An independent investigation into the care and treatment of a mental health service user (Miss B) in Rotherham

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

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Contents

1 Executive summary

1.1 On the 20 July 2015, Miss B was arrested on suspicion of murder, along with her partner Mr P. A Mr C was found deceased in his home in Wombwell, Barnsley, and subsequent enquiries suggest that he was stabbed to death on 13 July 2015. Mr C was found by family members on 17 July 2015.

1.2 NHS England, North regional office, commissioned Niche Patient Safety Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (Miss B). Niche is a consultancy company specialising in patient safety investigations and reviews.

1.3 The terms of reference for this investigation include the care and treatment of Miss B by Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH or the Trust). The full terms of reference are at Appendix A.

1.4 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[2]

1.5 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.6 This investigation will also review and comment on changes that have been made in the Trust as a result of learning from previous incidents.

1.7 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

1.8 The investigation team would like to express our sincere condolences to the family of Mr C.

Miss B's mental health history

1.9 Miss B was initially referred by her health visitor to what was then mental health services in Sheffield in June 2004. She was originally referred for assessment due to her psychological distress. She was assessed by a community psychiatric nurse in July 2004, and described disturbances of mood, memory and concentration, after experiencing domestic violence.

[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*
[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

1.10 Miss B was noted to have a diagnosis of schizophrenia or schizo-affective disorder, and was treated with antipsychotic medication. She experienced extreme mood swings and auditory hallucinations.

1.11 Miss B had been under the care of Sheffield substance misuse services, and moved to Rotherham from Sheffield in July 2009. She was referred by her GP to community mental health services, which are provided by Rotherham Doncaster and South Humber NHS Foundation Trust.

1.12 At the time of the homicide she was diagnosed with schizophrenia and harmful use of opioids, and she had been under the care of Rotherham Doncaster and South Humber NHS Foundation Trust since 2009.

Homicide

1.13 Miss B was present when her partner P stabbed the victim Mr C on 13 July 2015, in what was believed to be a robbery to gain money to settle their drug debts.

1.14 Miss B and P were jointly charged with the murder of Mr C on 13 July 2015, and found guilty of murder and given individual life sentences on 7 December 2015.

Internal Investigation

1.15 Rotherham Doncaster and South Humber NHS Foundation Trust undertook an internal investigation that has been reviewed by the investigation team.

1.16 The internal investigation for the Trust was carried out by an Assistant Director.

1.17 The internal investigation made five individual recommendations and the Trust developed an action plan.

Independent investigation

1.18 This independent investigation has drawn upon the internal process and has studied clinical information, police information, internal reports, and organisational policies. We met with mental health and substance misuse service staff who had been in contact with Miss B, and senior staff from the prison health services and from the Trust.

1.19 We have met with Miss B and given her an opportunity to discuss her views on her care.

1.20 We met with a representative of Mr C's family who requested that we review the approach of staff to assessing evidence of drug use, and stressed that there should be better training in recognising the signs of drug abuse.

1.21 We find that the recommendations made in the internal report did address the contributory factors found through the investigation.

1.22 It is our view that the homicide of Mr C was not predictable or preventable by mental health services. We were supplied with no evidence to suggest that his death was in anyway a result of Miss B's mental disorder. There remains a duty to alert authorities even if risk of serious harm is not due to mental disorder. We have seen no evidence to suggest that the Trust services could or should have been aware that she might take part in this robbery with her partner and that serious harm to others of any type would then follow. We do not think they were in a position to alert, prevent or predict the actions and choices made on the day in question.

Recommendations

1.23 We have made 11 recommendations, which have been grouped into four themes; policy adherence, staff training and development, service management and serious incident management. The recommendations about adherence to policy have been made after careful consideration of the evidence.

1.24 Where issues have been identified we have reviewed practice against the relevant Trust policy, which clearly state the expectation in the various areas. The policies appear reasonable and easy to follow therefore the lessons to be learned in the first six recommendations is how the Trust ensures policies are implemented and followed.

Policy adherence

Recommendation 1:
The Trust must provide assurance that the CPA policy is adhered to in the Rotherham Assertive Outreach Team.

Recommendation 2:
The Trust should revise care planning and risk assessment formats to include the date of the last CPA review, and indicate when the next review is due.

Recommendation 3:
The Trust must provide assurance that the NICE guidelines for the prevention and management of psychosis and schizophrenia are incorporated into treatment plans.

Recommendation 4:
The Trust must provide assurance that best practice prescribing guidelines as published by the General Medical Council are adhered to.

Recommendation 5:
The Trust must provide assurance that nursing staff adhere to best practice guidance in the administration of depot injections and the requirements of the Safe Secure Handling of Medicines Policy in the care of patients receiving antipsychotic medication.

Recommendation 6:
The Trust must provide assurance that the dual diagnosis policy is implemented in community teams.

Staff training/development

Recommendation 7:
The Trust must provide assurance that community mental health staff are equipped with the skills knowledge and policy awareness to assess for the harmful use of substances in community mental health services.

Recommendation 8:
The Trust should provide assurance that Trust clinical staff are equipped with skills and knowledge in recognising and assessing the impact of domestic abuse, including assessment of capacity where indicated.

Service management

Recommendation 9:
The Trust should provide assurance that there are no patients from outside the RDaSH catchment area being treated in community teams without a time limited explicit agreement as to rationale for that including duration and review processes.

Serious incident management

Recommendation 10:
The Trust should ensure that the approach to families involved in a serious incident committed by a Trust mental health service user is carried out in accordance with the principles of 'Being Open'.

Recommendation 11:
The Trust should address those areas within the internal action plan that have not been completed on internal recommendations 4 and 5.

2 Introduction

2.1 At the time of the homicide Miss B was under the care of mental health services provided by Rotherham Assertive Outreach Team (AOT), provided by RDaSH, under the Care Programme Approach (CPA). Her most recent care plans in June 2015 were focussed on achieving a tenancy, receiving her depot medication regularly, monitoring her mental state and referral to the crisis team in the event of problems. The FACE[3] risk assessment completed in June 2015 noted that she was at low risk of deliberate self-harm, significant risk of self-neglect, accidental self-harm, abuse by others and risk related to her physical health. No risk of violence to others or of suicide was noted. At this time no use of illicit drugs was noted.

2.2 Miss B had been living in Wombwell with her current partner P since late 2014 and was registered with a Barnsley GP. Although she was under the care of Rotherham Assertive Outreach Team, this address was outside their catchment area.

2.3 In June 2015 steps were taken by Rotherham AOT to transfer her to Barnsley AOT but this had not been concluded by the time of the homicide. Although services had discussed the transfer, due to uncertainties about Miss B's living arrangements the transfer had not concluded. On 26 June 2015 Miss B called staff at AOT to say that P had told her not to come back and she was therefore homeless. Emergency accommodation was provided for her in Rotherham. She also disclosed that they had shared some crack cocaine and had an argument. She denied regular drug use.

2.4 She was seen daily by AOT staff at the emergency accommodation, and although upset she denied any increase in mental health symptoms. By 29 June 2015 Miss B told AOT staff that the relationship with P had improved and she had moved back into his flat in Wombwell. A formal referral letter was then sent to Barnsley AOT, which was being actioned at the time of the homicide.

2.5 Miss B was seen fortnightly as planned by AOT staff, and her depot injection administered as prescribed. She was also prescribed medication for difficulty sleeping and procyclidine for reported stiffness following her medication increase. Miss B continued to report difficulty with sleeping, and was given sleep hygiene advice, and discussion took place about a possible prescription of alternative medication to aid sleep.

2.6 She was last seen by two AOT staff on 15 July 2015. She reported that she felt mentally well and there were no issues with hearing voices. She denied any illicit drug use. It later came to light that this was two days after the homicide had been committed, and she had been regularly using street drugs.

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[3] *FACE stands for 'Functional Analysis of Care Environments' The FACE risk profile is part of the toolkits for calculating risks for people with mental health problems, learning disabilities, substance misuse problems, young and older people, and in perinatal services. http://www.face.eu.com/solutions/assessment-tools*

The homicide

2.7 Mr C was found deceased at his home in Wombwell on 17 July 2015 by a family member. A murder inquiry was launched, and Miss B was seen on CCTV using Mr C's bank card to withdraw money.

2.8 The motivation behind the assault appears to have been robbery, to enable P to get money to settle a drug debt. It was accepted at court that P carried out the initial stabbing, and told Miss B to take Mr C's bank card to get some money out. Miss B left the house and went to a nearby bank, which was four minutes away. It appears that Mr C was alive when she left.

2.9 When she returned with the money she reported that she saw P stabbing Mr C and asked him to stop. They left and returned to their flat, P told her to change her clothes; then he burnt them, along with the knife he had used.

2.10 Both Miss B and P denied murder after their arrest on 23 July 2015, and later separately pleaded not guilty. They both received individual life sentences on 7 December 2015.

3 Independent investigation

Approach to the investigation

3.1 The independent investigation follows the NHS England Serious Incident Framework[4] (March 2015) and Department of Health guidance on Article 2[5] of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

3.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents.

3.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.

3.4 The investigation was commissioned by NHS England (North region) and the team comprised Carol Rooney, Head of Investigations and Dr Ian Davidson, Consultant Psychiatrist, with peer review by Professor Liz Hughes. The investigation team will be referred to in the first person plural in the report. The report was also peer reviewed by Nick Moor, Niche Director.

3.5 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[6]

3.6 The independent investigation team would like to offer their deepest sympathies to the family of Mr C. It is our sincere wish that this report does not contribute further to their pain and distress. We acknowledge how difficult it must have been for them in this tragic situation.

3.7 We have used information from Miss B's clinical records provided by the Trust, maternity notes, prison healthcare services and the GP practices where Miss B was registered.

3.8 We reviewed information from South Yorkshire Police, including the police case summary.

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[4] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf*

[5] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

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

3.9 A profile of the Trust is at Appendix B and a list of documents accessed and reviewed is at Appendix C.

3.10 We had meetings about the issues with:

- Head of Healthcare HMP New Hall (Spectrum CIC)
- Clinical Matron, mental health inreach (Nottinghamshire Healthcare NHS Foundation Trust)

3.11 As part of our investigation we held a workshop with:

- AOT and substance misuse service clinical staff who had provided care for Miss B in Rotherham and Wombwell before and during 2015, to review her care and treatment during the previous year. Through this process we developed a timeline of events, focussing in detail on the events preceding the 13 July 2015

3.12 We met with the following Trust staff individually:

- Assistant Director, Drug & Alcohol Services (internal report author)
- Adults Services Locality Manager
- Serious Incident Officer
- Trust Physiotherapy Lead/Adult Mental Health Patient Safety Lead
- Director of Nursing and Quality

3.13 Where these interviews were recorded they were transcribed, with transcripts returned to the interviewees for review and signature.

