An independent investigation into the care and treatment of Mr D

May 2023

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Our Final Report has been written in line with the terms of reference for the internal investigation into the care and treatment of Mr D. 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Events which may occur outside of the timescale of this review will render our report out-of-date.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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1.2 Mr D entered a plea of manslaughter by reason of diminished responsibility, which was accepted by the court. He was detained indefinitely under Section 37 of the Mental Health Act (MHA) in 2021.[1]

Investigation

1.3 The independent investigation follows the NHS England Serious Incident framework (SIF)[2] (March 2015) and Department of Health guidance 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'. The purpose of this investigation is:

- *"To independently assess the quality and management of the care and treatment of Mr D against best practice, national guidance and relevant organisational policy.*
- *To identify further opportunities for learning that may be applicable on a local, regional or national basis building on the provider Trust Level 2 investigation.*
- *To review the internal provider Trust investigation report process and implementation of the statutory Duty of Candour in this case. To review the oversight and monitoring of this internal investigation report by Somerset CCG."*

1.4 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.

1.5 The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system processes.

Relevant health history

1.6 Mr D did not have a documented history of concerns in relation to his mental health. Mr D had a history of underlying physical health conditions and was briefly admitted to hospital in early 2020. Mr D was classified as clinically vulnerable during the Covid-19 pandemic and had to shield.[3] His family reported that his mental health deteriorated significantly during the pandemic.

1.7 Mr D became concerned during the summer and early autumn of 2020 that his neighbour, Mr J, was spying on him and had malicious intent towards him. Mr D believed CCTV cameras Mr J had installed on his property had been put up solely to monitor his movements and that Mr J intended to harm him. Mr D's behaviour became increasingly abnormal in line with his persecutory beliefs e.g., closing the curtains during the day to prevent Mr J from seeing into the house, refusing to speak near the property adjoining wall in case Mr J was listening, and setting the house alarm on the ground floor early in the evening and relocating to the first floor for the rest of the day. Mr J did not actually live in the (vacant) property that adjoined Mr D's, but their gardens backed on to each other.

[1] Section 37 of the MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/37
[2] NHS England (March 2015) *Serious Incident Framework* https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
[3] During the Covid-19 pandemic, individuals considered to be 'clinically vulnerable' (at risk of becoming significantly unwell should they contract Covid-19) were advised to keep their contact with individuals outside of their immediate family to a minimum.

However, Mr J did have keys to the house that adjoined Mr D's, having historically helped the previous owner with tasks on occasion (e.g., food shopping).

1.8 Mr D asked his wife, Mrs D, to contact their GP on his behalf on day 1 to get him help. Mr D's GP spoke to him over the phone and referred him to the Home Treatment team (HTT) for assessment the same day. Mr D was seen by the HTT that afternoon. He told them his neighbour had positioned cameras facing Mr D's house so he could watch Mr D come and go. He said his neighbour was planning to "*get me sorted out*". Mr D indicated he felt he might have to do something to take care of the issue, "*club him with something or stick him*", but said he did not want to spend his life in prison. Mr D said he had intended to speak to the local police the weekend before, but the station was closed.

1.9 The HTT concluded that Mr D would benefit from assessment by the HTT consultant psychiatrist and arranged for him to be seen the next day.

1.10 Mr D was seen by the HTT consultant psychiatrist and HTT manager the next day (day 2). They noted Mr D was experiencing delusional persecutory beliefs, partition delusions[4] and delusional misinterpretations about his neighbour. Mr D said he wanted to be admitted to hospital for respite from his home and neighbour but did not consider himself to be mentally ill and would not take any medication. The assessing staff concluded Mr D would benefit from an inpatient admission but that Mr D did not have capacity to make a decision in this respect and he therefore warranted assessment under the MHA. They contacted the approved mental health professionals (AMHP) service requesting Mr D be assessed by the end of the week (day 2 was a Wednesday). The HTT consultant psychiatrist completed a Section 2 medical recommendation for the MHA assessment.[5]

1.11 The AMHP service agreed to assess Mr D and an appointment was made for him to be seen the next day (day 3). The HTT called Mr D's home on the morning of day 3 to give him the appointment details. They spoke to Mrs D who told the team Mr D had already left the house that morning; there is no evidence he was aware of the appointment prior to committing the homicide on day 3.

1.12 Mr D was arrested the same day following the homicide, and Trust staff attended the local police station to assess Mr D under the MHA. However, following liaison with the South West Provider Collaborative[6] for secure services (provided by a neighbouring NHS Trust, Trust A), it was agreed that, in the absence of a medium secure bed, Mr D should be processed through the criminal justice service with a view to him being diverting to mental health services under Section 48 of the MHA.[7] The clinicians did not universally agree with this plan and the AMHP was clear that Mr D should be assessed under the MHA and admitted to hospital, rather than be processed through the criminal justice system, but the plan remained.

1.13 There was confusion between the Trust and police during the evening of day 3 as to whether Mr D was to be processed under the MHA or the criminal justice system. The decision was taken by the AMHP on duty and another consultant psychiatrist (who had also been involved in the earlier discussions about where to place Mr D) that Mr D should be assessed under the MHA that night, and steps were taken to implement this. However, further discussions amongst healthcare professionals led the team to revert to the original plan to process Mr D through the criminal justice service.

1.14 Mr D began to experience chest pains on the night of day 3 and was transferred to hospital where he remained for five further days. Healthcare professionals remained of the view that Mr D should

[4] *"A partition delusion is the belief that people, objects or radiation can pass through what would normally constitute a barrier to such a passage. These delusions have been reported to be common in late paraphrenia and late-onset schizophrenia"*. Howard, R, Castle, D, O'Brien, J, Almeida, O, Levy, R (1992) 'Permeable walls, floors, ceilings and doors. Partition delusions in late paraphrenia'. *Int J Ger Psychiatry*, 7 (10), pp 719-724.
[5] Section 2 of the MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/2
[6] South West Provider Collaborative Group members are Devon Partnership NHS Trust, Cornwall Partnership NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, Somerset NHS Foundation Trust, Gloucestershire Health and Care NHS Foundation Trust, Livewell Southwest, Elysium Healthcare and Cygnet Health Care.
[7] Section 48 of the MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/48

be remanded in prison and then transferred to a medium secure setting on a Section 48 MHA. Mr D was transferred to prison and received by prison mental health services following his discharge from hospital.

Conclusions

1.15 Mr D's case was unusual in the sense he was only known to Trust services for the two days prior to the incident. His initial referral was handled promptly, and he was seen by the HTT in a timely manner on days 1 and 2. The actions undertaken by the HTT during the assessment process were reasonable and broadly in line with Trust practice. The HTT undertook a good first assessment and the decision by the HTT to refer Mr D for further assessment was appropriate.

1.16 The conclusion made by assessing clinicians on day 2 that Mr D would benefit from a period in hospital was also appropriate. However, it is our view that the decision that Mr D lacked capacity to consent to an admission was conflated with whether Mr D could consent to treatment. There is limited documented information about how Mr D's capacity was assessed, but it is our expectation that admission and treatment should have been considered separately. In Mr D's case focus should have been placed on the former because he was requesting an admission. There was also a missed opportunity to involve Mrs D in the assessment process, which would have been in keeping with best practice, despite her being identified as a protective factor[8] (at a time when Mr D was considered to lack capacity and insight).

1.17 However, we consider the decision to refer Mr D for an MHA assessment was appropriate given the conclusion he lacked capacity. The notes indicate Mr D's presentation was not such that the assessing clinicians considered he needed an immediate admission, therefore the ongoing plan for assessment under the MHA was timely and proportionate given the expectation he would be seen within a couple of days.

1.18 However, we do not agree with the Trust's decision on day 3 to process Mr D through the criminal justice system. We consider the rationale that he might successfully appeal his detention if processed via the MHA unlikely in view of the gravity of his offence. Further to this, the argument that Mr D was too much of an unknown quantity and risk to be placed in a psychiatric intensive care unit (PICU) or with acute services emphasises that he should have been admitted to a secure bed rather than the prison population in the first instance. The decision by clinicians to have Mr D processed through the criminal justice system with the expectation that he would be diverted to forensic services was convoluted. The clinicians had the means on day 3 to assess Mr D under the MHA with a view to him being admitted to secure services. The notes indicate a secure bed was not available, but the Trust has a protocol (locally known as the 'Regulation 28 Protocol'), developed by the South West Provider Collaborative Oversight Group, that sets out the steps to be taken in such a scenario to escalate the matter. There is no evidence this was considered, despite Trust staff not collectively agreeing how best to manage Mr D's treatment pathway.

1.19 We appreciate the situation was unprecedented for Trust staff and that discussions were lengthy and involved several professionals. There were two options available to staff, of which, staff decided to have Mr D processed via the criminal justice system. However, it is our view that it would have been more efficient to have processed him through the MHA on day 3, and to implement the escalation protocol for a secure bed admission.

1.20 The tables overleaf detail the care delivery problems (CDPs) and service delivery problems (SDPs) we identified during the investigation.

[8] Protective factors are influences associated with lowering risk or the likelihood of a negative outcome.

Table 1: CDPs

CDP
Mr D's wife was not involved in mental health assessments
Lack of documented capacity assessment
Conflation of purposes for possible admission under the MHA on day 2 – admission and/or treatment
Decision not to assess Mr D for admission under the MHA after the incident
Expectation that prison services, rather than health services, would provide care to Mr D after the incident

Table 2: SDPs

SDP
Protocol for emergency access to a medium secure mental health bed was not implemented after the incident
Changes to Mr D's management plan after the incident were not communicated consistently between/across teams
Reliance on criminal justice system as a means of accessing a secure bed for Mr D
Trust serious incident (SI) internal report authors not involved in report quality assurance process

Recommendations

1.21 This independent investigation has made six recommendations, based on our 28 findings, to improve learning from this event. Three recommendations relate to events leading up to the incident, three relate to events after the incident.

Pre incident

Recommendation 1: Family engagement. Families supporting[9] an individual must be involved in HTT mental health assessments. In instances where a family member is not involved, the assessing staff should document the rationale.

Recommendation 2: Crisis plans. Service user crisis plans should include planning for the service user's safety and the safety of others in the event of the service user's mental health deteriorating.

Recommendation 3: Capacity assessments. Capacity assessments for each separate decision must be documented by clinicians in line with the Trust's Using the Mental Capacity Act Policy and the legal requirements of the Mental Capacity Act (MCA).

Post incident

Recommendation 4: Protocol for emergency access to a medium secure mental health bed. The Trust, in collaboration with provider collaborative forensic services, must ensure that the protocol for emergency access to a medium secure mental health bed is adhered to by clinicians,

[9] We used the term 'supporting' in the broadest sense.

specifically in relation to:
a) its purpose and when it should be triggered;
b) escalation pathways if a secure bed is not immediately available;
c) the efficient direction to a secure bed when service users are unknown to services and/or are considered to be high risk; and
d) the criminal justice system not being used as an alternative route to access a secure bed.
This should be addressed within six months of receipt of this report.

Recommendation 5: Records management. Mental Health Act specific records and medical recommendations created by Trust staff, even if not used, must form part of the service user's enduring medical record.

Recommendation 6: SI quality assurance. SI investigation report authors must be involved in the SI investigation quality assurance process.

Good practice

1.22 The HTT processed Mr D's initial referral promptly and efficiently.

1.23 The first HTT assessment, undertaken on day 1, was comprehensive.

2 Investigation

Incident

2.1 Mr D killed his neighbour, Mr J, in 2020. Mr D was subsequently arrested and charged with murder.

2.2 Mr D entered a plea of manslaughter by reason of diminished responsibility which was accepted by the court. He was detained indefinitely under Section 37[10] the MHA in 2021.

Approach to the investigation

2.3 The investigation was commissioned by NHS England and NHS Improvement (South West region). The independent investigation follows the NHS England SIF[11,12] (March 2015) and Department of Health guidance Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in Mental Health Services. Please note NHS England and NHS Improvement became NHS England in July 2022. 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 overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

2.6 The investigation was carried out by Kathryn Hyde-Bales, Director for Niche; Mary Smith, Senior Investigator for Niche; and Dr Susan Benbow, Consultant Old Age Psychiatrist. The investigation team will be referred to in the first-person plural in the report.

2.7 The report was peer reviewed by Nick Moor, Mental Health Investigations Lead for Niche.

2.8 We undertook interviews with:

- Consultant Psychiatrist 1, HTT; and
- the joint authors of the Trust's internal investigation

2.9 We received Mr D's clinical notes from Somerset NHS Foundation Trust (SFT or 'the Trust'). We asked the Trust to provide all documents pertaining to Mr D covering three year period specified in the terms of reference. NHS Somerset Clinical Commissioning Group (CCG) provided records and Mr D's GP notes for the same period. Full details of the documents we received are listed in 'Appendix B'.

[10] Section 37 of the MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/37
[11] NHS England (March 2015) *Serious Incident Framework* https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
[12] Please note the Patient Safety Incident Response Framework (PSIRF) was published in August 2022 and replaces the SIF. However we have referenced the SIF for this investigation because it was in place at the time of the incident. https://www.england.nhs.uk/patient-safety/incident-response-framework/

Contact with the victim's family

2.10 NHS England and NHS Improvement liaised with Hundred Families[13] in relation to contacting Mr J's sister.

2.11 Mr J's sister confirmed to us that she intended to submit questions to the investigation, but wanted to review the draft report first. We sent the draft report to Mr J's sister at the end of the investigation with a view to her submitting questions to us following her review. We offered to meet her as part of this process. Mr J's sister subsequently submitted questions to the review which are addressed at the end of section 4 on page 40 ('Questions from Mr J's family').

2.12 We would like to offer our sincere condolences to Mr J's family for their loss.

Contact with Mr D's family

2.13 We met Mr D's wife, Mrs D, in April 2022. We discussed the purpose of the investigation and listened to her views about Mr D's wellbeing, care and treatment in the months leading up to the incident. We shared the terms of reference with Mrs D and offered her an opportunity to review and comment. We also invited her to submit any questions she had to the investigation. Mrs D submitted one question (why the assessing staff did not contact her as part of either assessment on day 1 or day 2), which we have responded to within the main report.

2.14 We met Mrs D at the end of the investigation to share the findings of the draft report and gave her an opportunity to provide feedback.

Contact with Mr D

2.15 We wrote to Mr D in April 2022 to inform him that we would be undertaking an independent review of his care and treatment and to offer a meeting. We shared the terms of reference. Mr D did not reply so we wrote again in May 2022 to reiterate an offer to meet. Mr D did not reply.

2.16 We shared the draft report with Mr D's responsible clinician with a view to it being shared with Mr D. We were told the executive summary was shared with Mr D but he declined to see any more of the report and had no comments to make.

Structure of the report

2.17 Section 3 provides a summary chronology of Mr D's care and treatment.

2.18 Section 4 examines the issues arising from the care and treatment provided to Mr D, and includes comments and analysis related to the terms of reference.

2.19 Section 5 examines the Trust's internal investigation and the progress made with the internal investigation's action plan. It also examines the Trust's and CCG's oversight and assurance processes in relation to the internal report and action plan.

2.20 Section 6 sets out our conclusions and recommendations.

[13] Hundred Families: a charity that supports families affected by mental health homicides. https://www.hundredfamilies.org/

3 Chronology of care and treatment

3.1 Mr D was 69 years old at the time of the incident. He had engaged with Trust services two days prior to the incident because he was experiencing anxiety and beliefs he was being spied on with malicious intent by his neighbour, Mr J. This was his first contact with Trust services.

Previous medical history

3.2 Mr D had underlying physical health conditions. He had secondary polycythaemia[14] and type 2 diabetes, both diagnosed in 2019. He was diagnosed with community acquired pneumonia in early 2020 which required a short inpatient admission. Mr D also had chronic obstructive pulmonary disease (COPD), diagnosed in 2015, which meant he was clinically vulnerable during the Covid-19 pandemic and had to shield.

3.3 Mr D did not have a documented history of contact with mental health services or of poor mental health.

Primary care referral to Trust services

3.4 Mr D handed a note to his wife, Mrs D, on the morning of day 1 asking her to contact their GP practice on his behalf. Mrs D contacted the GP practice and spoke to a member of reception staff and told them that Mr D urgently needed to be seen by a GP due to concerns about his mental health. The GP practice was not receiving walk-in patients because of the Covid-19 pandemic, therefore the receptionist agreed to speak to the GP with a view to arranging a phone consultation with Mr D. She said she would call Mrs D back.

3.5 Mr D left the house and drove to a local layby. He told Mrs D he was doing this to keep her safe from their neighbour. The GP practice receptionist called Mrs D who said Mr D had left the house but still needed to urgently speak to a doctor. She asked that the GP call him directly.

3.6 GP1 telephoned Mr D who answered her call. GP1 recorded in the notes that Mr D was very anxious and had said he felt he was "*about to explode*". He was convinced his neighbour was spying on him and Mr D had indicated he might attack the neighbour. Mr D told GP1 he was in a layby away from his house and asked that he be taken to a place of safety so that he did not hurt anyone.

3.7 GP1 telephoned the Trust's crisis team/HTT who said they would contact Mr D with a view to assessing him that day. GP1 followed up by submitting a written urgent referral to the HTT. In the referral GP1 described Mr D as "*demonstrating acute paranoia*" about his neighbour and noted he was requesting a psychiatric admission. GP1 detailed that Mr D did not have a psychiatric history. GP1 wrote that Mr D denied hearing voices and was not suicidal but was unable to concentrate on anything other than the thought his neighbour was spying on him. GP1 indicated that Mr D was aware suicide or any attempt to hurt his neighbour would cause his wife distress and he did not want to hurt her. GP1 advised Mrs D was concerned about Mr D.

3.8 GP1 concluded the referral asking the HTT to see Mr D that day if they were able to provide a place of safety in which to assess him.

First assessment by the HTT on day 1

3.9 Mr D was seen by a community psychiatric nurse, CPN1, and HTT Manager 1 in the HTT office in the early afternoon of day 1. The team documented that Mr D was experiencing paranoid thoughts

[14] Polycythaemia: Having a high concentration of red blood cells in your blood https://www.nhs.uk/conditions/polycythaemia/

about his neighbour, with whom he reported he had had problems since Mr J had moved to the area two years previously.

3.10 Mr D told the HTT that his neighbour had positioned CCTV cameras facing Mr D's house so he could watch Mr D come and go. He said his neighbour was planning to "*get me sorted out*". Mr D indicated he felt he might have to do something to take care of the issue, "*club him with something or stick him*", but said he did not want to spend his life in prison. Mr D said he had intended to speak to the local police the weekend before, but the station was closed.[15]

3.11 Mr D told the HTT that he did not think medication would help him because he did not think it would change his thoughts. He said the situation had been exacerbated by the Covid-19 lockdown restrictions. Mr D told the HTT he was aware his behaviour was having an impact on Mrs D's daily life and was causing her stress. For example, he had started to set the house alarm on the ground floor when they were at home, which meant she had to deactivate the alarm if she wanted to go downstairs. Mr D wondered if he should be in hospital for a period of respite and to prevent him from acting on his thoughts of violence towards the neighbour. Mr D told the HTT he did not believe his thoughts were the result of mental illness, but due to his neighbour's unreasonable behaviour towards him.

