent minor amendment in 2018.[1]

9.4. In 2015 NICE published *Personality Disorders: Borderline and Antisocial: Quality Standard* (June 2015).[2]

9.5. The three publications set out above provide a comprehensive set of national best practice guidance in relation to service configuration, diagnosis, care and treatment. This guidance has been widely available for a number of years (pre-dating Mr X's first contact with mental health services).

9.6. The NICE publications also provide robust and systematic guidance in the wake of the amendments made to the Mental Health Act (1983) in 2007 whereupon individuals with a Personality Disorder could be detained if assessed to be a danger to themselves or others by virtue of their disorder.

Local Picture

9.7. During the time Mr X received his care and treatment from the Trust a specialist therapy service was provided by Guild Lodge (the Forensic Service). All other services for personality disordered individuals were embedded with community mental health teams – these were not specialist services as advised by national guidance.

1 https://www.nice.org.uk/guidance/cg78
2 https://www.nice.org.uk/guidance/qs88

10 Care and Treatment

Overview to Chapter

10.1. The Independent Investigation Team adopted an evidence-based approach utilising a detailed examination of Mr X's clinical records and a series of focus groups embedded with a Trust workshop event; it should be noted that the workshop event whilst raising specific issues from this case also addressed issues relating to four other separate cases relating to four other Service Users – hence a high degree of triangulation was ensured. High-level interviews and meetings were held with senior officers of the Trust to seek clarification and validation of key findings.

10.2. The findings set out below are supported by 100 pages of objective and cross-referenced evidence particular to Mr X. In the interests of Mr X's privacy, and due to the nature of the desk top analysis, they have not been included in this report; however in the interests of fairness and transparency they have been made available to the Trust, the commissioners and for legal review. To this end the report contains concise findings without detailing intrusive content from the clinical record. The content of this report has been subject to factual accuracy examination by the Trust.

10.3. Each member of the Independent Investigation Team took the lead for the areas of their own speciality. The analysis of the findings is the consensus view of the entire Independent Investigation Team following all due investigation process being met.

10.4. Findings under report sub headings titled 'Findings from the Desktop Review of the Clinical Records' have been taken directly from Mr X's clinical records and are based factually upon them. The analysis provided has been set against objective local and national evidenced-based standards and guidelines (please see appendix 2).

10.5. Findings under report sub headings titled 'Reflections from the Workshop Held with the Trust' have been taken directly from the workshop transcript. The Independent Investigation Team has not adjusted them in any way and they are offered here as insights, reflections and evidence in their own right. The Independent Investigation Team recognises that the workshop findings represent a 'snapshot in time' that does not take into account any progress since made; however this is considered in the 'Progress the Trust has Made' section of the report below. The findings from the workshop (whilst not focusing on Mr X specifically) speak to the systemic issues relevant to his case. These findings explain and triangulate the findings from the clinical records and also provide insights as to how systems worked and where they need to be improved.

10.6. Findings under report sub-headings titled 'Conclusions' are the consensus view of the entire Independent Investigation Team and have been

developed in an objective and evidence-based manner using both local and national evidence-based standards and guidelines (please see appendix 2).

10.7. Key terms and phrases are explained in the glossary.

Diagnostic Process

What is Diagnosis? National Context

10.8. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs and symptoms and from the results of various diagnostic procedures.

10.9. The process of reaching a diagnosis can be assisted by *The International Statistical Classification of Diseases and Related Health Problems* (most commonly known by the abbreviation ICD). In the United Kingdom psychiatry uses the ICD 10 (10th revision - published in 1992) *Classification of Mental and Behavioural Disorders* which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

10.10. Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework that can provide an understanding of their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis can provide a platform on which to address care, treatment, and risk management issues.

10.11. A substantial number of service users may well meet the diagnostic criteria for more than one diagnosis at any given time.

Differential Diagnosis and Diagnostic Formulation: Process in General

10.12. When making a diagnosis it is sometimes difficult to understand exactly what is occurring. A differential diagnosis takes into account the process of weighing up the likelihood of one illness/disorder versus that of another being responsible for a person's condition and presentation. It is good practice for clinicians to keep an open mind and to record any considerations in the patient record when signs and symptoms do not fit neatly into one precise diagnostic category.

10.13. A diagnostic formulation (or a clinical formulation) is the process by which clinicians reflect upon a case and weigh up in a holistic manner what is known about an individual patient. The patient's risks, social situation and the impact of their illness on both themselves and others are used to

construct a deeper understanding of how a care and treatment plan should be developed.

Findings from the Desktop Review of the Clinical Records

Background Information: Mr X's Diagnostic History

10.14. The Independent Investigation Team considered the issue of diagnostic process to be pivotal to this case and therefore the examination of this aspect is provided in significant detail. The management of Mr X's ongoing care and treatment was highly reliant on the given diagnosis of Paranoid Personality Disorder which remained persistent despite the provision of a second opinion (that introduced the notion of a psychotic illness) and Mr X's increasingly psychotic presentation. It was evident that Mr X was not happy with this diagnosis and that his symptoms remained unabated during the four-year period he received care and treatment from the Trust under the given regimen he was subject to.

10.15. It is important to note that it is neither the role nor the function of an independent investigation team to 're-diagnose' a service user; this would be entirely inappropriate. However it is the role and function of an independent investigation team to consider the diagnostic processes followed and the subsequent care and treatment provided in the light of what was known or thought to be known at the time.

10.16. Information relied upon to form an opinion of the diagnostic process has emerged from the review of records provided to the Independent Investigation Team. It may be that not all clinical information has been provided, which if the case, might otherwise alter the conclusions or opinions arrived at. However all care has been taken to ensure a comprehensive set of clinical records were received over a period of some ten months to ensure the analysis has been both fair and valid.

10.17. At the time of writing this report Mr X was an inpatient at a High Secure Hospital, his current diagnosis being Paranoid Schizophrenia.

Short Chronology of Diagnostic events

10.18. There is virtually no narrative in the clinical record that details the diagnostic process followed. However it has been possible to determine the following events:

- In **2001** Mr X was examined for the purposes of completing a psychiatric report in connection with criminal charges. He was not considered to be suffering from either a Psychotic Disorder or a Personality Disorder at this time.

- In **2010** (on his release from prison) the mention of Emotionally-Unstable Personality Disorder appears in the clinical record and this corresponds with a request for a forensic psychiatry opinion. There is

no narrative as to how or why this particular diagnosis was arrived at – it is a 'simple mention'. It is important to note that there appears to have been no forensic diagnostic/risk formulation follow-up. Neither Trust-held records nor GP-held records provide any further information.

- Between **2011** and **2014** Mr X was in prison. At the point of his release on licence he was subject to MAPPA level 2 and was considered to have an Antisocial Personality Disorder. At this stage Forensic Outreach Services, Probation and the Police were involved. A formulation of some kind was developed at this time but with no reference to diagnosis or diagnostic process; however the available records indicate that he was regarded as someone with a Personality Disorder. Whilst there was a degree of multi-agency working during this period there is no mention of any psychiatrist assessment or input. A Clustering Tool assessment was undertaken by a Criminal Justice Liaison Practitioner which stated *"Personality Disorder Care Pathway (Non Forensic)".* **NB:** a Clustering Tool assessment is **not** a diagnostic process and the person completing the assessment was not qualified to provide a diagnosis.

- By **July 2015** there was clear evidence of prominent psychotic symptoms – Mr X was referred to the Trust's Crisis Resolution and Home Treatment Team. Mr X was described as experiencing violent intrusive thoughts and hearing voices. Reports indicate that these experiences were both *"inside and outside"* his head; Mr X was also described as *"socially paranoid".* He was not prescribed any medication. He reported being preoccupied at night, hearing voices and exhibiting a *"flight of ideas".* He was considered to be suffering from a temporary psychotic disorder most likely secondary to 'spice' ingestion (there is little reference to application of urine drug screening throughout his care and treatment by the Trust – and no changes to his diagnostic/risk formulation were made).

- In **August 2015** Mr X was commenced on Olanzapine, initially at a dose of 5mg daily, increased to 10mg daily after one week. By late **August** the voices were described as quieter. Following a Clustering Tool assessment he was categorised as meeting the criteria for Cluster 11 – ongoing recurrent psychosis – a change from his previous cluster (non-psychotic, personality disorder, non-forensic). However the Clustering Tool assessment process did not affect the actual care and treatment programme he received and did not lead to a re-evaluation of his diagnosis. Once again it should be noted that the completion of a Clustering Tool is not a diagnostic process and the person completing the tool was not qualified to make a diagnosis.

- In **October 2015** Mr X was referred to the Trust's Complex Care and Treatment Team (CCTT) – he recounted to health care professionals that during his prison sentence (some 18 months earlier) he had been *"paranoid, fearful and unpredictable".* At this time a CPA review was

undertaken, Mr X was noted to be *"severely paranoid",* he believed friends were talking about him and he was constantly accusing them of various things. He was described as paranoid during the meeting, talking to himself and *"acting weird".* Mr X was keen to know whether he had Schizophrenia. During the CPA review he described hearing a conversation from an adjoining room, and this was considered to be a hallucinatory experience. There was some evidence of objective benefit from Olanzapine; however Mr X reported it as being ineffective.

- In early **November 2015**, the Olanzapine was increased to 15mg daily. Within a few days Mr X reported fewer voices and this remained the case several weeks later; however he still reported paranoid thoughts and feelings. He had questions about his diagnosis and wondered about having a serious mental illness. Mr X was engaged in Cognitive Analytic Therapy (CAT) at this time (via Probation Services); he was being treated for a Personality Disorder.

- In **December** 2015 Mr X was reported as being anxious when using public transport; he felt paranoid about the people around him and thought they were talking about him. He believed he suffered with Paranoid Schizophrenia and not Paranoid Personality Disorder – the diagnosis he had been attributed with by his community consultant psychiatrist at the CCTT.

- In **January 2016** Mr X was reported as wanting to *"understand the paranoia"* when his case was being discussed in a CPA review meeting. He again raised issue with his diagnosis as he continued to disagree with the given diagnosis of Paranoid Personality Disorder. He was reported as being intimidating, hostile, angry and uncooperative. Mr X's position was that he was not angry but *"agitated"* at not having his diagnostic issues addressed. From his perspective he wanted a diagnosis that explained his symptoms. He wanted help to be rid of them.

- In **February 2016** Mr X's friend gave an account to health care professionals that he had *"never seen him so bad… talking about mad things".* Mr X had told his friend that there was a *"laser inside a card reader"* meaning that he could no longer go into shops as this would interfere with his brain. Mr X reported that no one (mental health services) appeared to be listening to him.

- In **March 2016** Mr X was described by his new care coordinator as loud, with rapid speech and that he remained unhappy about his diagnosis. There was a consideration about discharging him, although it was not evident on what basis. Mr X was no longer answering his telephone because of his levels of paranoia. Mr X was fixated on his diagnosis – he was reluctant to receive any level of service as he felt he was not being given the right treatment. It was clarified that Mr X was not open to forensic services (and never had been) instead he

was receiving CAT from a forensic service practitioner as part of the ongoing Probation Service provision.

- In late **March 2016** a second opinion was sought (from another consultant psychiatrist within the community team) and in late **April** the provider of that second opinion (and others) discussed with Mr X diagnosis and treatment. There is reference to *"bipolar personality disorder".* It is not clear from the records whether this was a term used by Mr X himself (erroneously believing it to be an entity) or else used by a health professional/s in error (as no such diagnostic category exists). It is the only time this term is used and is in any case a misnomer.

- The second opinion provided by the consultant psychiatrist formed a view that Mr X's psychotic illness *"may have played a remote factor in his offending"* without any further analysis or justification for this opinion (he was not a forensic psychiatrist). He provided a summary of his opinion in which he concluded that Mr X was suffering with Paranoid Personality Disorder and a *"Psychosis Not Otherwise Specified"* rather than Paranoid Schizophrenia. Little analysis was provided as to why he favoured the former and not the latter. It would appear that the consultant psychiatrist formed his opinion prior to meeting Mr X. When he met with Mr X to give his opinion Mr X (who was confused at what was being said to him) was advised to look the diagnoses up online.

- In **June 2016** a friend of Mr X was described as worried about him and that Mr X was increasingly paranoid with fixed ideas; he was no longer taking his medication. He was reported as taking Spice (a street drug); there was no reference to urine drug screens being conducted at that stage or up to that point. Mr X's friends and partner were reported as no longer being able to cope with his paranoia. This led to his friends actively avoiding him. He was noted to be neglecting himself. In mid-**June** the Olanzapine was increased to 20mg, despite some indication that he had not been taking it for about ten months. By the end of **June** and the beginning of **July** Mr X was described as much calmer, thought to be in response to the medication. However, he was still suspicious of others and insisted on searching his friends for knives when they came to his house. He was due to be seen in outpatients mid-**July** but apparently was too paranoid to attend.

- Between **August** and **October 2016** Mr X disengaged with mental health services. When seen in **November**, he was noted to be visibly agitated, sweating, with pressure of speech. He was not going out and was troubled by thoughts of wanting to eat people. He was expressing ideas related to the *"illuminati"* and *"aliens"* and other conspiracy theories. In late **November** an updated Clustering Tool exercise was completed. He was attributed Cluster 13 – ongoing psychosis, high symptom and disability (it had previously been Cluster 11). Despite the

change of cluster, there does not appear to have been a corresponding revision of his diagnosis or a change of approach to his management.

- In **December 2016** it was noted that since stopping his Olanzapine there had been an increase in his expressed thoughts about cannibalism.

- In **February 2017** Mr X was still experiencing hearing voices, feeling paranoid and his sleep and appetite were disturbed. He was preoccupied and was isolating himself from others so he would not cause harm to them.

- In **April 2017** Mr X's friend expressed concern that he *"was relapsing again and the medication was not working".* Quetiapine had been introduced and the dose was increased from 150mg to 300mg. In **May 2017** his partner reported that she thought he ought to be detained under the Mental Health Act (1983). In late **May** he was noted to be using cocaine heavily but there does not appear to be any other reference to cocaine use generally prior to this. In a letter to his GP his diagnosis was still referred to as having a Paranoid Personality Disorder. So great were Mr X's partner's fears for her safety that she eventually left the home she shared with him and took their baby with her.

- Mr X continued to engage with mental health services sporadically – he was paranoid and angry as he did not think he was being treated with dignity and that the diagnosis of Paranoid Personality Disorder did not explain what was happening to him. His lack of engagement led to Mr X being discharged back to the care of his GP on **7 June 2018**. The given diagnosis was Paranoid Personality Disorder.

- On **27 July 2018** the GP once again referred Mr X to Trust services. It was noted in the referral that Mr X *"reports that his mental health is difficult at the moment. He describes increased anxiety and stress and much of this related to threatened eviction from his accommodation due to non-rental payments and his own damaging of the property. He is also due in court next month for assault. He complains of hearing voices of other people who he cannot identify. He finds these voices threatening and causes him anxiety. He has no suicidal ideation and no thoughts of harming others and states he is compliant with medication".* Mr X was on 400mg Quetiapine – the given diagnosis was Paranoid Personality Disorder – it was noted that Mr X was extremely paranoid and might not answer his telephone. In the event Mr X did not engage with mental health services and was discharged on **19 September 2018** – his diagnosis remained Paranoid Personality Disorder. This was the working diagnosis up until the time Mr X killed Ms Y.

10.19. When interviewed by the Independent Investigation Team Mr X could not recall ever being seen by a psychiatrist between 2001 (following the report made for the Court) and his release from prison in 2010. He does not know where the diagnosis of Paranoid Personality Disorder first originated from. The Independent Investigation Team could find no mention in the clinical records (including those of the GP) of any psychiatric assessments during this period – the diagnosis appears to have been recorded as some kind of 'suggestion' from non-medical professionals. It would appear that a request for a medical forensic opinion was sought in 2014 but this was not forthcoming. By the time Mr X was accepted onto the CCTT caseload the diagnosis appears to have been 'set in stone' even though there were several mentions of this being a *"provisional"* diagnosis only. It would appear that Mr X was only ever assessed by a forensic psychiatrist on one occasion (in **2001**) prior to the killing of Ms Y.

10.20. Mr X's first significant contact with the Trust began in **2010** after his release from prison. He was considered at this stage to suffer from an Emotionally-Unstable Personality Disorder; he was seen by a Psychiatrist at this time – but the 'diagnosis' appears to have already been in existence prior to this meeting. Between **2011** and **2014** Mr X once again spent time in prison. Following his release from prison in **2014** he resumed contact with the Trust – the exact nature of this contact has been difficult to understand – it would appear that initially the forensic outreach service was involved (via Probation) – but this did not include any psychiatric consultant input.

10.21. By mid **July 2015** Mr X was placed on the CRHTT caseload and then graduated onto the CCTT caseload in **October 2015**. During this period (and up until his eventual discharge from Trust services in **September 2018**) there is scant documentation to evidence regular mental state examinations having taken place or any formal diagnostic process having taken place.

10.22. The contemporaneous clinical record is quite clear that from **2015**, there was a consistent and sustained clinical picture entirely typical of the relapsing and remitting serious mental illness, namely Paranoid Schizophrenia. Conversely there is nothing within the records to support the diagnosis of Paranoid Personality Disorder. However this diagnosis appears to persist throughout the records even after the clinical picture becomes evidently clearer and after his case was subject to a second opinion (which concluded that he had a psychotic disorder in **2016**). The diagnosis of Paranoid Personality Disorder continued to persist throughout **2017** and **2018**.

10.23. On Mr X's **2014** release from prison reference was also made to an Anti-Social Personality Disorder (ASPD) but this did not account for the plethora of psychotic symptoms that endured over the years of contact. That is not to say that he did not have some anti-social traits; given his history and early life experiences this is likely to have been the case. But the presence of such traits would not preclude him from having an

additional diagnosis of Paranoid Schizophrenia – this was not considered as a differential diagnosis as would have been usual given his presentation and lack of prior formal assessment. Despite ongoing concerns about Mr X's mental state (and in the light of his known and significant offending history) no forensic psychiatric assessment was formally requested; this was a missed opportunity – and given Mr X's known history and ongoing presentation – difficult to understand.

10.24. There is clear evidence of responsiveness to medication; with pronounced deteriorations in Mr X's mental state at times of poor compliance and/or disengagement. Conversely Mr X's mental health improved with anti-psychotic medication and support. This is indicative that an enduring psychotic illness was likely to have been present.

10.25. Mr X's friend and his partner both separately and collectively gave compelling corroborative accounts of a persistent and serious mental disorder characterised by paranoid ideas, suspiciousness, altered behaviour, hallucinatory experiences and deterioration in self-care. It is not evident that their accounts were truly acknowledged or incorporated into an overarching formulation.

10.26. Mr X himself was clear that the diagnosis he was assigned did not account for his experiences and little appears to have been done to address this, especially when considered alongside the accounts of his friend and partner, as referenced above.

10.27. The role of psychoactive substances is likely to have played a significant part in the course, nature and degree of his illness, but did not account solely for its protracted, persistent presentation. There is little reference to the routine use (or attempted use) of urine drug screens as a means of determining the relative contribution of illicit drugs at any point in time during his care and treatment by the Trust. It is acknowledged that Spice is notoriously difficult to detect but it is seldom used alone and it may have been helpful to have determined whether or not Mr X's presentation at particular junctures was contributed to by illicit drug use. The potential significance of Mr X's substance misuse was not built into his diagnostic and/or risk profile – this was a significant omission – particularly in relation to risk in general and child safeguarding in particular. It is possible that Mr X would not have cooperated – but this was never tested.

10.28. The Independent Investigation Team must reiterate that it is not its function to re-diagnose – however a re-diagnosis was conducted by specialist tertiary high secure services following the homicide of Ms Y and Mr X was found to be suffering from Paranoid Schizophrenia.

10.29. The Independent Investigation Team has set out its concerns above which need to be considered from a process point of view from the list set out below:

1. Mr X did not receive a formal series of psychiatric assessments on his release from prison in order to understand whether a Personality Disorder or mental illness was present. This is of note considering his psychiatric history, his MAPPA level 2 status, and his referral to mental health services for ongoing support.

2. No detailed psychiatric history was taken and/or recorded. Instead incomplete (and at times inaccurate histories) were passed from one service/agency to another.

3. The 2014 referral to Forensic Services did not lead to diagnostic assessments from a specialist psychiatrist as requested. Mr X would probably fall within the top 1% of service users with a significant and challenging risk profile – the lack of referral to forensic services for a full, specialist-psychiatric assessment cannot be explained away as an aberration or due to capacity issues. This represents a significant omission. NB: it should be noted that some 2.8 million people receive NHS mental health care support each year[3] – there were some 89,000 people subject to MAPPA in 2019 - a rise of 85 per cent since 2009 (NB: only 1.6% of these individuals were placed on level 2 for violent offenders like Mr X).[4] It can therefore be taken that Mr X's presentation was not typical for CMHT management and at least warranted specialist forensic assessment and monitoring at the point of his release from prison.

4. Mental state examinations were not routinely conducted and recorded.

5. Mr X's ongoing presentation and his lack of confidence in his diagnosis led to a second opinion in 2016 – however it appears that the newly introduced notion of a psychotic illness was discounted by the treating team who continued to only consider Paranoid Personality Disorder.

6. Considering the known and significant forensic history of Mr X it is of note that no detailed forensic diagnostic formulation was developed to understand how Mr X's presentation and known risks (such as drug taking) could impact upon his future wellbeing and his ongoing risk to others.

7. The evidence from the clinical record is quite clear – the notion of 'co-production' was almost entirely absent. Mr X, his friend and his partner were largely disregarded when they sought help. It was evident that Mr X had little confidence in the continued care and treatment plan his treating team provided – and also struggled to understand what his diagnosis meant. It is evident that when 'well' Mr X had enough insight to be deeply troubled about his thoughts and paranoia – he was embarrassed by these thoughts and struggled to articulate them –

3 https://commonslibrary.parliament.uk/research-briefings/sn06988/
4https://www.justiceinspectorates.gov.uk/hmiprobation/research/the-evidence-base-probation/specific-types-of-delivery/mappa/

when he did he was (in his own words as recorded in the clinical record) *"fobbed off".* Mr X knew he was a risk to others – when unwell his paranoia took over and he isolated himself so that he could not cause anyone any harm – this served to disengage him from mental health services. The ultimate response of these services was to discharge him. When interviewed by members of the Independent Investigation Team Mr X and his family corroborated what had been written in the clinical record.

Reflections from the Workshop Held with the Trust

10.30. Poor diagnostic practice and missed psychosis are reoccurring themes that have been identified by the Trust when investigating other similar incidents. The workshop held with Trust clinicians explored the issue of diagnostic practice. Four key issues that inhibit robust diagnostic practice were identified:

1. The general consensus was that in relation to psychiatric history taking *"some of that art had been lost… the art of history taking has gone and some of us in the group are of an age where as trainees ourselves, we would have been tasked with taking history, gathering information, getting old notes, collating things and creating a formulation"*. This reflection is based on the national changes to medical staffing and mental health service reconfigurations that took place over 12 years ago. The workshop participants also recognised that psychiatric histories (when they were done) were not updated and were often incomplete.

