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HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of a mental health service user Mr P in Plymouth

December 2021
Final Report

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

Our Report has been written in line with the Terms of Reference for the independent investigation into the care and treatment of Mr P. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. However, where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

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

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1.1 Mr P is an individual with complex mental health and substance misuse problems who was known to mental health and substances misuse services in Plymouth and Bristol.

1.2 Mr P told staff that he had no friendship group in Plymouth, but he did have a friend who lived about 30 miles away. However, in mid-November 2015 a new friend, Mr G, was often present at Mr P's home when mental health staff visited. By the end of November 2015 Mr G was in contact with mental health services on Mr P's behalf. There are no references to Mr G in Mr P's clinical records after December 2015.

1.3 On 16 December 2016 police contacted the community mental health team to establish whether anyone had been in contact with Mr P and whether he had any identifying tattoos. Police informed staff that a body had been found at Mr P's address.

1.4 It was later established that the body was that of Mr P's friend, Mr G, and Mr P was subsequently charged with his murder.

Independent investigation

1.5 NHS England (South) commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into Mr P's care and treatment. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.6 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance[2] on Article 2 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.

1.7 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] 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 incidents. https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

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

1.9 We would like to express our condolences to all the parties affected by this incident. It is our sincere wish that this report does not add to their pain and distress, and that it goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr P.

Internal investigation

1.10 The Trust undertook a serious incident investigation following Mr G's death. The investigation was completed by a senior mental health nurse and a consultant psychiatrist.

1.11 The internal investigation team identified a significant number of missed opportunities where Mr P's care could have been better organised. These were:

- not asking for full forensic history when probation services were known to be involved;
- no clear sharing of information from Lead Professional consultant via multi-disciplinary team (MDT) regarding probation involvement;
- referral/involvement of [Community Forensic Team] when Community Order with Mental Health Treatment Requirements known – probation order information was known by one person until October 2016;
- allocation of a care coordinator and being on Care Programme Approach;
- multi-professional meeting being organised in September 2016;
- involvement of the multi-disciplinary team when being considered for discharge from community support worker caseload;
- probation being made aware of his [non-attendance at mental health appointments] in September 2016 and not meeting the probation order requirements;
- Mental Health Act assessment process not being commenced in December 2016; and
- professional differences not being escalated.

1.12 Seven recommendations were made:

R1 All [multi-disciplinary team] actions to be followed up and recorded in tabbed journal – this is now complete.

R2 All professional letters to be [copied] into whoever is identified as working with the person e.g. Harbour, Probation.

R3 [Mr P's Care Programme Approach] risk assessment to be updated to reflect forensic history and incident.

R4 Full forensic history from [Police National Computer] PNC if agencies such as probation are involved.

R5 Thresholds for [Care Programme Approach] to be reinforced – [Mr P] would have fitted the criteria.

R6 When Community Orders with a Requirement for Mental Health Treatment are considered or in place a referral must [be] sent to the Community Forensic Team. Patients should be stepped up to [Care Programme Approach], if not the rationale/reasons must be clearly documented in the record.

R7 Escalation route to be clarified when professional differences [are] needing a [Mental Health Act assessment].

1.13 The Trust developed an action plan to respond to these recommendations and we have seen partial evidence of these actions being completed.

Forensic history

1.14 Mr P had a significant forensic history that was not known to mental health staff working with him until 6 December 2016. The information was provided in an email from the probation service to mental health services that stated Mr P had 29 convictions, 19 of which involved violent offending.

1.15 In addition, there were 11 offences against the person, 16 offences against property, ten public order offences and 38 offences relating to police/the courts/prison, and four offences which relate to him having offensive weapons.

Sentence

1.16 On 26 July 2017 Mr P pleaded guilty to manslaughter due to diminished responsibility. He was given a custodial sentence of 14 years with an extended licence period of five years.

Conclusions

1.17 We have set out below the care and service delivery problems associated with the care and treatment of Mr P.

Figure 1: Care and service delivery problems associated with the care and treatment of Mr P

1.18 There were three missed opportunities to arrange a face-to-face assessment of Mr P's mental state in the days prior to the death of Mr G. Whilst it is not possible to be certain of the outcome of a Mental Health Act assessment, this would have provided the opportunity to ensure that a full assessment was made, and informed decisions were taken about how to manage his care and treatment at that time.

1.19 In addition, there were failings in the delivery of care and treatment to Mr P in the preceding 12 months when:

- risk assessments and care plans were poorly completed, missing pertinent information;
- care planning was not completed in accordance with the Care Programme Approach Policy;
- a care coordinator was not allocated in accordance with the Livewell Southwest Policy; and
- care and treatment for psychosis and post-traumatic stress disorder was not delivered in accordance with NICE guidelines.

1.20 The internal investigation undertaken by Livewell Southwest was robust and met the terms of reference. However, we found no evidence of robust monitoring of completion of the action plan by either Livewell Southwest or NHS Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group (CCG). We therefore cannot say whether the actions have resulted in appropriate changes to patient safety or the way services function.

Predictability and preventability

1.21 Predictability[3] is "the quality of being regarded as likely to happen, as behaviour or an event". 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.[4]

1.22 Prevention[5] 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.

1.23 It is our view that Livewell Southwest staff could not have predicted that Mr P would kill Mr G. There were no reports of further violent behaviours from either his GP or the National Probation Service.

1.24 In the 16 days prior to the discovery of Mr G's body there were, however, concerns expressed by his GP, the National Probation Service, and the manager of the community forensic team that Mr P's mental state was disintegrating. This knowledge in the context of someone with diagnoses of psychotic episodes and post-traumatic stress disorder meant that a violent outburst was more likely.

1.25 It is therefore our view that there were actions that could have been taken in the weeks and months prior that might have resulted in the prevention of Mr G's death. This could have included:

- liaison with the community pharmacy where he was known to collect his methadone to establish when Mr P was last seen;
- liaison with the community pharmacy to ensure that Livewell Southwest staff were contacted when Mr P attended the pharmacy;
- consideration of using this information as a means to secure a face-to-face assessment; and
- consideration of using this information as a means to arrange a Mental Health Act assessment.

[3] http://dictionary.reference.com/browse/predictability

[4] 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

[5] http://www.thefreedictionary.com/prevent

Recommendations

1.26 This independent investigation has made nine recommendations to improve commissioning and clinical practice.

Recommendation 1: Livewell Southwest must ensure that the policy and procedure on engagement and support of families of victims and perpetrators involved in serious incidents to comply with current guidance.

Recommendation 2: NHS Devon Clinical Commissioning Group and Livewell Southwest must ensure that serious incidents are investigated in accordance with the Serious Incident Framework, that provider action plans are monitored, that assurance is sought and provided that action plans are completed, and changes to clinical practice and patient care are monitored.

Recommendation 3: NHS Devon Clinical Commissioning Group and Livewell Southwest must ensure that care and treatment for psychosis and schizophrenia, and post-traumatic stress disorder is delivered in accordance with the relevant NICE guidelines.

Recommendation 4: Livewell Southwest must provide assurance to their commissioners and the Board that risk assessments are undertaken and documented in accordance with organisational policy.

Recommendation 5: Livewell Southwest must provide evidence assurance to their commissioners and the Board that discharge decisions are taken in accordance with organisational policy.

Recommendation 6: Livewell Southwest must ensure that crisis/contingency plans clearly describe the actions required by patients and staff when a patient is in crisis.

Recommendation 7: Livewell Southwest must provide assurance to their Board and their commissioners that a system is in place to ensure that any patient waiting longer that ten days for allocation to a care coordinator is identified and the issue escalated to an appropriate manager for action.

Recommendation 8: Livewell Southwest must ensure an effective local interagency protocol with the National Probation Service is developed. This should agree specific responsibilities and actions for each organisation when a patient of Livewell Southwest is subject to a Community Order with a Requirement for Mental Health Treatment. Livewell Southwest must also ensure that in such circumstances, individual care plans are aligned to the Community Order and that clinical staff engage regularly with the patient's Offender Manager.

Recommendation 9: Livewell Southwest must provide assurance to their commissioners and the Board that the escalation route for professional differences between AMHP[6]s and community mental health team staff are used effectively.

Good practice

1.27 The consultant psychiatrist (CP07) wrote to Mr P on 31 August 2016 to inform him that she would be leaving her post on 30 September 2016. She advised that work was underway to identify a replacement for her by the time she left and provided contact details should Mr P have any concerns.

[6] Approved Mental Health Act Professional (AMHPs) are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act.

2 Independent investigation

Incident

2.1 Mr P is an individual with complex mental health and substance misuse problems who was known to mental health and substances misuse services in Plymouth and Bristol.

2.2 Mr P told staff that he had no friendship group in Plymouth, but he did have a friend who lived about 30 miles away. However, in mid-November 2015 a new friend, Mr G, was often present at Mr P's home when mental health staff visited. By the end of November 2015 Mr G was in contact with mental health services on Mr P's behalf. However, there are no references to Mr G in Mr P's clinical records after December 2015.

2.3 On 16 December 2016 police contacted the community mental health team to establish whether anyone had been in contact with Mr P and whether he had any identifying tattoos. Police informed staff that a body had been found at Mr P's address.

2.4 It was later established that the body was that of Mr P's friend, Mr G, and on 20 December 2016 police confirmed that they had charged Mr P with his murder.[7]

Approach to the investigation

2.5 The independent investigation follows the NHS England Serious Incident Framework[8] (March 2015) and Department of Health guidance[9] on Article 2 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.

2.6 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 are required which could help prevent similar incidents occurring.

[7] https://www.devon-cornwall.police.uk/News/newsarticle.aspx?id=56e5cf90-529c-4801-9524-1c2d4c283127

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

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

2.7 The investigation was carried out by:

- Naomi Ibbs, Senior Consultant for Niche (lead author);
- Dr Mark Potter, Consultant Psychiatrist;
- Helen Preston, Assistant Chief Officer of Probation.

2.8 The investigation team will be referred to in the first-person plural in the report.

2.9 The report was peer reviewed by Dr Carol Rooney, Associate Director, Niche.

2.10 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[10]

2.11 NHS England sought consent from Mr P for us to have access to relevant clinical records. Mr P consented but did not respond to NHS England to the offer of a meeting with us.

2.12 We used information from the following organisations to complete this investigation:

- Livewell Southwest (mental health service Provider based in Plymouth);
- Mr P's GP surgery;
- Harbour Centre (substance misuse service provider);
- NHS Devon CCG (formerly NHS NEW Devon CCG and where this organisation was the owner of the information referred to in this report, we have retained the use of the previous organisational name).

2.13 As part of our investigation we interviewed:

- Team Manager, Harbour Centre.
- Clinical Team Manager, West and North Community Mental Health Teams, Livewell Southwest;
- Deputy Locality Manager, West Community Mental Health Team, Livewell Southwest;
- Consultant Psychiatrist; West Community Mental Health Team, Livewell Southwest;
- Senior Mental Health Nurse who conducted the internal investigation, Livewell Southwest.

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

2.14 All interviews were digitally recorded, and interviewees were subsequently provided with a transcript of their interview.

2.15 A full list of all documents we referenced is in Appendix B, and an anonymised list of all professionals is in Appendix C.

2.16 The draft report was shared with:

- NHS England, South;
- Livewell Southwest;
- Mr P's GP surgery;
- Harbour Centre;
- NHS Devon CCG.

2.17 This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with Mr P family

2.18 We have not had any contact with Mr P. NHS England did not receive a response to the question about meeting with us to discuss the investigation. We have therefore not discussed the investigation nor shared a copy of the report with him.

Contact with Mr G's family

2.19 We have not had any contact with Mr G's family. NHS England did not receive a response to any correspondence with Mr G's family members. We have therefore not discussed the investigation nor shared a copy of the report with his family.

Structure of the report

2.20 Section 3 provides detail of Mr P's background.

2.21 Section 4 sets out the details of the care and treatment provided to Mr P. We have provided an anonymised summary of those staff involved in Mr P's care and treatment for ease of reference for the reader. These can be found at Appendix C.

2.22 Section 5 examines the communication the Trust had with affected families after the death of Mr P.

2.23 Section 6 provides a review of the internal investigation and reports on progress made in addressing the organisational and operational matters identified.

2.24 Section 7 examines the issues arising from the care and treatment provided to Mr P and includes comment and analysis.

2.25 Section 8 sets out our overall conclusions and recommendations.

3 Background of Mr P

3.1 As we have previously stated, we have not met with Mr P so have not been able to obtain any information about him first-hand. All of the following information has been taken from reports Mr P made to clinical staff.

3.2 Mr P had been placed in care by his mother at the age of about four or five years because she was unable to control him "for being hyperactive". In May 2014 it was reported that Mr P's parents were alive, but he stated he had no contact with them and that he had poor relationships with his siblings because he had been placed in care whilst they had remained in the family home.

3.3 Mr P stated that his childhood was "messy" and "rough" and that he was beaten and bullied by other children in the children's home.

3.4 Mr P reported that he had tried to hang himself at the age of six or seven years but was unable to recall why. Mr P also reported that he had suffered sexual abuse from one of his peers between the age of ten and 15 years that ceased only when he left the children's home. He stated he later engaged in sex work.

3.5 Mr P was unable to recall most of his twenties because of significant drug use and in 2014 reported that he had been unemployed for ten years.

4 Summary of events

4.1 This section provides a summary of events between from July 2013 to December 2016.

4.2 It appears that Mr P spent time living in Bristol and Plymouth. His GP records indicate a number of changes of registered GP practice.

2013

4.3 Mr P was admitted to a detoxification and stabilisation unit in Bristol, provided by Avon and Wiltshire Partnership NHS Foundation Trust, on 12 July 2013 where he received treatment for alcohol detoxification. It is not clear from the records we received exactly when he was discharged.

4.4 However, on 31 July 2013 Closereach, a drug and alcohol rehabilitation centre in Plymouth confirmed to a GP that Mr P was resident there and the intention was that he would remain for three to six months.

2014

4.5 Mr P remained in Plymouth and on 17 April 2014 he was referred by his GP to Harbour Drug and Alcohol Service for alcohol rehabilitation. It was documented that Harbour would arrange for Mr P to be seen by a consultant psychiatrist specialising in addiction.