3.12 The HTT documented that Mr D reported no suicidal ideation, but that he did have thoughts to cause harm to his neighbour. The HTT noted that Mrs D was a protective factor in both respects.

3.13 The HTT documented that they contacted Mrs D who said Mr D's behaviour had become increasingly "*paranoid*": he insisted the curtains remain closed all the time because he was worried, they were being watched. She said he asked her to be quiet so he could listen for noises coming from their neighbour's house.[16] Mrs D told the HTT it was affecting her mental health because she was very worried about Mr D and the impact the stress was having on his physical health.

3.14 The HTT completed a risk assessment for Mr D, documenting a significant risk (long term) of violence/harm towards others, but a low acute (immediate) risk. The HTT documented they considered Mr D to have capacity to agree to support offered by the team.

3.15 The team concluded Mr D should be discussed with the HTT consultant psychiatrist and be subject to a medical review given his physical health concerns.[17] Mr D was given a second appointment with the HTT for 1.30pm the next day.

3.16 CPN1 emailed Mr D's GP practice at 1.55pm to advise the HTT would be seeking an urgent review of Mr D by their consultant psychiatrist. They asked the GP practice to undertake physical health checks (blood and urine) and to complete an electrocardiogram (ECG)[18] with Mr D. They asked that the tests be completed in less than two days. They subsequently sent the GP practice a mental health service consultation summary and followed up with a call to GP1, who recorded in the GP notes that the HTT was of the view Mr D might need to be started on antipsychotic medication and possibly needed an admission to hospital.

3.17 Mr D, accompanied by Mrs D, attended the GP practice the same day for his physical health tests. GP1 spoke to Mrs D whilst Mr D was undergoing his tests. Mrs D told GP1 about her concerns about Mr D's mental health, who she described as becoming increasingly anxious and preoccupied

[15] The HTT notes do not say what Mr D wanted to speak to the police about, but Mrs D told us he intended to tell them about their neighbour and what he thought he had been doing e.g., spying on them.
[16] The notes do not indicate whether the HTT was aware that Mr J did not live directly next door to Mr D and Mrs D, but round the corner (their gardens were next to each other). Mrs D told us Mr J held a key for the house that adjoined theirs because he had helped the previous owner e.g., doing grocery shopping.
[17] The HTT documented Mr D suffered from COPD.
[18] ECG: https://www.nhs.uk/conditions/electrocardiogram/

with recurring thoughts about their neighbour, particularly over the previous month. She told GP1 she did not have concerns about their neighbour.

Second assessment by the HTT on day 2

3.18 Mrs D contacted the HTT on the morning of day 2 to let them know Mr D had gone out for the morning, leaving her a note to say he was going to clear his head. She told the HTT she expected he would go straight to his appointment with the team at the Trust that afternoon.

3.19 GP1 emailed the HTT to say all of Mr D's physical health tests were normal, but they were waiting for the blood results.

3.20 Mr D was seen by Consultant Psychiatrist 1 and HTT Manager 1 in the HTT office during the afternoon of day 2. Mr D was noted to become agitated and distressed when discussing his neighbour. The team recorded that Mr D was experiencing delusional persecutory beliefs, partition delusions and delusional misinterpretations that Mr D's neighbour could walk through and hear through walls.

3.21 Mr D said he did not want to confront his neighbour as he did not want to "*fuel*" their dispute. Mr D told the team his concerns for his safety got worse in the evening, so he and Mrs D would relocate upstairs, activating their house alarm before dusk. Mr D said he was afraid his neighbour would harm him, although he did not believe his wife was at risk. Mr D told the team he had not been to the police because he knew he sounded "*crazy*". He asked the team to bring a police officer into the assessment so he could feel validated and believed.

3.22 Mr D said he did not want support from the HTT and declined medication, telling the team he needed to stay "*sharp*" when at home. He asked for an inpatient admission as a means of respite from his home and neighbour. Mr D denied being mentally ill.

3.23 The team concluded that Mr D did not have the capacity to consent to an informal admission because he lacked insight and could not weigh up the potential benefits of an admission or understand the full scope of what an admission would entail. The team concluded that Mr D warranted an MHA assessment and told Mr D that they would arrange this. Mr D did not object

3.24 The team contacted the local AMHP hub who agreed to undertake an MHA assessment with Mr D "*by the end of the week*" (day 2 was a Wednesday). AMHP1 completed an AMHP hub MHA assessment referral checklist which documented that the HTT had described Mr D as 'very psychotic'. It was recorded that Mr D was experiencing delusional beliefs about his neighbours (plural), he thought cameras were watching him which would harm him, and his neighbours (plural) would harm him. AMHP1 noted the HTT considered Mr D lacked capacity to make a decision about his admission; on one hand he said he would not accept HTT input or take medication because it would make him drowsy when he needed to be vigilant in relation to his neighbour, but equally he was requesting an admission for respite. AMHP1 recorded Mr D was "*very suspicious*" of his neighbours but had said he would not harm them.

3.25 AMHP1 accepted the HTT referral and agreed the assessment should take place at the HTT office in order to safeguard Mr D's privacy. AMHP1 agreed to inform the HTT when an appointment had been scheduled; the HTT in turn would contact Mr D and Mrs D to give them the details. AMHP1 emailed the AMHP psychiatrist about their availability to undertake an assessment that week and informed the bed hub that a bed might be needed for Mr D.

3.26 Consultant Psychiatrist 1 completed a Section 2 MHA medical recommendation and left it in the HTT office safe.

3.27 The HTT notes were updated shortly after by HTT Deputy Manager 1, who documented that HTT Manager 1 had said Mr D needed an admission but there were concerns about his mental capacity therefore an MHA assessment was likely to take place the next day.

Care and treatment from day 3 to day 9

3.28 We would not usually consider events that took place after the homicide as part of a mental health homicide independent investigation, but the terms of reference extend to considering Mr D's care up to six days after the incident.

Day 3

3.29 It was recorded in the HTT notes at 12.15pm on day 3 that an MHA assessment had been booked for Mr D at the HTT office for 4pm the same day. Mrs D had been informed and agreed to take Mr D to the assessment. The notes do not say who contacted Mrs D or at what time.

3.30 AMHP2 called Mrs D at 12.45pm. Mrs D was very upset. She said Mr D had gone out for a walk shortly after 9am and had not returned home. She said this was unusual as his poor physical health meant he could not walk far. She was concerned and had repeatedly tried to call and text him, but with no response. AMHP2 told Mrs D to contact the police to report Mr D as missing. Mrs D said there were emergency vehicles outside the house of the neighbour that Mr D was fixated on. She was concerned something had happened.

3.31 Mr D called the police on day 3 to report that he had harmed Mr J. He was subsequently arrested on suspicion of murder. The advice and support in custody and court (ASCC) service updated the notes to reflect that Mr D had been arrested. They contacted the AMHP hub who confirmed Mr D was scheduled to have an MHA assessment that day, having been referred by Consultant Psychiatrist 1 the day before. Mr D was described as delusional with "*paranoid beliefs*" about his neighbour. The AMHP hub agreed to arrange for the MHA assessment to be relocated to police custody.

3.32 AMHP2 contacted Consultant Psychiatrist 1 to report Mr D had been arrested and asked Consultant Psychiatrist 1 to attend the police station to support an MHA assessment.

3.33 AMHP2, AMHP3 and Consultant Psychiatrist 2 attended the police station. Consultant Psychiatrist 1 was already present with ASCC Team Manager 1 and was speaking with Consultant Forensic Psychiatrist 1 by telephone; they were discussing whether a Section 2 MHA assessment should be undertaken with Mr D or if assessment through the criminal justice (forensic) system would be more appropriate.

3.34 Consultant Forensic Psychiatrist 1 advised Consultant Psychiatrist 1, based on Mr D's alleged offence and his unpredictable behaviour (in the context of having told Consultant Psychiatrist 1 the day before he had no thoughts to confront or harm his neighbour), that Mr D should be processed through the criminal justice (forensic) system. They agreed that Mr D should be charged and remanded in prison, with a view to being assessed under section 48 of the MHA. In the interim, if Mr D's behaviour escalated to a point that could not be managed in custody, they advised the protocol for emergency access to a medium secure mental health bed should be followed (this is locally referred to as the 'Regulation 28 Protocol' – please refer to paragraph 4.95 for further detail).

3.35 AMHP3 objected to the plan based on Mr D's mental state (fixed delusions), which they believed to be the reason Mr D had attacked his neighbour. AMHP3 was concerned Mr D's mental state would deteriorate further in prison. Consultant Psychiatrist 1 said that the local medium secure unit did not have a bed for Mr D. AMHP3 queried whether Mr D could be directed to the local PICU instead, but Consultant Psychiatrist 1 felt this would not be appropriate given Mr D's unpredictable behaviour. Consultant Psychiatrist 1 considered Mr D to be too much of an "*unknown quantity*" to be admitted

safely to a PICU. Consultant Psychiatrist 1 also felt detaining Mr D under Section 2 MHA could be "*precarious*" because Mr D might appeal to a tribunal and be discharged to his nearest relative (Mrs D). AMHP3 documented in the notes that he accepted a PICU bed might not be secure enough given the gravity of the situation, but he did not agree with Consultant Psychiatrist 1's reasoning in relation to a Section 2. They documented in the notes:

- "*a responsible clinician could override a nearest relative request in relation to a patient deemed* '*dangerous*'
- *it was unlikely a tribunal would discharge Mr D given the circumstances*
- *the police could arrest Mr D in the event of detention under the MHA being rescinded.*"

3.36 AMHP3 wrote in the notes that they "*reluctantly"* accepted the plan because it was the only option at the time in the absence of a "*suitably secure*" hospital bed.

3.37 The plan, documented by registered mental health nurse (RMHN1), was for Mr D:

- "*To be processed through the CJS* [Criminal Justice System] *with use of AA* [appropriate adult]
- *To be charged and remanded for MC* [mental capacity assessment] *tomorrow*
- *To be remanded to prison with a strong advisement re: S48 with a view to divert for a Forensic Secure Placement*".

3.38 SFT Worker 1 received a call from DC1 (detective constable) in the major crimes team shortly after 8pm. DC1 asked whether Mr D had been assessed under the MHA at 4pm as (the police understood to be) intended. DC1 asked for a copy of Mr D's notes but was told a formal request would need to be submitted to the team. DC1 was told to contact the ASCC service and was given their contact details. DC1 contacted SFT Worker 1 a second time to advise they had been unable to contact the ASCC service. SFT Worker 1 attempted to contact the AMHP hub duty manager on DC1's behalf, but there was no answer, so they left a voicemail.

3.39 AMHP3 called the HTT at 8.22pm to advise that if Mrs D contacted the team for clarification about Mr D's legal situation following his arrest, she could be directed to contact the AMHP hub.

3.40 Operational Service Manager 1 called DC1 at 9.21pm. They discussed the confusion around whether Mr D had been subject to an MHA assessment and agreed this needed to be completed before 10am the following morning (i.e., within 24 hours of Mr D's arrest). Operational Service Manager 1 told DC1 to contact the custody sergeant to convene an MHA assessment or to contact the AMHP hub. Operational Service Manager 1 recommended DC1 start the process given the time limitations.

3.41 DC1 and AMHP3 spoke at 9.40pm (the notes do not say who initiated contact). DC1 said they were concerned the MHA assessing team had provided no evidence as to whether Mr D was fit for interview, therefore the police had suspended the interview process until this was clarified.

3.42 AMHP3 contacted AMHP Hub Manager 1 and then Consultant Psychiatrist 2 to discuss whether the team needed to attend custody that evening to establish if Mr D was fit for interview or if an MHA assessment should be undertaken in the morning. Consultant Psychiatrist 2 agreed to discuss this with the police, but then called AMHP3 back to discuss it further and they decided Mr D should be admitted to the local PICU that night.

3.43 Consultant Psychiatrist 2 contacted Operational Service Manager 1, advising that the team wanted to undertake an MHA assessment with Mr D that night with a view to him being admitted to the local PICU. Operational Service Manager 1 was unable to make contact with the PICU to establish whether a bed was available. Operational Service Manager 1 contacted DC1 to provide an update and was told that Mr D had been taken to hospital complaining of chest pains. It was noted DC1 would liaise directly with Consultant Psychiatrist 2.

3.44 AMHP3 provided a handover to AMHP4 at 10.30pm (they were unaware Mr D had been taken to hospital). They said an MHA assessment was to be undertaken in the morning because they had been unable to clarify whether the local PICU had a bed, and it was considered inappropriate to assess Mr D late at night/in the early hours given his age. They were aware Consultant Psychiatrist 1's original medical recommendation was in a safe at the HTT office which could not be accessed until the morning (it was documented in the notes by AMHP3 later the same night that this was the reason they had been unable to proceed with an assessment that night). The assessing team would need to contact Consultant Psychiatrist 1 with a view to (preferably) involving them in the MHA assessment. An email was sent to Consultant Psychiatrist 1 (and other medics) to ask for their availability to support an MHA assessment in the morning.

3.45 AMHP4 contacted Consultant Psychiatrist 1 around 11pm to advise that the AMHP hub intended to undertake an MHA assessment with Mr D whilst he was in custody (they remained unaware Mr D had been taken to hospital). Consultant Psychiatrist 1 indicated this was a surprise given the original plan that Mr D would be processed via the criminal justice system. Consultant Psychiatrist 1 said the team should confirm the availability of a forensic bed if it was to assess Mr D under the MHA.

3.46 Consultant Psychiatrist 1 spoke to Operational Service Manager 1 shortly after the call with AMHP4. Consultant Psychiatrist 1 said they would like to discuss Mr D further with Consultant Psychiatrist 2 and DC1 with a view to Mr D being processed via the criminal justice route. Consultant Psychiatrist 1 said this was on the advice of the on-call forensic consultant (Consultant Forensic Psychiatrist 1) and that Mr D was not considered appropriate for the local PICU. Operational Service Manager 1 asked Consultant Psychiatrist 1 to liaise directly with Consultant Psychiatrist 2 and DC1. Consultant Psychiatrist 1 tried to call DC1 but there was no answer.

3.47 Consultant Psychiatrist 1 spoke to Consultant Psychiatrist 2 who said Mr D had been taken to hospital for physical health problems. Consultant Psychiatrist 2 agreed with Consultant Psychiatrist 1 that a PICU bed was not suitable for Mr D.

3.48 Consultant Psychiatrist 2 updated the AMHP team about Mr D's whereabouts. Consultant Psychiatrist 2 said DC1 would update the AMHP hub in due course.

Day 4

3.49 AMHP Hub Worker 1 called police custody at 8.27am on day 4. They were informed Mr D was still in hospital. They tried to contact the hospital, but the line was engaged. They documented that the ASCC had requested to be kept updated. AMHP Hub Worker 1 tried to return a call to DC1 but there was no answer. Mr D's case was allocated one AMHP (unnamed in the notes) to act as the lead.

3.50 Mr D was referred to the acute hospital Psychiatric Liaison team (PLT) caseload for assessment under the MHA.

3.51 Interim Medical Director 1 (also a consultant psychiatrist) updated the notes at 10.21am to say there were ongoing discussions with DC1 and Trust A's associate medical director and consultant forensic psychiatrist about Mr D. The police requested that Mr D be assessed under Section 2 or 3 of the MHA through the Trust's protocol (developed by the South West Provider Collaborative Oversight Group) for emergency access to a medium secure bed. However, it was documented that Trust's A associate medical director and consultant forensic psychiatrist (in conjunction with Consultant Forensic Psychiatrist 1, who had been involved the day before) did not agree the protocol applied in the circumstances.

3.52 A multi-agency professionals meeting was held to discuss Mr D's case. Interim Medical Director 1, Consultant Forensic Psychiatrist 1, Consultant Forensic Psychiatrist 2, Consultant Forensic Psychiatrist 3, Consultant Forensic Psychiatrist 4, and Trust A's associate medical director and forensic consultant psychiatrist had a Skype call to discuss Mr D's case. The meeting concluded that the protocol for emergency access to a medium secure mental health bed did not apply for Mr

D, but he needed a psychiatric assessment whilst he was in hospital. The clinicians wanted to establish Mr D's risks, his level of distress, and if he was eating/drinking because that might mean the protocol for emergency access to a medium secure mental health bed did apply. The meeting agreed to reconvene once a psychiatric assessment had been completed of Mr D.

3.53 HTT Deputy Manager 1 called Mrs D on behalf of the Trust. Mrs D was distressed and in shock. She gave a summary of recent weeks with Mr D, saying they had been very difficult, but she had been relieved when he had asked for help from their GP. The call cut out and when HTT Deputy Manager 1 called back it went to answerphone. They left contact details for the HTT and Mindline.[19]

3.54 Locum Consultant Psychiatrist 1 and Band 7 Nurse 1 undertook a general psychiatric assessment with Mr D. Locum Consultant Psychiatrist 1 recorded in the notes that the purpose of the assessment was "*… to capture* [Mr D's] *mental state as a snap shot to inform any future decisions*". Locum Consultant Psychiatrist 1 recorded that Mr D was not acutely distressed during the assessment and engaged well. They wrote there was "*evidence of an acute deterioration in mental health, likely exacerbated by lockdown/Covid and shielding at home. Presenting with persecutory delusional beliefs specifically about his neighbour. Also experienced possible partition delusions and ideas of reference*[20] *… denied having any thoughts to harm self or others.*"

3.55 Locum Consultant Psychiatrist 1 concluded that at that time Mr D had capacity to be interviewed by the police with an appropriate adult present. They said his mental state should be under constant review.

3.56 A second multi-agency professionals meeting took place at 4.30pm.[21] Locum Consultant Psychiatrist 1 relayed their assessment that Mr D did not meet the criteria for an MHA assessment and was fit to be interviewed by the police. The meeting agreed Mr D was not presenting in a manner that would invoke Part 2 of the protocol for emergency access to a medium secure mental health bed.[22] It was further noted that assessment under Section 2 or 3 of the MHA was not appropriate because:

- it was not appropriate to detain Mr D in an acute or PICU setting;
- of the severity of Mr D's behaviours and that he was unknown to services;
- his risk to others was too high; and
- he required a minimum of medium security facilities.

3.57 It was noted that Mr D was refusing to receive an angiogram scheduled for the next day. The meeting agreed Mr D would stay in the acute hospital until he was medically cleared to return to police custody. If Mr D's behaviour changed further consideration would be given to an MHA assessment with a view to invoking the protocol for emergency access to a medium secure mental health bed. RMHN1 updated Mr D's notes to reflect the plan for Mr D according to whether his mental health deteriorated, when he was medically fit and if/when he was remanded in prison.

3.58 Mr D was moved to an acute ward during the evening of day 4. He remained on one-to-one observations with an RMHN and a police officer present. A high risk care plan (HRCP) was implemented at 7pm, with a 12-hour review timeframe.