2. Workshop reflections also included the challenges posed by RiO (the Trust's electronic record system) whereby letters and historic PDF documents (hard copy records created prior to the implementation of RiO) are often stored in fields that are not easily accessed – this facilitated a *"discontinuity".* It was recognised that GP letters, psychology assessments and historic information are all stored in separate fields – this means that a degree of *"searching"* is required which is laborious and could lead to information being missed.

3. There was a clear sense that when service users moved between teams (and when those moves were reasonably frequent) there was a dilution of information as they *"passed through".* The difficulty presented by service user movement was increased when there were cross-boundary issues. Patient continuity was seen as a major barrier to psychiatric history taking, diagnostic formulation and risk assessment. It was acknowledged that on frequent occasions service users were only with a particular service for a couple of weeks before being passed over to another team (and another consultant). This meant that the clinical record system needed to *"work harder"* as it is a key foundation when ensuring continuity of care.

4. Workshop participants recognised the difficulties in making dual diagnoses and forensic referrals. In general referrals were not made due to the difficulty in getting service users accepted onto specialist caseloads; this as seen as being a capacity issue.

10.31. The reflections from the workshop both explained and verified some of the issues identified by the desktop review relating to Mr X's care and treatment.

Conclusions

10.32. The lack of diagnostic process can reasonably be said to be responsible for Mr X's 'unrecognised' psychosis. The diagnoses provided prior to April 2016 were described as *"provisional"* or *"differential".* This lack of clarity resulted in sub-optimal and inappropriate care and treatment approaches. It is evident from reading Mr X's clinical records that he presented with psychotic symptoms for a great deal of the time and was not always prescribed medication – instead a therapy-based approach was taken which was not effective and often had to be withdrawn due to Mr X's aggression and psychotic thinking. Even when presenting with symptoms of psychosis, distressed and paranoid – it was rare for Mr X to be offered an appointment with a psychiatrist or for his medication, care and treatment to be reviewed.

10.33. Co-production was minimal (Mr X appears to have been, in his own words, *"fobbed off"* a great deal of the time) and the specific risks relating to Mr X's forensic history, presumed Personality Disorder, psychosis and substance misuse did not inform a coherent risk management approach.

10.34. It is important to understand that Mr X struggled to manage his illness and sought help and support from Trust-based mental health services. During periods of acute psychosis he was too paranoid and unwell to engage with the community mental health team – the withholding of treatment was on occasion used as a method of 'bringing Mr X into line' and eventually discharge from service was used as a response to his non-attendance at meetings and reviews.

10.35. Mr X's level of frustration was an ever-present factor – however it is to his credit that he continued to seek help as he was intent on managing his symptoms and lived in fear of harming someone. During the four-year period he received care and treatment from the Trust he lost confidence with the service offered to him.

10.36. Since 2003 Personality Disorder has not been a diagnosis of exclusion – this was further underpinned by the 2007 changes to the Mental Health Act (1983). However during discussions with Trust personnel (during workshop focus groups) it was evident that a culture persists where people with Personality Disorder are sometimes discharged from service for non-compliance and disengagement – this goes against national guidelines for the management of people with severe and persistent Personality

Disorder. Workshop participants gave the impression that Personality Disorder is still a disorder of exclusion within some services – clinicians described the current practice of discharging service users from the caseload for non-attendance and disengagement regardless of the severity of the condition. This insight speaks directly to what happened to Mr X; despite the severity of his forensic history and his known levels of distress – he was somehow seen as being totally accountable for his behaviour and wellbeing and his treating team did not appear to feel responsible for his ongoing treatment and also (most significantly) his ongoing risk to others. This continued practice falls below national guidance expectation.

10.37. In actual fact Mr X suffered from Paranoid Schizophrenia. There is nothing recorded in the available clinical records to suggest a formal diagnostic process was followed (aside from the second opinion in 2016). The Independent Investigation Team could find no rational within the clinical records to explain why a seeming 'anchoring bias' prevailed (this is where clinicians and treating teams adhere to an original diagnostic impression despite evidence to the contrary). Had Mr X been diagnosed with Paranoid Schizophrenia at an earlier stage (and in the light of what was known and should have been about him at the time) it is entirely probable that he would have received the levels of support and specific treatment that he required to manage his psychosis and to maintain his wellbeing. Had this diagnosis been made it is also probable that Mr X would have been subject to higher levels of monitoring and supervision to ensure the safety of others.

10.38. The Trust acknowledged that poor diagnostic practice and 'missed psychoses' were a consistent feature already identified via its own thematic review processes (the historic review of cases which prompted improvement reviews and the development of the Personality Disorder Improvement work) when examining similar cases to that of Mr X. In the case of Mr X the Independent Investigation Team concludes that information sharing between disparate services and agencies led to a confusing picture where no one acknowledged or understood who the identified 'lead' was. Roles and responsibilities were not outlined and information (such as presumed diagnoses) was not discussed and validated.

10.39. The taking of a psychiatric history and the diagnostic process are important – they underpin the basic building blocks of care and treatment. Without a clear knowledge of a service user errors can be perpetuated over time; this is a patient safety issue. Without a clear diagnostic framework to underpin care and treatment, inputs run the significant risk of being neither efficient nor effective; this is of particular relevance when resources are limited. The key factors identified were:

- deficits in psychiatric history taking;
- ineffective diagnostic and formulation processes;
- lack of referrals to speciality services (substance misuse and forensic);

- poor continuity of care between disparate services and agencies;
- inadequate record access and retrieval.

10.40. This aspect is something that continues to cause Mr X a great deal of anguish. He cannot change the past but wants to ensure this does not happen again to someone else.

Medication, Care and Treatment

Findings from the Desktop Analysis of Mr X's Clinical Records: Medication

10.41. It is recorded in the clinical record that for a significant period of time, when receiving care and treatment from the Trust, Mr X was not prescribed any medication. It was also recorded that he was eventually prescribed Olanzapine – however this drug caused Mr X to experience significant side effects which he found to be distressing; consequently he often did not take it. When faced with the side-effects (and what he considered to be the relatively minimal effect the medication made to his psychotic experiences) Mr X could not justify its continued use.

10.42. The clinical record charts that Mr X's non-compliance with medication became a point of contention between him and his treating team. He was (on occasions) denied appointments and reviews (even when in crisis) until he re-commenced his medication regimen. This enforced compliance served to erode further Mr X's trust and confidence in the service. Mr X told the Independent Investigation Team that he felt he was being infantilised and not listened to.

10.43. During later periods Mr X was prescribed Quetiapine – but once again his compliance was sporadic and the effectiveness of the medication compromised. It should be noted – medication is only effective if it is taken – when a service user has no confidence in it and fears the side effects then a vicious cycle can commence. This was the case for Mr X.

10.44. The Independent Investigation Team reflected that a drug such as Clozapine, or an antipsychotic medication delivered by depot injection, should have been considered. Had Mr X received the correct diagnosis then this might have been more readily forthcoming (and accepted by Mr X). It should be understood that non-compliance is a far from unusual feature when treating service users with either a Personality Disorder or Paranoid Schizophrenia; this is a perennial challenge for mental health services and is something that has to be managed – it is not appropriate to withdraw service or to automatically consider discharge (as was the case with Mr X). Whilst Mr X might not have consented to this approach it should have been considered.

10.45. It should be noted that Mr X is currently receiving Clozapine and his psychotic symptoms have almost entirely abated.

Findings from the Desktop Analysis of Mr X's Clinical Records: Care and Treatment

Therapy

10.46. Mr X received Cognitive Analytic Therapy (CAT) – a treatment of choice for individuals with Personality Disorder. There are current professional debates regarding its effectiveness and safety in the use of Paranoid Schizophrenia and psychoses in general.

10.47. Regardless of whether CAT would have been a therapy of choice or not (given the issues with Mr X's given diagnosis) two factors served to undermine Mr X receiving therapy of any kind.

1. Mr X often had florid psychotic symptoms – this meant he could not engage in therapy – and when paranoid could not even attend appointments.

2. Successful therapy requires a sound therapeutic relationship between service user and therapist. The therapeutic relationship between Mr X and all members of his treating teams was undermined by his lack of trust and confidence based upon diagnostic ambiguity, poor service liaison (discussed in later sections of this report), and an impression that Mr X formed that people were *"fobbing him off"* and treating him in an undignified manner.

10.48. Not only are the treatments and therapies that were provided of relevance – of equal relevance are those that were not. Throughout Mr X's time with the Trust it was recognised that he had alcohol and substance misuse problems and that these might be making a contribution to his psychosis and paranoid thinking. The record provides no information as to how Mr X was supported with these issues (apart from being told to stop his alcohol and substance misuse habits). However a brief mention is made regarding Mr X having contact with the Inspire Service (alcohol and substance misuse). Whether Mr X attended this service could not be ascertained, aside from a single mention nothing else is recorded; it has not been possible to understand the course of events. Whether he attended or not it is evident that no liaison, shared assessments and risk management processes took place.

The General Model of Care

10.49. It is a fact that Mr X was receiving care and treatment based on the incorrect premise that he had a Personality Disorder instead of Paranoid Schizophrenia. This meant that the treatment offered was neither optimal nor entirely effective.

10.50. Of particular note is that whilst the treatment was not effective – neither was the care. It is important to differentiate between the two. Care is comprised of the general service provided and the levels of support, monitoring and crisis intervention offered.

10.51. During the time Mr X received his care and treatment from the Trust he was under the Care Programme Approach (CPA) – this was good practice as he met the criteria in full. This meant he had a care coordinator and could expect regular reviews, care planning and risk management. It also meant that he could expect regular follow-up and support whilst living in the community and that his carers could access assessment and support in their own right.

10.52. Mr X did receive care planning and risk management processes – he also received support. However the levels of proactive (and reactive) interventions were minimal. Plans and assessments were often 'cut and paste' containing inaccurate and out-of-date information. When Mr X was in crisis, or experiencing periods of relapse, support appears to have been sporadic and largely dependent upon him cooperating in full – even when he was too paranoid and psychotic to work with his treating team under his own volition.

10.53. The Independent Investigation Team has found that the rigid stance taken appears to have stemmed from the prevailing Trust culture regarding how individuals with Personality Disorder should be managed by community mental health teams. The Independent Investigation Team has found (via the Care Pathway Review) that individuals with a Paranoid Schizophrenia diagnoses are managed and treated very differently to those with a diagnosis of Personality Disorder.

Conclusions

10.54. As has already been mentioned above, diagnosis played a pivotal part in the manner in which care and treatment was provided to Mr X. It is reasonable to conclude that had Mr X received a diagnosis of Paranoid Schizophrenia his care and treatment would have been managed very differently by the Trust (with regards to medication, therapy, support and monitoring).

10.55. That being said – based upon the given diagnosis of Paranoid Personality Disorder – a great deal more both could and should have been achieved. It is erroneous to think that a diagnosis of Personality Disorder is of 'lesser' concern than that of Paranoid Schizophrenia; it is not. Personality Disorder has clear and evidence-based national guidance for care and treatment delivery; this guidance was not adhered to.

10.56. It is also reasonable to conclude that had the Trust put into place the national guidance for those with Personality Disorders then Mr X's case would have been managed better than it was and a less judgemental and rigid approach could have been taken to non-compliance and disengagement issues.

10.57. The Independent Investigation Team concludes that Trust services worked within a rigid and overly boundaried framework with regards to Personality Disorder. Given Mr X's forensic history, and MAPPA level 2 status, mental

health services should have taken a more proactive stance in both managing him and supporting his wellbeing. Personality Disorder is no longer a diagnosis of exclusion – the withdrawal of treatment (on occasions) and the eventual discharge from service for disengagement and non-compliance should not have occurred in the way that it did. The care and treatment model provided fell short of what could reasonably have been expected – placing both Mr X and those around him at increased risk.

Multi-Agency Working and Multi-Agency Public Protection Arrangements (MAPPA)

Findings from the Desktop Analysis of Mr X's Clinical Records

Multi-Agency Working

10.58. The records for Mr X could not be accessed across all of the services and agencies involved in his supervision, care and treatment. However the Trust-held records tell their own story about the levels of information sharing that took place. The Independent Investigation Team found there to be a relatively confusing picture with some 13 services and agencies involved over a four-year period – many at the same time – but it could not be ascertained what their roles and functions were and how they worked together. It is reasonable to assume that in the absence of information within Mr X's Trust-held records that the information shared was minimal. It is also reasonable to assume that joint working, assessment and care and treatment planning was also minimal.

10.59. In the early period following Mr X's release from prison in 2014 it is evident that Mr X had three care coordinators (one each from health, Probation and Police services). This can be ascertained from brief mentions of named individuals in the clinical records – there were also brief mentions of key workers and therapy leads from a disparate range of other services/agencies. It has not been possible to understand how everyone worked together and what was hoped to be achieved by the inputs provided. It is evident that in the first year Mr X was released from prison there was a great deal of activity put in place around him – but it would appear that services worked largely in parallel and not together.

10.60. The Independent Investigation Team discussed this with Mr X and his family at interview. They found the approach taken very confusing and to this day cannot understand who everyone was or how they worked together. They expressed a high degree of dissatisfaction in the duplication of the assessment processes and also in the lack of join up which often *"left them dangling"* waiting for connections to be made – which in the event were not forthcoming.

10.61. Once Mr X was placed on CPA efforts were made to invite the lead practitioners from other services and agencies (Probation, Social Services, the Police etc.) to attend review. However there is little evidence to suggest people actually met up on a face-to-face basis and no evidence to suggest supervision, care and treatment was planned and delivered in unison.

10.62. An area of particular concern is child safeguarding. Social Services were involved through the Courts in relation to Mr X's first two children (born before his release from prison in 2014). There is little on record about this. Mr X formed a new relationship and became a father again in 2015. It is evident that Social Services were involved in a sporadic manner – but it was also evident that there was scant liaison between mental health services and Social Services – even though concerns had been raised about Mr X's new baby. This is examined in more detail in the safeguarding section below.

Multi-Agency Public Protection Arrangements

10.63. The national MAPPA website says this:

> *"MAPPA stands for Multi-Agency Public Protection Arrangements. It is the set of arrangements through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.*
> *MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner. Agencies at all times retain their full statutory responsibilities and obligations".*

10.64. The Trust's MAPPA policy and CPA policy requires Care Coordinators to attend MAPPA meetings. However MAPPA is not managed by health services – the lead agencies are the police, Probation and the Prison Service. MAPPA guidance states that:

> *"MAPPA and the duty to co-operate enable different agencies to work together. MAPPA are not a legal entity but are a set of administrative arrangements. Authority rests with each of the agencies involved. Each agency will act in its own sphere and fulfil its own responsibilities, but has a duty to share information and co-ordinate action with MAPPA partners. While consensus may be reached and joint action agreed, decisions and actions remain the responsibility of the agency carrying them out. Co-operation between agencies ensures that all agencies involved know what the others are doing, prevents decisions being made in ignorance of other agencies' actions and enables joint working. Without co-operation, there is a risk of collision - agencies unintentionally frustrating or compromising each other's work, sometimes with dangerous consequences".*

10.65. It has not been possible to understand how MAPPA worked in relation to Mr X due to an absence of available information and the limitations of the Investigation Terms of Reference. It is evident Mr X was subject to MAPPA level 2 between 2014 and 2016. There is little mention of this in the CMHT records. It is not possible to understand who attended from mental health services (if anyone actually did) or how Probation, the Police, Social Services and the Trust worked together. There are a couple of Probation-led assessments shared with the Trust shortly after Mr X's release from prison in 2014 – but very little is mentioned thereafter. It is evident that the community forensic team was working with Mr X – but only as a provider of therapy as part of the Probation Services provision – the CMHT was the lead treatment provider. If a member from Trust services did attend MAPPA meetings – or was directly involved in any way – no records or communication appeared to have been maintained with the CMHT.

10.66. There is no available evidence to suggest how (or if) the Offender Pathway was implemented. What is evident is that Offender Services (Revolution Team etc.) were involved with Mr X – but it is not clear how this service worked with Mr X's Trust-based treating team.

10.67. Mr X and his family are of the view that support was lacking following his release from prison and that services did not work in a united or helpful manner. They reflected that a great deal was promised to them – but that this help and support was not delivered.

Reflections from the Workshop Held with the Trust

Multi-Agency Working

10.68. Workshop participants identified several issues in relation to multi-agency working. The first issue was the relationship between Trust services and those of substance misuse services. It was acknowledged that the relationship with substance misuse services needed strengthening. There was reluctance from some Trust-based professionals to refer patients to the service – the culture in the Trust remains that service users should 'self-refer' even when their mental health is precarious and they are not fit to do so. Workshop participants thought this needed to change. The Independent Investigation Team understands that since this incident, significant work has been undertaken in the Trust to have Dual Diagnosis Champions and to understand the referral pathways more; this work continues and is being embedded.

10.69. It was identified that there was an ongoing issue with one of the local Councils in terms of multi-agency working and continuity of care; this was because there is no information sharing agreement in place (and therefore) information does not follow the patient. This was not a new problem – but the absence of an information sharing agreement with the Council meant there was no continuity of care when service users moved from locality to locality (as they frequently do). This was regarded as a major barrier to professional communication and joint working.

10.70. Workshop participants from forensic services were of the view that interagency working with Probation and Social Services was improving but was still *"not good enough".* The MAPPA process as it currently stands (on the ground) requires inputs from forensic services. However when service users move through to other services (particularly to CMHTs) MAPPA information cannot be accessed. The ongoing communication process depends on the quality of handovers and regular professional liaison. This is not always achieved. Forensic out-reach services work across locality teams and find it difficult as teams are given different names and functions – they did not always know if they were referring to *"the right team with right function"*. It was acknowledged that if it was confusing for a Trust-based service, then it must be difficult for multi-agency partners to know how different teams within the Trust operate. The Independent Investigation Team notes: the practice as described by forensic services in relation to MAPPA does not readily equate to the Trust's MAPPA policy which states CMHT care coordinators should attend MAPPA meetings if under CPA with mainstream community-based services.

10.71. Getting professionals from representative agencies to contribute to Trust-based assessment and planning can be a *"big problem".* There are often problems with accessing information as the information sharing agreements across different agencies are not aligned. There are also problems when trying to access clinical records from out of area services. These difficulties have been exacerbated by Local Authorities Adult Services which were withdrawn from integrated Trust-based services. Social workers are no longer embedded in the CMHTs; they only have limited access to RiO, and there is a lack of continuity of input. This leads to 'uncoordinated care'; for example – CMHTs do not know when the social worker last visited and have no access to the social worker records. Neither was there a Trust-based understanding of how social workers were allocated to cases. The move to localities appears to have strengthened links with local partners; however there was an observation that some of the strategic overview has been lost that had existed through the old Mental Health Networks.

10.72. It was noted that care coordinators had to spend a *"significant chunk"* of their time liaising with multi-agency partners trying to get professionals together and to access information across teams. It was thought that more administrative support roles were needed to facilitate these processes.

10.73. Up-coming changes to the CPA process and the change from care coordination to key working were recognised as having a potential impact on multi-agency working. Whilst the existing operational links within localities were deemed to be strong there were concerns that there were some strategic links that might be missing.

10.74. Since the changes in the way social workers support service users (since their withdrawal from Trust teams) it was felt that patients are not being referred for social care assessments and not getting the support they need; it was also noted that carers are missing out on carer assessments.

A solution to this was to have an *"early trigger prompt"* on RiO to ensure referrals were made and followed-up.

Multi-Agency Public Protection Arrangements

10.75. MAPPA was not discussed at the workshop in full as it was a too specialist theme – however it was discussed during the corporate interviews. Participants acknowledged that this was an area that required review and service improvement in tandem with multi-agency partners. Of note interviewees recognised that there were no existing processes within the Trust to monitor service users subject to MAPPA via any extant assurance or governance process. A suggestion was made by a senior officer of the Trust that the Trust compiles a MAPPA register; this would enable the Trust to chart the progress of individual service users and would also facilitate resource allocation.

10.76. The reflections from the workshop (and interviews held with the Trust corporate team) both explained and verified some of the issues identified by the desktop review relating to Mr X's care and treatment.

Conclusions

10.77. The lack of multi-agency partnership working was a key feature of Mr X's case with particular reference to Probation and Social Services. Despite intense levels of input from several different agencies at the same time – there was little joint working (e.g. risk assessments, information sharing, care planning) that put the service user at the centre of the activity. It was also evident that shared access to information was problematic and that assessment, monitoring and planning took place in parallel.

10.78. Both the Trust and the commissioners of this Independent Investigation had already identified multi-agency working to be a key theme of concern within the locality. On close examination (with the support of the Trust workshop participants) it is apparent that there are several factors working together to hinder partnership working; these factors are as follows:

- IT systems that cannot be accessed by the different services and agencies, which is common across the NHS;
- a lack of synergy between the disparate policies and protocols of each service/agency (in particular those pertaining to information sharing);
- a culture where services and agencies do not automatically come together;
- significant caseload pressures which have a negative impact on professional communication and liaison.

10.79. The issues identified regarding MAPPA reflect those already identified in relation to multi-agency working by the Trusts thematic reviews. It is evident that Trust policy guidance does not map directly onto the reality of service provision. The Trust has a MAPPA policy – however this is very long and difficult to comprehend; it is unlikely that practitioners have read

this document and understand in full how MAPPA needs to work and how it actually works in practice.

10.80. Of concern was the general lack of day-to-day professional curiosity. Service users who are subject to MAPPA or on license with Probation Services represent a relatively small but high risk sub-set of the caseload. It would be reasonable to expect risk assessment and diagnostic formulation would take this into account. Whilst understanding the pressure care coordinators are under, this sub-set of service users will require heightened levels of liaison between services and agencies; these service users are priorities in relation to risk and public safety. It is a basic tenet of psychiatry that 'past behaviour predicts current behaviour'.

10.81. Future improvements are not for the Trust alone. In order to achieve the synergy required systems and process will need review across all of the relevant agencies. On a positive note, a multi-agency forum now meets on a regular basis; its purpose is to promote better interagency working. The Independent Investigation Team was able to feedback key interim findings from this process and the intention is for the findings and conclusions to be shared widely and for input to recommendations to be made.

Risk Management

Findings from the Desktop Analysis of Mr X's Clinical Records: Risk Management

Mr X's Release from Prison and MAPPA

10.82. The Independent Investigation Team is aware that it has not been privy to the records held by multi-agency partners and that the Trust's forensic therapy records for Mr X could not be made available as they are held by Probation Services. This means that the evidence relating to how risk was managed directly following Mr X's release from prison (and still on license) is sparse. At this time the Trust's Forensic Outreach Service appears to have been the health representative at MAPPA meetings – it remains uncertain how this worked in practice in relation to risk formulation and management.

10.83. It is a key finding that from July 2015 Mr X's main treating team was the Trust's Community Mental Health Team (CMHT) – this means that all activities pertaining to MAPPA working should have been routed through this service. It also means that Care Coordinators from the CMHT should have attended MAPPA meetings to ensure risk issues were shared, addressed and managed. This does not appear to have been achieved, as no documentation was provided relating to this. Instead a complex picture emerges with disparate services and agencies involved at the same time with unclear roles and communication processes – as a result any protective benefits from the MAPPA process would have been minimised.

