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HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of Patient A in Devon

Executive Summary

September 2022

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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 for the independent investigation into the care and treatment of Patient A. 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Events which may occur outside of the timescale of this review will render our report out-of-date.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. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

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Incident

1.1 Patient A had been known to mental health services for many years. In summer 2017 their Care Coordinator left, and a new Care Coordinator was not allocated. Patient A was last seen by a Consultant Psychiatrist during an outpatient appointment in October 2017.

1.2 There were two further contacts with community mental health team staff in January 2018 when Patient A appeared anxious and left the meeting abruptly. However, there was no follow up until June 2018, when two appointments were offered to Patient A, but they did not attend.

1.3 In summer 2018 Patient A fatally stabbed a stranger (Mr L) outside a shopping centre in Devon. Mr L later died of his injuries in hospital.

Investigation

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

1.5 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.

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

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

1.8 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

[1] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.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

distress, and that it goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Patient A.

1.9 Patient A has asked us to use the pronouns they/them/theirs in this report and that they be referred to as Patient A.

1.10 Although we spoke to Mr L's family at the start of the investigation, we have been unable to speak with them prior to publication of this report.

Relevant health history

1.11 Patient A had been known to mental health services in Devon for many years. They had a diagnosis of paranoid schizophrenia and their treatment had included clozapine.[3]

1.12 Between March and July 2016, the dose of clozapine was gradually reduced so that by 10 July 2016 it was stopped altogether. On 27 June 2016 the dose of aripiprazole[4] was increased from 10mg to 15mg.

1.13 Records indicate, and witness statements confirm, that Patient A had a positive relationship with their Care Coordinator (CCO1). We understand that CCO1 had been Patient A's Care Coordinator for a long time prior to the starting point for this review.

1.14 In January 2017 a decision was documented that Patient A would be managed as a non-Care Programme Approach (CPA) patient because they appeared stable. We have struggled to understand this decision because it was documented shortly after Patient A had been unwell and had not attended a number of art therapy sessions.

1.15 Despite being cared for as a non-CPA patient, Patient A continued to have contact with a Care Coordinator. It remains unclear whether their care was ever changed back to CPA when concerns were expressed about their mental state by their family member in July 2017. At that time CCO1 documented that Patient A should remain a care coordinated patient on the caseload of the Community Mental Health team (CMHT), rather than be transferred back to the care of their GP. CCO1 documented that some residual paranoia was present and that retaining Patient A on the team caseload would "protect against destabilisation".

1.16 Shortly prior to leaving the Trust in mid-July 2017 CCO1 documented that the plan for Patient A had been discussed in supervision and that the plan was for

[3] Clozapine is an antipsychotic medication used to treat schizophrenia in patients who are unresponsive to, or intolerant of, conventional antipsychotic drugs. https://bnf.nice.org.uk/drug/clozapine.html

[4] Aripiprazole is an antipsychotic medication. https://bnf.nice.org.uk/drug/aripiprazole.html

Social Worker 1 (SW1, a team Social Worker) to review Patient A's treatment and mental state and for an outpatient appointment to be offered.

1.17 There was no immediate follow-up to this, and Patient A's family member contacted the Trust again in late July 2017 expressing concerns about Patient A's mental state. Patient A was seen by CMHT staff in early August when it was documented that Patient A would be allocated to someone else in the team.

1.18 In early September 2017 Patient A contacted the CMHT and had a discussion with the Duty Worker. Patient A reported that they were struggling with shopping and wanted to talk to someone about getting Quay Care[5] involved again. The Duty Worker documented that a message would be left for SW1 to arrange to visit Patient A. There is no evidence that this was followed up.

1.19 Patient A was seen by a Consultant Psychiatrist for a medication review in October 2017. It was documented that Patient A appeared well with no evidence of depression, and that Patient A had denied experiencing any psychotic symptoms. A list of Patient A's medications was obtained the same day to clarify what Patient A was being prescribed, and an alternative medication regime was suggested if Patient A continued to experience high levels of anxiety. The Consultant Psychiatrist documented that Patient A had previously been care coordinated and that they were awaiting reallocation. It was also documented that a follow-up appointment would be offered six months later. This did not happen.

