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

July 2023

Final Report – Publication Advisory Notice

This report deals with difficult subjects relating to mental health conditions, care and treatment, and acts of violence. We have made efforts to write our report in a way which is not overly descriptive and limits the use of third party information. However, there are instances where information is necessary, for example, where a psychiatrists opinion has been quoted or a specific act has been documented and this is relevant to the case. We do advise caution in those who may be triggered by reading information which might be sometimes distressing, particularly, that they are helped to read this report in a safe and supported way.

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

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

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

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USE OF ITALICS IN THE TEXT OF THE REPORT

The use of italics in the text of this report reflects direct quotations or reported speech

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1 Executive summary

Incident

1.1 Mr A had been under the care and treatment of two mental health Trusts (Devon Partnership NHS Trust and Avon and Wiltshire Partnership NHS Foundation Trust) during the period June 2016 to December 2017. He had also been under the care of Cygnet Health Care in two hospitals (Cygnet Hospital Kewstoke in North Somerset and Cygnet Hospital Blackheath in London).

1.2 In the early hours of the morning on 11 February 2019, Devon and Cornwall Police received a report of a man acting aggressively at an Exeter hotel. Mr A was arrested and taken to Exeter custody suite. He was subsequently detained under Section 2 of the Mental Health Act 1983 (MHA)[1] and was transferred to a mental health hospital.

1.3 Three elderly men were found to have been killed in their homes in Exeter on 10 February 2019. Enquiries into these offences led to Mr A's Section 2 MHA detention being rescinded and his arrest for the homicides.

Investigation

1.4 NHS England and NHS Improvement commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into Mr A's care and treatment, an assessment of the internal investigation, and a review of the progress of associated action plans. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.5 The investigation follows the NHS England Serious Incident Framework[2] (March 2015); terms of reference for this investigation are given in full in Appendix A.

1.6 The main purpose of this review is:

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

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

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

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

[1] Section 2 Mental Health Act is admission for assessment for up to 28 days. https://www.legislation.gov.uk/ukpga/1983/20/section/2
[2] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf

1.10 We have liaised with the families of Mr A's victims; Mr P's family and the family of twin brothers whom we have referred to as Mr C1 and Mr C2.

Structure of the report

1.11 Section 3 provides a summary of the care and treatment provided to Mr A during the period from June 2016 to January 2019. Section 4 provides the timeline of mental health care related events in February 2019. We have included an anonymised summary of the staff involved in Mr A's care, for ease of reference for the reader. This can be found at Appendix B.

1.12 Section 5 examines the issues arising from the care and treatment provided to Mr A and includes comment and analysis.

1.13 Section 6 considers Devon Partnership NHS Trust's execution of Duty of Candour.

1.14 Section 7 provides an analysis of the internal investigation, subsequent action plans and oversight by clinical commissioning groups.

1.15 Section 8 sets out our overall conclusions and recommendations.

Relevant health history

1.16 During the period covered by this review (11 June 2016 onwards) Mr A's mental health care and treatment was the responsibility of three organisations:

- Devon Partnership NHS Trust (referred to as DPT in this report);
- Cygnet Health Care (Cygnet Hospital Kewstoke and Cygnet Hospital Blackheath); and
- Avon and Wiltshire Partnership NHS Foundation Trust (referred to as AWP in this report).

June 2016 to April 2017

1.17 Mr A's first contact with DPT was on 10 June 2016 when he was detained under Section 2 of the MHA. Mr A had been arrested for threats to kill and stealing his father's car. He was admitted to Moorland View Ward in Barnstaple.

1.18 At the time of admission Mr A presented as psychotic with delusional beliefs. He was known to use cannabis, but it was documented that he was not under the influence of drugs at the time of the assessment.

1.19 Mr A remained paranoid and confrontational with staff. During the night of 16 to 17 June Mr A set fire to a wardrobe in his bedroom, smashed his bedroom table and damaged the window and bedside cabinet. When the fire alarms sounded, he blocked the exit from the ward and then barricaded himself and other patients into the ward lounge. This event was described by staff as a "hostage-taking" incident. Staff eventually forced their way into the room and then managed Mr A in seclusion while a psychiatric intensive care unit (PICU) placement was found.

1.20 Staff documented the incident in accordance with Trust policy and reported the matter to the police. It was documented that the police declined to attend until normal working hours because the matter was not urgent, and Mr A was in a safe place.

1.21 Staff later learned from a number of other patients that during the evening prior to the incident Mr A had made comments suggesting he may set a fire. These comments resulted in Mr A's Consultant Psychiatrist (CP1) emailing the police on 28 July 2016 to state that his opinion was that Mr A's actions had been "premeditated and calculated". Consequently, he considered it would be detrimental to Mr A not to proceed with a criminal investigation "because he would learn that he could get away with such behaviour".

1.22 Mr A was transferred to a PICU placement at Nash Ward, Cygnet Hospital Kewstoke, Weston-Super-Mare on 17 June 2016. His detention was continued under Section 3 of the Mental Health Act on 6 July 2016.

1.23 A forensic assessment was requested by the inpatient Consultant Psychiatrist from DPT. The forensic report dated 30 August 2016 documented that Mr A's presentation was consistent with a diagnosis of paranoid schizophrenia, and mental and behavioural disorders due to cannabis use. It was also documented that it was "highly likely" that without assertive treatment with antipsychotic medication and abstinence from substance misuse, Mr A would suffer further relapse. The assessment supported the view of CP1 that the incidents of arson and "hostage-taking" should be investigated by police and that if that did not happen the risk was that Mr A would not appreciate the seriousness of his mental disorder. The assessment concluded that if Mr A needed to be admitted to a PICU in future, a re-referral to forensic services "would be considered" and that Mr A should be subject to a Community Treatment Order (CTO) on discharge from hospital.

1.24 Mr A was discharged from Cygnet Hospital Kewstoke on 12 September 2016 into the care of a community mental health team in Devon. Mr A's medication on discharge was olanzapine 20mg. Within 11 days (23 September 2016) he had requested that the dose be lowered to 15mg and by 24 October 2016 Mr A reported that he was "just about tolerating" 10mg daily.

1.25 A medical review on 17 November 2016 documented Mr A's diagnosis as drug induced psychosis and indicated that Mr A had reduced the dose of olanzapine to 5mg.

1.26 In January 2017 Mr A's Care Coordinator spoke to Mr A's partner who advised that she and Mr A had separated, and that Mr A was due to travel to France where he would be staying for a number of months. She reported that Mr A was no longer taking medication.

1.27 In April 2017 Mr A's Care Coordinator contacted Mr A's former partner again. She reported that she did not know where Mr A was and that she had not had any contact with him. The decision was made to discharge Mr A back into the care of his GP with a rapid re-access plan should he require further mental health assessment.

August to November 2017

1.28 There was no further contact with DPT services until August 2017 when Mr A's mother (Mrs A) contacted the Devon crisis team[3] expressing concern about Mr A's mental state. There were a number of contacts between Devon and Cornwall Police and DPT Street Triage team during the period 1 to 4 August when information about Mr A's mental health risk information was requested.

1.29 Mr A was assessed by the Criminal Justice Liaison and Diversion team (CJLDT, later referred to as Liaison and Diversion (L&D)) on 14 August 2017 after he was arrested on suspicion of assaulting a police officer. The Nurse assessing Mr A concluded that Mr A was mentally unwell but that he did not present as detainable under the MHA at that time. A second opinion was sought from the crisis team who concurred with the view of the CJLDT Nurse.

1.30 On 17 August 2017 Mr A was arrested by police in London for dangerous driving. He was assessed by mental health services in London, and they sought information from DPT to inform their assessment. The plan was to admit Mr A to a PICU placement at Cygnet Hospital Kewstoke. Mr A's admission was delayed due to administrative processes and Mr A was initially remanded to prison.

1.31 Mr A was admitted to Cygnet Hospital Kewstoke on 22 August 2017 under Section 2 MHA. His detention was converted to Section 3 MHA on 14 September 2017. Mr A's behaviour was unpredictable and confrontational, and he was verbally and physically aggressive to staff and other patients. Ward staff found that Mr A had tried to extort significant sums of money from another patient and a decision was taken to transfer him to a different PICU. Following consultation with the

[3] It is not clear which crisis team in Devon Mrs A contacted.

placement commissioners at DPT it was agreed that Mr A would be transferred to the PICU ward at Cygnet Hospital Blackheath, London on 22 September 2017.

1.32 On admission to Cygnet Hospital Blackheath Mr A's diagnosis was documented as possible drug induced psychosis and antisocial personality difficulties. His regular medication was olanzapine 15mg.

1.33 On 13 October 2017 Cygnet Hospital Blackheath staff reported to Mr A's Care Coordinator at DPT that he no longer required a PICU placement and that they (Cygnet Hospital Blackheath) were waiting for Mr A to be transferred back to an acute ward in Devon.

1.34 A nursing report completed by Cygnet Hospital Blackheath on 25 October 2017 documented that there was a "high probability" that Mr A might act in a dangerous manner on discharge from hospital. The report recommended that a CTO be considered, as a safe way for recalling Mr A back to hospital should he fail to comply with the conditions on discharge.

1.35 Mr A was transferred back to Sanford Ward, Cygnet Hospital Kewstoke on 4 November 2017, to an acute ward (rather than a PICU). Mr A's discharge summary from Cygnet Hospital Blackheath documented his diagnosis as possible drug induced psychosis and antisocial personality difficulties.

1.36 On admission to Cygnet Hospital Kewstoke, Mr A's diagnosis was documented as psychosis induced by cannabis with antisocial personality disorder traits.

1.37 On 14 November 2017 a discharge planning and Section 117[4] aftercare meeting was held. Mr A's diagnosis was recorded as drug induced psychosis and his medication had been reduced to olanzapine 10mg. It was documented that Mr A had been encouraged to remain compliant with this dose for at least six to 12 months. Staff documented that Mr A had plans to work in France from December 2017 and the plan was to discharge Mr A two to four weeks later to his mother's address in Wiltshire.

1.38 A First Tier Tribunal was due to take place on 27 November 2017, to hear Mr A's appeal against his detention. On the morning of the hearing Mr A's Consultant Psychiatrist reviewed Mr A; he determined that he no longer met the criteria for detention and rescinded the Section 3 MHA.

1.39 On 27 November 2017 Mr A was discharged from Cygnet Hospital Kewstoke into the care of community mental health services in Wiltshire where he was planning to stay with his mother. Mr A's discharge summary completed by Cygnet Hospital Kewstoke documented Mr A's diagnoses as drug induced psychosis, mental and behavioural disorder due to the use of cannabis and a provisional diagnosis of antisocial personality disorder. Medication on discharge was olanzapine 10mg.

1.40 Community staff in Wiltshire had a number of contacts with Mr A and his mother over the following two weeks.

1.41 On 12 December 2017 Mr A advised his Care Coordinator that he intended to go to France to work for several months. He left the UK on 15 December 2017 and was subsequently discharged from the community team caseloads in both Wiltshire and Devon (where responsibility for monitoring his aftercare requirements remained).