10.84. Mr X had a significant forensic history and was open to some 13 services and agencies between his release from Prison in 2014 and his eventual discharge from the Trust in the autumn of 2018. The fact Mr X was subject to MAPPA level 2 underlined the need for supervision and ongoing multi-agency working and liaison. The fact Mr X was referred to Trust services for mental health support and treatment indicates that a coordinated approach was required in relation to risk assessment and management by virtue of any mental illness or disorder he might have had. The relationship between the Trust's forensic services and the Trust's CMHT is confusing – it is not clear who knew what and when and who took the lead role in relation to MAPPA and risk management. However it would appear that forensic services delivered CAT to Mr X as part of a Probation Service contract and was not in actual fact working as part of mainstream Trust provision. This made the need for MAPPA input from the CMHT even more relevant once Mr X had been accepted onto the caseload.

10.85. Following Mr X's release from prison in 2014 an initial risk assessment was generated by Probation Services and shared with Trust services. Moving forward, the content of this risk assessment appears to have been the 'template' from which all others were generated. From this point in time it is difficult to understand how multi-agency working ensured risk assessments and management plans were developed jointly (in accordance with Trust and multi-agency policy guidance). Whilst some discussions were recorded to have taken place it was evident that the Community Mental Health Team was not involved with MAPPA processes and evolved a separate approach to Mr X's risk management. It is evident from the records available that whilst the CMHT noted the ongoing involvement of the Police, Probation Services, Forensic Services and Social Services it has not been possible to understand or evidence how Mr X's risk was assessed and managed in partnership with these agencies.

Community Mental Health Team Risk Management Process

10.86. During Mr X's time with the CMHT (from **July 2015**) he received care and treatment from the Crisis Resolution and Home Treatment Team (CRHTT) and/or the Complex Care and Treatment Team (CCTT). The majority of the time Mr X received his care and treatment from the CCTT – this was his main treating team; his inputs from the Forensic Service at this stage appear to have been for CAT therapy only under the aegis of Probation Services.

10.87. Mr X's placement with the CCTT acknowledged his need for the Care Programme Approach (CPA) and support from a Care Coordinator. The CCTT also utilised an enhanced risk assessment tool which recognised the severity of challenge presented by the service users on the caseload. The Trust's clinical risk policy requirement was (and still is) for enhanced risk assessments to be completed:

- at initial assessment following referral:
- at CPA reviews;

- when new information is received highlighting potential risks;
- when there is an escalation of known risk;
- when there is a significant change in presentation and worsening of mental state;
- prior to discharge.

10.88. The Independent Investigation Team found that there was no systematic approach taken when completing risk assessments for Mr X. The regularity of assessment, the content of assessment and the resultant management plans were often not in keeping with the Trust's policy guidance (this has been ascertained by mapping Mr X's clinical records against Trust and national standards – please see the standards proforma). Information was often incorrect and out-of-date; management plans were often cut and paste, brief and no longer relevant to Mr X's dynamic presentation. There are nine risk assessments on file for Mr X:

- **29 July 2015:** Completed by the CRHTT – this comprised a side of A4 with little information contained within it.

- **8 August 2015:** Completed by the CRHTT – this comprised a side of A4 with little information contained within it.

- **1 October 2015:** Completed by Criminal Justice Liaison – half a side of A4 – very basic information – no plan.

- **30 October 2015:** Completed by the CCTT – this appears to be a detailed assessment – but was lifted from an assessment completed a year previously by Probation Services – there is a detailed care plan but it did not address some of the key risks identified (e.g. paranoia and potential danger to his partner and friends).

- **15 January 2016:** Completed by the CCTT – cut and paste from prior documentation – little new and relevant information was recorded – no detailed plan.

- **14 June 2016:** Completed by the CCTT – cut and paste from prior documentation – little new and relevant information was recorded – no detailed plan.

- **30 May 2017:** Completed by the CCTT – cut and paste from prior documentation – little new and relevant information was recorded – no detailed plan (which was over a year out-of-date and no longer relevant).

- **7 June 2018:** Completed by the CCTT – this was completed at the point of discharge from service. Cut and paste from prior documentation – little new and relevant information was recorded – no plan was included.

- **16 January 2019:** Post incident conducted by Trust Forensic Services – a standard risk assessment tool was used when assessing Mr X in Police custody. The assessment was brief and offered no useful information or plan.

10.89. The mapping of Mr X's care pathway against specific Trust policy standards yielded the following areas of concern:

1. **Risk Assessment and Management Plans at Key Pathway Milestones:** Mr X did not always receive a risk assessment at key milestones on his care pathway (e.g. change of presentation, reported heightened levels of risk; discharge etc.). Examination of the clinical records shows that health professionals, family and friends often thought Mr X to present a significant level of risk; however these concerns did not always trigger a review of risk assessment and management plans.

   It is of note that at various times between 2014 and the killing of Ms Y in January 2019, Mr X had been involved with the Police for assault – these incidents were not examined by the CCTT (although known to them), a lack of professional curiosity was shown and no up-dates to Mr X's risk management plans were made. This was a significant omission.

   Relapse signatures were identified at an early stage in Mr X's contact with the Trust. It was noted that disengagement and non-compliance with medication were key features. However these relapse signatures were never taken into consideration when Mr X's mental state declined – instead discharge was considered and/or implemented.

   A consistent feature that runs through Mr X's entire clinical record is the steadfast anxiety that health professionals felt in his presence in relation to their own personal safety. This was often the focus of all risk assessment and care planning – however this anxiety did not translate into any concerns Mr X might pose to his child, family, friends and members of the general public. This was a significant omission.

2. **Crisis and Contingency Planning:** Crisis and contingency planning was largely absent from risk assessment documentation. It was evident from reading through the main body of the clinical record that Mr X's family and friends did not know what to do when he was in crisis and neither was a there a plan in place to support him. Key risks pertaining to relapse signatures (such as disengagement, substance misuse and non-compliance with medication) were not recorded. Crisis plans when developed were simple lists of telephone numbers to contact (e.g. the CRHTT – who Mr X did not want to engage with).

3. **Dynamic and Up-To-Date Risk Assessment:** The practice of 'cut and paste' was evident. It became increasingly apparent that a significant proportion of the risk assessment narrative had been lifted from prior

assessment documentation over the years – this meant that past errors were repeated and out-of-date information was supplied. It was a consistent feature to find risk assessment narrative which bore little or no resemblance to Mr X's dynamic levels of risk and presentation as recorded in the day-to-day contact notes. When the Independent Investigation Team discussed 'cut and paste' with clinicians from the Trust they immediately recognised and 'owned' this practice. They cited caseload overload as being a key factor for this practice having become an established 'short-cut'.

4. **Information Sharing:** Over the years there was little, and at times no, sharing of risk information between other services and involved agencies. On occasions potential risks pertaining to staff were shared, otherwise risk information was neither discussed nor passed on. In the early years problems were discussed with some of the other agencies involved – but it was not possible to understand how they worked together to minimise risk. By July 2015 virtually no risk assessment and management information was shared (even when Mr X was still on license with Probation Services and subject to MAPPA). It would appear that little risk information came into the Trust or was sent out of the Trust; multi-agency communication and joint working appears to have stalled.

5. **Multi-Disciplinary Approach to Risk Assessment:** Risk assessment appears to have been completed by lone professionals within the CCTT rather than by the multi-disciplinary team as a whole. When the Independent Investigation Team discussed the seeming lack of multi-disciplinary risk assessment and management process with clinicians from the Trust, they instantly recognised this to be a common problem. Trust clinicians cited caseload overload as being a major factor in not bringing the whole team together – consequently Trust clinicians recognised that risk assessments were also completed by relatively junior staff who were not supervised adequately. This made an impact on the overarching quality and effectiveness of risk management processes in general, and can be seen in the case of Mr X in particular.

6. **Risk Formulation:** Risk formulation appeared to be formulaic and often subject to 'cut and paste'. The 5P formulation process as advocated by the Trust's enhanced risk assessment tool did not serve to examine risk 'in the round' (5P stands for: presenting, predisposing, precipitating, perpetuating and protective factors). The 5P formulation process did not provide an opportunity to look at complex layers of risk and how they could interact together to heighten the likelihood of incidents occurring. Mitigation strategies were not developed as result and risk management plans were virtually absent from the record.

7. **Child Safeguarding:** A key concern was the virtual absence of child safeguarding processes. Mr X's children are sometimes listed as being 'protective' factors in relation to his levels of risk. However risk assessment did not examine how Mr X's psychosis, aggression,

paranoia and substance misuse might impact on their health, safety and wellbeing. Mr X's children were mentioned rarely in formal risk assessment documents; it is evident that his substance misuse was not considered in relation to their ongoing safety and wellbeing (as required by Trust policy guidance). A key factor is the absence of any child safeguarding fields on the risk assessment templates – this should be addressed by the Trust as a matter of urgency.

8. **Service User and Carer Involvement:** The risks to, and the concerns of, Mr X's family and friends did not appear to receive the consideration that they merited. Family and friends were consistently open and honest about their fears both for Mr X and for themselves. They were consistent in these views over a four-year period; they thought Mr X was capable of killing someone when unwell. In the end Mr X's partner left him as she could not live with the continued risks to her safety and that of her child. Mr X's family and friends had to put a distance between themselves and Mr X for fear of violent assault. They have reflected to the Independent Investigation Team that their fears and concerns were not taken seriously by the Trust. Most tellingly of all Mr X himself was in constant fear of harming someone – he knew his thoughts and paranoia were neither 'normal' nor within his control. He was always totally honest about his fears – but these did not appear to be taken seriously. It was evident that the treating team thought Mr X was accountable for his thoughts, feelings and actions by virtue of the diagnosis of Paranoid Personality Disorder and that it was not their primary duty to ensure the safety of others. This thinking was still evident when Mr X was assessed by Trust services whilst in custody following the killing of Ms Y and within the narrative the Trust's internal investigation report that was to follow some 18 months later.

10.90. One particular issue was considered by the Independent Investigation Team; it was noted that the format of both the enhanced and standard risk assessments tools did not lend themselves to holistic assessment. Child safeguarding and other particular risks to self and to others are not specified – this lends itself to omissions – especially if the person completing the assessment documentation is relatively inexperienced and working on their own. Key prompts are sometimes necessary to avoid omissions and the formats of both the enhanced and standard risk assessment tools do not provide for this.

10.91. The Independent Investigation Team noted that the risk assessments on record for Mr X do not include a formal forensic risk assessment utilising a nationally recognised forensic risk assessment tool. An assessment of this kind would have been able to examine Mr X's risk of future offending and could have provided a formulation to aide the development of a holistic risk management plan. It is possible that an assessment of this kind was undertaken (as Mr X received his CAT therapy from a clinical psychologist within the forensic service) however if this was the case then the Independent Investigation Team would have expected this information to have been shared with both the CRHTT and the CCTT once Mr X had

been accepted onto their caseloads. Given Mr X's known forensic history, his MAPPA status and his ongoing presentation, the absence of a forensic risk assessment and formulation can be regarded as a significant omission and something that should have been considered on his 2014 release from prison.

Reflections from the Workshop Held with the Trust

10.92. Poor risk management practice is a reoccurring theme that has been identified by the Trust when investigating other similar incidents. The workshop held with Trust managers and clinicians explored the issue of risk management practice. Four key issues that inhibit robust risk management practice were identified:

1. A key point of discussion was *"who does the risk assessment"*? It was recognised that a multi-disciplinary approach was more likely in an inpatient setting; however even when multi-disciplinary discussions took place risk assessments were not completed in 'real time' and were usually left to a lone individual to complete. This meant that the ultimate scrutiny of the whole team was missing; there was no process of sign off, endorsement, or quality review. Because there was no quality review the appropriateness and content of assessments were not monitored. It was also acknowledged that risk assessments and risk mitigation plans were not always connected. A *"sense of fear"* was described with regards to who signed risk assessment processes off as there was often the need to defend actions and decisions at Inquest. This led to further discussion about the need for risk assessment and management processes to be multi-disciplinary in nature with a formal sign off procedure.

2. It was identified that information from other services/agencies was not always incorporated. Trying to engage the Police, GP, and Social Services etc. was considered important but time consuming and not always possible.

3. Staff training was discussed. It was recognised that people needed to be trained and supervised – especially as less experienced, junior staff were often left to complete assessments and develop plans on their own. It was also recognised that without the required levels of experience and skill it was more likely for *"defensive"* and/or *"bland"* statements about risk to be recorded. Also missing was the detailed weighing up of not only the risk of harm, but positive risk taking; it was thought that the Trust needed to provide more training and support in this area. If risk assessment and mitigation planning was left to more junior and less experienced staff (without the support of the whole Multidisciplinary Team) then overly concise and (at times unhelpful) documentation was more likely as staff were *"anxious about completing a fully honest risk assessment, and that's partly because they feel they might be criticised".*

4. Time limitations were also identified as being a key factor when producing overly concise risk assessments and plans.

10.93. The reflections from the workshop both explained and verified some of the issues identified by the desktop review relating to Mr X's care and treatment.

Conclusions

10.94. Mr X had a known, and significant, forensic history. He was known to have been the perpetrator of several serious physical assaults and that he had spent the best part of 14 years in prison as a consequence. Mr X was released from prison in 2014 under license and was subject to MAPPA level 2. It was also known that he had anger control issues and ongoing mental health issues – he was thought to pose significant levels of risk and his treating teams were genuinely afraid of him. As already mentioned in para 10.23 bullet 3 - it is reasonable to conclude that Mr X would have represented service users in the top 1% requiring robust, multi-agency and specialist risk management processes. From the documentation made available to the Independent Investigation Team this does not appear to have happened.

10.95. The Independent Investigation Team concludes that Mr X's diagnosis of Paranoid Personality Disorder served to minimise the response and levels of input from Trust services. It is apparent from reading the clinical records and from talking with Trust clinicians that Personality Disorder is still sometimes seen as a diagnosis of exclusion. Mr X was not managed in the light of national (and local) best practice policy guidance. Whilst it is recognised that individuals with Personality Disorder often disengage from service – this can also be said of those with severe and enduring mental illness (such as Paranoid Schizophrenia). It is a perennial problem that all mental health Trust providers have to manage on a day-to-day basis; individuals should never be marginalised. From a risk perspective a great deal more both could and should have been achieved (e.g. multi-agency liaison, forensic psychiatric assessment and formulation, regular multidisciplinary review). It would appear that Mr X was regarded as being responsible for his behaviour and that Trust services were not required to intervene beyond a certain point.

10.96. It was difficult to understand the risk management process from a review of the clinical records alone due to the overly concise nature of the notes. However what was apparent was that risk and diagnostic formulation were not conducted in keeping with either local or national policy guidance. This was evident in that the different strands of diagnoses and risk presentation were not brought together in a meaningful way in order to understand the levels of risk incurred; this was of particular note when considering Personality Disorder and Psychosis side-by-side with complex and sustained substance and alcohol misuse (dual diagnoses).

10.97. A key concern was the lack of multi-agency risk assessment and planning. Information sharing was virtually absent in the clinical records viewed. This lack of coordination and liaison made risk mitigation problematic for Mr X, his carers and services alike. It would appear that multi-agency activity did not always equate to meaningful engagement and appears to have been run in parallel rather than in synchronisation.

10.98. The safeguarding of children is an area of particular concern and this is examined in the relevant report section below. However it should be noted here that the Trust must review its risk assessment documentation to ensure that child safeguarding is included within the template fields with immediate effect as this omission in formatting may perpetuate the seemingly 'blinkered' view taken by Mr X's treating team. Trust policies also need revision to pull child safeguarding responsibilities together – at present clinical risk, safeguarding and CPA policies do not synchronise and this lends itself to flawed assessment processes.

10.99. The key factors identified:

- a lack of multidisciplinary working;
- a lack of inter-service and multi-agency liaison and working;
- a lack of synergy between disparate Trust policies and assessment documentation;
- the lack of supervision, endorsement and sign-off of risk assessment documentation and process;
- the need for an overhaul of current systems and ethos in relation to risk and those with Personality Disorder;
- significant caseload pressures.

The Care Programme Approach and Care Planning Process

Findings from the Desktop Analysis of Mr X's Clinical Records: The Care Programme Approach and Care Planning Process

The Care Programme Approach (CPA): Policy

10.100. The Trust CPA policy (in place at the time Mr X received his care and treatment and amended in 2018) stated that *"The Care Programme Approach (CPA) is a framework to support professional and clinical practice and is founded on the principle of Service User and Carer involvement underpinning the delivery of high quality, recovery focused care".*

10.101. The policy also stated that *"The CPA documentation provides a vehicle for recording high quality assessments and care planning and for actively involving Services Users and their Carers, in decisions about their care and treatment which supports and promotes their aspirations, strengths, wellbeing, social inclusion and optimum personal recovery. Two central components of the CPA are the role of the care co-ordinator who has*

overall responsibility for the coordination of the assessment and care planning processes in partnership with the Service User and Carer, and multidisciplinary team working".

10.102. Policy expectation was that all service users had a CPA review at least 12 monthly – but that additional reviews would be called should there be a significant change in the service user's presentation. The purpose of the review was to focus on the effectiveness of the care plans. Every service user was entitled to ask for a review of their care and treatment at any time. Reviews were expected to pay close attention to the needs of services users, their children and their carers.

CPA and Mr X

10.103. Mr X was eligible for the Care Programme Approach (CPA) and received this via his contact with the CCTT – this was good practice. During his time with Trust community Services Mr X always had a named care coordinator – this was also good practice. However it was evident that Trust-based care coordination was made more complex by Mr X having (at the same time) two other care coordinators from other agencies – it is entirely unclear how the care coordination role worked – even in relation to other Trust-based services. The role of the care coordinator appears to have been that of community-based worker rather than that of a professional coordinating care between services and agencies. It is evident that the CCTT care coordinators were not invited to attend MAPPA meetings; this was not in keeping with Trust policy guidance. The Trust's MAPPA and CPA policies also state that if a service user is subject to MAPPA then it is an agenda item at every CPA review – in the case of Mr X this was not achieved.

10.104. Continuity of care and approach appears to have been virtually non-existent between external agencies and internal Trust services, something CPA is meant to facilitate and manage, but which appears to have been ineffective in Mr X's case. Professionals from different services and agencies who could not attend CPA review meetings were sometimes asked for contributions (when Mr X first entered service) but as the years went by this was irregular and caused Mr X a great deal of frustration. CPA reviews were often held with minimal contributions from relevant agencies and Trust-based health professionals alike and Mr X saw this as 'stalling' his progress.

10.105. Due to the fear professionals had for Mr X he was often asked to attend NHS sites for assessment and routine monitoring – he had a great many services involved and it is evident working with them was often a 'full time job' for him which he sometimes found difficult to accommodate – particularly when he felt too paranoid to travel from home. Mr X became angry when professionals from disparate services and agencies held different opinions from each other and when it was evident they had not communicated one with the other. A function of CPA is to facilitate continuity of care and in Mr X's case this was not achieved.

10.106. CPA reviews were held in a multidisciplinary forum – however there did not always appear to be opportunities to review Mr X's medication, care and treatment in light of his ongoing psychosis and aggressive behaviour. Assessment outcomes were neither holistic nor multidisciplinary – instead the same assessments and review documentation were duplicated (cut and paste) through time – often not changing apart from the smallest of details – and bore little relation to the ongoing contact progress notes which painted an increasingly concerning picture over the years. It is not clear how Mr X was engaged with the CPA process; his anxieties were often listed, but were not actually addressed as part of the CPA review procedure.

10.107. The Trust's CPA policy requires the ongoing review and monitoring of the safety and wellbeing of children, this was not achieved in the spirit of the policy guidance. The issue of child safeguarding is addressed in more details in the relevant report section below.

Care Planning

10.108. CPA reviews were held with Mr X present and the care planning process appears to have been held with him, however Mr X's aspirations, strengths and needs etc. were not examined in a dynamic manner and the care plans were not recovery focused. Mr X and his carers were involved over time, but disagreements and concerns were not managed robustly with the treating team often choosing a care plan that neither Mr X nor his carers understood or agreed with. Reviews tended to focus on short-term interventions and did not support Mr X in building up his daily living skills. This was an important omission as Mr X had (in effect) been in institutions from the age of nine (care homes, residential boarding schools, the army and prison) he had few life skills and often neglected himself when his mental health relapsed.

10.109. There are five care plans on record for a period spanning some four years. There are no care plans on file for the specific years 2014 and 2016. Care plans are often 'cut and paste' – the earlier care plans are the most comprehensive. Care planning does not equate to Mr X's changing presentation over the years and were not written in response to identified need. Mr X's needs were manifold – he articulated them well – and they were recorded during the assessment process – however the care plans bore no relation to the assessment narrative and Mr X usually refused to take a copies of the plans as a result.

10.110. Of particular note was the break down of the therapeutic relationship between Mr X and the health professionals within the CMHT treating teams. It should be acknowledged that some professionals worked well with Mr X. However others took a somewhat punitive stance and this led to a breakdown in therapeutic relationships. Mr X was rarely listened to (this can be evidenced by reading his clinical records) and he felt he was not shown respect; this caused him a great deal of frustration. It is evident that services were withdrawn from Mr X on occasions in an attempt to get him

to comply with the care and treatment offered (e.g. medication access withdrawn and no access to appointments when in crisis – 15 September 2017, 30 May 2017) – this should not have occurred as it placed Mr X and those around him at increased risk. This pressure on Mr X to comply with care plans he had no confidence in was a self-defeating course of action and poor practice. Ultimately discharge from both CPA and Trust services took place in 2018 in the face of Mr X's continued disengagement and non-compliance – when the Independent Investigation Team met with Mr X (as part of this review process) he explained that this was in part due to his mental illness and florid psychosis, and in part due to loss of trust and confidence in services. However the Trust's CPA policy states that discharge from CPA (and service) should not be considered as a response to disengagement – instead a more assertive outreach approach should be taken to re-engage and to re-build relationships. In the case of Mr X this ultimately was not achieved.

Reflections from the Workshop Held with the Trust

10.111. Trust-based clinicians offered some reflections in relation to how CPA was working across the Trust; these reflections have helped to explain and validate key findings from the desktop review of Mr X's clinical records.

1. CPA reviews/Multi-Disciplinary Team (MDT) meetings were often not attended by key professionals as people *"are pulled from pillar to post".* The consensus was that job planning would be supportive and enable people to manage service expectations better. Care coordinators (and CMHTs in general) are overwhelmed by the size of caseloads and the risks teams are carrying. They are focused on ticking boxes and getting deskilled in using *"clinical common sense".* Suggestions to resolve: more training and support is required to manage complexity; but this would require additional resources to reduce caseload numbers. Reduction in the numbers of teams was considered sensible as the 'hand-offs' take time and patients *"fall down the cracks".*

2. Workshop participants admitted to a 'cut and paste' approach in relation to care planning (knowing this would probably avoid detection during audit as long as something was written). Caseload overload was given as the main reason why this 'shortcut' was taken.