1.20 There was no further contact with Patient A until January 2018, when Patient A was seen twice by a student Social Worker (who was accompanied on one occasion by SW1). The entry made on 4 January 2018 indicated that Patient A had changed their name. Patient A told staff that they had decided to change their name "for personal reasons" citing a wish to "move on" from aspects of their life. It was documented that Patient A did not want to go into details with staff on that occasion. However, there is no indication that the rationale was explored further with Patient A at the following meeting, nor that there was any discussion within the team about whether the change of name was linked to any relapse in Patient A's mental state.

1.21 The student Social Worker raised concerns about Patient A's behaviour after the second meeting when Patient A had presented as anxious, holding their bag throughout the meeting, and had stated they "preferred females". The student Social Worker documented that they had been asked to look back through Patient A's records to identify whether there was any information that may clarify Patient A's behaviour.

[5] Quay Care is a provider of home care and support services in North Devon.

1.22 There is no evidence of any further review or discussion about Patient A until they did not attend an appointment with a female Community Mental Health Nurse on 4 June 2018. A further appointment was made on 29 June 2018 that Patient A also did not attend. It was documented that Patient A would be discharged from the caseload of the CMHT back into the care of their GP.

1.23 In summer 2018 it was documented that Patient A had come to the attention of the police and was suspected of killing Mr L.

Forensic history

1.24 Information in Patient A's clinical records provided to us included a report dated from 2018 that showed they had no convictions, reprimands, warnings or cautions prior to the offence in summer 2018.

Court outcome

1.25 Patient A was unfit to enter a plea at their trial, and therefore there was a trial of facts hearing. The jury found that Patient A had committed the killing.

1.26 Patient A was given a hospital order under Sections 37 and 41 of the Mental Health Act (MHA). This means that Patient A was detained in hospital rather than prison (Section 37) and that restrictions were added (Section 41) because Patient A was considered to be a risk to the public.

1.27 The inclusion of Section 41 means that the Secretary of State for Justice can decide whether Patient A moves from hospital to prison, and Patient A's Responsible Clinician will need to get permission from the Secretary of State for Justice before allowing Patient A to leave hospital. This is managed by a special department at the Ministry of Justice.[6]

Internal investigation and action plan

1.28 The Trust commissioned a serious incident investigation following the death of Mr L. The investigation was undertaken by Enable East, an independent NHS team that provides an alternative to commercial management consultancies.

1.29 No root cause is described but the internal investigation found that the fundamental reason for Mr L's death was a deterioration in Patient A's psychotic symptoms and that a significant contributory factor was their non-concordance with medication.

[6] Restricted patients are mentally disordered offenders who are detained in hospital for treatment and who are subject to special controls by the Justice Secretary due to the level of risk they pose. These controls include permission for community leave, transfer to another hospital, discharge and recall to hospital. The Mental Health Casework Section takes these decisions on behalf of the Justice Secretary. Working with restricted patients - GOV.UK (www.gov.uk)

1.30 We do not consider that the root cause was the deterioration in Patient A's psychotic symptoms as this does not meet the definition of 'root cause' as described by NHS England.

1.31 Other contributory factors included:

- The Care Coordinator leaving with no opportunity to provide a structured handover to a new Care Coordinator.
- A new Care Coordinator not being allocated.
- A failure to fully appreciate Patient A's mental health history.
- Pressures of increasing demands on the service set against a national shortage of appropriately qualified and experienced clinical staff, resulting in key vacancies.
- Lack of clarity about the risks to patient care of several service changes.
- Patient A being discharged from mental health services despite not having been seen for six months and consequently there being a lack of certainty about the state of their mental health at the time.

1.32 We note that the internal investigation team did not identify the change of name as a potential red flag and that they did not explore this further in their report.

1.33 Eight recommendations were made:

R1 "The Trust Caldicott Guardian[7] should be asked to consider policies on confidentiality, data protection and information governance to determine how circulation of [the report] should be managed.

R2 The Trust should strengthen practices in relation to discharge planning to ensure discharge meetings involving the team occur and develop a discharge protocol to help standardise decision-making.