4.6 Harbour provided regular support to Mr P throughout 2014 when he reported that he wanted to "turn his life around" and to stop the excessive drinking that had replaced his drug use.

4.7 In December Mr P reported to his GP that his father was extremely unwell and was in hospital in Surrey with a poor prognosis. He requested a methadone prescription to cover him whilst he visited his father.

2015

4.8 In January 2015 Mr P reported to his GP that he had returned to Plymouth after his father's funeral and had been using three bags of heroin daily on top of drinking heavily. He asked to recommence his methadone prescription. This was restarted at 30ml daily with collection twice weekly (Wednesday and Saturday).

4.9 In March Mr P reported to his GP that he was low in mood, experiencing thoughts of self-harm and suicide and hearing voices. Mr P's GP prescribed mirtazapine 30mg daily and olanzapine 10mg daily. Mr P was reviewed via telephone appointment two weeks later and reported that he had not noticed any impact of the medication, but his GP documented that he sounded euthymic. The GP agreed to issue a further prescription for two weeks but stated that no changes would be made until he had seen Mr P for a face-to-face review.

4.10 A Harbour Drug and Alcohol Service risk assessment completed in April 2015 documented that Mr P had a history of assault when he was intoxicated and identified him as a vulnerable person due to a lack of support.

4.11 Mr P remained under the care of Harbour Drug and Alcohol Services and in April 2015 Mr P took an overdose of methadone. By August 2015 he had returned to using heroin on a daily basis at the same time as drinking about 58 units daily, and being prescribed methadone, olanzapine, and mirtazapine. Risk of suicide was documented but it was reported that Mr P was not experiencing suicidal ideation at that time.

4.12 On 11 May 2015 Mr P reported to his GP that he had been hearing voices telling him to kill himself and that he had thought that he would overdose on cocaine and/or heroin in order to achieve this. Mr P also expressed thoughts of jumping in front of a train. The GP documented that Mr P had been found unconscious two weeks previously following a suicide attempt. The GP contacted the community mental health team and spoke to the duty worker who advised that Mr P needed to be referred to the home treatment team. Home treatment team staff advised the GP that they had no capacity to see Mr P that evening and therefore he would need to attend the emergency department. Mr P left the consulting room before the discussion concluded. The GP out of hours service had insufficient information to be able to follow up and therefore the police were contacted in order to secure an assessment under Section 135 or 136 of the Mental Health Act. However, Mr P was not at home when the police attended his flat.

4.13 The home treatment team followed up contact with the GP the following day advising that they needed more information. The GP advised that Mr P had refused any help and documented that he would continue with a referral for Mr P to be seen by mental health services.

4.14 On 20 May 2015 the GP documented that the response to his referral for Mr P was unsatisfactory and that Livewell Southwest were still in the process of obtaining all the information. Livewell Southwest did not document receipt of a referral until 29 May 2015.

4.15 On 8 June 2015 the home treatment team confirmed that they would assess Mr P that day. On assessment staff documented that they considered Mr P's voices to be pseudo-hallucinations rather than psychosis and that his care would be managed at home rather than by admission to hospital. It was documented that Mr P would be prescribed fluoxetine.

4.16 When home treatment team staff saw Mr P at home two days later, they documented that he had little food in the flat and that he found leaving the flat difficult due to his anxieties. Staff attempted to deliver medication to Mr P on 11 June but were unable to do so because he did not answer the door, so they left a note advising that they had attended.

4.17 Mr P reported to home treatment team staff that he often would not answer the door because he feared it would be debt collectors, he also stated that the buzzer was often disconnected. Staff agreed to text Mr P when they were

outside his property. Mr P described constant voices in his head, but staff documented that there was no evidence of this during the 50-minute appointment with him. Staff took Mr P to the community pharmacy to collect his methadone and documented that his presentation appeared to be in the context of personality issues rather than psychosis.

4.18 On 22 June 2015 when home treatment team staff visited, they noted a number of knives and empty beer cans on the floor. Staff documented "suspicious behaviour" when discussing medication and noted tablets resembling olanzapine and mirtazapine were found wrapped in Mr P's clothing. These were removed.

4.19 Four days later home treatment team staff documented that Mr P would be discharged back to the care of the community mental health team, his GP and Harbour Drug and Alcohol Service.

4.20 Mr P did not attend his appointment with the community mental health team on 23 July and on 28 July the community pharmacy reported to his GP that he had not collected his medication for three days.

4.21 A further appointment with the community mental health team was offered on 21 August but Mr P did not attend this appointment either. Liaison with Mr P's GP confirmed that he had been in contact with Mr P on 13 August and that he had advised he would be away until 24 August.

4.22 In September Mr P's request for a reduction in his methadone (made in July but due to an oversight not actioned until early September) was agreed. Mr P also asked to have unsupervised consumption. A plan was made to reduce Mr P's methadone prescription from 90ml to 30ml over several weeks. At that time Mr P was receiving his methadone by way of supervised consumption, meaning that he consumed it in the presence of community pharmacy staff. It was acknowledged that the reduction may have an impact on his mental health and therefore mental health medication was discussed by his GP. Mr P's GP agreed to reduce the dose, but it remained a supervised consumption prescription. However, three days later Mr P advised that he had stopped taking the methadone seven to ten days earlier.

4.23 On 2 October 2015 Mr P attended an outpatient appointment with a consultant psychiatrist who documented that he was responding to voices and hallucinations. Mr P had refused to engage with the home treatment team and therefore informal admission to an inpatient unit was required. Mr P was admitted to the Glenbourne Unit, a mental health inpatient unit provided by Livewell Southwest. Assessment during admission to hospital indicated diagnoses of post-traumatic stress disorder and ADHD, and possible diagnoses of schizophrenia and autism. It was documented that Mr P was a risk to others when psychotic. Mr P was prescribed quetiapine 200mg and lorazepam 1mg as required.

4.24 On 6 October Mr P requested one-to-one support because he felt anxious and agitated. He gave his headphones to staff because he did not feel safe to have them in his possession.

4.25 Mr P was discharged from inpatient care on 8 October after staff documented that there was no evidence of mental illness. Arrangements were made for home treatment team staff to follow up after discharge. Despite attempts on 9, 10, 11 and 12 October home treatment team staff were unable to see or speak to Mr P. Following discussion, it was agreed that if there was no contact with Mr P by 20 October he would be discharged from the service. Mr P's GP and his support worker at Harbour Drug and Alcohol Service were made aware of the decision.

4.26 In October 2015 the community pharmacy reported to Mr P's GP that he had not collected his methadone for three days, it was also established that he had not attended his appointment with his support worker at Harbour Drug and Alcohol Service.

4.27 On 23 October home treatment team staff were informed by Devon Liaison and Diversion Service that Mr P had been detained by police in Torquay following being found intoxicated and by a bridge. Mr P had become abusive towards police when they detained him. Mr P would remain in police custody overnight and that if he were not detained support may be requested from the home treatment team.

4.28 On 2 November Mr P contacted the home treatment team because he was feeling suicidal and hearing voices. He had understood he would be admitted to an inpatient unit. Home treatment team staff were unable to confirm this agreement and arranged an outpatient appointment.

4.29 On 9 November home treatment team visited Mr P at home, Mr P agreed to engage with them, and staff advised him to ensure that he was not intoxicated for the next appointment.

4.30 The following day Mr P's support worker at Harbour Drug and Alcohol Service contacted his GP to advise that Mr P would like to restart his methadone treatment. He also advised that Mr P was consuming about 560 units of alcohol a week. The GP advised that he would not prescribe methadone if the reported alcohol consumption was correct.

4.31 Home treatment team staff visited Mr P again on 12 November when he reported that the voices and agitation were getting worse and was feeling fidgety and restless. The following day it was agreed to start Mr P on a low dose of procyclidine 2.5mg three times daily.

4.32 When home treatment team staff visited on 14 November, they documented that Mr P had a friend (Mr G) present. Mr P advised that he had been taking his medication but was unable to say where it was and then stated that Mr G had them. Mr G however said he did not know where Mr P's medication was.

4.33 On 16 November Mr G was again present during the visit by the home treatment team. Mr P reported that he felt better but continued to hear voices and had disturbed sleep. Mr P asked for a consistent worker as he found it difficult seeing so many different staff.

4.34 On 20 November home treatment team visited and Mr G was again present during the appointment. Staff documented Mr P's presentation as "troubled", rubbing his head and hair and unable to sit still. Mr P reported he was due to attend court on 23 November for assaulting a police officer. He reported he was compliant with his medication and that he had thoughts to harm himself and others but was being supported by Mr G. Staff advised Mr P to speak to home treatment team staff about his thoughts.

4.35 On 22 November home treatment team staff received a message to call Mr P. On doing so Mr G answered the phone and stated that Mr P had asked for staff to escort him to court the following day. Staff stated they would not do this but agreed to help reschedule the GP appointment.

4.36 The following day Mr P contacted the home treatment team to advise that his court appearance had been adjourned until December and that he had been ordered to engage with probation.

4.37 On 24 November home treatment team documented that most of Mr P's issues stemmed from chaotic alcohol use and therefore it was difficult to identify a role for the home treatment team. It was noted that Mr P had a "care coordinator" at Harbour and therefore it was recommended that he be discharged from the home treatment team.

4.38 Attempts to visit Mr P at home in late November and early December were unsuccessful and there was no response to the letters that were delivered to Mr P's address. Plans were put in place to discharge Mr P from the home treatment team with follow up to come from the community mental health team and Harbour Drug and Alcohol Service.

4.39 On 12 December 2015 home treatment team staff met with Mr P at his home. Mr P believed that he would be seeing a consultant psychiatrist at the appointment and staff documented that he was confused about the different roles of staff and teams. They advised Mr P that he was being discharged from the home treatment team into the care of the community mental health team, Harbour, and his GP.

4.40 On 14 December Mr P's GP received an email from his support worker at Harbour Drug and Alcohol Service advising that Mr P had stopped drinking but had tested positive for benzodiazepines, morphine, and methadone. He was smoking about £40 of heroin a day. The support worker also advised that Mr P's mood was volatile and that he had a court hearing on 21 December for police assault following threats to throw himself from a railway bridge.

4.41 On 16 December after the GP had confirmed with the home treatment team that prescribing responsibility was now with primary care and not Livewell Southwest, Mr P's GP prescribed procyclidine 5mg, methadone 30ml for one day and 40ml thereafter with daily collection and supervised consumption, fluoxetine 20mg, quetiapine 200mg.

2016

4.42 On 22 January 2016 Livewell Southwest received a request from Plymouth Magistrates' Court for a psychiatric report for Mr P who had been charged with assaulting police. We have not been able to identify the report that the court received.

4.43 On 26 January the community mental health team documented that Mr P was awaiting allocation to a care coordinator.

4.44 Throughout January, February and March Mr P was discussed at community mental health team meetings when it was documented he continued to wait for a care coordinator to be allocated to him.

4.45 On 23 March the consultant psychiatrist (CP06) received a call from a probation officer seeking an update on Mr P. CP06 advised that he was due to see Mr P that afternoon and would seek permission for his clinic letter to be shared with the probation officer. At the appointment Mr P reported that he continued to be troubled by auditory hallucinations, but that he had not been using illicit substances or alcohol and was being prescribed methadone. CP06 documented that there were no clear symptoms of schizophrenia but that there were complex mental health issues including emotionally unstable personality disorder, psychosis, query ADHD and probable autistic spectrum disorder. The plan was for quetiapine to be increased to 300mg and for a community mental health nurse to be allocated.

4.46 On 5 April, a health care assistant from the community mental health team contacted Mr P in a "supportive phone call". Mr P reported that he had self-harmed a few weeks previously and that he continued to be paranoid, some days the television talked to him but on other days he did not experience this. Advised that the health care assistant would call again two weeks later.

4.47 On 6 April CP06 referred Mr P to Steps[11] and on 12 April staff from Steps wrote to Mr P to advise that there was a high demand for their service and there would be a delay in them being able to see him.

4.48 Throughout April, May and June Mr P continued to be discussed at the community mental health team meetings when it was documented that he was still waiting for a care coordinator to be allocated to him.

4.49 On 3 May community mental health team staff documented that a scheduled home visit had not taken place because an invitation letter had not been sent and the community mental health nurse was off work. A health care assistant contacted Mr P by phone instead who reported that things were "good". He asked for details of his consultant and was advised that he could contact the

[11] Steps is a community service run by Livewell Southwest which helps people with a range of problems and recovering from illness, to gain confidence and independence though community and group activities.

community mental health team if he needed support. Follow up calls were attempted on 19 and 20 May.

4.50 On 4 May Mr P's probation officer wrote to CP06 to advised that Mr P was subject to a Community Order that had a Mental Health Treatment Requirement for 12 months. The probation officer sought confirmation of Mr P's treatment plan and appointment schedule so that she could track his compliance, allowing her to return the matter to court if he failed to comply.

4.51 On 25 May Mr P was seen by CP07 who documented that Mr P's ADHD related physical restlessness was marked throughout the appointment and that Mr P had difficulty keeping track of the conversation; he struggled with short-term memory and disorganisation. CP07 provided a prescription of methylphenidate 19mg to be taken daily and asked Mr P's GP to increase the dose to 36mg. CP07 also noted that Mr P was on the waiting list for allocation to a care coordinator and hoped this would be expedited, but in the interim, he was receiving calls every two weeks from nursing staff. A copy of CP07's letter was sent to Mr P's probation officer.

4.52 On 8 and 9 June community mental health team staff attempted to contact Mr P but were unsuccessful.

4.53 On 16 June, a health care assistant contacted Mr P to advise that she had been allocated as his support worker and to arrange a home visit for 22 June. The visit went ahead as planned and Mr P advised that he continued to engage with probation, Harbour Drug and Alcohol Services but that he would like support from the community mental health team.

4.54 On 21 June, the community mental health team documented that Mr P was still awaiting allocation to a community support worker.

4.55 On 24 June, a support worker from Steps arranged to meet with Mr P on 29 June. This meeting did not take place because Mr P did not answer his door and although attempts were made to speak to Mr P on the phone these were not successful. Further attempts by the Steps support worker were made to contact Mr P on 14 July that were also unsuccessful.

4.56 On 1 July, the community support worker from the community mental health team confirmed that Mr P did require a care coordinator. Arrangements were made for a student nurse to visit Mr P on 14 July but there is no indication this visit went ahead.