3.59 AMHP Hub Worker 2 updated the AMHP hub notes at 7.39pm. She documented that a collective decision made by regional secure services, the police, forensic psychiatry, ASCC, PLT and the Trust's on-call manager (i.e., the multi-agency professionals meeting), had concluded Mr D would

[19] Mindline: an emotional support and mental health helpline, open 24 hours a day, seven days a week. https://www.mindinsomerset.org.uk/our-services/adult-one-to-one-support/4269-2/
[20] Ideas of reference: A false belief (delusion) that external events/occurrences relate to the individual.
[21] RMHN1 provided a summary of the meeting in Mr D's notes as part of her record of the day's events.
[22] The protocol follows the MHA, indicating that if an assessment (and subsequent detention) is required this can be under either Part 2 or Part 3 of the MHA, whilst ensuring that the assessing team are mindful of the time restrictions under the Police and Criminal Evidence Act 1984 see MHA and also https://www.legislation.gov.uk/ukpga/1984/60/contents

be processed through the criminal justice system. This meant he was to be remanded to prison and forensic services would undertake a psychiatric assessment. The ASCC would monitor Mr D when he returned to police custody.

Day 5

3.60 PLT Practitioner 1 reviewed Mr D's HRCP at 7am. Mr D informed him that he had no recollection of his actions but was willing to "*put his hands up*" to the crime. Mr D had shown no overt signs of mental illness during the night.

3.61 PLT Practitioner 2 contacted the ASCC to request an update on Mr D. She asked to be told if there were changes to the plan to process him through the criminal justice system. She provided her contact details in case a secure bed was required for Mr D.

3.62 RMHN1 liaised with staff at the local acute hospital who advised Mr D continued to refuse an angiogram. The care team intended to review Mr D two days later and until then he would remain in hospital.

3.63 RMHN1 sent an update to Consultant Forensic Psychiatrist 3 to advise Mr D continued to refuse an angiogram, but there his presentation was unchanged.

3.64 PLT Practitioner 3 reviewed Mr D's HRCP at 6.28pm. No concerns were identified.

Day 6

3.65 PLT Practitioner 1 reviewed Mr D's HRCP at 7.10am. No concerns were identified.

3.66 Mrs D left a message for HTT Deputy Manager 1 asking for an update on Mr D. HTT Deputy Manager 1 was off work and intended to call her the next day when she returned (she updated On-call Manager 1).

3.67 RMHN1 emailed the (Provider Collaborative) forensic consultants, On-call Manager 1 and ASCC Team Manager 1 to advise it was thought Mr D was now accepting medical investigations, but this was to be confirmed. She said it was unlikely Mr D would remain in hospital much longer.

3.68 Nurse in charge 1 undertook a mental health review with Mr D. He concluded Mr D had capacity to consent to the interview and did not meet the criteria for an MHA assessment at that time.

Day 7

3.69 RMHN1 spoke to Mr D's Registered Mental Health Nurse (unnamed) who said an angiogram was being arranged for Mr D, who had started to complain of chest pain. Mr D was described as engaging well – he demonstrated awareness of what had happened and understood he would be returning to police custody and not going home.

3.70 HTT Deputy Manager 1 called Mrs D who said she had spoken to Mr D; he appeared confused about the timing of the incident, believing it had happened three weeks before instead of in the last few days. Mrs D described the weeks leading up to the incident as "*mental torture*" and gave examples of his recent behaviour.

3.71 The PLT reviewed Mr D at 8.15pm and no concerns were identified. It was intended Mr D would have an angiogram the next day, and subject to being medically fit, he would be discharged into custody in the evening.

Day 8

3.72 RMHN1 liaised with the PLT and police custody at 9am in relation to Mr D's likely return to custody that day.

3.73 Nurse in Charge 1 saw Mr D shortly after 9am. They noted Mr D had given "*capacitous*"[23] consent to have an angiogram. Nurse in Charge 1 identified no concerns in relation to Mr D's mental health. Mr D had capacity to consent to the police interview and did not meet the criteria for an MHA assessment.

3.74 HTT Deputy Manager 1 submitted a carers assessment request. They later spoke with RMHN1 who agreed to speak to the police about family liaison support. RMHN1 made a number of calls during the day, liaising with medical and police staff in preparation for Mr D's discharge from hospital. They also spoke with two local prison in-reach (mental health) teams about the fact Mr D would likely require a Section 48 MHA application and transfer to a medium secure bed, but it was unclear at the time which prison he would be sent to. They agreed to update the teams when more information was available.

3.75 Mr D had an angiogram at 3pm. No further medical intervention was required, and he was medically fit for discharge from hospital.

3.76 Consultant Psychiatrist 3 and PLT Practitioner 2 reviewed Mr D. No concerns were identified in relation to his mental health; they concurred with Locum Consultant Psychiatrist 1's previous assessment that Mr D was fit for interview with the police. They said Mr D could be discharged into police custody.

3.77 RMHN1 spoke to DC2 who said Mrs D did not meet the police criteria for a family liaison officer but they had been assigned to update her as the case progressed. RMHN1 left a voicemail for HTT Deputy Manager 1 providing an update.

3.78 Mr D returned to police custody on the afternoon of day 8. RMHN1 and RMHN2 undertook a mental state examination (MSE) and risk assessment with Mr D. They recorded that he showed some evidence of underlying paranoid ideation which required further specialist assessment. They recorded in the notes that Mr D was unknown to mental health services, therefore healthcare professionals had concluded he should be remanded to prison and then transferred on a Section 48 to a medium secure setting.

3.79 RMHN1 and RMHN2 completed a nil report[24] for the court. Mr D was described as a high-risk vulnerable adult at "*high risk of suicide following the implications surrounding the nature of his arrest*". He was also noted as a high risk to others due to being unknown to services and the nature of his offence. Mr D's risk assessment was updated to reflect his risk to self. The ASCC undertook to liaise with court and prison services.

Day 9

3.80 HTT Deputy Manager 1 spoke with Mrs D who said she had been informed by the police that Mr D would be attending court that morning. It was recorded in the notes that Mrs D said she was upset that Mr D had not been honest with the mental health teams who assessed him on days 1 and 2. She believed if he had been honest, they would have been aware of how unwell he was and would have admitted him to hospital.

3.81 The ASCC emailed its nil report to the court in advance of Mr D's attendance. Mr D attended court that day and was charged with murder.

3.82 RMHN1 emailed the prison mental health team to refer Mr D to their services. They asked that Mr D be assessed for a Section 48 application; they copied the local forensic psychiatrists into the correspondence. RMHN1 highlighted Mr D's risk to self, that he was unknown to services and therefore could continue to be a high risk to others. Mr D was transferred to prison and received by prison mental health services on the afternoon of day 9.

[23] Capacitous: someone who has the capacity to make a decision.
[24] ASCC has a service level agreement with Her Majesty's Courts and Tribunals Service (HMTCS) to share service user screening reports with the court. In instances where a service user has withheld consent to share such information, a 'nil report' must be completed. There are circumstances in which information can still be shared with the court e.g., risk (as was the case for Mr D).

4 Discussion and analysis of Mr D's care and treatment

4.1 In this section of the report we provided our analysis of Mr D's care and treatment. We consider:

- the HTT assessments undertaken on day 1 and day 2;
- the HTT risk assessment and risk management plan for Mr D;
- Mr D's treatment pathway following his assessments on day 1 and day 2;
- HTT liaison with the AMHP hub;
- Mr D's treatment pathway following his arrest on day 3; and
- Trust engagement with Mr D's family during the assessment process.

HTT assessments on day 1 and day 2

4.2 The HTT standard operating procedure (SOP, 2020) says the service will:

- "*Act as a gatekeeper for all patients who may require mental health inpatient admissions*
- *Rapidly assess individuals with an acute mental health need, referring patients to the most appropriate service if necessary, including participating in Mental Health Act assessments …*
- *… Work with patients and family/carers to provide information and develop a care plan working towards the individual's recovery, making risk-based decisions together whenever possible*
- *Work collaboratively with other healthcare professionals involved in the person's care and other agencies and services within the community*"

4.3 The HTT operates a 24 hours a day, seven day a week service. The HTT accept referrals from any source, which should be made verbally in the first instance. The SOP says GP referrals should be followed up with a fax or email, detailing issues and risk. The referring GP should have had contact with the individual they are referring within the previous 24 hours. The HTT will contact individuals referred to the service on the same day (usually in the form of a triage telephone call). The SOP says that individuals unknown to the service or those who have not been subject to extended assessment should be seen for an in-person assessment. Assessment outcomes should be sent to the referring GP.

4.4 The HTT accepts referrals for people with acute mental health needs which include those who "*present with an immediate and significant risk to others or self due to their mental health*".

Day 1

4.5 GP1 submitted an urgent referral to the HTT the morning of day 1. Mr D was seen within four hours of the HTT receiving the referral. This is the timeframe required for 'very high risk' or 'very urgent' referrals, in keeping with UK Mental Health Triage Scale.[25] GP1's classification of the referral as 'urgent' required a 24-hour response. The HTT managed the referral promptly.

4.6 CPN1 completed a mental health consultation summary as part of the HTT assessment with Mr D (they also completed a risk assessment, please see paragraphs 4.45-4.72 for further information). It documented Mr D's presenting problem, his current risks and risk management. CPN1 documented that Mr D was having "*paranoid*" thoughts about his neighbour, detailed his complaints about the neighbour, and that Mr D had said he might have to "*club him with something or stick him*" but he did not want to go to prison. The primary risk identified was Mr D's thoughts to harm his neighbour. CPN1 completed a risk assessment and MSE as part of the assessment. They documented that Mr D showed evidence of "*paranoid thinking*" and that he believed his neighbour was monitoring his

[25] UK Mental Health Triage Scale: https://ukmentalhealthtriagescale.org/uk-mental-health-triage-scale/

every move and listening to him through the wall of the adjoining house. It is not clear if the assessing staff were aware that Mr J did not live in the adjoining house, instead his house was separate and around the corner, but their gardens backed on to each other. Mr J did have keys to the adjoining house (which was empty) for historical reasons, but there is no evidence he had been going into the property.

4.7 CPN1 noted that Mr D could not be challenged on his views and whilst he described himself as "*paranoid*" he did not consider himself to be experiencing exaggerated thoughts about his neighbour. Mr D's cognitive state was not formally tested, but he was noted to be oriented to time, place and person.

4.8 CPN1 and HTT Manager 1 concluded that Mr D warranted a psychiatric assessment and arranged for him to see the HTT consultant psychiatrist the next day. CPN1 also liaised with primary care services to arrange physical health tests for Mr D, requesting that they be undertaken within two days.

Finding: The HTT screened and actioned Mr D's urgent referral on day 1 promptly and in line with Trust policy.

Finding: The HTT assessment undertaken on day 1 was comprehensive and undertaken in line with Trust policy.

Day 2

4.9 Mr D was assessed by Consultant Psychiatrist 1 and HTT Manager 1 on day 2. They concluded that Mr D might need an inpatient admission but that he did not have the capacity to agree to this and he therefore needed to be assessed under the MHA. We consider this below in terms of Mr D's capacity, an MHA referral, Mr D's safety, and the team's engagement with his family as part of its assessment (paragraphs 4.10 to 4.44).

- *Mr D's capacity*

4.10 The MCA (2005)[26] says:

"*A person must be assumed to have capacity unless it is established that he lacks capacity.*

A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

A person is not to be treated as unable to make a decision merely because he makes an unwise decision."

4.11 If a service user needs to be in hospital, is fully compliant with an admission and has the capacity to make that decision, a voluntary (or informal) admission would usually be appropriate.[27] However, in instances when a service user is considered to need an admission, but lacks capacity to consent to the admission, the alternatives must be discussed with them. These considerations would usually include whether an admission was necessary as the least restrictive option, and if so, what legal framework would ensure the service user's rights were fully protected once admitted.

4.12 NICE guidance on assessing capacity (2018)[28] says:

"*Practitioners should be aware that a person may have decision-making capacity even if they are described as lacking 'insight' into their condition. Capacity and insight are 2 distinct concepts. If a practitioner believes a person's insight/lack of insight is relevant to their assessment of the person's*

[26] MCA: https://www.legislation.gov.uk/ukpga/2005/9/section/1
[27] Department of Health (2015) *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
[28] NICE Guideline (2018) *Decision-making and mental capacity*. https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917

capacity, they must clearly record what they mean by insight/lack of insight in this context and how they believe it affects/does not affect the person's capacity."

4.13 The HTT medical review concluded that Mr D lacked capacity to consent to a voluntary admission, despite asking to be admitted to hospital. It was recorded in the notes:

"*He asked for an admission on the grounds of having a respite from home and his neighbour. He denies however that he may be mentally ill at present. He does not have the capacity to consent to informal admission as he lacks insight and he cannot weigh the potential benefits of an admission or understand the full scope of admission i.e., medication, boundaries etc. On these grounds, I believe that a MHA* [assessment] *is required*".

4.14 The MCA Code of Practice (2007)[29] says it is good practice to assess an individual's capacity to make particular decisions and to document the findings:

"*A doctor or healthcare professional proposing treatment should carry out an assessment of the person's capacity to consent … and record it in the patient's clinical notes*"

4.15 Similarly, the Trust's Using the Mental Capacity Act Policy (2020) says:

"*Assessments of capacity should be recorded in a proportionate way. For decisions that could have a significant impact on the person, this should be documented comprehensively…*

RiO Users: Assess and document capacity using the RiO Consent and Capacity form…

Significant Decisions that should be documented comprehensively include: Admission for care and treatment as an inpatient …"

4.16 The HTT did not document their assessment of Mr D's capacity using the RiO Consent and Capacity form as directed by both Trust policy and the legal requirements of the MCA.

4.17 Consultant Psychiatrist 1 concluded that Mr D did not have capacity to make a decision about an informal admission to hospital. However, it is our view that the above conflates two issues: whether Mr D should be admitted and whether he should be treated (e.g., medication).

4.18 Mr D had asked for admission, albeit for respite. We appreciate Mr D did not consider he was mentally ill, but we assume he was aware he was being seen by mental health professionals; the notes do not suggest any confusion or misunderstanding on his part as to why he was at the HTT office. The notes do not reflect whether the assessing staff discussed Mr D's mental health with him in the context of others being concerned he was unwell (e.g., his GP had referred him to the HTT, who in turn had arranged a second assessment for him).

4.19 Mr D could have been offered an admission for assessment on the grounds of needing to determine a) if he was mentally ill, and b) what treatment might be appropriate. In turn, this might have offered him the respite he was seeking.

4.20 The HTT notes in relation to Mr D's capacity do not provide detail of the discussion with him about his capacity and insight, or their conclusions in relation to either point. We do not know the extent to which individual elements – assessment, treatment options, the implication of being in an inpatient unit, and Mr D's views of these elements – were discussed with him. Consultant Psychiatrist 1 told us they discussed admission at length with Mr D which led them to conclude he did not grasp the full purpose of an admission and consequently that he could not consent to an informal admission. Consultant Psychiatrist 1 told us they also discussed Mr D with an AMHP colleague who agreed that Mr D should be subject to an MHA assessment; however, this discussion with the AMHP is not documented in the notes.

[29] Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: code of practice*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

4.21 The nature of the summary notes means we cannot form a view as to whether the assessment of Mr D's capacity in relation to admission and treatment was comprehensive and/or if all elements of the summary were discussed with him. We discuss this further below.

Finding: The HTT assessment of Mr D's capacity on day 2 was not documented in line with Trust policy or national guidelines.

Finding: The summary nature of the assessment notes means we cannot form a view as to whether Mr D should have been considered for admission despite the assessing team's concerns about his capacity.

- *MHA referral*

4.22 The HTT SOP says

"*There are times when concerns for someone's welfare and risks can become of such significance that it is necessary to make decisions on their behalf to keep them and sometimes others safe. If it is felt that this is the case a MHAA* [MHA assessment] *may be requested via the Approved Mental Health Professional (AMHP) hub. This would only occur when significant and immediate concerns regarding someone's safety and welfare have been identified in relation to their mental health.*"

4.23 The SOP goes on to say any decisions in relation to MHA assessments should, where possible, be discussed with the patient and their carer.

4.24 At the point of seeking an admission (and if required, possible treatment), the assessing team would need to consider:

- whether Mr D required an admission (with consideration of the risks of Mr D not being admitted);
- whether Mr D could consent to an admission;
- the legal frameworks available to facilitate an admission; and,
- the urgency of the admission.

4.25 When an individual is assessed as lacking capacity to consent to a psychiatric admission but is agreeable to an admission, the assessing team must consider the legal frameworks set out in the MHA and MCA Deprivation of Liberty Safeguards (DoLS).[30]

4.26 The MHA Code of Practice indicates, where an individual meets the criteria for detention under Sections 2 or 3 MHA, lacks capacity to consent to admission but does not object to the admission (and some or all of the treatment available) then "*in principle a DoLS authorisation (or potentially a Court of Protection order) and detention under the Act would both be available (subject to the assessments required for a DoLS authorisation, including the eligibility assessment). This is the one situation where the option of using either the Act or DoLS exists.*"

4.27 When considering which legal framework is most appropriate, the MHA Code of Practice is not prescriptive, leaving the assessing team to make the decision. However, the Code of Practice does say "*In deciding whether a patient objects to being admitted to hospital, or to some or all of the treatment they will receive there for mental disorder, decision-makers should err on the side of caution and, where in doubt, take the position that a patient is objecting*".

4.28 The assessing team did not record whether they considered the alternative option of admitting Mr D under the MCA DoLS so we are unable to determine or comment on the rationale behind their decision-making. We discussed this with Consultant Psychiatrist 1 who said, whilst they could not recall the detail, their expectation was anything discussed during the assessment with Mr D would have been documented in the notes.

[30] Deprivation of Liberty Safeguards (DoLS): https://www.legislation.gov.uk/ukpga/2005/9/schedule/AA1

4.29 However, whilst the use of DoLS may have been an alternative route for admission, it is reasonable to assume that the unknown quality of Mr D's compliance with any proposed treatment (he refused to consider that he was mentally unwell or required medication) influenced the team's decision regarding both the nature of his consent, and their proposed use the MHA.

4.30 The Somerset AMHP Operational Policy (2015, review date September 2016) states "*It is the expectation that all referrals received will have an immediate response from an AMHP in the Hub AMHP team … Where the matter is urgent, the Hub AMHP team will consider utilising its own resources to ensure that there is minimal delay to the appropriate provision of care to the patient*".

4.31 Consultant Psychiatrist 1 referred Mr D to the AMHP hub who accepted the referral, requesting Mr D be seen "*asap*".

4.32 We have previously noted that the documentation pertaining to Mr D's capacity assessment was brief. We note Mr D was concerned about his own wellbeing, had left the house and waited in a layby for his appointment to avoid being at home and near his neighbour, and had asked for admission despite not believing himself to be mentally ill. Similarly, Mr D was described in the AMHP screening checklist as 'very psychotic'. However, the same screening assessment recorded Mr D's risk summary as:

"*Main risk is around further deterioration of his MH* [mental health] *without further input.* [Mr D] *has said he will not self-harm (… as he is aware of the effect of his wife) … and whilst he is very suspicious of his neighbours has said he will not harm them*".