R3 The Trust should establish standards and processes for the continuity of care for long-term clients including Care Coordinator allocation and handover arrangements.

R4 The Trust should identify how responsibility for monitoring concordance with medication is assured at either an individual patient level or at an organisational level with the development of clear guidance.

R5 The Trust should undertake regular evaluation to ensure multidisciplinary team meetings facilitate discussions that aim to understand caseload risk and to promote the delivery of safe care.

[7] A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. All NHS organisations and local authorities which provide social services must have a Caldicott Guardian.

R6 The Trust should assure itself that it has robust and audited systems to record the contact details of identified next of kin or other people of significance to patients.

R7 The Trust should assure itself that it has systems in place which allow the concerns of relatives and carers to be recognised, considered and acted upon.

R8 The Trust should develop an action plan to address the recommendations contained within this report which meets the minimum requirements for action plans listed in the NHS England Serious Incident Framework."

1.34 The Trust developed an action plan to respond to the recommendations and included two additional areas of learning. These were:

"AA1 Community mental health services schizophrenia/bi-polar pathway to clearly state the need to be assertive in the approach for individuals who do not engage.

AA2 Core services chief nurse and clinical director to work with the team to identify if there are further concerns regarding competency of staff involved and address appropriately."

1.35 The terms of reference required us to review the completion of the action plan.

1.36 Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a numerical grading system to support the representation of 'progress data'.

1.37 Our measurement criteria are set out in Figure 1 below.

Figure 1: Niche Investigation Assurance Framework (NIAF) action plan assessment criteria

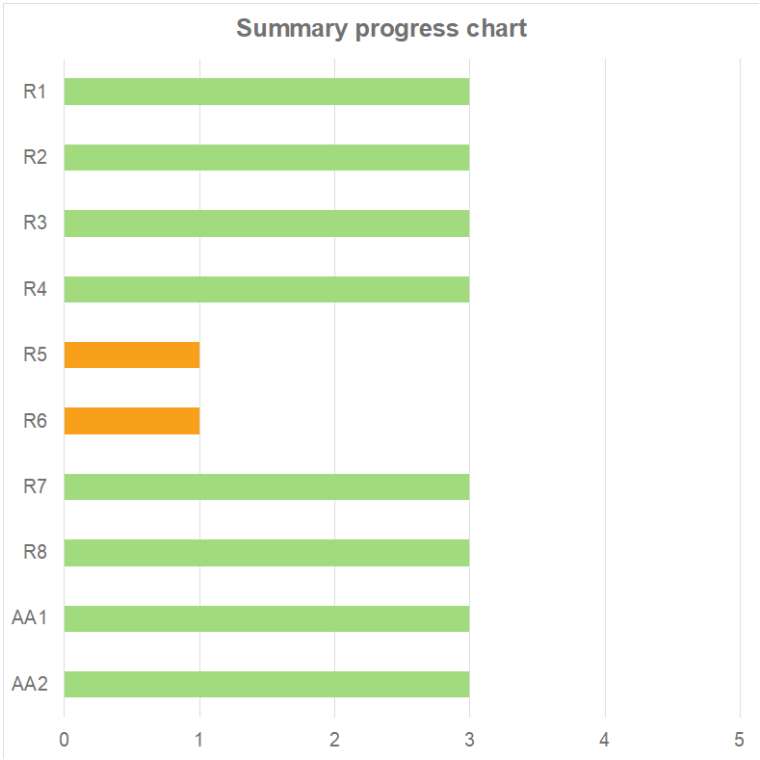
Score and assessment category	
0	Insufficient evidence to support action progress /action incomplete/not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement

1.38 The Trust provided evidence of actions for each recommendation. Of the eight recommendations, we found that six were complete and two were commenced but not complete (recommendations 5 and 6). We also found that the additional two recommendations were complete. However, we consider that the Trust has further work to do to evidence that the changes

have been embedded into everyday practice. We were also concerned that actions remained incomplete two years after the incident.

