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

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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 draft report has been written in line with the terms of reference as set out in our Letter of Engagement for an independent external quality assurance review following an internal investigation into the care and treatment of a mental health service user A in Somerset in 2016. 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Events which may occur outside of the timescale of this review will render our Report out-of-date.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.

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1.2 Mr K admitted manslaughter on the grounds of diminished responsibility after two consultant psychiatrists told the court that Mr K had been suffering from a delusional disorder at the time of Mr P's death.

Independent investigation

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

1.4 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.

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

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

1.7 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 K.

[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

Mental health history of Mr K

1.8 Information held by Mr K's GP practice indicated that Mr K lived on the border of Somerset and Devon but was registered with a GP practice in Somerset. Information that came to light after the death of Mr P indicated that Mr K lived about ten miles inside the Devon border. He was not well known to mental health services in either Somerset or Devon.

1.9 On 10 August 2016 Mr K saw a GP (not his usual GP) for a planned appointment during which time he presented with behaviours that the GP considered to have been delusional and paranoid.

1.10 As a consequence of this the GP referred Mr K for assessment by mental health services, specifically requesting a Mental Health Act assessment. He was directed to call the Approved Mental Health Practitioner (AMHP) hub, which is the service provided by Somerset County Council that coordinates Mental Health Act assessments in Somerset. The GP was unable to speak to someone at the AMHP hub, so spoke to the local community mental health team[3] again who agreed to pass on the referral information.

1.11 Although the GP felt that Mr K did not present an immediate risk, he said he was prepared to sign detention papers in order that Mr K could be assessed and detained under the Mental Health Act that day.

1.12 A discussion between the AMHP hub and the home treatment team determined that the home treatment team did not have the capacity to respond to Mr K's referral that day, but they would follow it up the following day. The home treatment team relayed this information to the GP who expressed concern about the delay in follow up and stressed that contact with Mr K should be face to face and not on the telephone. The GP again stated he was prepared to sign relevant Mental Health Act paperwork.

1.13 There was a further discussion between the home treatment team and the AMHP hub that concluded that the home treatment team would contact Mr K the following day.

1.14 Mr K attended his GP surgery again that day just prior to them closing. He saw the same GP who documented increased concerns about Mr K's mental state and risks.

1.15 The following day (11 August) the home treatment team contacted Mr K but were not able to arrange a face-to-face appointment. Mr K denied any mental health problems and said that his diabetes was now stable. The home treatment team documented that Mr K was difficult to follow and that it was likely he held some "long term and chronic suspicious beliefs". The home treatment team noted that further discussion with the GP was required to inform him of the discussion with Mr K.

[3] Provided by Somerset Partnership NHS Foundation Trust

1.16 On 12 August the home treatment team wrote to the GP to advise that Mr K had declined contact with mental health services and therefore he had been discharged.

1.17 The GP spoke to the home treatment team again and reiterated his concerns about Mr K's paranoid delusions. At the conclusion of the discussion the GP documented that he understood that the home treatment team would arrange for a Mental Health Act assessment due to Mr K's lack of insight.

1.18 The AMHP hub and home treatment team discussed Mr K's referral again and concluded that it was not appropriate to proceed with a Mental Health Act assessment.

1.19 The GP spoke to the home treatment team again to express his frustration at the lack of action from mental health services. The home treatment team advised that that they had tried again to arrange a face-to-face appointment with Mr K, but he had refused to engage with them. The GP reiterated in detail the information that Mr K had provided to him that caused him such concern about Mr K's mental state and described Mr K as being agitated and intense. The GP said that he felt that Mr K was displaying "Knight's Move thinking".[4] At the conclusion of this discussion the home treatment team documented that it was "evident that [Mr K] was delusional" but it was difficult to assess whether this was a new or longer-term presentation.

1.20 The referral was discussed again with the AMHP hub, but they did not feel that Mr K required a Mental Health Act assessment.

1.21 There was no further contact with mental health services until June 2017 when police in Devon contact mental health services following Mr K's arrest for the murder of Mr P.

Internal investigation

1.22 NHS Somerset Clinical Commissioning Group commissioned an internal investigation that was conducted by a former GP that held a portfolio for the clinical commissioning group for quality and assurance for mental health services and was also experienced at conducting investigations into serious incidents.

1.23 The internal report made a number of recommendations for the Trust and the wider health and social care system. An action plan was developed, but this only addressed issues that related to the Trust and there was no direct correlation between the recommendations in the report and the recommendations cited in the action plan. In addition, the remaining recommendations were not addressed in any action plan. A fact that was not identified until we requested various documents to complete our independent investigation.

[4] Knights move thinking: In psychiatry, derailment (also called loosening of association, knight's move thinking) is a thought disorder characterised by discourse consisting of a sequence of unrelated or only remotely related ideas.

1.24 Although this was the case, the clinical commissioning group had continued to work on the issues about improving access to mental health services.

Conclusions

1.25 It is our view that there should have been a much more proactive and robust response from the health and social care system following the GP's request for an urgent Mental Health Act assessment. It is also our view that the local authority did not properly discharge their duty under Section 13 Mental Health Act.[5]

1.26 The GP made extensive attempts to secure an assessment and ultimately believed that Mr K would be followed up by mental health services, even if a Mental Health Act assessment was not conducted.

1.27 Despite Mr K being seen by a GP with experience in mental health care his assessment was given insufficient weight by Trust and local authority staff who had not assessed Mr K. When mental health staff did make contact with Mr K they did not take the advice of the GP, which was to make face to face contact, not telephone contact.

1.28 Mr K presented with a delusional disorder that with hindsight appears to have been persistent in nature. Had a proper assessment of his mental state been undertaken in 2016 it would have been more likely that this delusional disorder could have been identified. It is of note that the way that Mr K's delusions manifested in 2016 were similar to those described following his arrest for the death of Mr P.

1.29 Although we consider there were failings in the health and social care response in August 2016, it is not our view that these failings directly led to the death of Mr P.

1.30 There was also a failure by NHS Somerset Clinical Commissioning Group to ensure that all the recommendations present in the serious incident investigation report were reflected in a combined action plan. It is our view that this failure resulted in a loss of oversight of progress of key changes, and that there has been insufficient evidence gathered to provide assurance that the service changes that have been made have delivered positive changes for all stakeholders, most importantly patients, their families, and primary care.

[5] Section 13 MHA 1983: Duty of approved mental health professionals to make applications for admission or guardianship. http://www.legislation.gov.uk/ukpga/1983/20/section/13

Predictability and preventability

1.31 Predictability[6] 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.[7]

1.32 Prevention[8] 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

1.33 The clinical commissioning group report cited the root causes as being that the homicide occurred because Mr K believed he was being "persecuted and targeted by powerful people" and that this belief arose from an untreated paranoid psychosis. A root cause cannot be patient factors, it has to be the earliest point that service intervention could have made a difference.

1.34 It is our view that Mr P's death in June 2017 was neither predictable nor preventable by mental health services. The time lapse between August 2016 and June 2017 is too great to be able say with certainty that appropriate interventions in August 2016 would have resulted in Mr K remaining well ten months later.

1.35 In addition, even if health and social care staff had intervened appropriately and conducted a Mental Health Act assessment, it is not certain what the outcome of that assessment in either the short or longer term would have been. Mr K's mental state did not deteriorate to the point that he came to the attention of primary care or mental health services again for another ten months.

1.36 However, if Mr K had been assessed under the Mental Health Act it is more likely that he would have been treated, and therefore it would have been less likely that he would have attacked Mr P. We do consider that there were actions that the Trust and the local authority should have taken following the referral from GP1 for a Mental Health Act assessment in August 2016.

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

[7] 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

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

Recommendations

1.37 This independent investigation has made six recommendations to improve practice.

Recommendation 1: NHS Somerset Clinical Commissioning Group must ensure that quality assurance of investigation reports and associated action plans is consistently completed and evidenced, and that a process is in place that ensures reports are picked up at future Serious Incident Review Group meetings.
Recommendation 2: NHS Somerset Clinical Commissioning Group must ensure that a system is in place to check that recommendations in investigation reports are fully reflected in associated action plans.
Recommendation 3: NHS Somerset Clinical Commissioning Group must assess the impact to relevant stakeholders of the actions completed by the Trust.
Recommendation 4: NHS Somerset Clinical Commissioning Group must work with stakeholders to assess the impact of service changes on all groups of stakeholders, specifically patients and their families, and GPs. Particular attention must be given to evidencing an improvement in access to urgent Mental Health Act assessments.
Recommendation 5: NHS Somerset Clinical Commissioning Group must work with local authority partners and the Trust to understand the reasons behind a reducing number of Mental Health Act assessments and to understand more fully what happens to those people who are assessed but not detained under the Mental Health Act, and how their mental health needs are being met.
Recommendation 6: NHS Somerset Clinical Commissioning Group must work with local authority partners to gain assurance that the AMHP service working practices comply with the Mental Health Act Code of Practice.

2 Independent investigation

Incident

2.1 On 6 June 2017 Mr K stabbed Mr P who was working in a religious chapel in Honiton. Mr K was not known to Mr P, but after his arrest it was reported that Mr K thought the religious group were spying on him and spreading false rumours about him on the internet.

2.2 Mr K admitted manslaughter on the grounds of diminished responsibility after two consultant psychiatrists gave evidence to the court that Mr K had been suffering from a delusional disorder at the time of Mr P's death.

Approach to the investigation

2.3 The independent investigation follows the NHS England Serious Incident Framework[9] (March 2015) and Department of Health guidance[10] 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.

2.4 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.

2.5 The investigation was carried out by:

- Naomi Ibbs, Senior Consultant for Niche (lead author);
- Dr Mark Potter, Consultant Psychiatrist;
- Matt Walsh, Approved Mental Health Professional.

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

2.7 The report was peer reviewed by Dr Carol Rooney, Deputy Director, Niche.

2.8 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[11]

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

[10] 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

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

2.9 NHS England contacted Mr K at the start of the investigation, explained the purpose of the investigation and sought his consent to access relevant records. Mr K gave conditional consent for us to access his records and therefore NHS England sought authorisation from Somerset Partnership NHS Foundation Trust Caldicott Guardian for Mr K's clinical records held by them to be released. The Caldicott Guardian for the GP practice gave authorisation for Mr K's GP records to be released.

2.10 We used information from the Trust, Mr K's GP surgery, Somerset County Council, NHS Somerset Clinical Commissioning Group, and Mr K to complete the investigation into his care and treatment.