4.33 The level of urgency documented on the AMHP screening checklist was "*by the end of the week*" (i.e., within 48 hours in this instance). This level of urgency is not set out in the UK Mental Health Triage Scale which refers to immediate, 4 hours, 24 hours, 72 hours and 4 week timescales. Following the discussion with Consultant Psychiatrist 1, the AMHP service arranged an MHA assessment for the next day. The assessment was to be in the HTT office, away from Mr D's home (to maintain his privacy) and the AMHP service informed the bed team an inpatient bed might be needed.

4.34 In hindsight it would be easy to say that a next day assessment was not sufficiently urgent, and that Mr D should have been seen and assessed that day. However, we do not believe this to be a reasonable criticism. From a review of the notes made of the handover to the AMHP service and the risk information provided by Consultant Psychiatrist 1, we believe the AMHP response was proportionate, mindful of Mr D's request for privacy (i.e., to be seen at the Trust rather than at home), and appropriate to the circumstances indicated. There is no suggestion in the notes that Consultant Psychiatrist 1 disagreed with this plan or that they requested a more urgent response; this was later confirmed to us by Consultant Psychiatrist 1.

Finding: The HTT decision on day 2 to refer Mr D for an MHA assessment was reasonable and proportionate based on the assessing practitioner's conclusion that he lacked capacity. However, a thorough capacity assessment was not documented.

Finding: The AMHP plan to assess Mr D the next day, away from his home, was in keeping with the assessed level of risk. The plan also met the indicated level of urgency.

- *Mr D's safety*

4.35 The HTT SOP says an MHA assessment should be requested when there are "*significant and immediate concerns regarding someone's safety*"; however, there is no evidence in the notes that the HTT discussed with Mr D what he should do during the time it took for the MHA assessment to be arranged. For example, there is no evidence they discussed with Mr D – or Mrs D – whether he could stay elsewhere until he received the appointment. Equally, the notes do not reflect the extent to which the assessing staff considered Mr D's safety or the extent of his concerns – he was told to call 101 (the non-emergency police contact number) should he have concerns.

4.36 Mrs D told us that when Mr D returned home on day 2, he was aware he would be given another appointment, but did not know when. Mrs D also said Mr D told her the assessing clinicians had said there was not a bed available for him at that time; however, the notes make no reference to the availability of a bed. We asked Consultant Psychiatrist 1 whether alternative assessment and treatment options were discussed with Mr D. Consultant Psychiatrist 1 confirmed that the team had suggested input from the HTT, but Mr D had declined this option and said that he wanted to be admitted to hospital.[31]

4.37 The team's assessment of Mr D's risk would have been a key factor in determining the treatment options, but Mr D's risk assessment was not updated during or after the assessment. The referral did not make a recommendation in relation to treatment, although it noted Mr D was refusing medication and support from the HTT.

Finding: There is no evidence the HTT discussed with Mr D what steps he should take to ensure his safety and the safety of others whilst he waited for an appointment for his MHA assessment.

- *Contact with Mrs D/family engagement*

4.38 Trust policy and guidance is clear there is an expectation that Trust staff will work with, and share information with, family members/carers as appropriate and reasonable. The HTT SOP says:

"*An assessment should be conducted in a manner that maximises the involvement of the patient and carer/family/significant others. Confidentiality will be discussed with the patient and consent should be sought regarding the involvement of a patient's family member/carer and the disclosure of information where appropriate. If a patient's risk is significant to others or self, confidential information may be shared without prior consent in line with risk management protocol, MDT discussion and involving the Caldicott Guardian[32] if necessary*".

4.39 The Trust's Clinical Assessment and Management of Risk of Harm to Self and Others Policy (2019) says:

"*We should always have a presumption of sharing risk information with families/carers*."

4.40 CPN1 recorded in the notes that they telephoned Mrs D to discuss Mr D as part of the assessment on day 1. CPN1 noted Mrs D reported that Mr D showed increasingly "*paranoid*" behaviour and she was very worried about the impact his levels of stress were having on his physical health. However, whilst CPN1 detailed contact with Mrs D in the notes, the 'carer and family concerns and support' section of the mental health service consultant summary was not completed.

4.41 Similarly a member of the HTT recorded in the notes that they spoke to Mrs D on the morning of day 2 to give the details of Mr D's appointment that afternoon. Mrs D had indicated Mr D had gone out to "*clear his head*" but she anticipated he would attend his appointment that day, which he did.

4.42 We note both assessments identified Mrs D as a protective factor. However, Mrs D told us that none of the assessing HTT contacted her on either day 1 or day 2. We have been unable to address this discrepancy in relation to the HTT assessment on day 1. The HTT did not contact Mrs D as part of the assessment on day 2. It is possible Mr D did not want his wife involved in the assessment, but the notes do not indicate whether this was discussed with Mr D. We note the HTT had identified concerns about Mr D's capacity and insight but conversely his intimation that Mrs D was a protective factor was not tested with her. We discussed this with Consultant Psychiatrist 1 who confirmed that the team had not considered contacting Mrs D as part of the assessment.

[31] Whilst not explicitly included in the scope of this review, we note the judge's sentencing remarks at the end of the Mr D's trial, which highlighted that Mr D reported he was told he would be admitted to hospital but shortly after learnt a bed was not available, and was sent home.
[32] Caldicott Guardian: "*… a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly*." https://www.gov.uk/government/groups/uk-caldicott-guardian-council#:~:text=A%20Caldicott%20Guardian%20is%20a,must%20have%20a%20Caldicott%20Guardian .

4.43 Based on what is recorded in the notes, there were no indications from the contact with Mrs D to suggest there was an imminent risk or that anyone was in immediate danger, rather it appeared the situation had been ongoing for several months and Mrs D was relieved that Mr D had at last sought help. This is reinforced by the AMHP screening tool, which noted "*Wife has lived with* [Mr D]*'s state for some time*", and the referrer [Consultant Psychiatrist 1] "*described* [her] *as at end of tether*".

4.44 Taking these records together, it appears reasonable that the AMHP service believed the situation to be manageable overnight, and that there was no immediate need to contact Mr D's wife. It is reasonable to assume that had the MHA assessment taken place, Mrs D could have been contacted as part of the assessment in her role as nearest relative.[33]

Finding: The HTT neither involved Mrs D, nor discussed with Mr D her possible involvement, in the day 2 assessment. This is not in keeping with Trust policy.

Risk assessment and risk management plan

4.45 The Healthcare Quality Improvement Partnership (HQIP, 2018)[34] says a good risk assessment combines "*consideration of psychological (e.g., current mental health) and social factors (e.g., relationship problems, employment status) as part of a comprehensive review of the patient to capture their care needs and assess their risk of harm to themselves or other people.*"

4.46 A comprehensive risk assessment will take into consideration the patient's needs, history, social and psychological factors, and any negative behaviours (e.g., drug use).

4.47 Risk management planning is defined as a cycle that begins with risk assessment and risk formulation, which in turn leads to a risk management plan that is subject to monitoring and review.

4.48 The Department of Health (2009)[35] identifies 16 best practice points for effective risk management which include:

"*… a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions be taken by practitioners and the service user in response to crisis*"; and

"*Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.*"

4.49 Best practice in managing risk is based upon clinical information and structured clinical judgement. It involves the practitioner making a judgement about risk based on combining:

- an assessment of clearly defined factors derived from research (historical risk factors);
- clinical experience and knowledge of the service user, including any carer's experience; and
- the service user's own view of their experience.

4.50 The Trust's Clinical Assessment and Management of Risk of Harm to Self and Others Policy (2019) defines risk and risk management as:

[33] Mr D's wife is recorded as the nearest relative on the AMHP screening tool. In most circumstances the assessing AMHP must let a nearest relative know if an application is going to be made, or has been made, to detain their relative under Section 2 of the MHA. This is different to the duty to consult under an assessment for Section 3. However, given her involvement, it is reasonable to assume that in this case the AMHP would have spoken to Mrs D to get her views as part of their assessment. (See MHA Code of Practice, chapters 4, 5 and 14).
[34] University of Manchester (2018) *The assessment of clinical risk in mental health services. National confidential inquiry into suicide and safety in mental health (NCISH)*. https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-70-Mental-Health-CORP-Risk-Assessment-Study-v0.2.docx.pdf
[35] Department of Health (2009) *Best practice in managing risk*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

"*Risk relates to a negative event (i.e., violence, self-harm/suicide or self-neglect) and covers a number of aspects:*

- *How likely it is that the event will occur?*
- *How soon it is expected to occur?*
- *How severe the outcome will be if it does occur?*"

4.51 The policy defines risk assessment as "*working with the service user to help estimate each of these* [above] *risks*". The policy defines risk factors for violence to include static (unchangeable), dynamic (that change over time), demographic, psychological and psychosocial, current factors and context.

4.52 The policy says risk assessment should be undertaken at every clinical contact, including at admission/assessment. The policy places emphasis on positive risk management which it defines as:

"*… being aware that risk can never be completely eliminated, and aware that management plans inevitably have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user*"

4.53 The policy details several factors to positive risk management which include:

- "*Working with the service user to identify what is likely to work;*
- *paying attention to the views of the carers and others around the service user when deciding a plan of action;*
- *weighing up the potential benefits and harms of choosing one action over another; and,*
- *being clear to all involved about the potential benefits and the potential risks;*
- *developing plans and actions that support the positive potentials and priorities stated by the service user, and minimise the risks to the service user or others*"

4.54 The policy says a crisis plan should be developed as part of an integrated care plan.

4.55 The policy contains a checklist for assessing risk of harm to self and others and includes a question about whether carers/family/others involved in the service user's care have had an opportunity to discuss their concerns, and whether they have been consulted and/or involved in the risk management plan.

Day 1

4.56 CPN1 completed a risk assessment as part of the HTT assessment with Mr D on day 1. It documented Mr D's current risk as thoughts to harm his neighbour and identified the triggers to be his belief that the neighbour meant to cause him harm and was watching and listening to him. The notes specifically refer to a 'neighbour' – they do not name Mr J. Mr D's wife, Mrs D, was identified as a mitigating factor in relation to Mr D acting on his concerns. The notes indicate that CPN1 spoke to Mrs D as part of the assessment on day 1, but the risk assessment does not reflect input from Mrs D. Mrs D told us she was not contacted by the assessing teams on day 1 or day 2; we have been unable to address this discrepancy.

4.57 Mr D's long-term risk of violence/harm to others was recorded as 'significant' but his acute (imminent) risk was graded as 'low'. Mr D's physical health conditions were also recorded as a 'significant' risk (to him).

4.58 The key actions to manage Mr D's risk were for him to see his GP for physical health tests, and for the assessing staff to discuss Mr D with the HTT consultant psychiatrist with a view to Mr D being assessed further.

4.59 We note Mr D's risk management plan largely focussed on his physical health, as opposed to his mental health needs. We agree it was important to take Mr D's physical health into consideration, particularly given his medical history, but the risk management plan did not address Mr D's threats to cause harm to his neighbour (beyond referral for further assessment).

Day 2

4.60 Mr D attended his appointment with Consultant Psychiatrist 1 and HTT Manager 1 alone. There is no evidence the HTT completed a risk screen as part of the second assessment on day 2. However, it could reasonably be assumed the HTT's assessment of Mr D's risk was unchanged at this point, the notes signpost the reader to the assessment undertaken the day before, though we would have expected this approach to have been documented in the notes.

4.61 The HTT did not contact Mrs D as part of their assessment. This was a missed opportunity to discuss Mr D's recent behaviour with her, the extent of her concerns about his mental health and wellbeing, and to seek her input in relation to a risk management plan. A risk management plan was not developed with Mr D as part of the assessment on day 2.

4.62 We note the HTT placed emphasis on the role of Mrs D as a protective factor in mitigating Mr D's risk because of his assertion that he did not want to cause her distress by hurting himself or others. However, during the same assessment Mr D was considered to lack insight and capacity to make a decision about an admission to hospital and he indicated he would refuse medication. He was described as 'very psychotic' in the AMHP checklist which further emphasises the HTT concerns in relation to Mr D's mental health; it is not clear why the assessing team accepted Mr D's statement he would not harm anyone given their broader doubts about his capacity and decision-making. The notes do not suggest the HTT explored this with Mr D or discussed the steps he should take to mitigate his risk, beyond advising him to call 101.

4.63 The AMHP referral checklist recorded Mr D's main risk to be further deterioration in his mental health. It was noted Mr D was "*very suspicious*" of his neighbour but he would not harm them (Mr J is not identified in the notes). The checklist makes no reference to Mr D's statement to the HTT on day 1 that he would "*club*" or "*stick*" his neighbour – there is no evidence this was shared as part of the referral.

4.64 Consultant Psychiatrist 1 destroyed the Section 2 recommendation after Mr D was arrested because it was no longer required. We were told this is in keeping with Trust practice. In our experience, it is unusual practice to destroy a medical record regardless of whether it was used. Our expectation would have been that the Section 2 recommendation was marked as redundant (e.g., struck through) but remained part of the enduring medical record. We raised this with the Trust who said there is not a Trust policy or SOP in relation to this but "*if medical recommendations have been completed but in the end are not used to detain the patient, they will be destroyed as they would be considered void and not form part of the medical record.*"

4.65 We do not agree with this approach, particularly in Mr D's case because of the gravity of the situation, which Trust staff were aware of at the time the record was destroyed. We note the debate amongst professionals on day 3 as to whether Mr D should have been subject to an MHA assessment, and that whilst it was agreed he should be processed via the criminal justice system, this plan changed for a short period on the night of day 3 in favour of an MHA assessment (we also note that this assessment was in part deferred because the staff could not access the Section 2 recommendation which was locked in an office safe that no one had access to outside of working hours).

4.66 Consultant Psychiatrist 1's decision to destroy the Section 2 recommendation was in line with what we were told is expected Trust practice, but we would encourage the Trust to review the guidance available to staff in this respect, particularly in rare scenarios such as a mental health homicide.

Mr D's age

4.67 The Royal College of Psychiatrists (2018) notes older people can often be "*stereotyped as ill, dependent and incompetent*".[36] Benbow, Bhattacharyya and Kingston's (2019) analysis of domestic homicide reviews involving adults over 60 years of age said:

"*The significant factor that emerges from the analysis is the role of assumptions/prejudices/stereotypes about older age which influence risk assessments and management of potentially abusive situations … In particular, risk may be underestimated in individuals with physical and/or mental health problems or individuals who are regarded as old and frail.*" [37]

4.68 Rosen et al. (2019)[38] noted that whilst older people were more often the victim of violence, they could be the perpetrators of violence, particularly intimate partner violence and violence in dementia. They identified medical or psychiatric illness as common risk factors for violence in older people.

4.69 Mr D was 69 years old and in relatively poor physical health at the time of the assessments. We acknowledge he was never described as 'frail' in the notes, but the primary concern of the HTT on day 1 was his physical health. Equally, we note Mrs D told Trust staff on day 3 that Mr D could not walk far due to poor physical health.

4.70 It is our view that Mr D's age may have been an influencing factor in the assessing clinician's consideration of his risk to self and others. The priority after the first assessment was to refer him for physical health checks. The management plan made little reference to helping Mr D manage his thoughts of harming his neighbour.

4.71 We believe that if Mr D had the same presentation but had been considerably younger, his risk to others (specifically his neighbour) would likely have been viewed as more significant. We note Mr D's acute risk of violence was graded as low by the HTT on day 1, the same rating as that given to his risk of accidental self-harm/neglect (including wandering disorientation). We appreciate our view is speculative but note the above research that indicates the tendency of individuals, including those in healthcare, to view older people as victims, as opposed to perpetrators, of violence.

4.72 We discussed Mr D's physical presentation with Consultant Psychiatrist 1 who indicated the team had no concerns about Mr D's physical health during the assessment on day 2.

Finding: The HTT completed a risk assessment screening with Mr D on day 1. A risk management plan was developed as part of the assessment. These actions were in line with Trust policy. However, Mr D's risk management plan primarily addressed his physical health concerns rather than the risk to his neighbour.

Finding: Mr D's risk assessment and risk management plan was not updated as part of the second assessment on day 2.

Finding: The HTT placed too much emphasis on the role of Mrs D as a protective factor in preventing Mr D from harming himself or others, despite not involving her in its assessment, and given the team's concerns about Mr D's mental health, insight and capacity.

[36] Royal College of Psychiatrists (2018) *Suffering in silence: age inequality in older people's mental health* (CR211). https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr221.pdf?sfvrsn=bef8f65d_2
[37] Benbow, S.M., Bhattacharyya S, and Kingston P (2019) Older adults and violence: an analysis of domestic homicide reviews in England involving adults over 60 years of age. *Ageing & Society,* 39(6), pp.1097–1121.
[38] Rosen, T, Makaroun, L.K., Conwell, Y, Betz, M (2019) Violence in older adults: scope, impact, challenges, and strategies for prevention. *Health Affairs,* 38(10), pp. 1630–1637.

Treatment pathway on day 1 and day 2 (including care and crisis plan)

4.73 NHS England's Personalised Care and Support Planning Handbook (2016)[39] defines personalised care and support planning as:

"*… a process in which the person with a long-term condition is an active and equal partner. The process should normally be recorded in a personalised care and support plan: but this plan is only of value if the process has taken place effectively.*"

4.74 The Care Coordination Association (CCA)[40] defines a care plan as:

"*A plan that describes in an easy, accessible way the needs of the person, their views, preferences and choices, the resources available, and actions by members of the care team, (including the service user and carer) to meet those needs. It should be put together and agreed with the person through the process of care planning and review.*"[41]

4.75 The CCA *Writing Good Care Plans: A Good Practice Guide* (2016)[42] sets out several factors involved in care planning which include:

- "*A systematic review of the needs of the person.*
- *Exploring and discussing choices: to help work out what's the most important, and the implications of different choices.*
- *Goal setting: what do we want to achieve and by whom.*
- *Action planning: what are we going to do, who is responsible, and when will it be reviewed?*
- *Safety: how do we make care as safe as possible?*
- *Support: for someone to manage their own health as much as possible.*"

4.76 The guidance says a care plan should be a written plan of action to meet an individual's health and social care needs, including aims, actions and responsibilities.

4.77 A care plan was developed with Mr D on day 1,[43] although the author is not listed. The plan detailed two goals:

- "*To avoid confrontation with your neighbour*
- *To meet with* [the] *HTT to discuss ongoing care plans*"

4.78 The care plan included a crisis plan, providing the contact details of Trust and other agency services (e.g., the Samaritans). It is not documented whether the care plan was shared with Mr D.

4.79 Mr D's care plan lacked detail or depth, but it was completed by HTT staff with the understanding Mr D would be subject to further assessment by the HTT consultant the next day. As such, we do not consider it unreasonable for Mr D's care plan to have lacked depth at that stage of the assessment process.

[39] NHS England (2016) *Personalised care and support planning handbook*. https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf
[40] Care Coordination Association: http://www.cpaa.org.uk/
[41] CCA. *Writing Good Care Plans*. http://www.cpaa.org.uk/writing-good-care-plans-handbook.html
[42] CCA. *Writing Good Care Plans*. http://www.cpaa.org.uk/writing-good-care-plans-handbook.html
[43] The care plan is has the wrong date, but we assume this is an administrative error because it is also recorded within the same document that it was shared with Mr D's GP on day 1.