3.14 We met with the Trust Director of Nursing to discuss and review evidence of implementation of the action plan and of lessons learned.

3.15 We wrote to Miss B at the start of the investigation, explained the purpose of the investigation and asked to meet her. We met with Miss B with the NHSE England investigation lead to introduce the investigation and invite her participation in March 2016. The lead investigator and clinical advisor met with Miss B in prison in September 2016.

3.16 Miss B read the draft report and gave us her feedback. She told us she thought the report was fair and she agreed with some of our conclusions. She said she believes it would have been better if she had been transferred to the Barnsley team.

3.17 A meeting with a representative of Mr C's family was facilitated by NHS England, and it was requested that the family be kept informed of the outcome of the investigation. They requested that we review the approach of staff to assessing evidence of drug use, and stressed that there should

be better training in recognising the signs of drug abuse. The family of Mr C were given the opportunity to read and comment on the draft report but have not made any comments.

3.18 Miss B told us she has no close family with whom we might discuss her care.

3.19 The draft report was shared with all identified stakeholders prior to publication. This provided an opportunity for those organisations that had contributed significant pieces of information, to review and comment upon the content.

Structure of the report

3.20 Section 3 sets out the background of the care and treatment provided to Miss B. We have covered her care and treatment in detail from 2014 up to July 2015.

3.21 Section 4 examines the issues arising from the care and treatment provided to Miss B and includes comment, analysis and recommendations, with reference to the terms of reference for the investigation.

3.22 Section 5 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

3.23 Section 6 sets out our overall analysis and recommendations, and comments on predictability and preventability.

4 The care and treatment of Miss B

Personal history

4.1 Miss B was born in Barnsley and brought up in the Huddersfield area. Miss B's parents separated when she was one and a half years old. She was brought up mostly by her mother with input from her grandmother. Her mother died when Miss B was 21.

4.2 Miss B reported that her mother may have had mental health problems, and said she physically abused her as a child. There are two siblings, neither of whom are in contact with her. She reported that she had never been very close to her father, but used to see him infrequently.

4.3 Miss B left school aged 15 with no qualifications, and said she had interrupted schooling due to physical injures by her mother and family moves. As a result she can read and write with some difficulty and do basic maths.

4.4 Miss B left the family home to live with a boyfriend at aged 15 and had her own flat in the same village. She moved to Sheffield in about 1997. Her grandmother was reported to have stopped contact in 2005 after discovering that Miss B was using illicit drugs.

4.5 Miss B has said her longest relationship was between the ages of 15 and 20. Subsequent relationships have featured domestic violence towards Miss B.

4.6 Miss B gave birth to her youngest child in December 2012. She has two older children who are in the care of their father.

Offending and contact with criminal justice systems

4.7 Miss B's first convictions date from April 2004 when she was 28. She has been convicted of multiple offences of theft, shoplifting, offending relating to police/courts and drug offences. She served seven jail sentences between 2007 and 2014.

4.8 She was convicted of the murder of Mr C on 7 December 2015 and given a life sentence, with a tariff of 20 years to serve.

Relationships and domestic violence

4.9 In 2002 Miss B told Rotherham Borough Council children's and young people services staff that her relationship with her then partner S was characterised by domestic violence. S is the father of her two eldest children. In December 2002 he assaulted her in front of her children and in March 2003 the relationship ended. Miss B later reported abusive texts, harassment and threats to kill from S. A non-molestation order was obtained by Miss B in July 2003.

4.10 In mid-2003 Miss B began a relationship with J. In September 2003 Miss B was assaulted in front of her children by J, resulting in her being hospitalised with concussion.

4.11 In March 2004 J assaulted Miss B twice, beating her and threatening her with a baseball bat. Miss B suffered extensive cuts and bruising. Four days later he assaulted her again by slapping and kicking her in an assault lasting an hour.

4.12 At a child protection conference in April 2004 it was noted that Miss B was frightened to end her relationship with J because of possible repercussions. She had dropped charges in April for this reason and claimed that someone else had assaulted her. This relationship ended in June 2004, and in July 2004 J was jailed for three and a half years for the two assaults on her in March 2004.

4.13 She began a new relationship with A, who was also a heroin user. A was imprisoned in early 2005.

4.14 Miss B disclosed to CMHT staff in February 2010 that her new partner W had been physically abusive at the start of their relationship and had gone to prison, but things were better later in 2010. W was also a client of Rotherham drug and alcohol services.

4.15 Police were called by Miss B in March 2011 alleging assault, but physical assault was denied by W and she had no evidence of injuries when police attended.

4.16 It is notable that W was present for most of Miss B's contacts with mental health staff. Miss B alleged in April 2011 that he was making her mental health symptoms worse by mimicking her and she was supported to move to a refuge. She returned to live with him in May 2011, and he again was present for all of the community mental health team visits.

4.17 She was supported to leave again in June 2011 and was seen by a domestic violence advocate, but returned to live with W in July 2011.

4.18 In April 2012 W assaulted Miss B outside the GP surgery they had just attended. W hit Miss B's head against a wall and a car, and bit her face.

4.19 Police were called and arrested W, who was remanded in custody. Police referred her case to the multi-agency risk assessment conference (MARAC)[7] as she was felt to be at risk if W was not remanded into custody.

4.20 A safeguarding strategy meeting was held in early May 2012, and it was decided not to hold a safeguarding investigation until after the police investigation. Miss B's request to transfer to a different substance misuse

[7] *A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.* *http://www.safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf*

service (Clearways)[8] was agreed, to avoid contact with her partner. W received a 15 month custodial sentence for assaulting her. Miss B later disclosed ongoing verbal abuse and physical violence from W.

4.21 A relationship with another drug user R started shortly afterwards, when Miss B went to stay with him following the assault. In May 2012 Miss B discovered she was pregnant and it was initially understood to be R's child, however it became clear after DNA testing that the father was W, the ex-partner who had been imprisoned for the assault on her.

4.22 At a multidisciplinary team meeting in May 2012 with the mental health team and the domestic violence advocate, Miss B was advised on measures to keep herself safe, including to ensure she was on the name of any tenancy agreement if she cohabited with R, not to put herself at risk of coming into contact with W (who had been bailed by this time) and that a background check would be done on R for any history of domestic violence.

4.23 She denied any physical violence from R, but was noted to have a bruise on her arm. Miss B said she had been playing at 'pinching' with R. There were no reported issues of concern with R, and he was remanded in custody in October 2012 for theft. R was again remanded in custody for theft in February 2013.

4.24 A follow up safeguarding meeting was held in October 2012, and the safety plan included Miss B not having any contact with W when he was released from prison in February 2013, and changing to a female care coordinator.

4.25 In August 2013 at the handover meeting between Miss B, recovery team and AOT staff, Miss B disclosed that she had been forced to have sex to pay off drug debts, and was hiding this from R. She was advised to contact her GP for health advice, and obtain her contraceptive injection. It was noted that Miss B had capacity and realised she was putting herself at risk in many ways. At this time she was using crack cocaine and heroin heavily, and had refused the offer of a drug rehabilitation placement.

4.26 This relationship ended when R came out of prison in September 2013, and he left her after stealing from her.

4.27 Miss B was subsequently seen in the company of another male J2 in September 2013, who was hostile, and outpatient visits were arranged at probation due to concerns about safety. Miss B appeared to be under the influence of drugs when seen with this male.

4.28 In August 2014 Miss B alleged to an AOT staff member that she was being forced to steal by an unnamed male who was physically violent to her. She was advised to inform the police, however shortly after this she was imprisoned for 23 weeks for shoplifting.

[8] *Clearways is the team base of Rotherham substance misuse services, provided by RDaSH*

4.29 The relationship with the co-defendant P appeared to start in November 2014, when she moved to Wombwell after release from prison. She was evasive with AOT staff at first about whether they were in a relationship. In December 2014 she said he was wary about giving his address out because he was 'under probation' and had a previous conviction for manslaughter, not related to women. Miss B was adamant that he was not violent, just wary of professionals.

4.30 P was present on some occasions when AOT staff visited Miss B at home, but she also saw them alone at home, and at other venues. This relationship continued until June 2015, when Miss B said that P had 'kicked her out'. She returned to live with him however, and was seen by AOT staff at his flat in Wombwell, both alone and with P. This relationship then continued until her arrest.

4.31 There has been a probation service investigation into the supervision of P.

4.32 Miss B told us at interview in September 2016 that P was not violent to her, but was emotionally abusive and controlling, although she said she was not afraid of him. She said he had disclosed his previous conviction for murder to her.

4.33 However witness statements reported that P was seen slapping Miss B in the days after the homicide was committed. After her arrest she reported to police that he had beaten her up in the past and controlled her finances and told her what to do, and she was afraid of him.

Physical health history and treatment

4.34 Miss B has a history of deep vein thrombosis (DVT)[9] and abscesses in her legs. She was treated for cellulitis and an abscess in her lower leg in January 2007, and in February 2007 she was treated in hospital for a DVT in her right leg and was treated with enoxaparin.[10] This reoccurred in June 2007, when she had bilateral DVTs and was again treated with enoxaparin. It was noted these were thought to be as a result of injecting into her leg veins. She did not cooperate with follow up treatment.

4.35 In 2007 Miss B had several episodes of fainting, and was admitted to hospital for observation, later having investigations for a possible heart murmur. She again did not cooperate with follow up.

4.36 Miss B was seen in hospital in June 2013 with pain and swelling of her right thigh, which was an infected abscess. This was treated with antibiotics. She was admitted to accident and emergency after fainting in August 2013, but did not wait for treatment.

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[9] *Deep vein thrombosis (DVT) is a blood clot that develops within a deep vein in the body, usually in the leg. http://www.nhs.uk/conditions/Deep-vein-thrombosis/Pages/Introduction.aspx*

[10] *Enoxaparin injection contains the active ingredient enoxaparin, which is a type of medicine called a low molecular weight heparin. It is used to stop blood clots forming within the blood vessels. http://www.netdoctor.co.uk/medicines/heart-and-blood/a6416/clexane-enoxaparin/*

4.37 Correspondence from her GP in August 2014 indicates that she had been prescribed warfarin[11] for possible DVT, but that she had not returned for follow up.

Mental health history and treatment

4.38 Miss B has never been treated as an inpatient in a mental health hospital. She was originally referred by her health visitor to a community mental health team (CMHT) in Rotherham in June 2004 due to psychological distress. She was seen in July 2004 for assessment by a community psychiatric nurse, and reported that her distress was due to physical and emotional abuse from her ex-partner, ongoing verbal abuse and threats from the father of her sons, and being currently homeless since her new partner was imprisoned. She appeared to benefit from talking, and was advised to contact housing support. No further action was taken, although the referral response advised that she could be seen if required.