2.11 As part of our investigation, we interviewed:

- GP, Essex House Medical Centre;
- Support, Time & Recovery Worker, Yeovil Home Treatment Team (now working as a Trainee Assistant Practitioner), employed by the Trust;
- Community Mental Health Nurse, Yeovil Home Treatment Team (now working as the Operational Manager for the Home Treatment Service across the county), employed by the Trust;
- Manager, Yeovil Home Treatment Team, employed by the Trust;
- current Mental Health Act Coordination Lead for the Trust;
- Strategic Manager, Mental Health and Safeguarding, Somerset County Council;
- GP Patient Safety Lead, NHS Somerset Clinical Commissioning Group.

2.12 We undertook telephone interviews with:

- AMHP, Somerset County Council;
- Care coordinator employed by the Trust.

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

2.14 We also conducted a long unrecorded telephone discussion with the Associate Director of Safety and Quality Improvement at NHS Somerset Clinical Commissioning Group.

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, the Trust, the GP surgery, Somerset County Council and NHS Somerset Clinical Commissioning Group. 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 the victim's family

2.17 The support organisation Hundred Families[12] has been in contact with Mr P's family; Hundred Families informed NHS England they Mr P's family did not want any involvement in the investigation. However, they wanted to know when the report was expected to be published, and to receive a copy of the final version. These requests have been actioned by NHS England.

Contact with Mr K

2.18 We contacted Mr K's treating team at the start of the investigation and were advised that Mr K was keen to meet with us. We met with him in March 2019 and have provided a summary of our discussion with him in Section 3.

2.19 Although Mr K was very keen for us to meet with him to discuss the findings of the investigation, the COVID pandemic meant that this was not possible. NHS England therefore shared a copy of the final draft report with his care team for them to discuss with him. NHS England has not received any questions or points of clarification in response to this but has informed Mr K's care team of the expected date of publication.

Structure of the report

Section	Content
Section 3	Mr K's relevant background.
Section 4	Mr K's care and treatment. A full chronology was developed in accordance with the terms of reference, but this has been excluded from the final report to comply with privacy requirements. We have provided an anonymised summary of those staff involved in Mr K's care and treatment for ease of reference for the reader. These can be found at Appendix C.
Section 5	Trust communication with affected families after the death of Mr P.
Section 6	Review of the clinical commissioning group level 2 investigation and progress made in addressing the organisational and operational matters identified.
Section 7	Summary of changes within mental health services.
Section 8	Issues arising from the care and treatment provided to Mr K, comment, and analysis.
Section 9	Overall conclusions and recommendations.

[12] Hundred Families is a charity that provides support, information and advocacy to families whose relatives have been killed by people suffering from mental illness. https://www.hundredfamilies.org/difference/

3 Background of Mr K

Relevant medical history

3.1 Mr K's GP records show that he took two overdoses of paracetamol and one overdose of lorazepam[13] in the 1980s. At the time all secondary care services in Somerset were provided by a single organisation called Somerset Health Authority.

3.2 The first overdose was in August 1980 when Mr K was aged 18. It was reported that he had taken 12 to 14 paracetamol tablets and some alcohol and was drowsy and uncooperative on examination at hospital in Taunton. Mr K had his stomach "washed out" and was seen by the on-call psychiatrist whom it is reported was unable to get Mr K to talk about his problems. No further appointments with mental health staff were arranged but Mr K was encouraged to see his GP in the "near future".

3.3 The second overdose was in February 1981 when Mr K took an overdose of lorazepam. Mr K's GP had prescribed lorazepam 2.5mg the day prior to the overdose with instructions to take one at night. Mr K took one tablet on the first night and then took 29 tablets the following morning. It was reported that Mr K's parents thought he was rather drowsy at lunchtime and did not discover until the evening that he had taken an overdose. Mr K was treated in hospital in Taunton and a follow up appointment with mental health staff was arranged for two weeks after discharge, but Mr K did not attend.

3.4 The third overdose was on the day of his follow up appointment with mental health staff. Mr K took an overdose of 30 to 40 paracetamol tablets. This was not discovered until Mr K disclosed the fact to his GP about five hours after he had taken the tablets. Mr K was again treated in hospital in Taunton where he "made a good recovery". Mr K was discharged two days after admission, and another follow up appointment was arranged for 12 days later.

3.5 However, Mr K did not attend the arranged appointment with the psychiatrist. In a letter to Mr K's GP the psychiatrist reported that he had liaised with Mr K's probation officer to take him to the appointment, it appeared that Mr K was "so frightened of meeting a psychiatrist that he refused to attend". We discuss the role of Mr K's probation officer in the next section.

3.6 There were no further overdoses and no other references to mental health problems in Mr K's GP records until early 2000 when he reported to his GP that he was suffering from symptoms of anxiety. Mr K was signed off sick from 14 to 28 March 2000 with a "stress related problem" and then again from 5 May to 21 August 2000.

[13] Lorazepam is part of a group of medicines called benzodiazepines or anxiolytics. It is used for short-term treatment of severe and distressing anxiety and sleeping problems. https://www.nhs.uk/medicines/lorazepam/

History of violence

3.7 There is no indication in any records held by Somerset Partnership NHS Foundation Trust that Mr K was known to have a history of violent behaviour.

3.8 A letter dated March 1981 from Somerset Health Authority to Mr K's GP stated that Mr K had been involved in "an upset with his girlfriend" and that it was believed he was in trouble with the police because of "anti-social behaviour".

3.9 We identified references in Mr K's GP records of the involvement of a probation officer in April 1981, but the records do not indicate the reason for the involvement of probation services.

Mr K's views of his care and treatment

3.10 When we met with Mr K in March 2019, he remained of the view that when he saw his GP in summer 2016, he did not require a mental health assessment. He told us that his mother had died three months prior to his GP appointment (we can see from the GP records that Mr K told the GP that his mother had died in late October 2015) and that his father had been ill at the same time. Mr K said that he wanted someone to talk to and someone to help him and that he felt nobody had listened to him.

3.11 Mr K told us that in summer 2016 he had a motor home and his father was living in sheltered accommodation.

3.12 Mr K talked about his previous difficulties in 2000 when he said that he was under stress, but he was adamant he was not suffering from depression at that time.

4 Care and treatment of Mr K

4.1 Information held by Mr K's GP practice indicated that Mr K lived on the border of Somerset and Devon but was registered with a GP practice in Somerset. Information that came to light after the death of Mr P indicated that Mr K lived about ten miles inside the Devon border. He was not well known to mental health services in either Somerset or Devon.

10 August 2016

4.2 On 10 August 2016 Mr K saw a GP (not his usual GP) for a planned appointment during which time he presented with behaviours that the GP considered to have been delusional and paranoid.

4.3 As a consequence of this the GP referred Mr K for assessment by mental health services, specifically requesting a Mental Health Act assessment. He was directed to call the AMHP hub (the service coordinating Mental Health Act assessments in Somerset) but was unable to speak to someone, so spoke to the South Somerset community mental health team (based in Yeovil, provided by Somerset Partnership NHS Foundation Trust) again who agreed to pass on the referral information.

4.4 Although the GP felt that Mr K did not present an immediate risk, he said he was prepared to sign detention papers in order that Mr K could be assessed and detained under the Mental Health Act that day.

4.5 A discussion between the AMHP hub and the home treatment team determined that the home treatment team did not have the capacity to respond to Mr K's referral that day, but they would follow it up the following day. The home treatment team relayed this information to the GP who expressed concern about the delay in follow up and stressed that contact with Mr K should be face to face and not on the telephone. The GP again stated he was prepared to sign relevant Mental Health Act paperwork.

4.6 There was a further discussion between the home treatment team and the AMHP hub that concluded that the home treatment team would contact Mr K the following day.

4.7 Mr K attended his GP surgery again just prior to them closing. He saw the same GP who documented increased concerns about Mr K's mental state and risks.

11 August 2016

4.8 The following day (11 August) the home treatment team contacted Mr K but were not able to arrange a face to face appointment. Mr K denied any mental health problems and said that his diabetes was now stable. The home treatment team documented that Mr K was difficult to follow and that it was likely he held some "long term and chronic suspicious beliefs". The home

treatment team noted that further discussion with the GP was required to inform him of the discussion with Mr K.

12 August 2016

4.9 On 12 August the home treatment team wrote to the GP to advise that Mr K had declined contact with mental health services and therefore he had been discharged. The letter was faxed the same day.

4.10 The GP spoke to the home treatment team again and reiterated his concerns about Mr K's paranoid delusions. At the conclusion of the discussion the GP documented that he understood that the home treatment team would arrange for a Mental Health Act assessment due to Mr K's lack of insight.

4.11 The AMHP hub and home treatment team discussed Mr K's referral again and concluded that it was not appropriate to proceed with a Mental Health Act assessment.

4.12 The GP spoke to the home treatment team again to express his frustration at the lack of action from mental health services. The home treatment team advised that that they had tried again to arrange a face to face appointment with Mr K, but he had refused to engage with them. The GP reiterated in detail the information that Mr K had provided to him that caused him such concern about Mr K's mental state and described Mr K as being agitated and intense. The GP said that he felt that Mr K was displaying "knight's move thinking". At the conclusion of this discussion the home treatment team documented that it was "evident that Mr K was delusional" but it was difficult to assess whether this was a new or longer-term presentation.

4.13 The referral was discussed again with the AMHP hub, but they did not feel that Mr K required a Mental Health Act assessment.

17 June 2017

4.14 There was no further contact with mental health services until June 2017 when police in Devon contacted mental health services following Mr K's arrest for the murder of Mr P.

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 carefully considered whether Duty of Candour applied in this case and have concluded that it did not. The death of Mr P was ten months after the referral to the Trust and contact between the Trust and Mr K.

Being Open

Mr K's family

5.4 During the investigation in 2017 Somerset Clinical Commissioning Group considered whether Duty of Candour applied to Mr K's father at that point. The clinical commissioning group was unclear but felt they should talk to him. It is our view that Duty of Candour did not apply because we do not consider that Mr K's father was a "relevant person".

5.5 However, we do consider that it was appropriate that Somerset Clinical Commissioning Group and GP surgery engaged with Mr K's father after Mr K's arrest, in the spirit of being open. Staff from the clinical commissioning group and Mr K's GP surgery visited Mr K's father to say sorry and establish if there was any information that he was able to provide about Mr K's mental state in the previous few weeks.

Mr P's family

5.6 Somerset Clinical Commissioning Group contacted Devon and Cornwall Police in order to establish contact with Mr P's family. The Family Liaison Officer asked the clinical commissioning group to provide a rationale for establishing contact with Mr P's family and whether the clinical commissioning group considered it would help Mr P's wife and other family members.