4.57 On 14 July it was again documented that Mr P was waiting for a care coordinator to be allocated to him. It was agreed that the community support worker could discharge Mr P from her caseload because he was receiving input from a support worker from Steps.

4.58 Further attempts by the Steps team and the community mental health team to contact Mr P in June were unsuccessful.

4.59 Mr P did not attend his appointment with CP07 on 16 September. CP07 documented that there was difficulty maintaining engagement with Mr P but noted that there were no reported concerns from third parties in recent months. The plan was for Mr P to be discussed in the next multi-disciplinary team meeting and a further outpatient appointment to be arranged for three months later.

4.60 Further attempts to contact Mr P by telephone and home visits in September were also unsuccessful.

4.61 On 4 October, the support worker from Steps documented that he had still not been able to contact Mr P and that he would contact Mr P's probation officer that week to identify what options were available.

4.62 On 11 October, the support worker from Steps spoke to a duty worker at probation who advised that Mr P had been seen on 20 September and was due to be seen again on 18 October. No concerns had been documented about Mr P in September and it was agreed that Mr P's probation officer would contact Steps when she was in the office the following week.

4.63 On 20 October Mr P's probation officer contacted his support worker from Steps to advise that Mr P had attended his appointment with her and appeared to be well and stable in mood. It was subsequently agreed by the team manager that Mr P could be discharged from the support worker's caseload because he had not engaged and appeared to be managing well without support.

4.64 On 30 November community mental health team staff informed Mr P's probation officer that Mr P had been discharged from the support worker's caseload and that he had not attended his outpatient appointment with CP07. They also advised that staff had tried on a number of occasions to see or speak to him, but Mr P had not responded. Mr P was due to see CP06 on 19 January 2016 and staff asked that the probation officer inform Mr P of how he could contact the community mental health team if he wanted to discuss his mental health.

4.65 Also, on 30 November Mr P attended an appointment with his GP who documented that Mr P was paranoid, experiencing social phobia, had strong thoughts of self-harm and harm to others, hearing negative voices. The GP therefore requested an urgent review by the community mental health team.

4.66 On 5 December Mr P's probation officer called the community mental health team to advise that his mental health was deteriorating. It was agreed that community mental health team staff would attempt to see Mr P at home on 8 December. This information was given to Mr P's probation officer who also advised that Mr P collected his methadone from a specific community pharmacy on a Wednesday and that a message could be left with pharmacy staff.

4.67 The following day Mr P's probation officer emailed community mental health team staff to advised that he had been experiencing high levels of auditory

hallucinations, scored by Mr P as eight in a range of zero (low) to ten (high). He was paranoid and believed that the television and other appliances were sending messages to him. He had been using up to £80 worth of heroin per day. The probation officer advised against a lone home visit due to the risks to staff and advised that he was due to see her at the Probation office on 7 December. She also advised that Mr P had 29 convictions, 19 of which involved violent offending. Community mental health team staff forwarded the email to the clinical manager of the community forensic team for advice and to see whether he would be able to attend the visit at the probation office the following day.

4.68 On 7 December, the community forensic team clinical manager attempted to see Mr P with his probation officer. Mr P did not attend the appointment and therefore the clinical manager and the probation officer attempted to see Mr P at home. Mr P was leaving the property as they arrived and appeared to have forgotten about his appointment. He stated he had to collect his methadone and therefore staff walked with him hoping to engage him in conversation and to persuade him to attend the probation office which was nearby. The clinical manager documented that Mr P appeared to be disorientated in the "context of auditory hallucinations, rather than withdrawal from substances or through use of substances". He appeared physically unwell and was dishevelled. The clinical manager documented that his impression was that Mr P was using substances to manage an increase in auditory hallucinations and that his mental state was deteriorating. He recommended that proactive attempts were made to see Mr P.

4.69 Community mental health team staff were unable to contact Mr P and on 8 December they asked the home treatment team to accept a referral because they would be able to contact Mr P outside normal working hours. The home treatment team did not accept the referral because it was felt that the entry from the community forensic team clinical manager did not specifically identify home treatment as the most appropriate way forward.

4.70 The community mental health team clinical manager therefore contacted an Approved Mental Health Professional (AMHP)[12] to discuss the situation. The AMHP recommended that the community mental health team continue to engage Mr P and that on 12 December a Mental Health Act assessment be considered. The AMHP later advised that Mr P had been "picked up" on Section 136 Mental Health Act assessment. Arrangements were therefore made for Mr P to be seen by CP06 on 12 December. Mr P's probation officer contacted the community mental health team (whilst she was off duty) and advised that she intended to attend the appointment on 12 December in order to see Mr P.

4.71 On 9 December the home treatment team service manager advised that the decision made by home treatment team staff not to see Mr P was not

[12] Approved Mental Health Professionals (AMHPs) are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act. They are responsible for coordinating a person's assessment and admission to hospital if they are detained. They may be social workers, nurses, occupational therapists, or psychologists.

appropriate and asked staff to assess Mr P and to establish what had happened with the Section 136 Mental Health Act assessment. It was later established that there was no record of an assessment under Section 136 Mental Health Act and it remains unclear how this misunderstanding came about. Home treatment team staff also advised that they had spoken with the community forensic team clinical manager who had indicated that it was unlikely Mr P would engage with home treatment team staff. The plan was for home treatment team staff to also attend the appointment with CP06 and that if Mr P did not attend that or the probation appointment a Mental Health Act assessment may be necessary.

4.72 Mr P did not attend the appointment with CP06 on 12 December and the following day a request by CP06 for community mental health team staff to conduct a home visit was discussed and declined on the basis of the risks identified by Mr P's probation officer. It was documented that the AMHPs were aware of the situation and that they needed to know if Mr P would accept informal admission or input from home treatment team staff before they could consider a Mental Health Act assessment.

4.73 On 15 December community mental health team staff attended Mr P's home on two occasions but Mr P was not at home. Contact was made with the duty AMHP who advised that staff contact Mr P's probation officer as he may be in breach of his licence. Probation office staff were contacted, and they advised that Mr P was not on licence and therefore he could not be recalled. Community mental health team staff therefore again requested a Mental Health Act assessment which was declined on the basis that there were insufficient grounds for a warrant or a Mental Health Act assessment. The AMHP suggested that community mental health team staff contact the police for a welfare check. Community mental health team staff contacted the police but were advised that because there was not an "immediate threat to life" the police would not attempt to see him but would log him as a missing person.

4.74 On 16 December police contacted community mental health team staff requesting more information about Mr P. This resulted in the police treating him as a "medium risk" missing person which meant they would be actively looking for him.

4.75 On 17 December, the police again contacted the community mental health team asking for confirmation about specific aspects of Mr P's appearance. Staff from the community mental health team and the inpatient unit were unable to provide the confirmation being sought. Later that day police advised that they had found a body in Mr P's flat that they were seeking to identify.

4.76 On 18 December, the police advised inpatient staff that they had identified that the body at Mr P's flat was not him and that Mr P was a suspect in their investigation.

5 Duty of Candour

5.1 We have reviewed the Trust's recording of its actions under the Care Quality Commission Regulation 20: Duty of Candour. Regulation 20 was introduced in April 2015 and is also a contractual requirement in the NHS Standard Contract. In interpreting the regulation on the Duty of Candour, the Care Quality Commission uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- **"Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it."

5.2 To meet the requirements of Regulation 20, a registered provider has to:

- "Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person."

5.3 We have included the full excerpt of the regulations at Appendix D.

5.4 The regulations are clear that the "relevant person" to whom Duty of Candour applies means the service user, or on the death of the service user, a person acting lawfully on their behalf.

5.5 In this case therefore, Mr P was the "relevant person".

5.6 Livewell South West has stated in the internal investigation report that Duty of Candour had been applied:

- staff were trying to ascertain whether they could visit Mr P in the hospital wing of the prison where he was detained; and
- staff had telephoned and written to Mr G's sister.

5.7 Staff did the right thing by trying to visit Mr P. However, in the absence of being able to do so, it would have been appropriate for a Duty of Candour letter to have been sent to him. We saw no evidence that Livewell Southwest had a process in place to monitor and oversee that Duty of Candour is correctly applied in each instance.

5.8 On the assumption that Mr G was not a patient of Livewell South West, technically Duty of Candour did not apply to him. However, it is good practice and in the spirit of Being Open to have made contact with Mr G's family.

Recommendation 1: Livewell Southwest must ensure that the policy and procedure on engagement and support of families of victims and perpetrators involved in serious incidents to comply with current guidance.

6 Internal investigation

6.1 The terms of reference for this independent investigation require us to review the internal investigation, in particular the adequacy of its findings, recommendations and implementation of the action plan and identify:

- if the investigations satisfied their own terms of reference;
- if all key issues and lessons have been identified and shared; and
- whether recommendations are appropriate, comprehensive and flow from the lessons learnt.

6.2 We are also required to:

- review progress made against the action plans;
- review processes in place to embed any lessons learnt and any evidence to support positive changes in practice; and
- review the clinical commissioning groups oversight of the resulting action plan.

6.3 We have developed a robust framework for assessing the quality of investigations based on international best practice, called the Niche Investigation Assurance Framework (NIAF). We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency,[13] NHS England Serious Incident Framework (SIF) and the National Quality Board Guidance on Learning from Deaths.[14] We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

6.4 In developing our framework we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA^2 (or Root Cause Analysis and Action, hence 'RCA Squared')[15] which discusses how to get the best out of root cause analysis investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

6.5 The warning signs of an ineffective RCA investigation include:

- There are no contributing factors identified, or the contributing factors lack supporting data or information.

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

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

[15] National Patient Safety Foundation (2016) - RCA2 - Improving Root Cause Analyses and Actions to Prevent Harm – published by Institute of Healthcare Improvement, USA.

- One or more individuals are identified as causing the event; causal factors point to human error or blame.
- No stronger or intermediate strength actions are identified.
- Causal statements do not comply with the 'Five Rules of Causation'.[16]
- No corrective actions are identified, or the corrective actions do not appear to address the system vulnerabilities identified by the contributing factors.
- Action follow-up is assigned to a group or committee and not to an individual.
- Actions do not have completion dates or meaningful process and outcome measures.
- The event review took longer than 45 days to complete.

6.6 We also considered proposals for the new NHS Improvement Patient Safety Incident Response Framework on how to improve learning from investigations which has identified five key problems with the current application of the process:

- defensive culture/lack of trust, e.g. lack of patient/staff involvement;
- inappropriate use of serious incident process, e.g. doing too many, overly superficial investigations;
- misaligned oversight/assurance process, e.g. too much focus on process related statistics rather than quality;
- lack of time/expertise, e.g. clinicians with little training in investigations trying to do them in spare time; and
- inconsistent use of evidence-based investigation methodology, e.g. too much focus on fact finding, but not enough on analysing why it happened.

6.7 Our detailed review of the internal report is at Appendix E. In summary we have assessed the 25 standards as follows:

- Standards met: 15.
- Standards partially met: 6.
- Standards not met: 4.

[16] Marx, D. Patient safety and the "just culture": a primer for health care executives. New York: Columbia University Press, 2001.

6.8 We discuss our analysis below.

Analysis of Provider internal investigation

6.9 The date of the incident was 18 December 2016, but the internal investigation did not start until 15 September 2017. At interview we were told that the clinical commissioning group had agreed a 'stop-the-clock' extension because of the ongoing police investigation. There was some confusion within Livewell Southwest about the involvement of NHS England in the investigation process and whether this would impact the need for an internal investigation. It remains unclear to us why Livewell Southwest would not follow their own serious incident policy in order to complete the internal investigation in accordance with their own processes.

6.10 The terms of reference were set by the Livewell Southwest Serious Incident Panel and included establishing the facts of what happened to Mr G, when, where, how and why. This is not an appropriate remit for a serious incident investigation and indeed the investigation team were unable to meet this term.

6.11 There is no description of how staff were supported following the incident and no evidence of input to the investigation from Mr P, his family, or Mr G's family. Mr G's sister was however contacted by the lead investigator who explained the role of the investigation and why there had been a delay in the investigation starting.

6.12 The investigation team identified good practice, missed opportunities, and contributing factors.

6.13 The root cause section was completed but it does not identify a single root cause or discuss the absence of a root cause. It does however identify missed opportunities where Mr P's care could have been better organised:

- not asking for full forensic history when probation services were known to be involved;
- no clear sharing of information from Lead Professional Consultant via multi-disciplinary team regarding probation involvement;
- referral/involvement of community forensic team when Community Order with mental health treatment requirements known – the probation order information was known by only one person until October 2016;
- allocation of a care coordinator and being on Care Programme Approach;
- multi-professional meeting being organised in September 2016;
- involvement of the multi-disciplinary team when being considered for discharge from community support worker caseload;
- probation being made aware of Mr P's failure to attend appointments in September 2016 and not meeting the probation order requirements;

- Mental Health Act assessment process not being commenced in December 2016; and
- professional differences not being escalated.

6.14 There were seven recommendations made:

R1 All multi-disciplinary team actions to be followed up and recorded in tabbed journal.

R2 All professional letters to be copied into whoever is identified as working with the person, e.g. Harbour, Probation.

R3 Mr P's Care Programme Approach risk assessment to be updated to reflect forensic history and incident.

R4 Full forensic history from PNC [Police National Computer] if agencies such as probation are involved.

R5 Thresholds for Care Programme Approach to be reinforced – Mr P would have fitted the criteria.

R6 When Community Orders with a Requirement for Mental Health Treatment are considered or in place, a referral must be sent to the community forensic team. Patients should be stepped up to Care Programme Approach, if not the rationale/reasons must be clearly documented in the [patient] record.

R7 Escalation route to be clarified when professional difference regarding needing a Mental Health Act assessment.

6.15 We broadly agree with the findings and recommendations made by the Livewell Southwest internal investigation. We have however explored the issues further in our analysis and note that further emphasis could have been placed on the long-term lack of risk assessments.

Action plan

6.16 The Provider developed an action plan that included all the recommendations as set out above. Two further actions were identified that included sharing the report with the community mental health teams and the AMHPs and sending a "letter of comfort" to the family "as requested".