8 to 10 February 2019

1.42 There was no further contact with mental health services until 8 February 2019 when Mr A was referred to the Devon Liaison and Diversion (L&D) service after being arrested for burglary. Mr A was seen by L&D staff but declined the offer of support from mental health services at that time.

[4] Some people who have been kept in hospital under the Mental Health Act can get free help and support after they leave hospital. The law that gives this right is section 117 of the Mental Health Act, and it is often referred to as 'section 117 aftercare'. https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/

1.43 The following day, 9 February 2019, Mr A was arrested for grievous bodily harm (GBH) and was again referred to L&D staff. The L&D Practitioner conducted the triage over the phone (she was in Exeter and Mr A was in Barnstaple) and documented that she believed Mr A required an MHA assessment but advised she did not have sufficient time in her span of duty to see Mr A face to face. She advised police to ask a forensic medical examiner (FME) to carry out a face-to-face assessment. She planned to check the following morning if Mr A was still in custody, and to see if he would agree to an L&D assessment.

1.44 On 10 February 2019, just after 8am, the L&D Practitioner called Barnstaple custody suite and was told that Mr A was due to be released on bail within the next hour. A copy of an opt-in letter was sent to the police to give to Mr A, because for L&D to have any further contact, he would need to agree to their involvement once he had left custody.

11 to 13 February 2019

1.45 At about 8am on 11 February 2019 a triage assessment was completed by L&D staff after Mr A had been arrested for alleged public order offences, assault, and possession of an offensive weapon following an incident at a local hotel.

1.46 A G4S[5] FME tried to examine him for his physical injuries, but Mr A refused to consent to be examined. An emergency referral was made by police to the L&D service due to concerns about his mental state. Mr A spoke of a series of experiences that appeared psychotic in nature and was unpredictably very aggressive.

1.47 An L&D triage tool was completed, based on the information provided, noting the expiry time of the PACE clock[6] (5.50am on 12 February 2019). Staff did not enter Mr A's cell, at the request of the Custody Sergeant who felt that Mr A's risk to healthcare staff was high. The impression from the information provided was that he may be experiencing a relapse of a psychotic illness with a possible mood component.

1.48 An MHA assessment was conducted later that day (11 February 2019). It was documented that Mr A had a diagnosis of unspecified non-organic psychosis and appeared to be experiencing a relapse in his mental health.

1.49 Due to his unpredictability, it was felt that he would require admission to a PICU. Mr A was transferred to the Juniper Ward PICU at Wonford Hospital, Exeter on 11 February 2019, and was admitted into seclusion because of his level of aggression in custody.

1.50 On the evening of 12 February 2019 contact was made by police trying to ascertain Mr A's whereabouts. Senior Trust staff were informed that police wanted to arrest him on suspicion of murder. Given the seriousness of the charges, it was decided to rescind the Section 2 MHA, rather than agree Section 17 leave. A referral was made to the L&D team to help ensure that Mr A's mental health needs would be met as far as possible while in local custody and that clinical information would be communicated to any further establishment to which he might be transferred.

Documented offending history

1.51 In June 2016, Mr A set fire to a wardrobe on Moorland View Ward at North Devon District Hospital and barricaded himself and other patients in a room. Mr A refused to allow the other patients to leave the room while the fire alarm was sounding; this incident was documented by staff as a "hostage-taking" event.

1.52 The incident was reported to police but does not appear in Mr A's forensic history.

[5] G4S Health Services (UK) Limited is a national provider of critical primary and forensic healthcare services for the public and private sectors. https://www.g4s.com/en-gb/what-we-do/health-services

[6] The PACE (Police and Criminal Evidence Act) requires in most circumstances that a person should not be kept in police custody for more than 24 hours without being charged. https://www.legislation.gov.uk/ukpga/1984/60/section/41

1.53 Offences documented in a psychiatric report for a Tribunal, dated 3 November 2017, showed that Mr A was known to the police:

- 14 August 2017: He was arrested for kicking a police officer in the head; he was due to appear at Barnstaple Magistrates Court on 3 November 2017 (the same date as the report was written).
- 22 August 2017: He was arrested for dangerous driving; he was due to attend Harrow Crown Court on 17 November 2017.
- He had two pending cases relating to charges for resisting arrest.

1.54 Mr A's discharge summary date 27 November 2017, completed by staff at Cygnet Hospital Kewstoke documented that his mother reported to Cygnet Hospital Kewstoke staff that she had needed to "bail him out financially" on a number of occasions while he was travelling abroad.

Sentence

1.55 In November 2019 Mr A appeared in Exeter Crown Court charged with the three murders in Exeter in February 2019. A jury found him not guilty of murder by reason of insanity and the judge issued a hospital order with restrictions under 37/41 MHA[7] which ordered his detention in a secure hospital for treatment.

Internal investigation

1.56 In liaison with AWP, DPT commissioned a serious incident investigation following the death of the elderly gentlemen. The investigation was undertaken by Enable East, an independent NHS team that provides an alternative to commercial management consultancies.

1.57 At paragraph 3.32 the report author stated that suggestions were made regarding "fundamental and contributory causes", but it was not possible to gain a complete picture by looking at only one aspect of the range of services provided. Hence the recommendation regarding the need for a multi-agency review.

1.58 There was no use of classification frameworks or examination of human factors. No root cause is described, but the report concluded that "a significant contributory factor may have been his non concordance with his medication".

1.59 Other contributory factors included:

- the diffusion of responsibility regarding his care (across agencies and geographical areas);
- a failure to fully appreciate Mr A's "psychiatric pattern";
- a failure to recognise the level of risk and the extent and pattern of criminal behaviours; and
- the demand on services over the weekend of 8 to 10 February 2019.

1.60 Learning was identified and six recommendations were made for Devon Partnership NHS Trust:

R1 *"The Trust should ensure that it has an agreement in place with partner agencies, which provides a clear procedure and line of communication, to pursue as appropriate criminal investigation and action. This should include the procedure for informing health staff if criminal investigations are not to be pursued. The Trust should also review evidence to determine if the views expressed by staff that appropriate criminal action is not pursued with clients known to mental health services have substance.*

[7] Powers of courts to order hospital admission or guardianship. https://www.legislation.gov.uk/ukpga/1983/20/section/37 Power of higher courts to restrict discharge from hospital. https://www.legislation.gov.uk/ukpga/1983/20/section/41

R2 Trust senior staff should liaise with senior staff in partner organisations to share information from individual organisational investigations and undertake a multi-organisational review of this case. This review should recognise each organisation's legislative requirements and capacity demands and improve the speed of access to services.

R3 As the [Devon Liaison and Diversion] DL&D service operating hours, together with the time constraints of PACE regulations, and the reported pressure on [Devon County Council Emergency Duty Team] DCCEDT services compromised the provision of an MHA assessment I recommend that DPT ask services commissioners to review current operating arrangements.

R4 As it is possible that partner agencies, including the private hospital provider, Police and Devon County Council, will need to make contact with [Mr A] as part of their investigations; I recommend that any approach to [Mr A] on behalf of AWP and DPT is coordinated with those agencies.

R5 The Caldicott Guardian should be asked to determine how circulation of this report should be managed having consideration of policies on confidentiality, data protection and information governance. This consideration will need to be made jointly with the A&W Caldicott Guardian.

R6 The Trust should develop an action plan to address the recommendations contained within this report which meets the minimum requirements for actions listed within the NHS England Serious Incident Framework."

1.61 Six recommendations were also made for Avon and Wiltshire Partnership NHS Foundation Trust:

R1 "The Trust should review any existing protocols regarding communication arrangements and agreements with criminal justice agencies to determine if they require development.

R2 Community Clinical Services should be asked to review arrangements to allow patients with complex needs to have timely review by medical staff.

R3 As it is possible that partner agencies, including the private hospital provider, Police and Devon County Council, will need to make contact with [Mr A] as part of their investigations; I recommend that any approach to [Mr A] on behalf of AWP and DPT is coordinated with those agencies.

R4 Community Clinical Services should be asked to review arrangements for ensuring that available patient information is placed on the Trust's clinical records systems in a timely manner.

R5 The Caldicott Guardian should be asked to determine how circulation of this report should be managed having consideration of policies on confidentiality, data protection and information governance. This consideration will need to be made jointly with the DPT Caldicott Guardian.

R6 The Trust should develop an action plan to address the recommendations contained within this report which meets the minimum requirements for actions listed within the NHS England Serious Incident Framework."

Action plans

1.62 The terms of reference required us to review the completion of the action plans.

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

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

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

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

1.65 DPT provided evidence of actions for each recommendation. Of the six recommendations, we found that four were complete. We had insufficient evidence from the Trust to be able to assess the completeness of the remaining two actions. Table 1 below sets out our assessment.

Table 1: Devon Partnership NHS Trust action plan progress

Recommendation	Score	Assessment category
1	0	Insufficient evidence to support action progress/action incomplete/not yet commenced
2	3	Action completed but not yet tested
3	0	Insufficient evidence to support action progress/action incomplete/not yet commenced
4	3	Action completed but not yet tested
5	3	Action completed but not yet tested
6	3	Action completed but not yet tested

1.66 AWP also provided evidence of actions for each recommendation. Of the six recommendations, we found that three were complete and two were significantly progressed. We had insufficient evidence from the Trust to be able to assess the completeness of the remaining action. Table 2 below sets out our assessment.

Table 2: Avon and Wiltshire Partnership NHS Foundation Trust action plan progress

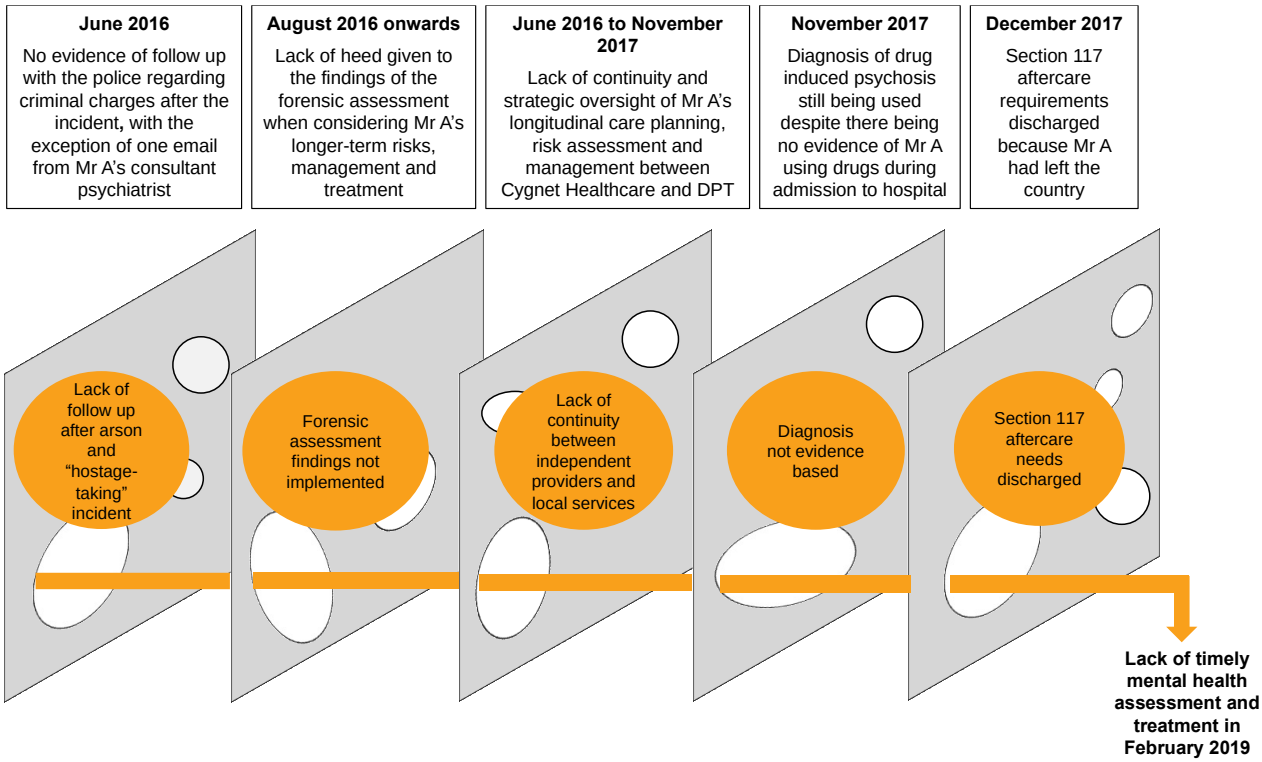
Recommendation	Score	Assessment category
1	3	Action completed but not yet tested
2	2	Action significantly progressed
3	3	Action completed but not yet tested
4	2	Action significantly progressed
5	0	Insufficient evidence to support action progress/action incomplete/not yet commenced
6	3	Action completed but not yet tested