5.7 The clinical commissioning group provided a detailed rationale citing learning from previous homicide investigations and the importance of establishing contact with victims' families. The clinical commissioning group also provided a link to the Hundred Families website as evidence of the importance of communication between health services and families of victims.

5.8 The response from the police was that they would speak to Mr P's family to obtain views about discussing the investigation. Somerset Clinical Commissioning Group received no response to their last email which was dated 20 November 2017 and therefore the organisation was not able to contact the victim's family.

5.9 It is our opinion that there was little more that the clinical commissioning group could have done in obtaining the relevant details from the police. The clinical commissioning group acknowledge that they never directly asked for the contact details for the victim's family and could have done so. However, the clinical commissioning group was keen that the family did not receive correspondence from the clinical commissioning group without any support and to this end had wanted to engage with the police family liaison officer so that communication could be handled in a sensitive way.

6 Clinical Commissioning Group investigation

6.1 NHS Somerset Clinical Commissioning Group was informed of the incident by both the Trust and the GP practice. During discussion between the clinical commissioning group and the Trust it became clear that the Trust did not consider the incident to be a serious incident attributable to their organisation. The view of the clinical commissioning group was that a serious incident had occurred that needed to be recorded on StEIS[14] and therefore the decision was taken that the clinical commissioning group would make that entry.

6.2 The reason for the Trust's position was that their brief contact with Mr K had been ten months previously. The clinical commissioning group identified that Mr K had been seen in primary care in October 2016, and therefore managed the incident as a primary care investigation rather than a Trust investigation.

6.3 NHS Somerset Clinical Commissioning Group commissioned an investigation into Mr K's care and treatment. That investigation commenced on 4 July 2017 and the report was finalised on 5 January 2018.

6.4 The terms of reference for the investigation were:

1. To investigation Mr K's presentation to NHS services in August 2016 and subsequent contact with any health services until the date of the incident on 6 June 2017.

2. To make recommendations about pathways of referral and process.

6.5 The clinical commissioning group investigation was undertaken by a former GP (CCG1) who had previously been a Section 12 approved doctor[15] and had experience in undertaking reviews of deaths in custody, investigations into suicides, and a domestic homicide review. At interview CCG1 confirmed that he had been trained in root cause analysis.

6.6 The clinical commissioning group investigation highlighted a number of care and service delivery problems:

1. Patient was assumed to be living in Somerset, his registered address was in Chard. In fact, he was living in Devon which could have complicated Mental Health Assessment and Treatment.

2. The patient presented with one single episode only of paranoid delusional disorder without insight, on two occasions to the GP on the same day. No other presentation occurred. Ten months later a homicide occurred.

3. GP referral was to [the Trust] Single Point of Access by telephone as an urgent case. As a result of this, activity occurred by telephone, but no face to face contact with [Mr K] occurred. The case was received onto the

[14] StEIS (Strategic Executive Information System) is the system that facilitates the reporting of serious incidents and the monitoring of investigations between NHS providers and commissioners.

[15] Section 12 Approved doctor is one who has been authorised to make assessments under the Mental Health Act.

[Trust] Caseload for the Crisis Team, and then discharged. No referral onward was made for other services or assessment.

4. The [Trust] Crisis Team did contact by telephone and discuss with AMHP Hub, case was not deemed to be urgent enough to warrant same day [Mental Health Act Assessment]. It is noted in the [Trust] Report that there are difficulties in obtaining a [Mental Health Act Assessment], with the AMHP Hub sometimes requesting that the Crisis Team assess first, and sometimes also a medical assessment carried out, especially if client not previously known. The Trust report goes on to note that there is a risk that the main focus (if a [Mental Health Act Assessment] does occur) is not longer-term mental illness – the focus of a [Mental Health Act Assessment] is on suicide or harm to others, not on being able to provide treatment for those unwilling to accept it but in need of it.

5. The AMHP Hub comments that a risk assessment is done on the basis of information received, and that a [Mental Health Act Assessment] may be convened on occasion even without previous psychiatric assessment.

6. Although [Mr K] may or may not have met the threshold for an [Mental Health Act Assessment] on the basis of the information received, no further onward secondary care of the case occurred, or appears to have been considered – possibilities include referral for community or local outpatient assessment.

7. High volume of new cases referred to [the Trust] may have prevented this case from further follow up.

8. GP thinking evolved in that initially although GP stated no risk to others (which echoed [Mr K] saying that he was placid and had no intention to commit physical violence), later GP stated he was prepared to sign section papers, which presumably indicates that, upon reflection, a level of concern that [Mr K] was a danger either to his own health, or safety, or that of others. The initial verbal statement from the patient (of no intention to harm) may have been taken at face value by both GP and the CPN team, and this may have played down the urgency of the situation at the time to those who had not seen for themselves, as the GP had, [Mr K's] agitated and intense state. It is not clear if agreement for an assessment was obtained from [Mr K]. The passage of time, however, showed that ten months were to elapse[d] before [Mr K] actually caused injury to anyone else.

9. GP request for MHA is unusual, but did not lead to any face to face assessment.

10. GP referral was not confirmed in writing. GP understanding on [12 August 2016] was that the referral of the case would still result in a Mental Health Act assessment.

6.7 The clinical commissioning group report cited the root causes as being that the homicide occurred because Mr K believed he was being "persecuted and

targeted by powerful people" and that this belief arose from an untreated paranoid psychosis.

6.8 A root cause cannot be patient factors, it has to be the earliest point that service intervention could have made a difference. In this case there is no direct connection between the failure to assess Mr K and the death of Mr P.

6.9 The recommendations made by the clinical commissioning group report were:

R1 GP request for a Mental Health Act assessment should be seen as a red flag, and a new case of delusions of persecution should mandate face to face assessment.

R2 Telephone referrals from primary care should be followed up in writing, with full clinical information and possibly copies of clinical notes.

R3 Single Point of Access should ensure appropriate assessment and disposal to an appropriate team. Clear disposal/onward referral should be considered, as well as demographics for risk and actual presentation.

R4 [The Trust] could give thought as to how to build communication between local teams and GP practices. In this case, a [tele]phone call by the GP to the locality team in the same town might have facilitated either an assessment or ongoing engagement.

R5 Electronic confirmation following call to support referral (as per Somerset Primary Link referral), to include risk identified, appropriate communication methods and copy of clinical records.

R6 Electronic discharge of mental health patients to be sent to GPs.

R7 Screening assessments to be built into the initial contact.

R8 Screening assessments undertaken over the [tele]phone to be recorded on RiO.[16]

R9 Ensure that if two medical concerns from a GP practice that a mental health assessment is carried out (if concern is raised by one GP this should still be investigated).

R10 If no response from the person who is refusing to engage, process to be put into place to identify risk, i.e. RiO screening tool.

R11 Consideration of process review for severe cases to formalise process to have GP to psychiatrist conversation in extreme cases.

[16] The electronic patient record used by the Trust

R12 In cases where patients are talking out of context and there is some doubt regarding the nature of the context of the conversation staff should seek a psychiatrist's opinion.

6.10 We consider that the terms of reference for the investigation were met. The recommendations arising from the level two investigation are very transactional and were not written in a way that addressed wider system issues. However, we do not disagree with any of the principles underlying these recommendations and consider the findings to be adequate.

Clinical Commissioning Group sign off

6.11 The process for submission of the final report, quality assurance and closure of a serious incident investigation report is set out in the NHS Somerset Clinical Commissioning Group policy for managing serious incidents. That policy states that the clinical commissioning group will:

- undertake a quality assurance review of the report within ten calendar days;
- require a robust investigation report, generated following a full root cause analysis, to include root causes, lessons learned and a time bounded action plan. The action points need to address each lesson learnt and associated recommendations with timescales and named lead for implementation.

6.12 The management of serious incidents sits within the quality, safety and governance team that is responsible for ensuring that an appropriate process is followed to ensure that a full investigation is undertaken.

6.13 We have seen evidence that the report was discussed at two Serious Incident Review Group meetings on 31 October 2017 and 9 February 2018.

6.14 At the meeting on 31 October 2017 the minutes of the meeting indicate that the panel reviewed the report and comments were provided by the panel. It was noted that a multi-disciplinary team meeting to discuss the incident was due to take place on 23 November 2017 and it was therefore agreed that the report would be discussed again at a subsequent Serious Incident Review Group meeting.

6.15 The minutes of the meeting held on 9 February 2018 state that the panel reviewed the report and agreed to close the incident on StEIS once the action plan had been presented.

6.16 We have not seen any evidence that the report was discussed again, nor have we seen a complete action plan that responds to each recommendation in the serious incident report.

Recommendation 1: NHS Somerset Clinical Commissioning Group must ensure that quality assurance of investigation reports and associated action plans is consistently completed and evidenced and that a process is in place that ensures reports are picked up at future Serious Incident Review Group meetings.

Action plan

6.17 The Trust developed an action plan that detailed four recommendations and associated actions. We have set out the actions and associated recommendations present in that plan in Appendix D.

6.18 All actions detailed in the plan provided to us by the clinical commissioning group were marked as complete by 31 January 2018. There are four 'recommendations' cited on the action plan, with associated actions but none of these actions map directly to any recommendations within the internal report. This is the first stage at which there is a risk that key findings from the investigation have not been addressed.

6.19 We understand that ordinarily the provider's report, recommendations and action plans are monitored by the clinical commissioning group. However, it appears that because the report was generated by the clinical commissioning group staff, and action plans were devised by both clinical commissioning group and Trust staff, those actions to be taken forward by the clinical commissioning group were not captured in a plan that was presented and monitored.

6.20 The clinical commissioning group believes that the reason a full and detailed action plan was not developed is the result of an administrative error, because the wrong clinical commissioning group action plan (for a different case) was logged to the case record. This error was not identified by the clinical commissioning group until we requested the relevant documents for our investigation.

6.21 This is the second stage at which there is a risk that key findings from the investigation have not been addressed.

Recommendation 2: NHS Somerset Clinical Commissioning Group must ensure that a system is in place to check that recommendations in investigation reports are fully reflected in associated action plans.

6.22 Table 1 below provides our interpretation of where the recommendations within the report have been addressed in an action plan.