3. In relation to care coordination workshop participants discussed the national changes to the Care Programme Approach (CPA).[5] Care coordinators will be replaced by key workers – it was uncertain how the changes would support staff experiencing burn-out and tiredness which resulted in them not updating risk assessments and care plans. It was discussed that the Trust suite of assessment templates possibly made a contribution to an overly concise record being developed as staff were *"reluctant to stray"* from templates as it helped them *"get the job*

5 Care Programme Approach NHS England and NHS Improvement position statement 1 July 2021 Version 1.0

done"; it was recognised that this approach did not support patient-centred care.

4. The interface between CMHTs and Forensic Services was discussed in relation to CPA; it was agreed that *"there's no one way of everybody who needs information getting hold of it"* – this was due to the incompatibility of different record systems. It was also understood that the threshold for referring to forensic services (and dual diagnoses services) was high and that there was an expectation that CMHTs should *"manage".* CMHT services were stretched with *"big caseloads, lots of complex patients on those caseloads".* Care Coordinators are expected to *"to do"* everything and often work in isolation. This was a key factor in care coordinators not having enough time to:

> *"… keep up on top of all that paperwork, and also we were talking about lack of time in reading notes before going to a CPA review. It was mentioned that staff can also often join that meeting blindly. Having not read everything before hand because they simply don't have the time to do that, which obviously affects the quality of that meeting and what could be the outcomes of that. So we were just talking about how we can manage that better and there's a suggestion for a need for job planning, just to ensure that staff do get that dedicated time".*

5. A key reflection was that due to pressures on specialist services (e.g. forensics and dual diagnoses) that care coordinators and CMHTs were expected to manage a level of complexity that they did not know how to deal with. Service user caseloads held high amounts of risk and this caused a great deal of stress to practitioners. It was mentioned:

> *"I think that's where the process can slip up a little bit, because it just comes down to one person. We are human beings, we make mistakes and if it is just on one person to fill in all that paperwork when you've got caseloads of 30, plus duty tasks, plus any complaints to investigate or whatever else that you do, something is going to go wrong. And unless that changes I think things are going to continue to happen, and I think the job planning thing was music to me".*

6. Trust clinicians also reflected that services and agencies have access to different recording systems. There is an inconsistency in cross-team/agency access; this inconsistency was deemed to *"cause risk".* Workshop participants asked whether they could (as a minimum) have read-only access to the following electronic databases: EMIS; LAS; RiO; CiTO, Windup; LPRES; ECR; and IAPTUS. The lack of access to record systems made CPA difficult to implement in keeping with Trust policy guidance.

10.112. The Independent Investigation Team is grateful to the Trust workshop participants for their honesty and insights which enabled a greater level of understanding than could be yielded from a desktop analysis alone.

Conclusions

10.113. The workshop contributions were able to highlight three main issues that were compromising the effectiveness of CPA:

1. Caseload overload and professional burnout (in part due to Covid).
2. The need for work plans and protected time.
3. Incompatible and inaccessible record systems (NB: new systems are being implemented at present).

10.114. The Trust also recognises (via its own thematic review processes) that CPA and care coordination sometimes does not meet policy expectations in general. Caseload overwhelm and resource restrictions appear to be making a significant contribution to:

- early discharge from CPA;
- complex cases being 'held' by CMHTS due to a lack of caseload capacity with other services (e.g. forensics and dual diagnosis);
- a lack of true multi-disciplinary working due to time constraints and competing priorities;
- problems with professionals having no time to contribute to joint assessment and planning meetings;
- time restrictions which make a contribution to records being inadequately accessed, developed and shared.

10.115. These generalised findings can be directly overlaid onto Mr X's particular care pathway. The Independent Investigation Team also concludes that the loss of trust and confidence on the part of Mr X in the services provided, and the seeming barriers presented by Mr X's diagnosis of Paranoid Personality Disorder worked together to prevent the CPA processes from being effective in both helping Mr X with his mental health issues and maintaining a coordinated means of keeping him and members of the general public safe.

Managing Disengagement

Findings from the Desktop Analysis of Mr X's Clinical Records

10.116. There were frequent occasions between 2014 and the autumn of 2018 when Mr X either disengaged from service or was non-compliant with care and treatment – this was usually triggered by his severe paranoia and psychosis and/or a general lack of trust and confidence in the care and treatment being provided. However over the years most requests for help and support were initiated by him – it is evident that he wanted to engage with services – however he did not always have enough confidence in them to sustain full cooperation.

10.117. Over the years Mr X was routinely followed up when he disengaged or became non-compliant with care and treatment – however the approach taken depended on the individual practice of each health professional involved. The reasons for Mr X's disengagement were neither examined nor addressed. This meant follow-up was reactive and did not take his relapse signature into account (disengagement and increased paranoia). Over the years some care coordinators did their very best to stay in touch with Mr X – however Mr X's paranoia and deep frustration with the treating team damaged relationships – and this specific factor was not reviewed and should have been.

10.118. In Mr X's case there are no records of proactive discussions taking place in relation to Mr X's frequent lack of engagement – interventions tended to be reactive and (on occasions) unsatisfactory (e.g. discharge). Disengagement and withdrawal were listed as relapse signatures – it was also recorded that when paranoid Mr X could not leave his home or use public transport to travel to appointments – however no plan was recorded as to how to manage this. Calling him on the telephone or leaving messages were not enough to re-engage him when unwell.

10.119. On two occasions when Mr X had disengaged from service an assessment under the Mental Health Act was requested (once by Mr X's partner and once by his care coordinator) due to Mr X's distress, aggression and paranoia – on both occasions the consultant psychiatrist declined to undertake an assessment – Mr X was instead urged to comply with medication.

10.120. It is evident that when Mr X disengaged no contact was made with his friends and family as required by Trust policy and procedure – neither was consideration made regarding Mr X's young child who lived at home with him – even though it was known Mr X disengaged when he was paranoid and relapsing.

10.121. Ultimately Mr X's disengagement and paranoia led to him being discharged twice – once in the summer of 2018 and once in the autumn of 2018. On both occasions (he had been referred back to service by his GP) he was discharged before being assessed in a face-to-face meeting. On both occasions the treating team (who had detailed prior knowledge of him) did not take into account his extreme paranoia (detailed by the GP who had referred him). Both referrals were picked up by the CCTT and it is without doubt that Mr X met the criteria for CPA on both occasions and a more assertive follow up should have taken place. This went against Trust CPA policy guidance.

Reflections from the Workshop Held with the Trust

10.122. Workshop participants identified the following issues:

1. It was recognised that the level of effort required to engage service users depended upon the amount of 'leverage' the teams had at their

disposal. For instance forensic services could ensure engagement because of Court and Probation involvement. In the main there was felt to be a tension between managing risk and ensuring engagement – this was felt to be difficult – especially when more than one team was involved.

2. There was a sense that the responsibility to engage did not rest with clinical teams alone and that service users needed to share responsibility, especially if they had a personality disorder, as it was thought this type of diagnosis conferred an additional layer of accountability to the service user. It was understood that service users with personality disorder were sometimes discharged if it was thought to be *"the only option"* – however there was some unease voiced about this. It was also thought that the role of mental health services needed to be defined when service users persistently disengaged and refused to comply with care and treatment. This was seen as being of relevance due to caseload overload and restrictions on the resource available. Workshop participants discussed the need for a more honest communication with service users, referrers and commissioners, setting out the practical limits to what a service can achieve because sheer willpower and intense follow up could not always ensure an independent third party (the service user) cooperated. There was a feeling that mental health services were expected to *"fix"* everything when in reality they could not.

3. This theme was considered further in relation to initial GP referrals when mental health teams found it impossible to make contact with the service user in order to assess them and allocate an appropriate team. The dilemma faced by service was explored and the lack of 'leverage' was recognised as a key problem – mental health teams could not enforce engagement and often felt like their *"hands were tied"*.

4. It was noted that specialist Assertive Outreach Teams had been disbanded ten years previously. However Trust policy guidance still mentioned referral to Assertive Outreach when in reality this service no longer existed – instead it was yet another adjunct to already overloaded CMHTs. This was an area that workshop participants felt had not been sufficiently thought through by the Trust.

5. The key factors identified were:

   - large caseloads hindered care coordinator efforts to maintain contact;
   - there is a tendency to discharge service users with personality disorders (described as *"uncooperative patients")* – teams often do not have the time to reflect on what steps could be taken to prompt further engagement;
   - Home Treatment Teams sometimes feel stuck in the middle when people do not engage;

- START finish their working day at 5pm, which is sometimes not helpful in engaging service users and liaising with referrers (this is currently under review as part of service improvement processes);
- caseload sizes reduce the flow between teams;
- more support is needed to facilitate engagement;
- the Trust should undertake a review of who is discharged (and why) in order to understand if decisions are taken appropriately;
- mental health services need to be honest and transparent about what they can achieve and what they cannot (with service users, commissioners and referrers alike);
- better partnerships need to be built with referrers;
- mandate reflection time for teams together with individual thematic analysis.

Conclusions

Policy

10.123. The Independent Investigation Team found the Trust engagement policy to be an exemplar of best practice; the issue, however, is whether it is achievable. How feasible it is to liaise with the GP and Social Services (for example) every time a service user disengages? How responsive will these other services be? What exactly is the Trust trying to achieve by doing this? What does the Trust actually expect of these other services? The policy might be a bit over optimistic and it is evident many of the actions advised are not put into practice.

10.124. The Trust's Promoting Engagement and Access to Mental Health Services Standard Operating Procedure (March 2021 – March 2022) suggests the use of Assertive Outreach, but in reality this is not a uniform provision across the whole Trust – the expectation is unrealistic. In reality assertive outreach teams were disbanded some 10 years ago and CMHTs have to add this function into their day-to-day working.

Trust-wide Issues

10.125. Workshop participants identified the legitimate difficulties all mental health services across the country face in relation to service user disengagement. The insights offered were both valid and useful. It would be good practice for clear guidelines regarding expectations to be set out; mental health services, referrers and service users should work in partnership whenever possible. However it should be noted that mental health services have a duty of care to ensure that all due process is followed before any decisions to discharge a service are taken – due process (in keeping with Trust policy guidance) should include:

- the development of a care plan to manage disengagement (which is agreed between service and service user);
- the identification of relapse indicators;
- the involvement of carers (where appropriate)

- the implementation of key safeguarding measures (particularly in relation to children)
- discussions with all stakeholders (including service users where possible);
- a multidisciplinary-based risk assessment;
- instruction for GPs and service users as to how to re-enter service at any point in the future.

Issues Relating to Mr X

10.126. Disengagement and non-compliance with medication were assessed as being early relapse indicators for Mr X not long after his 2014 release from prison – however these factors were never recognised as a marker for his deteriorating mental health as the years passed. When he was paranoid he could not leave his house or travel on public transport – this led him to miss appointments on many occasions (exacerbated by health professionals' reluctance to visit him in his own home).

10.127. It is evident that Mr X wanted help and support and sought it out actively over the years. The reasons for his disengagement and non-compliance were very specific – paranoia and a lack of trust and confidence in the approach taken by his treating teams. Mr X did not present as a person with personality disorder, he made his issues clear and was consistent, he sought out help and support consistently – however it is evident that service saw his disengagement through the lens of a personality disorder diagnosis and thought it was a legitimate course of action to discharge him. It must be noted here that this stance regarding the management of people with personality disorder should be thought through by the Trust; whilst treating people with personality disorder can be challenging on occasions – it is essential that all due process is followed first (disengagement management care plans, assertive follow up etc).

10.128. The Independent Investigation Team concludes that Mr X's diagnosis of Paranoid Personality Disorder and his often threatening demeanour distanced him from services. It is mentioned in the clinical record on many occasions that home visits were no longer to be made due to the risk Mr X posed to staff. However this stance became a significant barrier – Mr X could not attend outpatient appointments due to his severe paranoia – and on frequent occasions service did not want to visit him at home. This was not sufficient reason for service (in effect) to disengage from Mr X (rather than Mr X disengaging from service). A more assertive approach should have been taken – being afraid of Mr X was not sufficient reason to not follow up. In fact the significant anxieties health professionals had for their own safety should have meant additional measures were taken when Mr X disengaged and was known to be paranoid – this should have been a 'trigger' for more assertive action (not less) to have been taken.

Safeguarding

Findings from the Desktop Analysis of Mr X's Clinical Records

Safeguarding Children

10.129. Mr X is the father of three children – two were born before his release from prison in 2014 and one was born after. Mr X's access to his two older children was restricted and ongoing Court processes were in play. There is no narrative within the clinical record that sets out any further details regarding this, or which Local Authority took the lead responsibility. Mr X's two older children did not live with him and they receive little mention in the Trust-based records. No professional curiosity was shown.

10.130. Mr X's new partner became pregnant with his third child following his release from prison. Mental health services were aware of this situation from an early stage in the pregnancy.

10.131. There is no evidence to suggest liaison with health visitors or primary care took place when Mr X's partner was expecting their child in 2014 (presumably because Mr X's partner was not the patient and did not want services involved with her or her child). Mr X was asked to report the new baby to Social Services himself (as instructed by the CMHT) – this was not in keeping with Trust safeguarding policy expectations. There appears to have been a very literal interpretation of the policy guidance (in that Mr X's partner was not the patient during the pregnancy) which did not consider the potential health, safety and wellbeing of the child. Ultimately the unborn baby was referred to Social Services (it is unclear which service/agency did this) but it is evident that Mr X and his partner were confused about this and that the reasons had not been discussed with them – it would appear that contact by Social Services was not maintained.

10.132. In July 2014 Social Services decisions to withdraw safeguarding input appear to have been made due to Mr X's non-cooperation, fears about his levels of threat to staff and resourcing issues. It is unclear how other services continued to monitor child safeguarding. Child welfare and protection issues are absent from Trust risk assessment and CPA documentation formats. Decisions as to whether to refer to Social Services were usually taken dependent on Mr X and his partner's views – limited consideration was given to Mr X's forensic history, mental health, substance misuse and anger management issues. There is little in the Trust-based records that details Social Services inputs (when they did take place) or what triggered them – there are no shared care plans or risk assessments on record.

10.133. Assessments in relation to the health, safety and wellbeing of Mr X's children are largely absent from risk assessment and CPA documentation

– even when Mr X was psychotic, misusing substances, drinking alcohol, and being overtly angry, aggressive and threatening. Mr X had Court restrictions on access to his older children (overseen by Social Services) this was not addressed appropriately in any formulation, assessment or ongoing management plan in relation to the potential risks to his third child.

10.134. In January 2016 an email referral to *"Child Social Services"* was made because Mr X had become angry during a CPA meeting in front of his baby (who had been brought into the meeting by his parents). There are no follow-up actions listed – and there were no changes made to any ongoing risk assessments or management plans. It is also unclear how this was communicated to other services/agencies in relation to Mr X's MAPPA status. A member of the CMHT conducted a 'child safeguarding review' which was in a 'tick box' format with no narrative, plans, or actions detailed (this tool appears to have been used across Trust and other agency services). It would seem that Social Services did not provide any ongoing safeguarding inputs following this referral.

10.135. Even following the 2016 referral to Social Services, assessments and documentation usually state 'no risk to children'. It should be noted that much of the time Trust staff were too afraid to visit Mr X at his home due to his levels of violence and aggression. Trust CPA and Safeguarding policies are explicit in the requirement to have a 'families first' ethos. This was not achieved in the case of Mr X and his third child – no assessment in relation to child safeguarding was made in the home. This was a significant omission.

10.136. It is apparent that electronic risk and CPA assessment formats do not include specific mention of child safeguarding – it is probable that a very literal view was taken by those recording assessment and that they only completed the fields on the templates that were required. This is something that should be reviewed by the Trust.

Safeguarding Vulnerable Adults

10.137. Mr X, his carer, family and friends would not have met the formal criteria to be considered as vulnerable adults as detailed in the Mental Capacity Act (2005). However the contact notes often describe Mr X as losing weight (four stones at one time) and that he could not look after himself once his partner had left him. It is evident that at this time Mr X could not leave his home on frequent occasions due to extreme paranoia and increasing auditory hallucinations. Mr X was not seen as a vulnerable adult and perhaps should have been; this aspect should have been considered in keeping with Trust policy guidance. It is clear that the contact note narrative describes a vulnerable adult. It should also be remembered that Mr X had only ever lived independently in the community for very short spans of time. He had been in residential care (boarding schools) since the age of nine, in the army from his late teens, and in prison for 14 years between the ages of 20 and 35 years. Consequently Mr X had few

functional daily living skills – when combined with his paranoia and psychosis (and the withdrawal of family and friends due to their fear of him) he did not function well and severely neglected himself. His self neglect was recorded in the contact notes – but no assessment or care planning appears to have been put into place. This was a missed opportunity to understand Mr X's needs better.

Reflections from the Workshop Held with the Trust

10.138. Workshop participants offered many useful insights which supported the findings from the desktop analysis.

1. The consensus of the workshop participants was that each team should have a safeguarding champion; the purpose being to embed safeguarding in day-to-day practice. This would also prevent the intense workload of the duty safeguarding practitioners (Trust advisory and support staff for safeguarding) who were *"getting up to 40 calls a day so dealing with significant volume, which is why they want to invent the safeguarding champion role more".* NB: the Independent Investigation Team understands the volume of calls is due in large part to the advisory and support role of the practitioners rather having 40 serious safeguarding alerts raised each day.

2. RiO (the Trust's electronic clinical record system) and Trust assessment templates were discussed – 'Liquid Logic' has a relationship tab so matches and links can be made with families and service users; but this was not possible on RiO. It was noted that the safeguarding children form was *"less visible"* on RiO and that there was a *"feeling"* that child safeguarding assessment forms were not routinely filled in as the standard risk assessment template had no specific mention of children on it. If children were not mentioned on the template then any omissions in child safeguarding assessment would not be detected during template compliance audits. A concern was expressed about creating yet more paperwork and it was thought that child safeguarding should be made more explicit in existing documentation (risk assessment, CPA etc) and Trust policy aligned accordingly. If child safeguarding documentation remained separate then there was a feeling that it would never be integrated into mainstream thinking and assessment.

3. It was recognised that the quality of assessment and content of the clinical record relied upon the competence, experience and curiosity of the clinicians involved. It was felt the Trust needed to focus more on wellbeing (school attendance, age appropriate toys in the home etc.) not just risk and the categories of abuse. Clinicians needed to have full discussions with families rather than ask questions by *"rote";* in order for a more well-rounded approach to be taken additional training was indicated.

4. The incompatibility of electronic patient recording systems (and lack of general professional communication processes) also needed consideration. It was recognised that service users and their families were often involved with a multitude of other services/agencies but that there was no method by which Trust practitioners could access information (or provide it) on a central system.

   The key factors identified were:

   - good support from safeguarding practitioners and safeguarding supervision were in place but would be supported further by safeguarding champions;
   - communication between different services/agencies is challenging;
   - electronic databases do not lend themselves to good safeguarding practice;
   - Trust assessment templates (risk, CPA, safeguarding) need to be integrated to ensure seamless child-centred processes;
   - there is a need to link incident reports to risk assessments which will require updating;
   - it is important to highlight whose continued responsibility safeguarding is (and at what point) particularly when patients transfer between teams e.g. START, HTT, CMHT;
   - confidence of practitioners is sometimes lacking (not always knowing what to document and assess including those outside of the Trust e.g. GPs);
   - safeguarding training needs to include some practical aspects e.g. what to document, such as age, appropriate toys in the home, attendance at school etc. rather than 'ticking' categories of abuse;
   - lots of services link in but there is no central recording system;
   - safeguarding should be built into the culture of teams and services so it is seen as everyone's business;
   - the culture of communication needs to change – there are too many emails which are impersonal and just seems to offload problems rather than deal with them;
   - there is not enough experience on the ground dealing with high risk patients – there is a need for more Band 7 practitioners engaged directly with service users;
   - sometimes patients have to engage with many teams – perhaps there needs to be a single team focused around a child-centered model.

Conclusions

Child Safeguarding

10.139. It is evident that even the most basic of child safeguarding measures were absent in the case of Mr X's third child. Given Mr X's forensic history and known risk profile this was unacceptable. It must be said that Mr X and his partner appear to have been loving parents – however this is not the point. Any service user subject to MAPPA, who is misusing illicit substances and

has ongoing anger control issues should instantly raise child safeguarding alerts. It should be remembered that CCTT personnel were usually too afraid to visit Mr X at this home, and yet there was no recorded consideration for the ongoing health, safety and wellbeing of his baby.

10.140. The issue of safeguarding links directly into the issues of multi-agency working and MAPPA processes (as already examined above). Systems and processes do not appear to have been joined up and joint working does not appear to have been a feature. This was a significant omission.

Vulnerable Adults

10.141. Mr X presented as a large and aggressive individual. It was evident that both health and social care professionals were afraid of him and were intimidated by him; this led to a somewhat boundaried and guarded provision of service. However it is also evident (from what was routinely recorded in the day-to-day contact notes) that he struggled to cope with even the most basic of daily living activities. Mr X was desperate for help but he found it difficult to trust people. Working with Mr X on his daily living skills would undoubtedly have provided support and could possibly have built up a more solid therapeutic relationship with him. The Recovery Team and Floating Support Services are mentioned in Mr X's clinical record – but these are mentions only – it has not been possible to understand if he actually received a service from them. In the event (due to his reported self-neglect) it would appear these services (if provided) were not involved for long. Presumably they were involved directly after his release from prison but did not continue for a prolonged period of time – the Independent Investigation Team can only speculate.

10.142. Risk and CPA assessment documentation allows for the assessment of vulnerable adults – however assessment processes did not match the narrative from the day-to-day contact notes. It is evident that a recovery model was not the basis upon which Mr X's care and treatment was provided.

Summary

10.143. The Trust has safeguarding processes 'split' between three distinct policies, Clinical risk, CPA and safeguarding. The word 'split' is used because that is in effect what has happened – it is not that safeguarding is mentioned as a priority thread within all three policies – it is that function, inputs and responsibilities have been divided up. Unless all three policies are read and addressed in tandem omissions are likely to take place – as was for the case for Mr X and his family. This is something that Trust workshop participants recognised in support of the desktop analyses findings.

10.144. It is also evident that risk assessment documentation omits any mention of child safeguarding and without prompts (and in conjunction with divided policy documentation) child safeguarding is rendered 'invisible'. Trust

workshop participants felt this presented a significant risk when relatively inexperienced and junior health professionals were left with assessment responsibilities. This is compounded by caseload pressures, restrictions to proper multidisciplinary working and fragmented partnership working with other agencies.

10.145. The Trust workshop participants provided insightful analyses and solutions to the current challenges facing safeguarding practice. They described the need to 're-boot' the safeguarding culture within the Trust and to ensure that it is everyone's business and a central feature of all clinical assessment, planning and multiagency working.

Carer Assessment and Involvement

Findings from the Desktop Analysis of Mr X's Clinical Records

10.146. There is a single carer assessment on file for Mr X's partner. Mr X's partner was offered this assessment but the only form within the clinical record is blank.