Conclusions

1.67 We found that a number of elements of Mr A's mental health care and treatment could have been managed differently.

1.68 The diagram below illustrates the James Reason[8] model of incident risk analysis. The individual elements represent points in Mr A's care pathway where alternative actions could have been taken. Decisions made about Mr A's treatment and follow-up prior to December 2017 contributed to the lack of timely mental health assessment and treatment in February 2019.

Figure 2: James Reason model of incident risk analysis



1.69 There was insufficient follow-up by Trust staff with the police regarding criminal charges being brought against Mr A following the incident of arson and "hostage-taking" on Moorland View Ward in June 2016. The Consultant Psychiatrist CP1 documented that he had emailed Devon and Cornwall Police on 28 July 2016 when he provided his opinion that the incident was "pre-meditated and calculated" despite Mr A suffering from psychotic symptoms at the time of the incident. CP1 also documented that he considered it would be detrimental to Mr A not to proceed with a criminal investigation "because he would learn that he could get away with such behaviour".

1.70 The forensic assessment completed in August 2016 concluded that Mr A's insight into his mental disorder and the consequences of his actions when unwell remained "poor and untested in a community setting". It recommended that:

- Mr A's care and treatment be provided "assertively under the MHA… in order to prevent risk of harm to others";
- a CTO be considered on discharge from hospital;
- re-referral to forensic services be considered if Mr A required further treatment in a PICU.

[8] Human error: Models and management by James Reason https://www.behavioursafetyservices.com/wp-content/uploads/2017/03/Reason-Paper-Human-Error.pdf

1.71 Mr A's diagnosis was documented by the forensic assessment in August 2016 and by CP2 at Cygnet Hospital Kewstoke in September 2016 as schizophrenia. There does not appear to be any explanation in the records from Cygnet Hospital Kewstoke for the change in diagnosis to drug induced psychosis on discharge in November 2017. Mr A's drug screen was negative when he was arrested in London, and it was still reported as negative on admission to Cygnet Hospital Kewstoke a few days later. There were no reports of any suspicion of him using drugs during his admission and no urine drug screens showing evidence of use of drugs during this time.

1.72 A diagnosis can influence treatment plans, especially decisions about longer-term care following discharge from hospital. The issue of documenting an appropriate diagnosis is essential to ensure continuity of care between episodes of illness. This is particularly important for patients who are reluctant to engage with community services and who are transient, as was the case with Mr A.

1.73 Mr A was discharged from Cygnet Hospital Kewstoke twice (12 September 2016 and 27 November 2017). On both occasions he was discharged directly into the community. There was a lack of strategic oversight of Mr A's longer-term needs as a result of this discharge decision. This meant there was a lack of continuity regarding his longitudinal care planning, risk assessment and management between Cygnet Hospital Kewstoke and local services in Devon.

1.74 When services in Devon learned that Mr A had gone to France for a second time, after his discharge from Cygnet Hospital Kewstoke to community services in Wiltshire, this resulted in a decision to discharge his Section 117 aftercare needs. There was no evidence that Mr A's mental health needs no longer required treatment and this decision was not in accordance with the MHA Code of Practice.

1.75 It is our opinion that the combination of these elements meant that when Mr A presented in crisis in February 2019, mental health staff were making decisions based on incomplete knowledge of Mr A's mental health history.

1.76 There is no documentary evidence of consideration of decision making about Duty of Candour. Following an interview with a Devon Partnership NHS Trust senior manager, we were told that although the case was "the most serious we would likely report" it was not "considered as a patient safety incident". The Trust justified this on the basis that the incidents (the deaths of the elderly gentlemen) did not report specific harm to Mr A. However, Mr A's mother was invited to contribute to the internal investigation.

1.77 We have carefully considered the Trust's stated position and have concluded that there was not a requirement to execute Duty of Candour. At the time of the offences in February 2019, Mr A was not subject to any section of the MHA, he was not on the caseload of the Trust and some efforts had been made to provide him with information about how to access Trust services.

1.78 We found no reference in the Duty of Candour or Serious Incident policies to the Trust's approach to engaging families affected by homicide and serious incidents. NHS England (London) Investigation issued guidance in April 2019 on engaging with families after a mental health homicide.[9] This provides clear best practice guidance to mental health provider organisations and states that "families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation".

1.79 The internal investigation report satisfied the terms of reference set, and suggestions were made regarding "fundamental and contributory causes", but it was not possible to gain a complete picture by looking only at one aspect of the range of services provided. Thus, a recommendation was made regarding the need for a multi-agency review.

1.80 No root cause is described, but the report concluded that "a significant contributory factor may have been his non concordance with his medication".

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

1.81 The internal report made six recommendations for Devon Partnership NHS Trust (DPT) and six recommendations for Avon and Wiltshire Partnership NHS Foundation Trust (AWP).

1.82 Our assessment of the progress of DPT's action plan found that of the six recommendations, four were complete. We had insufficient evidence from the Trust to be able to assess the completeness of the remaining two actions.

1.83 Our assessment of the progress of AWP's action plan found that of the six recommendations, three were complete and significant progress had been made on two recommendations. We had insufficient evidence from the Trust to be able to assess the completeness of the remaining recommendation.

1.84 Devon Clinical Commissioning Group (CCG) provided evidence that it had reviewed the internal investigation report and had signed off the action plan. We found that the CCG's oversight and monitoring processes could be strengthened by detailed follow-up of action plans relating to high-profile, complex, or high-risk serious incidents.

1.85 Bath and North East Somerset, Swindon and Wiltshire (BSW) CCG has reported that it has monitored AWP's action plan through attendance at the AWP Learning and Review Panel meetings. BSW CCG has further advised that the action plan was last reviewed by the AWP Learning and Review Panel on 24 October 2021 when the last action was closed because assurances were given that it had been completed. The action plan was also reviewed by the BSW CCG Serious Incident Panel; closure of the serious incident was agreed in November 2021.

Recommendations

1.86 This independent investigation has made 12 recommendations to be addressed to improve learning from this event.

Recommendation 1: Cygnet Health Care and Devon Partnership NHS Trust must ensure that any changes to a diagnosis are formally documented and include the rationale and evidence base for such change, and agreed to by the patient's consultant psychiatrist. This information must be included in all relevant discharge communication between clinical services.

Recommendation 2: Devon County Council and NHS Devon Clinical Commissioning Group must ensure that discharges from Section 117 aftercare enacted by Devon Partnership NHS Trust on behalf of health and social care commissioners are in keeping with the Section 117 aftercare legislation.

Recommendation 3: Where a forensic assessment has been undertaken in the previous 12 to 18 months, Cygnet Health Care, Devon Partnership NHS Trust, and any provider contracted by Devon Partnership Trust must follow the advice within unless there is good reason not to do so. In which case they must formally document the rationale why the advice is not being followed.

Recommendation 4: Devon Partnership NHS Trust must ensure that risk assessments lead to risk formulation and risk management.

Recommendation 5: Devon Partnership NHS Trust must provide clear guidance to frontline staff and managers regarding how to escalate concerns relating to criminal offences committed on Trust property. The guidance must also provide clarity about what information staff are expected to document in the relevant clinical record.

Recommendation 6: Devon Partnership NHS Trust (DPT) must ensure that there is clearly documented communication and liaison with a patient's clinical team when considering a patient's needs prior to discharge from an independent provider. DPT must also ensure that there is a shared

and agreed plan if detention under the Mental Health Act is rescinded by independent providers commissioned by DPT.

Recommendation 7: Devon Partnership NHS Trust must ensure that there is clear guidance for staff and managers about how communication with families and carers is managed and documented if there is a significant issue (such as this) affecting the care of an inpatient.

Recommendation 8: Devon Partnership NHS Trust (DPT) must ensure that local policies clarify how to consider and apply Duty of Candour regarding an incident that is also the subject of a criminal investigation, with the expectation that decisions made should be documented.

Recommendation 9: Devon Partnership NHS Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide: Mental Health-Related Homicide: Information for Mental Health Providers (April 2019) NHS England (London) Investigations.

Recommendation 10: Devon Partnership NHS Trust must implement the outstanding recommendations from their own report (recommendations 1 and 3) without any further delay.

Recommendation 11: The NHS Devon CCG Serious Incident report quality review template should be revised to reflect detailed expectations with NHSE Serious Incident Framework guidance.

Recommendation 12: NHS Devon CCG (and any future Integrated Care System) must implement a process to (a) identify high-profile, complex or high-risk serious incidents, (b) ensure that the provider action plan is followed up in detail, (c) seek assurance that all actions are implemented in a timely manner.

Good practice

1.87 Devon Partnership NHS Trust (DPT) has implemented a robust procurement and contract management process that is applied to all non-forensic placements for patients whose needs cannot be met by services provided the Trust.

1.88 DPT has a detailed quality assurance process that is applied to all such providers and has a policy of not placing patients with any unit that is rated as inadequate.

1.89 When plans were being made to discharge Mr A from Cygnet Hospital Kewstoke, his Care Coordinator from DPT had a short period of time to arrange for a transfer of his care to Avon and Wiltshire Partnership NHS Foundation Trust (AWP). Despite the short timeframe, this was achieved, and Mr A was followed up by AWP within 24 hours of discharge and by DPT within seven days of discharge.