4.39 Her GP saw her in May 2005 when she described feeling depressed because of child custody issues and her partner being in prison. She described feeling tearful and low in mood. Her GP prescribed sertraline,[12] and referred her for counselling at the GP surgery in June 2005. There is no record of her accessing this counsellor, which may be because she was remanded in custody in July 2005.

4.40 Miss B was seen by the mental health in reach team whilst in prison at HMP Newhall in October 2005, and a discharge report to her GP suggested she would benefit from a referral to secondary mental health services. Her history of substance misuse was noted and she reported felling low in mood and had harmed herself in the form of superficial cuts.

4.41 She was treated by Sheffield substance misuse services during her periods out of prison in 2006 and 2007.

4.42 Miss B was seen in prison in July 2007 for assessment by a psychiatrist, with a view to giving an opinion on sentencing options. Miss B reported she had started experiencing fluctuations in mood in about 1997, with extreme highs and lows, not associated with taking drugs. When high she described spending money, giving presents to people, not eating or sleeping. At these times her drug use tended to decrease. When low she described lacking energy, feeling paranoid and hiding away from people. She reported that she tended to sleep through the day and had thoughts of self-harm.

4.43 At this assessment Miss B reported that she had been feeling ‘paranoid’ for about 10 years, she felt as if people were constantly talking about her and knew what she is thinking. She stated that she felt that nothing was real, and feared for her safety, sometimes keeping a knife under her pillow.

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[11] Warfarin is the main oral anticoagulant used in the UK. Oral means it's taken by mouth. An anticoagulant is a medicine that stops blood clotting. http://www.nhs.uk/conditions/Anticoagulants-warfarin-/Pages/Introduction.aspx

[12] Sertraline is a Selective serotonin reuptake inhibitor (SSRI) which is a widely used type of antidepressant medication. http://www.nhs.uk/conditions/ssris-(selective-serotonin-reuptake-inhibitors)/Pages/Introduction.aspx

4.44 Miss B also reported hearing voices more or less all the time, which started in about 2002. She had not told any of the substance misuse or mental health workers about these. A diagnosis of schizophrenia and bipolar disorder was made.

4.45 A referral to a Sheffield CMHT was turned down in November 2007, after discussion with the Sheffield substance misuse services. It was felt that she should remain under their care, with psychiatric outpatient appointments provided by the service to oversee her mental state and review her response to risperidone. She was reported to have responded well to risperidone[13] 3mg by November 2007, with paranoid ideas having subsided, and the voices had receded to occasional background muttering. This was seen as a period of positive engagement, with no drug use detected on urine testing, and cooperation with methadone prescription.

4.46 In July 2009 Miss B had moved to Rotherham and was referred by her GP to the CMHT based at Rotherham, under the care of Rotherham Doncaster and South Humber Mental Health Foundation Trust (the Trust). She was assessed by a psychiatrist in July 2009.

4.47 At this assessment a diagnosis of schizophrenia or schizoaffective disorder was suggested, and it was noted that her auditory hallucinations were independent of her substance misuse. Her risperidone was increased and she was referred to the CMHT for allocation of a community psychiatric nurse or social worker, and further outpatients appointments were arranged.

4.48 Her medication was changed to olanzapine[14] 10mg in February 2010, after she reported persistent auditory hallucinations and difficulty sleeping, and this was increased to 20 mg in April 2010 after she reported her symptoms had worsened. She reported increased anxiety, and visual hallucinations such as seeing a woman staring in at her through her window.

4.49 During this time she was being seen regularly by the Rotherham CMHT, then later the recovery team. Her engagement with outpatient appointments was intermittent, and she was often unavailable when CMHT staff went to see her at home. She had three monthly planned outpatient appointments with recovery team psychiatrist Dr C, but missed many appointments.

4.50 Her youngest child was born in December 2012, and she was provided with specialist substance misuse midwifery input. Her medication was changed to risperidone during this time because of the risk of taking olanzapine during pregnancy, and olanzapine[15] was prescribed again after

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[13] Risperidone belongs to a group of medicines called antipsychotics. These medicines work on the balance of chemical substances in the brain. http://patient.info/medicine/risperidone-risperdal

[14] Olanzapine is an antipsychotic medication prescribed to relieve the symptoms of schizophrenia http://patient.info/medicine/olanzapine-arkolamyl-zalasta-zyprexa

[15] Extrapyramidal effects and withdrawal syndrome have been reported occasionally in the neonate when antipsychotic drugs are taken during the third trimester of pregnancy. Following maternal use of antipsychotic drugs in the third trimester, neonates should be monitored for symptoms including agitation, hypertonia, hypotonia, tremor, drowsiness, feeding problems, and respiratory distress. https://www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system/42-drugs-used-in-psychoses-and-related-disorders/421-antipsychotic-drugs#PHP2204

the birth. She continued to use crack cocaine and heroin throughout the pregnancy, and was erratic about attending appointments with all professionals.

4.51 In June 2013 it was noted that she was not taking her prescribed olanzapine and had marked schizophrenic symptoms; she believed people knew what she was thinking, could interfere with her and were talking about her, and she was hearing voices continually. Because of her fears for her safety she had told staff she had been carrying a knife, but told Dr C that she had stopped this in late June 2013, as she was only going out of the flat with her current partner R and felt safe with him. Dr C requested that her GP restart olanzapine and zopiclone[16] at night.

4.52 In August 2013 Dr C wrote to her GP outlining concern about her engagement, noting she would not consider a rehabilitation placement, and that her current partner R was in prison. At this time it was noted that she was taking many substances, often not knowing exactly what she was taking, and was being taken advantage of for sex. It was agreed that she would be transferred to Rotherham AOT.

4.53 She was transferred to the care of the assertive outreach team (AOT) in September 2013. Her new consultant Dr R noted her continued drug use and chaotic lifestyle and arranged for health screening to be completed before prescribing antipsychotic medication.

4.54 In October 2013 there was a chaotic period when Miss B was missing, and then was in and out or prison for short periods. She was sentenced to six months in prison in January 2014. A depot injection of flupentixol[17] 40 mg was suggested by Dr R, and this was conveyed to the prison inreach mental health team.

4.55 She was released in June 2014, and discharge letters confirmed she had been receiving flupentixol depot 40mg fortnightly in prison.

4.56 An outpatient medical review was arranged, and she was assisted to register with a new GP. Miss B disclosed that she was still using crack cocaine and heroin at this time. The psychiatrist attempted unsuccessfully to see her at home in July 2014, and the AOT were unable to locate her to see her and administer her depot injection. It was eventually given in August 2014 in a custody suite after another arrest, after she missed probation and court appointments.

4.57 Miss B was then in prison until November 2014, and was treated by the inreach mental health team in HMP New Hall. A discharge letter from the prison mental health inreach team confirmed she had been treated with depot flupentixol 40mg fortnightly. This November letter referred to dates of

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[16] *Zopiclone tablets are sleeping pills (hypnotics) which work by acting on the brain to cause sleepiness. They may be used for short term treatment of difficulties in falling asleep, waking up at night or early in the morning or difficulty in sleeping.* https://www.medicines.org.uk/emc/medicine/18157

[17] *Flupentixol is a long acting injection given to relieve the symptoms of schizophrenia.* http://patient.info/medicine/flupentixol-tablets-depixol-fluanxol

release in June 2014, and this caused some confusion until the AOT contacted the prison to clarify.

4.58 She was unwilling to give her Wombwell address to AOT staff initially, and was evasive about whether the man she was living with was her boyfriend. Her mental state however appeared stable and she said she was not using drugs.

4.59 In November 2014 Miss B was seen in a local chemist to administer her depot and plan care. Miss B said she was staying in Wombwell and wanted to live there. Miss B said she was not taking any substances, and had stopped using drugs altogether, but drank alcohol occasionally.

4.60 Her depot was increased in December 2014 to 60mg after a review by the AOT junior psychiatrist Dr S (CT2[18] to Dr R), and Miss B stated she heard voices that are derogatory in nature, and saw 'little things crawling along the floor', in the shape of animals or spiders. She reported a poor sleep pattern, often only sleeping two hours a night. She said she had only used drugs on two occasions since release in November; that she does not want to return to drug use; and her current boyfriend P is helping her with this. She said she drank alcohol occasionally.

4.61 In January 2015 Miss B was reviewed again by Dr S. She reported a reduction in the intensity of her hallucinations since her depot had been increased, but her sleep pattern was still poor. Her depot was increased to 80mg fortnightly. This was the last occasion that a face to face medical review was carried out.

4.62 In February 2015 Miss B was seen by AOT staff and was subdued and low in mood. She reported that she often felt unable to get out of bed, and could lay in bed all day. She reported that she had about three hours of broken sleep a night and asked if she could have sleeping tablets. She denied any drug use, and stated the depot of 80mg was helping, with no voices or hallucinations of any kind, but sleeping was her main concern.

4.63 After an AOT team meeting in March with Dr D (locum psychiatrist), her depot was increased to 160 or 150mg (the notes give both doses) and a zopiclone prescription was started, without her being seen by the psychiatrist. Dr D did not make an entry in her clinical record. On 8 March Miss B was noted to be reporting stiffness since the depot was increased. On 17 March she asked for an increase in her depot as she was still hearing voices, and would tend to stay in bed all day when they were intrusive. Dr D was reported to be arranging to see her prior to prescribing but this did not occur. Dr D agreed to prescribe zopiclone for two weeks and increased the depot to 170mg fortnightly. Her stiffness and restlessness increased and Dr D prescribed two weeks of procyclidine.[19]

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[18] *CT2 is a junior doctor in training, on the specialist register.* http://www.gmc-uk.org/Medical_career_structure___doctors_in_training.pdf_25417075.pdf

[19] *Procyclidine is used to relieve unwanted side-effects caused by antipsychotic medicines.* http://patient.info/medicine/procyclidine-arpicolin-kemadrin

4.64 In April 2015 she reported no voices and was feeling much better and able to spend more time in activities, and in May said she was sleeping better and the voices were hardly troubling her. The prescriptions for procyclidine and zopiclone were continued, and Miss B did not report any further side effects. In June she reported feeling mentally well and sleeping through most nights. On three occasions in June Miss B was still in her nightwear and had just got up, stating that she was hungover from drinking the night before.

4.65 A referral to mental health services (AOT) in Barnsley was agreed in June 2015, because Wombwell was out of the catchment area of Rotherham AOT.