10.147. It is evident that Mr X's partner struggled with Mr X's mental health issues – she was recorded as being afraid for her safety. She frequently sought help for Mr X (requests for appointments to be brought forward, assessment for detention under the Mental Health Act (1983) etc.) – but her requests were rarely acted upon in a timely manner (or at all). Mr X's partner attended CPA review meetings – but it is difficult to understand how a two-way communication process was facilitated – it appears that CPA reviews did not address the issues brought to the meeting by Mr X and his partner, instead they were opportunities for the treating team to state its preferred care and treatment options. Eventually Mr X's partner left him and took their baby with her; she was afraid of him as he grew more paranoid and suspicious.

10.148. Mr X's family and friends were also extremely concerned about him. They had varying levels of success in getting help and support for Mr X. Mr X's family spoke with the Independent Investigation Team – their view was that they were largely ignored and that the likelihood of Mr X perpetrating another violent assault was only a matter of time. The family grew increasingly afraid of Mr X and withdrew from his life, but before doing so they wrote to the CCTT to express their fears. The letter was written anonymously as by this time they were very afraid of what Mr X would do to them should he find out they had contacted mental health services. This hand-written letter is still on file, it would appear it was ignored.

10.149. An important feature was that Mr X welcomed and depended upon the support of his family and friends (until his paranoia became too great). There is nothing on record to suggest Mr X's capacity was ever assessed

in relation to third party inputs or that he ever requested information to be withheld from family and friends.

Reflections from the Workshop Held with the Trust

10.150. Workshop participants agreed that some teams within the organisation worked well with carers. Examples of good practice could be identified when service users gave their consent at the outset for carers to be involved – however it was recognised *"that it's much harder when the patient has capacity and they say they don't want the carer involved, and then something goes wrong".*

10.151. Clinical staff were often uncertain how to work with carers, but were aware they could listen to information offered – even if they could not divulge information when service user consent was withheld.

10.152. It was recognised that where significant risks were present (such as safeguarding children or a known risk to family members) the Trust needed to do more to ensure carers were worked with and that information needed to be shared (with or without consent). However it was also recognised that this was a challenging issue as no one wanted to breach patient confidentiality or to potentially disrupt a therapeutic relationship with the service user.

10.153. The withdrawal of Social Workers by Local Authorities as embedded members of community mental health teams had impacted upon how carer assessments were conducted and also how frequently they were offered.

Conclusions

10.154. The 2020/2021 Annual General Meeting report describes the Trust's commitment to the 'Triangle of Care'. The report states that The Trust has completed Phase 1 of the Triangle of Care (ToC) and was awarded a star in July 2019 for its carer inclusive and supportive commitment. The ToC is a therapeutic partnership (between carers, people who use services and professionals) based on engagement, information sharing and support. It aims to promote safety, recovery and to sustain wellbeing in mental health by including and supporting carers. This is good practice and demonstrates that the Trust has a robust model to work with; however it would appear that coverage might not be Trust-wide.

10.155. It is evident that Mr X's carers, family and friends were not worked with in the spirit of the 'Triangle of Care'. This ultimately led to Mr X's carers, family and friends withdrawing their support from him in an attempt to maintain their own safety. This served to isolate Mr X further and made his ongoing engagement with Trust services more difficult.

Service User Involvement

Findings from the Desktop Analysis of Mr X's Clinical Records

10.156. The Independent Investigation Team found that the therapeutic relationship between Mr X and his treating teams (HRCTT and CCTT) was compromised at an early stage. The clinical record charts clearly that Mr X felt embattled and that people were not listening to him. Throughout his life he had been aware of racial slurs and was sensitive to potential negative judgements being made about him. Mr X found it difficult to talk about his 'inner world' and found discussing his paranoid ideas embarrassing and humiliating. As a consequence Mr X had learnt to mask his symptoms and from an early stage his reticence to discuss his thoughts and psychotic beliefs was documented in the clinical record. The few psychiatric assessments that were conducted made comment on how difficult it was to 'read' Mr X and get a clear impression of his problems.

10.157. The clinical record demonstrates that at times health professionals appeared to challenge Mr X about his psychotic thinking, auditory hallucinations and beliefs rather than explore them with him. Consequently he tended to 'clam up' for fear of sounding foolish – it was also evident he did not have the words to explain what was going on in his head. Instead of working with Mr X to draw him out and to understand him better – health professionals appear to have taken his difficulty in articulating himself as evidence that his symptoms were not part of a genuine psychotic picture.

10.158. The disagreements between Mr X and his Trust-based treating teams are recorded in detail within the contemporaneous clinical notes. The main areas of disagreement were his diagnosis and care and treatment plan. Mr X felt that he was being *"fobbed off"* – he remained convinced that his given diagnosis of Paranoid Personality Disorder did not explain the severity of his symptoms. It is evident that Mr X and his treating teams got caught in a seeming battle of wills – Mr X would ask for help – but it was always conditional on him taking medication he had no confidence in (due to the side effects) and attending meetings on NHS premises (even when he was too paranoid and unwell to leave his house).

10.159. It is without doubt that when frustrated Mr X presented in an aggressive and threatening manner – it is also without doubt that a somewhat punitive response was taken which Mr X found humiliating and shaming (there are several examples of this kind of interaction in the clinical records which have not been included here due to Scott and Salmon issues and the desktop nature of this Investigation). This served to put further distance between him and his treating teams.

10.160. Consequently discharge was regarded as the final solution to Mr X's disengagement and non-compliance. At no time was the deterioration in the therapeutic relationship discussed fully and honestly. This was a

significant omission. Instead Mr X was viewed as being a 'problem' that could only be managed by ever-increasingly rigid boundaries – a course of action that was doomed to failure as it served to make the situation worse over the months and years.

Conclusions

10.161. The issues that affected the therapeutic relationship between Mr X and his treating teams (aggression, differences in opinion and non-compliance) are not unusual when providing care and treatment to individuals with significant mental health problems; neither should a breakdown in a therapeutic relationship be considered that unusual either. However what is unusual is that this situation was allowed to continue for a period of years when it was evident that it was having a negative impact upon both engagement and treatment outcomes.

10.162. It is not possible to understand in full how the diagnosis of Paranoid Personality Disorder and the growing tension between Mr X and his treating teams worked in combination; but they appear to have done so. Mr X became more angry and frustrated and in turn his treating teams became more boundaried and distanced. Mr X's case was complex, his diagnosis ambiguous and differences in opinion were rife (both between Mr X and his treating teams, and the second opinion diagnosis and the CCTT). Mr X did not appear to significantly improve over the years (aside from a partial response to Olanzapine lessening his auditory hallucinations) – a complex case review was indicated (in keeping with best practice guidance – please see the standards proforma). Unfortunately this does not appear to have been considered and the opportunity not taken advantage of.

Documentation and Professional Communication

Findings from the Desktop Analysis of Mr X's Clinical Records

Clinical Records

10.163. The clinical records as made available to the Independent Investigation Team took ten months to assemble. It is evident that these records are either not complete, or that various assessments and review processes did not take place (in accordance with Trust policy expectations). Some of the records viewed were overly concise making it very difficult to understand the full course of events in play. Another feature of the clinical records that raises concern is the routine practice of 'cut and paste' where previous entries (sometimes several years old) were passed off as dynamic and contemporaneous assessment and planning processes.

10.164. There is a virtual absence of multi-agency information sharing and little evidence of joint assessment and care planning development. It cannot be

determined if this is because joint working did not take place, or because electronic record systems did not 'speak to each other'.

Professional Communication

10.165. It has been difficult to understand how professional communication took place between services and agencies. The Independent Investigation Team noted mentions in the clinical record to emails and telephone calls having been made. but the responses and progress of the communications cannot be charted; for example – the 2016 child safeguarding referral to Social Services. Single mentions in relation to queries and referrals are made but there are few examples of follow up. The following issues were identified from an examination of the clinical records:

1. Overly concise recording of clinical information.
2. Significant gaps in the clinical record.
3. The relative absence of notes written by medical members of the multidisciplinary team.
4. Significant examples of 'cut and paste' (particularly with regards to risk assessments and care planning documentation).
5. Inaccuracies in the clinical record (due to 'cut and paste' practice which meant records were not always updated appropriately).
6. The incomplete filling in of forms and other documentation (e.g. referral forms, carer assessments etc.).
7. A virtual absence of multi-agency documentation/communication (as evidence of liaison and joint working) even when Probation and Social Services were involved actively.

10.166. During interviews and meetings held with the Trust's corporate team the complex range of disparate IT systems that were/are in place was discussed. The different systems operated by different services sometimes made both access and information sharing difficult. The Independent Investigation Team was also told (by the workshop participants) that RiO (the Trust's main electronic patient record system) was complex and time consuming to use – this meant that certain fields were not always accessed or utilised.

10.167. The Independent Investigation Team remains uncertain as to whether a complete set of records has been shared, not due to any wish on the part of the Trust to not cooperate, but because of access and retrieval issues. This is an important finding in its own right; if records can not be accessed for audit/investigation processes, then it is reasonable to assume that

neither are they readily available in 'real time' for the clinicians treating patients.

10.168. During meetings with the Trust (and during corporate interviews) the Independent Investigation Team was told that the Trust had several different clinical record recording systems in play; not everyone had access to them. It remains unclear what impact this might have made to Mr X's case – but it appears to be a problem that is known throughout the Trust when accessing and retrieving patient information.

Reflections from the Workshop Held with the Trust

10.169. From an internal Trust perspective it was recognised that there was inconsistency in the access that people had to different patient record systems across different teams; it was felt this posed a huge risk. Examples were discussed where even managers (on occasions) had not been able to access the clinical recording systems of the services that they were responsible for. The workshop participants attempted to 'count up' the number of recording systems that were operating across the Trust, but this proved to be outside of their actual knowledge; they reflected *"when you don't have access to them, what does that mean?… it's just massively frustrating to staff".*

10.170. Workshop participants were completely honest in their views; the general consensus was that professional communication did not happen as well as it should – particularly with multi-agency partners. *"Getting hold of people"* was seen as being a real challenge, particularly when seeking timely information to aide interventions. On reflection it was thought that the Trust information sharing protocol was not clear and that access to Social Services (or third sector agency) information was a challenge; it was also recognised that Trust information sharing protocols did not always match those of other agencies. Having 'read only access' to GP records and safeguarding systems was identified as something that would *"help massively".*

10.171. High volume and acuity caseloads (and a general lack of time) was seen as a genuine reason why community-based staff did not complete clinical records in either a timely or *"high quality"* manner. The possible use of Dictaphones was discussed – it was noted that consultant psychiatrists had access to them (and also a pool of staff to transcribe the audio notes). The question was *"could that be extended to our care coordinator colleagues"*? It was noted that some staff were already using their work phones to record notes; they then transcribed the information via email which could then be cut and pasted into RiO.

10.172. The workshop participants also considered other reasons why record keeping was not optimal and why professional communication (both regarding inter-Trust services and those with multi-agency services) often failed. In summary these are as follows:

- the increasing use of relatively junior and inexperienced staff who fill in forms/documentation templates in an overly concise and *"bland"* manner (this was exacerbated by a lack of supervision and multidisciplinary team *"sign off"*);
- Trust templates (e.g. risk assessment and CPA forms) were too simplistic and often missed key fields (such as those for safeguarding children); this rendered the omissions 'invisible' to Trust audit processes;
- the practice of 'cut and paste' from previous documents was seen as means of saving time and ensuring audit compliance (in that audit only picked up whether templates were filled in and did not undertake a longitudinal quality review of the records);
- there are too many documents to fill in, described as *"too much paperwork"*; the multitude of different documents served to fragment assessments and increase the amount of time needed to complete them – the view was that documents needed to be aggregated – this would be more patient-centered and would also save time;
- difficulties in contacting GPs, social service partners etc. in a timely manner – things could 'slide' and key information was missed;
- RiO was difficult to navigate; some of the *"tabs"* were difficult to locate and it was a laborious and time-consuming task for clinicians to access and collate relevant information (such as psychiatric histories and risk assessments);
- Caseload overload meant that multidisciplinary and multi-agency discussions were often compromised; this made a direct impact on the both the quality of the information recorded and general professional communication processes.

Conclusions

10.173. The workshop inputs validated many of the findings from the desktop analysis of the clinical records, although the Independent Investigation Team acknowledges that the workshops included only a small sample of staff from the teams. The issues regarding the many different electronic record-keeping systems were also discussed during various meetings held with the Trust.

10.174. The Independent Investigation Team found the issues regarding clinical records and professional communication to be multi-faceted. There was no single factor identified – instead there was a complex interweaving of a multitude of blocks and barriers.

10.175. The Independent Investigation Team concludes that on occasions internal investigation findings have focused on the record keeping of individual practitioners. However a closer examination of the situation has demonstrated that the problem is perhaps more wide-ranging encompassing individual practitioners, teams, services and systems alike.

Adherence to Policy and Procedure (local and national best practice)

Findings from the Desktop Analysis of Mr X's Clinical Records

10.176. The examination of Mr X's clinical records identified the following:

1. The Thematic Pathway Review Proforma used to assess Mr X's care and treatment is an evidence-based standards audit tool. The proforma identified a consistent lack of policy and procedure adherence over a number of years.

2. Based on the findings, the Independent Investigation Team is of the view that extant Trust audit processes are not sensitive enough to detect the breadth and depth of non-adherence. This is to be expected when 'snapshot' audits are undertaken which do not take into account a longitudinal view of clinical records (things like 'cut and paste' practice can be missed and a false assurance given).

3. The Independent Investigation Team understands that there are significant caseload/workload pressures within community-based teams. We heard that practitioners often take short-cuts in order to save time, that supervision, multidisciplinary sign off and endorsement often does not occur, and that relatively junior staff are becoming de-skilled in relation to what they need to do.

Reflections from the Workshop Held with the Trust

10.177. Issues relating to the non-adherence of policy and procedure had been identified by the thematic review processes undertaken by the Trust in 2020.

10.178. Workshop participants described a workforce under significant pressure. This pressure led to short cuts and also a decrease in 'real time' supervision and support for more junior and less experienced staff. Workshop participants voiced the view that most practitioners understood how audit worked and also knew how to 'work around it' to avoid poor practice being detected.

Conclusions

10.179. The Independent Investigation Team recognises that it is relatively rare for such a detailed-level of audit (such as this investigation) to be undertaken; it is likely that if replicated across other Trusts in England similar findings would be found. That being said, a review of current audit practice within the Trust would ensure a deeper level of curiosity was deployed and better patient safety information yielded.

Part Five

Conclusions and Lessons for Learning

11 Conclusions

11.1. When drawing conclusions it is important to acknowledge the inter-connectivity between the components that comprise the 'basic building blocks of care'. Diagnosis, clinical risk assessment and care and treatment planning create an essential triad of clinical practice and process. This triad is supported by other components such as record keeping systems, multi-agency working and evidence-based policy guidance. Underpinning everything is the access to (and provision of) appropriate services which have both the capacity and capability to deliver.

11.2. In the case of Mr X it is evident that many different factors all contributed to a less than optimal care and treatment approach being taken. It is important to acknowledge that Mr X experienced significant deficits in the care and treatment he received. These deficits made a significant contribution to his continuing paranoia and unmanaged psychosis prior to the homicide taking place – of equal concern is the limited and incorrect assessment view which was taken of him post-homicide based upon the extant clinical record that was available when he was first placed in custody after his arrest; this led to him initially being placed in prison instead of within a high secure hospital. However following his incarceration in prison it became evident, very swiftly, that Mr X was severely mentally ill – this ensured his transfer to a high secure hospital where a diagnosis (Paranoid Schizophrenia) was made and an effective course of care and treatment begun. However this negative and unhelpful view was seemingly continued with the Trust's internal investigation report findings and conclusions, this served to render Mr X's ongoing problems and situation 'invisible' to those reviewing his case at the time. It is a fact that the contemporaneous records, made by Mr X's treating team prior to the homicide, have had a long-lasting impact upon Mr X – the effects of which are still being felt. It is important that Mr X's experience is shared and that lessons are learnt, both for his sake and that of other service users in the future.

11.3. The Independent Investigation Team considered the factors identified above under the traditional Fishbone Analysis headings; these headings form part of the Root Cause Analysis approach advocated by the NHS at the time this report was commissioned – by using these headings the interconnectivity of all the factors in play can be understood. The main issue at the Head of the Fish Bone is: 'did Mr X receive effective care and treatment that managed his mental health challenges, maintained his wellbeing, and kept both Mr X and those around him safe'?

1. **Patient Factors:** Mr X was an individual who inspired feelings of fear and intimidation within his treating teams. His forensic history was significant and the potential threat of future violence was very real. However Mr X retained good levels of insight most of the time. He understood that the thoughts, feelings and beliefs he held were

dangerous – he was also of the view that they were generated by a mental illness, not a Personality Disorder. Mr X was afraid of what he might do when in the grip of paranoia and psychosis. It is a fact that he tried to get help repeatedly as he feared what he might do and realised that he could not control himself when unwell. Mr X disengaged from service and was non-compliant with medication on occasions – it is evident that he had lost trust and confidence in his treating teams; he also had little confidence in his medication regimen (Olanzapine) as it caused him side-effects he could not tolerate and only minimised his symptoms. Instead Mr X chose to self-medicate with illicit drugs and alcohol which in turn made his condition worse.

2. Mr X told members of the Independent Investigation Team that he has a fundamental need to understand why he was not listened to and he cannot help wondering if things would have worked out differently for both Ms Y and himself had he been. This is beyond the powers and scope of the Independent Investigation Team – however it is reasonable to conclude that had Mr X been diagnosed correctly (based on what was known and should have been known at the time) a more effective care, supervision and treatment package would have been in play. This could reasonably have been expected to have made a positive impact upon his symptoms and wellbeing – with a consequent beneficial impact regarding his levels of risk.

3. **Task:** the key tasks the Trust treating teams had to achieve were those relating to diagnosis, clinical risk assessment, and care and treatment planning and provision. There is no evidence to suggest these processes were managed in accordance with either local or national best practice guidance. Over the four years Mr X received his care and treatment from the Trust it is evident these processes were either non-existent or incomplete. This had an impact on the effectiveness of the care and treatment Mr X received. It also had an impact on his levels of wellness and risk.

   The Independent Investigation Team concluded that (in general) the Trust had good, evidence-based policies and procedures to support key tasks – however it was evident that a review needs to take place in order to ensure a synergy between them (particularly with regards to safeguarding and multi-agency working). This review also needs to encompass the assessment document templates (for CPA, risk and safeguarding) to ensure that clear prompts are provided and that there are no omissions.

4. **Team and Social Factors/Working Conditions:** It is evident that *"caseload overwhelm"* as described by Trust personnel was a factor in how closely Mr X's treating teams adhered to established policy and practice. Workforce pressures also served to 'dislocate' both multi-agency and multidisciplinary working.

Pressures on time made a direct contribution to the lack of supervision for junior and less experienced staff on whom the main burden of assessment and documentation keeping appears to have fallen. This cycle of pressures on service, the reliance on junior staff to perform complex functions, combined with a lack of supervision led to a series of short-cuts (such as the 'cut and paste' of out-of-date information) being taken. The notions of burn out, exhaustion and overwhelm are real to Trust staff – this quite probably made a contribution to what can be evidenced within Mr X's clinical record. The findings and conclusions of the Independent Investigation Team dovetail exactly with those of the Care Quality Commission (CQC Inspection report of September 2019. The CQC inspection report detailed the underlying systems issues in relation to the recruitment and retention of clinical staff; the report drew the conclusion that junior staff were consequently pressured to undertake tasks they were not always experienced enough to take on.

5. **Education and Training:** It is evident that the Trust has the benefit of employing many experienced and knowledgeable professionals. However many of these individuals are in management positions and are taken increasingly away from direct clinical practice. This has led to many more junior and less experienced individuals working on complex cases without a full understanding of how to complete key tasks (such as risk assessment and safeguarding referrals etc.). The Independent Investigation Team was told of the need for greater awareness and training – combined with adequate and ongoing supervision for junior and less experienced staff.

6. **Communication:** Internally: Trust clinical record systems were (and remain) difficult to access and navigate – this causes frustrations to clinical staff and also creates significant and ongoing continuity of care and patient safety issues. Externally: extant policies, procedures and working practice also make it difficult for recorded information about service users to pass from one agency to another. Access to information, and the sharing of that information, is a problem in its own right – but it is also symbolic of the fact that inter-service and inter-agency working is not happening in real time.

   When clinical records cannot be accessed or shared with ease professional communication has to work harder. When services are overwhelmed, and workforce capacity limited, it is unrealistic to expect professionals to attend all of the meetings they are invited to or to be making constant telephone calls (which often need a high degree of perseverance and tenacity) to make the contacts required. An over-reliance on email communication results; this kind of communication has its limitations and can serve to lull people into a false sense of security that messages have been received, understood, and actioned when they have not.

In the case of Mr X it is evident that communication (whether written, face-to-face, or by any other means) was limited and not effective. This reflects the inherent problems with electronic recording systems (both inside and outside of the Trust) and also the fact that joined up working did not happen.

7. **Strategic Management:** The Trust has in place a comprehensive collection of evidence-based policies and procedures. The Trust can definitely be described as a learning Organisation with an open and transparent culture. Thematic reviews into past incidents have been undertaken in order to maximise learning and to improve patient safety and there is ongoing work to ensure service improvement is a key priority within the Trust.

   However there would appear to be a consistent culture of non-adherence to policy and procedure within the organisation (for the reasons set out above). It would appear that the Trust's current audit processes are not sensitive enough to detect when and where policy non-adherence takes place. It is evident that health professionals are aware of how the audit process works (and how to circumnavigate it) in order to provide assurance where there should be none. At present audit processes appear to take limited 'snap shots' of practice (record keeping, risk assessments and care planning etc). But these processes are not detecting things like 'cut and paste' practice as no longitudinal study is undertaken. A false level of assurance has been arrived at. However when the Trust took a more longitudinal stance with its thematic review process it found consistent problems with clinical assessment and the CPA process. The Trust's review work is to be commended and demonstrates how the thematic reviews of clinical incidents can work alongside audit to understand the effectiveness (or otherwise) of clinical systems.

   Strategic management is responsible for ensuring the Trust works effectively with its multi-agency partners. In reality strategic planning and policy development with multi-agency partners does not appear to facilitate joined up working 'on the ground'. In the case of Mr X it appears to have been ineffective and made a direct contribution to his loss of trust and confidence in service; the ineffective nature of multi-agency working also ensured that Mr X's ongoing levels of risk were neither monitored nor managed.

8. **Individuals:** The Independent Investigation Team has not examined the actions and practice of individual practitioners for two reasons. First: the investigation scope was limited to that of a desktop review – whilst workshops and high-level interviews were possible (in order to understand underlying systemic issues) – structured interviews in keeping with Scott and Salmon compliant processes were not; therefore a detailed and structured analysis of the actions and decisions of key individual professionals could neither be examined nor ascertained. Two: the NHS England *Patient Safety Incident Response*

Framework (2022) requires the moving away of assigning blame to individuals and instead requires the focus to be on the underlying systems within which such individuals work.