2 Investigation

Incident

2.1 Mr A had been under the care and treatment of two mental health Trusts (Devon Partnership NHS Trust and Avon and Wiltshire Partnership NHS Foundation Trust) during the period 2016 to 2018. He had also been under the care of Cygnet Health Care in two hospitals (Cygnet Hospital Kewstoke in North Somerset and Cygnet Hospital Blackheath in London).

2.2 In the early hours of the morning on 11 February 2019, Devon and Cornwall Police received a report of a man acting aggressively at an Exeter hotel. Mr A was arrested and taken to Exeter custody suite. He was subsequently detained under Section 2 of the Mental Health Act 1983 (MHA)[10] and was transferred to a mental health hospital.

2.3 Three elderly men were found to have been killed in their homes in Exeter on 10 February 2019. Enquiries into these offences led to Mr A's Section 2 MHA detention being rescinded and his arrest for the homicides.

Approach to the investigation

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

2.5 The investigation follows the NHS England Serious Incident Framework[11] (March 2015); the terms of reference for this investigation are given in full in Appendix A.

2.6 The main purpose of this review is:

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

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

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

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

[10] Section 2 Mental Health Act is admission for assessment for up to 28 days. https://www.legislation.gov.uk/ukpga/1983/20/section/2

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

2.10 We have liaised with the families of Mr A's victims; Mr P's family and the family of twin brothers Mr C1 and Mr C2.

2.11 Mr P's family has asked that he be referred to as Mr P.

2.12 Mr C1 and Mr C2's family has asked that they be referred to as Mr C1 and Mr C2.

2.13 The investigation was carried out by:

- Naomi Ibbs, Senior Consultant for Niche (lead author);
- Dr Huw Stone, Consultant Forensic Psychiatrist;
- Christopher Gill, Family Support Advisor.

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

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

2.16 The investigation comprised interviews with a range of staff from all organisations who were involved in Mr A's care and treatment and a review of clinical records, policies and procedures, with reference to the National Patient Safety Agency (NPSA) guidance[12].

2.17 Mr A gave us permission to review his clinical records for the purpose of this investigation but declined to meet with us at the start of the investigation.

2.18 As part of our investigation, we interviewed staff from Devon Partnership NHS Trust, Avon and Wiltshire Partnership NHS Foundation Trust, Devon Clinical Commissioning Group, Enable East[13] and Cygnet Health Care.

2.19 A full list of all documents we referenced is available on request.

2.20 The draft report was shared with the contributing organisations to provide an opportunity for those that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with Mr A's family

2.21 We met with Mr A's mother (whom we refer to as Mrs A in this report) at the start of the investigation. She told us that while nothing could change what had happened, she wanted to know why services were not properly joined up.

2.22 Mrs A expressed concern that after Mr A was detained on Section 2 in February 2019, the detention was rescinded, and the police were allowed to interview him under caution. Mrs A remains concerned that the police did not listen to Mr A's solicitor when he repeatedly told police that Mr A was not fit to be interviewed.

2.23 Mrs A told us that when she was interviewed by police, she raised a number of issues that she considered were relevant to Mr A's mental health presentation and recent contacts with police and mental health services. However, she was discouraged from including them in her statement (by the police officer taking the statement) on the basis that the information was "not relevant".

2.24 Mrs A told us that she had four questions that she wanted answered:

- Why did the police think it was safe to release Mr A just after they had needed to restrain him?
- How did the G4S doctor get it so wrong?

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

[13] Enable East is an independent NHS team, offering an alternative to commercial management consultancies. https://enableeast.org.uk

- How could Mr A's detention (in February 2019) have been rescinded so quickly?
- Who is legally responsible for the deaths of the elderly gentlemen?

2.25 We will attempt to answer the questions where we have jurisdiction regarding NHS commissioned services. However, some of the questions would be better answered by the organisations themselves, or at Coroner's Court. The systems report should also be referred to, however it would not be appropriate for any such NHS commissioned report to determine legal responsibility for the death of any person.

2.26 We met with Mrs A again on 13 July 2022 at the conclusion of the investigation. Mrs A confirmed that Mr A returned to the UK from France in March 2018. She also told us that Mr A then had a job working as a 'roadie' from March to December 2018 and that he was unmedicated throughout that period of time.

Contact with Mr P's family

2.27 We offered to meet with Mr P's family to discuss the approach to the investigation and to understand their concerns and questions. They did not wish to meet with us but asked a number of questions through their Police Family Liaison Officer.

2.28 We have detailed those questions in Appendix H, along with answers where it has been possible to provide them.

2.29 We remain committed to meet with Mr P's family at the conclusion of the investigation if they so wish.

Contact with Mr C1 and Mr C2's family

2.30 We met with the family of Mr C1 and Mr C2 at the start of the investigation. They had understandable concerns about Mr A's care and treatment and were keen to see what lessons had been learned by organisations who had been involved with Mr A in the months, weeks and days prior to the death of their family members.

2.31 We met with family members again on 25 July 2022 at the conclusion of the investigation. We provided a summary of the report and offered the opportunity for the family to ask any questions about the content.

Structure of the report

2.32 Section 3 provides a summary of the care and treatment provided to Mr A during the period from June 2016 to January 2019. Section 4 provides the timeline of mental health care related events in February 2019. We have included an anonymised summary of the staff involved in Mr A's care, for ease of reference for the reader. This can be found at Appendix B.

2.33 Section 5 examines the issues arising from the care and treatment provided to Mr A and includes comment and analysis.

2.34 Section 6 considers Devon Partnership NHS Trust's execution of Duty of Candour.

2.35 Section 7 provides an analysis of the internal investigation, subsequent action plans and oversight by clinical commissioning groups.

2.36 Section 8 sets out our overall conclusions and recommendations.

3 Mr A's care and treatment

3.1 This section provides a narrative chronology of Mr A's care and treatment.

3.2 There were four specialist mental health providers that had responsibility for Mr A's mental health care and treatment during the period under review:

- Devon Partnership NHS Trust (DPT);
- Cygnet Hospital Kewstoke (commissioned by DPT);
- Cygnet Hospital Blackheath (commissioned by DPT);
- Avon and Wiltshire Partnership NHS Foundation Trust (AWP).

3.3 In addition, Mr A was registered with two GP surgeries during the period under review. These GP surgeries responded to requests to prescribe mental health medication.

Admission to Moorland View Ward, North Devon District Hospital, Barnstaple – 11 June 2016

3.4 On 11 June 2016 Mr A was admitted to Moorland View Ward, a mental health ward based at North Devon District Hospital, a general hospital. He had been detained under Section 2 MHA[14] after being arrested for threatening to kill his father, stealing his car and being chased by the police. This was Mr A's first known contact with mental health services. On admission his Responsible Clinician (RC)[15] was CP1.

3.5 Mr A presented as thought disordered, he also presented as psychotic with delusional beliefs. It was documented that he was known to use cannabis and on admission to the ward a urine drug screen tested positive for cannabis.

3.6 Mr A was unhappy at having been detained and became fixated on wanting to know the names of the staff who were responsible for his detention and details of the ingredients of his medication.

3.7 Mr A refused oral medication and consideration was given to administering depot medication.

3.8 In the early hours of 17 June 2016, Mr A set fire to a bin in the wardrobe in his bedroom. When staff attempted to evacuate the ward Mr A barricaded himself and other patients into the patient lounge and prevented them from leaving the ward. Staff eventually forced their way into the lounge, restrained Mr A and took him to seclusion. The matter was reported to the police who advised that they would attend in the morning. It was documented that senior Trust staff recommended that Mr A should be held in police custody to face criminal charges. However, police advised they did not consider it to be an emergency and that Mr A was currently in a safe place. Other patients later reported that the previous evening Mr A had been seeking aerosol cans and had made comments suggesting he may set a fire.

3.9 A referral was made to a psychiatric intensive care unit (PICU) and Mr A was transferred later the same day to Nash Ward, Cygnet Hospital Kewstoke.

Admission to Nash Ward PICU, Cygnet Hospital Kewstoke – 17 June 2016

3.10 On 17 June 2016 Mr A was admitted to Nash Ward, Cygnet Hospital Kewstoke in Weston-Super-Mare, North Somerset. On admission his RC was CP2.

[14] Section 2 Mental Health Act is admission for assessment for up to 28 days. https://www.legislation.gov.uk/ukpga/1983/20/section/2

[15] A Responsible Clinician (RC) is the mental health professional in charge of a patient's care and treatment while they are detained under the Mental Health Act. https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/responsible-clinician/

3.11 On 20 June 2016 staff at DPT received notification that a First Tier Tribunal[16] had been scheduled to be heard at Cygnet Hospital Kewstoke on 30 June 2016.

3.12 On 23 June 2016 CP1 completed a referral to the forensic services at DPT, Mr A's offending history was documented as:

- threats to kill his father;
- threats to kill his father's new partner and cut her up;
- holding a knife to a dog's throat;
- setting fire on the general mental health ward;
- "hostage-taking" on the general mental health ward;
- attempting to punch the ward consultant;
- threatening staff with a pool cue.

3.13 On 29 June 2016 staff at DPT received an email from staff at Cygnet Hospital Kewstoke to advise that Mr A was due to be discharged from Section 2 the following day. It was reported that Mr A's Nearest Relative[17] (Miss D) had written to the hospital managers requesting this and CP2 had agreed. Mr A's Care Coordinator at DPT (CCO1) highlighted the seriousness of Mr A's presentation and was informed that CP2 had considered this when making his decision. CCO1 documented that CP1 from DPT would discuss the matter with CP2 and that a forensic assessment had been requested by CP1. The conclusion of further discussion was that Mr A would continue to be detained and a forensic assessment would be conducted.

3.14 The First Tier Tribunal took place the following day. Mr A's detention was upheld on the grounds of dangerousness. It was documented that CP2 had felt "uneasy" giving his medical evidence because of Mr A's behaviour. Mr A was referred for consideration of detention under Section 3[18] of the MHA.

3.15 An MHA assessment was undertaken on 6 July 2016. It was documented that Mr A's recollection of events was poor and he denied suffering any psychotic symptoms. His presentation was calm, but he minimised the consequences of his actions. Mr A stated that:

- he believed his father's partner had poisoned two dogs, and had bizarre beliefs about what she had done with their remains;
- the incident on Moorland View Ward would not have happened if the staff had "handled things differently"; and
- he would not take medication if he left hospital.

[16] A First Tier Tribunal (Mental Health) is responsible for handling applications for the discharge of patients detained in psychiatric hospitals. They also handle applications to change community treatment orders and the conditions placed on a 'conditional discharge' from hospital. https://www.gov.uk/courts-tribunals/first-tier-tribunal-mental-health

[17] Nearest Relative is a special term used in the Mental Health Act 1983. It gives one member of a patient's family certain rights and responsibilities if their relative is kept in hospital under sections 2, 3, 4 or 37, on a community treatment order, or under a guardianship. The Mental Health Act has a list of who will be a patient's Nearest Relative. The list is in strict order and the person who is highest on the list is the patient's nearest relative. A patient can change their nearest relative in certain situations. https://www.mind.org.uk/information-support/legal-rights/nearest-relative/overview/

[18] Section 3 of the Mental Health Act allows for a patient to be detained in hospital for up to six months and to be treated without the patient's consent, with approval from a second opinion approved doctor. Section 3 of the Mental Health Act 1983 allows for a person to be admitted to hospital for treatment if their mental disorder is of a nature and/or degree that requires treatment in hospital. In addition, it must be necessary for their health, their safety or for the protection of other people that they receive treatment in hospital. The patient can be detained for up to six months. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

3.16 The Approved Mental Health Practitioner (AMHP)[19] spoke to Miss D who was keen for Mr A to return home but accepted that he needed to be well. She expressed surprise that Mr A had not agreed to take his medication when he left hospital. Mr A was informed of the conversation with Miss D and became angry, saying that he had not said that he would not take his medication.