4.80 Mr D's care plan was not updated by the assessing staff on day 2. Again, we assume this was because the assessment was ongoing and there was an expectation Mr D would be assessed under the MHA within days.

4.81 However, we note that Mr D was vocalising persecutory beliefs and delusions that his neighbour could hear him through walls during both assessments. The HTT noted on day 1 that Mr D could not be challenged on these thoughts, despite describing himself as "*paranoid*". The notes say Mrs D reported Mr D's paranoid behaviour to the HTT on day 1, although as previously noted, Mrs D had said she was not contacted by the team. It is not clear if the HTT were aware that Mr J did not live in the house adjoining Mr D's and therefore had no reason to be in the next-door building; his house was entirely separate to Mr D's, but their gardens backed on to each other.

4.82 The symptoms of delusional disorder have been noted in elderly patients with other underlying disorders.[44] Delusional disorder refers to patients who reveal persistent delusions without prominent hallucinations in the absence of dementia, schizophrenia or mood disorders. The delusions of these patients are usually non-bizarre in nature, well circumscribed and may include beliefs about physical illnesses, jealousy, persecutions, theft, marital infidelity and mistaken identity. In a study of elderly patients referred to forensic psychiatric services, Lewis et al. (2006) found that violent offences were strongly associated with paranoid symptoms at the time of the offence,[45] and that active symptoms at the time of the offence were more predictive of a violent offence than was a previous history of mental disorder. Ticehurst et al. (1992) found that nearly 50 per cent of homicides were thought to be caused by delusional beliefs, the most common being delusions that trigger jealousy.[46]

4.83 Mr D's care plan made no reference to addressing his paranoid thoughts, particularly whilst he awaited an MHA assessment. We appreciate the HTT had an expectation that Mr D would be subject to further assessment, but we consider it an omission to have not factored his immediate mental health into care planning, either on day 1 or day 2.

Finding: Mr D had a care plan and a crisis plan in place at the time of the incident. The care plan focussed on Mr D's physical health and his being subject to further review by the HTT. It was not updated to reflect the detail of his assessment on day 2 or the decision to refer him for assessment under the MHA. The care plan did not detail any immediate steps to address Mr D's persecutory delusions about his neighbour.

Consideration of safeguarding

4.84 Section 42 of the Care Act applies:

"… where a local authority has reasonable cause to suspect that an adult in its areas (whether or not ordinarily resident there) –

a) has needs for care and support (whether or not the authority is meeting any of those needs),

b) is experiencing, or is at risk of, abuse or neglect, and

c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it".[47]

4.85 The terms of reference for this investigation extend to consideration of Mr D's safeguarding, and consideration of use of the Care Act (2014).[48] We did not identify safeguarding concerns in relation

[44] Gurian B.S., Wexler D., Baker E.H. (1992) Late-life paranoia: possible association with early trauma and infertility. *Int J Ger Psychiatry,* 7, pp. 277–284.
[45] Lewis, C, Fields, C, Rainey, E. (2006) A study of geriatric forensic evaluees: who are the violent elderly*? Journal of the American Academy of Psychiatry and the Law* 64, pp. 324–32.
[46] Ticehurst, S., Ryan, M., Hughes, F. (1992) Homicidal behaviour in elderly patients admitted to a psychiatric hospital. *Dementia,* 3: pp. 86–90.
[47] The Care Act (2014): https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted
[48] Care Act (2014): https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

to Mr D. it is our view that issues around safeguarding were considered in terms of protecting Mr D's health, wellbeing and human rights under the MHA and MCA.

- *Regarding whether a separate adult safeguarding referral should have been considered or made for Mrs D*

4.86 At the time of the incident Mrs D was not known to adult mental health or social care services other than as wife and carer for Mr D. There is no indication from the records that Mrs D felt at risk or identified herself as being at risk of abuse. Regardless of this, had Mr D received further care, it would have been appropriate for Mrs D's needs as carer to be assessed and considered under the Care Act, and this assessment could then have considered any adult safeguarding concerns (if identified) and discussed them with her.

- *Regarding whether a separate adult safeguarding referral should have been considered or made for Mr J*

4.87 At the time of Mr D's referral into services we understand Mr J was not identified by name – he is not named in the clinical notes.

4.88 We found no evidence to suggest that 'the neighbour' (as refenced in the notes) was identified in the referral as an adult with care and support needs. It would have been appropriate for the assessors to try and identify the neighbour and clarify whether they were a vulnerable adult if there had been any indication of this. If this had been the case consideration of an adult safeguarding referral would have been appropriate.

4.89 At the time of Mr D's referral, however, the concerns identified focused on Mr D's beliefs about his neighbour, rather than concern that the neighbour was at risk from Mr D.

4.90 We have previously identified and commented upon how this risk was assessed elsewhere in this report (e.g., see paragraphs 4.70-4.71). We also recognise that the care team would have been mindful of sharing information about Mr D without evidence to suggest that any neighbour was in immediate or imminent risk.

4.91 Given the above, we do not believe an adult safeguarding referral was indicated for Mrs D or Mr J at the point Mr D was referred into services.

Finding: Adult safeguarding referrals were not indicated for Mrs D or Mr J at the point Mr D was referred into services.

Treatment pathway following arrest on day 3

4.92 Mr D was arrested, detained in police custody, and screened by the ASCC team after the homicide on day 3. The ASCC record indicated that they contacted the AMHP hub to inform them of the situation and to discuss the planned MHA assessment of that date.

4.93 The record concludes that "*MHA must now be moved to Bridgwater Police Custody - Agreed AMHP hub to contact all involved and advise of relocation*". The notes indicate that following this discussion, an assessment was planned and the AMHP plus the required two doctors agreed to attend the police station.

4.94 In situations where there are concerns about an individual's mental health, after an arrest for a 'serious' offence, the Trust provides guidance which advises:

"*If detainee has been arrested on a serious allegation that may lead to a serious charge for example:*

- *Murder*
- *Attempted murder*

- *Section 18* [Grievous Bodily Harm]
- *Serious sexual offence (rape)*
- *Arson*

Then recommend Consultant Psychiatrist/Section 12(2) practitioner consider early liaison with Secure Service Consultant Psychiatrist for advice as to the appropriateness of emergency admission to a secure mental health bed". [49]

4.95 The Trust's guidance, provided as a flow chart, is known locally as the 'Regulation 28 Protocol'. In March 2020 the Coroner for Exeter and Greater Devon delivered a Regulation 28[50] ruling with respect to a death in custody that occurred in March 2017. The Coroner identified that there was no mechanism for the ready transfer of a person in police custody within the police areas of Devon and Cornwall, Avon and Somerset, Wiltshire, and Gloucestershire from police custody to a medium secure mental health facility for assessment and treatment under Sections 2 and 3 of the Mental Health Act 1983 where such a person is suspected of or charged with a serious crime.

4.96 The South West Provider Collaborative has responsibility for the medium and low secure mental health care of adults originating from the south-west, since NHS England formally transferred its commissioning responsibilities. The new arrangements came into effect on 1 October 2020. The South West Provider Collaborative has eight partners, comprising five NHS organisations, one community interest organisation and two independent sector companies. Devon Partnership NHS Trust (DPT) is the Lead Provider for the Collaborative and holds the new contract with NHS England.

4.97 In response to the Coroner's ruling, the South West Provider Collaborative Oversight Group developed a protocol for emergency access to a medium secure mental health bed. A protocol and flowcharts were developed, for secure mental health services, police, CPS and HM Courts and Tribunals Service. This clearly describes the decision-making points and referral pathways for police, Liaison and Diversion, Approved Mental Health Professionals and acute mental health services, guiding the process of referral from police custody to secure services. The guidance refers to arrest for serious offences, for example, murder, attempted murder, Section 18,55 serious sexual offence (rape) and arson.

4.98 We reviewed the case notes made against the guidance provided by the protocol, to understand the options available to Trust services and the subsequent decisions made.

- *Discussion and advice from secure services*

4.99 The records indicate that alongside the plan to assess Mr D under the MHA, the team contacted Consultant Forensic Psychiatrist 1, who was on call for the area, for advice on day 3. Consultant Psychiatrist 1 and ASCC Team Manager 1 had a telephone discussion with Consultant Forensic Psychiatrist 1 whilst they were at the police station. Given the circumstances leading to Mr D's arrest, the previous concerns about his mental state and the planned MHA assessment, it was appropriate that the assessing team considered all available pathways for Mr D's continued detention. In line with the protocol for emergency access to a medium secure mental health bed, it was appropriate that secure services were involved in those considerations.

4.100 We did not have access to the notes from Consultant Forensic Psychiatrist 1. The AMHPs and Consultant Psychiatrist 2 (the other assessing doctor) were not involved in this discussion, although AMHP3 was aware of the possible requirement for a secure bed. Consultant Psychiatrist 1 told us it was a lengthy, detailed discussion.

[49] Flow chart for secure mental health services, police, the Crown Prosecution Service (CPS) and HM Courts & Tribunals Service (HMCTS) guiding the pathway from police custody to detention in secure mental health units. This document is also referred to as *Process flow chart supporting MoU for emergency admission to a secure mental health bed*.
[50] https://www.judiciary.uk/wp-content/uploads/2020/04/Lewis-Francis-2020-0074.pdf

4.101 AMHP Hub manager 1 recorded in the notes that they had emailed the South West provider collaborate about sourcing a secure bed. They noted: "[Devon Partnership NHS Trust member of staff] *has contacted* [Consultant Forensic Psychiatrist 1]*, on-call psychiatrist at* [secure service]*, who will liaise with ASCC as to whether* [Mr D] *requires a secure bed should it be appropriate for him to be detained under the Mental Health Act*".

Finding: The decision by Trust staff to seek advice from secure services in relation to Mr D's management and detention following his arrest was appropriate and in keeping with Trust guidance.

- *Decision to refer, or not, to secure services*

4.102 Regarding whether an individual who has been arrested should be referred to secure services, the protocol for emergency access to a medium secure mental health bed guides practitioners to consider whether the individual presents with a "*Serious risk of violence to others*" (thus indicating a referral to secure services), or with a "*Predominant risk to self and no serious risk of violence to others*" (indicating no referral to secure services).

4.103 To support their considerations, the protocol says "[the] *Key decision here is to detain or not and would be guided by whether the detainee's behavioural disturbance by virtue of their mental disorder is such that a police interview cannot progress. Note a person with an abnormal mental state can still be considered fit for interview under PACE* [Police and Criminal Evidence Act 1984][51] *with the support of an Appropriate Adult*".

4.104 From the circumstances and the lack of previous knowledge about Mr D's mental state, it would be reasonable to assume that Mr D may, if assessed, have been appropriate for detention under the MHA rather than proceeding at that time with a police interview. Consultant Psychiatrist 1's notes of the discussion with the on-call forensic psychiatrist indicates that their discussion focussed on "*whether a S2* [MHA assessment] *should be carried out or whether disposal through the forensic system should be followed*".

Finding: Consideration of the use of the MHA to assess Mr D and refer him to secure services after the homicide was appropriate and in line with the MHA and Trust guidance.

- *Decision not to assess Mr D under the MHA*

4.105 The protocol for emergency access to a medium secure mental health bed guidance advises, in relation to deciding on assessment for admission, "*Senior secure clinician to assess whether admission indicate* [sic]*. Given the urgent nature of the referral assessment will likely not be based on a face-to-face or even virtual assessment but based on the information provided by the referring Consultant Psychiatrist/section 12(2) approved Doctor*".

4.106 Whilst this suggests a face-to-face assessment may not be required in urgent situations, arrangement for the MHA assessment under Part 2 of the MHA were in place, and the team was available and already at the police station. Consequently, it may have been appropriate for the assessment to proceed, particularly given the nature of the offence, Mr D's vulnerabilities and possible inability to be placed in the general prison population, and the previous decision that Mr D required assessment under the MHA.

4.107 However, after the discussion with Consultant Forensic Psychiatrist 1, Consultant Psychiatrist 1 documented in the notes that it had been concluded that Mr D should be processed through the criminal justice system: "*Advise* [sic] *from* [Consultant Forensic Psychiatrist 1] *was that given* [Mr D's] *offence and unpredictability of behaviour (when I met with him yesterday he denied any thoughts to confront/ harm his neighbour) the forensic disposal system would be preferable. This means that* [Mr D] *will have to be processed by the police, charged and attend magistrates' court tomorrow, after which he can be remanded to prison and then S48 of the MHA can be pursued*". The rationale for this decision was that "[Mr D] *was processed by the police and he was under*

[51] PACE: https://www.gov.uk/guidance/police-and-criminal-evidence-act-1984-pace-codes-of-practice

constant observation. He was cooperative and calm". Consultant Psychiatrist 1 told us that Consultant Forensic Psychiatrist 1 informed him the service would not be able to accept Mr D under a Section 2 or Section 3 MHA admission and that processing through the criminal justice system was the preferred option. One reason for this was the perceived risk that Mr D might be able to appeal his detention; we discuss this further in 'Discussion with AMHP on day 3' (paragraphs 4.112 to 4.119).

4.108 The note made by the ASCC service also indicated that the protocol for emergency access to a medium secure mental health bed was not considered to be appropriate: "*Decision made not to use Regulation 28 Protocol* [protocol for emergency access to a medium secure mental health bed] *as not presenting in a floridly psychotic manner*".

4.109 In this instance, the protocol says "*Decision to admit is a clinical decision based on mental state (Barometer being opinion of serious behavioural disturbance leading to being unfit to interview) and assessed risk to others. Expected that care pathway will be determined by this clinical opinion, other factors that may be considered include existing community treatment plan, Diagnosis, likely response to secure inpatient treatment, health and safety assessment of clinical and environmental risks) and CPS advice to charge or not.*"

4.110 We are unsure how helpful this protocol is, as it indicates both that Mr D could have been assessed (and, if necessary, admitted to secure services) given the unpredictable nature of the offence and his behaviour, but also that this may not be required as he was cooperative and calm in police custody.

4.111 Having reviewed the notes and in light of the unknown quality of Mr D's mental state, the decision not to assess Mr D under the MHA could be open to debate. However, it is our view that Mr D met the criteria for assessment under the MHA, based on his presentation and the guidance in the protocol for emergency access to a medium secure mental health bed. We note the AMHP was not in agreement with the decision to process Mr D via the criminal justice system (paragraphs 4.112 to 4.119). The forensic notes were not provided to us therefore we can only surmise that the discussion with, and the decision and advice provided by Consultant Forensic Psychiatrist 1, alongside the presentation of Mr D in custody, overtook the previous decision to assess Mr D under the MHA.

Finding: Mr D met the criteria for assessment under the MHA on day 3, based on his presentation, and the guidance in the protocol for emergency access to a medium secure mental health bed.

- *Discussion with the AMHP on day 3*

4.112 Having decided that an MHA assessment was not required, this decision was then communicated to the AMHP who recorded "[Consultant Psychiatrist 1] *told us that there would be no MHA assessment and that the plan was that* [Mr D] *should be charged with the offence and placed before the magistrates' court with the recommendation that he be remanded to prison where he can then be transferred to an appropriate psychiatric setting under S48 of the MHA. I expressed my objection to this plan due to concern about* [Mr D's] *mental state as it was clearly due to his fixed delusions about his neighbour that led to today's unfortunate outcome and I was concerned that his mental state would deteriorate even further inside prison*".

4.113 The AMHP noted "[Consultant Psychiatrist 1] *confirmed that* [secure service] *have no bed"*. We discuss this in 'Possible lack of secure service bed' (paragraphs 4.120 to 4.125).

4.114 The AMHP recorded their discussion regarding alternative provision (i.e., an acute or PICU ward) but was told "[Consultant Psychiatrist 1] *felt this would not be appropriate at this time in view of the fact that yesterday,* [Mr D] *had stated he did not intend to attack his neighbour but had done so today. He felt that* [Mr D] *was too much of an unknown quantity to be able to safely admit him to a PICU bed …*" Again, this appears contradictory, implying Mr D's mental state was unknown and

unsafe to be managed in an acute or PICU environment, yet he was considered to be suitable for remand in prison.

4.115 In response to this, the AMHP recorded their belief that assessment and possible admission under Section 2 would be an appropriate route to consider, that any nearest relative request to discharge would be dismissed, and that a tribunal would not discharge Mr D given the circumstances. These assumptions are reasonable and in line with the MHA; however, the decision not to assess Mr D for admission under the MHA stood.

4.116 We find this contradictory. Despite the firm decision not to assess Mr D under the MHA, it appears Consultant Psychiatrist 1, in consultation with Consultant Forensic Psychiatrist 1, had decided Mr D would still require a secure admission. To achieve this, the plan was to strongly recommend to the remanding magistrate that Mr D be immediately diverted to hospital under Section 48 of the MHA,[52] "[Mr D] *to be remanded to prison with an [sic] strong advisement re: S48 with the view to divert for a Forensic Secure Placement*".

4.117 Following this, Mr D was to be remanded in prison (albeit hopefully to a hospital wing) whilst the courts were advised to seek a diversion to a secure hospital. This is a circuitous route into secure services and appears to have placed Mr D in the very circumstance that the protocol for emergency access to a medium secure mental health bed was set up to avoid.

4.118 In addition to providing advice on the use Section 48, the record by ASCC details their view on Mr D's care needs. Their record indicates that despite not requiring an MHA assessment, Mr D needed continual observations, and that when on remand he would require the prison health care wing because he was at high risk of suicide and had physical health care needs. Alongside this, Consultant Psychiatrist 1 also provided a plan should Mr D's (previously noted 'unpredictable') presentation change, "[Mr D's] *behaviour escalate in custody and he presents with behaviour unable to be managed in custody then Regulation 28* [protocol for emergency access to a medium secure mental health bed] *can be followed. According to Regulation 28 a MHA* [assessment] *and Section 2 can be pursued for the patient's safety and wellbeing. However please note that if that is the case then* [Mr D] *should still be transferred to a forensic bed as his unpredictability could significantly increase the risks to himself and others in a non-forensic environment (acute or PICU).*"

4.119 We would suggest that these plans indicate that Mr D was vulnerable, and possibly required assessment and treatment of his mental health. We would further suggest the decision to transfer Mr D to a prison environment whilst awaiting a diversion to a secure bed may not have been in his best interests although this cannot now be fully determined as the records do not provide a rationale or discussion of how this decision was reached.

Finding: The assessing clinicians did not collectively agree a treatment plan for Mr D following his arrest. There were conflicting opinions as to whether Mr D should be admitted to secure services under the protocol for emergency access to a medium secure mental health bed or processed through the criminal justice system.

Finding: The rationale to process Mr D through the criminal justice system because he was considered to be too unsafe and unpredictable to manage in a PICU setting indicates he should have been directed to a secure setting rather than remanded to prison.

Finding: The decision to process Mr D under the criminal justice system with the expectation he would be diverted to secure services, as opposed to admission under the MHA, was convoluted and not in his best interests.