The Independent Investigation Team concludes that whilst the actions of some individual health care professionals appears to have been outside the guidance of Trust policy and procedure – it would seem that these actions were in keeping with the prevailing culture of the Trust (with regards to the management of individuals with Personality Disorder). They were also as a result of inherent systemic challenges (e.g. service capacity and capability, electronic record systems, multi-agency working etc.). Taking this into account the Independent Investigation Team concludes that any acts or omissions on the part of individual health professionals should be considered against the backdrop of a service experiencing *"caseload overwhelm"* and resource and access issues in combination with ineffective clinical record systems and a fixed cultural stance on the treatment and management of Personality Disorder.

11.4. The above factors all worked together to present barriers and challenges to the effective delivery of care and treatment to Mr X. The Independent Investigation Team concludes that Mr X received a sub-optimal level of care and treatment over a period of some four years. It is reasonable to conclude that Mr X represented service users in the top 1% requiring robust, multi-agency and specialist risk management processes. From the documentation made available to the Independent Investigation Team this does not appear to have happened.

11.5. Based on what was known, and what should have been known, about Mr X it is certain that he met the criteria for a full forensic assessment on his release from prison and that this did not happen. Mr X was accepted onto the CCTT caseload and met the CPA criteria in full – as such he should have received assertive follow-up, multidisciplinary risk assessment and holistic care and treatment planning; he also should have been provided with a robust diagnostic process. This was not achieved.

11.6. The Independent Investigation Team acknowledges that several of the professionals who worked with Mr X over long periods of time tried their best to keep him engaged and in receipt of the services and support he needed; this is to their credit. However individual practitioners cannot ensure positive results when they are in effect working 'alone' and in isolation – the challenges to ensuring effective multidisciplinary working took place were seemingly insurmountable given caseload pressures and made a negative impact on the management of Mr X's case.

Summary

11.7. It is universally acknowledged by mental health care professionals and investigators alike that the provision of care and treatment to individuals with severe and enduring mental illness and/or disorders can be complex

and challenging; on occasions even the most focused approach can fail to maintain wellness or provide risk mitigation. It should be recognised that mental health recovery is often cyclical with periods of wellness and stability followed by periods of crisis and relapse – hence the need for consistent levels of input and monitoring. Services are required to be there for the 'long haul' – even when service users want to walk away and reject the care and treatment being offered.

11.8. However, that being said, if an evidence-based (and consistent) approach to care and treatment is taken then it is reasonable to expect those with mental health problems to maintain wellness for longer, experience improvements to their quality of life, and for levels of risk to be minimised and managed. This is the basic tenet of all mental health care provision across the United Kingdom. When an evidence-based approach is not taken then it is reasonable to expect deterioration in mental health and wellbeing and for risk management processes to fail over time.

11.9. Given that there are no 'silver bullets' or guarantees when providing mental health services the question has to be 'was everything that could (or should) have been done achieved'? In the case of Mr X the answer is 'no'. In summary, Mr X did not receive the levels of care and treatment that he needed. Even though he should have been regarded as a high priority case he slipped through the safety net of care to the extent that services appear to have ultimately disengaged from him. This left him without the monitoring, support, and care and treatment that he required.

11.10. Given Mr X's known forensic history and ongoing presentation it was highly likely Mr X would offend again. Most tellingly if a service user tells service 'I am worried that I might kill or harm someone when unwell' – they should be believed. As a consequence Mr X was left partially treated and entirely unmanaged in the community and he was left to manage his Paranoid Schizophrenia alone. His treating team adhered to the idea that he was solely accountable for his actions and that he was not driven by a mental illness; however the Independent Investigation Team concludes that more could and should have been done to maintain his mental health and wellbeing and that Trust services had a duty to do more.

11.11. The Court Report for the Prosecution at Mr X's trial for the killing of Ms Y stated that Mr X was *"suffering an abnormality of the mind at the time of the homicide (caused by Paranoid Schizophrenia). This substantially reduced Mr X's ability to form rational judgements and to exercise self control. It was thought Mr X had been suffering from Paranoid Schizophrenia for a 'number of years"*. This was accepted by the Court – and Mr X was found guilty of manslaughter.

12 Lessons for Learning

12.2. The Independent Investigation Team has identified five high-level central lessons for learning under which a myriad number of sub-issues can be placed – these will form the basis of the recommendations for both the Trust and for the commissioners of service to action.

12.3. The report details a complex interweaving of issues and themes which has identified a multitude of areas that require action. However the Independent Investigation Team is of the view that whilst these areas will all require attention, the Trust needs to focus in the main on the five headings below in order to bring about change on a deeper systemic level.

12.4. An example of how identifying key systemic headings will work can be illustrated by the following example. Caseload overload appears to have become a key factor in routine 'short cuts' being taken. Workshop participants recognised this to be 'de-skilling' and that this is slowly leading to a culture change where policy adherence is no longer considered necessary or 'doable'. This means risk assessments are not completed and care plans are 'cut and paste'. The traditional approach would be for an NHS investigation to require (for example) an audit of risk assessment process, or remedial action to be taken with identified staff, or for staff to be 'reminded' to adhere to policy; none of which is usually effective. Workshop participants identified caseload overload and service user complexity to be exacerbated by the current CMHT service model, the lack of connectivity between record keeping systems and Trust policy and procedure, and poor accessibility to specialist services for referral. Therefore it is evident that focusing on the 'symptom' (e.g. a lack of risk assessments) is not going to affect the underlying cause (e.g. a need to streamline service and system via service model reconfiguration).

Therapeutic Relationships and Co-production with Service Users and Carers

12.5. The therapeutic relationship is pivotal to the delivery of effective care and treatment. When trust and confidence breaks down treating teams should be realistic about this and do what they can to remedy it. Complex case reviews, second opinions and/or a reallocation of the service user should be considered. A 'soldiering on mentally' should be resisted – as should discharge when a seeming impasse has been reached.

12.6. The ethos of co-production is essential. Service users and their carers have insights to offer – they also know what will be acceptable to them and what will not. It should be remembered that medication will always be entirely ineffective if it is not going to be taken. Whilst mental health providers cannot guarantee engagement and compliance by facilitating a co-production ethos, it is one of the most simple and effective ways to maximise the possibility of full engagement and the development of workable and realistic care and treatment approaches moving forward.

Development of Clinical Care Pathways

12.7. The Trust is currently in the process of developing clinical care pathways – Personality Disorder being one of them. In conjunction with the reconfiguration of the service model it will be possible to provide a more focused framework for clinicians and service users alike.

12.8. Robust diagnostic process, access to both mainstream and specialist services, and the development of operational policies should all become embedded into a streamlined pathway. This will focus workforce activity and should also provide a widening of care and treatment options within the existing resource available.

12.9. The distinct advantage of developing a care pathway model is that monitoring and assurance can be undertaken in an evidence-based and systematic manner. It is a key lesson for learning that complex service provision requires a high degree of planning and a structured, evidence-based framework for delivery is also required. Care pathways also provide the opportunity to align Trust services, policies and guidelines. Large service providers often develop 'organically' over a period of years, especially when mergers and acquisitions have occurred – it is good practice to review after a period of change.

Service Model Reconfiguration

12.10. Service model reconfiguration is currently ongoing at the Trust. National changes to service provision, combined with Trust mergers and remodelling, require periods of review and staff consultation. Workshop participants were able to articulate how the current service model slows down patient flows, duplicates effort, and creates inherent 'pockets of risk'. The current model was seen as ineffective and as creating additional workforce pressures.

12.11. Many of the barriers to effective working appeared to be internal Trust issues – several of which appear to be the legacy of recent expansion and service acquisitions. Workshop participants said they did not really 'know' or 'understand' how some aspects of their own organisation worked - this led to a somewhat 'heads down' attitude where individuals focused on the work 'in front' of them. Staff were described as being *"tired and burnt out".* Non-adherence to Trust policy guidance, fragmented multi-disciplinary team working, and poor clinical record keeping were all regarded as a direct result of underlying systemic and service model pressures.

12.12. COVID has presented additional challenges on top of those already present; however workshop participants did not choose to dwell on this citing more fundamental areas that required review and change. Moving forward it is evident that Trust staff have strongly-held views and high levels of insight as to how service improvements should be implemented; the Trust is currently engaging its staff in the modernisation process; this is good practice.

Strengthening Trust Audit and Assurance Systems

12.13. It is apparent that Trust audit systems are not sensitive enough to detect the extent to which Trust personal are non-compliant with policy and procedure. It is also apparent that policy guidance and documentation templates do not always align and that gaps and omissions caused by this are rendered 'invisible' to audit (e.g. the lack of child safeguarding).

12.14. The Investigation Team found the suggestion of an 'on the ground' culture of staff non-compliance with policy guidance; this was driven by caseload overload and frustrations with complex and ineffective systems.

12.15. It is a fact that we find audit 'answers' to audit 'questions' – audit will only provide feedback to what is specifically asked of it. The Trust needs to consider what it is auditing, how standards are going to be assessed and monitored, and how to introduce a qualitative system to sit alongside its current quantitative processes.

Clinical Record Keeping and Professional Communication

12.16. When there are challenges with multi-agency working (combined with fragmented service models), clinical record keeping and professional communication have to work harder to ensure seamless provision and continuity of care for service users.

12.17. The Trust currently has a suite of electronic record keeping systems that do not appear to foster safe and effective working. Combined with caseload overload, and difficulties with accessing and working with inter-Trust and multiagency services, this creates another layer of challenge and frustration.

12.18. Policies (such as those for safeguarding, CPA and risk management) are not integrated one with the other; neither is the accompanying paperwork and assessment documentation. Not only is there significant duplication of the information recorded (due to a lack of integration) there are also significant omissions. The current documents are myriad, time consuming to complete, and the underpinning information held on RiO difficult to access. When individuals try to conduct assessments they often run out of time due to the myriad forms and they also cannot be certain that they have been able to access the correct and most up-to-date information from the multitude of systems available (most of which they do not have access to).

12.19. Of significance is the resulting insidious change to the 'culture on the ground'. Short-cuts are common place (such as cut and pasting of often out-of-date information) and an overly concise record is developed. The Investigation Team was told practitioners understood well how to confound a quantitative audit and that this was reflected in day-to-day practice.

12.20. Complex and fragmented services, combined with a model that requires service users to be 'moved through the system' on a regular basis, reduces continuity of care. Workshop participants identified that service users sometimes remained with services for a few weeks only before being transferred to a different community team – this would also lead to a change in consultant psychiatrist. This increased the workload and also increased the likelihood for poor levels of handover; this provides an example of how challenges related to the service model also impact upon the challenges intrinsic to record keeping and professional communication.

Multi-Agency Working

12.21. Whilst we recognise a great deal of work has already been conducted Multi-agency working requires a further review to ensure integrated policies and protocols are agreed. There is a need for all agencies and services to work in a more service user-centered manner. This should prevent duplication of effort and should also prevent omissions from occurring (particularly in relation to safeguarding and protection of the public). This should lead to a more efficient and effective use of resource.

12.22. A key factor identified by the Investigation Team was that service users had to work very hard to remain engaged with numerous agencies and services that were not working in partnership. Intense levels of activity were noted – but this level of activity did not appear to make a positive impact upon the service user and their carers.

12.23. It is evident that child safeguarding and MAPPA processes are not working in accord with national policy expectation. For example, despite the recommendations set over 20 years ago by the Laming Inquiry there appears to be no access to a centrally-held child safeguarding recording system. It is essential that connectivity is developed and maintained.

12.24. It should be acknowledged that when Trusts merge and expand their boundaries, or when Local Authorities change their working practice, the entire health and social care economy is affected. It does not take long for what once might have been an integrated system to become fragmented. This requires ongoing networking, relationship building, planning and general vigilance.

13 Progress the Trust has Made

13.1. The Trust has embarked upon a significant journey of improvement since 2019, following receipt of a Care Quality Commission (CQC) inspection and a system-wide review of Mental Health, which is being taken forward by a newly appointed senior leadership team, including new Board members and a new Network Leadership model, to ensure enhanced clinical and operational leadership across the Trust. Significant transformation and improvement programmes have been progressed, despite the challenges faced with COVID-19, and the Trust continues to

work with commissioners to invest across services and pathways of care, utilising the Mental Health Investment Standard (MHIS), which is a national priority to address recognised historic under-funding of Mental Health Service provision. The Trust welcomes this work to enhance and further support its improvement journey. With regard to the themes within this report the following is noted in the text below.

Multi-Agency Working

13.2. Multi-agency working has and remains a key focus for the Trust in the delivery of safe and quality patient care. The Trust has built strong relationships with providers who input into the care of patients under Trust services. This includes regular engagement with CQC and commissioning teams, the co-working with Probation Services, co-investigations with local health care partners, further developments in areas of safeguarding, policy, and shared access to patient reporting systems.

13.3. There are multi-agency forums that the Trust attends and relationships have been strengthened, supported by increased cross organisational working during COVID-19. For example, a Listening into Action programme and workshop has been held relating to Dual Diagnosis with an online resource portal and Dual Diagnosis Champions created internally, with more clarity regarding referral pathways.

13.4. The Trust works in partnership across the system with partners as part of the Suicide Prevention Oversight Board. There are also similar arrangements for Homicides that have been developed, ensuring that there are multi-agency strategies in place to prevent harm to service users and the public.

Safeguarding

13.5. To ensure the integration of safeguarding across Trust and Agency services, the leads for MAPPA and Safeguarding have been working closely together to strengthen joint working, information sharing where required, and recording of information on RiO.

13.6. The Trust's MAPPA Policy has been aligned to the national MAPPA policy and has been enhanced by a MAPPA leaflet available to all staff and service users. The Trust has also developed a MAPPA staff guidance document, which simplifies the process into a flow chart and list of forms to be completed within the process.

13.7. Amendments were introduced to RiO in March 2022 to support Trust practitioners in recording the application of routine safeguarding enquiry. This included the integration of assessments relating to the safeguarding of children. To support practitioners to understand which documentation is required to report and asses the safeguarding of adults and children, this is covered within annual mandatory safeguarding training. Advice can also be sought from the safeguarding team, and referenced in Trust policy.

13.8. The safeguarding champions model has been implemented Trust-wide and is delivered in line with Trust policies and procedures, training and the Local Safeguarding Adult Board (LSAB) and the Children's Safeguarding Assurance Partnership (CSAP) guidance. The integration of the safeguarding champions model across the Trust offers a robust support process within each service area in conjunction with the support offered through Trust safeguarding advice and consultation.

Service Model Reconfiguration and Transformation

13.9. The Trust launched a new operating model on April 1 2021, based on five networks supported by new clinical and managerial leadership. The five networks are: The Bay (South Cumbria and North Lancashire), Fylde Coast (Blackpool, Fylde and Wyre), Pennine Lancashire (Blackburn with Darwen, Hyndburn, Ribble Valley, Pendle and Rossendale), Central & West, Preston and West Lancashire, and Specialist Services – forensic, dental, perinatal, CAMHS and Learning Disability and Autism services.

13.10. This leadership model offers additional support and leadership at a network level, with the senior leadership teams being closer to the teams delivering services, to enhance the way the Trust operates moving forward. It also aligns Trust services and leadership to place and local neighbourhoods, ensuring that the local health population needs are met and that transformation plans meet the changing needs of patients, service users and their carers.

13.11. The Trust is currently delivering an expansive programme of system-wide, organisational and service transformation, which will significantly improve the quality of not just the services the Trust provides, but will also improve health services across the whole of Lancashire and South Cumbria.

13.12. To ensure the maintenance of good patient care during the COVID-19 pandemic, the Trust has increasingly been working collaboratively with other provider Trusts, and across the wider health and care system. There is now an opportunity to build on this collaboration to further improve health and care. To this end, the five provider NHS Trusts have come together as a Provider Collaborative to agree joint priorities and how to best deliver them for the benefit of people across Lancashire and South Cumbria. Together aiming to drive up quality by sharing and standardising best practice to reduce unwarranted variation and duplication.

13.13. The Trust is the Lead Provider for Specialist Mental Health services, working as part of Lead Provider Collaboratives (LPC) across Lancashire and South Cumbria; Children and Young People Tier 4 Mental Illness, Eating Disorder and Learning Disabilities Services, and Adult Low and Medium Secure Specialist Services.

13.14. The Adult Secure programme, aims to establish a clinical pathway that will reduce overall reliance on inpatient care by developing community support

services to enable admission avoidance, facilitate discharge and reduce length of stay.

13.15. Improved pathways of care, where different services work more closely together, will be developed alongside improved community infrastructures through partnership, including the voluntary sectors and non-NHS services.

13.16. As part of the NHS Long-Term Plan and learning from patients, carers, staff and stakeholders and experiences through COVID-19, the Trust also has ambitious plans to transform community mental health services for adults and older adults across Lancashire and South Cumbria, through enhanced community based support for people living with moderate to severe mental illness and complex needs. The new model will focus on supporting people living in their communities with long term severe mental illness, bringing together primary and secondary care with social care, other local authority services, third sector and local communities.

13.17. In the past year – during the COVID-19 pandemic – the Trust has launched a variety of different innovations and initiatives to respond effectively to increasing high demand for services. These include working with system partners to implement new Mental Health Urgent Access Centres (MHUACs). Established as a safe and calm assessment space for those who are experiencing urgent mental health needs, the MHUACs focus on therapeutic needs, meaning those in distress can be more effectively supported – lowering the need for admission in some instances.

13.18. The Trust also launched a Crisis Line telephone support service, which operates 24 hours a day, seven days a week, with trained medical professionals on hand to provide immediate assistance to those who need it. This crisis line enables callers to receive a mental health assessment and referral on to appropriate services.

13.19. The Trust is also working on plans for its 'Initial Response Service' to be Trust wide; this is a new single point of access for all those experiencing mental health issues or crisis, which will work in a similar way to NHS 111. This will streamline and simplify mental health access for people across Lancashire and South Cumbria. These services have been launched in the Pennine and Central and West Lancashire Networks and have plans to ensure this service is provided across the Trust geographical footprint. In addition Street Triage Services has been expanded aligned with IRS implementation; a collaborative partnership between the Trust, North West Ambulance Service and Lancashire Constabulary to help people experiencing a mental health crisis.

13.20. The CMHT national Transformation Programme is being implemented across the Trust. This is part of a national transformation programme, of which the Trust is an early adopter, to help develop place-based community mental health service models, modernising the CPA approach,

working with partners, to offer whole person, whole population interventions and health approaches.

Clinical Record Keeping and Professional Communication

13.21. In late 2020, the Trust introduced RiO, the new patient record system, which replaced ECR. The change in systems has allowed for the alignment of RiO records with the Lancashire Patient Record Exchange Service (LPRES), so all primary and secondary care clinicians across Lancashire and South Cumbria can access patient records on their clinical systems. The development of the RiO system is ongoing, and currently the Trust is at a stage of development with service users and clinicians to determine which other suitable documents/information should be shared from RiO to LPRES.

13.22. Following the introduction of RiO (electronic patient care records) assessment templates for safeguarding were integrated into the system. Further amendments were introduced in March 2022 to support Trust practitioners to record routine enquiry within case records. Included in these system amendments were access to care plans, crisis contingency plans, discharge letters to GPs, and daily summaries of care. The optimisation work continues across the Trust, being led by Clinical Information Officers, roles which the Trust has invested in at Trust level and Network level.

13.23. The Trust's new Digital Strategy developed in 2021/22 will accelerate the Trust towards new and innovative ways of working that improve patient outcomes and the care experience, as well as efficiency for staff. The Trust has recently become the first mental health Trust to achieve accreditation as a Digital Leader for completing all the requirements of the Global Digital Exemplar (GDE) programme. Following the delivery of 19 projects over a three and a half year GDE Fast Follower programme, the Trust has been awarded HIMSS Level 5 status, which is an international standard for digital adoption.

13.24. The Trust's current Health & Social Needs Assessment is under review within its continuous improvement program and will become the new Patient Core Needs Assessment, which will be electronically available to all practitioners involved in a service user's care. The Trust plans to ensure from this QI programme that all service users have a good quality, current version of the Trust's identified core needs assessment in their electronic care record, which will be readily accessible and actively used by clinicians to inform & manage clinical risks and day to day care. In the interim the Health & Social Needs Assessment remains in place and there is continuous work to ensure this assessment fully retains the key historic and current service user information that informs care.

Person-Centered Approach

13.25. The Trust has invested significantly into its Person-Centred Framework, which is a key part of its Service User and Carer Involvement Strategy. Significant work underway as part of this is:

- establishment of a Trust and five Network Service User and Care Forums across the Trust footprint, to ensure meaningful co-production is in place; the Chair of Service User & Carer Council attends the Board of Directors;
- accelerated roll out of Triangle of Care, to ensure there is education, awareness amongst staff regarding the important role that carers plan;
- drop the jargon campaign across the Trust, so that language being used can engage service users and carers, as part of their plan of care;
- investment in Dialogue Plus across the Trust, as a tool to ensure routine service user-clinician meetings are therapeutically effective, with goal based outcomes being agreed and monitored- this has been piloted on the Trust's Rehabilitation Ward and is being adopted Trust-wide;
- care coordination policy being reviewed with co-production from service users, carers and staff, to support Community Mental Health Transformation programme.

Development of Clinical Care Pathways

13.26. The Trust is currently in the process of a full review of its clinical care pathways aligned to transformation. As part of a newly developed Clinical Services Strategy, there are a number of transformation programmes underway to transform pathways in adult and older adult mental health, including the urgent care pathway, rehabilitation and community services via the following transformation programmes: Urgent Care Programme, Rehab Programme, Community Mental Health Transformation Programme and the IRS Programme. There has also been a review of the Personality Disorder Pathway within the Trust, with support from Cumbria, Northumberland, Tyne and Wear (CNTW) Foundation Trust, who the Trust has been working with via a strategic partnership agreement.

13.27. In order to take forward these pathway reviews, the Trust has developed a Clinical Senate and a number of Trust-wide Best Practice groups to ensure that evidence based pathways are in place and developed for Trust clinical services, this also includes various Trust partners in the delivery of these pathways.

Trust Governance and Assurance System – Including Audit

13.28. In the 2019 CQC inspection report, the Trust's governance, risk management and learning processes were criticised with regulatory breaches being incurred for governance across core services inspected

and the Trust. Since 2019, a robust improvement plan has been put in place for governance and risk management.

13.29. The Trust's incident, complaints and Duty of Candour processes have been completely reviewed, with standardised policies, processes, report templates and investigations training being put in place. A weekly Executive led Safety Summit is now in place, with Network Safety Incident Review Panels (SIRPs) which also meet weekly. Here learning from incidents are discussed and Serious Incident investigations are Quality Assurance checked, so there is a multi disciplinary review of each case and actions are overseen and monitored. There are central safety specialists, who have specialist training in investigations and human factors, who support investigation leads within the Trust. External investigators are also sought for high profile/high risk investigations, such as homicides. The Trust has been working towards implementing the new National Patient Safety Strategy and as part of this, has implemented a Just Culture Charter, enhanced safety and improvement training and strengthened its round-table learning approach.

13.30. A full review of the Trust's policy and procedural framework has been undertaken to ensure that it is robust and fit for purpose, including having training in place for policy authors and staff to help implement policy standards, having clear policies that are outline contemporary practice and monitoring policies and standards aligned to accreditation and auditing of practice e.g. the engagement policy and procedures.