6.17 We have provided a summary of actions and completion timeframes in Table 1 below.

Table 1: Summary of provider action plan

Rec	Action	Date completed
1	Shared with community mental health team staff and all multi-disciplinary team minutes are now recorded in	31/12/2017

Rec	Action	Date completed
	SystemOne (electronic patient record). Monitored through caseload management.	
2	This was shared with community mental health team staff. Monitored through caseload management.	31/12/2017
3	Mr P's Care Programme Approach risk assessment to be updated to reflect forensic history and incident.	19/03/2019
4	This is to be shared with community mental health team staff. Monitored through caseload management.	19/03/2019
5	This is to be shared with community mental health team staff. Monitored through caseload management.	19/03/2019
6	This is to be shared with community mental health team staff. Monitored through caseload management.	19/03/2019
7	Discussion and pathway agreed by Community Mental Health Team and AMHP Manager – to be shared across mental health services.	19/03/2019

6.18 The actions described in the action plan were not completed in a timely fashion. In addition, we have not been provided with evidence of their implementation nor an assessment of how the lessons learned have been embedded within the organisation.

6.19 There is a significant focus on monitoring actions through the use of caseload management. We would expect to see a greater description of how this is being undertaken, which teams are involved, what the findings are, and how assurance was then established.

6.20 We asked Livewell Southwest to share a copy of the evidence the organisation had used to provide assurance of the progress of the action plan. However, we received no information. Because of this, we are unable to assess how effective the caseload management monitoring process is in ensuring that the recommendations are implemented, or whether it has identified any ongoing or new concerns.

6.21 Following circulation of the report for factual accuracy comments we received an updated action plan that included further narrative about the efficacy of the actions taken. However, we have seen insufficient source evidence to be able to provide an independent assessment of the implementation of the recommendation or the efficacy. In addition, the narrative raises further concerns that the organisation has to address, for example the issue of PNC information being included in risk assessments, but the document then cannot be shared.

6.22 We note that the action plan states that the pathway for Community Orders with a Requirement for Mental Health Treatment would not include Livewell Southwest. In addition, no process has been implemented to rectify the communication about these issues.

6.23 The terms of reference for our investigation required us to review processes in place within the CCG and provider to manage the quality of the internal investigation, and the processes in place to embed the lessons learned. We sought to obtain more information about these aspects but did not receive a response to our requests.

6.24 See our Recommendation 2.

Clinical commissioning group sign off

6.25 The administrative process for managing the submission, quality assurance and closure of a serious incident investigation report is set out in the NHS NEW Devon CCG Policy for Managing Serious Incidents. That policy includes the process for placing a 'stop the clock' on an incident:

"Incidents that involve a death or that have been agreed as [stop the clock] (STC) should continue to be investigated where possible and the investigation report submitted within the usual timeframe. The incident will be noted as STC until the outcome of, for example, the coroner's inquest, is known. Once the reporting organisation is informed of the Coroners verdict, this should be forwarded to the NEW Devon CCG allowing for the incident to be reviewed with the new information and closed on STEIS[17] in the usual way..."

6.26 We can see that there were a number of exchanges between Livewell Southwest and the CCG regarding the extension to the deadline for the internal investigation. These indicate that Livewell Southwest was advised by the police not to start the review until after the court proceedings had concluded (it was expected to be early June 2017).

6.27 We can see that from email correspondence that the CCG received the investigation report on 31 July 2018. The email states that the report was reviewed by two CCG officers and closure was agreed. We have not seen a copy of the review document.

6.28 We asked the CCG to provide information in support of the CCG oversight of the progress of the action plan and were advised that these are "monitored and escalated through clinical commissioning group assurance processes and mechanisms". These include:

- Review of Trust's monthly Performance & Quality Reports.
- Review of Trust's monthly Governance Committee Report.
- Clinical Commissioning Group Associate Chief Nursing Officer attendance at Trust's monthly Governance Committee meeting.

[17] Strategic Executive Information System (StEIS) is the serious incident recording system used in the NHS

- Review of and thematic analysis of Yellow Cards – all, including mental health providers.
- Monitoring of and thematic analysis of serious incidents – all, including mental health.
- Monitoring of and thematic analysis of clinical commissioning group complaints – all, including mental health.
- Internal Quality Reporting through the clinical commissioning group Quality Assurance Framework (QAF), Flash Reports and so on, to the Quality Assurance Committee (then Quality Committee).

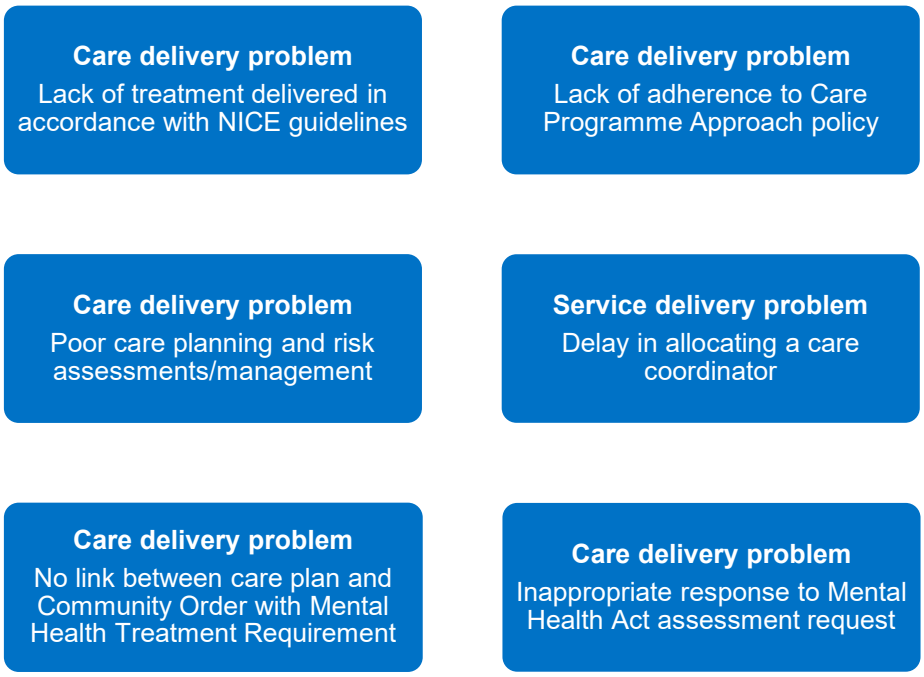
6.29 We have not been provided with any evidence of discussions about the actions related to this investigation.

Recommendation 2: NHS Devon Clinical Commissioning Group and Livewell Southwest must ensure that serious incidents are investigated in accordance with the Serious Incident Framework, that provider action plans are monitored, that assurance is sought and provided, and that action plans are completed, and changes to clinical practice and patient care are monitored.

7 Discussion and analysis of Mr P's care and treatment

7.1 We identified a number of care and service delivery problems associated with Mr P's care and treatment. We have summarised these in Figure 2 below and discuss them in further detail in the following sections.

Figure 2: Care and service delivery problems associated with Mr P's care and treatment



Diagnoses

7.2 Mr P was described as having complex mental health needs, compounded by a history of drug and alcohol misuse. During the period of time we have reviewed, we can see that he was ascribed a number of diagnoses:

Date	Diagnosis	Where documented
17 May 2013	Alcohol dependence syndrome. Borderline emotionally unstable personality disorder.	Letter from Avon and Wiltshire Partnership NHS Foundation Trust (AWP) to Mr P's GP in Bristol.
20 Aug 2014	Personality disorders.	GP summary.
11 Jun 2015	Emotionally unstable personality disorder. Moderate depressive episode.	Home treatment team community review.
26 Jun 2015	Emotionally unstable personality disorder. Moderate depressive episode.	Home treatment team discharge review.

Date	Diagnosis	Where documented
15 Jul 2015	Schizoaffective disorder. Post-traumatic stress disorder.	Letter from CP05 to Mr P's GP.
19 Aug 2015	Schizoaffective disorder.	GP summary.
2 Oct 2015	Schizoaffective disorder. Post-traumatic stress disorder ADHD.	Letter from CP05 to Mr P's GP.
6 Oct 2015	Not confirmed as needed to be assessed on the ward for a few days.	Multi-disciplinary team ward round.
8 Nov 2015	Depression. Anxiety. Paranoid delusions.	Home treatment team advice note.

7.3 It was also reported in Mr P's Care Programme Approach risk assessments that he had previous diagnoses of borderline personality disorder, depression and schizoaffective disorder. It is not clear to us how these previous diagnoses informed his care and treatment by Livewell Southwest.

7.4 We have benchmarked the interventions offered by Livewell Southwest against the NICE guidance for the:

- Prevention and management of psychosis and schizophrenia with the full analysis in Appendix F.
- Post-traumatic stress disorder with the full analysis in Appendix G.

7.5 Mr P did not receive NICE compliant treatment for the management of his psychosis:

- staff did not take time to build supportive and empathic relationships with Mr P;
- peer support delivered by a trained peer support worker was not offered;
- psychological interventions were not offered; and
- long-acting injectable anti-psychotic medication was not offered.

7.6 The lack of a supportive and empathic relationship with a care coordinator was a significant absence in Mr P's treatment plan. We address this further on page 47.

7.7 Mr P also did not receive care and treatment for post-traumatic stress disorder that was compliant with NICE guidelines:

- there is little evidence that staff considered Mr P's presentation in the context of the diagnosis of post-traumatic stress disorder;
- support in this context was not provided when moving between services; and
- risk assessments were not developed in the context of post-traumatic stress disorder.

7.8 The combination of the lack of compliance with NICE guidelines for these two significant diagnoses was not insignificant. Mr P struggled with trusting staff and found it difficult to manage the variety of staff that were involved in his care when on the caseload of the home treatment team. Greater consideration should have been given to the impact of these diagnoses on his presentation and the way he interacted with services.

Recommendation 3: NHS Devon Clinical Commissioning Group and Livewell Southwest must ensure that care and treatment for psychosis and schizophrenia, and post-traumatic stress disorder is delivered in accordance with the relevant NICE guidelines.

Risk assessments

7.9 The Care Programme Approach policy[18] provides guidance on the completion of risk assessments. This states that a risk assessment should be updated when additional information becomes available and reviewed every six months. The risk assessment is a holistic assessment and is the method of identifying health and social care risks that should be carried over to the care plan, "professionals are responsible for fully completing the narrative elements detailing specific risks".

7.10 The policy sets out the expectation of a minimum assessment for those patients who are not accepted onto team caseloads, for patients on standard care and for patients on Care Programme Approach.

7.11 There is a list of circumstances that should always prompt the completion of a risk assessment, this includes:

- when there is a change in mental health presentation; and
- patients awaiting allocation of a care coordinator when the risk assessment template must be completed every two weeks.

7.12 We can see that a number of risk assessments were completed for Mr P between June 2015 and March 2017. We have summarised these in Table 2 below.

[18] Care Programme Approach Policy version 1.3

Table 2: Summary of risk assessments completed

Date	Risks/new risks identified	Risks to be taken into care plan
8 Jun 2015	Overdose of mirtazapine and olanzapine two days previously, ten days previously. Ligature attempt reported aged seven years. Felt he would be better off dead. Deterioration in mood over previous months – presented with poor eye contact, passive nature. Described derogatory voices telling him to harm himself. Had not acted on voices, recent overdose due to low mood. Self-reported weight loss. Difficulty maintaining hygiene – presented with body odour and unkempt smell, fingernails very dirty. Using heroin twice a week as well as methadone prescription. History of alcohol abuse, attended rehab in Plymouth. Not compliant with olanzapine or mirtazapine. Self-reported violent history – when paranoid Mr P had hit and kicked people when he felt under threat. Information from referrer reports past forensic history related to assault. Major mental health diagnoses: emotionally unstable personality disorder	Moderate depression on background of emotionally unstable personality disorder, biological symptoms of depression present, trauma in childhood. Experienced internal critical voices for "as long as he can remember". Recent deterioration in mood. Home treatment team to liaise with Harbour drugs worker. Home treatment team to complete ongoing assessment as Mr P not known to mental health services in Plymouth. Joint visits to home address due to drug use and unknown acquaintances. Prozac 20mg prescribed.
27 Jun 2015	No thoughts of suicide expressed, however unwilling to discuss this in depth. Mr P felt little efficacy from fluoxetine, sporadic compliance with medication but was collecting methadone from pharmacy. Little improvement in mood but no further deterioration.	Mr P no longer willing to engage with home treatment team. More comfortable discussing problems with Harbour drugs worker and his GP and happy for transfer of care back to Harbour. Refused seven days of medication offered and said he would collect it from his GP.
3 Oct 2015	Major mental health diagnoses: borderline personality disorder, depression, schizoaffective disorder. Emotionally unstable personality	Major mental health diagnoses: depression, anxiety, paranoid delusions

Date	Risks/new risks identified	Risks to be taken into care plan
	disorder diagnosed by services in Bristol in 2013. Reported no control over his life due to delusions, believes thoughts were put into his head to control him and could not distinguish between these and his own thoughts. Reported that his flat was bugged with cameras but could not identify who had placed them there, believed that people outside wanted to kill him. Evidence of paranoid delusions during admission assessment. Reported that he could see a person in the room during assessment. Delusional speech present, grandiose ideas – claimed he had powers that others did not, said he would jump off a bridge because nothing could hurt him. Father passed-away in January 2015. Reported growing up in foster care, disclosed previous sexual abuse and bullying. Positive for Hepatitis C. Reported that he had served prison sentence for Grievous Bodily Harm.	about others, hallucinations. No control over life, failing to eat properly, difficulty maintaining hygiene, previous incidents of violence, violent command hallucinations, abuse of others.
6 Oct 2015	No change.	No change.
8 Oct 2015 completed at 01:20	On 6 October Mr P placed his hand under the boiler for two seconds causing minor burn. Failed to return from leave as planned on two occasions, Mr P returned of own accord approximately three hours late.	Failure to return from leave as planned.
8 Oct 2015 completed at 08:57	Reported auditory hallucinations telling him to harm himself whilst on leave, did not act on them.	No change.
9 Nov 2015	Picked up on Section 136 Mental Health Act two days previously, was intoxicated and standing on a wall threatening to jump. Fluctuating thoughts about suicide and self-harm, reported doing "stupid things" and getting picked up by the police. Stated that it would have been his father's birthday that day.	No change.