- *Possible lack of secure service bed*

[52] Under Section 48 MHA prisoners on remand (without sentence) can be transferred to a hospital on the recommendation of two doctors for treatment for mental disorder. For full details see https://www.legislation.gov.uk/ukpga/1983/20/section/48

4.120 As discussed, the decision not to assess Mr D under the MHA was made with a plan instead to remand Mr D in prison, with the recommendation (but no certainty) that he be transferred to a secure hospital bed from prison.

4.121 We reviewed the records to explore this decision, and whilst the records by Consultant Psychiatrist 1 and the ASCC do not mention the availability of a bed, the AMHP did record "*reluctantly accepted that the plan as suggested above, to charge him and put him before the court was the only option at this time, with no suitably secure hospital bed being available as an alternative*."

4.122 Given this and the previous comment made by the AMHP about bed availability, we question whether the decision not to assess Mr D may have been related to a lack of a suitable bed. If this were the case, we would find this argument difficult to justify.

4.123 We asked Consultant Psychiatrist 1 if there was an issue in relation to locating a secure bed. We were told a medium secure bed was not available, although the team was aware there was potentially a low secure bed available out of area. Consultant Psychiatrist 1 reiterated that forensic services were clear in the advice that Mr D should be processed through the criminal justice system (with the expectation of being diverted to forensic services).

4.124 In the first instance, the records indicate that Mr D was unpredictable, he was suspected of committing a violent act, and the team who had previously met him (which included Consultant Psychiatrist 1), had felt he was appropriate for urgent assessment under the MHA even before the incident. In addition, Mr D was seen as a vulnerable adult, unsuitable for the general prison population and requiring constant monitoring and observations. He was also described as vulnerable due to his physical health and suicide risk, and again a hospital prison environment (healthcare or vulnerable persons wing) was recommended rather than being placed within the general prison population. Finally, the team had the available means to assess Mr D and to consider whether he required an admission under the MHA for assessment. This is further supported by the agreed plan to try and arrange a transfer to a secure hospital under Section 48 of MHA.

4.125 We believe that if the team had proceeded to assess Mr D under the MHA and then identified that a bed was required, the case could then have been made for a secure bed. In fact, the protocol for emergency access to a medium secure mental health bed flow chart, if followed through to this point, provides clear guidance on the escalation routes available in this instance: "*If no bed can be identified then only viable alternative will be remand while all efforts are made to safeguard the detainee until a bed is identified. To be reported as a reportable incident.*"

Finding: The plan to send Mr D to prison on remand to await a transfer to a secure bed was contrary to the South West Provider Collaborative Oversight Group protocol for emergency access to a medium secure mental health bed.

- *Communication between Trust services and other agencies after the decision not to assess Mr D under the MHA/ protocol for emergency access to a medium secure mental health bed on day 3*

4.126 The assessing staff had originally attended the police station with the expectation of assessing Mr D under Section 2 MHA. The plan changed quickly although there was not universal agreement in this respect. Mr D was to be charged and remanded in prison on day 4 with the recommendation for an assessment under Section 48 MHA with a view to Mr D being diverted to forensic services. The notes say the ASCC service was to liaise with the prison in-reach team and consultant psychiatrist.

4.127 However, the notes suggest a breakdown in communication between the consultants, AMHP hub, Trust out-of-hours service, ASCC service and police after the plan was agreed. The police contacted the Trust out-of-hours service on the evening of day 3 to ask why Mr D had not been subject to an MHA assessment; they appeared unaware of the plan that Mr D be charged and diverted to forensic services. The police were unclear if Mr D was fit for interview, which in turn led Consultant Psychiatrist 2 and AMHP3 to conclude Mr D should instead be subject to an MHA

assessment that night and admitted to the local PICU (although there were difficulties in establishing whether a bed was available) – in direct contradiction of the earlier agreed plan that Mr D be processed through the criminal justice system. However, neither were able to access Consultant Psychiatrist 1's Section 2 recommendation because it was locked in the HTT office safe, therefore the plan was revised again to undertake an assessment the following morning (it was also noted that it was too late to undertake an assessment with Mr D given his age and it should therefore be delayed until the morning). It was only when the AMHP hub contacted Consultant Psychiatrist 1 to ask that he attend the MHA assessment the next day that he learned of the change to the plan. Consultant Psychiatrist 1 contacted Consultant Psychiatrist 2 and they then agreed Mr D was not suitable for a PICU admission. Any further plans for Mr D were paused at this point as Trust staff became aware he had been admitted to hospital complaining of chest pains.

4.128 The notes were clear that clinicians originally intended that Mr D be charged and remanded in prison with the expectation he would then be diverted to forensic services. However, the notes also indicate that when staff were contacting each other throughout the evening of day 3, there was a general lack of clarity about the plan for Mr D, despite it being documented in earlier entries in the notes. This was further compounded by subsequent changes to the plan and staff experiencing difficulties trying to contact each other e.g., the police were unable to contact the AMHP hub or ASCC; the Trust's on-call manager was unable to contact the AMHP hub. The notes give no indication of what information was being shared with Mr D at this time.

4.129 The ASCC service, referred to as the "*Custody and Courts Referral Service*" in its 2017 service specification, details the key functions of the team as:

"*… clinical functions; liaison and advice; referral; short-term interventions; data collection and monitoring; and, safeguarding.*"

4.130 There is no evidence in the notes that the ASCC service contacted the police major crimes team to inform it of the agreed plan for Mr D. The police custody sergeant was involved in the discussions that concluded Mr D should be charged, but the notes suggest they were later unable to inform the major crimes team what the plan was and were confused as to whether Mr D had been subject to an MHA assessment that day. This in turn led to the police liaising with Trust out-of-hours services (e.g., the on-call manager) and the AMHP hub out-of-hours service to try to establish the situation.

4.131 Whilst the ASCC service was in part responsible for communicating the plan to the relevant agencies on day 3, they were not informed by the AMHP hub of changes to Mr D's treatment plan as the evening progressed. We note the ASCC provides an out-of-hours service within police custody but these are agreements undertaken at local level – it is not clear if the ASCC was available in this instance. AMHP3 did relay the revised treatment plan to the detention officer at around 11.15pm after being informed the custody sergeant was unavailable. However, we note the plan changed again following a discussion between Consultant Psychiatrist 1 and Consultant Psychiatrist 2. The notes provide insufficient detail as to the rationale for any of these changes or agreement on how these were to be communicated to the other teams or the police.

Finding: Staff from the AMHP hub, Trust out-of-hours service and police were trying to communicate changes to Mr D's treatment plan throughout the evening of day 3. However, this was not undertaken in a consistent, systematic manner and changes continued to be made to Mr D's treatment plan, rendering early communications redundant.

Finding: There was a lack of a central figure coordinating the management of Mr D's treatment plan up to his admission to hospital for chest pains. There was no collective understanding between the services about the intended treatment plan; some staff believed he was to be processed through the criminal justice system, whilst others believed he was to be assessed under the MHA.

Questions from Mr J's family

4.132 Mr J's sister submitted the following questions to us after reviewing the draft report:

- **Day 1**. There was a clear threat and risk to Mr J's life, why was he not informed of this or the police?
- **Day 2**. Mr D attended an appointment with a nurse and psychiatrist to which he was told they would organise his admission to hospital but shortly afterwards told him they could not identify a bed - why?

4.133 Mr J's sister also drew our attention to the judge's sentencing remarks at Mr D's trial in relation to bed availability. She said that the absence of a bed was in the report to the police and prosecution and read out as part of the judge's summary. She asked the following question:

- Surely there is more than one safe place for a mental health patient if they are a risk if there are no beds?

4.134 Mr J's sister told us she considered the incident would have been avoidable had a bed been available for Mr D on Day 2.

Why wasn't Mr J (or the police) told on Day 1 about Mr D's threats?

4.135 Article 2 of the Human Rights Act (1998) states:

"Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."[53]

4.136 During a landmark case, Osman vs United Kingdom[54] at the European Court of Human Rights in 1998, the police were found to be under a positive duty to protect a person's life (under Article 2) in certain well-defined circumstances.

4.137 In discharging this duty the police can issue so-called 'Osman' letters or warnings. This duty only applies in certain circumstances, set out in the Osman case, and include the belief that the threat to an individual indicates *'real and immediate*' danger.

4.138 In the case of Mr D, it is our view that the threats Mr D made about his neighbour were not seen as serious and/or credible by the clinicians involved and so they did not inform the police. We believe the clinicians held this view based on several facts:

- Mr D's thoughts about his neighbour were seen in the context of his paranoia.
- Mr J was not identified by Mr D to clinicians.
- Mr D's views were longstanding.
- Mr D was actively seeking help/respite from the thoughts about his neighbour.
- Mr D said he had not acted on his thoughts because he did not want to go to prison.

4.139 We have criticised the clinical team for not speaking to Mrs D about Mr D, although we reflect an inconsistency in this respect on Day 1, where notes reference contact with Mrs D.

[53] Article 2 Human Rights Act (1998): https://www.legislation.gov.uk/ukpga/1998/42/schedule/1
[54] https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22002-6781%22]} case referring to the alleged failure of authorities to protect right to life

4.140 The clinicians considered Mr D to be a low acute risk (as documented in the risk assessment) and had arranged for Mr D to be assessed by the team's consultant the next day: there is no evidence in the notes they considered it was necessary to contact the police.

Was Mr D's admission delayed due to a lack of bed?

4.141 We spoke at length to Mrs D who told us her expectation was that Mr D would be admitted to hospital following his assessment on Day 2. This was based on her opinion that he was very unwell – she had not been advised by Trust staff that he would be admitted. We have previously detailed in the chronology:

"Mrs D told us that when Mr D returned home on day 2, he was aware he would be given another appointment, but did not know when. Mrs D also said Mr D told her the assessing clinicians had said there was not a bed available for him at that time; however, the notes make no reference to the availability of a bed…"

4.142 There is no evidence in the notes that any attempt was made to source a bed for Mr D on Day 2. We interviewed Consultant 1 who was clear with us his expectation was that Mr D would be subject to an MHA assessment that week - which was being arranged – there was no suggestion he sought to find a bed for Mr D on Day 2.

4.143 The report sets out Mr D's understanding that he was to be admitted on Day 2, but a bed was not available, and he went home. We also set out that the notes do not reference a lack of bed as the basis for his return home, rather Mr D was to be assessed under the MHA and clinicians were taking steps to arrange this (and he was sent home whilst this was taking place).

4.144 We have detailed in the report that we considered the plan to refer Mr D for an MHA assessment to be reasonable and proportionate based on the assessing practitioner's conclusion that he lacked capacity (although we note a thorough capacity assessment was not documented).

Judge's sentencing comments regarding a lack of bed

4.145 Mr J's sister referenced comments made during the court process and the judge's sentencing summary about bed availability.

4.146 As previously stated, we found no evidence throughout our investigation to suggest that Mr D was not admitted on Day 2 due to a lack of bed, rather the intention was he would be assessed under the MHA, and arrangements were being made for this.

4.147 Our investigation is based on clinical records and interview evidence. We typically do not use sentencing remarks as evidence in a care and treatment review. However, we have added the following footnote to the report, linked to paragraph 4.36:

"Whilst not explicitly included in the scope of this review, we note the judge's sentencing remarks at the end of Mr D's trial which highlighted that Mr D reported he was told he would be admitted to hospital but shortly after learnt a bed was not available, and he was sent home".

Surely there is more than one safe place for a mental health patient if they are a risk if there are no beds?

4.148 The Trust has protocols and escalations pathways in place to access beds, but in this instance there is no suggestion a bed was sought for Mr D on Day 2.

5 Trust internal investigation and action plan

5.1 The NHS England SIF (2015) does not give an explicit definition of an SI, rather it says the classification should be judgement based. It gives examples which include:

"[a] *homicide by a person in receipt of mental health care within the recent past*"

5.2 There are seven principles to SI management which include being open and transparent, objective, proportionate, timely and responsive. The SIF says:

"*Investigations of serious incidents are undertaken to ensure that weaknesses in a system and/or process are identified and analysed to understand what went wrong, how it went wrong and what can be done to prevent similar incidents occurring again*".

5.3 The framework says a systems-based methodology – typically known as root cause analysis (RCA) – should be adopted to identify:

1. "*The problems (the what?);*
2. *The contributory factors that led to the problems (the how?) taking into account the environmental and human factors; and*
3. *The fundamental issues/root causes (the why?) that need to be addressed*".

5.4 The SIF says that when more than one organisation has been involved in a service user's care, all parties, where possible, should take steps to undertake a single investigation.

5.5 The Trust's Serious Incidents Requiring Investigation (SIRI) Policy and Procedure (2017)[55] describes the responsibilities of key roles in the SIRI process (e.g., the head of clinical risk and the SIRI investigation lead). In the event of a SIRI, a DATIX[56] report must be completed followed by a 72-hour report. The policy details the three levels of SIRI investigation (concise, comprehensive and independent) and the respective timescales for completing an investigation. The policy states that in instances of unexpected deaths, the investigation must be undertaken by two investigators, one of whom must be a doctor.

5.6 The policy has supporting documents in the appendices which include: a SIRI procedure checklist, an investigating an SI flow chart, and a Trust sign-off for SIRI investigations flow chart.

5.7 The Trust operates a policy of using a pool of SIRI investigators, whom the head of division is responsible for allocating to a SIRI.

5.8 In parallel with the SIRI investigation, the relevant team manager must arrange an SI multidisciplinary review within two weeks of the incident. The review should involve all staff who contributed to the service user's care within the preceding six months. Where possible, the SIRI investigator should also attend the meeting.

5.9 The Trust's SIRI and Mortality Review Group (SIRI and Mortality Group – also referred to as the SIRG) is responsible for reviewing investigation reports and action plans. In turn, the draft report will be submitted to Somerset CCG for review and sign-off.

Internal investigation

5.10 The Trust undertook an RCA investigation into Mr D's care and treatment. It was jointly led by a consultant psychiatrist and clinical service manager. The internal investigation report is dated 24 February 2021; however, the approval date for sign-off by the SIRG and CCG is recorded as 15 June 2021 within the same report. We have seen correspondence between the Trust and CCG

[55] The policy was due for review in February 2020 and was replaced by the Trust's Incident Policy in September 2021. We have referred to this policy in relation to the investigation methodology because it was in place when the SI began.
[56] Online patient safety system used to report incidents.

about the internal report which indicates the CCG had ongoing queries in relation to the report after June 2021. The notes indicate there was an expectation on the part of the CCG that the internal report would be signed off at the August 2021 SIRG (it was approved at the July SIRG). We discuss this further under 'Oversight and quality assurance of Trust internal investigation and action plan' (paragraphs 5.50 to 5.65).

Analysis of the Trust's internal investigation

5.11 We have developed a framework of 24 standards for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency (NPSA),[57] the NHS England SIF[58] and the National Quality Board (NQB) Guidance on Learning from Deaths.[59] We also reviewed the Trust's policy for completing SI investigations to understand the local guidance to which investigators would refer.

5.12 The 24 standards for assessing the quality of SI reports are based around the three key themes of credibility, thoroughness and whether the report was likely to lead to change in practice.

5.13 Details of our assessment of the internal investigation using these standards can be seen in 'Appendix C'. Our findings are summarised in the table below:

Rating	Description	Number
	Standards met	4
	Standards partially met	12
	Standards not met	8

5.14 In our view, the Trust's investigation provided a reasonable summary of events, but lacked detail, underpinning analysis and reference to expected practice. We consider there were areas in which further detail and commentary was warranted, with a view to providing the reader with a comprehensive understanding of the events both leading up to, and after, the incident on day 3.

Credibility

5.15 The Trust's internal investigation was undertaken by two senior Trust staff who had investigative experience. It was an RCA investigation with terms of reference tailored to Mr D's case.

5.16 We noted several formatting and typological errors throughout the report. Sections of the report are incomplete, and the report is marked as signed off the by the Trust's SIRG in June 2021, but we are aware there was ongoing dialogue between the Trust and CCG at this time with regards to the report and outstanding queries. The report was signed off/approved at the SIRG on 13 July 2021 (although communications continued with the CCG about the report in August 2021).

5.17 It is our view that the investigation report appears incomplete from an administrative perspective, despite being marked as final. It would benefit from a final review to ensure all sections have been completed and administrative details updated (e.g., correct sign-off date and the footer of the report should include the incident details).

[57] National Patient Safety Agency (2008) *Independent investigations of serious patient safety incidents in mental health services*.
[58] NHS England (2015) *Serious Incident Framework: supporting learning to prevent recurrence*. https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf
[59] National Quality Board (2017) *National guidance on learning from deaths*. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Thoroughness

5.18 The report contains two chronologies, narrative ('Background and context of the incident') and tabular. It is our view that the former contains a reasonable level of detail but neither chronology provides a complete account of events. For example, the narrative chronology does not reflect that the AMHP3 did not agree with the care plan on day 3, and the tabular chronology contains a gap between 4.30pm and 11pm on day 3, despite this being a period when there were several contacts between staff about Mr D's care pathway and the original Section 2 application.

5.19 The report did not identify any CDPs and SDPs. Whilst this assessment is reasonable in the context of Mr D's care on day 1 and day 2, we do not agree with this in relation to his care after the incident. There was confusion amongst staff and the police about the agreed care pathway for Mr D and whether he was to be processed through the criminal justice system or the MHA. This resulted in numerous contacts and at one point a change to the agreed plan; however, this change was not put into practice because Mr D was transferred to an acute facility after experiencing chest pains. The internal report does identify this point as a 'lesson' but provides limited underpinning narrative to explain this to the reader. Equally, there is no explanation as to the patient pathway options, and whilst a process flow chart is attached to the report, it is not referenced in the main body of the report. Further context would have been helpful for the reader (e.g., explanations about the treatment pathways, whether under the protocol for emergency access to a medium secure mental health bed or through the criminal justice system).

5.20 The report lacks analysis and reference to expected practice. It is not necessarily clear to the reader how the investigators reached their conclusions and/or identified the lessons learned and the resultant recommendations. For example, one lesson learned was "*ASCC was unable to contact the Trust communications team when attempting to report this incident*". The report does not set out what the expected practice would be in such a scenario and provides no information about why the ASCC was unable to contact the communications team or if this was explored with them.

5.21 On balance we consider the report answered its terms of reference, but further narrative and analysis would have provided a more detailed assessment of Mr D's care and treatment.

Impact

5.22 The structure of the report is such that it does not logically flow and at times is difficult to follow. There is little analysis or reference to expected practice (Trust policy) underpinning findings, therefore it is unclear how the authors reached their conclusions.

5.23 The report contains two recommendations which relate to the lessons learned but these do not comprehensively reflect the broader investigation findings. For example, the Trust's investigators identified that staff had different understandings of Mr D's forensic pathway from police custody, but the report makes no recommendation in response to this.

5.24 The recommendations are not supported by SMART[60] actions and make no reference to testing, measuring and/or monitoring the progress of the action plan.