4.66 Miss B said that P 'kicked her out' in late June 2015, and she was assisted to obtain emergency accommodation.

4.67 She was seen by the Rotherham crisis team and it was reported that she appeared sedated, but she denied using drugs. She told crisis team staff that P had said she could return, she was encouraged not to make any decisions until she had the support of the AOT after the weekend. However she returned to live with P a few days later.

4.68 Her care plans from 25 June 2015 include reference to her homelessness, and the goal was to secure a tenancy in an area of her choice. The team were made aware of her desire to stay in Wombwell shortly after this date, so it would be reasonable to review this plan within a few days of this time.

4.69 A referral was discussed with Barnsley AOT and it was agreed that she would be referred. She was seen on 1 July to administer her depot injection, and said she was mentally well but unable to sleep.

4.70 The locum team psychiatrist Dr L was asked to review her medication in July 2015, and advised, without seeing Miss B, that the prescription for night sedation (zopiclone) should be gradually stopped because it is for short term use only. The procyclidine prescription was not changed. Dr L suggested that sleep hygiene be discussed with her and consideration could be given to a different medication if sleep problems continued.

4.71 Miss B was seen at home for the last time by AOT staff on 15 July 2015. P was also present. While Miss B was still in her nightwear (as she had been on many occasions) she was reported as saying she felt mentally well and there were no issues with hearing voices or any other symptoms. She denied any use of illicit drugs and was described as pleasant and chatty. It became clear after this that the homicide had already been committed, on 13 July 2015.

Substance misuse history and treatment

4.72 Miss B reported having her first alcoholic drink aged 14, and after a period of heavy alcohol abuse in 2003, stopped drinking regularly but drank occasionally usually with partners.

4.73 She reported using cannabis and amphetamines first at aged 15 and continued to use amphetamines. She took this orally and reported heavy usage, and often experienced flashbacks, paranoid feelings and nightmares.

4.74 She started using crack cocaine and heroin in about 2005 when she lost custody of her children. She injected heroin and was using four to six bags a day when she was assessed by Sheffield substance misuse services in November 2005.

4.75 In 2006 Miss B was being treated by Sheffield substance misuse service, part of Sheffield NHS Care Trust. She was prescribed buprenorphine (subutex)[20] as substitute prescribing for her heroin addiction, but this was stopped due to her non-compliance. Methadone[21] prescription was started in November 2006. She was discharged in March 2007 for non-compliance with treatment.

4.76 Miss B did not cooperate with a drug rehabilitation order in 2007, this was revoked and she was imprisoned. On release she was seen again in June 2007 by the Sheffield substance misuse as part of probation conditions. Prior to custody she had been injecting heroin and crack cocaine, and was maintained on 30mg methadone in prison.

4.77 At a psychiatrist's review in June 2007 it was agreed she would be prescribed methadone. Risperidone 1mg was prescribed, because she disclosed hearing voices interfering with her daily life and encouraging her to score, and increasing paranoid symptoms. Miss B said that she uses drugs to drown out the voices and get on with her life. It was suggested that her GP refer her to secondary mental health services.

4.78 A referral to Sheffield CMHT was turned down in November 2007, following discussion with Sheffield Health and Social Care NHS Foundation Trust substance misuse services. It was felt that she should remain under their care, with psychiatric outpatient appointments provided by the service to oversee her mental state and review her response to risperidone. Miss B was treated by Sheffield substance misuse services, and was prescribed risperidone and was on a maintenance methadone regime until her move to Rotherham in 2009.

4.79 Miss B was referred to Rotherham central CMHT by her GP in July 2009. A likely diagnosis of schizophrenia or schizo-affective disorder was suggested by the consultant psychiatrist after assessment. She was using cannabis but had been opiate free for several months. She complained of hearing distressing auditory hallucinations. Her risperidone was increased and she was referred to the CMHT for allocation to a community nurse or social worker. She was seen two monthly in outpatients, and in August 2011 was referred to the recovery team, and was seen by their consultant

[20] *Buprenorphine was approved to treat opioid addiction and dependence, which means that if someone was physically dependent on an opioid, they could be prescribed buprenorphine to counter the withdrawal symptoms and cravings that can lead to relapse. Buprenorphine is a substitute for street drugs like heroin which cause addiction.* http://patient.info/medicine/buprenorphine-for-addiction-treatment-prefibin-subutex

[21] *Methadone is prescribed a substitute for heroin.* http://patient.info/health/methadone-replacement-for-heroin

psychiatrist in out patients', attending sporadically. Her GP informed the recovery team psychiatrist that Miss B had started using heroin again in October 2011.

4.80 Miss B was referred to Rotherham drug and alcohol service in October 2011. It was noted that she was using heroin, crack cocaine and occasionally alcohol. She requested to transfer to Clearways following the assault by W in April 2012, as he was also a client of Rotherham drug and alcohol services)

4.81 Following her confirmed pregnancy in May 2012, the need for lifestyle changes was discussed with her, and she agreed to be drug screened as she stated her intention was to come off all illicit drugs. A specialist substance abuse midwife was allocated, who worked closely with drug and alcohol services.

4.82 In July 2012 she tested positive for methadone, heroin and crack. Due to her breaching her agreement not to use crack cocaine whilst pregnant she was discharged from 'shared care'[22] back to Rotherham community drug and alcohol services. She was prescribed methadone, and continued to test positive for crack cocaine and heroin, attending sporadically.

4.83 She reported injecting heroin in October 2012 and was given more information by the specialist midwife about drug use in pregnancy and the risks to her and the unborn baby. Throughout her pregnancy she was seen by the specialist midwife and a substance misuse worker, and her substitute prescriptions were overseen by the substance misuse psychiatrist Dr H. She continued to use crack cocaine and heroin up to and after the birth.

4.84 Miss B continued to attend community drug and alcohol services during 2013, although sporadically. At times her methadone prescription was stopped due to non-attendance. In July 2013 she received a Drug Rehabilitation Requirement[23] (DRR) from court and she was drug screened by Rotherham community drug and alcohol services and the recovery focused drug treatment plan was explained. She again attended sporadically, with periods of no contact, and tested positive for crack cocaine and heroin up until her imprisonment in December 2013 for theft.

4.85 She re-engaged with substance misuse services after being released in February 2014, and continued in the same pattern of attendance and drug use until her imprisonment again later in February 2014.

4.86 Miss B was referred to Clearways again after her release in July 2014, and she was prescribed methadone. She disclosed using heroin and crack cocaine on one occasion since release. She expressed her determination to be drug free, and said her current boyfriend was a non-drug user and

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[22] *Shared care is a primary care service to drug abusers by the GP, the Trust and drug & alcohol services.* *http://www.rotherhamccg.nhs.uk/Downloads/Drugs%20and%20Alcohol/2918_1112NHSR%20P6.pdf*

[23] *Drug Rehabilitation Requirement is a Community Treatment Order which was introduced as a sentencing option in April 2005 as one of the provisions of the Criminal Justice Act 2003.* *https://www.gov.uk/guidance/healthcare-for-offenders*

was encouraging her to stay drug free. However she tested positive for opiates and cocaine at her next arrest on 31 July 2014.

4.87 There is some evidence that methadone has antipsychotic properties[24] and can reduce the need for antipsychotic medication in people using heroin.[25] The potential effects of this interaction on Miss B's mental state do not appear to have been considered.

4.88 Miss B failed to attend all her DRR appointments in August and was discharged from the care of substance misuse services after her six month sentence started in August 2014.

4.89 Miss B tested positive for benzodiazepines[26] when screened in prison after her arrest in July 2015, and said she was buying between 40mg and 80mg of street diazepam[27] daily.

5 Arising issues, comment and analysis

5.1 We have reviewed Miss B's care from first contact with adult mental health services. We have however focused in detail on the period of 2014 and before her arrest on 23 July 2015. We address each element of the terms of reference in separate sections, supporting our analysis with evidence as appropriate. Where concerns have been addressed by the internal review recommendations we have noted these and not repeated them.

- Review the care, treatment and services provided by the NHS and other relevant agencies from the service user's first contact with services to the time of the offence
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family
- Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern including any areas of future risk

Care planning

5.2 Miss B was originally diagnosed as having opiate dependence syndrome and a 'prolonged psychotic episode' in 2007, when she disclosed hearing voices and feeling paranoid. She was prescribed antipsychotic medication and treated by her GP and the substance misuse service. A mood disorder was suggested by a psychiatrist in 2007 but this was not diagnosed.

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[24] *McKenna GJ. Methadone and Opiate Drugs: Psychotropic Effect and Self-Medication. Ann N Y Acad Sci 1982; 398: 44–53*
[25] *Pacini, M. and Maremmani, I., 2005. Methadone reduces the need for antipsychotic and antimanic agents in heroin addicts hospitalized for manic and/or acute psychotic episodes. Heroin Addict Relat Clin Probl, 7(4), pp.43-48.*
[26] *Benzodiazepines are indicated for the short-term relief of severe anxiety; long-term use should be avoided. www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system/41-hypnotics-and-anxiolytics/412-anxiolytics/benzodiazepines*
[27] *Diazepam is used for short term relief (2-4 weeks only) of severe anxiety and belongs to a group of medicines called benzodiazepines. https://www.medicines.org.uk/emc/medicine/18061*

5.3 She was diagnosed in 2007 as suffering from paranoid schizophrenia (ICD 10 code F20.0)[28] and mental and behavioural disorder due to use of opioids (F.11.0) in Sheffield mental health services, prior to her move to Rotherham.

5.4 Miss B reported to professionals many times that she had been diagnosed as 'bipolar' in the past and had mood swings. She had also been diagnosed with schizophrenia in 2007 in prison, and it appears from records that rather than make a new assessment, her diagnosis was accepted by new care teams as fact, based on her self-reporting and previous psychiatrists' letters.

5.5 Miss B had been under the care of Rotherham AOT since 2013. Assertive outreach teams are intended to provide a service to people with mental health problems who are hard to engage. Rotherham Assertive Outreach Team is described as 'helping people experiencing severe mental disorder, who do not effectively engage with standard mental health services, to live successfully in the community. Assertive outreach is a way of organising and delivering care by a specialist team comprising community psychiatric nurses, consultant psychiatrists, junior medical staff, occupational therapists, social workers support time and recovery workers, along with administration staff, to provide high intensity, highly coordinated, flexible support and treatment'.

5.6 Accepting that Miss B was hard to engage, the AOT did try to ensure they saw her regularly, and engaged with her in a variety of settings, including the GP surgery and local chemist treatment rooms. These meetings latterly were primarily to administer her depot medication and she was seen twice at home in June 2015 before she left after an argument on 29 June. She was seen daily at the crisis house until she returned to Wombwell at the end of June. She was seen at home with P on 1 July 2015, and again on 15 July (after the homicide).