Date	Risks/new risks identified	Risks to be taken into care plan
	Previous date of discharge/transfer from last care setting documented as 8 June 2015. N.B. This assessment failed to recognise that Mr P had been discharged from inpatient care just one month previously.	
17 Nov 2015	Reported having no money for food, requested food vouchers as all money had been spent on alcohol. Friend present. Appeared to have showered but fingernails still dirty and unkempt. Suspected non-compliance with medication – fluoxetine noted on floor in flat and medication scattered around the house. Mr P reported his friend looked after his medication, but this was denied by his friend. Continued to withdraw from alcohol/substance misuse – drinking six litres of cider per day. Too paranoid to answer the door (11 November) and reported the voices were worse at night.	No change.
12 Dec 2015	Believed he had a lack of control in his life, high expectations of what home treatment team and other services could offer him. Believed he was eligible for a social worker – stated a member of staff on Harford ward (Glenbourne) told him this. Moderate distress related to hearing voices. Did not take responsibility for current stressors, indicating sense of helplessness. Recently stopped drinking after drinking "a colossal amount" for a number of months. No support network in Plymouth, but a friend called "G" (believed to be Mr G, his victim) who helped him with preparing meals and ensuring he drank "adequate amounts". Erratic engagement with home treatment team indicated he had missed some doses of medication. Discharged from home treatment team into the care of GP, with	

Date	Risks/new risks identified	Risks to be taken into care plan
	support from Harbour. Outpatient appointment with CP06 (consultant psychiatrist) in January 2016.	

7.13 We can find only one risk summary document. This was completed on 3 October 2015 on admission to Harford Ward (mental health ward). This document summarised Mr P's history of suicide attempts that included hanging, overdose of medication and attempts to jump from bridges. It also documented that Mr P reported:

- being admitted to a psychiatric intensive care unit following self-harm in early 2015;
- that he had served a prison sentence for GBH;
- that he had a forensic history of assault, criminal damage and dangerous driving; and
- that when he had felt paranoid in the past he had hit and kicked people when he felt threatened.

7.14 It appears that Mr P's risk assessments were appropriately reviewed during contact with inpatient services and the home treatment team during 2015. However, we can find no evidence of any risk assessments being completed or reviewed during 2016. This is of particular concern because:

- It was at a time when Mr P was waiting for a care coordinator to be allocated to him – organisational policy states that risks should be reviewed every two weeks in these circumstances.
- On 19 January 2016, the organisation had been asked to provide a psychiatric report for court.
- On 21 April 2016 Mr P was given a Community Order with a Mental Health Treatment Requirement. A copy of this order was sent to CP06 on 4 May 2016.
- By 29 September 2016, just prior to leaving her post, CP07 was aware that Mr P had informed his probation officer that he had received no contact from mental health services since May 2016. CP07 suggested that a multi-professionals meeting be arranged in the near future in order to review his progress and remind him that engaging with mental health services was a requirement of his Community Order.
- On 6 December, the community mental health team received a letter from GP3 who advised that he had seen Mr P the previous day at the request of Mr P's probation officer. Mr P had described increased paranoia,

thoughts of harming others, hearing voices, and feeling that people were able to "put stuff in his head".

7.15 We can see no evidence that Mr P's risk was reviewed in accordance with the policy whilst he was waiting for a care coordinator to be allocated to him. We discuss the delay in more detail in the next section, but Mr P waited more than 120 working days for a care coordinator to be allocated. According to the policy the risk assessment template should have been completed every two weeks (every ten working days). We found no evidence that the risk assessment template had been completed at all during this period.

Recommendation 4: Livewell Southwest must provide assurance to their commissioners and the Board that risk assessments are undertaken and documented in accordance with organisational policy.

Care planning and use of Care Programme Approach

7.16 The Livewell Southwest Care Programme Approach Policy is described as the "principle framework" for providing services to patients needing mental health care and treatment by the organisation. The policy describes patients who would likely be allocated to standard care as those receiving services from:

- memory services;
- care homes;
- where only one professional is involved;
- patients who are low risk to themselves or others; and
- unlikely to disengage from services.

7.17 It states that all patients receiving services under Standard Care will have a Lead Professional who will be a practitioner of Band 4 or above who has primary responsibility for delivering care.

7.18 The policy describes those patients assessed as needing Care Programme Approach as being:

- anyone needing admission to an inpatient unit, under the care of the assertive outreach service or the home treatment team;
- where the practitioner will be responsible for coordinating the involvement of more than one agency;
- medium to high risk to themselves or others;
- likely to disengage from services or difficulties with engagement;
- little or no supportive networks; and

- multiple service provision from different agencies including housing, physical care, employment, criminal justice, voluntary agencies.

7.19 Patients who are assessed as needing Care Programme Approach will have a named care coordinator who will take responsibility for coordinating all the functions of Care Programme Approach. The care coordinator will be a Band 4 or above from any profession within the multi-disciplinary team.

7.20 It is unusual for a Care Programme Approach care coordinator not to be a registered mental health nurse, social worker, or occupational therapist.[19]

7.21 Patients who have been referred for a care coordinator should have one allocated within a maximum of ten working days of an assessment being completed. If allocation is not possible within this time frame "individual operational policies should be consulted for the process of managing this" and risk review should be maintained in accordance with operational policies.

7.22 The policy is also clear about patients who have co-existing mental health and alcohol or drug problems (dual diagnosis). It recognises that there are a number of increased risks such as:

- suicide;
- non-engagement and non-compliance;
- poorer prognosis; and
- social exclusion.

7.23 The policy states that the primary responsibility for care planning sits within mental health services.

7.24 Mr P was initially managed on Care Programme Approach but was transferred to Standard Care on 26 June 2015 after the home treatment team was unable to engage him in treatment. The decision was taken because home treatment team staff were transferring care coordination responsibility to Mr P's support worker at Harbour Drug and Alcohol Service. We would question this decision, given the statements within the Care Programme Approach Policy about increased risks for patients with dual diagnosis.

7.25 Mr P was moved back to Care Programme Approach when he was admitted to Harford Ward on 2 October 2015. We consider that this decision was in accordance with the policy.

7.26 We have seen evidence of four Care Programme Approach review meetings were held for Mr P but he was not always present for the discussion:

[19] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

- 26 June 2015 – present were home treatment team staff, Mr P, and his drugs worker from Harbour (HDAS2). The review took place because Mr P's care was going to be managed solely by HDAS2. Mr P was transferred to Standard Care.

- 8 October 2015 – during ward round whilst an inpatient on Harford Ward. The review took place because Mr P's care was being transferred to the home treatment team on discharge from inpatient care. Mr P was to remain on Care Programme Approach and nursing staff were to request the allocation of a care coordinator.

- 20 October 2015 – completed by the home treatment team with no other parties present, in order to discharge Mr P from their caseload and transfer to HDAS2. Mr P had not responded to numerous attempts by home treatment team staff to contact him.

- 12 December 2015 – completed by the home treatment team with input from Mr P prior to discharge from the home treatment team. Increasingly erratic engagement with the home treatment team since 8 November. Mr P reported he had recently stopped drinking and was experiencing auditory hallucinations and paranoid ideation. Mr P was concerned about who would be following him up after discharge from the home treatment team. Discharged into the care of his GP with support from HDAS2. Outpatient appointment with CP02 on 26 January 2016. Mr P to remain on Care Programme Approach.

7.27 It is unclear to us how Mr P could have remained on Care Programme Approach when the decision had been taken to discharge him into the care of his GP. It is our view that these two decisions combined (remaining on Care Programme Approach and discharge back to GP) are incompatible and therefore outside of policy.

Recommendation 5: Livewell Southwest must provide evidence assurance to their commissioners and the Board that discharge decisions are taken in accordance with organisational policy.

7.28 We have reviewed the care plans and crisis/contingency plans that had been written for Mr P. A summary of these can be found in Table 3 below.

Table 3: Summary of care plans and crisis/contingency plans

Date	Care plan	Crisis/contingency plan
8 Jun 2015	Care Programme Approach care plan. You are experiencing an increase in thoughts of self-harm and decrease in mood. Agreed to work with home treatment team who will monitor symptoms, risks, and effectiveness of medication. Home treatment team will	Not completed

Date	Care plan	Crisis/contingency plan
	prescribe and provide Prozac. You will continue to obtain methadone prescription via usual method – daily collection from pharmacy. Home treatment team will liaise with Harbour drugs worker.	
3 Oct 2015	Care Programme Approach care plan. Managing mental health – admitted to Harford Ward after outpatient review appointment with CP02 (consultant psychiatrist). Nursing observations every 15 minutes, administration of medication (regular and as required), review future care, treatment, and discharge arrangements, provide one-to-one time with nursing staff daily. Monitor and encourage dietary intake using a food chart, refer to physical health specialist regarding reported foot pain. Monitor opiate withdrawal using Clinical Opiate Withdrawal Scale four times daily.	Take my regular medication and as required medication when offered. Engage with my named/ associate nurse. Engage during weekly ward round reviews Engage with occupational therapy department to learn and develop coping mechanisms. I will present as more withdrawn when I feel increasingly agitated. I can approach any member of the nursing team if I feel distressed. I have not yet given consent for nursing staff to share information with my family/carers.
8 Oct 2015 01:20	Care Programme Approach care plan. Managing mental health – did not return from ward leave as planned, Mr P reported that he struggled with auditory hallucinations which told him to harm himself and not return to the ward. Nursing observations every 15 minutes, administration of medication (regular and as required), review future care, treatment, and discharge arrangements, provide one-to-one time with nursing staff daily. Monitor and encourage dietary intake using a food chart, refer to physical health specialist regarding report foot pain.	Take my regular medication and as required medication when offered. Engage with my named/ associate nurse Engage during weekly ward round reviews Engage with occupational therapy department to learn and develop coping mechanisms. I will present as more withdrawn when I feel increasingly agitated. I can approach any member of the nursing team if I feel distressed. I have not yet given consent for nursing staff

Date	Care plan	Crisis/contingency plan
		to share information with my family/carers.
8 Oct 2015 08:57	Care Programme Approach care plan. As per plan timed at 01:20 with the following added: You are being nursed on general observations which means hourly checks. You are hearing voices less since being on the ward and fewer thoughts about harming yourself. You have told the nursing team that you enjoy going on leave because you find the ward "boring".	As per plan timed at 01:20.
8 Oct 2015 18:39	Care Programme Approach care plan. As per plan timed at 08:57 with the following added: Plan: 1. Nursing staff to request care coordination. 2. Discharge from hospital today. 3. Refer to home treatment team for follow up. 4. TTA (medication to take home) 3+4 days medication.	As per plan timed at 08:57.
17 Nov 2015	Care Programme Approach care plan. Recently assessed due to being picked up by the police because of suicidal ideation. Possible non-compliance with medication. Currently in financial difficulty due to spending benefits on alcohol. Home treatment team staff to visit on a regular basis and will link with HDAS2.	Not completed.
27 Jul 2016	Statement of care plan. Mr P to be referred to Steps, structured plans for routines and exposure to social scenarios to be created. Mr P had poor short-term memory – plan to be created to help with this. Mr P vulnerable to paranoid psychosis and dependency on opiates.	

7.29 The majority of the care plans for Mr P refer to his relatively brief period of time as an inpatient. No care plan was developed whilst he was waiting to be allocated to a care coordinator and the care plan dated 27 July 2016 referred only to the intervention by the Steps team.

7.30 The absence of crisis and contingency plans is particularly concerning given that Mr P frequently disengaged with services and then presented when in crisis. A clearly described crisis and contingency plan may have helped to ensure that the appropriate service response was in place when crises occurred and when Mr P was waiting for allocation to a care coordinator.

Recommendation 6: Livewell Southwest must ensure that crisis/contingency plans clearly describe the actions required by patients and staff when a patient is in crisis.

Allocation to a care coordinator

7.31 We can see that the plan was for Mr P to be referred for a care coordinator to be allocated to him on discharge from Harford Ward on 8 October 2015. After discharge there were attempts by the home treatment team to see him, but he did not respond so he was discharged from the home treatment team caseload. At this time Mr P's support worker at Harbour had also reported difficulties contacting Mr P and advised that Harbour were also considering discharging him from their caseload.

7.32 It appears that Mr P was never formally allocated to a care coordinator during the periods of time that he was on the caseload of the home treatment team.

7.33 We have not found evidence of a formal request for a care coordinator to be allocated to Mr P. However, the first reference in community mental health team records that Mr P was on the waiting list for a community support worker is 3 February 2016. On this basis, he should have been allocated a care coordinator by 17 February 2016.

7.34 However, in correspondence from CP06 on 23 March 2016 that Mr P reported he was still waiting for a care coordinator to be allocated to him. And in correspondence from CP07 on 6 June CP07 wrote again to say that Mr P was still waiting for a care coordinator.

7.35 On 16 June 2016 it appears that Mr P was allocated a community support worker, but records show he remained on the waiting list for a care coordinator. Mr P was discharged from the community support worker's caseload on 18 July when it was documented that he would be taken on by a care coordinator.

7.36 Mr P was eventually allocated a care coordinator on 20 July 2016, more than 120 working days after the organisation first formally documented the referral.

7.37 In the period prior to the allocation of a community support worker, we found evidence that Livewell Southwest staff were in contact with Mr P on just three occasions for what is described in the records as a "supportive phone call", there is evidence that staff made attempts to contact Mr P on four other occasions but were unsuccessful.

- 5 April 2016 – documented that it sounded as though Mr P had just woken up and that he had said he needed support with "day to day life, debt, bills and mental health stuff". Mr P also provided a brief history of his self-harming behaviour and reported that he had self-harmed several weeks previously. It was documented that the health care assistant (CMHT1) would call again two weeks later and that CP07 would be informed of the call.

- 3 May 2016 – documented that Mr P reported things were "good" and that he had been contacted by the Department for Work and Pensions about his benefits. HCA1 (a health care assistant) advised Mr P to seek help from the Citizens' Advice Bureau. It was documented that HCA1 would call again two weeks later.

- 19 May 2016 – a different health care assistant (HCA2) attempted to speak to Mr P on the telephone but was unable to get a response.

- 20 May 2016 – HCA2 again attempted to speak to Mr P on the telephone but was unable to get a response.