1.39 Figure 1 below sets out a summary of our findings.

Figure 1: Summary progress chart for action plan



Conclusions

1.40 We have identified a number of care and service delivery problems that we have set out in Table 1 below.

Table 1: Care and service delivery problems

Care delivery problems	Service delivery problems
Lack of detailed and up-to-date care plans	Absence of an allocated Care Coordinator
Lack of an up-to-date risk assessment	Insufficient staff to run a safe team caseload
Failure to follow up on requests for contact by Patient A and their family	Confusion about whether Patient A was being managed as a CPA or non-CPA patient
Lack of professional curiosity	

1.41 Patient A had been known to mental health services in Devon for many years. They had a diagnosis of paranoid schizophrenia and had been prescribed clozapine for some time.

1.42 There was a failure to ensure that Patient A's mental health care and treatment was provided in accordance with the Trust's Care Planning Policy:

- Patient A was moved from a Care Programme Approach (CPA) pathway to a non-CPA pathway in January 2017 because they appeared to be stable, but there is no evidence that this was ever reviewed when concerns were expressed about Patient A's mental health by Patient A's family and Patient A's Care Coordinator (CCO1) in July 2017.
- Patient A continued to have a Care Coordinator despite the Care Planning Policy stating that non-CPA patients have a named worker rather than a Care Coordinator.
- No alternative Care Coordinator was allocated after CCO1 left in July 2017.

1.43 It is our view that Patient A should not have been taken off Care Programme Approach in January 2017. However, records indicate little change in the way that their care and treatment was managed after that time. There was no indication that when Patient A became unwell later in 2017 that consideration was given to moving them back onto CPA, and it is possible that this caused confusion about allocation of another Care Coordinator after CCO1 left in summer 2017.

1.44 There were missed opportunities to assess Patient A's mental health:

- By the Community Mental Health team (CMHT) in September 2017 when Patient A stated they were struggling.
- By a Consultant Psychiatrist in April 2018, the time when a follow-up medical review should have been scheduled (six months after the last medical review in October 2017).
- By the CMHT in June 2018 when Patient A did not respond to appointment letters.

1.45 After concerns were expressed about Patient A's behaviour in January 2018 there was no evidence that CMHT staff reviewed Patient A's longitudinal risks. Had Patient A's previous risk assessments been reviewed, staff would have seen that Patient A's relapse indicators included:

- increased paranoia;
- bizarre thoughts;
- low mood;
- suicidal thoughts;
- self-neglect; and
- increased agitation.

1.46 Patient A also told us that when they were unwell, they struggled to leave their home and would find it difficult to seek out support. Although this was not explicitly described in Patient A's risk assessment, had staff reviewed it they would also have identified that a more assertive approach was required when Patient A was unwell.

1.47 The final missed opportunity to identify concerns about Patient A's mental state was in June 2018 when Patient A did not attend appointments that had been sent via Royal Mail. Patient A told us that they received the appointment letters after the appointment dates. It is impossible for us to know whether the letters arrived in time, but Patient A was too unwell by that time to deal with them, or if they were indeed delayed. Regardless, Patient A was a chronically unwell patient who had previously been prescribed clozapine for treatment resistant schizophrenia, and who was discharged from caseload with no checks on compliance with prescribed treatment.

1.48 GP records show that no prescriptions were issued for aripiprazole (the antipsychotic medication prescribed for Patient A at that time) after 16 January 2018. Therefore, it is unlikely that Patient A had any antipsychotic medication after the middle of February 2018 and therefore would have become increasingly unwell after their interaction with CMHT staff in January 2018. This fact was not identified by the Trust prior to them discharging Patient A in June 2018.

1.49 We consider that it is reasonable that this information should have been known to staff involved in the decision to discharge Patient A. Actions taken by Patient A's Care Coordinator the previous year had sought to understand the degree of their compliance with medication when concerns were expressed about their mental health. On that occasion the enquiries confirmed that Patient A was collecting their medication at expected times.

1.50 We were told by the CMHT that had they known that Patient A was not compliant with their medication they would not have discharged them from their caseload.