Table 1: Assessment of recommendations in report compared with action plan

Recommendation	Addressed in action plan
1. GP request for a Mental Health Act assessment should be seen as a red flag, and a new case of delusions of persecution should mandate face to face assessment.	Not addressed in action plan.
2. Telephone referrals from primary care should be followed up in writing, with full clinical information and possibly copies of clinical notes.	Not addressed in action plan.
3. Single Point of Access should ensure appropriate assessment and disposal to an appropriate team. Clear disposal/onward referral should be considered, as well as demographics for risk and actual presentation.	Addressed in actions 1 and 2.
4. [The Trust] could give thought as to how to build communication between local teams and GP practices. In this case, a [tele]phone call by the GP to the locality team in the same town might have facilitated either an assessment or ongoing engagement.	Not addressed in action plan.
5. Electronic confirmation following call to support referral (as per Somerset Primary Link referral), to include risk identified, appropriate communication methods and copy of clinical records.	Not addressed in action plan.
6. Electronic discharge of mental health patients to be sent to GPs.	Not addressed in action plan. The clinical commissioning group has advised that at the time the internal investigation was considered by them (October 2017 to February 2018) roll out of electronic discharge summaries at the Trust had started but was not complete due to technical difficulties. Given this, it would have been more appropriate for the recommendation to have been amended to reflect this position when quality control checks were completed.
7. Screening assessments to be built into the initial contact.	Not addressed in action plan.
8. Screening assessments undertaken over the phone to be recorded on RiO.	Not addressed in action plan.

Recommendation	Addressed in action plan
9. Ensure that if two medical concerns from a GP practice that a mental health assessment is carried out (if concern is raised by one GP this should still be investigated).	Not addressed in action plan.
10. If no response from the person who is refusing to engage, process to be put into place to identify risk, i.e. RiO screening tool.	Partially addressed in action 1.
11. Consideration of process review for severe cases to formalise process to have GP to psychiatrist conversation in extreme cases.	Not addressed in action plan but process addressed in Appendix 1 of protocol developed in relation to action 3.
12. In cases where patients are talking out of context and there is some doubt regarding the nature of the context of the conversation staff should seek a psychiatrist's opinion.	Not addressed in action plan.

6.23 The clinical commissioning group told us that the bulk of the recommendations have been carried forward into wider commissioning development actions with the Trust, but this has not been reflected in any associated action plan.

6.24 We have seen evidence that the clinical commissioning group was monitoring the implementation of the recommendations set out in the Trust action plan. In addition, we can see that the Trust provided the clinical commissioning group with evidence that the actions set out in the Trust plan had been completed. However, there is no evidence that either the clinical commissioning group or the Trust sought assurance that the actions had resulted in beneficial changes to patients or health and social care colleagues.

6.25 It is our view that not all key lessons have been identified and shared and we have not seen evidence that learning has been embedded in services.

Recommendation 3: NHS Somerset Clinical Commissioning Group must assess the impact to relevant stakeholders of the actions completed by the Trust.

7 Mental health service changes

7.1 This incident was among a number of factors that contributed to significant service changes to community mental health services in Somerset.

7.2 Around the same time the Sustainability and Transformation Partnership[17] for Somerset was established that included a group of very senior officers in the system (from the clinical commissioning group, Local Authority, and three NHS trusts).

7.3 Benchmarking work undertaken by the clinical commissioning group showed that mental health services in Somerset were significantly underfunded when compared to similar organisations across the country. This led to a gap analysis being undertaking in early 2018 and key areas identified as requiring investment were:

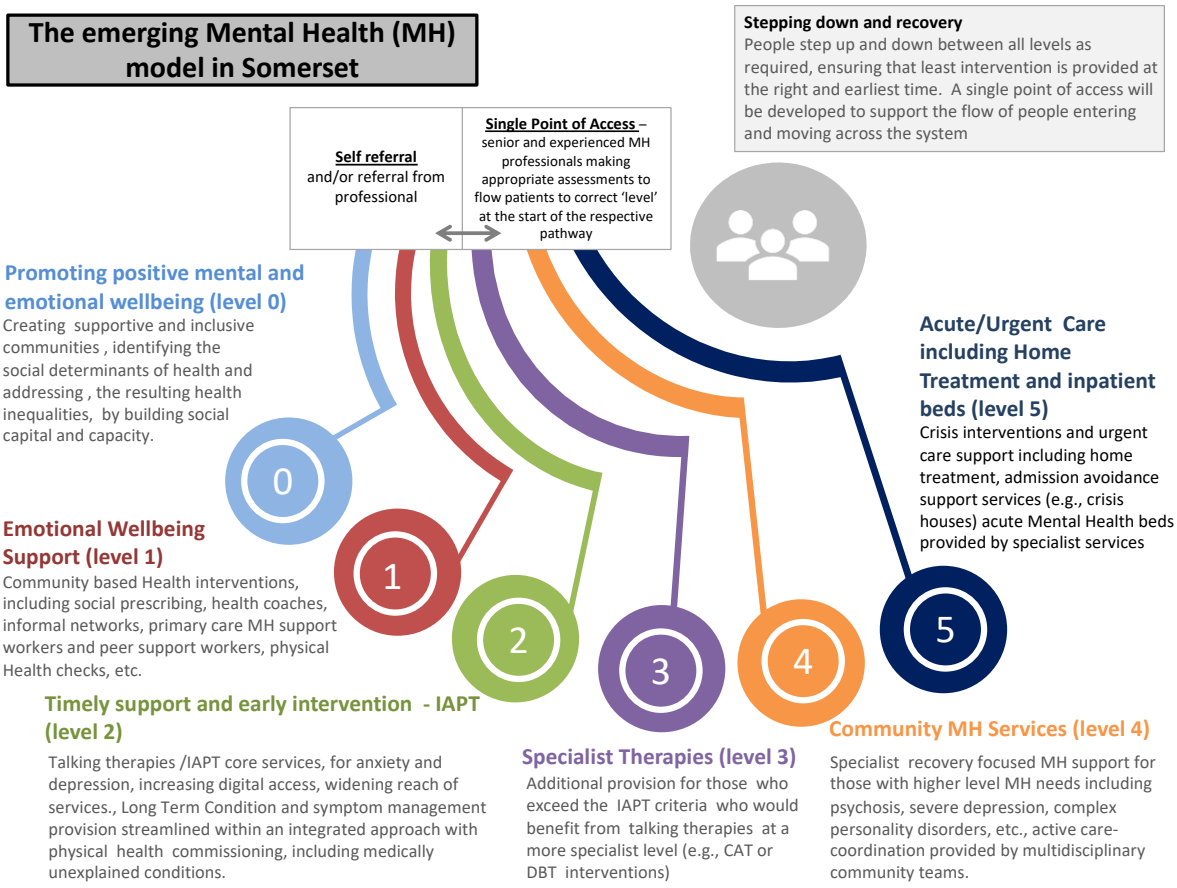
- community mental health teams;
- home treatment teams;
- psychiatric liaison services.

7.4 During the financial year 2019/20 the mental health commissioning team (part of NHS Somerset Clinical Commissioning Group) developed a number of proposals to further develop improvements in mental health support in the county. Resources were targeted at parts of the mental health provision that had been identified as requiring investment due to concerns about the quality and safety of the existing provision.

7.5 Part of this work led to the development of the emerging mental health model for Somerset (see Figure 1 below) that seeks to address the gaps in service provision across the whole pathway from first symptom to urgent and crisis care. This model was coproduced with service users and partner agencies such as the Trust, adult social care, and public health.

[17] Sustainability and Transformation Partnerships were formed in 2016 with the aim of running local services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day to day health. https://www.england.nhs.uk/integratedcare/stps/

Figure 1: The emerging mental health model in Somerset



7.6 In addition to increased financial resources the clinical commissioning group has told us that there were also a number of cultural issues that needed to be addressed. Some of this cultural change has been achieved through the appointment of peer support workers in the community mental health team and home treatment team services. We have been told that the impact of people with lived experience working alongside clinicians in the Trust has dramatically changed how services are provided, but no qualitative evidence has been provided to support this statement.

7.7 The clinical commissioning group has also told us that the Trust has undertaken a number of reviews, looking at what and how services are provided. One commitment has been that of being far more responsive to referrers especially primary care colleagues. There has been a recognition that too often thresholds were too high and too many referrals were 'bounced back'.

7.8 A new expanded primary care mental health service has been developed with three levels:

- the emotional wellbeing service, delivered in partnership with the voluntary and community sector;
- core improving access to psychological therapies;

- specialist talking therapies service – for people whose needs exceed the improving access to psychological therapies criteria but do not meet the thresholds for secondary mental health care.

7.9 The development of the emerging model for mental health led to a successful bid for investment in expanded community mental health services. Somerset was the only locality in the south west to achieve this and this will see a total of more than £13 million of additional funding for mental health services over the three years 2019/20 to 2021/22.

7.10 The additional investment is being directed to:

- improved psychiatric liaison services in acute hospitals that are compliant with national policy;
- 24/7 home treatment support across the county;
- an expanded community mental health team service spanning primary and secondary care support.

7.11 These were all of areas of service that were cause for concern in 2017.

7.12 Corresponding cultural changes are also critical. The clinical commissioning group has told us that the attitude to service access by the Trust now is that of 'no wrong door', meaning wherever people present with mental health needs they will be seen, assessed and supported appropriately.

7.13 We have heard from the clinical commissioning group that "…relationships across the whole system have improved dramatically…". However, the clinical commissioning group also recognises that further work is required and that the new services are still in the stage of being developed.

7.14 The clinical commissioning group's perspective is that anyone in a mental health crisis today will have an improved experience and easier access to support.

7.15 We can see that the intentions to improve service provision and patient experience are present in the documents we have received from the clinical commissioning group. The clinical commissioning group has also acknowledged that they are in the early stages of embedding the changes. However, we have not been able to get a sense of how these changes are actually improving patient or stakeholder experiences. We heard from the GP practice involved in Mr K's case that their perspective is that it is just as difficult to secure an urgent assessment today as it was in 2016. The clinical commissioning group should seek assurance that the service response to urgent requests for Mental Health Act assessments is much improved.

Recommendation 4: NHS Somerset Clinical Commissioning Group must work with stakeholders to assess the impact of service changes on all groups of stakeholders, specifically patients and their families, and GPs. Particular attention must be given to evidencing an improvement in access to urgent Mental Health Act assessments.

Access to Mental Health Act assessments

7.16 It is reported by the Association of Directors of Adult Social Services (ADASS) that there are concerns that as the numbers of Mental Health Act assessments has increased across the country, the numbers of AMHPs available to undertake assessments has decreased. Other national reports have suggested that the lack of AMHPs was a primary cause of delay in the Mental Health Act process. ADASS also reported that routine data on the number of Mental Health Act assessments undertaken by AMHPs is not collected or reported nationally.

7.17 We sought to understand how the service changes might have influenced the number of Mental Health Act assessment requests in Somerset and how these are responded to. We therefore asked the local authority to provide us with information about the:

- number of requests for Mental Health Act assessments received;
- number of Mental Health Act assessments conducted;
- number of assessments that resulted in detention;
- outcome of assessments for those that were not detained.