- 25 May 2016 – Mr P reported that his probation officer had helped him to complete his benefits application. His probation officer had also asked to attend his outpatient appointment with CP07. HCA1 advised that this was Mr P's choice and that he should discuss it with CP07. Mr P also said that he was still waiting for a support worker to be allocated to him.

- 8 June 2016 – a community support worker (CSW2) attempted to speak to Mr P on the telephone but was unable to get a response.

- 9 June 2016 – CSW2 again attempted to speak to Mr P on the telephone but was unable to get a response.

7.38 Livewell Southwest staff did not comply with organisational policy about remaining in contact with patients who were waiting to be allocated to a care coordinator.

7.39 In addition, there was confusion about what level of care Mr P should have been managed on. Community mental health team staff told us that at the time that they believed Mr P was being managed on Standard Care but in hindsight believed he should have been managed on Care Programme Approach. The documents we have reviewed show that his care plans indicated that he was on Care Programme Approach and remained on Care Programme Approach after discharge from the home treatment team in December 2015.

7.40 We have not been able to clarify how the misunderstanding arose, but it was clear that the issue was not identified or escalated at the time.

Recommendation 7: Livewell Southwest must provide assurance to their Board and their commissioners that a system is in place to ensure that any patient waiting longer that ten days for allocation to a care coordinator is identified and the issue escalated to an appropriate manager for action.

Inter-agency communication and liaison

7.41 Given Mr P's complex presentation, communication and liaison between the different agencies working with him would have been particularly important.

7.42 The consultant psychiatrist responsible for reviewing Mr P's medication always followed up the appointment with a letter to Mr P's GP. This contained appropriate information. There is also evidence of frequent and appropriate communication between Harbour Drug Alcohol Service staff and Mr P's GP.

7.43 There is some evidence of communication between Harbour Drug Alcohol Service staff and Livewell Southwest but the frequency of this was impacted negatively by the absence of a care coordinator.

7.44 Mr P was subject to a community order for 12 months effective from 21 April 2016. He was supervised by a probation officer from the National Probation Service who first contacted Livewell Southwest on 4 May 2016.

7.45 There is evidence of communication by Livewell Southwest staff with National Probation Service staff:

- Letter from CP06 to North Road West Medical Centre dated 24 March 2016, also copied to PO2 (Probation Officer). The letter provides a brief history, clinical update, treatment plan and details of CP06's replacement (CP07).

- Letter from CP07 to North Road West Medical Centre dated 6 June 2016, also copied to PO3 (Probation Officer). The letter provides diagnoses, medication, clinical update and treatment plan.

- Letter from CP07 to North Road West Medical Centre dated 29 September 2016, also copied to PO3. The letter advised that Mr P had not attended his appointment on 16 September and that review of clinical records showed that he had not engaged with repeated attempts by nursing staff and a community support worker to see him in the community. The letter also documented that CP07 had received an email[20] from PO3, who advised that Mr P had reported that he had received no contact from mental health services since May. CP07 documented that she had suggested that PO3 was likely to confront Mr P about this because engagement with mental health services was part of

[20] We found no evidence of the email in Mr P's clinical records.

his Community Order. CP07 also suggested that a multi-professional meeting in the near future so that this information could be made clear to him and to review his progress.

- 6 October 2016 community mental health team staff attempted to contact PO3 because staff had not been able to get in touch with Mr P. Advised that PO3 was not at work until the following week.

- 11 October 2016 community mental health team staff spoke to the duty officer at the probation service who reported that Mr P had been seen on 20 September and was due to be seen again on 18 October. It was further reported that at the time he appeared "safe and well with no concerns". Community mental health team staff advised that a multi-disciplinary team meeting was being arranged and asked that PO3 make contact when she was back in the office.

- 20 October 2016 community mental health team staff spoke to probation service staff who advised that Mr P had attended his appointment on 18 October and was "apparently managing well" and was "stable in mood".

- 30 November 2016 community mental health team staff emailed PO3 to advise that a community support worker (CSW2) had been allocated to work with Mr P and despite numerous attempts to engage with him Mr P had not responded. Community mental health team staff advised that Mr P had been discharged from CSW2's caseload and that an outpatient appointment had been arranged with CP06 on 19 January 2016 (we assume this should have read 2017). PO3 was asked to make Mr P aware that he could contact the community mental health team if he wished to discuss his mental health.

- 12 December 2016 CP06 contacted PO3 to advise that Mr P had failed to attend his appointment. PO3 advised that she had failed to make contact with Mr P, and she remained very concerned about his deteriorating mental health. CP06 documented that PO3 advised that Mr P was in breach of his probation order requiring compliance with mental health treatment, but it was "only a community order".

7.46 There is also evidence of communication from the probation service to Livewell Southwest staff:

- Letter to CP06 dated 4 May 2016 seeking confirmation of Mr P's treatment plan and appointment schedule so that his probation officer could track his compliance. Meeting with CP06 also requested. CP06 had left his locum post by this point and Mr P's mental health treatment was being covered by CP07.

- Letter to CP07 dated 2 June 2016 asking to be notified of any Care Programme Approach reviews or meetings regarding management of Mr P's mental health.

- 5 December 2016 PO3 called community mental health team staff to express concerns that Mr P's mental health was deteriorating. Later discussion within the community mental health team concluded that the Home Treatment Team worker (HTT5) would make an unannounced visit to Mr P's home address on 8 December. PO3 also advised that Mr P collected his methadone prescription from a specific pharmacy on a Wednesday afternoon, so a message could be left with pharmacy staff if required.

- 6 December 2016 PO3 emailed community mental health team staff to advise against a home visit undertaken by a single member of staff. PO3 stated that Mr P had been experiencing "high levels of auditory hallucinations" and that he had "scored them as 8 in a range of 0 to 10" (low level to high level). PO3 further advised that Mr P was due to see her the following day. PO3 advised that Mr P had 29 convictions, 19 of which had involved violent offending.

- 7 December 2016 the Community Forensic Team manager (CFT1) attended the probation office in order meet with Mr P and PO3. Mr P did not attend the appointment and therefore PO3 and CFT1 went to Mr P's home address. He did not answer the intercom but left the flat. Mr P was reluctant for CFT1 and PO3 to go inside and talk and he "could not be persuaded" to go to the probation office. CFT1 documented that Mr P appeared to be "disorientated in the context of auditory hallucinations, rather than withdrawal from substances or through use of substances". CFT1 described Mr P had looking physically unwell and dishevelled and that his opinion was that Mr P had been using heroin to manage an increase in auditory hallucinations.

7.47 There was a missed opportunity to consider liaison with the pharmacy to establish when they had last seen him. Livewell Southwest staff could have considered asking the pharmacy to contact staff when he arrived, or to use it as a method of a face-to-face assessment, or potentially an opportunity for a Mental Health Act assessment without the need for a warrant.

7.48 It is clear that there was an established route of communication between National Probation Service staff and Livewell Southwest staff. We are aware of one communication between National Probation Service staff and Livewell Southwest staff that was not documented in Mr P's clinical records (the email referenced in CP07's letter to Mr P's GP dated 29 September 2016). It is therefore possible that there were other communications that were not documented and that we therefore have not reviewed.

7.49 The quality of the information between Livewell Southwest and the National Probation Service was satisfactory in conveying information about Mr P. It is our view that the absence of a care coordinator impacted negatively on the frequency of the communication from Livewell Southwest to the National Probation Service.

7.50 The internal investigation report made a recommendation about the involvement of the community forensic team when a patient has a Community

Order with a Requirement for Mental Health Treatment. This goes some way to addressing the gap that they and we identified in Mr P's care and treatment. However, it is our view that the recommendation should also have referenced the impact that such a Community Order should have on a patient's care planning and crisis planning.

Recommendation 8: Livewell Southwest must ensure an effective local interagency protocol with the National Probation Service is developed. This should agree specific responsibilities and actions for each organisation when a patient of Livewell Southwest is subject to a Community Order with a Requirement for Mental Health Treatment. Livewell Southwest must also ensure that in such circumstances, individual care plans are aligned to the Community Order and that clinical staff engage regularly with the patient's Offender Manager.

Mental Health Act assessment

7.51 The community mental health team requested a Mental Health Act assessment for Mr P on three occasions in the eight days prior to Mr G's body being found in Mr P's flat. In our opinion the response to these requests reflect three missed opportunities to assess Mr P under the framework of the Mental Health Act:

- Thursday 8 December 2016 following Mr P being seen by the clinical manager of the community forensic team who documented that Mr P's mental state was deteriorating. The AMHP advised that the community mental health team would need to review Mr P first. A Mental Health Act assessment could then be discussed the following Monday (12 December 2016).

- 12 December 2016 by CP06 after Mr P failed to attend his appointment and following discussion between CP06 and PO2 who advised that she remained "very concerned about his deteriorating mental health". The AMHP declined the request until a member of staff had visited Mr P and offered input from the home treatment team. If Mr P declined home treatment team input, then the AMHPs would arrange a Mental Health Act assessment.

- 15 December 2016 after community mental health team staff had made two unsuccessful unannounced attempts to visit Mr P at home. The duty AMHP advised there were insufficient grounds for a warrant or a Mental Health Act assessment and advised the community mental health team to contact the police to arrange a welfare check.

7.52 We share the view of the internal investigation team that by 8 December 2016, because Mr P had already been assessed by an experienced community forensic nurse who had documented their findings, it was an

unnecessary requirement for him to be seen again by a member of the community mental health team.

7.53 The issue of the requirement for home treatment team input to be offered was escalated to the clinical team manager for the home treatment team. On 9 December 2016 she emailed her staff advising that insisting on another community mental health team assessment placed unnecessary delays in the process and this would not be good for Mr P. She asked home treatment team staff to determine whether Mr P required hospital treatment and to chase the Section 136 Mental Health Act assessment that had been mentioned in a previous clinical entry.

7.54 Home treatment team staff responded advising that there was no record of a recent Section 136 Mental Health Act assessment nor presentation in police custody. They also advised that it was felt that that Mr P would not work with home treatment team staff. This could have been considered sufficient information to proceed to a Mental Health Act assessment.

7.55 The refusal by the AMHP to apply for a warrant in order that a Mental Health Act assessment could be conducted was insufficiently explained in Mr P's clinical records. An AMHP can apply to a magistrates' court for a warrant to get access to a patient's home. The AMHP may ask for a warrant if:

- the patient is likely to refuse the health professionals entry to their home;
- there is a risk that the patient or other people with them will become violent;
- there is a risk the patient will run away before the assessment is completed; and
- the patient is likely to harm themselves.

7.56 If an AMHP believes that they will be able to safely assess a patient's mental health without a warrant, they will not apply for one. As we have stated above the duty AMHP advised community mental health team staff that he felt there were "insufficient grounds for a warrant". However nowhere is it documented in Mr P's records why the AMHP held this view.

7.57 It could also have been possible for arrangements to have been made to assess Mr P when he collected his methadone prescription. This would have negated the need for an application for a warrant.

7.58 The AMHPs were located within Livewell Southwest and ultimately reported to one of two Deputy Directors of Operations who had responsibility for social care staff that had transferred into the organisation from the local authority (Plymouth City Council).

7.59 This meant that there was opportunity for the difference of opinion regarding the appropriateness of a Mental Health Act assessment to be escalated to senior managers.

7.60 The internal investigation highlighted the concerns about the professional differences in relation to arranging a Mental Health Act assessment and made an associated recommendation. However, we have not seen any evidence that the actions put in place to respond to that recommendation have been effective.

Recommendation 9: Livewell Southwest must provide assurance to their commissioners and the Board that the escalation route for professional differences between AMHPs and community mental health team staff are used effectively and in a timely fashion.

8 Conclusions and recommendations

8.1 There were three missed opportunities to arrange a face-to-face assessment of Mr P's mental state in the days prior to the death of Mr G. Although it is not possible to be certain of the outcome of a Mental Health Act assessment, this would have provided the opportunity to ensure that a thorough assessment was made, and informed decisions were taken about how to manage his care and treatment at that time.

8.2 In addition, there were failings in the delivery of care and treatment to Mr P in the preceding 12 months when:

- risk assessments and care plans were poorly completed, missing pertinent information;
- care planning was not completed in accordance with the Care Programme Approach policy;
- a care coordinator was not allocated in accordance with Livewell Southwest policy; and
- care and treatment for psychosis and post-traumatic stress disorder was not delivered in accordance with NICE guidelines.

8.3 The internal investigation undertaken by Livewell Southwest was thorough and met the terms of reference. However, we found no evidence of robust monitoring of completion of the action plan by either Livewell Southwest or NHS NEW Devon Clinical Commissioning Group. We therefore cannot say whether the actions have resulted in appropriate changes to patient safety or the way services function.

Predictability and preventability

8.4 Predictability[21] is "the quality of being regarded as likely to happen, as behaviour or an event". 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.[22]

8.5 Prevention[23] 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

[21] http://dictionary.reference.com/browse/predictability

[22] 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

[23] http://www.thefreedictionary.com/prevent

the knowledge, legal means, and opportunity to stop the incident from occurring.

8.6 It is our view that Livewell Southwest staff could not have predicted that Mr P would kill Mr G. There were no reports of violent behaviours from either his GP or the National Probation Service.

8.7 In the 16 days prior to the discovery of Mr G's body there were, however, concerns expressed by his GP, the National Probation Service, and the manager of the community forensic team that Mr P's mental state was disintegrating. This knowledge in the context of someone with diagnoses of psychotic episodes and post-traumatic stress disorder meant that a violent outburst was more likely.

8.8 It is therefore our view that there were actions that could have been taken in the weeks and months prior that might have resulted in the prevention of Mr G's death. This could have included:

- liaison with the community pharmacy where he was known to collect his methadone to establish when Mr P was last seen;
- liaison with the community pharmacy to ensure that Livewell Southwest staff were contacted when Mr P attended the pharmacy;
- consideration of using this information as a means to secure a face-to-face assessment; and
- consideration of using this information as a means to arrange a Mental Health Act assessment.

Recommendations

8.9 This independent investigation has made nine recommendations to improve commissioning and clinical practice.

Recommendation 1: Livewell Southwest must ensure that the policy and procedure on engagement and support of families of victims and perpetrators involved in serious incidents to comply with current guidance.