5.7 We could not locate a CPA review in her clinical notes in either 2013, 2014 or 2015. The structure of the 'full needs assessment' and 'care planning' documents do not include a section to indicate when the last CPA review took place. Again accepting that Miss B was erratic in her engagement, we consider that the most recent release from prison in November 2014 would have been an appropriate opportunity to carry out a CPA review. The absence of these reviews was a missed opportunity to incorporate any changes and ensure Miss B's care was relevant to her presenting needs.

5.8 The care plans written on 25 June 2015 include reference to her homelessness, and the goal was to secure a tenancy in an area of her choice. The team were made aware of her desire to stay in Wombwell shortly after this date, so it would be reasonable to review this plan within a few days of this time. These were not in fact reviewed, and the next full

[28] *ICD 10: International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).* http://www.who.int/classifications/icd/en/

needs assessment and care plan was written in November 2015 when Miss B was in prison after the homicide.

5.9 The second item on her 25 June 2015 care plan was 'receives a depot injection', with the goal 'to receive this in a timely fashion in safe surroundings'. This care plan refers to monitoring her mental state and side effects of medication. We do not consider this an adequate care plan to address her complex mental health needs as expected by an assertive outreach service.

5.10 The only other element to her care plan was a 'crisis plan' which documented signs when things may be going wrong, which were that her mental health may deteriorate, she may start using illicit substances, and may stop accepting her depot. The actions to be taken were for referral to the consultant to review medication and the care coordinator to refer to the crisis team in the event of relapse.

5.11 The 'full needs assessment' on which this care plan is based has some 2015 updates noted, but without specific dates recorded. For instance: '2015 - says she is drug free at this time and no evidence to the contrary/she has smoked cannabis occasionally and there is indication she is drinking more alcohol, she is always reporting hangovers'. There are areas where there are no dates to the updated information.

Recommendation 1:
The Trust must provide assurance that the CPA policy is adhered to in the Rotherham assertive outreach team.

Recommendation 2:
The Trust should revise care planning and risk assessment formats to include the date of the last CPA review, and indicate when the next review is due.

5.12 The principles within the NICE guidelines for the prevention and management of psychosis and schizophrenia[29] in adults are outlined below:

'Continue treatment and care in early intervention in psychosis services or refer the person to a specialist integrated community-based team. This team should:

- offer the full range of psychological, pharmacological, social and occupational interventions recommended in this guideline
- be competent to provide all interventions offered

[29] *NICE prevention and management psychosis and schizophrenia in adults (2014)* https://www.nice.org.uk/guidance/cg178?unlid=919618946201682011134O

- place emphasis on engagement rather than risk management
- provide treatment and care in the least restrictive and stigmatising environment possible and in an atmosphere of hope and optimism in line with Service user experience in adult mental health (NICE clinical guidance 136).

Consider intensive case management for people with psychosis or schizophrenia who are likely to disengage from treatment or services'.

5.13 We suggest that the care plans in place did not provide a full range of interventions to Miss B. It may be that these were offered and not accepted, but we would expect that there would be documented evidence of this. We asked Miss B what she would have wanted as part of her care planning. She said she would have liked more information about her mental illness, what signs to look for, and what to do if she noticed relapse signs.

Recommendation 3:
The Trust must provide assurance that the NICE guidelines for the prevention and management of psychosis and schizophrenia are incorporated into treatment plans.

5.14 The most recent psychiatric review of her mental health and medication was in December 2014 and January 2015, by a junior doctor. The consultant psychiatrist role in AOT was filled with locum posts during this period. Of concern is that medication was prescribed and increased without the patient being seen by the prescribing psychiatrist. Miss B's depot medication was doubled without the locum psychiatrist having seen her (or having ever met her). The prescription of zopiclone was written without meeting her, and continued for a period beyond what is recommended. A different psychiatrist later arranged for this to be gradually reduced and discontinued, again without meeting her. With regards to the prescription of medicines to aid sleep, NICE guidance[30] recommends 'that doctors should consider using non-medicine treatments, and then, if they think that a hypnotic medicine is the appropriate way to treat severe insomnia that is interfering with normal daily life, they should prescribe one for only short periods of time and strictly according to the licence for the drug'. This prescription for zopiclone had been in place since March 2015, well over the recommended time frame.

5.15 The internal report highlighted the issue of prescribing, but did not make a recommendation to address it. We have reviewed the Trust policy v10: Safe Secure Handling of Medicines Policy, which contains specific guidance for doctors in prescribing practice. Whilst there may be times

[30] *NICE guidance on the use of zaleplon, zolpidem and zopiclone for the short-term management of insomnia (2004)* https://www.nice.org.uk/guidance/TA77

when the prescriber may not see the patient in person (which is described as best practice within the policy) for good reasons, the policy states:

'The Trust appreciates that face to face assessment, by the prescriber, of a patient prior to any prescribing decision is the ideal situation, however the reality is that in many instances this is simply not possible or in the patient's best interest – most notably in out of hours situations, community teams where patient assessment may be by another healthcare professional (HCP) or occasions where a patient receives a repeat prescription from us as part of their on-going care. In such instances the Trust supports national and professional guidance which requires prescribers to work within their competencies and assure themselves of the patient's health and their need for the medication prior to prescribing. This assurance may be informed by telephone conversation with the patient or their carer, the patient's clinical notes or care plan, referral letters from other HCPs, adequate feedback from other HCPs who have assessed the patient, other sources that are considered reliable. When making such prescribing decisions, due regard should be given to the prescriber's experience, the seriousness of the patient's clinical condition and specific drug considerations such as potency, monitoring requirements and abuse potential'.

5.16 The General Medical Council (GMC)[31] guidance is also very clear:

'As with any prescription, you should agree with the patient what medicines are appropriate and how their condition will be managed, including a date for review. You should make clear why regular reviews are important and explain to the patient what they should do if they:
a. suffer side effects or adverse reactions, or
b. stop taking the medicines before the agreed review date (or a set number of repeats have been issued).
You must make clear records of these discussions and your reasons for repeat prescribing'

5.17 We suggest that the prescribing practice from March to July 2015 fell short of the expected standards, including an absence of information shared with the patient, or a discussion about risks and benefits of the proposed change and a record of the explicit review process for the change. We suggest this issue is raised at psychiatrists' peer groups and as part of appraisal for individual practitioners concerned.

Recommendation 4:
The Trust must provide assurance that best practice prescribing guidelines as published by the General Medical Council are adhered to.

5.18 The responsibility and accountability for the administration of medication rests with the individual practitioner. In this case it was known that the prescription of antipsychotic medication had been doubled without seeing the patient. The dose given was not accurately recorded in the clinical

[31] *GMC guidance on prescribing : http://www.gmc-uk.org/guidance/ethical_guidance/14325.asp*

notes. There were subsequent reports of extra pyramidal symptoms without checking these against the assessment tool Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS)[32]. This policy also recommends that the LUNSERS is administered at least annually to all patients who have been prescribed antipsychotic medication. The report of increased side effects should have triggered an attempted medical review.

Recommendation 5:
The Trust must provide assurance that nursing staff adhere to best practice guidance in the administration of depot injections and the requirements of the Safe Secure Handling of Medicines Policy in the care of patients receiving antipsychotic medication.

Compliance with local policies and statutory guidance

- Review and assess the Trusts compliance with local policies, national guidance and relevant statutory obligations including Care Programme Approach, Dual Diagnosis and Safeguarding Processes

5.19 We have discussed issues pertaining to the NICE guidelines for the prevention and management of psychosis and schizophrenia, and to the Trust's CPA and Safe Secure Handling of Medicines Policy above.

5.20 The national policy position[33] identifies that the primary responsibility for the treatment of individuals with severe mental illness and problematic substance misuse should lie with mental health services. This approach is referred to as "mainstreaming" and aims to lessen the likelihood of people being "shunted" between services or losing contact completely. The rationale for this is that mental health services are better placed to offer services such as assertive outreach, crisis management and long term care than substance misuse services.

5.21 NICE guidelines[34] on psychosis with substance misuse in over 14s: assessment and management, states that

'Before starting treatment for adults and young people with psychosis and coexisting substance misuse, review:

- the diagnosis of psychosis and of the coexisting substance misuse, especially if either diagnosis has been made during a crisis or emergency presentation and

[32] *A Self-Rating Scale for Measuring Neuroleptic Side-Effects Validation in a Group of Schizophrenic Patients JENNIFER C. DAY, GRAHAM WOOD, MIKE DEWEY and RICHARD P. BENTALL. British Journal of Psychiatry (1995), 166, 650-653*
[33] *Department of Health (2002) Dual Diagnosis Good Practice Guide.* http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4009058
[34] *NICE Psychosis with substance misuse in over 14s: assessment and management.(2011)* http://www.dualdiagnosis.co.uk/uploads/documents/originals/NICE%20Substance%20Use%20and%20psychosis.pdf

- the effectiveness of previous and current treatments and their acceptability to the person; discontinue ineffective treatments.

When developing a care plan for an adult or young person with psychosis and coexisting substance misuse, take account of the complex and individual relationships between substance misuse, psychotic symptoms, emotional state, behaviour and the person's social context.

Ensure that adults and young people with psychosis and coexisting substance misuse are offered evidence-based treatments for both conditions'.

5.22 Miss B was well known to services as a previous drug user, and it was also equally well known that she was not always honest in giving her account of drug use. Prior to 2014 she was treated in accordance with good practice in dual diagnosis; with a care coordinator from mental health services, and good communication links in place between substance misuse treatment and mental health services.

5.23 Following her discharge from substance misuse services in 2014, the approach of the AOT to her substance misuse appears to have been less structured.

5.24 The Trust policy for the management of patients with a dual diagnosis of mental health problems and substance misuse v-3 (Dual Diagnosis) described the appropriate assessments and pathways to care for individuals with both diagnoses. Miss B was noted to be in Cluster 11[35] (Ongoing Recurrent Psychosis - Low Symptoms) and as such her care plans would be expected to focus on maintaining optimum mental health and recovery. It appears to have been accepted that she was no longer using drugs, based on her own account, rather than any objective testing.

5.25 However her history clearly shows an inability to maintain independent living and stability in her mental health over many years. We consider that AOT professionals showed a lack of curiosity in assessing her current functioning, and there was no comprehensive assessment of her ability to maintain her own mental health. There was a lack of attention to the possibility that she may be taking drugs, and a lack of assessment of what changes she may have made that would have enabled her to live a drug free life.

5.26 We believe that she should have been referred back to the substance misuse service which would have supported a more structured assessment. This is a missed opportunity to reassess her care in relation to drug misuse, and develop a comprehensive care plan.