7.18 Table 2 below shows the number of Mental Health Act assessments requested, and the number conducted. The data shows that the percentage of requests that result in an assessment being conducted has fallen significantly from 2015/16 to 2018/19.

Table 2: Conversion rates for Mental Health Act assessments 2015/16 to 2018/19[18]

	2015/16	2016/17	2017/18	2018/19
Number of requests	921	964	1176	1337
Number conducted	233	240	220	187
Conversion rate	25.3%	24.9%	18.7%	14.0%

7.19 An ADASS report[19] published in April 2018 found that during 2016/17 on average there were 268 Mental Health Act assessments per 100,000 population. The population of Somerset is about 550,000 which would suggest that, based on the national average, 1474 Mental Health Act assessments should have been carried out.

7.20 NHS Digital official statistics on the use of the Mental Health Act currently only consider those patients who have been detained on a section of the Mental Health Act, rather than the number of requests for assessments. Therefore, there is no national benchmark for us to compare the conversion rate in Somerset with other areas.

[18] Data provided Somerset County Council from Somerset Partnership NHS Foundation Trust source

[19] https://www.adass.org.uk/media/6428/nhsbn-and-adass-social-care-national-report.pdf

7.21 The outcome for the assessments conducted are shown in Table 3 below. The local authority did not have the outcome information for all assessments conducted. We can see that the number of assessments where the outcome is not known has reduced significantly in the last two reporting years, which is indicative of improved recording and reporting systems.

Table 3: Outcomes for Mental Health Act assessments 2015/16 to 2018/19[20]

	2015/16	2016/17	2017/18	2018/19
Number conducted	233	240	220	187
Current section to continue	3	-	4	-
Mental Health Act invoked	106	99	91	87
Informal admission	20	21	21	20
No admission	64	71	86	69
Other	3	3	2	4
Outcome not known	37 (16%*)	46 (19%*)	16 (7%*)	7 (4%*)

* of total assessments conducted

7.22 For those patients who were not detained, and for whom the outcome was known, the type of support offered to them after their assessment was also recorded. Table 4 below provides the support offered.

Table 4: Types of support offered to patients who were not detained following a Mental Health Act assessment 2015/16 to 2018/19[21]

	2015/16	2016/17	2017/18	2018/19
Not detained where outcome known	67	74	88	71
Another appointment	3	2	12	7
Discharge – refer to consultant or community team	9	11	5	3
Discharge – refer to GP	4	7	1	1
Discharge – no onward referral	3	8	4	1
Other	3	4	2	1
Outcome not known	45 (67%**)	42 (57%**)	64 (73%**)	60 (84%**)

** of patients who were not detained, and the outcome was no admission, or other

[20] Data provided Somerset County Council from Somerset Partnership NHS Foundation Trust source

[21] Data provided Somerset County Council from Somerset Partnership NHS Foundation Trust source

7.23 We are concerned that on the basis of these statistics there appears to be a lower than expected number of referrals for Mental Health Act assessment in Somerset than the population would indicate there should be. Of those assessments, the number of assessments conducted seems to be reducing over time. Alongside this there is an increasing proportion of those people assessed but not detained (60 people in 2018/19) and it is not recorded what happened to them after assessment. We are therefore concerned about the lack of information about the outcomes for those people who have not been detained but who were presumably presenting as ill enough to warrant assessment under the Mental Health Act.

Recommendation 5: NHS Somerset Clinical Commissioning Group must work with local authority partners and the Trust to understand the reasons behind a reducing number of Mental Health Act assessments and to understand more fully what happens to those people who are assessed but not detained under the Mental Health Act, and how their mental health needs are being met.

8 Discussion and analysis of Mr K's care and treatment

Referral for Mental Health Act assessment

8.1 On 10 August 2016 Mr K presented on three occasions seeking help for his mental health. He was seen by GP1 on two of those occasions and on the final occasion he only spoke to reception staff before leaving the surgery.

8.2 The outcome of the medical assessments by GP1 was a request for an assessment under the Mental Health Act. The request was made by telephone at about 2:30pm on the same day to the Somerset County Council Approved Mental Health Professionals (AMHP) on duty, known as the AMHP hub.

8.3 Although GP1 spoke to a social worker (SPFT1) who had been a practicing AMHP, it is clear to the investigating team that her role on that day involved working as a member of the community mental health team taking a call as the GP could not get through to the AMHP hub. SPFT1 took the clinical details from the GP and understood that this was an unambiguous request for an assessment under the Mental Health Act 1983 by an Approved Mental Health Professional.

8.4 At 4:36pm on 10 August 2017 SPFT1 who was working for the Trust wrote up the clinical entry into RiO with the details of the circumstances as described by the GP and the request for an assessment under the Mental Health Act. This information was shared with the AMHP hub in two ways:

- via a phone call to AMHP1 who was the AMHP on duty operating from the AMHP hub service;
- by AMHP1 having access to the clinical entry made on RiO by SPFT1.

Mental Health Act & Code of Practice

8.5 The Mental Health Act is clear at s.13 (1) what the duties are for a local authority and an AMHP:

> 13 Duty of approved mental health professionals to make applications for admission or guardianship.
>
> (1) If a local social services authority have reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patient's case on their behalf[22].

8.6 Furthermore, the Mental Health Act is accompanied by the Code of Practice where at Chapter 14 it sets out the role of the local authority and the AMHP:

[22] http://www.legislation.gov.uk/ukpga/1983/20/section/13#commentary-c18685551

14 Responsibilities of local authorities

14.35 Local authorities are responsible for ensuring that sufficient AMHPs are available to carry out their roles under the Act, including assessing patients to decide whether an application for detention should be made. To fulfil their statutory duty, local authorities should have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs.

14.36 Section 13 of the Act places a specific duty on local authorities to arrange for an AMHP to consider the case of any patient who is within their area if they have reason to believe that an application for detention in hospital may need to be made in respect of the patient. Local authorities must make such arrangements if asked to do so by (or on behalf of) the nearest relative[23].

8.7 We are of the view that there exists within the phrase "consider the case" a clear responsibility to undertake some form of assessment. We set out our deliberations below in the findings on this point about whether the AMHP actually undertook an assessment under the Mental Health Act, or passed the responsibility for an assessment of mental health to another agency.

The role of AMHPs

8.8 The role of the AMHP is also set out in the Mental Health Act Code of Practice. Paragraph 14.49 states:

AMHPs may make an application for detention only if they:

- have interviewed the patient in a suitable manner;
- are satisfied that the statutory criteria for detention are met; and
- are satisfied that, in all the circumstances of the case, detention in hospital is the most appropriate way of providing the care and medical treatment the patient needs.

8.9 And further, at paragraph 14.52 it states:

Although AMHPs act on behalf of a local authority, they cannot be told by the local authority or anyone else whether or not to make an application. They must exercise their own judgement, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the Act. The role of AMHPs is to provide an independent decision about whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision, and taking account of the least restrictive option and maximising independence guiding principle.

[23] Mental Health Act 1983: Code of Practice. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

AMHP involvement in Mr K's care and treatment

8.10 The actions that followed the telephone call from the GP who had seen Mr K on two occasions need careful scrutiny. We have considered the written clinical records and spoken to both the GP who made the referral and the clinicians involved at the time in order to examine the actions of Trust home treatment team clinicians and the AMHPs involved, and whether or not they fulfilled their statutory responsibilities.

8.11 AMHP1 who was one of the Duty AMHPs working in the AMHP Hub[24] took the referral from SPFT1 and made a decision to pass the information to the Trust home treatment team covering the South Somerset area. This is recorded in the electronic patient records at 3:47pm on 10 August 2016. AMHP1 made a call to the Trust home treatment team to take over the assessment of the mental health needs of Mr K based on the following criteria:[25]

- Mr K was not known to services;
- it was the least restrictive option, and therefore;
- it was considered by AMHP1 to be good practice.

8.12 AMHP1 told us that the Trust home treatment team and AMHP Hub work closely together and it would have been usual for the home treatment team to:

- make contact with the patient;
- undertake their own assessment;
- see if they could treat at home;
- then feedback to the AMHP Hub only if an assessment under the Mental Health Act was needed.

8.13 The Trust home treatment team then took over the process of arranging to communicate back to the referrer and assessing the clinical needs of Mr K. During interview with us AMHP1 indicated that it was good practice for the home treatment team to take over the assessment process when a patient was not previously known to mental health services.

8.14 There were two further occasions of the AMHP Hub involvement:

- AMHP1 recorded at 5:46pm on 10 August 2016 that after a conversation with the home treatment team "… given that the GP has stated that he is at no immediate risk to himself or others, [the home treatment team] will try and make contact tomorrow."
- There is a further entry on the 12 August, two days after the initial referral whereby AMHP1 discussed with SPFT4 the telephone calls with the GP