3.17 On 28 July 2016 CP1 emailed Devon and Cornwall Police regarding the incident when Mr A set fire to the ward and took patients hostage. CP1 stated that it was his opinion that although Mr A "was suffering with psychotic symptoms during the admission, the incident in question was premeditated and calculated". CP1 documented that he considered that it would be detrimental to Mr A not to proceed with a criminal investigation "because he would learn that he could get away with such behaviour".

3.18 On 3 August 2016 CCO1 discussed Mr A with staff at Cygnet Hospital Kewstoke. CCO1 documented that he was informed that Mr A had been transferred to a less secure ward and that the member of staff at Cygnet Hospital Kewstoke did not know whether the forensic report had been completed. CCO1 was informed that Cygnet Hospital Kewstoke staff were arranging a Section 117 aftercare and discharge planning meeting. CCO1 documented concerns about whether discharge was appropriate at that time and relayed this concern to the clinical team.

3.19 On 11 August CCO1 discussed Mr A with CP2 at Cygnet Hospital Kewstoke. CP2 reported that Mr A continued to take olanzapine 20mg, that he was doing well, with no signs of psychosis and that a "mixed presentation of some sort" was the most likely. CCO1 documented that they had discussed Mr A's risk and possible discharge and that he reminded CP2 of the reason for the forensic assessment being requested.

3.20 A discharge planning and Section 117 aftercare meeting was held on 22 August 2016. It was agreed that although Mr A did not meet the criteria for admission to forensic services at that time, the full report was required prior to planning discharge so that the recommendations could be properly considered. Mr A would remain an inpatient until such time. CCO2 (covering for CCO1 while on planned leave) expressed concern that Miss D had minimised previous incidents and had "pathologised the risks against others". This was a concern because there was potential for Miss D to collude with Mr A after discharge from hospital. CCO2 sought clarification of whether Mr A had engaged with Psychology and documented that CP2 had stated "we're not really geared up for that". CCO2 advised that it was "imperative" that Cygnet Hospital Kewstoke staff informed the police and the crisis team prior to any unescorted leave in North Devon being granted.

Forensic report, completed by DPT forensic services – 30 August 2016

3.21 A forensic report dated 30 August 2016 documented that in the opinion of the assessor, Mr A had suffered a first episode of psychosis with features consistent with a diagnosis of paranoid schizophrenia, and mental and behavioural disorders due to cannabis misuse. It was considered highly likely that without assertive treatment with anti-psychotic medication and abstinence from substance misuse, Mr A would suffer further relapse.

3.22 The forensic report also documented that:

- Mr A's behaviour when acutely unwell had resulted in the current charges and serious risk incidents while detained that required further investigation by police and were likely to result in significant charges of arson.
- Mr A's insight into his mental disorder and consequences of his actions when mentally unwell remained poor and untested in a community setting. Therefore, there was evidence to exercise caution on Mr A's ongoing inpatient care while being mindful of the principle of the least restrictive setting for treatment.

[19] Approved Mental Health Practitioner (AMHP) is a mental health professional who has been approved by a local social services authority to carry out specific duties under the Mental Health Act. They are responsible for coordinating assessments, and admissions to hospital.

3.23 The incidents of arson and preventing others from leaving the ward while fire alarms were sounding were considered to be "extremely grave" incidents and in the view of the assessor should be reported as a crime and investigated by police, in addition to the existing charges. If this did not happen, it was stated that the risk was that Mr A would not appreciate the seriousness of his mental disorder, potentially placing others at risk in the future. It would also be important for Mental Health Review Tribunals to be aware of the facts so that Mr A's care and treatment could be provided assertively under the MHA, if necessary, in order to prevent risk of harm to others.

3.24 The assessor documented support for the plan for continued rehabilitation and recovery in an open inpatient setting, at Cygnet Hospital Kewstoke, a local inpatient ward or a dedicated psychiatric rehabilitation service. If Mr A's care needed to be stepped back up to a PICU setting in future and he required a longer period in a secure setting, then re-referral to forensic services should be considered.

3.25 In order to support his recovery in the community after a further period of rehabilitation and recovery, depot anti-psychotic medication was recommended if compliance in the community was poor. It was also recommended that Mr A be engaged in a psychological intervention programme and that he be made subject to a Community Treatment Order (CTO)[20] on discharge from hospital, particularly if there was doubt about his compliance with oral medication or misuse of substances.

Discharge from Nash Ward PICU, Cygnet Hospital Kewstoke – 12 September 2016

3.26 On 12 September 2016 a discharge planning and Section 117 aftercare meeting took place. It was documented that Mr A's unescorted leave had been uneventful and that he had been settled on his return to hospital with no positive drug tests. Staff were unsure how much insight Mr A had into his condition, but it was felt it was likely he would continue to comply with medication on discharge.

3.27 It was documented that Mr A did not meet the criteria for a Community Treatment Order. Discharge into the community was agreed for that day.

Informal treatment in the community, North Devon – 15 September 2016

3.28 On discharge from hospital, Mr A's care and treatment was the responsibility of the early intervention in psychosis team (Specialist Team for Early Psychosis (STEP) team) for North Devon.

3.29 Mr A was seen by CCO1 on 15 September 2016. Mr A reported that he could not remember the incidences that lead to his detention and that psychosis was confusing for him. He stated that he did not wish to talk about the incident on Moorland View Ward. Mr A appeared friendly but was subdued and CCO1 considered this to be because of the olanzapine.

3.30 On 23 September 2016 CCO1 discussed Mr A with CP3, the community team consultant psychiatrist. A medical review would be arranged for November. The sedating effect of olanzapine was also discussed, CP3 suggested reducing from 20mg to 15mg and that further reduction could be considered "as necessary".

3.31 On 24 October 2016 Mr A and Miss D attended an appointment with CCO1. CCO1 documented that Mr A had not wanted to attend the appointment; he had been worried about it most of the morning and had turned down a work opportunity in order to attend. Mr A reported that he did not wish to continue taking his medication and that he was "just about tolerating" 10mg daily. The risks of not taking medication were discussed, but both Mr A and Miss D stated that they considered the ongoing involvement of mental health services to be "unnecessary and stressful". Mr A also reported that he had had no further contact from the police in relation to the incident on Moorland View Ward in June 2016.

[20] A Community Treatment Order allows a person who has been detained in hospital for treatment to leave hospital (discharged from detention) and receive treatment in the community. A Community Treatment Order will have rules that the person will have to follow; if they do not, they could be taken to hospital and detained. https://assets.nhs.uk/prod/documents/MH-CoP-Community-Treatment-Orders.pdf

3.32 On 11 November 2016 CCO1 received a telephone call from Mr A's father to say that the police were waiting for Mr A to contact them. Mr A's father also questioned how safe Miss D would be now that Mr A was no longer in hospital.

3.33 On 17 November Mr A (accompanied by Miss D) attended an appointment with a doctor in the STEP team (JD1). His diagnosis was documented as drug induced psychosis and it was documented that his medication was olanzapine 5mg, with Mr A having chosen to reduce the dose from 20mg in September. Mr A reported that he had not experienced any recurrence of psychotic symptoms. Mr A and Miss D described a build-up of life stressors that had led to Mr A's admission to hospital.

3.34 JD1 documented that there were no concerns about Mr A's mental state and that he had insight into his recent mental health difficulties. Mr A agreed to continue with olanzapine 5mg and JD1 advised continuing with antipsychotic medication for a minimum of six months. She also recommended that Mr A try an antidepressant to help with his mood, but Mr A stated he was not keen on taking medication.

3.35 JD1 documented that Mr A's main risks were "historic" and that he should be seen for a further medical review six months later.

3.36 On 30 January 2017 CCO1 attempted to speak to Mr A but spoke to Miss D who reported that Mr A was doing well and was going to France the following week for several weeks. Miss D stated that she was unable to talk further but agreed to talk again the following day.

3.37 After three attempts to speak again to Miss D, CCO1 was able to talk to her on 6 February 2017. Miss D reported that she and Mr A had separated at Christmas and that she had decided the relationship should end because she did not really "know his character". However, they had remained in contact with each other. She stated that Mr A had gone to France and that she did not know when he planned to return to the UK. CCO1 documented that he would discuss Mr A's case with the team at the end of March.

Discharge from mental health services – 27 April 2017

3.38 On 27 April 2017 CCO1 spoke to Miss D again who reported that she had had some contact with Mr A but that she was unsure where he was. Miss D said that she did not know about Mr A's mental state; CCO1 documented that he had not come to the attention of any agencies at that time.

3.39 CCO1 further documented that Mr A would be discharged back to the care of his GP and that if he needed further assessment or re-referral this could be arranged as a rapid re-access to mental health services.

Involvement of Street Triage team, North Devon – 2 and 4 August 2017

3.40 On 2 August 2017 the crisis team at DPT received a call from Mr A's mother (Mrs A) who reported concerns that Mr A was having "another episode". Mrs A said that she had tried to encourage Mr A to attend hospital, but he had been reluctant to do so.

3.41 Later the same day the Street Triage team received a call from Devon and Cornwall Police asking for information about Mr A. They reported that Mrs A had contacted them expressing concern about Mr A and had reported him as a missing person. Information about Mr A's previous contact with mental health services and "historic" risks was shared with the police. It was documented that Mr A was located later by the police.

3.42 On 4 August 2017 the Street Triage team was again contacted by Devon and Cornwall Police. It was documented that he had been "on Facebook caught stealing a bike". Information about Mr A's previous contact with mental health services was again shared with the police.

Assessment in police custody, Devon – 14 August 2017

3.43 On 14 August mental health staff from the CJLDT were asked to assess Mr A in custody. It was documented that he had been arrested on suspicion of assaulting a police officer. The police had wanted to speak to him regarding a different matter, but Mr A had resisted arrest and during his attempt to escape had assaulted an officer.

3.44 The Nurse assessing (CJLD1) documented that it was difficult to assess Mr A and he "avoided a lot of areas". She documented that he presented as "slightly elevated and arrogant at times but jovial and communicative at others". Mr A stated that he was not unwell and that it did not require a mental health assessment. Mr A stated that he hated mental health services because they had detained him previously and believed that staff had "had the wool pulled over their eyes by his family". He stated that he had spent some time under the care of the STEP team but that he had just told staff what they wanted to hear. He also continued to have bizarre beliefs about what his father's partner had done with the family pet dog.

3.45 CJLD1 documented that Mr A attempted to "control the conversation" and raised some "strange ideas" about eating dogs, black magic and being able to see the future. Mr A denied that he had any psychotic symptoms, stated that he had never been unwell and that he did not use cannabis.