Recommendation 2: NHS Devon Clinical Commissioning Group and Livewell Southwest must ensure that serious incidents are investigated in accordance with the Serious Incident Framework, that provider action plans are monitored, that assurance is sought and provided that action plans are completed, and changes to clinical practice and patient care are monitored.

Recommendation 3: NHS Devon Clinical Commissioning Group and Livewell Southwest must ensure that care and treatment for psychosis and schizophrenia, and post-traumatic stress disorder is delivered in accordance with the relevant NICE guidelines.

Recommendation 4: Livewell Southwest must provide assurance to their commissioners and the Board that risk assessments are undertaken and documented in accordance with organisational policy.

Recommendation 5: Livewell Southwest must provide evidence assurance to their commissioners and the Board that discharge decisions are taken in accordance with organisational policy.

Recommendation 6: Livewell Southwest must ensure that crisis/contingency plans clearly describe the actions required by patients and staff when a patient is in crisis.

Recommendation 7: Livewell Southwest must provide assurance to their Board and their commissioners that a system is in place to ensure that any patient waiting longer that ten days for allocation to a care coordinator is identified and the issue escalated to an appropriate manager for action.

Recommendation 8: Livewell Southwest must ensure an effective local interagency protocol with the National Probation Service is developed. This should agree specific responsibilities and actions for each organisation when a patient of Livewell Southwest is subject to a Community Order with a Requirement for Mental Health Treatment. Livewell Southwest must also ensure that in such circumstances, individual care plans are aligned to the Community Order and that clinical staff engage regularly with the patient's Offender Manager.

Recommendation 9: Livewell Southwest must provide assurance to their commissioners and the Board that the escalation route for professional differences between AMHPs and community mental health team staff are used effectively.

Appendix A – Terms of reference for independent investigation

Purpose of the Review

- To independently assess the quality of the care and treatment provided to [Mr P] against best practice guidance.
- To review the quality of the Provider's Level 2 internal investigation and its resulting action plan against the same standards.
- To comment on any resulting, embedded change to practice, service provision or systems across the organisation or local health provision.
- To identify further opportunities for learning that may be applicable on a local, regional or national basis.

The outcome of this review will be managed through corporate governance structures in NHS England, the CCG and the provider's formal board sub-committees.

Terms of reference

NB: The following Terms of Reference remain in draft format, until they have been reviewed at the formal initiation meeting and agreed with the families concerned.

Livewell Southwest commissioned an internal level 2 RCA investigation. This investigation will build on that review in the following areas:

1. Produce a full chronology of Mr P's contact with Mental Health and Primary Health Care Services to determine if his healthcare needs and risks were fully understood and that is reflected in the most recent treatment plans.
2. Review the quality of the mental health treatment/care plans in place for Mr P at the time of the incident against best practice and national guidelines.
3. Review the quality of the longitudinal risk assessments, contingency and crisis plans in place for Mr P at the time of the incident.
4. Identify any factors that hindered the risk assessment and management processes and what plans were put in place to mitigate those risks
5. Review the quality of interagency and inter-service liaison, communication and planning with particular reference to the request for a Mental Health Act assessment prior to this incident.
6. Review the application of the Care Programme Approach in line with Provider Guidance, National Policy and best practice.

7. Determine whether there were any missed opportunities to engage other services and/or agencies to support Mr P.

8. Make recommendations for the Provider, CCG and/or NHS England as appropriate.

9. Review the provider's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

    - If the investigations satisfied their own terms of reference.
    - If the investigation was completed in a timely manner
    - If all root causes and potential lessons have been identified, SMART recommendations made and shared within the organisation.
    - Whether recommendations are appropriate, comprehensive and flow from the lessons learnt and root causes.

10. Review whether the subsequent action plan reflects the identified contributory factors, root causes and recommendations, and those actions are comprehensive

11. Review progress made against the action plans.

12. Review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety culture of the provider services

13. Review whether the Providers Clinical Governance processes in managing the Level 2 investigation were appropriate and robust.

14. Review whether the CCG Governance/Assurance processes in managing the Level 2 investigation were appropriate and robust.

15. Make further recommendations for improvement to patient safety and/or governance processes as appropriate.

16. Review the Providers application of its Duty of Candour to the family of the perpetrator and the victim.

Timescale

17. The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter.

Initial steps and stages

NHS England will:

- Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved including influencing the terms of reference

- Arrange an initiation meeting between the Provider, commissioners, investigator and other agencies willing to participate in this investigation

Outputs

18. We will require monthly updates and where required, these to be shared with families, clinical commissioning groups and providers.

19. A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

20. At the end of the review, to share the report with the Provider and meet the victim and perpetrator families to explain the findings of the review and engage the clinical commissioning group with these meetings where appropriate.

21. A final presentation of the review to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

22. A briefing document of key learning points that can be shared with the Regions, CCGs and Providers.

23. The investigator will deliver learning events/workshops for the Provider, staff and commissioners if appropriate.

Other

24. Should the family formally identify any further areas of concern or complaint, about the care received or the final report, the investigation team should highlight this to NHS England for escalation and resolution at the earliest opportunity.

Appendix B – Documents reviewed

Livewell Southwest documents

- Clinical records for Mr P
- Internal investigation report
- Action plan
- SIRI Policy v2.4
- SIRI Policy v2.6
- Care Programme Approach Policy v1.3
- Care Programme Approach Policy v1.5
- Duty of Candour in investigations update 30 April 2018
- Health and Corporate Records Policy v1
- Health and Corporate Records Policy v2.1
- Template for developing data sharing protocols v1.1
- Clinical Supervision Policy v3.3

Harbour Centre documents

- Clinical records for Mr P

Other documents

- GP clinical records
- NHS NEW Devon Clinical Commissioning Group documents

Appendix C – Professionals involved

Pseudonym	Role and team	Organisation
AMHP1	AMHP	Livewell Southwest
CFT1	Team Manager	Community Forensic Team, Livewell Southwest
CMHN1	Community mental health nurse	Livewell Southwest
CMHS11	Nurse Access Role	Community Mental Health Team, Livewell Southwest
CMHS13	Healthcare Assistant	Community Mental Health Team, Livewell Southwest
CMHS14	Student Nurse	Community Mental Health Team, Livewell Southwest
CMHS6	Nurse access role	Community Mental Health Team, Livewell Southwest
CMHS7	Team Manager	Community Mental Health Team, Livewell Southwest
CMHS8	Administration Support	Community Mental Health Team, Livewell Southwest
CP01	Locum Consultant Psychiatrist	Bristol Specialist Drug and Alcohol Service
CP02	Consultant Psychiatrist	Bristol Specialist Drug and Alcohol Service
CP03	Consultant Psychiatrist	Livewell Southwest
CP04	Consultant Psychiatrist	Community Mental Health Team, Livewell Southwest
CP05	Locum Consultant Psychiatrist	Community Mental Health Team, Livewell Southwest
CP06	Consultant Psychiatrist	Community Mental Health Team, Livewell Southwest
CP07	Consultant Psychiatrist	Community Mental Health Team, Livewell Southwest
CP08	Consultant Psychiatrist	Livewell Southwest
CP09	Consultant Psychiatrist	Livewell Southwest
CP10	Consultant Psychiatrist	Livewell Southwest
CP11	Locum Consultant Psychiatrist	Glenbourne Unit, Livewell Southwest
CSW1	Community Support Worker	Home Treatment Team, Livewell Southwest
CSW2	Community support worker	Steps, Livewell Southwest

Pseudonym	Role and team	Organisation
GB1	Nurse access role	Glenbourne Unit, Livewell Southwest
GB3	Nurse access role	Glenbourne Unit, Livewell Southwest
GB4	Nurse access role	Glenbourne Unit, Livewell Southwest
GB5	Nurse access role	Glenbourne Unit, Livewell Southwest
GB6	Nurse access role	Glenbourne Unit, Livewell Southwest
GB7	Nurse access role	Glenbourne Unit, Livewell Southwest
GB10	Nurse access role	Glenbourne Unit, Livewell Southwest
GB11	Nurse access role	Glenbourne Unit, Livewell Southwest
GB12	Nurse access role	Glenbourne Unit, Livewell Southwest
GB13	Health Professional Access Role	Glenbourne Unit, Livewell Southwest
GP1	General Practitioner	Ivybridge Medical Practice
GP2	General Practitioner	Ernesettle Medical Centre
GP3	General Practitioner	North Road West Medical Centre
GP4	General Practitioner	North Road West Medical Centre
GP5	General Practitioner	North Road West Medical Centre
GP6	General Practitioner	North Road West Medical Centre
GP7	General Practitioner	Kingswood Health Centre
HCA1	Health care assistant	Livewell Southwest
HCA2	Health care assistant	Livewell Southwest
HDAS1	Unknown	Harbour Drug and Alcohol Service
HDAS2	Key Worker	Harbour Drug and Alcohol Service
HDAS3	Key Worker	Harbour Drug and Alcohol Service
HTT2		Home Treatment Team, Livewell Southwest
HTT3	Nurse Access Role	Home Treatment Team, Livewell Southwest
HTT4	Occupational Therapist	Community Mental Health Team, Livewell Southwest
HTT5	Nurse Access Role	Community Mental Health Team, Livewell Southwest
HTT6	Nurse Access Role	Home Treatment Team, Livewell Southwest
HTT7	Student Healthcare Access Role	Home Treatment Team, Livewell Southwest
HTT8	Unclear	Home Treatment Team, Livewell Southwest

Pseudonym	Role and team	Organisation
HTT9	Unclear	Home Treatment Team, Livewell Southwest
HTT10	Service Manager	Home Treatment Team, Livewell Southwest
HTT11	Nurse access Role	Home Treatment Team, Livewell Southwest
HTT12	Mental Health Nurse	Livewell Southwest, Home Treatment Team
HTT13	Mental Health Nurse	Livewell Southwest, Home Treatment Team
HTT14	Mental Health Nurse	Livewell Southwest, Home Treatment Team
HTT15	Nurse access role	Livewell Southwest, Home Treatment Team
HTT16	Nurse access role	Community Mental Health Team, Livewell Southwest
HTT17	Nurse access role	Home Treatment Team, Livewell Southwest.
HTT18	Nurse access role	Home Treatment Team, Livewell Southwest.
HTT19	Mental Health Nurse	Home Treatment Team, Livewell Southwest
HTT20	Health Care Assistant	Home Treatment Team, Livewell Southwest
HTT21	Nurse Access Role	Home Treatment Team, Livewell Southwest
HTT22	Mental Health Nurse	Home Treatment Team, Livewell Southwest
HTT23	Mental Health Nurse	Home Treatment Team, Livewell Southwest
HTT24	Nurse Access Role	Home Treatment Team, Livewell Southwest
HTT25	Mental Health Nurse	Home Treatment Team, Livewell Southwest
HTT26	Student Nurse	Home Treatment Team, Livewell Southwest
HTT27	Nurse Access Role	Home Treatment Team, Livewell Southwest
HTT28	Healthcare Assistant	Home Treatment Team, Livewell Southwest
HTT29	Community Support Worker	Home Treatment Team, Livewell Southwest

Pseudonym	Role and team	Organisation
HTT30	Student Nurse	Home Treatment Team, Livewell Southwest
HTT31	Unclear	Home Treatment Team, Livewell Southwest
HTT32	Nurse Access Role	Home Treatment Team, Livewell Southwest
HTT33	Clinical Support	Home Treatment Team, Livewell Southwest and Harford Ward
HTT34	Community Support Worker	Unclear
HTT35	Health Professional Access Role	Home Treatment Team, Livewell Southwest
HTT36	Nurse Access Role	Home Treatment Team, Livewell Southwest
HTT38	Unclear	Home Treatment Team, Livewell Southwest
HTT39	Nurse access role	
JD1	Unknown	Glenbourne Unit, Livewell Southwest
JD2	Doctor	Glenbourne Unit, Livewell Southwest
JD3	HTT Doctor	Home Treatment Team, Livewell Southwest
KW1	Key Worker	Avon & Wiltshire Partnership NHS Foundation Trust
NP1	Nurse Practitioner	North Road West Medical Centre
PCDN1	Police Custody Diversion Nurse	Devon Liaison and Diversion Service
PO1	Probation Officer	National Probation Service
PO2	Probation Officer	National Probation Service
PO3	Probation Officer	National Probation Service
SVS1	Health Professional Access Role	Steps Vocational Service

Appendix D – Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
The regulation applies to registered persons when they are carrying on a regulated activity.

CQC can prosecute for a breach of parts 20(2)(a) and 20(3) of this regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action. See the offences section of this guidance for more detail.

The regulation in full
20.—

1. Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.
2. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—
    a. notify the relevant person that the incident has occurred in accordance with paragraph (3), and
    b. provide reasonable support to the relevant person in relation to the incident, including when giving such notification.
3. The notification to be given under paragraph (2)(a) must—
    a. be given in person by one or more representatives of the registered person,
    b. provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,
    c. advise the relevant person what further enquiries into the incident the registered person believes are appropriate,
    d. include an apology, and
    e. be recorded in a written record which is kept securely by the registered person.
4. The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—
    a. the information provided under paragraph (3)(b),
    b. details of any enquiries to be undertaken in accordance with paragraph (3)(c),
    c. the results of any further enquiries into the incident, and
    d. an apology.
5. But if the relevant person cannot be contacted in person or declines to speak to the representative of the registered person —
    a. paragraphs (2) to (4) are not to apply, and

b. a written record is to be kept of attempts to contact or to speak to the relevant person.