[24] The AMHP Hub is a service provided by Somerset County Council

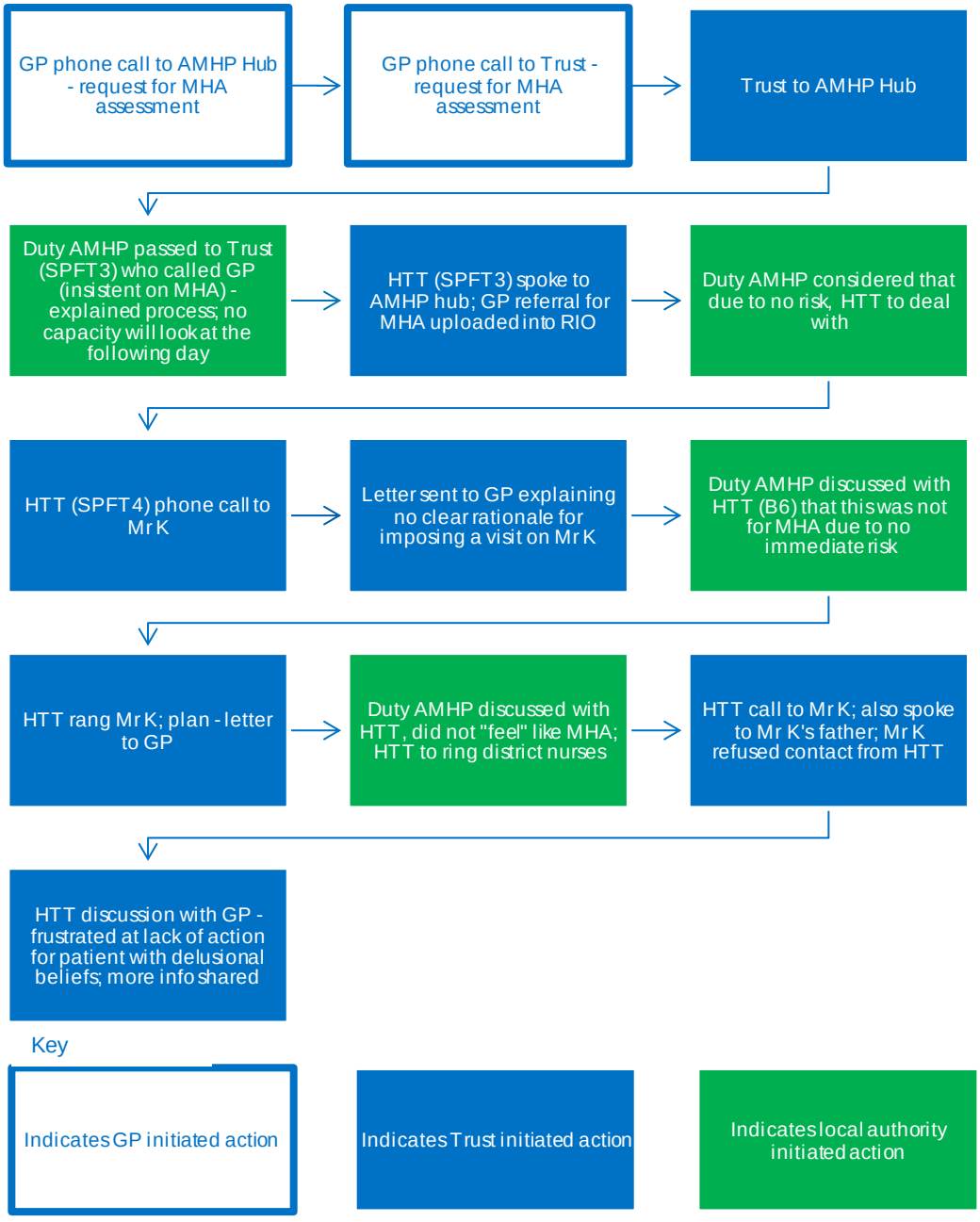
[25] Related to investigation team at interview

and to Mr K, and concluded that it did not feel that a Mental Health Act assessment was required.

Analysis of Mental Health Act assessment request and outcome

8.15 Figure 2 below provides an overview of the communication process from the point of the telephone call from GP1 requesting a Mental Health Act assessment.

Figure 2: Communications between organisations in August 2016



8.16 The investigation team is clear that the GP who saw Mr K:

- made a sound assessment of the presenting problem;
- corroborated his view with a senior colleague who had extensive experience in psychiatric emergencies;
- prescribed antipsychotic medication;
- made a sustained effort to effect the most appropriate clinical intervention by way of an assessment under the Mental Health Act and undertook the necessary communication to do this.

8.17 At the time of GP1's request for a Mental Health Act assessment, the service arrangements had recently changed. Historically AMHPs had been integrated into community mental health teams, based in Trust offices and working alongside Trust staff in a multi-disciplinary team. However, plans had taken place to dissolve the integrated arrangements and for:

- AMHPs to be line managed by and directly accountable to Somerset County Council;
- AMHPs to be co-located within the same building as Trust staff but in a separate office[26] as a discreet AMHP team working to the Somerset County Council work priorities (Mental Health Act, Safeguarding and Care Act work);
- this resulted in the setting up of the AMHP Hub to which AMHPs were recruited to provide a 24-hour service, seven days per week. This service would have additional support from the remaining AMHPs located within community mental health teams who would come onto the rota but for a much-reduced demand than previously.

Findings

8.18 It is our view that the case of the GP referral would clearly be a set of circumstances where the requirements of s13 of the MHA1983 are met:

- **13 (1)** If a local social services authority has reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patient's case on their behalf.

8.19 The case was then passed without delay to the AMHP who decided on how to proceed; in this case by handing to the home treatment team. The investigation team could not find evidence within the clinical records the rationale for the AMHP passing the referral straight to the home treatment team. In particular, there is no articulation of the legal requirement to consider the patient's case on behalf of Somerset County Council within which it was reasonably believed that Mr K was residing and receiving GP services.

[26] At the time of the referral in 2016 the AMHP Hub was located within a hospital in Taunton, above one of the wards

8.20 The Mental Health Act sets out in some detail what the AMHP should do if they think an application is necessary but is virtually silent on what should happen if they don't think the patient should be detained. The Code of Practice is a guide for AMHPs that is not to be departed from save for good reason or faith. However, what is clear to us is that is that a form of an assessment must be undertaken, and therefore that the duty to consider the patient's case on their behalf should be an assessment.

8.21 This is considered further in the Mental Health Act Manual[27] when dealing with s.13(1) in the explanatory notes there is clarity around the role of the AMHP in "considering the case". The role of the AMHP is to arrange and coordinate the assessment, taking into account all factors to determine if detention in hospital is the best option for the patient or if there is a least "restrictive alternative"[28]. In the view of the team AMHP1 did not evidence that they arranged and coordinated an assessment under the Act. If it was the intention of the AMHP to use the Home Treatment Team to undertake the assessment, the team consider that the AMHP held vicarious responsibility for that assessment.

8.22 In Mr K's case the alternative way of providing the treatment or care was to pass the case to the home treatment team. However, throughout the clinical records provided to the investigation team, there is no clear analysis or consideration of the case by the AMHP Hub or an acknowledgement of holding the responsibility for arranging or coordinating the assessment. There was no communication by the AMHP Hub to the GP to that effect, or a clear communication that the AMHPs have considered the case that falls within their jurisdiction.

8.23 There could be an argument made that the AMHP on duty had regard to another part of the Code of Practice:

- **14.13** Professionals must consider available alternatives, having regard to all the relevant circumstances, to identify the least restrictive way of best achieving the proposed assessment or treatment. This will include considering what is the person's best interests (if the person lacks capacity, this will be determined in accordance with the Mental Capacity Act).

8.24 At face value, it would appear that the AMHP (AMHP1) did consider a viable alternative to achieve the proposed assessment or treatment, in that the case was handed over to the home treatment team. However, there is a lack of evidence that sets out how the AMHP considered this decision with knowledge of all the circumstances of the case (the context of the GP's request), and in particular how the AMHP has used their knowledge of mental disorder[29] to support the decisions made in relation to all of the circumstances

[27] Mental Health Act Manual, Jones, R

[28] Mental Health Act Manual, Jones, R, explanatory notes, paragraph 71

[29] Regulation 3(2) The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 ; https://www.legislation.gov.uk/uksi/2008/1206/contents/made

of the case (the delusional nature of the illness being described by the GP). The GP's request was clear in that he was asking for an assessment under the Mental Health Act.

8.25 The GPs assessment of Mr K was that he was suffering from a delusional disorder and that he needed a formal Mental Health Act assessment, not just assessment by mental health services. He and colleagues had a sufficient clinical expertise in mental health disorders to recognise the presenting symptoms and risks.

8.26 We have not been able to establish from clinical records nor from interview that the AMHP drew on skills or knowledge to properly consider:

- the information provided by the GP about Mr K's presentation;
- what was being asked for by the GP;
- the treatment options and efficacy of those for delusional disorders;
- what action was being proposed by the Trust home treatment team; and
- to deliberate the outcome of the home treatment team intervention or lack of.

8.27 The Code of Practice further guides the AMHP:

- **14.33** The objective of the assessment is to determine whether the criteria for detention are met and, if so, whether an application for detention should be made.

8.28 At interview and within the clinical records provided to the investigation team, there does not appear to be an evaluation by the AMHP of how the home treatment team was going to use the assessment to determine if the criteria for detention were met. There is a lack of a rationale offered as to the purpose of the home treatment team's proposed intervention, save for the fact that Mr K was not known to local mental health services. We found no evidence that AMHP1 clearly instructed the home treatment team to consider this criteria, nor is this instruction explicit in the final communication by the home treatment team.

8.29 The Code of Practice continues to offer the AMHP service a paragraph to support using the home treatment team:

- **14.34** Because a proper assessment cannot be done without considering alternative means of providing care and treatment, AMHPs and doctors should, as far as possible in the circumstances, identify and liaise with services which may potentially be able to provide alternatives to admission to hospital, such as crisis and home treatment teams.

8.30 It is our view that although AMHP1 indicated at interview that this was their train of thought when passing to the home treatment team, we would argue that there was a misinterpretation of this by AMHP1. We set out our rationale below.

8.31 Implementation of paragraph 14.34 is not articulated within the clinical records. There is no indication that the AMHP was considering the home treatment team as an alternative to admission along the principle of "least restrictive" as a potential outcome of the assessment because no such assessment had occurred under the act at that point in time.

8.32 It is our view that:

- the legal duty to coordinate and/or complete a Mental Health Act assessment rests with the AMHP; and
- that consideration of the least restrictive alternative should form part of an actual assessment of the facts of the case and all of the circumstances of the case.

8.33 At interview AMHP1 articulated the view that the case was passed to the home treatment team because:

- Mr K was not known to services;
- it was the least restrictive option, and therefore;
- it was considered by AMHP1 to be good practice.

8.34 It is our view that AMHP1's views do not accord with the evidence provided by the GP as to the necessity for the AMHP to "consider the case on behalf of the Local Authority". The fact that Mr K was not known to services does not of itself constitute a sufficient justification for not coordinating and arranging an assessment under the Mental Health Act as requested by the GP.

8.35 If though, the AMHP in passing the "process and procedure" for undertaking an assessment of Mr K's mental health is of the view that this constituted a least restrictive option, then it is the view of the team that this either falls foul of the intention of the decision-making flowing "from" and after an assessment. The Code of Practice states:

14.11 In deciding whether it is necessary to detain patients, doctors and AMHPs must always consider the alternative ways of providing the treatment or care they need. Decision-makers should always consider whether there are less restrictive alternatives to detention under the Act, which may include:

- informal admission to hospital of a patient based on that person's consent (see chapter 19 for guidance on consent to informal admission for children and young people)
- treatment under the Mental Capacity Act (MCA) if the person lacks capacity to consent to admission and treatment. If a deprivation of liberty occurs, or is likely to occur, either the Act, a DoLS authorisation or a deprivation of liberty order by the Court of Protection must be in place (see chapter 13)

- management in the community – e.g. by a crisis and support team, in a crisis house or with a host family (see chapter 29 on community patients), or

- guardianship (see chapter 30 and 31).