1.51 If the discharge protocol included a requirement for proactive contact by the CMHT with a patient's GP (in the event that a patient had not been seen for a period of time) this would have ensured that CMHT staff knew that Patient A had not been compliant with their medication. This should then have prompted more assertive attempts to engage Patient A in an assessment of their mental health.

1.52 There was no evidence that the Trust made attempts to execute the Duty of Candour responsibility to Patient A. The investigation team documented that they would have liked to have had the opportunity to discuss with Patient A's family member the concerns they raised prior to the incident in 2018. The report then stated that because their contact details could not be established,

Duty of Candour could not be met. We are concerned that the Trust did not take the lead on considering and attempting to execute Duty of Candour. It is our view that it was not appropriate for the Trust to have delegated this statutory responsibility to Enable East.

1.53 We found no reference in the Duty of Candour or Serious Incident policies to the Trust's approach to engaging families affected by homicide and serious incidents. NHS England (London) Investigation issued guidance in April 2019 on engaging with families after a mental health homicide.[8] This provides clear best practice guidance to mental health provider organisations and states that "families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation". The Trust should review this publication and ensure that its own policies reflect the best practice referenced.

1.54 The internal investigation report satisfied the terms of reference set, but it did not describe how RCA tools were used to arrive at the findings. No root cause was described, but the report concluded that "the fundamental reason … was that the client had a deterioration in [their] psychotic symptoms". We do not consider that the root cause was the deterioration in Patient A's psychotic symptoms as this does not meet the definition of 'root cause' as described by NHS England.

1.55 The Trust developed an action plan to respond to the eight recommendations from the internal investigation. The Trust also included two additional areas of learning.

1.56 Our assessment of the progress of the action plan found that of the eight recommendations, six were complete and two were commenced but not complete (recommendations 5 and 6). We also found that the additional two recommendations were complete. However, we consider that the Trust has further work to do to evidence that the changes have been embedded into everyday practice. We were also concerned that actions remained incomplete two years after the incident.

1.57 The CCG provided evidence that it had reviewed the internal investigation report and had signed off the action plan. We found that the CCG's oversight and monitoring processes could be strengthened by closer alignment to the quality assurance checklist in the NHS England Serious Incident Framework and detailed follow up of action plans relating to high-profile, complex, or high-risk serious incidents.

[8] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/08/Information-for-Mental-Health-Providers_V4.0.pdf

Recommendations

1.58 Although we have some concerns about the internal investigation, we broadly concur with their findings. Our recommendations build on those from the internal investigation and focus on implementing and embedding those recommendations.

Recommendation 1: The Trust must provide assurance to the Board and its commissioners that care plans are updated in accordance with Trust policy.

Recommendation 2: The Trust must provide assurance to the Board and its commissioners that risk assessments and risk management plans are updated in accordance with Trust policy, and that staff evidence a review of existing clinical risk documents when concerns are raised about a patient's presentation.

Recommendation 3: The Trust must strengthen the discharge protocol to include a review of recent medication compliance (including liaison with the patient's GP) prior to discharging a patient from caseload. The Trust must also implement a system to monitor compliance with the whole protocol on a frequent and regular basis.

Recommendation 4: The Trust must ensure that when national guidance relating to Duty of Candour (regarding an incident that is also the subject of a serious criminal investigation) is published, local policies and procedures are updated. The Trust must also ensure that staff understand and implement the new policies and procedures.

Recommendation 5: The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide; Mental Health-Related Homicide: Information for Mental Health Providers (April 2019) NHS England (London) Investigations.

Recommendation 6: The Trust must implement an audit programme to provide assurance that the changes in response to the internal recommendations 2, 3, 4 and 7, and additional action 1 have been embedded. The Trust must also provide assurance that actions are not signed off as complete when there remain documented concerns about the efficacy of the changes made.

Recommendation 7: The NHS Devon CCG Serious Incident report quality review template should be revised to reflect detailed expectations with NHSE Serious Incident Framework guidance.

Recommendation 8: NHS Devon CCG (and any future Integrated Care System) must implement a process to (a) identify high-profile, complex or high-risk serious incidents, (b) ensure that the provider action plan is followed up in detail, (c) seek assurance that all actions are implemented in a timely manner.

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