5.25 In summary, whilst the report provides a reasonable account of events, we consider it lacks detail and analysis. There is no reference to expected practice and it is not clear how the investigators reached their conclusions. We do not consider the report to have thoroughly explored the issues identified and believe this was a missed opportunity to develop recommendations and actions that would seek to improve practice e.g., in relation to family engagement during assessments, staff understanding of the forensic pathway, and the communication and management of changes to the care pathway.

5.26 However, in mitigation of the above, we note the Trust does not have a dedicated investigative resource, rather there is a pool of staff who have received investigative training which is drawn on. We were told SI investigators are not given protected time to undertake an investigation, rather

[60] SMART: Specific, Measurable, Achievable, Relevant and Time-Bound.

there is an expectation this will be done in addition to their normal role. SI investigations are often complex; to complete a thorough investigation our expectation would be that staff be provided with protected time.

Finding: The Trust's internal investigation provided a reasonable summary of events, but lacked sufficient detail, underpinning analysis and reference to expected practice. The internal investigation recommendations do not comprehensively reflect the investigation findings.

Communication with Mr D's and Mr J's families during the internal investigation

5.27 The Trust's SIRI policy states "*The Being Open principle is now a statutory requirement, which places a Duty of Candour on providers to advise patients and/or their family of a serious incident, to apologise and offer them an opportunity to be advised of the outcome.*"

5.28 The Trust's Being Open and Duty of Candour Policy (2015)[61] is underpinned by the principles of being open:

"*A sincere, meaningful apology for the event should be offered as early as possible where it is clear that there has been an error or harm has been caused.*"

5.29 The policy says patients and their carers should be informed of the issues surrounding the event and offered a meeting:

"*Information about the event must be relayed in an honest and candid open manner, by the appropriate person, as soon as is practicable. It should be based only on the facts known at the time, and provide the patient with a step-by-step explanation of what happened.*"

Mr D's family

5.30 Trust staff were in contact with Mrs D on the day of the incident and thereafter. A duty of candour letter was sent eight days after the incident.

5.31 The internal investigators met with Mrs D in late 2021. She told us that the timing of this meeting, close to the Christmas period, was difficult for her but she felt pressure to attend the meeting to adhere to the Trust's schedule.

5.32 There is no evidence the final report or summary findings were shared with Mrs D.

Mr J's family

5.33 The Trust was in contact with Mr J's sister from late 2020 onwards. The report does not say why there was a delay in making contact. The Trust's investigation and learning lead spoke to Mr J's sister in early 2021. She raised a small number of questions about Mr D's care, but these are not clearly addressed in the report i.e., there is no section for family questions.

5.34 The Trust did not share its final report with Mr J's sister (which she requested) but provided her with a summary of the findings in late 2021. The Trust told Mr J's sister that it could not share the report for legal reasons due to the volume of sensitive information it contained about Mr D. We note the July SIRG minutes detailed a discussion in relation to sharing the report with Mr J's sister. The group was unclear of whether it could do this and agreed guidance should be sought from the Trust's Litigation team to ensure any information shared was done so in line with confidentiality protocols.

5.35 In our experience, this is a grey area for trusts, and some do share investigation reports whilst others do not. NHS England provided guidance to mental health providers in 2019 which said:

[61] The policy was due for review in July 2018.

"*NHS England, London has obtained legal advice on the release of investigation reports to relatives following mental health homicide. The advice is clear: investigation reports should always be released to families.*"[62]

5.36 Based on this guidance, the Trust should have shared the full report with Mr J's sister. However, it did share its summary findings, which we consider a reasonable compromise based on its own legal advice not to share the report. Whilst noting mental health homicides are rare, we would encourage the Trust to review its process for sharing investigation reports with victim's families to ensure it is in line with national guidance.

Finding: The Trust engaged with Mr D's and Mr J's families after the incident on day 3 and as part of its investigation. This was in line with the principles of Being Open. However, neither family received a copy of the final internal investigation report, although the Trust sent Mr J's sister a letter outlining the investigation summary findings. It is our view, in keeping with NHS England (London) guidance, that the internal report should have been shared with both families.

Trust's progress with the internal investigation action plan

This section contains the findings arising from the assurance review of the action plan. Our assessment is meant to be useful and evaluative. We use a numerical grading system to support the representation of 'progress data', which is intended to help organisations focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained. These are as follows:

Score	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 completed and tested, but not yet embedded
5	Can demonstrate a sustained improvement

5.37 The Trust's internal investigation made two recommendations. The action plan provided to us was dated June 2021 with an expected completion date for both actions of July 2021. We detail below our assessment of the Trust's progress in implementing both recommendations.

- "*Recommendation 1: For serious incidents such as this, and where a forensic pathway is being considered, then the forensic on-call consultant is best placed to advise on the appropriate patient pathway. Once the plan has been agreed, it should be adhered to.*"

5.38 We note Consultant Forensic Psychiatrist 1 was contacted for advice on day 3, therefore we are unclear why this is part of the recommendation: the issue was adherence to the treatment plan (the second part of the recommendation).

5.39 The action required in response to recommendation 1 was:

"*Within daytime/service hours LADS service* [liaison and diversion service] *in conjunction with AMHP/local Somerset consultant/on-call consultant agree/advise escalation for consideration by*

[62] NHS England (April 2019) *Mental health-related homicide: information for mental health providers*. https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/03/MHRH_Info-for-Mental-Health-Providers_V4.0-1.pdf

[Trust A] duty/on-call consultant. Out of hours – AMHP/duty on [-call] *consultant to seek/arrange for view from on-call [Trust A] forensic consultant. As per agree Reg 28 pathway".*

5.40 The above action sets out expected practice and makes it clear there is an expectation that staff liaise with the Trust A forensic service on-call consultant in relation to the forensic pathway.

5.41 However, whilst the action addresses the first part of recommendation 1 – engaging the forensic on-call consultant (although we have inferred this rather than it being explicitly stated) – it does not address the second part of the recommendation about adhering to the agreed treatment plan.

5.42 The action is not owned by a specific individual, rather the action plan states the services and roles that would be involved in the process e.g., Trust on-call consultant and the Trust A forensic on-call consultant. We note the Trust A consultant would not be in a position to assume ownership of an SFT action.

5.43 The action plan says the forensic pathway process flow chart was circulated to all medical staff in February 2022, but we have not seen evidence of this (e.g., staff email).

5.44 The Trust's action plan documents that the actions associated with recommendation 1 are complete. We do not agree with this assessment based on the evidence. The Trust has provided no evidence of assurance that the forensic on-call consultant is contacted in instances when a forensic pathway is being considered. Equally there is no evidence of testing whether agreed treatment plans are being adhered to.

- "*Recommendation 2: For the Somerset FT communications team to be advised of the ASCC's unsuccessful attempts to contact them to highlight the high profile case.*"

5.45 As above, the actions associated with this recommendation is expected practice:

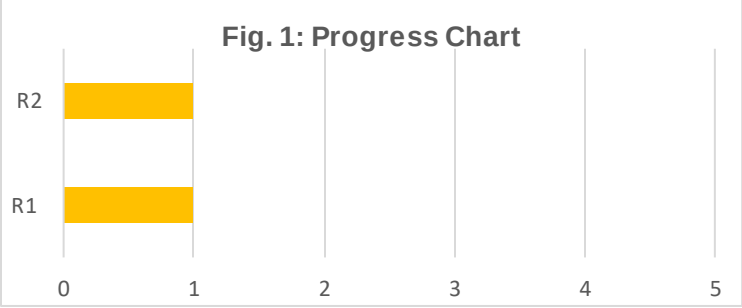
"*LADS service to advise communications team within daytime service hours …*"

5.46 The action is not owned by a specific individual, but by LADS.

5.47 The action plan records the action as "*delay in progress*". We agree with this assessment: there is no evidence this recommendation has been progressed (e.g., a protocol developed and shared with the LADS), and/or evidence of testing (e.g., example of the on-call manager being informed about SIs in a timely manner).

5.48 The Trust provided a Homicide Action Plan which included updates in relation to this action. It was noted in May 2022 a communications team rota was being developed, and in June 2022 a document was to be shared confirming the on-call arrangements. The Trust provided no further information; we have no assurance that practice has been tested or become embedded.

5.49 The chart below provides a summary of our assessment of the Trust's progress with its action plan.



Finding: The Trust's action plan is incomplete. Further work is required in relation to both actions in terms of ownership, implementation and monitoring.

Oversight and quality assurance of the Trust's internal investigation and action plan

5.50 In this section of the report, we consider the Trust's internal assurance processes in relation to signing off the internal investigation. We also consider the CCG's role in quality assuring and signing off the Trust's internal investigation and action plan.

Trust

5.51 The Trust has a SIRG which is responsible for overseeing the SI process, and for reviewing and signing off all SI reports. As of 2022 this meeting is chaired by the Medical Lead for Clinical Governance, who chairs both SIRGs across the Trust. Previous to this, and in relation to this SI, the meeting was chaired by the medical director for mental health and learning disabilities. Other attendees include the Trust's incident investigation and learning lead, the director of mental health and learning disabilities care and the head of mental health and learning disabilities community services.

5.52 The Trust's SIRI Policy (2017) has a flow chart that sets out the Trust's process for signing off an SI. This includes submitting the draft report to an SI panel, submission to the head of risk for sign-off and final presentation of the report to the SIRG.

5.53 The SI authors told us they did not attend an SI panel to discuss the report. They also told us, as per Trust practice, they submitted their SI report to the SIRG but did not attend the meeting and were not involved in subsequent discussions about the report. The SI authors were unaware of ongoing queries from the CCG as part of its own assurance process and did not know whether the draft report had been shared with Mr J's sister or Mrs D. We note the Trust's SIRI Policy (2017) says SI authors should attend the SIRG to present their final report, discuss learning and good practice. This policy was due for review in February 2020 and was replaced by the Trust's Incident Policy (September 2021). The latter policy says SI reports should be signed off at the SIRG, but it makes no comment in relation to the authors attending the meeting.

5.54 We consider that not involving the SI authors in the oversight and assurance of the report dilutes the investigative process. It would have been best practice to have continued to involve the SI authors in the process. They were best placed to address any queries the CCG or other parties may have had.

5.55 The SI report was approved at the July 2021 SIRG and the report authors were not present. Minutes of the meeting indicate the report had been discussed at a previous meeting and changes had been made to the report as a result.

5.56 As part of its review of this report, the Trust informed us that it has reviewed its internal governance arrangements for homicides and created a Homicide subgroup which reports to the SIRG. There is also an ongoing programme of improvement work which includes undertaking an overall review of the governance processes for homicides. We were given the terms of reference for this workstream which were agreed with Devon Partnership NHS Trust and NHS England in July 2022 ('*Peer review of the governance and oversight of mental health serious incident investigations at Somerset NHS Foundation Trust*').

CCG[63]

5.57 The CCG has a SOP[64] that sets out the role of the CCG in the SI process. This includes authorising any extensions beyond 60 days to complete the report and the completion of a quality review template as part of the CCG oversight and assurance of an SI. The SOP says CCG quality leads must complete their review of the SI and provide feedback for the Trust within 10 working days. Where the quality lead(s) is not assured by the SI report, the investigation cannot be closed and further liaison with the Trust is required.

[63] Please note, the CCG became an Integrated Care Board (ICB) in July 2022 https://www.england.nhs.uk/publication/integrated-care-boards-in-england/

[64] We have referred to the 2019 SOP in place at the time of the incident but note the CCG has since implemented a more detailed SOP (January 2022) with supporting flow charts.

5.58 We note the 2022 version of the SOP sets out that the provider should then submit the revised/updated SI report to the CCG for another review; again, the CCG review and quality review template must be completed within 10 working days. The SI should not be closed by the CCG until the quality lead(s) has confirmed they are assured by the final SI report. However, we note the incident and subsequent Trust internal investigation preceded this SOP. This process is not described in the 2019 SOP, which was in place at the time the CCG reviewed the Trust's internal report, but the evidence indicates this was the expected process (e.g., emails indicate the quality leads provided feedback on the second version the SI report they received, and they anticipated this would be relayed to the Trust). The 2019 SOP said an SI could only be closed if the quality leads/reviewers were in agreement.

5.59 The CCG received the 72-hour report for the incident and submitted questions to the Trust to be taken into consideration as part of the terms of reference.

5.60 The Trust's incident investigation and learning lead submitted the SI report to the CCG on 6 May 2021. They outlined in the covering email that the SI had been approved by the SIRG earlier in the week[65] but that the report had not been shared with the families involved due to ongoing criminal proceedings. The CCG Patient Safety team quality improvement facilitator shared the report (with a request for comments to be returned by 20 May 2021) with the CCG quality leads on 7 May 2021. As part of the initial review of the SI report it was noted by the CCG Patient Safety team that it did not feel the report fully addressed the questions submitted by the CCG previously (see paragraph 5.59).

5.61 Three quality leads submitted feedback about the SI report within the agreed timeframe, although only one completed a quality review template. A homicide review meeting attended by the quality leads took place on 20 May 2021. The feedback and meeting identified a number of outstanding issues and queries about the report. The CCG emailed its feedback to the Trust on 20 May 2021; it asked for more information to be added to the report and submitted five questions (e.g., had a capacity assessment been completed and had the Trust's MHA lead reviewed the report?).

5.62 The Trust submitted the revised SI report to the CCG in July 2021, and it was circulated to the quality leads for review on 20 July 2021 (feedback was requested by 3 August 2021).

5.63 The CCG submitted further feedback to the Trust on 8 August 2021. The CCG noted:

- Further learning had not been picked up by the report (e.g., family engagement as part of assessments).
- The action plan was incomplete, and it was unclear whether the Trust's MHA lead had reviewed the report.
- It was unclear what support the Trust had provided to the community consultant psychiatrist.
- A formal capacity assessment on day 2 would have been helpful.

5.64 The Trust responded to the CCG's points by email on 25 August 2021. They did not provide a revised report or a completed action plan. There is no evidence the CCG's feedback was considered by the Trust's SIRG or that it led to further revisions being made to the SI report (e.g., no recommendation was made in relation to involving families in assessments).

5.65 The CCG reported as part of its own internal oversight process in January 2022 that some questions it had submitted to the Trust had not been addressed in the SI report and the SI action plan had not been received.

5.66 The CCG told us that it was aware the Trust had not incorporated its feedback into the final report. However, it did not pursue this with the Trust because NHS England and NHS Improvement had taken the decision to commission an independent investigation, the terms of reference for which

[65] We assume the report was approved in the context of being shared with the CCG rather than final sign-off which occurred at the July SIRG.

included reviewing the Trust's internal investigation. We were told that had an independent investigation not been commissioned there would likely have been ongoing dialogue with the Trust until the CCG was assured by the investigation, recommendations and action plan. Had that dialogue been unsuccessful it is likely there would have been a meeting between the two parties to discuss the report in greater detail.

Finding: The SI was submitted to, and approved by, the Trust's SIRG in keeping with Trust policy. However, there is no evidence the SI authors were involved in the quality assurance review of their report and they did not attend the SIRG. We were advised this was Trust practice, but this does not reflect the SI policy in place at the time.

Finding: The CCG completed a thorough review of the Trust's SI report and submitted feedback to the Trust in May and August 2021.

Finding: The Trust did not incorporate the CCG's August feedback into the SI report. The Trust responded to the CCG feedback by email but did not amend the report further.

Finding: The CCG did not complete its quality assurance process for the Trust's SI and there is no evidence of a dialogue with the Trust in relation to receiving and/or commenting on the action plan. The CCG advised this was because an independent investigation was to be undertaken into Mr D's care and treatment that would also consider the Trust's internal investigation and action plan.

6 Conclusions

6.1 Mr D's case is unusual in the sense he was unknown to Trust services until two days prior to the incident. His initial referral was handled promptly, and he was seen by the HTT in a timely manner on day 1 and day 2. The actions undertaken by the HTT during the assessment process were reasonable and broadly in line with Trust practice. The HTT undertook a good first assessment and the decision to refer Mr D for further assessment by the HTT was appropriate.

6.2 The conclusion made by assessing clinicians on day 2 that Mr D would benefit from a period in hospital was also appropriate. However, it is our view that the decision that Mr D lacked capacity to consent to an admission was conflated with whether Mr D could consent to treatment. There is limited documented information about how Mr D's capacity was assessed, but it is our expectation that admission and treatment should have been considered separately. In Mr D's case focus should have been placed on the former because he was requesting an admission. There was a missed opportunity to involve Mrs D in the assessment process, despite her being identified as a protective factor (at a time when Mr D was considered to lack capacity and insight).

6.3 We consider the decision to refer Mr D for an MHA assessment was appropriate given the conclusion he lacked capacity. The notes indicate Mr D's presentation was not such that the assessing clinicians considered he needed an immediate admission, therefore the ongoing plan for assessment under the MHA was timely and proportionate given the expectation he would be seen within a couple of days. However, we note the absence of a crisis plan that specifically addressed Mr D's persecutory ideas about his neighbour.

6.4 We do not agree with the Trust's decision on day 3 to process Mr D through the criminal justice system. We consider the rationale that he might successfully appeal his detention if processed via the MHA unlikely in view of the gravity of his offence. Further to this, the argument that Mr D was too much of an unknown quantity and risk to be placed in a PICU or with acute services emphasises that he should have been admitted to a secure bed rather than detained in prison in the first instance. The decision by clinicians to have Mr D processed through the criminal justice system with the expectation that he would be diverted to forensic services was convoluted. The clinicians had the means on day 3 to assess Mr D under the MHA with a view to him being admitted to secure services. The notes indicate a secure bed was not available, but the protocol for emergency access to a medium secure mental health bed sets out the steps to be taken in such a scenario to escalate the matter; there is no evidence this was considered, despite Trust staff not collectively agreeing how best to manage Mr D's treatment pathway.

6.5 We appreciate the situation was unprecedented for Trust staff and that discussions were lengthy and involved several professionals. There were two options available to staff, and a rationale was documented for the decision to have Mr D processed through the criminal justice system. However, it is our view that it would have been more efficient, to have processed him through the MHA on day 3 and to implement the escalation protocol for a secure bed admission.

Appendix A: Terms of reference

INDEPENDENT REVIEW OF THE CARE AND TREATMENT RECEIVED BY MR D

Purpose of the Review

- To independently assess the quality and management of the care and treatment of Mr D against best practice, national guidance and relevant organisational policy.
- To identify further opportunities for learning that may be applicable on a local, regional or national basis building on the provider trust Level 2 investigation.
- To review the internal provider trust investigation report process and implementation of the statutory Duty of Candour in this case. To review the oversight and monitoring of this internal investigation report by Somerset CCG.
- The outcome of this review will be managed through corporate governance structures in NHS England and Improvement, the Clinical Commissioning Group, NHSE Specialist Commissioning and the provider's/other statutory agencies formal Board sub-committees.

Terms of Reference

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

1. Case specific:

1.1 Compile a comprehensive chronology of indications of deterioration in mental health leading up to the incident starting from 2017 to six days after the incident.

1.2 Review the care, treatment and services provided by the NHS and other relevant agencies in regard to mental health including Mr D's first contact with mental health services up to and including the period after the incident.