8.36 Failure to follow this process means that the decision-making and actions of the AMHP do not satisfy the test that they retained an overall duty and responsibility for the assessment, because they did not communicate back to the GP who made the request for the assessment under the Mental Health Act. There is no clear discernible evidence from the AMHP that they in effect downgraded the GP request from an assessment under the Mental Health Act to just an assessment of mental health needs (a function provided by the Home Treatment Team).

8.37 We are clear that at interview and evidenced within both the GP and Trust records, there is evidence that the GP was, without ambiguity requesting an assessment under the Mental Health 2. Such an assessment did not take place within the meaning of the Mental Health Act or the Code of Practice. This request was not just for an assessment of Mr K's mental health, a function which he could have presumably requested via a routine referral to the appropriate team in the Trust.

8.38 We were keen to understand if formal arrangements existed between Somerset County Council and the Trust to meet the following requirement within the Code of Practice:

- **14.41** Unless different arrangements have been agreed locally between the relevant authorities, AMHPs who assess patients for possible detention under the Act have overall responsibility for co-ordinating the process of assessment.

8.39 No policy or protocol that sets out the relationship between the Trust home treatment team and the AMHP Hub was referenced in:

- the Trust 72-hour report;

- the level 2 investigation report commissioned by the clinical commissioning group;

- within the clinical and policy records provided to us;

- at interview by the clinicians involved in the care and treatment of Mr K.

8.40 It is therefore our view that the AMHP retained an overall legal duty and responsibility to co-ordinate the process of Mr K's assessment under the Mental Health Act. This did not occur.

8.41 Finally, the Code of Practice sets out the expectation for the AMHP in relation to the undertaking of the assessment with other professionals:

- **14.45** Unless there is good reason for undertaking separate assessments, patients should, where possible, be seen jointly by the AMHP and at least one of the two doctors involved in the assessment.

8.42 If the AMHP service had undertaken an assessment of Mr K it is likely that this would have been conducted with either an on-call consultant or a Section 12 Approved doctor. However, it is clear from the records that the AMHP did not see Mr K nor did the home treatment team see Mr K for the purposes of the assessment that the GP had requested. This was despite the fact that GP1 stated he was prepared to sign the necessary Mental Health Act paperwork.

8.43 It is highly unlikely that the GP would have had access to the relevant Mental Health Act paperwork (Form A4 Regulation 4(1)(b)(ii)). These documents are usually carried and provided by the AMHP involved in the assessment. It is common for the completion of the Mental Health Act paperwork to be undertaken with the AMHP present when a GP is involved in the assessment. Technically, had the GP had access to the relevant Mental Health Act paperwork, he could have signed the form when he saw Mr K in surgery. However, it is the request for a Mental Health Act assessment that triggers an AMHP's consideration of a case, rather than completion of Mental Health Act recommendations. That said, had the GP had access to and completed the relevant Mental Health Act paperwork prior to contacting the AMHP it is likely this would have sharpened the focus of the duty AMHP.

8.44 In summary, no assessment of Mr K was carried out by the AMHP on duty when the request was made by the GP. However, we are of the view that by passing the assessment to the Home Treatment Team, the AMHP retained vicarious responsibility for arranging and coordinating the assessment process. Therefore we are of the view that the relevant sections of the Code of Practice that refer to an assessment having been carried out are relevant.

8.45 The Code of Practice does reference the expectation of an AMHP where the decision is not to apply for detention:

- **14.104** Where AMHPs decide not to apply for a patient's detention they should record the reasons for their decision. The decision should be supported, where necessary, by an alternative framework of care or treatment (or both). AMHPs should decide how to pursue any actions which their assessment indicates are necessary to meet the needs of the patient. That might include, for example, referring the patient to social, health or other services.

8.46 No assessment actually took place within the meaning of the Mental Health Act or Code of Practice. It is our view that the AMHP retained vicarious responsibility for the assessment that did occur over the phone and that the AMHP also has a Duty to inform other professionals about the outcome of their decision.

- **14.107** Arrangements should be made to ensure that information about assessments and their outcome is passed to professional colleagues where appropriate, e.g. where an application for admission is not

immediately necessary but might be in the future. This information will need to be available at short notice at any time of day or night.

8.47 This did occur in the context of a letter back to the GP after the telephone assessment by the Home Treatment Team. However, it is our view that this fell short of meeting the requirements of the duties and responsibilities held by the AMHP.

8.48 As we have previously stated, the it is our view that the AMHP held vicarious responsibility for feeding back the outcome of their decision-making to consider the request for assessment. There is a lack of evidence about how the AMHP fed back to the referrer the outcome of the request for the Mental Health Act assessment. Instead a telephone call and then a letter was sent from the Trust home treatment team to the GP. The GP and Trust clinical records, and evidence provided at interview clearly indicate that the GP was not satisfied with the response from the home treatment team. The Code of Practice outlines the duties of the AMHP where such disagreements exist:

- **14.109** Sometimes there will be differences of opinion between professionals involved in the assessment. There is nothing wrong with disagreements: handled properly these offer an opportunity to safeguard the interests of the patient by widening the discussion about the best way of meeting their needs. Doctors and AMHPs should be ready to consult other professionals, especially care co-ordinators and others involved with the patient's current care, and to consult carers and family, while retaining for themselves the final responsibility for their decision. Where disagreements do occur, professionals should ensure that they discuss these with each other.

8.49 It is our view that the duty remained with the AMHP from the point of referral to the decision to not proceed with a Mental Health Act assessment, albeit vicariously if the AMHP decided to pass the function of assessment to another service. The Code of Practice clearly states that the AMHP "retain[s] for themselves the final responsibility for the decision"[30] and therefore it was incumbent on them to inform the referrer of how to make a re-referral if the clinical necessity arose. If the AMHPs involve other staff, they still have overall responsibility and must feedback to referrers and other concerned parties if they decide not to proceed with an application.

8.50 We are not assured that at the point of the communication back to the GP by the home treatment team there was an alternative plan in place, or a risk assessment and identified method of managing those risks. The Code of Practice again directs mental health professionals on this matter in relation to the dispute that existed between the GP and the home treatment team/AMHP Hub service:

- **14.110** Where there is an unresolved dispute about an application for detention, it is essential that the professionals do not abandon the patient. Instead, they should explore and agree an alternative plan – if necessary

[30] 14.109 Mental Health Act Code of Practice

on a temporary basis. Such a plan should include a risk assessment and identification of the arrangements for managing the risks. The alternative plan should be recorded in writing, as should the arrangements for reviewing it. Copies should be made available to all those who need it (subject to the normal considerations of patient confidentiality).

8.51 The AMHP service should have been clear when their assessment had ended and that there would need to be a new referral to get them involved again. Until they had done this the responsibility remained with the Somerset County Council AMHP service.

Recommendation 6: NHS Somerset Clinical Commissioning Group must work with local authority partners to gain assurance that the AMHP service working practices comply with the Mental Health Act Code of Practice.

8.52 Notwithstanding the issues regarding a Mental Health Act assessment, it remains that the Trust could have referred Mr K for a longer-term assessment following the telephone assessment. There was a clear statement from the GP expressing significant concern about Mr K's delusional presentation. It is well understood that patients that present with a persistent delusional disorder are unlikely to recognise that they are unwell and therefore will reject all offers of support from services. However, this is not a reason to attempt to engage them in the first instance. Had the Trust done so and concerns about Mr K's delusional state persisted, this would have added weight to the need for a Mental Health Act assessment.

Record keeping

8.53 Somerset County Council AMHPs continue to write directly into the Trust electronic patient record. Therefore, Somerset County Council was unable to provide us with any information as 'data owners' for the clinical actions and interventions of AMHPs working in their service.

8.54 On one level this makes the viewing of written clinical notes by the two agencies visible and accessible. However, it may also lead to a blurring of the legal duty of AMHPs to carry ownership of Mental Health Act requests for the duration of the clinical process. It may also lead to problems of data-gathering and analysis of Mental Health Act assessment requests and AMHP activity.

9 Conclusions and recommendations

9.1 It is our view that there should have been a much more proactive and robust response from the health and social care system following the GP's request for an urgent Mental Health Act assessment. It is also our view that the local authority did not properly discharge their duty under Section 13 Mental Health Act.

9.2 The GP made extensive attempts to secure an assessment and ultimately believed that Mr K would be followed up by mental health services, even if a Mental Health Act assessment was not conducted.

9.3 Despite Mr K being seen by a GP with experience in mental health care his assessment was given insufficient weight by Trust and local authority staff who had not assessed Mr K. When mental health staff did make contact with Mr K they did not take the advice of the GP, which was to make face to face contact, not telephone contact.

9.4 Mr K presented with a delusional disorder that with hindsight appears to have been persistent in nature. Had a proper assessment of his mental state been undertaken in 2016 it would have been more likely that this delusional disorder could have been identified. It is of note that the way that Mr K's delusions manifested in 2016 were similar to those described following his arrest for the death of Mr P.

9.5 Although we consider there were failings in the health and social care response in August 2016, it is not our view that these failings directly led to the death of Mr P.

9.6 There was also a failure by the clinical commissioning group to ensure that all the recommendations present in the serious incident investigation report were reflected in a combined action plan. It is our view that this failure resulted in a loss of oversight of progress of key changes, and that there has been insufficient evidence gathered to provide assurance that the service changes that have been made have delivered positive changes for all stakeholders, most importantly patients, their families, and primary care.

Predictability and preventability

9.7 Predictability[31] 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.[32]

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

[32] 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

9.8 Prevention[33] 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

9.9 The clinical commissioning group report cited the root causes as being that the homicide occurred because Mr K believed he was being "persecuted and targeted by powerful people" and that this belief arose from an untreated paranoid psychosis. A root cause cannot be patient factors, it has to be the earliest point that service intervention could have made a difference.

9.10 It is our view that Mr P's death in June 2017 was neither predictable nor preventable by mental health services. The time lapse between August 2016 and June 2017 is too great to be able say with certainty that appropriate interventions in August 2016 would have resulted in Mr K remaining well ten months later.

9.11 In addition, even if health and social care staff had intervened appropriately and conducted a Mental Health Act assessment, it is not certain what the outcome of that assessment in either the short or longer term would have been. Mr K's mental state did not deteriorate to the point that he came to the attention of primary care or mental health services again for another ten months.

9.12 However, if Mr K had been assessed under the Mental Health Act in August 2016 it is more likely that he would have been treated, and therefore it would have been less likely that he would have attacked Mr P. We do consider that there were actions that the Trust and the local authority should have taken following the referral from GP1 for a Mental Health Act assessment in August 2016. However, because of the large time gap between the referral for assessment and the homicide, we do not think the incident was predictable or preventable.