13.31. The Trust's clinical audit program is aligned to local and national priorities with the overall aim of improving patient outcomes and reflecting regulatory and commissioning requirements. The Trust clinical audit programme reports to the Patient Safety & Effectiveness Sub Committee for awareness of the topics and progress of clinical audits registered through the Clinical Audit portal. Regular summary clinical audit reports, together with recommendations, are communicated to all relevant areas of the organisation and Trust committees, in addition to the newly formed Best Practice Groups.

14 Notable Practice

14.1. Notable practice (in that it was over and beyond what could reasonably be expected of an NHS provider service) was identified in one area; that of organisational learning culture.

14.2. The Investigation Team found the Trust to be open to learning and reflection. Trust workshop participants, and members of the Trust's senior management team, were enthusiastic, focused and supportive of the investigation process. All contributions were made in an honest and open manner with the emphasis on patient safety and service improvement. The Independent Investigation Team found this to be impressive.

15 Recommendations

Background

15.1. It should be understood that the Trust has been on a significant journey of service improvement since 2019; the beginning of this journey is charted in the Care Quality Commission (CQC) inspection report of September 2019. In May 2019 the Trust was categorised as being offered 'targeted support' by the NHS Improvement Single Oversight Framework. Following this a mental health quality committee was set up with membership from (the then) NHS England, (the then) NHS Improvement, stakeholders, commissioners and regulators to develop a whole-system strategy for mental health across the integrated care system. A significant amount of focus was placed on multi-agency working and how to improve it. It was recognised at this time that key actions were not the sole responsibility of the Trust and that ownership by multi-agency partners and NHS commissioners alike was required to redesign the care pathway across the mental health services footprint.[6]

15.2. Since this time the Trust has launched its five-year improvement strategy (April 2021 – 2026) which includes care pathway redesign and service remodeling. The Trust is modernising and implementing a wholescale service transformation agenda which encompasses in full the systemic issues found to be in need of improvement by this Independent Investigation. Running alongside this are the two thematic reviews that the Trust conducted in 2020 (please see paragraphs 3.10 and 3.11) and the subsequent recommendations that were set.

15.3. The Independent Investigation Team is aware that its examination of Mr X's care and treatment reviewed services as they were prior to the incident occurring in early 2019; the documentary findings (based on the clinical record) therefore relate to the service provision of over four years ago. The workshop held with Trust participants took place in November 2021 and represented a 'snapshot' of how service was at that time as the Trust began its transformation processes. It should be recognised that service improvements are moving forward and the Trust has provided an update of progress to-date (report section 13) and the recommendations set out below are intended to support the ongoing service development and performance management processes that are already in train.

15.4. The Independent Investigation Team has not been privy to all of the outstanding issues or the levels of performance monitoring that have taken place to-date as it is outside the scope of this work. To this end the recommendations fall into two distinct categories: the first requiring a degree of oversight (and possible further development) from the integrated care system, and the second requiring practical, operational service

6 Care Quality Commission report - Lancashire Care NHS Trust (11 September 2019)

change within the Trust, requiring a less intensive level of oversight and support from external bodies.

Ethos of Recommendation Setting

15.5. The NHS England *Patient Safety Incident Response Framework* (2022) advocates the embedding of the *"patient incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management".* As such when a known body of work is ongoing (that is already addressing identified areas from incident investigation) then it is advocated that any further response is coordinated and synthesized with what is already known and incorporated into current patient safety management processes. This guidance reflects the approach taken by the Independent Investigation Team in the setting of the recommendations below.

15.6. An investigation of this kind is asked to identify areas that require improvement; therefore the subsequent recommendations and action plans should be designed to achieve those improvements. Recommendations and action plans should consider:

- what is required (recommendation setting process);
- what needs to be achieved (recommendation setting process);
- which particular risk/s are being mitigated against (recommendation setting process);
- who needs to take responsibility for implementation (action planning process).

15.7. Recommendation setting is the first part of the process that develops an implementable action plan. The action plan will be developed with Trust by key commissioning stakeholders following the publication of this report. The action plan will specify:

- milestones, aims and objectives;
- performance targets and indicators;
- methods of audit and evidence collection, progress review and assurance;
- costings and resource implications;
- indications of where multi-agency inputs are required;
- timeframes and completion dates;
- methods of accountability and oversight.

15.8. With this in mind the Independent Investigation Team has reviewed the progress made by the Trust in relation to the findings and conclusions of this Investigation. The recommendations have been set with the intention of supporting the work that the Trust has already embarked upon and to also ensure that future strategic planning incorporates inputs from commissioners; particularly where multi-agency partners also need to make significant contributions to planning, process and service provision.

Category One: High-Level Recommendations Requiring External Oversight and Further Development with Stakeholders and Commissioners

Recommendation 1: Clinical Care Pathways

15.9. **Areas Identified for Improvement:** The Independent Investigation Team found myriad areas requiring improvement related to clinical care pathways; these were applicable to Personality Disorder, Psychoses, Paranoid Schizophrenia and Substance Misuse. The identified issues included those at the beginning of Mr X's pathway (diagnosis, allocation to the 'best fit team', care and treatment) right through to those in the middle and end of his care pathway (crisis management, recovery-based interventions, and discharge planning). The National Institute for Health and Care Excellence (NICE) provides detailed guidance for the delivery of clinical care pathways for all major mental health conditions in England; in the case of Mr X these guidelines were not adhered to.

15.10. **Progress Made:** The Trust is developing clinical care pathways in conjunction with its service transformation. The Trust has developed a Clinical Senate and Trust-wide Best Practice Groups to both oversee and implement the work. At the time of writing this report the work to implement new clinical care pathways was in the process of being embedded.

15.11. **Action Required:** Action is required to ensure evidence-based practice is delivered by the Trust, this to minimise the risks associated with less optimal care and treatment being delivered associated with poorer clinical outcomes. The Clinical Senate and Trust-based Practice Groups should:

1. **Undertake a mapping review of the findings and conclusions of this report against the Trust's newly embedded care pathways. This to ensure the care pathways cross-match with the areas identified for improvement as a result of this Investigation.**

2. **Undertake a selection of case study reviews against the standards proforma used for this investigation process. This will provide an early indication to evaluate the effectiveness of the new care pathways when mapped against the provision of basic building blocks of care' issues.**

Recommendation 2: Service Model Reconfiguration and Transformation

15.12. **Area Identified for Improvement:** Two areas for improvement were identified. First: Mr X experienced difficulties accessing the range of services that he needed when he needed them (e.g. forensic assessment, substance misuse services, assertive outreach and rapid access to the 'best fit' community-based team). Second: Trust workshop participants recognised that the past configuration of community mental health teams

slowed down referrals and made a negative impact on continuity of care as was sometimes the case for Mr X.

15.13. **Progress Made:** The Trust launched its new operating model in April 2021. The new model seeks to reconfigure community-based services and improve access; this is in keeping with the NHS England National Transformation Programme.[7] This national programme also requires modernising the Care Programme Approach (for which the Trust is an early adopter) and working with both NHS and multi-agency partners to support people with mental health problems. It is evident that the Trust is working collaboratively with external partners and stakeholders to redesign and modernise its services, this to ensure improved access and patient-centred working to offer whole person, whole population interventions and health approaches.

15.14. **Action Required:** The transformation process comprises a five-year strategic plan. At the time of writing this report the Trust and its partners had been working on service change for 18 months. Action is required to focus on the progress made to-date in order to minimise the risk of a reoccurrence of the access issues Mr X experienced. The Trust, its commissioners, partners and stakeholders should:

1. **Review the strategic plan to ensure that all of the identified areas for improvement identified in this report have been addressed and have been incorporated. Particular focus should be placed on access to community forensic services, substance misuse services, crisis intervention and recovery-based services.**

2. **Review progress in relation to implementation as set against the findings and conclusions of this report. A mapping exercise should be conducted to ensure there are no omissions in the strategic plan.**

3. **Review the costs (and other implications) of any additional service additions and changes that might be required.**

Recommendation 3: Multi-Agency Working

15.15. **Areas Identified for Improvement:** Over the past five years the Trust, the Care Quality Commission, NHSE/I and this Independent Investigation have identified key areas requiring improvement in relation to multi-agency working. Information sharing, partnership working (systems and culture), and a lack of policy alignment have been, and remain, priorities. This Investigation found that Mr X was not placed in the centre of the service provision offered; instead he had to work very hard to engage with multiple services and personnel who were not working in partnership. This was to the detriment of his care and treatment.

7 https://www.england.nhs.uk/mental-health/adults/cmhs/

15.16. **Progress Made:** Over the past four years (following the CQC 2019 inspection) there has been regular engagement with the CQC, commissioning teams, probation services and local health care partners. This has led to developments in areas of safeguarding, policy, and shared access to patient reporting systems. There are multi-agency forums that the Trust attends and relationships have been strengthened.

15.17. **Action Required:** During the investigation process it was evident that multi-agency collaboration was improving and that there was a strong willingness for partnership working. What was not so evident was how the inputs of the past four years could be evidenced in a practical manner when it came to examining an actual service user pathway (such as that for Mr X). Strategic thinking needs to be implemented 'on the ground' and in a practical manner to minimise the risk of service users receiving fragmented service provision. The Trust, its commissioners and multi-agency partners should consider:

1. **Realigning all relevant policies and protocols to include: information sharing, safeguarding, MAPPA and collaborative working. Short information leaflets short be made available to facilitate usage.**

2. **Realigning incident investigation and lessons for learning work in order to promote a whole-systems learning and improvement approach.**

3. **Evaluating the findings of this investigation report in order to understand whether the experience of Mr X could be mapped onto present day services. The question should be asked 'are the problems identified with Mr X's pathway still a real possibility for other service users today'?**

Recommendation 4: Safeguarding (Adults and Children)

15.18. **Areas Identified for Improvement:** In the case of Mr X both child and adult safeguarding assessment and safety management processes failed. Systems did not join up and partnership working was not evident.

15.19. **Progress Made:** The Trust has been working with its multi-agency partners to strengthen joint working and improve information sharing; the new Trust electronic record system (RiO) is being used to facilitate this. The Trust's Safeguarding Champions Model has been implemented to offer increased levels of guidance and support to practitioners on the front line.

15.20. **Action Required:** Steady progress against the findings and conclusions of this report appears to have been made by the Trust in conjunction with its multi-agency partners. In order to embed new processes, to minimise the risk of child and adult safeguarding issues going undetected and unmanaged, consideration should be given to the following:

1. **Child and adult safeguarding policies and procedures need to be re-aligned between agencies – with particular regard to information sharing protocols.**

2. **In order to promote a culture where robust communication takes place the Trust and its multi-agency partners need to agree how safeguarding alerts should be made without relying so heavily on the use of emails.**

3. **There should be an examination of current safeguarding recording systems across all agencies (education, health, police, probation, social services). This to ensure that they align and all alerts and concerns are managed in a synchronised manner.**

4. **Child safeguarding training should be re-visited to also incorporate wellness and child developmental and psychological safety. A multi-agency and multi-disciplinary approach should be taken to this.**

5. **An evaluation of the findings of this investigation report should be undertaken in order to understand whether the experience of Mr X and his family could be mapped onto present-day service provision. The question should be asked 'are the problems identified with Mr X's pathway still a real possibility for other service users and their families today'?**

Category Two: Recommendations Concerning Localised Operational Service Change

Recommendation 5: Basic Building Blocks of Care

15.21. **Areas Identified for Improvement:** This report details numerous areas required for practice-based improvement. These areas include:

- diagnostic practice;
- medication, care and treatment,
- risk management,
- CPA and care planning;
- managing disengagement.

15.22. The Investigation findings and conclusions (in keeping with those of the Care Quality Commission in September 2019) focus on the context of poorly performing systems and service provision models. When systems and service models do not align with day-to-day working realities, clinical staff are unduly pressured to work in accordance with good-practice guidance. When this occurs the basic building blocks of care will be compromised; this is the finding of the Independent Investigation Team.

15.23. **Progress Made:** The Trust has embarked on major care pathway and service reconfiguration developments. This work should in large measure address some of the identified basic building blocks of care issues. However strategic planning can often take several years to embed within frontline service delivery and it should be remembered that the Trust's modernisation programme is part of a five-year strategy not due for completion until 2026.

15.24. **Action Required:** In the here-and-now the Trust should examine the numerous findings contained within this report (and detailed in the Standards Proforma). A mapping exercise should be undertaken to minimise the continued risk of clinical service omissions and the subsequent potential for risk to service users and their families. The following should be undertaken.

1. **A mapping exercise should be undertaken comprising frontline staff and those managers leading the care pathway and transformation agenda. The findings from this Investigation should be used as a discussion tool in order to assess how practical considerations and frontline service insights can be run alongside high-level strategic thinking and planning. This would also provide an evidence-based progress monitoring opportunity.**

2. **The Trust should review clinical supervision attendance, content, frequency and purpose. Clinical supervision should be aligned to the Trust's clinical audit cycle and have a clear evidence-based focus. Competency-based training and supervision should be available for newly qualified staff and those returning to the workplace after a long break away from the workplace. Clinical supervision should make quite clear the responsibilities of each registered practitioner within the Trust to adhere to best practice policy guidance and how to raise an alert if it is not possible to do so.**

3. **The medical workforce should be provided with clear expectations about conduct, practice and adherence to both NICE guidance and local policy expectation. Expectations should be clarified and built into development and performance management processes. This process should make quite clear the responsibilities of each medical practitioner within the Trust to adhere to best practice policy guidance and how to raise an alert if it is not possible to do so.**

4. **The Trust should review its key clinical policies to ensure they align and that there are no omissions (e.g. safeguarding, clinical risk management, CPA and care planning). The Trust should also ensure its policies are easy to read, and where they comprise numerous pages (some are in excess of 80 pages) easy to follow. Flow charts and information leaflets are also be considered for ease of access and reading. The Trust should also ensure that**

assessment templates capture all of the information required; especially in the areas of risk and safeguarding.

5. **The Trust should review its 'alert' system so that frontline staff can raise concerns about anything (such as staffing levels, lack of training, ineffective documentation templates etc.) that might inhibit the adherence to either good or safe practice.**

Recommendation 6: Therapeutic Relationships and Co-Production with Service Users and Carers

15.25. **Areas Identified for Improvement:** The therapeutic relationship between Mr X and his treating team broke down entirely. This made a significant contribution to Mr X regularly disengaging from service and becoming non-complaint with his care and treatment plan. There was little in the way of co-production and a lack of awareness on the part of the treating team as to how to manage a compromised therapeutic relationship.

15.26. Carers did not have their concerns addressed by Mr X's treating teams and carer assessments were not made available even though they were indicated.

15.27. **Progress Made:** At a strategic and service-planning level work is progressing to ensure a person-centered approach is taken for service users and their carers. The progress made to-date is set out in paragraph 13.26 above.

15.28. **Action Required:** It is without doubt that the Trust is making steady progress in this area. There is however one outstanding issue requiring attention and that is Carer Assessment.

1. **The Trust should set out clear policy guidance in relation to carer assessments; this should be developed in conjunction with Social Service partners. An audit should be conducted against the reviewed policy guidance to ensure carers are being offered assessment and also being provided with appropriate levels of support.**

2. **The Trust should consider the findings of this report and consult directly with Mr X and his family; the Trust should take the opportunity to listen to their lived experience and explain to them the work it is currently undertaking. The Trust should then test its current work and progress against their feedback and reflections.**

Recommendation 7: Clinical Record Keeping and Professional Communication

15.29. **Areas Identified for Improvement:** Five key areas were identified; they were:

- disparate electronic recording systems (both internal and external to the Trust) that did not 'speak' to each other;
- poor joint working practices that hindered face-to-face planning and professional communication;
- ineffective clinical record templates (particularly risk and safeguarding) which impacted negatively on the recording of accurate information;
- endemic 'cut and paste' practice and a culture of incomplete and inadequate clinical record keeping;
- the need to embed the new Trust clinical record system (RiO).

15.30. **Progress Made:** The introduction of RiO allows for a patient record exchange across all primary and secondary care clinicians across Lancashire; work is also ongoing to share other kinds of information across other electronic systems. This will facilitate continuity of care and joined-up working

15.31. **Action Required:** Whilst progress has been achieved with the introduction of RiO there are still several areas that need to be addressed in order to minimise the risks associated with poor professional communication. The Trust should ensure the points below are incorporated into its transformation agenda.

1. **Discussions should be held with multi-agency partners to see if improved access to service user information can be facilitated (see recommendations 3 and 4 above).**

2. **Process modeling in relation to practical multi-agency working should be considered as part of the transformation process. An analysis needs to be worked through regarding what multi-agency working actually means in practice and how it can be made to happen in real time on the front line.**

3. **Clinical Information gathering should be re-examined in relation to RiO-based templates, and other Trust-based documentation, to check for compatibility with Trust policy guidance. This should include risk assessment, safeguarding and care planning electronic templates.**

4. **The practice of 'cut and paste' should be strongly discouraged and form part of clinical supervision discussions, clinical audit activity and clinical policy guidance.**

5. **Additional support and training should be provided for those clinicians still struggling to navigate the new RiO system. Checks should also be undertaken to ensure historic information has been reliably transferred from the old system to the new.**

Recommendation 8: Strengthening Trust Audit and Assurance Systems

15.32. **Areas Identified for Improvement:** Trust audit systems have not been sensitive enough to detect non-compliance with Trust policy guidance.

15.33. **Progress Made:** The Trust has been working on its governance agenda since September 2019 following inspection feedback made by the Care Quality Commission (CQC). A recent review was conducted of the Trust's policy and procedural framework to ensure it is fit for purpose. This process has reviewed policies, brought them up-to-date, provided training and aligned guidance with the Trust's clinical audit process.

15.34. **Action Required:** The Independent Investigation Team recognises the work that has been undertaken by the Trust over a period of years to improve its governance issues. However evidence suggests the organisation would benefit from a regular longitudinal care pathway review of selected cases managed by the Trust; this to understand better how policies and clinical guidance work together in the delivery of care and whether optimal care and treatment is being delivered in an evidence-based manner.

1. **The Trust should conduct a review of selected case studies against the standards proforma used for this Investigation; this to be conducted as part of an annual audit cycle. This review should take a longitudinal stance and ensure that all systems, policies and clinical guidelines are working together in an optimal manner. This approach will highlight areas for service improvement and provide an early alert to systems that are under stress and not working in an optimal manner.**

Recommendation 9: Internal Incident Investigation Process

15.35. **Areas Identified for Improvement:** the internal investigation examining the care and treatment Mr X received from the Trust was not fit for purpose. The seriousness of the incident when coupled with Mr X's known history and levels of risk merited an in-depth review; this was not achieved. This prevented Mr X's treating teams and the Trust from learning important lessons, and also deviated from the Duty of Candour the Trust owed to Ms Y's family, Mr X, and his family.

15.36. **Progress Made:** The 2019 CQC inspection report criticised the Trust's risk management and learning processes. Consequently the Trust revised its investigation policy and procedures. The Independent Investigation Team has been to verify that recent investigation reports are improved and are examples of good practice.

15.37. **Action Required:** While new processes complete the embedding process the Trust should consider monitoring its current practice on a regular basis and should ensure the following:

1. **Terms of Reference are written on a case-by-case basis to ensure the basic building blocks of care are always reviewed as part of a quality assurance process.**

2. **Investigations should be supported by suitably skilled and trained staff who have protected time to complete the work.**

3. **Detailed investigation archives should be kept on a centralised Trust system designed for this purpose.**

4. **Treating Teams should have the opportunity to be interviewed and/or met with whenever possible during the course of an investigation. Emphasis should be placed on good investigation principles that support Trust staff to ensure their full engagement and maximise opportunities for learning. Recommendations should be developed with treating teams to ensure they are both relevant and achievable.**

5. **Duty of Candour principles should be made explicit in the Trust's investigation policy guidance.**

Glossary

Antipsychotic medication	Antipsychotics are a range of medications that are used for some types of mental distress or disorder - mainly schizophrenia 1 and bipolar disorder 2 (sometimes called manic depression). They can also be used to help anxiety or depression 3 where it is severe or difficult to treat.
Care Coordinator	A care coordinator is a mental healthcare professional (mental health nurse, occupational therapist, social worker or psychologist) who takes overall responsibility for ensuring that a service user's needs are assessed and planned and that those plans are carried out. The care coordinators also provides liaison between services and agencies.
Care Programme Approach (CPA)	Care programme approach (CPA) is an approach that is used in specialist mental health services to assess needs and then plan, implement and evaluate the care that is required. CPA is provided for those individuals with severe and enduring needs and who usually have more than one service/agency involved.
Cognitive Analytic Therapy	CAT stands for Cognitive Analytic Therapy; a collaborative programme for looking at the way a person thinks, feels and acts, and the events and relationships that underlie these experiences (often from childhood or earlier in life). As its name suggests, it brings together ideas and understanding from different therapies into one user-friendly and effective therapy.
Crisis Resolution and Home Treatment Team	This is a team that provides emergency care and treatment in a person's home in order to prevent hospital admission whenever possible.
Community Mental Health Team (CMHT)	This is a team that provides care and treatment in the community – it is comprised of other specialist teams including the HTT and CCTT.
Complex Care and Treatment Team	This is a clinical team working in the community that provides ongoing maintenance support to individuals who have severe and enduring mental illness. At the time Mr X received his care and treatment it was part of the CMHT.

Dual Diagnoses	Dual diagnosis is the term to describe people who have severe mental heath problems and drug or alcohol problems. The mental health problems may include schizophrenia, depression or bi-polar disorder, manic depression or personality disorder.
Duty of Candour	Duty of Candour sets out some specific requirements NHS providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Forensic Mental Health Teams	A Forensic Mental Health Team provides specialist psychological and psychiatric interventions to assess, treat and manage individuals who, as a consequence of mental illness or personality disorder, have offended, or, present a potential to offend and therefore pose a risk to themselves or others.
GP	General practitioner: a person who provides general medical care.
Holistic	The word ‘holistic’ is used in health and social care when describing how a person should be viewed. A holistic approach will take into account a person’s emotional, mental, physical, social and spiritual needs.
National Institute of Health and Care Excellence (NICE)	NICE provides national guidance and advice to improve health and social care. In April 2013 NICE was established in primary legislation, becoming a Non Departmental Public Body (NDPB). As an NDPB, NICE is accountable to its sponsor department, the Department of Health, but operationally it is independent of Government. Its guidance and other recommendations are made by independent committees. The way NICE was established in legislation means that its guidance is officially England-only. However, it has agreements to provide certain NICE products and services to Wales, Scotland and Northern Ireland.
Paranoid Schizophrenia	A person with schizophrenia may experience delusional thinking, including paranoid thoughts.

It may not be possible for the person to distinguish between this and regular thinking.

Schizophrenia affects a person's perception and can involve hallucinations and delusions. When these happen, it can be hard to know what is real and what is not.

Paranoid delusions can cause a person to fear that others are watching them or trying to harm them. Also, a person experiencing a delusion may believe that media such as the television or the internet are sending them special messages.

These feelings and beliefs can cause severe fear and anxiety, disrupt daily life, and limit a person's ability to participate in work and relationships, including those with family[8].