6. The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4).
7. In this regulation—
"apology" means an expression of sorrow or regret in respect of a notifiable safety incident; "moderate harm" means—
    a. harm that requires a moderate increase in treatment, and
    b. significant, but not permanent, harm;
    "moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);
    "notifiable safety incident" has the meaning given in paragraphs (8) and (9);
    "prolonged pain" means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;
    "prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;
    "relevant person" means the service user or, in the following circumstances, a person lawfully acting on their behalf—
    c. on the death of the service user,
    d. where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or
    e. where the service user is 16 or over and lacks capacity in relation to the matter;
    "severe harm" means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.
8. In relation to a health service body, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—
    a. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or
    b. severe harm, moderate harm or prolonged psychological harm to the service user.
9. In relation to any other registered person, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional—
    a. appears to have resulted in—
        i. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,

ii. an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,
iii. changes to the structure of the service user's body,
iv. the service user experiencing prolonged pain or prolonged psychological harm, or
v. the shortening of the life expectancy of the service user; or

b. requires treatment by a health care professional in order to prevent—
i. the death of the service user, or
ii. any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

Appendix E – NIAF: internal investigation report

Rating	Description	Number
	Standards met	**15**
	Standards partially met	**6**
	Standards not met	**4**

Standard		Niche commentary	
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident	The report identifies that it is a root cause analysis investigation report. The Provider Serious Incident Policy (v2.4) identifies that a SIRI[24] undertaken by investigators within Livewell Southwest is required.	
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	The nature of the incident is noted as: "… arrested in Bristol… following a body being found in his flat… subsequently charged with and convicted of murder…" Terms of reference were noted, these included "establish the facts of what happened to [the victim], when, where, how and why." This is not the remit of serious incident investigation. The remit of an investigation is the care and treatment of the perpetrator. All other terms of reference are appropriate.	
1.3	The person leading the investigation has skills and training in investigations	The investigation was conducted by a senior mental health nurse and a consultant psychiatrist. No information is provided within the report about appropriate skills and training. At interview we established that the professional lead was experienced in conducting serious incident investigations and that the organisation provides root cause analysis training.	
1.4	Investigations are completed within 60 working days	The incident occurred on 18 December 2016 and the investigation start date was 15 September 2017. The "investigation completed date" is blank. This is beyond 60 working days, and there is no explanation of whether there was an extension or 'stop the clock' agreed.	

[24] Serious incident requiring investigation as defined in the NHS England Serious Incident framework

Standard		Niche commentary	
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The report is written in plain English without typographical errors.	
1.6	Staff have been supported following the incident	There is no description of how staff were supported following the incident.	
Theme 2: Thoroughness			
2.1	A summary of the incident is included, that details the outcome and severity of the incident	There is a summary of the background to the incident, and of the actions after the Trust became aware of the incident.	
2.2	The terms of reference for the investigation should be included	The terms of reference are included.	
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people	The report describes that the internal investigation team met with relevant staff, reviewed organisational clinical records and medication information held by the patient's GP. Contributory factors are set out.	
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	The victim's sister was contacted verbally and in writing. This did not take place until May 2017, but an explanation was provided. Attempts were made to arrange to visit Mr P whilst he was in prison. There is no evidence of any contact with the patient's family.	
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	There is no evidence of input from Mr P. The victim's family was invited to contribute to the investigation in a letter sent on 16 May 2018, not May 2017 as stated in the internal investigation report.	
2.6	A summary of the patient's relevant history and the process of care should be included	A summary of Mr P's relevant history and process of care was included.	
2.7	A chronology or tabular timeline of the event is included	A chronology of Mr P's care was not included but the organisation had completed this separately. Livewell Southwest has advised that the clinical commissioning group do not want a chronology included in serious incident reports.	

Standard		Niche commentary	
2.8	The report describes how RCA tools have been used to arrive at the findings	A fishbone diagram was completed and provided to us following circulation of the report for factual accuracy checks. However, it does not appear in the report.	
2.9	Care and Service Delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	No care and service delivery problems are explicitly identified, but different factors are identified.	
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	Contributory factors are identified.	
2.11	Root cause or root causes are described	The root causes section is completed but it provides a narrative, but this does not identify or discuss a clear root cause. It identifies missed opportunities where Mr P's care could have been better organised.	
2.12	Lessons learned are described	The missed opportunities described in the root causes section provide areas where learning could be applied.	
2.13	There should be no obvious areas of incongruence	There were none.	
2.14	The way the terms of reference have been met is described, including any areas that have not been explored	The way the terms of reference have been met is not described. The investigation team has not been able to answer the first (inappropriate) term of establishing what happened to the victim, when, where, how and why.	
Theme 3: Lead to a change in practice – impact			
3.1	The terms of reference covered the right issues	With the exception of establishing what happened to the victim, the terms of reference covered the right issues.	
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	The report considers what factors contributed to poor care and missed opportunities that are linked with how a recurrence might be prevented.	
3.3	Recommendations relate to the findings and that lead to a change in practice are set out	Seven recommendations were made, all relate to the findings.	
3.4	Recommendations are written in full, so they can be read alone	Recommendations are written in full, so they can be read alone.	

Standard		Niche commentary	
3.5	Recommendations are measurable and outcome focussed	Recommendations are measurable and outcome focussed.	

Appendix F – NICE guidance psychosis and schizophrenia in adults: prevention and management – clinical guideline (CG178)

Standards	Available to Mr P?
Service user experience	
Use this guideline in conjunction with service user experience in adult mental health (NICE clinical guidance 136) to improve the experience of care for people with psychosis or schizophrenia using mental health services, and: • work in partnership with people with schizophrenia and their carers • offer help, treatment and care in an atmosphere of hope and optimism • take time to build supportive and empathic relationships as an essential part of care.	No. There is no evidence that Mr P's family was involved in his life. Absence of care coordinator and multiple staff from the home treatment team involved in visits when Mr P was on caseload.
Physical health	
People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.	Yes.
If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance (see obesity [NICE clinical guideline 43], lipid modification [NICE clinical guideline 67] and preventing type 2 diabetes.	No evidence that Mr P was overweight.
Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine.	No evidence.
Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report.	Attempts to carry out by the GP, but no evidence of team routine monitoring of results.
Trusts should ensure compliance with quality standards on the monitoring and treatment of cardiovascular and metabolic disease in people with psychosis or schizophrenia through board-level performance indicators.	Evidence of attempts only when an inpatient.
Support for carers	
Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a	Not offered to Mr G who was the only person Mr P identified as having

Standards	Available to Mr P?
care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually.	supportive responsibilities.
Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this.	Not offered.
Give carers written and verbal information in an accessible format about: • diagnosis and management of psychosis and schizophrenia • positive outcomes and recovery • types of support for carers • role of teams and services • getting help in a crisis. When providing information, offer the carer support if necessary.	Not offered.
As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users and carers and respects their individual needs and interdependence.	Not offered.
Review regularly how information is shared, especially if there are communication and collaboration difficulties between the service user and carer.	Not offered.
Offer a carer focussed education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should: be available as needed, have a positive message about recovery.	Not offered.
Include carers in decision-making if the service user agrees.	Not offered.
Peer support and self-management	
Consider peer support for people with psychosis or schizophrenia to help improve service user experience and quality of life. Peer support should be delivered by a trained peer support worker who has recovered from psychosis or schizophrenia and remains stable. Peer support workers should receive support from their whole team, and support and mentorship from experienced peer workers.	Offered by Harbour Drug and Alcohol Service.
First episode psychosis standards	**Not applicable**
Subsequent acute episodes of psychosis or schizophrenia and referral in crisis	
Offer crisis resolution and home treatment teams as a first-line service to support people with psychosis or schizophrenia during an acute episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it.	Yes, at times. Mr P struggled with the variety of staff who visited him.

Standards	Available to Mr P?
Crisis resolution and home treatment teams should be the single point of entry to all other acute services in the community and in hospitals.	Yes.
Consider acute community treatment within crisis resolution and home treatment teams before admission to an inpatient unit and as a means to enable timely discharge from inpatient units. Crisis houses or acute day facilities may be considered in addition to crisis resolution and home treatment teams depending on the person's preference and need.	Yes.
If a person with psychosis or schizophrenia needs hospital care, think about the impact on the person, their carers, and other family members, especially if the inpatient unit is a long way from where they live. If hospital admission is unavoidable, ensure that the setting is suitable for the person's age, gender and level of vulnerability, support their carers, and follow the recommendations in service user experience in adult mental health (NICE clinical guidance 136).	Yes.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer: • oral antipsychotic medication, in conjunction with • psychological interventions (family intervention and individual CBT).	Yes. No.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer oral antipsychotic medication or review existing medication. The choice of drug should be influenced by the same criteria recommended for starting treatment (see sections 1.3.5 and 1.3.6). Take into account the clinical response and side effects of the service user's current and previous medication.	No.
Offer CBT to all people with psychosis or schizophrenia. This can be started either during the acute phase or later, including in inpatient settings.	No.
Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings.	Mr P did not involve his family in his life in Plymouth.
Consider offering arts therapies to all people with psychosis or schizophrenia, particularly for the alleviation of negative symptoms. This can be started either during the acute phase or later, including in inpatient settings.	No.
Behaviour that challenges	
Occasionally people with psychosis or schizophrenia pose an immediate risk to themselves or others during an acute episode and may need rapid tranquillisation. The management of immediate risk should follow the relevant NICE guidelines.	Not applicable.
Follow the recommendations in self-harm (NICE clinical guideline 16) when managing acts of self-harm in people with psychosis or schizophrenia.	Not applicable.

Standards	Available to Mr P?
Psychological interventions	
Offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. Deliver CBT as described in recommendation 1.3.7.1	No.
Offer family intervention to families of people with psychosis or schizophrenia who live with or are in close contact with the service user. Deliver family intervention as described in recommendation 1.3.7.2	No – family not involved in Mr P's life.
Consider offering arts therapies to assist in promoting recovery, particularly in people with negative symptoms.	No.
Pharmacological interventions	
The choice of drug should be influenced by the same criteria recommended for starting treatment.	No.
Do not use targeted, intermittent dosage maintenance strategies routinely. However, consider them for people with psychosis or schizophrenia who are unwilling to accept a continuous maintenance regimen or if there is another contraindication to maintenance therapy, such as side-effect sensitivity.	No.
Consider offering depot /long-acting injectable antipsychotic medication to people with psychosis or schizophrenia: • who would prefer such treatment after an acute episode • where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan.	No.
Using depot/long-acting injectable antipsychotic medication	
When initiating depot/long-acting injectable antipsychotic medication: • take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and organisational procedures (for example, home visits and location of clinics) • take into account the same criteria recommended for the use of oral antipsychotic medication (see sections 1.3.5 and 1.3.6), particularly in relation to the risks and benefits of the drug regimen • initially use a small test dose as set out in the BNF.	Not applicable.
Employment, education and occupational activities	
Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.	No.
Routinely record the daytime activities of people with psychosis or schizophrenia in their care plans, including occupational outcomes.	No.

Appendix G – NICE post-traumatic stress disorder – clinical guideline (NG116)

This analysis includes references to guidelines in place on 2005. It excludes guidelines that were added when the guidance was reviewed in 2018. However where the wording of an existing standard was amended in 2018, we have not reverted to the 2005 text.

Standards	Available to Mr P?
Recognition of post-traumatic stress disorder	
Be aware that people with post-traumatic stress disorder may present with a range of symptoms associated with functional impairment.	Despite a documented diagnosis of post-traumatic stress disorder there is little evidence that staff considered Mr P's presentation in the context of that diagnosis.
Be aware of traumatic events associated with the development of post-traumatic stress disorder. These could be experiencing or witnessing single, repeated or multiple events.	Mr P discussed childhood trauma and staff documented this.
When assessing for post-traumatic stress disorder, ask people specific questions about re-experiencing, hyperarousal, dissociation, negative alterations in mood and thinking, and associated functional impairment.	Some evidence.
When assessing for post-traumatic stress disorder ask people with symptoms associated with functional impairment if they have experienced one or more traumatic events. Provide specific examples of traumatic events listed in the guidance.	No evidence.
For people with unexplained physical symptoms who repeatedly attend health services, think about asking whether they have experienced one or more traumatic events and provide specific examples of traumatic events listed in the guidance.	Not applicable.
Specific recognition issues for children.	Not applicable.
Screening of people involved in a major disaster, refugees, and asylum seekers.	Not applicable.
Assessment and coordination of care	
For people with clinically important symptoms of post-traumatic stress disorder presenting in primary care, GPs should take responsibility for assessment and initial coordination of care. This includes determining the need for emergency physical or mental health assessment.	Not applicable.

Standards	Available to Mr P?
Assessment of people with post-traumatic stress disorder should be comprehensive, including an assessment of physical psychological and social needs and a risk assessment.	No evidence.
Where management is shared between primary and secondary care, healthcare professionals should agree who is responsible for monitoring people with post-traumatic stress disorder. Put this agreement in writing (if appropriate using the Care Programme Approach) and involve the person and if appropriate their family or carers.	Some evidence of communication with GP, but not in the context of post-traumatic stress disorder.
To support transitions when people with post-traumatic stress disorder are moving between services: • give the person information about the service they are moving to, including the setting and who will provide their care • ensure there is effective sharing of information between all services involve • involve the person and, if appropriate, their family or carers in meetings to plan the transition.	No evidence in the context of management of post-traumatic stress disorder.
Provide additional support: • to children and young people with post-traumatic stress disorder who are within the care system when they are transitioning between services or settings • during admission and discharge to people with post-traumatic stress disorder who are admitted to hospital because of other mental or physical health problems.	Not applicable.
Access to care	
Promote access to services for people with post-traumatic stress disorder by: • reassuring them that post-traumatic stress disorder is a treatable condition • providing care that places a positive emphasis on the range of interventions offered and their likely benefits • ensuring that methods of access to services take into account the needs of specific populations of people with post-traumatic stress disorder, including migrants and asylum seekers, people who are homeless or not registered with a GP, looked-after children and young people, and preschool-aged children • minimising the need to move between different services or providers • providing multiple points of access to the service, including self-referral • establishing clear links to other care pathways, including for physical health care needs • offering flexible modes of delivery, such as text messages, email, telephone or video consultation, or care in non-clinical settings such as schools or offices	No evidence.

Standards	Available to Mr P?
• offering a choice of therapists that takes into account the persons trauma experience for example they might prefer a specific gender of therapist • using proactive person-centred strategies to promote uptake and sustained engagement.	
Language and culture	
Pay particular attention to identifying people with post-traumatic stress disorder in working or living environments where there may be cultural challenges to recognising the psychological consequences of trauma (see recommendations on avoiding stigma and promoting social inclusion in the NICE guideline on service user experience in adult mental health).	Not applicable.
Ensure that screening, assessment and interventions for post-traumatic stress disorder are culturally and linguistically appropriate.	Not applicable.
If language or culture differences present challenges to the use of psychological interventions in post-traumatic stress disorder, think about using interpreters or offering a choice of therapists. See recommendations on communication in the NICE guideline on patient experience in adult NHS services.	Not applicable.