3.46 CJLD1 documented that Mr A's mental state may have been deteriorating but he did not present as detainable at that time. She documented that he was coherent and able to hold a conversation. Mr A had refused all referrals to mental health teams.

3.47 CJLD1 documented that she had discussed the case with the crisis team who had agreed with her formulation. She documented that there was nothing mental health services could do to support Mr A and that he was insufficiently unwell to warrant detention.

Mental Health Act assessment, London – 17 to 18 August 2017

3.48 On 17 August 2017 the crisis team in Devon received a call from an Approved Mental Health Practitioner (AMHP) in London who reported that Mr A had been arrested for dangerous driving. He had refused to give a breath test and a MHA assessment had been requested. The AMHP sought background information about Mr A and information about bed availability in Devon. Recent progress notes, risk assessment and previous MHA assessments were sent. Information about the incident on Moorland View Ward was also provided. The intention was for Mr A to be transferred to a PICU that day.

3.49 The following day the bed capacity team at DPT contacted the crisis team (also at DPT) to advise that Mr A had not been transferred to a PICU the previous day. It was established that the necessary authority to transfer Mr A had not been received prior to the end of court hours and therefore Mr A had been transferred to the hospital wing at HMP Brixton until the following Tuesday.

Admission to Nash Ward PICU, Cygnet Hospital Kewstoke – 22 August 2017

3.50 On 22 August 2017 Mr A returned to court and an MHA assessment was completed. He was detained under Section 2 MHA and admitted to Nash Ward PICU, at Cygnet Hospital Kewstoke, under the care of CP2.

3.51 On 12 September 2017 Devon Partnership NHS Trust staff received a request for an AMHP to participate in an MHA assessment to consider detaining Mr A under Section 3 MHA.

3.52 The following day an AMHP discussed Mr A's assessment with Mrs A (Mr A's mother) who was nominated as Mr A's Nearest Relative. Mrs A reported being concerned about Mr A's care arrangements, his pending court cases and him being back in touch with his former partner (Miss D). It was documented that Mrs A's view was that if Mr A was discharged, he would stop taking medication, return to taking drugs and make poor decisions. Mrs A reported that Mr A did not

see the risk in his actions and that she would not object to the use of Section 3. It was documented that at that time Mr A had two outstanding court hearings:

- 15 September 2017 in Barnstaple regarding assault on a police officer in Devon on 14 August 2017; and
- 19 September 2017 in London regarding dangerous driving in London on 17 August 2017.

3.53 On 14 September 2017 an MHA assessment was completed by a doctor from Devon Partnership NHS Trust, an independent doctor and AMHP3. Staff from Cygnet Hospital Kewstoke reported that Mr A remained unwell, grandiose, argumentative and confrontational. He had threatened staff and other patients and had required intra-muscular (IM) injection on four separate occasions. At interview Mr A stated that he was fine and denied any psychotic symptoms. He did not believe he needed to be in hospital or that he needed medication. Mr A minimised the police chase on the motorway and the use of the police helicopter (but stated that he hoped it had been filmed and broadcast on television) and stated that he had not threatened or assaulted anyone. He stated that all of his actions had been in self-defence. It was documented that he lacked insight and capacity and the decision was to detain him under Section 3 of the MHA.

Transfer to Tyler Ward PICU, Cygnet Hospital Blackheath, London – 22 September 2017

3.54 On 22 September 2017 Mr A was transferred from Cygnet Hospital Kewstoke PICU to Cygnet Hospital Blackheath PICU due to his problematic behaviours and safeguarding risk to other patients at Cygnet Hospital Kewstoke (attempting to extort large sums of money from another patient and antisocial behaviour). He was under the care of CP4, the consultant psychiatrist for the unit.

3.55 On 25 September 2017 CP4 documented that Mr A considered that all of the allegations against him were untrue because of his religion. CP4 documented that his diagnosis was possible drug induced psychosis and antisocial personality difficulties. Regular medication prescribed at that time was olanzapine 15mg at night.

3.56 On 13 October 2017 CCO3 (Mr A's Care Coordinator from DPT) spoke to Cygnet Hospital Blackheath staff who reported that Mr A was successfully using Section 17[21] escorted leave. He was compliant with his medication and there had been no incidents of violence or aggression since transfer from Cygnet Hospital Kewstoke. Staff at Cygnet Hospital Blackheath stated that they were waiting for a transfer back to an acute ward in North Devon as they felt Mr A no longer required a PICU ward.

3.57 A nursing report prepared on 25 October 2017 documented that Mr A believed he was taking medication to make him a "nicer person" and that he did not believe the medication "did anything for him". Staff documented that this perspective could have a negative outcome for him when in the community. Staff also documented that there was a high probability that Mr A might act in a dangerous manner on discharge from hospital. It was recommended that a CTO be considered as a safe means of recalling Mr A back to hospital should he fail to comply with the conditions on discharge.

3.58 On 31 October 2017 Devon Partnership NHS Trust staff documented that the plan was to transfer Mr A from Cygnet Hospital Blackheath to an acute bed (rather than PICU) at Cygnet Hospital Kewstoke.

[21] Section 17 leave means that while detained under the Mental Health Act, a patient may be able to leave the hospital if authorised by the doctor or clinician in charge of their care (the RC). This leave is often referred to as "Section 17 leave", as it is Section 17 of the Mental Health Act that allows this leave. The RC in charge can place conditions on the leave, such as where the patient should stay while away from the hospital and whether this will be for a fixed period of time. The responsible clinician can revoke leave and make a patient return to hospital at any time. If a patient does not return to the hospital at the end of the leave period, they can be made to return to the hospital. https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act/

Admission to Sandford Ward, Cygnet Hospital Kewstoke – 4 November 2017

3.59 Mr A was stepped down from a PICU bed to an acute bed at Cygnet Hospital Kewstoke. The discharge summary from Cygnet Hospital Blackheath documented a provisional diagnosis of possible drug induced psychosis and antisocial personality difficulties. It also noted that Mr A had been due to attend Harrow Crown Court on 31 October 2017 in relation to charges of dangerous driving and resisting arrest; and Barnstaple Magistrates Court the previous day, 3 November 2017. It was further documented that the Crown Prosecution Service (CPS) were prepared to waive the assault charge if Mr A pleaded guilty to the other charges.

3.60 Staff at Cygnet Hospital Kewstoke documented that Mr A had been transferred there in order to be closer to home (Devon).

3.61 A care plan completed on admission to Cygnet Hospital Kewstoke documented Mr A's diagnosis as psychosis triggered by illicit substance use. It also documented that when unwell Mr A could present as verbally and physically aggressive towards others.

3.62 A request was made for the First Tier Tribunal scheduled for 27 November 2017 to be postponed because CP2 only worked on a Tuesday and a Thursday. This request was subsequently refused because Mr A opposed a postponement and the MHA Administrator for Cygnet Health Care had stated that CP2 would be available. The First Tier Tribunal was scheduled to be heard at Cygnet Hospital Kewstoke, but the RC report was provided by CP4 because he had treated Mr A recently.

3.63 On 7 November 2017 CP2 documented that Mr A's diagnosis was psychosis induced by cannabis with antisocial personality disorder traits. CP2 also documented that Mr A reported he had been sexually assaulted when he was a child although there was "no clear evidence of this".

3.64 On 14 November 2017 CCO3 joined a discharge planning and Section 117 aftercare meeting by conference call. CCO3 documented that Mr A was keen to be discharged and that it had been agreed that he would live with Mrs A in Wiltshire prior to travelling to France in December for planned work. CCO3 also noted that Mr A was due to attend a court hearing on 28 November 2017. Mr A was aware of the importance of remaining abstinent from cannabis as this appeared to trigger a psychotic disorder. His medication at that time was olanzapine 10mg and he had been encouraged to continue to take this for at least six months to a year after discharge from hospital.

3.65 CP2 documented that it was recommended that Mr A receive weekly or fortnightly input from a care coordinator and input from a consultant psychiatrist in the community, along with a psychological referral or educational options and a referral to drug and alcohol services. CP2 documented that the plan was to discharge Mr A two to four weeks later.

3.66 A multidisciplinary team meeting also took place on 14 November 2017. The record of this meeting showed Mr A's diagnosis as drug induced psychosis. It was documented that Mr A had a First Tier Tribunal hearing on 27 November 2017 and that Cygnet Hospital Kewstoke staff expected Mr A to be discharged due to his "good presentation".

3.67 On 16 November 2017 CCO3 referred Mr A to the relevant community mental health team in Wiltshire.

3.68 On 21 November 2017 CP2 documented that Mr A was settled with no overt signs of psychosis although he was worried about the court hearing the following week (28 November 2017). Discharge from hospital was being planned for the same day as the First Tier Tribunal hearing on 27 November 2017. A community mental health team in Wiltshire were willing to provide aftercare.

3.69 A multidisciplinary team meeting the same day documented Mr A's diagnosis as drug induced psychosis and his medication as olanzapine 10mg once daily. Mr A had been using Section 17 leave appropriately and further overnight leave to his mother's address had been arranged for 25 November 2017.

3.70 On 27 November 2017 Devon Partnership NHS Trust staff received a telephone call from Cygnet Hospital Kewstoke staff to advise that Mr A had been reviewed that morning and Section 3 detention had been rescinded. The First Tier Tribunal had therefore been cancelled.

3.71 Mr A was discharged to his mother's address in Wiltshire the same day. The discharge summary documented his diagnosis as drug induced psychosis, mental and behavioural disorder due to the use of cannabis and gave a provisional diagnosis of antisocial personality disorder.

Informal treatment in the community, Wiltshire – 27 November 2017

3.72 On 27 November 2017 CCO4 (Mr A's new Care Coordinator from Avon and Wiltshire Partnership NHS Foundation Trust (AWP)) attempted to call Mr A but he was not available. Staff then spoke to Miss D who provided assurance that Mr A was fine.

3.73 Staff from the Intensive service[22] in Wiltshire spoke to Mrs A the following day to arrange a home visit by two members of staff (given Mr A's risks to others). Mrs A advised that Mr A had attended Harrow Crown Court that day and that the case had been adjourned until 5 December 2017. Staff then left a message on Mr A's mobile phone asking him to return the call.

3.74 On 29 November 2017 staff from the Intensive service attempted to speak to Mr A, but the telephone number they called belonged to Miss D. Further attempts to speak to Mr A on his mobile were unsuccessful. Staff then called Mr A's mother (Mrs A) who expressed no specific concerns about Mr A. She suggested that staff visit the following afternoon because Mr A would be with her for the day. Mrs A reported that Mr A had been given seven days' medication on discharge from hospital. She had made an appointment with the GP for 4 December to arrange a further supply.

3.75 Later that day Mrs A called CCO4 to discuss the court hearing. Sentencing had been adjourned until 5 December 2017 so that a care plan could be incorporated into the proposal. CCO4 returned a call to London Probation Service (whom we believe were completing a court report) to provide what information he had about Mr A.