Personality Disorder

Symptoms vary depending on the type of personality disorder.

For example, a person with borderline personality disorder (one of the most common types) tends to have disturbed ways of thinking, impulsive behaviour and problems controlling their emotions.

They may have intense but unstable relationships and worry about people abandoning them.

A person with antisocial personality disorder will typically get easily frustrated and have difficulty controlling their anger.

They may blame other people for problems in their life, and be aggressive and violent, upsetting others with their behaviour.

Someone with a personality disorder may also have other mental health problems, such as depression and substance misuse[9].

8 https://www.medicalnewstoday.com/articles/192621
9 https://www.nhs.uk/mental-health/conditions/personality-disorder/

Appendix 1

TERMS OF REFERENCE

The Terms of Reference for Independent Investigation 2019.26680 and Thematic Pathway Review are set by NHS England and NHS Improvement. These Terms of Reference will be developed further in collaboration with the investigative supplier and stakeholders, including the affected families.

Part A
Purpose of the Review

To undertake a desktop review to consider the internal investigation commissioned by Lancashire and South Cumbria NHS Foundation Trust into the care and treatment of the service user. The review will examine the terms of reference and key lines of enquiry identified within the internal investigation to ensure they have been adequately considered and explored. The review should also identify any potential gaps or omissions that may require further examination.

Involvement of affected family members and the perpetrator

The Independent Investigations team are to ensure that the affected families are informed of the review of 2019/326680, and the review process. The investigating team will offer the families the opportunity to contribute, including development of the terms of reference.

Ensure that updates on progress are communicated to family members in the format and timescales they request.

Offer a minimum of two meetings with the service user; one to explain the process and contribute as appropriate and a second to receive the report findings.

Scope of the desktop review

The desktop review will consider the internal investigation commissioned by Lancashire and South Cumbria NHS Foundation Trust, which may include virtual meetings with the Trust if needed, and will include:

- A review of the trust internal investigation to ensure that the terms of reference were met and that the key lines of enquiry were appropriate.
- The sourcing and review of relevant documents to develop a comprehensive chronology of events by which to evaluate the investigations findings against. Which will include access to both the Trust and the GP records.

- Review the internal investigation and consider the care, treatment and services provided at the time against compliance with local policies, national guidance and where relevant statutory obligations.

- To hold virtual staff discussions or meetings with provider organisations for clarification purposes.

- Inform Lancashire and South Cumbria NHS Foundation Trust and East Lancashire CCG of any gaps or omissions in the key lines of enquiry within the internal investigation.

- Agree with the relevant providers and commissioner any remedial recommendations or actions.

Output

- Provide an anonymised written report to NHS England and NHS Improvement, identifying the key findings and providing outcome focussed recommendations. The report should follow both the NHS England style and accessible information standards guide.

- Provide NHS England and NHS Improvement with a monthly update, detailing actions taken, actions planned, family contact and any barriers to progressing the investigation.

- Deliver a learning event for the Trust, CCG and wider stakeholders highlighting the key findings and recommendations.

DUNCAN &
JOHNSTONE
Investigation, Learning, Improvement

Duncan and Johnstone Consultancy Ltd

Investigation Review Proforma & Quality Standards

2022

The standards are based upon local and national best practice guidance. This ensures:

- **an objective evidence-based approach to the work;**
- **a structured way in which to identify specific gaps or good practice in service;**
- **an audit tool for future assurance and monitoring purposes.**

Colour Key:

- **data from clinical records: black**
- **data from workshops: green**
- **data from other documentary sources: brown**
- **data from interviews: purple**

Quality Standard	Met: ✓ Partially Met: ✓ Unmet: ✘	Evidence Drawn from the Review (comments may include a robust appraisal of the criteria, and may include any unusual or atypical circumstances relating to the item)
Themes from Internal Trust Thematic Reviews and Confirmed by the Independent Review Process		
1. Diagnostic Practice and Missed Psychosis/ Substance Misuse/Dual Diagnosis		
Diagnostic Process and Formulation • A full and relevant history is taken. • Comprehensive mental state examinations are undertaken and recorded. • In making the diagnosis and differential diagnosis psychiatrists use a widely accepted diagnostic system. • Service users and their carers are worked with in partnership during the assessment process. • Psychiatrists seek (and consider) advice, assistance or a second opinion if there are uncertainties in diagnosis and management or if there is conflict between the clinical team and the patient and/or their carer and family regarding diagnosis. • The reasoning behind clinical assessments/decisions is explained and written in the record. If appropriate an account of alternative plans considered but not implemented is recorded. • The ethos of co-production with service users and their families is both promoted and maintained. • The service user's right to a second opinion is respected		

and supported. • Risk assessments and care plans take full account of diagnostic formulation when designing and assigning the required pathway. • Referrals are made/advice sought to/from specialist colleagues (i.e. to forensic psychiatry, dual diagnosis services) to seek further opinions if service users have multiple aspects to diagnosis/formulation.		
Issues for further consideration		
2. Risk Management		
Policy • There is a systematic approach to risk assessment and management in relation to violence, self harm/suicide and self neglect. • Training and support are provided (in keeping with the Trust policy to ensure adherence). • Supervision provides regular scrutiny of clinical assessment and management plans (in keeping with the Trust policy to ensure adherence). • Network Governance Groups provide regular monitoring and assurance that the Trust risk policy is adhered to (in keeping with the Trust policy to ensure adherence).		
Risk assessment **In General** • Any new information gained which highlights any previously unidentified risk, or escalation of known risk, results in a further formal risk assessment being documented. • A formal risk assessment is completed and recorded at initial assessment. On-going risk assessments are conducted for all service users and inform the care planning process.		

• Risk assessments are discussed with the wider care team and actions agreed to manage/minimise identified risks. This is recorded in the care plan. • A consultant psychiatrist is directly involved in clinical decision making. **Standard Risk Tool** • Practitioners assess the likelihood of harm to self or others as part of an overall assessment of need. • Practitioners identify any current or historical risks on the three clinical risk domains; risk to self; risk to others; vulnerability (and domestic violence added to the 2021 policy). • The practitioner completes a Risk Formulation and Risk Management Plan. • When risk areas are identified consideration is given to the management of these risks and input from other teams within LCFT is sought if required. **Enhanced Tool:** • Risk assessment selects the risk behaviours and factors for harm to self, harm to others and vulnerability. • The practitioner articulates the nature of the risk/s including the behaviours, characteristics and context and completes a formulation. • Risk formulation summarises and documents the types of risks and to whom, what escalates or decreases the risk, how imminent, serious and volatile the risk is, what strategies can reduce the risk and how effective the management plan will be. • The risk assessment is reviewed and updated in accordance with the care programme approach policy, mental health clustering guidelines, other related procedural documents and the service's standard operating procedures.		

5P Formulation model • The 5P formulation model is used. • Risk assessments are holistic and comprehensive.		
Risk Planning • Clear plans (with specific actions) are developed to mitigate the risks identified. • Risks and risk management plans are communicated to all relevant stakeholders (other services, GP, carers etc.). • Plans are updated when risk profile alters. • Plans are updated in keeping with policy guidance. • Positive risk management is part of carefully constructed plans. • Named practitioners/services are set against specific actions/interventions.		
Crisis and Contingency Planning • Robust relapse and crisis plans are developed providing clear instruction for the service user, carer and treating team.		
The Protection of Children • The needs of children are paramount at all times and the Think Family Approach is considered during every risk assessment and planning process. • The impact of substance misuse or alcohol use is considered in relation to child safety and wellbeing.		
MDT working • Risk assessment is developed in conjunction with the whole multi-disciplinary team. • Managers and team leaders initiate and review risk assessments and management plans.		
Multi-agency/Inter-Service working • Risk assessments and plans are shared with all Trust services involved with the service user.		

• When appropriate risk assessment is developed in a multi-agency manner. • Risk assessments are shared with multi-agency partners. • General Practice is notified of all relevant risk assessments and management plans.		
Service User and Carer Involvement • Service users are involved in risk assessment, planning and management whenever possible. • Carers are involved in risk assessment, planning and management whenever possible. • Carers are able to escalate concerns. • Carers at risk are informed by practitioners and supported in keeping safe.		
Issues for further consideration		
3. CPA, Care Planning and Care Coordination		
CPA Process • Corporate assurance and oversight procedures are in place to monitor policy adherence. • Service managers and modern matrons ensure policy adherence via management supervision. • All staff receive face-to-face training. • All service users on CPA are allocated a care coordinator and the care plan identifies the care coordinator and consultant psychiatrist.		
Eligibility Criteria • The eligibility criteria for CPA (in accordance with Trust policy) are adhered to (risk of suicide, self- harm, harm to others - including history of offending - relapse history requiring urgent response, self-neglect/non concordance with treatment plan, vulnerable adult; adult/child protection, multiple service/agency provision).		
Assessment		

• Care plans are informed by the risk assessment process. • Assessment is holistic and multidisciplinary in nature. • Assessments include reference to risk, safeguarding, parenting/caring roles, and carer involvement. • All staff involved in the service user's care contribute towards assessment and formulation. The views and aspirations of the person being assessed are also recorded. • Risks to children and vulnerable adults form part of the risk assessment and appropriate advice sought and referrals made in line with the safeguarding policy and procedures. • A comprehensive multi-disciplinary assessment of the service user's health and social care needs (including any risks they may face) is undertaken collaboratively with them, their carers and any partner agencies. Assessments are ongoing and require continued monitoring for any changes required. Where possible other agency's assessments will be combined.		
Care Planning • The care plan includes plans to support parenting or caring roles for children and vulnerable adults. • All service users are encouraged to be involved in the development of their care plan which is recovery focused. The assessment identifies the person's aspirations and strengths as well as their needs. • Where service users are prescribed medication for mental health problems it is identified as part of the care plan who prescribes the medication, where it is obtained from, the instructions for its administration, the desired effects, the potential side effects and how these will be monitored. The care plan must include what other medications are being prescribed for physical health problems.		

• A crisis plan is developed. • In keeping with the CMHT OP - All service users have the opportunity to draw up a plan of care, written alongside their care coordinator and carers where appropriate, that describes their relapse signatures and action to be undertaken.		
Review and Discharge • All service users have a formal review with their care team, including their consultant psychiatrist, at least 12 monthly. This focuses on the effectiveness of the care plan. An earlier review is held should there be a significant change in the service user's presentation, transfer of care arrangements between teams or service areas and in accordance with Mental Health Clustering Review guidelines. • The decision to discharge from the CPA is agreed within a CPA review. • Discharge is discussed with the service user and any carers involved. • The reasons for discharge are clear and conveyed to the service user and their views sought. When planning discharge, consideration is given to any on-going care/support required and possible future involvement with services. The service user and GP are given a copy of the discharge care plan which details advice/information about how to access the service in the future and relapse prevention strategies. • Recovery is the focus of all mental health interventions and discharge from services is planned in partnership with the individual and carer (where appropriate) at their initial assessment and reviewed regularly. • (On discharge) If the service user receives a depot injection from primary care, the care coordinator will		

ensure that the service user has attended their first appointment prior to being discharged or transferred.		
Service User Involvement • Service users are involved throughout assessment and planning stages. • Carers are involved throughout assessment and planning stages whenever possible. • (CPA Policy) all service users will be treated with respect and will be enabled to make informed choices.		
Care Coordination • The care coordinator oversees the implementation of the assessment and care planning process. • The responsibilities of the care coordinator as set out in Trust policies (past and present) are adhered to. • When care coordinators change a thorough handover takes place. • Problematic/overly large caseloads are notified to service managers/network directors. • Professionals and Services involved who are unable to attend the formal review make any relevant information available to the care coordinator prior to the formal meeting so that this can be discussed at the review. • Reviews are organised at a time and location which best meets the needs of the service user. • Care coordinators receive regular supervision to ensure the CMHT operational policy is adhered to.		
Multi-disciplinary Input • A consultant psychiatrist is directly involved in clinical decision making. • All staff involved in the care of the service user are consulted throughout the assessment and planning process.		
Issues for Further Consideration		

4. Managing Disengagement		
• Service users referred for care co-ordination are not left without follow up (due to the disengagement of the service user). • Service users not on CPA are followed up and a risk assessment considered and a plan of care developed. • When a service user does not engage every effort is made to find out why and the reasons recorded. • CMHTs include an outreach service that provides support to service users who are difficult to engage. • Service users who meet the criteria for CPA are not discharged solely on the grounds they are uncooperative. • All possible efforts are made by the care coordinator to stay in touch with the service user and work at developing a relationship that will enable increased engagement. • The decision to discharge from services is agreed by the care team at a CPA Review. Service users who meet the criteria for CPA are not discharged solely for disengaging or failing to keep a fixed number of appointments – consideration is always given to the degree of mental illness and the level of risk posed. • As part of the assessment and review process a proactive discussion takes place with the service user/carer to agree the actions and risk management plan in the event of their early or longer term disengagement and a care plan agreed. • If there is a serious risk of suicide, self-neglect or harm to others through the service user's refusal to engage then compulsory admission and treatment under the Mental Health Act is considered. • An agreed care plan is developed for service users who do not engage with care and treatment (this to be multi-agency if indicated).		

• For service users with a history of a loss of contact, trigger factors are identified and action is documented within the risk management strategies recorded on the care plan in relation to relapse. • If a service user misses an appointment and contact cannot be established then third parties such as relatives, carers, GP, support services, the Police are liaised with. • Where there are dependent children within the household of a service user with mental health needs, special consideration is given to the implications this may have for those children.		
Issues for Further Consideration		
5.Carer Engagement and Involvement		
Carer Assessment • All service users are asked at assessment and reviews to identify carers who provide regular and substantive care. Where such carers are identified they are offered a carer assessment and an annual reassessment of their needs (under the requirements of the Care Act 2014).		
Carer Engagement and Involvement • There is evidence to demonstrate that carers are involved, listened to with respect and that any concerns raised by them are considered respectfully and examined appropriately. • Carers are kept informed if any issues affecting their personal safety are identified. • Carers are consulted when services users disengage from service.		
Issues for Further Consideration		
6. Access to Service, Resource, Referral and Waiting Times		

• Patient tracking lists are monitored for adherence. • Caseload numbers and high risk service users are reviewed monthly in supervision. • Duty Workers ensure all relevant information about referrals is recorded and liaison with referrers/transferors to service takes place. • All service users who can no longer be managed in a primary care context are accepted and managed by CMHT services (including service users with severe personality disorders). • Resource, referral and waiting time issues are monitored and the necessary actions taken. • When referrals are not accepted the reasons for this are sent to the referrer in writing within 72 hours of the decision being made. • Following referral service users are contacted by telephone to arrange an initial appointment – if this is unsuccessful the service user is contacted in writing urging them to contact the service. After 2 weeks if no contact is made then a further letter is sent. The case is discussed with the MDT and if there are no concerns the service user is discharged back to the care of the GP. • When a service user DNAs the first appointment 2 attempts to contact the service user are made. A new appointment is made and details sent to the service user giving a 2-week notice period. If the service user DNAs the second appointment they are removed from the waiting list. • Following DNA the decision to remove from a waiting list is made following a recorded risk assessment and the GP written to. • When there are concerns about a service user's condition this is escalated to the service manager.		

7. Multi-Agency Working		
• Communications between agencies is guided by agreed policies and protocols. • Records pertaining to service users and pertinent to their ongoing care, treatment, wellbeing and safety can be accessed by all agencies as required. • Care planning, risk assessment and documentation processes are developed/shared in an interagency manner following consultation and ongoing team working in the best interests of service users and the safety of the general public. • Policies and protocols are reviewed by senior officers in a multi-agency forum within in regular and pre-determined timeframes.		
Issues for Further Consideration		
8. Adherence to Policy and Procedure (local and national best practice)		
• Trust policies and procedures are adhered to. • The Trust has clear and demonstrable assurance processes to ensure policy adherence. • All staff access mandatory training appropriate to their roles.		
Themes from the Independent Review Process		
9. Safeguarding		
Children • Staff in adult mental health services caring for a parent always considers the child's needs and the potential for physical and psychological harm as primary task of the CPA and as part of multiagency risk assessment processes.		

• Risk assessments of mental health service users are not based solely on the information they can provide. If the service user has, or resumes contact with children, this triggers an assessment of whether there are any actual or potential risks to the children, including delusional beliefs involving them, and drawing on as many sources of information as possible, including compliance with treatment. • Assessments, CPA monitoring, reviews, and discharge planning arrangements and procedures prompt staff to consider if the service user is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the service user, and consideration is given to any risks posed to those children. • All staff ensure safeguarding and promoting the welfare of children and young people forms an integral part of all stages of care and assessment. • Information about the child/children in families is recorded at assessment or as soon as possible and recorded on CPA documentation/client records. When any pre or postnatal service user is receiving care the health visitor/midwife must be routinely informed of mental health services involvement, to aid sharing of information. • Staff implementing the CPA process are mindful of service users/carers responsibility for children and consider the welfare of children at every stage of the CPA process utilizing the Framework for Assessment of Children in Need and their Families (see LCFT Safeguarding and Protecting Children Procedures SG001). • When a service user poses any threat to children then a CPA review is called at the earliest opportunity and a		

consultant psychiatrist is directly involved in all clinical decision making. • A referral to children's Social Services is made under Local Safeguarding Children Board procedures as soon as concerns are identified for a child/children's welfare, there is a problem, suspicion or concern about a child, or if the child's own needs are not being met. • The care coordinator and all staff providing care are made aware of any disclosures made and Police Public Protection Unit notified as well as children's social care, in line with LSCB procedures. Staff identify if Multi-agency Public Protection Arrangements (MAPPA) have been put into place. • Service users with substance misuse problems who live with children/vulnerable adults are notified to Social Services.		
Vulnerable Adults • Risk assessments of mental health service users are not based solely on the information they provide. If the service user has or may resume contact with a vulnerable adult or is at risk him/herself this triggers an assessment of whether there is actual or potential risk; drawing on as many sources of information as possible to assess that risk and including delusional beliefs involving them or another vulnerable adult. • Assessments, CPA monitoring, reviews, and discharge planning arrangements and procedures always include consideration of potential vulnerability of the service user and/or other potentially vulnerable adults or children the service user may have contact with and consider any risks posed. • When a service user poses a risk to a vulnerable adult or is at risk of abuse as a vulnerable adult a CPA review is		

called at the earliest opportunity and the LCFT Safeguarding Adult Procedures SG008 are followed.		
10. Escalation Pathways and Access to Mental Health Services		
• Services are accessible so that appropriate treatment can be obtained when and where it is needed. • Where risks are complex and hard to formulate the case is taken to a Complex Case Forum so that the most senior clinicians in the team are involved in the care and clinical management. • Relapse signatures are identified, and when apparent, urgent communication takes place to manage care.		
11. Record Keeping		
• Clinical data is captured in an accurate and timely manner. • All procedures (diagnostic assessments, histories, and other kinds of assessments) are documented and updated. • The NHS Number and another identifier (e.g. patient name or date of birth) are used at all times with patient identifiable data. • Staff and patients are not put at risk through invalid or incorrect decisions being made about a patient's care (due to poor record keeping practice). • All Trust treating teams have access to a service user's complete clinical record when making specialist assessments (e.g. when services users are in police cells awaiting forensic assessment). • All staff are trained to use clinical data systems.		
12. Multi-Disciplinary Team Working		
• MDTs work in a coordinated manner in order to promote efficient and effective care. • Individual members of the MDT demonstrate respectful and supportive behaviours one to the other.		

• Assessments are conducted following full MDT contribution and discussion. • Clinical decisions are based upon the views and clinical expertise of the entire MDT. • Disagreements between MDT team members are managed in an objective and supportive manner by the team manager.		
13. Professional Communication (inter-service and inter-agency)		
• There are clear information sharing protocols across all relevant agencies. • Trust services have access to all other Trust service records when a service user receives packages of care from multiple services within the organisation. • Serious incidents relating to the poor management of data are avoided. • Staff and patients are not put at risk through invalid or incorrect decisions being made about a patient's care (due to failures in clinical records access). • All staff make accurate and timely entries in the clinical record. • Services make efforts to contact members of current treatment teams when making specialist assessments (e.g. when services users are in Police cells awaiting forensic assessment).		
14. Care Pathways and Evidence-Based Practice		
• Clinical decision making is guided by national best practice evidence-based guidance. • Trust services and operational provision are constructed in a manner to facilitate NICE guidance and other national research-based evidence guidance.		
15. Care Clustering and Assessment		
• The care clustering tool is not used in lieu of a clinical assessment – but is instead based upon a MDT holistic		

clinical assessment. • Each person completing the care clustering tool has had training to ensure that they complete the tool correctly. • Transitions between services are considered following the use of the care clustering tool only when clear milestones and clustering criteria have been met. • Changes to care clusters are considered after a service user experiences a period of recovery and stability.		
16. Service User Involvement		
• Service users as involved fully in their care and treatment. • Service users are treated with dignity and respect at all times. • Requests for second opinions/complaints about service are taken seriously and actioned with immediate effect. • Advanced statements are discussed with service users and recorded appropriately.		
17. MAPPA and Transition from Prison		
• The Offender Pathway is followed. • If a service user is on MAPPA then this is an agenda item at every CPA review. • Comprehensive risk assessments are developed which take advantage of coordinated information sharing across agencies. • Care coordinators from community teams attend MAPPA meetings. • The MAPPA policy and procedures are adhered to.		

Reference Documents

NB: the internal Trust policies listed below are those made available to the Independent Investigation Team. The policies are either recent or current and provide a guide to the standards in operation at the time care and treatment was delivered.

1. Procedure for the Assessment and Management of Clinical Risk in Mental Health Services (May 2015 – May 2018)
2. Assessment and Management of Clinical Risk in Mental Health Services Policy and Procedure (March 2021 – March 2024)
3. *Best Practice in Managing Risk published* Department of Health (2007)
4. *National Confidential Inquiry into Suicide and Safety in Mental Health* (2019) Annual Report 2019; England, Northern Ireland, Scotland and Wales. The University of Manchester
5. Care Programme Approach Policy (and CPA Procedures) (August 2015 – September 2018)
6. Care Programme Approach Policy (and CPA Procedures) (April 2019 – April 2022)
7. Community Mental Health Team Standard Operating Procedure (2021)
8. Data Quality Policy (2018 – 2021)
9. Waiting Times and Patient Access to Services Policy (2018 – June 2021)
10. Medicines Management Policy (2020 – 2023)
11. Data Quality Policy IMT 018 (May 2018 – March 2021)
12. Protocol for the Transition of Service Users between Lancashire Care NHS Foundation Trust Prisons & Mental Health Services (2017)
13. Multi-Agency Public Protection Arrangements (MAPPA) Procedure (2021 – 2023)
14. Promoting Engagement and Access to Mental Health Services Standard Operating Procedure (March 2021 – March 2022)
15. *The Mental Health Clustering Tool: How to allocate to Care Clusters in IAPT services* Royal College of Psychiatry (2021)
16. *Mental Health Clustering Booklet* NHS England (2015/2016)
17. *Core Values for Psychiatrists* College Report CR204 – Royal College of Psychiatrists (2017)
18. *Good Psychiatric Practice* Royal College of Psychiatrists (2009)