Recommendations

9.13 This independent investigation has made six recommendations to improve practice.

Recommendation 1: NHS Somerset Clinical Commissioning Group must ensure that quality assurance of investigation reports and associated action plans is consistently completed and evidenced, and that a process is in place that ensures reports are picked up at future Serious Incident Review Group meetings.

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

Recommendation 2: NHS Somerset Clinical Commissioning Group must ensure that a system is in place to check that recommendations in investigation reports are fully reflected in associated action plans.
Recommendation 3: NHS Somerset Clinical Commissioning Group must assess the impact to relevant stakeholders of the actions completed by the Trust.
Recommendation 4: NHS Somerset Clinical Commissioning Group must work with stakeholders to assess the impact of service changes on all groups of stakeholders, specifically patients and their families, and GPs. Particular attention must be given to evidencing an improvement in access to urgent Mental Health Act assessments.
Recommendation 5: NHS Somerset Clinical Commissioning Group must work with local authority partners and the Trust to understand the reasons behind a reducing number of Mental Health Act assessments and to understand more fully what happens to those people who are assessed but not detained under the Mental Health Act, and how their mental health needs are being met.
Recommendation 6: NHS Somerset Clinical Commissioning Group must work with local authority partners to gain assurance that the AMHP service working practices comply with the Mental Health Act Code of Practice

Appendix A - Terms of reference for independent investigation

Purpose of the investigation

To identify whether there were any gaps, deficiencies or omissions in the care and treatment that Mr K received, which, had they been in place, could have predicted or prevented the incident. The investigation should identify opportunities for learning and areas where improvements to local, regional and national services are required that could prevent similar incidents from occurring.

The outcome of this investigation will be managed through corporate governance structures within NHS England, Clinical Commissioning Groups and Providers.

Terms of Reference

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

NHS Somerset CCG commissioned an internal level 2 investigation following the incident in June 2017.

This investigation will build on that review in the following areas:

1. Provide a full chronology of Mr K's contact with mental health services.

2. Comment on the clinical pathways between Somerset Partnerships services, Primary Care and the local AMHP Hub identifying any unintended barriers to accessing appropriate and timely services.

3. Review the communication and liaison at transition points between Somerset Partnership Trust and Primary Care and whether that met the Trusts Policy.

4. Identify any organisational factors that hindered the risk assessment and management processes.

5. Review the discharge planning process following the request for a Mental Health Act assessment in August 2016.

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

7. Review the CCGs internal investigation reports and assess the adequacy of its findings, recommendations and implementation of the action plans and identify:

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

- 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.
- Review the CCGs oversight of the resulting action plan.

8. Having assessed the above, to consider if this incident was predictable, preventable or avoidable and comment on relevant issues that may warrant further investigation.

9. To review and comment on the CCGs enactment of the Duty of Candour.

10. To assess and review any contact made with the victim and perpetrator families involved in this incident, measured against best practice and national standards.

11. To review and test the Trust and Clinical Commissioning Group's governance, assurance and oversight of serious incidents with particular reference to this incident.

12. To review the CCGs family engagement policy for homicide and serious patient incidents, measured against best practice and national standards.

13. Assist the family in the production of an impact statement for inclusion in the final published report, if appropriate.

Timescale

14. 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

15. 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 GP primary care service, Trust, commissioners, investigator and other agencies willing to participate in this investigation.
- Seek full disclosure of the perpetrator's clinical records to the investigation team.

Outputs

16. We will require monthly updates and where required, these to be shared with families.

17. A succinct, clear and relevant chronology of the events leading up to the incident which could help to identify any problems in the delivery of care.

18. A chronology of Mr K's mental health history.

19. A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome.

20. 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).

21. Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference, to answer any questions relevant to the investigation process and scope.

22. At the end of the investigation, to share the report with the GP practice and Trust and meet the victim and perpetrator families and the perpetrator to discuss the findings of the investigation and engage the Clinical Commissioning Group with these meetings where appropriate.

23. A concise and easy to follow presentation for families.

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

25. We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public.

26. The investigator will deliver learning events/workshops for the Trust, staff and commissioners as appropriate.

Other

27. We expect the investigators to include a lay person on their investigation panel to play a meaningful role and to bring an independent voice and challenge to the investigation and its processes.

28. 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

Somerset Partnership NHS Foundation Trust documents

- Clinical records for Mr K
- 72 hour incident report
- Local services serious incident review
- Action plan
- Mental Health Act assessment request flowchart
- Interim home treatment operational procedure
- Protocol for the management of referrals
- Guidance for GPs requesting a Mental Health Act assessment
- Risk management policy
- Serious incident policy

NHS Somerset Clinical Commissioning Group documents

- Serious incident investigation report
- Multi agency meeting notes 27 November 2017
- Emails regarding implementation of Trust recommendations
- Email communication with Devon and Cornwall Police regarding execution of Duty of Candour responsibilities
- Description of service changes since 2016 and supporting documents

Somerset County Council documents

- Description of service changes
- Activity and outcome data for Mental Health Act assessments

Appendix C – Professionals involved

Pseudonym	Role and organisation
GP1	GP, Essex House Medical Centre
GP2	GP, Essex House Medical Centre
SPFT1	Care Coordinator, Somerset Partnership NHS Foundation Trust
AMHP1	Approved Mental Health Practitioner, Somerset County Council
SPFT3	Nursing Assistant, Somerset Partnership NHS Foundation Trust
SPFT4	Care Coordinator, Somerset Partnership NHS Foundation Trust
SPFT5	Mental Health Nurse, Somerset Partnership NHS Foundation Trust
SPFT6	Mental Health Nurse, Somerset Partnership NHS Foundation Trust
SPFT7	Criminal Justice Mental Health Practitioner, Somerset Partnership NHS Foundation Trust

Appendix D – Action plan progress

Recommendation	Action	Evidence and assurance	Status
1. Clarity required around action to be taken by [Trust] staff on receipt of request for Mental Health Act assessment	Flowchart to be developed outlining action to be taken following request for Mental Health Act assessment	Draft flowchart provided and action marked as complete on 16 January 2018	
2. Clarity required for GPs and AMHPs regarding home treatment team operating procedures	Home treatment team service operating procedure to be shared with GPs county wide and AMHP service once completed	Operational procedure provided and action marked as complete on 31 January 2018	
3. Clarity required for GPs and AMHPs regarding home treatment team telephone and face to face assessments	Protocol for management of telephone referrals and face to face assessment for home treatment service to be shared with GPs county wide and AMHP service once completed	Protocol provided and action marked as complete on 31 January 2018	
4. Clarity required for GPs and [Trust] staff especially home treatment team regarding Mental Health Act process	Guidance on making requests for Mental Health Act assessments to be shared with GPs and home treatment team once this has been completed	Guidance provided and action marked as complete on 31 January 2018	

Appendix F – Definition of a 'root cause' in patient safety

Definition of the term root cause

The term root cause has been referred to since as early as 1905, where the root cause of a problem with health care in the Rhondda Valley was reported in the Lancet.[34]

Over the years since, the term root cause has been used in investigation methodology, where safety investigations have been conducted using root cause analysis principles. Thinking has developed to move around from simply identifying the root cause as the most basic causal factor to one that, if changed, would have changed the outcome.

The purpose of carrying out root cause analysis investigations is to make improvements so that the chance of error is reduced or removed. In order to do this one cannot simply look for the most basic causal factor but look for the most basic causal factor which could be corrected. As a result, root cause analysis methodology now refers to the root cause being the most basic/earliest causal factor which is ***amenable to management intervention.***

A ***root cause*** is the deepest cause in a causal chain that can be resolved. If the deepest cause in a causal chain cannot be resolved, it's not a real problem. It's the way things are. http://www.thwink.org/sustain/glossary/RootCause.htm

Useful definitions include the definition used by Paradies and Busch (1988)[35], that is: "*the most basic cause that can be reasonably identified and that management has control to fix",*

Applying safety methodology to healthcare was accepted by the National patient safety agency. The National patient safety agency Root cause analysis training tools and guidance refer to the root cause as follows:

"A fundamental contributory factor. One which had the greatest impact on the system failure. One which, if resolved, will minimise the likelihood of recurrence both locally and across the organisation."

Some of the anxieties that are experienced about identifying a factor as a root cause stem from our continued problem with approaching investigations in order to learn. The purpose of root cause analysis is to learn what caused something bad to happen and how to stop it from happening in the future. It is predicated on systems theory and should not be used to identify individual culpability. However, with the increasing chance of litigation it is increasingly difficult for organisations to simply identify learning from an investigation.

In 2016 the American National Patient Safety Forum recommended a new approach to root cause analysis that makes the purpose of the investigation process much

[34] *The Present State of Medical Practice in the Rhondda Valley". The Lancet 18 November 1905*

[35] *HSE (2001) Root causes analysis: Literature review Prepared by WS Atkins Consultants Ltd for the Health and Safety Executive*

clearer. They have produced guidance on the subject, and they have renamed root cause analysis as RCA². In the guidance pack[36] they make the following statement:

"*The actions of an RCA² must concentrate on systems-level type causations and contributing factors. If the greatest benefit to patients is to be realized, the resulting corrective actions that address these systems-level issues must not result in individual blaming or punitive actions. The determination of individual culpability is not the function of a patient safety system and lies elsewhere in an organization."*

Further they include an explanation of why "Human Error" is not an acceptable Root Cause?

While it may be true that a human error was involved in an adverse event, the very occurrence of a human error implies that it can happen again. Human error is inevitable. If one well-intentioned, well-trained healthcare worker working in his or her typical environment makes an error, there are system factors that facilitated the error. It is critical that we gain an understanding of those system factors so that we can find ways to remove them or mitigate their effects. Our goal is to increase safety in the long term and not allow a similar event to occur.

When the involved member of staff is disciplined, counselled, or re-trained, we may reduce the likelihood that the event will recur with that person, but we don't address the probability that the event will occur with other providers in similar circumstances. Wider training is also not an effective solution; there is always turnover, and a high-profile event today may be forgotten in the future. Solutions that address human error directly (such as remediation, training, and implementation of policies) are all weaker solutions. Solutions that address the system (such as physical plant or device changes and process changes) are much stronger. This is why it's so important to understand the system factors facilitating human error and to develop system solutions.

The report also includes a guide on how to state a root cause so that it is clear what the cause an effect relationship has been.

The term root cause in a systems/root cause analysis investigation remains as identified by the National Patient Safety Agency (England) – ***the most significant contributory factor, one that had the most impact on system failure and one that if resolved would minimise the likelihood of a re-occurrence***.

36 *National patient safety foundation (January 2016) RCA2 - Improving Root Cause Analyses and Actions to Prevent Harm, Boston, Massachusetts. www.npsf.org*