[35] *This group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a sustained period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf*

Recommendation 6:
The Trust must provide assurance that the dual diagnosis policy is implemented in community teams.

5.27 With regard to safeguarding, a formal referral was made to the local authority in May 2012 when Miss B was thought to be vulnerable from an ex-partner. The Trust engaged fully in multiagency meetings, which were attended by mental health and substance misuse workers. Actions agreed were implemented by the Trust, and a follow up meeting was arranged with Miss B by her care coordinator, with the domestic violence advocate to discuss measures to keep herself safe in detail. The October 2012 follow up meeting was also attended with actions agreed and implemented. The safeguarding referral was closed in October 2012.

5.28 A further concern was noted in August 2013 that Miss B was being forced to have sex to pay off her drug debts. This was shared by her care coordinator with her substance misuse worker, and was explored by both professionals. She disclosed that she was in debt to a notorious drug dealing family, and the individuals drove up and down her street. It was noted that she had capacity and advice was given about the risks she was exposing herself to.

5.29 The Trust Safeguarding Adults Policy v-4 (2013) provides clear guidance on considerations to be undertaken if a vulnerable adult appears to be under duress from others.

5.30 We suggest that Miss B would have met the 2013 policy definition of an 'adult at risk':

> Vulnerable Adult Definition according to 'No Secrets DOH 2000'
> "A vulnerable adult is any person aged 18 or over "who is" or "may be" in need of care because of disability, age or physical or mental illness "and" is unable to protect themselves against significant hare and/or exploitation.
> The currently used definition within Safeguarding Adults work remains that 'Abuse is a violation of an individual's human and civil rights by any other person or persons' (No Secrets, Dept. of Health, 2000):
> • Abuse may consist of a single act or repeated acts
> • It may be physical, verbal or psychological
> • It may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which they have not consented, or cannot consent
> • Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it".

5.31 This was a chaotic period in Miss B's life, and previous risks of domestic violence and coercive control were well documented. While there is a note of Miss B's presumed capacity, we consider this should have been

explored in more depth, and advice sought from the Trust safeguarding team about whether a formal referral was indicated. She was however seen for formal assessment by the AOT psychiatrist and new AOT care coordinator in early September 2013, and discussed being in debt to her current dealer, but was not worried about this. The question of capacity assessments should be included in the risk assessment relating to domestic violence (see Recommendation 8).

Risk assessment including domestic violence

- Review the adequacy of risk assessments and risk management, including the risk of Domestic Violence to the service user as well as their risk of harming themselves or others

5.32 The Trust Clinical Risk Assessment and Management Policy v-8 sets out the expectations of staff with respect to risk assessment. There is a list of authorised tools, and these are: FACE[36] for adult mental health services, and DICES[37] for substance misuse services. In the substance misuse service the DICES assessment was carried out with Miss B at regular intervals, the last being June 2014.

5.33 In June 2014 Miss B was assessed as being at risk of self-neglect and vulnerability to exploitation by others. This triggered the completion of a DICES- SN&V, which is a risk assessment of self-neglect and vulnerability to exploitation. This was noted in her mental health services care plan, and it was noted she was working on the risks associated with substance misuse with Clearways and probation.

5.34 FACE risk assessments were carried out by her care coordinators at regular intervals. The Trust policy does not state a mandatory review interval, but states that appropriate intervals should be agreed by service management teams and made clear in service operational policies. The most recent FACE risk assessment was carried out in June 2015 and this was an updated risk assessment made after she was made homeless when her partner P 'kicked her out'. This assessment identified no clinical symptoms indicative of risk (such as early warning signs of relapse), and noted that she has carried knives in the past to protect herself; this was not current but was noted to be changeable. The 'descriptive summary of risks identified' makes reference to past occurrences of domestic violence and bereavement, with no reference to current difficulties, although her current increased risk of engaging with old acquaintances in Rotherham and using substances again was noted.

5.35 In June 2015 her 'current risk status' was noted as no apparent risk of harm to others or suicide, low risk of deliberate self-harm, significant risk of severe self-neglect, accidental self-harm risk of abuse/exploitation by others, and risk related to her physical condition. The evidence from within

[36] *FACE stands for 'Functional Analysis of Care Environments' The FACE risk profile is part of the toolkits for calculating risks for people with mental health problems, learning disabilities, substance misuse problems, young and older people, and in perinatal services.* http://www.face.eu.com/solutions/assessment-tools

[37] *DICES is a risk assessment tool developed by APT: D-describe the risk, I- identify your options, C- Choose your preferred option, E-Explain your choice, S-Share with relevant colleagues.* http://www.apt.ac/risk.html

the clinical notes supports this assessment. There are notably no incidents of harm to others recorded, apart from the abusing of drugs while pregnant. The carrying of a knife to protect herself is noted, but there is no evidence that this was used for any purpose, and seems to be apparent when Miss B has been either mentally unwell and having paranoid thoughts, or when she has been harassed by ex-partners or drug dealers.

5.36 Miss B told AOT staff that she had not been using illicit drugs regularly since release from prison. She said she had only used drugs on two occasions since release in November 2014, but there were indications that she was abusing alcohol in June 2015, with several references to her being hungover. She also admitted that she and P had used crack cocaine on the weekend that they argued in June 2015. There is a reference to her possibly being under the influence of cannabis on 26 June. The internal report notes that there does not appear to be any work done to properly assess whether Miss B was engaging in drug or alcohol use.

5.37 There is a clear Trust Policy for the Identification and Screening of problematic substance misuse using the Drug Abuse Screening Test (DAST-10). The use of this tool could have supported the identification of drug and/or alcohol abuse, and we consider it was a missed opportunity to make a more in-depth assessment of Miss B's situation. The internal report makes a recommendation about this point, but recommends a review rather than an outcome focussed plan. The internal report notes that use of objective urine testing is not usual practice in AOT, however the prospect of requesting this could have been discussed within the AOT team, and with Miss B herself. There is clear evidence that she had been using illicit street drugs, obtained after her arrest in July 2015. While we do not consider this necessarily increased her risk of violence; if the AOT team had discovered this, they could have undertaken a more thorough assessment of her situation.

Recommendation 7:
The Trust must provide assurance that community mental health staff are equipped with the skills knowledge and policy awareness to assess for the harmful use of substances in community mental health services

5.38 Miss B's past history of domestic violence was well known to services, and she had been the subject of a MARAC case conference in May 2012. The risk of violence and abuse from ex-partners was incorporated into her FACE risk assessment, with the contingencies that Miss B has the number of the domestic violence advocate, crisis team and police. It is noted that historically Miss B has lacked insight into the risks associated with relationships she has been in, which have been with male partners who have been abusive and controlling. This was not incorporated into a care plan however.

5.39 We suggest it would have been helpful and appropriate for this aspect of her presentation to be explored by her care coordinator, with some psychological work on her own coping mechanisms.

5.40 At interview AOT staff were able to describe a high index of suspicion about the potential for P to be violent towards Miss B, and looked for signs such as him appearing controlling, or insisting on being present for all the AOT visits, and they had asked Miss B privately about the relationship.

5.41 Staff appeared well aware of potential signs of domestic abuse, and had not detected any at AOT visits. Miss B had however disclosed that P had 'beaten her up in the past', which was not explored further. There had been an enquiry to police in earlier years about a previous partners' history of abuse against women under 'Clare's law'.[38] There was no evidence of such an enquiry made about P, or of in-depth exploration with Miss B.

5.42 Accepting that Miss B has given varied responses to the question of whether P was abusive, she told us he was not violent, but was controlling. Miss B said she had been 'beaten all her life' starting as a child. It may well be that the absence of regular physical abuse from P made this relationship appear to her to be a relatively positive one.

Recommendation 8:
The Trust should provide assurance that Trust clinical staff are equipped with skills and knowledge in recognising and assessing the impact of domestic abuse, including assessment of capacity where indicated.

Transfers of care and interagency working

- Review the effectiveness of the transfer process from the provider organisation to external health providers (including Prison and Barnsley GP) identifying any service delivery or commissioning issues.

- Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement

5.43 When Miss B moved to Wombwell from Rotherham in November 2014, she was initially evasive about where she was living and with whom. The AOT were aware that she was formally evicted by the council from her flat in Rotherham in December 2014. She was registered with a new GP at Chapelfield Medical Centre in Wombwell on 22 December 2014, and her previous records were requested. There do not appear to be any issues regarding the transfer of care from the Woodstock Bower GP Practice in Rotherham.

5.44 The move to Wombwell however, placed Miss B outside the catchment area of the Rotherham AOT, and into the catchment of Barnsley

[38] *A scheme allowing police to disclose to individuals details of their partners' abusive pasts will be extended to police forces across England and Wales from March 2014.* https://www.gov.uk/government/news/clares-law-to-become-a-national-scheme

community mental health services, provided by a neighbouring Trust. The question of her moving to Wombwell permanently was first discussed with her in December 2014, and she was assisted to register with the new GP. At this time Miss B requested support to apply for housing, but by January 2015 had decided she would continue to live with her new partner P in his flat.

5.45 The question of transferring her to the Barnsley mental health team was first noted in an MDT meeting on 18 June 2015, with no other explanation or record of discussion. This question was revisited when she required crisis housing in Rotherham over the weekend of 23 June in terms of whether it was the right time, as her Wombwell address was then in question. However on 29 June onwards there is a reference to sending a referral letter to Barnsley following a discussion with that team. The internal report notes this as an issue and the recommendation made was that the arrangements for management of a potential transfer of care for patients residing outside the Rotherham catchment area are reviewed. While we agree in principle, the CPA Policy is clear that patients who are out of area should be transferred in a way that is planned and organised to facilitate the continuity of care. Furthermore it is stated that it is the duty of the care coordinator to make a referral to the appropriate mental health service.

5.46 Members of the AOT told us that a significant lesson learned has been that they should have referred her to Barnsley earlier. The rationale given for not referring earlier was that they knew Miss B well and were supporting her settling in Wombwell, with the distance seen as not problematic. Miss B herself has said that with hindsight she would have preferred to be transferred to Barnsley. She stated she felt that AOT staff were fitting her in between visits, and had time pressures. At recommendation 2 we recommend that there is assurance that the CPA policy is implemented in the Rotherham AOT, which should include transfer. However we also suggest that assurance should be given that no patients from outside the Trust's catchment area are being treated in community teams without a time limited explicit agreement as to the rationale for that including duration and review processes.

Recommendation 9:
The Trust should provide assurance that there are no patients from outside the RDaSH catchment area being treated in community teams without a time limited explicit agreement as to rationale for that including duration and review processes.