3.76 On 30 November 2017 Mr A was visited at home by two members of staff from the Intensive service. They documented that there was no evidence of thought disorder, and that Mr A had not reported any psychotic symptoms because (he considered that) "they were treated by the olanzapine".

3.77 On 4 December 2017 Mr A's case was discussed in the community mental health team multidisciplinary team meeting. It was documented that his diagnosis according to Cygnet Hospital Kewstoke was drug induced psychosis. His risks included significant previous risk to others including fire setting, assault and dangerous driving.

3.78 CCO4 received a call from Mr A's new GP asking for advice regarding the number of doses of olanzapine to prescribe. CCO4 advised that there was no evidence that Mr A had overdosed on medication previously and that prescribing one month's worth "should be okay".

3.79 Later the same day CCO4 met with Mr A and his mother at her home. CCO4 documented that since discharge Mr A had been managed well by medication and abstinence from illicit substances. Mr A's mood appeared flat during the appointment, but this seemed to be because of the court hearing and because he was away from his home and his friends in North Devon. CCO4 documented that Mr A was compliant with his medication but that he did not have any medication for that evening because his supply from Cygnet Hospital Kewstoke had run out and he could not collect his prescription until the following day. Mr A advised that he planned to work in France if the outcome of the court hearing allowed him to do so. His intention was to remain in France until March 2018.

[22] AWP Intensive Teams consist of experienced mental health staff who offer assessment and home treatment for people aged over 16 years experiencing a mental health crisis, as an alternative to hospital admission. The team operates 24 hours a day 7 days a week. However, the team does not provide an 'emergency' service such as a 999 response. http://www.awp.nhs.uk/services/community/intensive-services/

3.80 On 5 December 2017 CCO3 from Devon Partnership NHS Trust contacted Mr A to check on his progress following discharge from hospital. CCO3 reported that this was done as part of a seven-day follow-up check. Mr A reported that he was "doing okay", taking his medication and that he had already met with his new Care Coordinator from Wiltshire. Mr A advised that at Harrow Crown Court he had been given a suspended sentence and a driving ban for 18 months.

3.81 On 8 December 2018 CCO4 from Wiltshire called Mr A, and then Mrs A to enquire about the outcome of the court hearing. Mrs A advised that Mr A had received a fine and a suspended sentence order (four months custody suspended for 12 months) with no requirements and was disqualified from driving for 18 months. She reported that Mr A had been relieved but had become "stroppy" with her within about 48 hours, possibly because he had not taken olanzapine for a few days. Mrs A reported that Mr A had questioned the need to take his medication, but Mrs A had told him he did need it for stability. She said that Mr A had collected the prescription and had gone to stay with a friend in London.

3.82 On 12 December 2017 CCO4 visited Mr A at home. He stated that as the court had not imposed any restrictions on him, he would be going to France at the weekend to work in a ski resort. Mr A said that he was finding the olanzapine 10mg too sedating and that he was sleeping most of the night and a lot of the day. He sought advice about whether the dose could be reduced to 5mg or stopped altogether. CCO4 stated that the consultant psychiatrist would need to advise but reinforced the benefits of medication. CCO4 documented that he doubted Mr A would take any medication once in France.

3.83 On 15 December 2017 CCO4 spoke to Mr A who confirmed that he would be going to France the following day and that he had already reduced the dose of olanzapine. CCO4 documented his concerns about Mr A's psychosis and the fact that if it was untreated it may result in further reckless behaviour towards others. Mr A felt he was well and over the worst of his psychosis. He stated that he did not want to take the olanzapine for much longer because of the sedating effects. His intention was to lead an active life in France and the medication would not allow him to do this. His mother intended to continue to collect his medication from the GP and send it to him in France.

3.84 On 22 December 2017 CCO3 documented that she had established from services in Wiltshire that Mr A had gone to France and that his intention was to stay there until March 2018. Mr A was formally discharged from Section 117 aftercare by CCO3 (Mr A's Care Coordinator from DPT), and then was discharged from the caseload of the North Devon team.

3.85 Mr A was discharged from the caseload of the AWP CMHT on 27 December 2017.

3.86 There was no further contact with NHS services until October 2018 when Mr A consulted his GP.

GP consultation, Patford House Surgery, Calne, Wiltshire – 24 October 2018

3.87 Mr A was seen in a GP appointment at Patford House Surgery in Calne, Wiltshire on 24 October 2018. He complained of a recurrent history of discomfort in his throat. He also complained of mild pains in his left knee. The GP documented that Mr A's mood was normal with no signs of psychosis.

Emergency department attendance, Homerton Hospital, London – 17 December 2018

3.88 On 17 December 2018 Mr A attended the emergency department at Homerton Hospital, London complaining of pain and sensation of a foreign body in his eye. He was diagnosed with a small corneal ulcer in his left eye. An attendance summary was received by Patford House Surgery on 21 December 2018.

GP consultation, Patford House Surgery, Calne, Wiltshire – 10 January 2019

3.89 Mr A was seen at a GP appointment at Patford House Surgery on 10 January 2019, complaining of a worsening sensation in his throat.

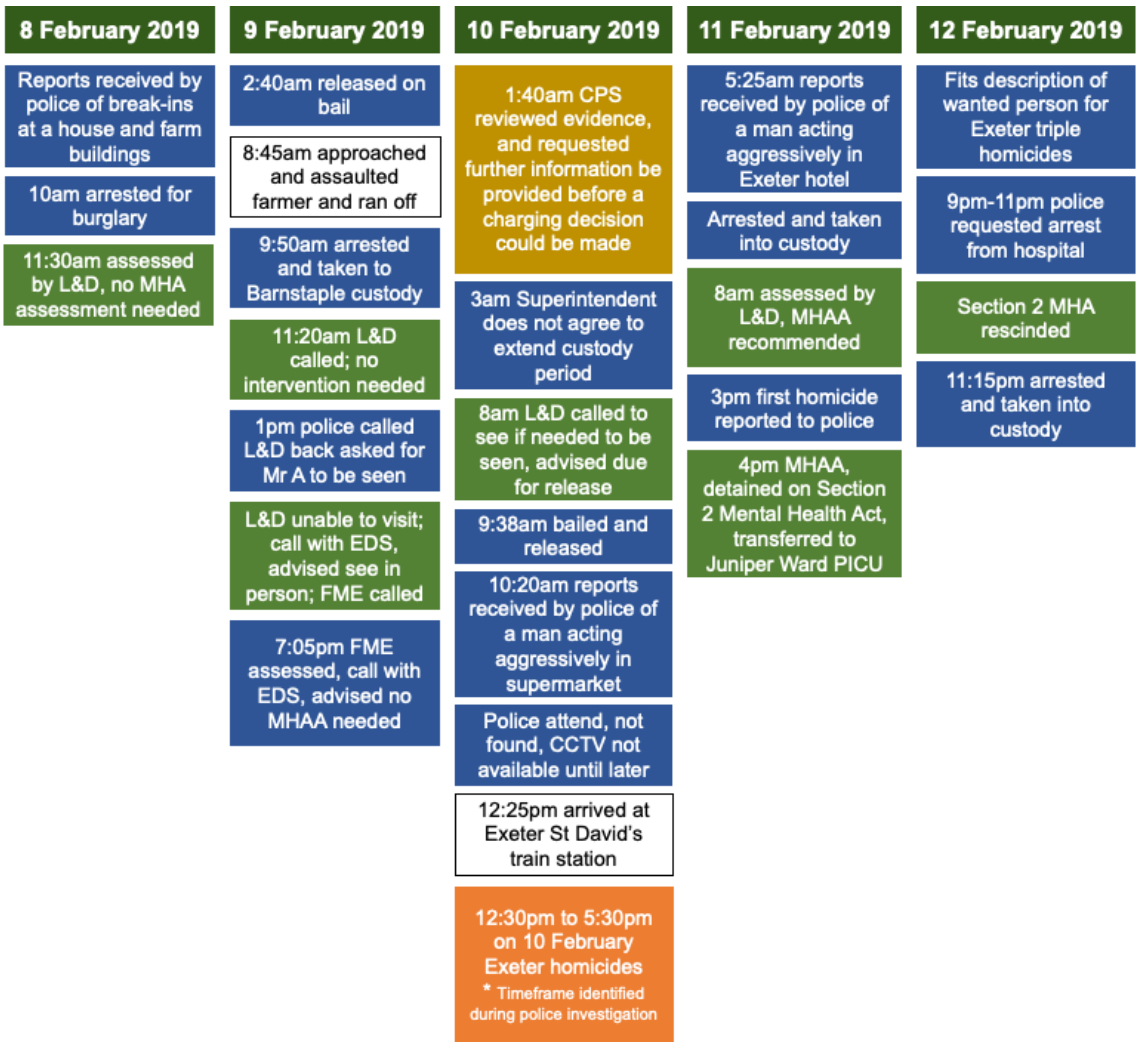
3.90 Examination of his throat was normal. He was asked about his mental health which he described as “good currently”. A note was made that he was “taking no drugs”.

3.91 It was documented that he was anxious about the cause of his throat symptoms and GP agreed to refer him to the Ear, Nose and Throat Department for an assessment. A referral was made on 15 January 2019 but there are no further references to this referral in his records.

4 Timeline of events in February 2019

4.1 This section provides a detailed timeline of events in February 2019 (**Figure 3** below provides an overview of these). We have included information taken only from healthcare records and interviews. For a complete narrative of all agencies' contact with Mr A during this period, please refer to our systems review report dated March 2023.

Figure 3: Timeline of key events in February 2019



Referral to Devon Liaison and Diversion Service – Friday 8 February 2019

4.2 After Mr A's arrest on 8 February 2019, an assessment of his mental health was requested from the Liaison and Diversion team (L&D) of Devon Partnership NHS Trust (DPT), due to his mental health history.

4.3 He was seen by a mental health practitioner (L&D1) at about 11.30am on 8 February 2019 and the L&D Peninsula Liaison and Diversion triage tool[23] was completed. His history of contact with mental health services was referenced and noted, and that Mr A declined a full assessment.

4.4 Mr A also declined the offer to provide him with the contact details of support services, including accommodation, and he reported that he was "staying in a van". He had informed custody staff that he was homeless but had been engaging in paid work. He denied that he was a current risk to

[23] The L&D Triage Tool is used to structure the assessment.

himself or others. He agreed to update custody staff if he became willing to engage with the L&D service. It was recorded that it was a brief interaction, but L&D1 did not find any evidence that he lacked mental capacity. L&D1 documented that no current role was identified with L&D.

Referral to Devon Liaison and Diversion Service – Saturday 9 February 2019

4.5 Mr A was arrested again on 9 February 2019 at about 9.50am, after a report of him assaulting a farmer near Barnstaple.

4.6 The Street Triage team was informed that he was in custody and had a mental health history, so called the L&D practitioner on duty (L&D2), who was based in Exeter.

4.7 L&D2 phoned Barnstaple custody suite at about 11.20am and spoke to police custody staff. They advised L&D2 that they did not currently have any concerns regarding Mr A; he had been in custody the day before but had declined an assessment or any support from the L&D service. It was agreed that L&D2 would allow him to settle and call back again to offer him an assessment.