1.3 Review and assess organisational compliance with local policies, national guidance and relevant statutory obligations in particular:

- The application of the Mental Capacity Act
- The decision making and outcome in regard to the Mental Health Act Assessment and inpatient bed availability (Trust and Local Authority as required with joint working arrangements), and
- The Care Act 2014 and statutory guidance.
- This should include a review of any safeguarding considerations.

1.4 Consider the adequacy of risk assessments, formulation and risk management plans, including specifically the risk of the perpetrator harming themselves or others.

1.5 Examine the effectiveness of Mr D's care plan and crisis plan including the involvement of the service user and their family.

Family Questions:

- Submitted by both families. Please refer to the main report for detail.

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

2.1 If the investigation satisfied its own terms of reference and were specifically aligned to the individual case covering the required scope of the investigation.

2.2 If the investigation was completed in a timely manner.

2.3 If all root causes and potential lessons have been identified, SMART recommendations made and shared within the organisation.

2.4 Whether recommendations are appropriate, comprehensive and flow from the contributory factors, lessons learnt and root causes.

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

2.6 Review progress made against the action plan.

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

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

2.9 Review whether the Clinical Commissioning Group (CCG) Governance/Assurance processes in monitoring and oversight of the Level 2 investigation and its subsequent recommendations were appropriate and robust.

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

2.11 Review the Providers application of its Duty of Candour in being open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf).

2.12 Evidence of families of victims and alleged perpetrators being treated as key stakeholders and an integral part of the investigation.

3. Timescale

3.1 The review process starts when the investigator receives the Provider documents and the review should be completed within 6 months thereafter.

4. Initial steps and stages

NHS England and NHS Improvement will:

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

4.2 Arrange an initiation meeting between the Provider, commissioners, investigator and other agencies willing to participate in this review**.**

4. Outputs

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

4.2 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, proofread and shared and agreed with participating organisations and families (NHS England and NHS Improvement style guide to be followed).

4.3 At the end of the review, to share the report with the Provider and meet the victim and perpetrator families to explain the findings of the review and engage the Clinical Commissioning Group with these meetings where appropriate.

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

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

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

4.7 Somerset CCG / ICS to report to the SW-IIRG post publication of the independent investigation report and action plan:

- Progress report and evidence of implementation after 3 months
- Progress report and evidence of implementation after 6 months
- Progress report and evidence of implementation after 12 months

4.8 The learning from the investigation and evidence of improvement in care, treatment and system working will be shared across the SW Region as appropriate.

4.9 Contact should be made by the Trust / ICS with both families to offer them the opportunity to receive a progress report within 12 months post publication.

5. Other

5.1 Should the families 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 and NHS Improvement for escalation and resolution at the earliest opportunity**.**

Appendix B: Documents reviewed

The Trust

- Mr D's clinical records including risk assessments and AMHP report
- 72-hour report
- Radar report
- Trust's internal investigation report
- Trust's internal investigation action plan
- Correspondence between the Trust and Mrs D
- Correspondence between the Trust and Mr J's sister
- Correspondence between the Trust and Mr J's friend
- Trust policies and procedures
- Flow chart for secure mental health services, police, CPS and HMCTS guiding pathway from police custody to detention in secure mental health units (Protocol for emergency access to a medium secure mental health bed - 'Regulation 28 Protocol')
- Homicide Action Plan v0.24
- Homicide sub-group terms of reference 2022

Somerset CCG

- Mr D's GP records
- Mr D's community mental health records
- Correspondence between the Trust and CCG in relation to the Trust's internal investigation:
  - terms of reference
  - draft internal report
  - CCG sign-off process
- First and second versions of the Trust's internal investigation submitted to the CCG
- Trust's action plan

Appendix C: Niche investigation assurance framework – internal investigation reports

Analysis and review method

Rating	Description	Number
	Standards met	4
	Standards partially met	12
	Standards not met	8

Standard		Niche commentary & rating	
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident.	The internal report does not set out the level of the investigation.	
1.2	The investigation has clear terms of reference that include what is to be investigated, the scale and scope, methodology and type of investigation.	The internal investigation has five terms of reference which have been tailored to the investigation. The terms of reference do not set out the scope of investigation (e.g., timeframe of review). The terms of reference do not include questions from the families of Mr D or Mr J.	
1.3	The person leading the investigation has the appropriate skills and training in effective systems investigation processes.	The investigation team was composed of two individuals – a consultant psychiatrist and a clinical service manager. The internal report does not detail the investigative experience of the team, but they told us they had received investigation training at the Trust, which included the RCA methodology.	
1.4	The investigation was completed within 60 working days or there is clear evidence of the reasons for delay and a process for approving this with commissioners.	The investigation report does not say when the investigation began but the internal SI investigators told us they undertook field work in late 2020. There was ongoing dialogue between the Trust and CCG in relation to the internal report; and in view of the dates of these communications (e.g., in August 2021) we consider it unlikely the internal investigation was completed in 60 days. The Trust requested an extension to the report in January 2021 due to staff absence which meant the SI report would not be presented to the SIRG until the end of February. The CCG agreed a revised submission date of 21 March 2021. The CCG provided us with a copy of what it considered to be the final investigation report. The report itself is the same as that provided by the Trust to us but its file name lists it as version 1.3 and it is dated 10	

Standard		Niche commentary & rating	
		November 2021.The Trust version provided to us did not have a version number or date in the file name.	
1.5	The report is a description of the investigation, it is accessible to readers and written in plain English, without typographical errors.	The report is written in plain English and has a clear structure. However, there are typological errors and sections of the report have not been completed e.g., 'Sharing of the report', 'Implement missing/additional safeguards' and 'Arrangements for shared learning'. 'Template v2.1' has not been removed from the report front page and the footer details have not been completed (e.g., incident reference number, version and date of report). The report is marked as 'final' and dated 24 February 2021; but is also dated as signed off by the CCG in June 2021. Correspondence between the Trust and CCG indicates the report was not signed off until later in the summer (e.g., August 2021).	
1.6	Staff have been supported following the incident, provided with information about the investigation and have had an opportunity to contribute to the process.	The report says a debrief meeting was held with staff the month of the incident, and additional support was offered to staff (e.g., from the Trust's psychologist). The report says interviews took place with "*a range*" of clinicians and a social worker but does not give details; it does not say if the final report was shared with Trust staff. The internal investigators gave us details of the staff they spoke to which included Consultant Psychiatrist 1 and the other assessing HTT staff.	
Theme 2: Thoroughness			
2.1	The methodology used for the investigation is described and includes the any analytical tools used and how the information and evidence needed was obtained (interviews, mapping, review of clinical records or visits and observations).	The report states it is a "*root cause analysis investigation report*". It provides details of staff interviews, the records review and policies referenced. A chronology is available, but the report does not set out the nature of its analysis to support its findings (e.g., fish bone diagram or the five whys).	
2.2	Bereaved or affected patients, families and carers are informed about the incident and of the investigation process.	• *Mrs D* The Trust's incident investigation and learning lead wrote to Mrs D two weeks after the incident to inform her the Trust would be undertaking an investigation into the events leading to the incident. The investigators met with Mrs D in late 2020.	

Standard		Niche commentary & rating	
		Mrs D told us the timing of the meeting was not good for her, given the proximity to the Christmas period, but she felt pressure to adhere to the Trust's schedule. • *Mr J's sister* The Trust's investigation and learning lead wrote to Mr J's sister in late 2020 to advise that the Trust would be undertaking a review into Mr D's care and treatment. The Trust's investigation and learning lead acted as a liaison with Mr J's sister. The Trust's investigation and learning lead spoke to Mr J's sister by telephone in early 2021. Mr J's sister asked a number of questions about Mr D's care.	
2.3	Bereaved/affected patients, families and carers have had input into the investigation by testimony and have identified any concerns they have about the care provided.	• *Mrs D* There is no evidence Mrs D was invited to contribute to the internal investigation terms of reference. The Trust's investigators met with Mrs D in late 2020. Mrs D provided information about Mr D's mental and physical health and his general wellbeing, historically and in the weeks/days leading up to the incident. • *Mr J's sister* There is no evidence Mr J's sister was invited to contribute to the investigation terms of reference. The Trust's investigation and learning lead and Mr J's sister spoke in early 2021. Mr J's sister asked a number of questions about Mr D, but there is no evidence they were specifically addressed by the Trust's investigation (e.g., the report does not have a subsection for family questions). The Trust did not share the internal investigation report with Mr J's sister for legal reasons. They wrote to her in late 2021 to advise they could not share the report given the volume of personal information about Mr D. They provided summary findings within the same letter. A similar, shorter letter was sent to a friend of Mr J's the same day.	
2.4	It is clear how the duty of candour regulations have been met for this incident or reasons why this has not been possible are included.	The report detailed verbal contact with Mrs D on day 3. The Trust sent a letter to Mrs D the same month, but this is not referenced in the investigation report. The Trust's incident investigation and learning lead wrote to Mr J's sister in late 2020. The internal report says individuals must be informed within 10 days of an incident being reported: it does not say why Mr J's sister was contacted nearly two months after the incident.	
2.5	A chronology or tabular timeline of the service user's care is included.	The report contains narrative and tabular chronologies, almost one after the other.	

Standard		Niche commentary & rating	
		The tabular chronology is less detailed – we note there is a gap in the timeline between 4.30pm and 11pm on the day of the incident despite extensive comms across teams and the police, and general confusion about Mr D's care pathway.	
2.6	The report describes how tools and methods have been used or the evidence and reasoning for the conclusions, and any recommendations.	The report details the information and evidence gathered and the methods used (timeline mapping). However the report does not provide detail of the analysis underpinning its summary conclusions. For example, the investigators were "*satisfied*" with the risk assessments undertaken but there is no reference to what policy or guidance they used to reach this conclusion (e.g., the Trust's risk assessment policy). The report does not reference expected practice (e.g., Trust policy) with the exception of the "*flow chart support MoU for emergency admission to a secure mental health bed*". However, whilst this flow chart is attached to the report it does not feature in the analysis other than to say there was varying levels of understanding of the policy amongst staff. The authors make no comment about the flow chart in reference to the conflicting views as to whether Mr D should have been assessed under the MHA or processed through the criminal justice system.	
2.7	CDPs and/or SDPs are identified (and it is clear whether they were CDPs **and/or** SDPs).	The Trust's internal investigation identified no CDPs and SDPs. We agree that there were no significant CDPs and SDPs prior to the incident on day 3. However, we identified an SDP after the incident. Whilst a plan was initially agreed (although with reluctance on the part of the AMHP) this was not clearly communicated across agencies (e.g., to the police) and there was confusion as to whether Mr D would be subject to an MHA on the night of day 3. Leading from this, the same night, clinicians decided to deviate from the original plan without including those involved earlier in the day. The intended changes were not implemented because Mr D became unwell and was transferred to an acute hospital.	
2.8	Underlying contributory factors are identified (including whether they were contributory factors, the use of classification frameworks, the examination of human factors).	The report identified two contributory factors – patient and communication. In the case of the latter, the report incorrectly states that concerns regarding Mr D's mental state were only reported the day before the incident. They were reported two days before the incident. The main report identified that the teams had been restructured, therefore ready access to AMHPs had diminished. The investigators go on to say "*It could be asked whether if the assessment* [had] *taken place immediately, how likely it is that it would have changed the outcome. The investigators feel this would be purely speculative and would be hindsight biased with too many variables and possible outcomes.*" We agree it would be speculative to suggest what the outcome might have been had an AMHP assessment taken place on day 2, but we consider it was still a team contributory factor that should have been reflected in the findings.	
2.9	Key causal factors are identified and described (may be	The report identified no root cause. It can often be the case that a root cause is not identified, but we consider the report lacks the underpinning analysis by which this conclusion was reached.	

Standard		Niche commentary & rating	
	referred to as root causes).		
2.10	Lessons learned are described.	The report identifies two lessons learned: one in relation to the care plan after the incident, and one in relation to the ASCC communicating with the Trust's communications team. We consider this second point to be out of the scope of the internal investigation and unrelated to the incident.	
2.11	There should be no obvious areas of incongruence.	The report says there is no record of mental health professionals liaising with Mr D's wife, but CPN1 documented as part of the assessment on that she called Mrs D. We are aware Mrs D told Trust investigators (and later ourselves) that she was not contacted by Trust staff during either assessment. The internal report makes no comment on this discrepancy. The report says concerns about Mr D's mental health were not reported until the day before the incident. This is inaccurate: they were reported two days before the incident. The report identifies six areas of good practice, some of which we agree with. However, "*good partnership working with the South West Provider Collaborative in agreeing the patient pathway and supporting decisions in relation to the consideration of Regulation 28*", does not reflect that the AMHP was excluded from these discussions and did not agree with the decision to process Mr D through the criminal justice system. The report notes there were no medium secure beds available on the night of day 3 but makes no comment as to whether it was appropriate that this was an influencing factor in deciding Mr D's care pathway.	
2.12	The way the terms of reference have been met is described; with an explanation given for any areas that have not been explored.	On balance we consider the report did answer its terms of reference, but further narrative and analysis would have been helpful. In particular, we consider the commentary in relation to terms of reference point 2, "*was the identified forensic patient pathway clear in informing professionals in their decision-making*", should have been expanded. The report includes the "*Flow chart supporting MoU for emergency admission to a secure mental health bed*" but makes little reference to it and the reader is given limited detail as to what Mr D's patient pathway options were. We note the assessing AMHP documented in the notes that they did not agree with the identified patient pathway and as such we would have expected the Trust's internal investigation to have explored this further.	
Theme 3: Impact			
3.1	The report examined the problems (the what happened), the contributory factors (the how it happened) and the fundamental issues (the why it happened).	The structure of the report is such that it does not flow logically and is at times difficult to follow. It provides a reasonably detailed narrative chronology ('Background and context of incident') which is followed by 'View of family members and/or carers'. This is then followed by a tabular chronology – largely a less detailed version of the narrative chronology. Of note, there is a gap in events documented between 4.30pm and 11pm on the day of the incident despite there being extensive communication across teams at this time in relation to the patient pathway. It is not clear why the report has two chronologies – essentially one after the other. The report moves to 'Findings' but as noted previously, there is little preceding analysis or reference to Trust policy to underpin the findings. It is not clear how the authors reached their conclusions (the why).	

Standard		Niche commentary & rating	
		We consider there were a small number of areas in which further detail, reference to expected practice (Trust policy) and analysis could have been undertaken. Of note: • the decision-making in relation to Mr D's capacity on day 1; • where the assessing team should have contacted Mrs D as part of the assessment on day 1; • the timeliness of the intended MHA assessment; • the decision-making in relation to the protocol for emergency access to a medium secure mental health bed; • the lack of an available medium secure bed; • the confusion amongst professionals as to the detail of Mr D's care pathway on the night of day 3; and • the decisions by the AMHP and Consultant Psychiatrist 2 to deviate from the agreed care pathway on the night of day 3. In conclusion, the report examined the problems related to Mr D's care and treatment (what happened) but would have benefitted from further exploration of issues (leading to the how) in order to provide the reader with a comprehensive understating of the fundamental issues (the why).	
3.2	Recommendations are clearly related to the findings.	The Trust's internal investigation made two recommendations: "*1. For serious incidents such as this, and where a forensic pathway is being considered, then the forensic on-call consultant is best placed to advise on the appropriate patient pathway. Once the plan has been agreed it should be adhered to.* *2. For the Somerset FT communications team to be advised of the ASCC's unsuccessful attempts to contact them to highlight the high profile case.*" It is our view that these recommendations do not clearly relate to the internal investigation findings. In relation to recommendation 1, we are aware that there were changes made to the plan on day 3. However, we established this through our own review of the notes – this is not reflected in the Trust's internal report, therefore the purpose of this recommendation is not obvious to the reader. Conversely, the investigators identified varying levels of understanding amongst staff in relation to the forensic pathway from police custody. There is no recommendation made in relation to this. In relation to recommendation 2, it is noted in the tabular chronology that the ASCC experienced unsuccessful attempts to contact the Trust's communications team, and it is listed under 'Lessons learned'. However, there is no commentary in relation to this point and we do not consider it relevant to Mr D's care or the incident. The report identifies that Mrs D stated that Trust staff did not contact her as part of their assessments. We have previously noted that there is a discrepancy in relation to this point, but we note the internal investigation has not made a recommendation in relation to the involvement of family members in assessments.	

Standard		Niche commentary & rating	
3.3	It should be clear that the recommendations support measurable and outcome focussed actions.	The recommendations are not supported by SMART actions. The actions make no reference to testing, measuring or monitoring.	
3.4	The affected service user(s)/ families have had an opportunity to review and comment on the draft report.	The draft report was not shared with Mr J's family for legal reasons. The Trust sent a letter in November 2021 providing a summary of the investigation findings. The letter does not invite further dialogue about the internal investigation. There is no evidence the internal report or summary finding were shared with Mrs D. She told us she had not received a copy of the report. There is no evidence the internal report or summary findings were shared with Mr D.	
3.5	Staff involved have had an opportunity to review and comment on the draft report.	The report provides no indication as to whether staff involved in the investigation had an opportunity to review and comment on the draft report. The internal investigators told us they submitted the draft report to the SIRG and did not know if it had been shared with relevant staff.	
3.6	The action plan reflects and responds to each of the recommendations, with identified owners of actions and realistic timeframes.	We have previously noted we do not agree with the recommendations and do not consider them to be supported by SMART actions. The action plan does not identify action owners, rather those who should be responsible for practice at the time. It is difficult to comment on the adequacy of the action in relation to recommendation 2 because it is not clear why the ASCC was unable to contact the Trust's communications team. We do not know what expected practice is, and whether the actions (e.g., "*on-call manager to be made aware at the time of such incidents"*) would serve to mitigate the problem or if it was already policy that was not adhered to.	

Appendix D: Glossary

AA	appropriate adult
AMHP	approved mental health professional
ASCC	advice and support in custody and court
CCA	Care Coordination Association
CCG	Clinical Commissioning Group
CDP	care delivery problem
CJS	Criminal Justice System
CPN	community psychiatric nurse
CPS	Crown Prosecution Service
DoLS	Deprivation of Liberty Safeguards
ECG	electrocardiogram
GP	general practitioner
HMCTS	HM Courts and Tribunals Service
HQIP	Healthcare Quality Improvement Partnership
HRCP	high risk care plan
HTT	Home Treatment team
LADS	liaison and diversion service
MC	mental capacity
MCA	Mental Capacity Act
MDT	multidisciplinary team
MHA	Mental Health Act
MoU	memorandum of understanding
MSE	mental state examination
NPSA	National Patient Safety Agency
NQB	National Quality Board
PACE	Police and Criminal Evidence Act 1984
PICU	psychiatric intensive care unit
PLT	Psychiatric Liaison team
PSRIF	Patient Safety Incident Response Framework
RCA	root cause analysis
RMHN	registered mental health nurse
SDP	service delivery problem
SFT	Somerset NHS Foundation Trust
SI	serious incident

SIF	Serious Incident framework
SIRG	Serious Incident Review Group
SIRI	serious incident requiring investigation
SOP	Standard operating procedure
SW-IIRG	South West Internal Investigation Review Group

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