5.47 Miss B was difficult to engage by both the mental health and substance misuse services. She frequently missed appointments, and was missing for periods of time. The care planning from substance misuse services appears to be in parallel with mental health services, rather than both services being part of an interagency care planned approach.

5.48 Her engagement was further complicated by being in and out of HMP New Hall for short but frequent periods. We have reviewed the correspondence and records of contact from HMP New Hall inreach mental health team to the AOT in 2014 and 2015. At this time the prison primary healthcare service was provided by Spectrum CIC.[39] The mental health inreach service was provided by Nottinghamshire Healthcare NHS Foundation Trust.

5.49 There is evidence of positive working relationships, and reasonably timely communication between the prison and the AOT. Discharge summaries had been sent by the prison inreach team with medication and treatment history. This has not always been smooth, sometimes occurring on the day of release, partly because prison releases are not planned through healthcare. The inreach team reported having tried to communicate by phone where this has occurred. There was one incident where incorrect dates were given on a discharge letter which was quickly corrected by phone.

5.50 The internal report noted the challenges around communication on discharge and recommended that communication links be established between prison inreach services.

5.51 There is evidence of regular communication between mental health services and Miss B's various GPs, and between physical health providers and her GPs. The difficulty in maintaining contact with Miss B was acknowledged across services, and information was shared between these services.

5.52 Miss B was aware that P was under the supervision of the probation service, and had told Trust staff this. We were made aware that the probation service conducted an investigation into their supervision of P in this case, but we have not had access to it. Regarding the question of what disclosures about an offender's supervision or history, if any, might be made, we were informed that "disclosure to a third party is to assist offender managers (probation officers) to manage the risk of serious harm to the public or known individuals. Consideration of disclosure to a third party will always be on a case by case basis and used only when it is assessed as the minimum necessary to protect victims, potential victims, staff or the public from serious harm."

5.53 We are therefore unable to include any consideration of the question of interagency working in relation to the probation service in this case.

[39] *Spectrum CIC is a social enterprise that provides prison health care http://spectrumhealth.org.uk/*

6 Internal investigation

6.1 The terms of reference for this element of the investigation require that we:

Review the Trust's internal investigation of the incident to include timeliness and methodology to identify;

- If the internal investigation satisfied the terms of reference
- If all key issues and lessons were identified
- If recommendations are appropriate and comprehensive
- The implementation of the internal action plan through evidence
- If the affected families were appropriately engaged with

6.2 The Trust conducted an internal investigation into the care and treatment of Miss B, completing this in December 2015. The report was authored by the Assistant Director of Drug and Alcohol Services, and the intention was to ensure objectivity by requesting that a senior member of staff from another service carry out the investigation. He was assisted by a panel including the Assistant Director of adult mental health, patient safety staff, chief pharmacist, and head of professions.

6.3 The terms of reference for the internal investigation were to

- Review the care and treatment of Miss B while engaged in RDaSH Services, taking into account Trust policy and best practice guidelines
- To identify areas of good practice and key care problems
- To identify any systems failure
- To form recommendations and action plans
- To assure that any identified disciplinary or performance issues are flagged up for separate investigation

6.4 The report is constructed using the techniques of root cause analysis,[40] with a clear chronology and detailed contributory factors listed and analysed. The report was finalised six months after the homicide. There was an agreement in this case that the final report should be finished after the trial outcome.

6.5 The internal review gives an overview of Miss B's care from mental health services only. The timeline for the review did not include a review of her substance misuse care, which was also provided by the Trust, and so missed the opportunity to describe the full spectrum of care by the Trust. The report is detailed but succinct, and made five recommendations for action. It does appear to have met the terms of reference.

6.6 Local ownership of the implementation of the action plan is maintained by the relevant Locality Manager. Oversight of the implementation of

[40] *Root cause analysis investigations identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for patients* http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/ .

recommendations and actions from incidents is kept by the patient safety team department reporting to the Director of Nursing and Quality.

6.7 The Trust is currently reshaping the approach to learning from serious incidents, and this has been changing since October 2015. A larger patient safety team is planned, it is anticipated this team will carry out serious incident investigations and maintain oversight of the completion of action plans. There is an organisational learning approach which is focussed on embedding new ways of learning from serious incidents.

6.8 The patient safety department maintain a register of all serious incidents, and groups the findings and action plans into themes. A programme of spot check audits and 'deep dives' on the completion of these action plans is maintained, and reported to the Director of Nursing.

6.9 A monthly 'organisational learning communication' is developed from summary themes that have been taken from the findings of serious incidents, and is conveyed to all staff through internal networks, and discussed at team briefings. We saw an example of the August 2016 briefing that focussed on communication.

6.10 The adult business division team has a monthly governance meeting run by an Assistant Director, and feedback and learning from serious incidents are discussed. Feedback from serious incidents is a standing agenda item on team meetings.

6.11 These structures are intended to support lessons to be learned from incidents where things go wrong.

Engagement with families

6.12 The internal report notes that Miss B had no close family to engage, and we have had the same experience in carrying out the independent investigation.

6.13 The internal report notes that it was understood that Mr C had no close family, and it was also noted that several attempts were made to access information about family through the police, but no response was received. The intention had been to offer the chance for any family to contribute through police family liaison.

6.14 This was not actually the case, and we have found that there are a number of close family members, who have been supported by the police through the process of police investigation, trial and beyond. We agree with the statement that the Duty of Candour does not apply to the victim's family in this case, but consider that contact should have been made in the spirit of being open; and we consider that the request for contact with family through police liaison should have been escalated. Mr C's family have not had sight of the internal report.

6.15 We consider the lack of contact made with families was not good practice.

Recommendation 10:
The Trust should ensure that the approach to families involved in a serious incident committed by a Trust mental health service user is carried out in accordance with the principles of 'Being Open'.

Internal recommendations

6.16 The internal incident review made five recommendations:

1. Review arrangements for patient referred into the services with a previous diagnosis of schizophrenia where copies of the full psychiatric assessment are not made available at the point of referral.

2. Review arrangements for management and potential transfer of care for patients residing outside the Rotherham borough/CCG area on an on-going basis.

3. Explore how concerns around poor communication with prison mental health services and community teams around patient release can be improved.

4. Review processes for objectively testing for illicit drug use by mental health services and utilising alcohol and drug screening tools for patients who do require care and treatment by drug and alcohol teams.

5. To review arrangements for ensuring that multi-disciplinary and consultant-led discussions around a patients care take place, and are documented in clinical records within Rotherham Assertive Outreach Team.

6.17 We agree with the areas identified for action, and have made several comments on the detail above. However we suggest the action plan should have been more outcome focussed, and the use of the word 'review' invites possible scrutiny and consideration rather than action.

6.18 Our overall view is that the report provided a robust and challenging internal investigation, but did not identify all key issues and lessons. The report is somewhat limited by not reviewing the substance misuse, primary care and prison issues. A lack of response by the GP and prison health services to the request to be involved in the internal investigation was described, and we believe this should have been escalated. The prison healthcare provider has changed since this incident, to CARE UK from September 2016, and new communication pathways will need to be established.

Internal investigation action plan

6.19 The action plan was written in an action-focussed format, with timelines and individuals allocated responsibility for carrying out actions.

6.20 We have seen the RDaSH evidence file for the action plan, and have had the opportunity to discuss this with the Locality Manager. We review the evidence provided against each recommendation below.

1. Review arrangements for patient referred into the services with a previous diagnosis of schizophrenia where copies of the full psychiatric assessment are not made available at the point of referral.

6.21 Local working instructions have been updated and are in place as an 'aide memoire' for staff, and it is part of all new staff inductions. This includes referrals from prison. Electronic copies of the CPA policy were circulated to all staff.

6.22 It was confirmed by the Clinical Lead that this was also discussed at the relevant medical clinical meetings and discussed extensively with Access team consultants in North Lincolnshire and Rotherham. These meetings are not ordinarily minuted, but learning from serious incidents have been taken into consideration and are embedded in the practice of access/home treatment teams in all three localities. An example of team minutes where this issue was included was provided.

6.23 A shared care agreement and protocols for out of area arrivals are in the process of being agreed with GPs.

An audit of new patients during 2016 showed evidence of time between transfer and medical review, and an example of a completed initial summary proforma for a new patient was seen.

2. Review arrangements for management and potential transfer of care for patients residing outside the Rotherham borough/CCG area on an on-going basis.

6.24 This incident has been discussed at a Rotherham Manager's meeting in November 2016, and learning points particularly regarding escalation processes have been addressed.

6.25 Learning from serious incidents was shown to be a standing agenda item at Team Manager Meetings, which is intended to ensure that they are discussed and feedback given to teams following investigations.

3. Explore how concerns around poor communication with prison mental health services and community teams around patient release can be improved.

6.26 It is acknowledged that this is a national issue, and a problem for many agencies, in terms of knowing when a prisoner is due to be released. There is no 'local prison' for Rotherham so the forging of local relationships is more challenging. However there have been meetings between the hospital liaison team, access team and HMP Doncaster about mental health pathways.

6.27 There are strong links with the local Vulnerable Persons Unit, which provides a multi-agency strategy for Vulnerable Adult Risk Management (VARM).

6.28 RDaSH has established a 'complex and serious service users' multidisciplinary, multi-agency meeting that is attended by Police from the Vulnerable Persons Unit. This was set up to provide multiagency risk management planning and case management support to case holders. An example of the minutes of the meetings show multi-agency input to discussions and plans. An example of a structured case discussion was seen, which included detail of actions to be taken by various agencies. An example of an urgently arranged case review meeting was also seen, which was arranged in response to a patient being released from prison on Christmas Eve.

4. Review processes for objectively testing for illicit drug use by mental health services and utilising alcohol and drug screening tools for patients who do require care and treatment by drug and alcohol teams.

6.29 The Dual Diagnosis Policy was circulated to all relevant staff. Audits suggest that drug use is being identified and actions suggested to patients. The DAST-10 tool was reported to be available but not widely used.

6.30 The Service Manager for the Drug and Alcohol service is now providing formal supervision into the Rotherham AOT.

6.31 We did not see evidence of actions to address objective testing for illicit drug use.

5. Review arrangements for ensuring that multi-disciplinary and consultant-led discussions around a patients care are documented in clinical records within Rotherham Assertive Outreach Team.

6.32 A back log of minutes from multi-disciplinary meetings that had not been entered in the clinical notes has now been addressed.

6.33 It was acknowledged that further work is needed regarding content, and this has been referred to the Rotherham Care Group Director and Associate Nurse Director for action.

Recommendation 11:

The Trust should address those areas within the internal action plan that have not been completed on internal recommendations 4 and 5.

7 Overall analysis and recommendations

7.1 The internal investigation by RDaSH identified areas of learning, which we support and have expanded upon. We have made 11 recommendations for wider systems learning, having had the advantage of reviewing the care provided by substance misuse services, the GP and prison.

Predictability and preventability

7.2 This is to determine through reasoned argument the extent to which this incident was either predictable or preventable, providing a detailed rationale for the judgement

7.3 In its document on risk, the Royal College of Psychiatrists scoping group observed that:

'Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. However, adverse outcomes cannot be eliminated. Accurate prediction is challenging for individual patients. While it might be possible to reduce risk in some settings, the risks posed by those with mental disorders are difficult to predict because of the multiplicity of, and complex interrelation between, factors underlying a person's behaviour.' [41]

7.4 The RDaSH clinical risk assessment policy states:

'Risk assessment is an essential and ongoing element of good mental health practice and a critical and integral component of all assessment, planning and review processes'.

7.5 Predictability is '*the quality of being regarded as likely to happen, as behaviour or an event*'.[42] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[43]

7.6 Prevention[44] means to '*stop or hinder something from happening, especially by advance planning or action*' and implies '*anticipatory counteraction*'; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

7.7 In answering these we have asked two key questions:

- Was it reasonable to have expected agencies and individual clinicians

[41] *Royal College of Psychiatrists (2016) Rethinking risk to others in mental health services. Final report of a scoping group http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr201.aspx*
[42] *http://dictionary.reference.com/browse/predictability*
[43] *Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120*
[44] *http://www.thefreedictionary.com/prevent*

to have taken more proactive steps to manage any risk presented by Miss B?

- Did they take reasonable steps to manage any known risks?

Was the homicide preventable?

7.8 The terms of reference for the internal report did not include the question of preventability or predictability. We considered the Trust's approach to Miss B's assessment and treatment, and have concluded that she was provided with elements of recovery focused evidence based mental health care, but with some gaps as outlined, and her medication did not have sufficient professional oversight from a consultant psychiatrist. The possible use of illicit drugs was not effectively assessed.

7.9 However we have considered the following points in relation to preventability:

- Within Miss B's history of risk behaviours, there is no history of violence to others, and a history of carrying knives for her own protection some years previously. Any assessment of risk on the information reasonably available at the time, would not, we believe, have regarded Miss B as a potentially high risk of violence to others.

- Her 'full needs assessment' noted that she lacked insight into the risks associated with relationships she has been in, which have been with male partners who have been abusive and controlling. This was not incorporated into a care plan, and there was no evidence of any supportive or psychological work with her on building her insight and resilience.

- Her history of vulnerability to coercive relationships was well documented, and the consequences have been neglect of herself and exposing herself and her children to serious violence and drug taking. Staff within RDaSH mental health services reported being vigilant for signs that P was coercive and controlling, but did not make a holistic assessment of the situation, taking Miss B's mental state and possible drug taking into account.

- In our view the interaction between Miss B's vulnerability, passivity, and her mental state increased the likelihood of her being vulnerable to coercive control.

- The missing element is the lack of information about any potential risks posed by P.

7.10 The factors above led us to conclude that more assertive treatment might have reduced the risk of Miss B being vulnerable to coercive control. However we were supplied with no evidence to suggest that Mr C's death was in any way a result of her mental disorder. There remains a duty to

alert authorities even if risk of serious harm is not due to mental disorder. We have seen no evidence to suggest that the Trust services could or should have been aware that she might go on this robbery with her partner and that serious harm to others of any type would then follow. We do not believe they were in a position to alert, prevent or predict the actions and choices on the day in question.

7.11 However Miss B's part in the homicide was regarded at court as falling under the definition of 'joint enterprise'.[45]Joint enterprise can apply where two or more persons are involved in an offence or offences. The parties to a joint enterprise may be principals (P) or secondary parties (accessories / accomplices) (D). A principal is one who carries out the substantive offence i.e. performs the conduct element of the offence with the required fault element. A secondary party is one who assists or encourages (sometimes referred to as "aids, abets, counsels or procures") P to commit the substantive offence, without being a principal offender.

7.12 It is beyond our scope to debate the law as applied in this case, but the findings were that Miss B did not actually commit the murder, but was aware of P's intention to rob Mr C, did nothing to stop it, and did nothing to get help for Mr C when P attacked him although she had the opportunity to do so.

7.13 We have had no information to suggest that the homicide outcome would have been different even if Miss B had not been present or indeed not in a relationship with P; so the question of preventability cannot be applied to Miss B's actions. The question of the preventability of the homicide we believe can only be applied to P's actions.

Was the homicide predictable?

7.14 There is no nationally agreed definition of predictability in use, and we have drawn from the approach taken by Munro & Rumgay (2000) in their analysis of the role of risk assessment in reducing homicides by people with mental illness. If a homicide was judged to have been predictable, it was suggested that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.

7.15 We believe that an assessment of any 'probability of violence' applied to Miss B, based on her previous history and current presentation, would not have concluded that she was at risk of violence to others.

7.16 However Miss B was seen by AOT staff two days after the homicide, and showed no evidence of an altered mental state, or excessive concern about P.

7.17 We conclude that there is no evidence to suggest that this homicide could have been predicted by mental health services.

[45] *Joint Enterprise Charging Decisions. https://www.cps.gov.uk/legal/assets/uploads/files/Joint_Enterprise.pdf*

Recommendations

7.18 The recommendations have been grouped into four themes; policy adherence, staff training and development, service management and serious incident management. The recommendations about adherence to policy have been made after careful consideration of the evidence.

7.19 Where issues have been identified we have reviewed practice against the relevant Trust policy, which clearly state the expectation in the various areas. The policies appear reasonable and easy to follow therefore the lessons to be learned in the first six recommendations is how the Trust ensures policies are implemented and followed.

Policy adherence

Recommendation 1:
The Trust must provide assurance that the CPA policy is adhered to in the Rotherham Assertive Outreach Team.

Recommendation 2:
The Trust should revise care planning and risk assessment formats to include the date of the last CPA review, and indicate when the next review is due.

Recommendation 3:
The Trust must provide assurance that the NICE guidelines for the prevention and management of psychosis and schizophrenia are incorporated into treatment plans.

Recommendation 4:
The Trust must provide assurance that best practice prescribing guidelines as published by the General Medical Council are adhered to.

Recommendation 5:
The Trust must provide assurance that nursing staff adhere to best practice guidance in the administration of depot injections and the requirements of the Safe Secure Handling of Medicines Policy in the care of patients receiving antipsychotic medication.

Recommendation 6:
The Trust must provide assurance that the dual diagnosis policy is implemented in community teams.

Staff training/development

Recommendation 7:
The Trust must provide assurance that community mental health staff are equipped with the skills knowledge and policy awareness to assess for the harmful use of substances in community mental health services.

Recommendation 8:
The Trust should provide assurance that Trust clinical staff are equipped with skills and knowledge in recognising and assessing the impact of domestic abuse, including assessment of capacity where indicated.

Service management

Recommendation 9:
The Trust should provide assurance that there are no patients from outside the RDaSH catchment area being treated in community teams without a time limited explicit agreement as to rationale for that including duration and review processes.

Serious incident management

Recommendation 10:
The Trust should ensure that the approach to families involved in a serious incident committed by a Trust mental health service user is carried out in accordance with the principles of 'Being Open'.

Recommendation 11:
The Trust should address those areas within the internal action plan that have not been completed on internal recommendations 4 and 5.

Appendix A – Terms of reference

The individual terms of reference for independent investigation 2015/25081 were set by NHS England with input from Barnsley CCG. These terms of reference will be developed further in collaboration with the offeror, family members and other appropriate stakeholders. However the following terms of reference will apply:

Core Terms of Reference

- Review the Trust's internal investigation of the incident to include timeliness and methodology to identify:
  - If the internal investigation satisfied the terms of reference
  - If all key issues and lessons were identified
  - If recommendations are appropriate and comprehensive
  - The implementation of the internal action plan through evidence
  - If all affected families were appropriately engaged with

- Review the care, treatment and services provided by the NHS and other relevant agencies from the service user's first contact with services to the time of the offence

- Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern including any areas of future risk

- Review and assess the Trusts compliance with local policies, national guidance and relevant statutory obligations including Care Programme Approach, Dual Diagnosis and Safeguarding Processes

- Review the adequacy of risk assessments and risk management, including the risk of Domestic Violence to the service user as well as their risk of harming themselves or others

- Review the effectiveness of the transfer process from the provider organisation to external health providers (including Prison and Barnsley GP) identifying any service delivery or commissioning issues

- Review the effectiveness of the provider organisation's investigation of communication with external health providers, including GP & Prison healthcare, and if issues are identified examine if these were appropriately raised with the relevant commissioner

- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family

- Establish contact with both the families of those affected as fully as is considered appropriate, in liaison with the Police and other identified support organisations.

- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing a detailed rationale for the judgement

- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.

- Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement

- Provide a written report to the NHS England North that includes measurable and sustainable recommendations.

- Assist NHS England in undertaking a brief post investigation evaluation.

- **Supplemental to Core Terms of Reference**

- Support all appropriate organisations to develop robust, outcome focussed action plans based on the report's recommendations

- Support the commissioners to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest

- Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CGG and Trust and provide a brief report detailing the outcome of the assessment to NHS England, North

Appendix B – Profile of the Trust

Rotherham Doncaster and South Humber NHS Foundation Trust

Adult Mental Health Services provides inpatient and community support in Doncaster, Rotherham and North Lincolnshire.

The Trust also provides Early Intervention in Psychosis Services in Doncaster, Rotherham, North Lincolnshire, and Manchester.

The Trust provides community-based drug and alcohol services across Doncaster, Rotherham and North East Lincolnshire.

Rotherham Drug and Alcohol Services offers a range of interventions at various sites across the borough including supporting service users with difficulties with drug use into treatment to support them with stabilisation and through a journey into recovery and exit from treatment.

Appendix C – Documents reviewed

RDaSH documents
Standard operating procedure for the multi-agency risk assessment conference (MARAC) v2
Clinical risk assessment and management policy v8.1
Being Open policy v6.2
Rotherham shared care guidelines 2012
CPA policy v9
Drug abuse screening test (DAST) 7.10.14
Dual diagnosis policy v3
Engagement and discharge of clients referred to and in contact with substance misuse services policy v3
Incident reporting flowchart v1.3
Incident reporting policy April 2016
Lone working policy v4
Safe secure handling of medicines policy v4
Safeguarding adults policy v4 2013
Serious incident policy v14.1
Serious incident flowchart v14.1

Other documents

General Medical Council (GMC) 2013 prescribing guidance

South Yorkshire police case summary