4.8 Because of concerns about Mr A's presentation, the Custody Sergeant contacted the L&D team at about 1pm. They expressed concerns that some of his comments did not make sense and queried whether his mental health may be deteriorating; he told one officer that he was "sad because he had lost his unicorn". L&D2 called at about 2pm to speak to Mr A and was asked to call back after handover.

4.9 L&D2 spoke to Mr A over the phone at some point between 2:30pm and 3pm, to carry out a telephone assessment. The Peninsula Liaison and Diversion Service Triage Tool was completed.

4.10 The assessment found that there was some evidence of paranoid thoughts; he was hungry but stated that he would not eat any of the food in custody as it was "tampered with" by the police. It was challenging to try and direct the conversation. Mr A was difficult to interrupt, he seemed agitated, talking rapidly, and talked over L&D2 frequently throughout the conversation.

4.11 He was quite eloquent in his use of language, repeatedly asking a question, listening to the answer and then repeating it back using different wording. He accused L&D2 of stealing his food, and then repeatedly said he had been assaulted.

4.12 Mr A said he was not taking any medication, did use cannabis but not had any recently, and was of no fixed abode. He was orientated to time and place but said he did not think his mental health was deteriorating and denied he had ever experienced any mental health issues. Mr A said he had a "duty of care to protect the environment, the animals and all sentient beings in the universe". He felt that his last hospital admission was manipulated in order to prevent him from carrying out his "duty of care".

4.13 L&D2 noted that there was a potential risk to the public in terms of further offending and his potential lack of insight into his mental state. L&D2 was concerned about his presentation, so called the Emergency Duty Service (EDS) (based in Exeter) to discuss options and spoke to EDS1.

4.14 A discussion about possible ways forward took place, without discussing details of Mr A's circumstances. The following suggestions were made:

- a Liaison and Diversion (L&D) practitioner to undertake a face-to-face visit;
- a forensic medical examiner (FME) to undertake a face-to-face visit;
- police to use powers under Section 136 of the MHA;[24] or

[24] Section 136 allows the police to take a person to (or keep a person at) a place of safety. They can do this without a warrant if: the person appears to have a mental disorder, **and** they are in any place other than a house, flat or room where a person is living, or garden or garage that only one household has access to, **and** the person is "in need of immediate care or control" (meaning the police think it is necessary to keep the person or others safe). https://www.mind.org.uk/information-support/legal-rights/police-and-mental-health/sections-135-136/

- psychiatric assessment to be undertaken in prison, should the nature of offence be serious enough for remand into custody.

4.15 The usual practice would have been that an L&D practitioner would make a face-to-face assessment, then if indicated, request a MHA assessment (MHAA) from the AMHP team in office hours, or from the EDS out of hours or at weekends. If this cannot be done or is outside the hours of work of the L&D service, a request is made for the G4S FME to assess and consider whether an MHAA is needed.

4.16 L&D2 at that time did believe Mr A required an MHAA but advised they did not have sufficient time in their span of duty to see Mr A face-to-face. They advised police at about 4:30pm to request an FME to carry out a face-to-face assessment. They planned to check the following morning if Mr A was still in custody, and to see if he would agree to an L&D assessment. Their form concludes that he was "likely to be charged with the offence of GBH, if he is he will remain in court until Monday morning".

Referral to Devon Liaison and Diversion Service – Sunday 10 February 2019

4.17 On the Sunday morning, L&D2 started duty in Exeter. Just after 8am they called Barnstaple custody suite and were told that Mr A was due to be released on bail within the next hour. A copy of an opt-in letter was sent to the police to give to Mr A, because for L&D to have any further contact, he would need to agree to their involvement once he had left custody.

4.18 At about 3.15pm the same day the Street Triage team was contacted by Devon and Cornwall Police. Mr A's mother had contacted the police to express concern that she had not been able to contact him, and the police enquired whether there had been recent communication with L&D.

Referral to Devon Liaison and Diversion Service – Monday 11 February 2019

4.19 At about 8am on 11 February 2019 a triage assessment was completed by L&D staff after Mr A had been arrested for alleged public order offences, assault, and possession of an offensive weapon following an incident at a local hotel where he had been staying in temporary accommodation. Hotel staff had reported that Mr A had picked up a lamp and had been "running amok" around the hotel with it. Mr A had made threats to other residents and hotel staff and had damaged several cars.

4.20 The police had been called and Mr A had been aggressive on three occasions; he had urinated in a glass and tried to throw it over officers, attempted to grab the police taser and had been combative during the arrest. Mr A had been tasered but remained challenging until placed in the police van.

4.21 A G4S FME tried to examine him for a physical assessment as part of the police post-taser protocol, but he refused to consent to be examined. An emergency referral was made by police to the L&D service due to concerns about his mental state. Mr A spoke of a series of experiences that appeared psychotic in nature and he was unpredictably very aggressive.

4.22 Mr A asked to see the G4S healthcare professional because he believed his hand was broken. During the assessment, Mr A punched them in the face.

4.23 An L&D triage tool was completed by L&D3, based on the information provided, noting the expiry time of the PACE clock (5.50am on 12 February). Staff did not enter Mr A's cell at the request of the Custody Sergeant who felt that Mr A's risk to healthcare staff was high. Mr A was coughing and spitting on the floor, expressing bizarre ideas. The impression from the information provided was that he may be experiencing a relapse of a psychotic illness with a possible mood component.

4.24 L&D3 requested an MHAA to be carried out and this was convened for 2pm that day. The application for Section 2 of the MHA was documented by the AMHP at 4:30pm. It was noted that he had a diagnosis of unspecified non-organic psychosis and appeared to be experiencing a relapse in his mental health.

4.25 It was agreed that Mr A had a mental disorder of a nature and degree that required a period of assessment in hospital in the interest of his health and safety and the protection of others. Due to his unpredictability, it was felt that he would require admission to a psychiatric intensive care unit (PICU). The AMHP has a duty to inform the Nearest Relative, and at that time Mr A's father would have been the Nearest Relative. Mr A's mother clarified that the functions of the Nearest Relative had been delegated to her after Mr A's last detention, and she was informed of his detention under Section 2 MHA.

4.26 Mr A was transferred to the Juniper Ward PICU at Wonford Hospital, Exeter, and was admitted into seclusion because of his level of aggression in custody.

Tuesday 12 to Saturday 16 February 2019

4.27 On 12 February 2019 Mr A's mother called the PICU and was informed, after establishing his consent to share the information, that he had been admitted. She was advised not to visit until he was more settled.

4.28 Mr A came out of seclusion later that day; he was nursed on one-to-one observation but was able to stay in the ward area and interact safely with others. He accepted oral medication and there was no aggression.

4.29 On the evening of 12 February contact was made by police trying to ascertain Mr A's whereabouts. Senior Trust staff were informed that police wanted to arrest him on suspicion of murder. Given the seriousness of the charges, it was decided to rescind the Section 2 MHA, rather than agree Section 17 leave. A referral was made to the L&D team to help ensure that Mr A's mental health needs would be met as far as possible while in local custody and that clinical information would be communicated to any further establishment to which he might be transferred.

4.30 It was noted that a clinical plan would be needed if there were no plans to charge and remand Mr A. Police arrested him during the night of 12 February in the PICU and he was transferred to the Exeter custody suite. No medication was supplied with him, and the PICU did not have a prescription pad on site to supply a prescription.

4.31 Mr A's mother was due to visit him in the PICU on 13 February; it was noted that staff believed that she could not be informed of recent events because staff did not have permission from Mr A. This was discussed with the Chief Operations Manager (COM), to plan contact.

4.32 Mr A's mother phoned on 13 February 2019, and was told that no information could be shared, and the enquiry was passed to the COM. Mrs A later called the L&D team, as she had been informed that he had been arrested. L&D staff requested that police contact her to share what information was appropriate. Mrs A told us that when she called the ward, she spoke to a member of staff who then did not put the phone on mute, and she heard them say "it's his mother and she knows nothing". Mrs A told us that she was very distressed that she had no support from any organisation and, despite being Mr A's Nearest Relative and his next of kin, she was not given any information from mental health services.

4.33 On the morning of 13 February 2019, the L&D team were informed that Mr A had been arrested and was in custody in Exeter, and likely to remain in custody for more than 24 hours. It was noted that there was a possibility that Mr A might not be charged with any offence if the threshold for charge was not met. The plan was that his mental health needs and vulnerabilities were to be monitored while the criminal justice process was completed.

4.34 If no charge was deemed likely, a clear plan to meet his mental health needs was needed to reduce risks to others as highlighted from previous assessment in custody. If a charge was applied, Mr A would appear initially at the Magistrates Court and remand to prison might be requested. If he was remanded in custody the plan was for L&D to liaise with the mental health team at HMP Exeter to request an urgent assessment.

4.35 L&D arranged for Mr A to have a prescription written by the Consultant Psychiatrist at the PICU. There were delays in arranging this, because it was written on a prescription that required Mr A's consent to collect from a community pharmacy. He was unable to consent for a police officer to collect it on his behalf. L&D staff then arranged for a different kind of prescription and collected medication on his behalf.

4.36 L&D staff visited Mr A in custody at about 6pm on 13 February 2019. He was advised that medication was available to him, and that L&D staff would continue to visit to offer support.

4.37 They visited again on 14 February 2019, and Mr A was able to converse but expressed some paranoia about food and refused any medication.

4.38 A report to the Court was provided by L&D on 15 February 2019, advising that L&D staff could attend if needed. L&D staff visited Mr A on 15 February, and he stated that he had no issues at present. He appeared orientated and told L&D staff that he was likely to still be in custody the following day.

4.39 On 16 February 2019 Mr A appeared at Exeter Magistrates Court and was charged with murder and GBH. He was remanded in custody to HMP Exeter. L&D staff forwarded notes of his recent history to the healthcare team at HMP Exeter and arranged a handover call with the mental health team. They attended Court on 18 February 2019 to ensure that all relevant agencies had up-to-date health information.

4.40 Shortly after this Mr A was moved to another prison and there was no further contact with the L&D service.

5 Discussion and analysis of Mr A's care and treatment

5.1 Mr A had been admitted to hospital on two occasions prior to the fatal assaults in February 2019, and both times he had been detained under the MHA:

- 11 June 2016 to 12 September 2016 (3 months or 93 days): initially under Section 2 MHA, then from 6 July 2016 under Section 3 MHA; and
- 22 August 2017 to 27 November 2017 (3 months or 97 days): initially under Section 2 MHA, then from 14 September 2016 under Section 3 MHA.

5.2 On discharge in September 2016 Mr A very quickly sought to reduce the dose of olanzapine:

- by 27 September 2016 it had been reduced from 20mg to 15mg;
- on 24 October 2016 Mr A reported he was "just about tolerating" 10mg;
- on 17 November 2016 it was documented that Mr A had reduced the dose to 5mg;
- in January 2017 Mr A left the country to work in France for a few months.

5.3 On 12 December 2017, after being discharged just 15 days earlier, Mr A sought advice about reducing the dose of olanzapine from 10mg to 5mg or stopping altogether. He went to France again, on 16 December 2017.

5.4 Every contact with mental health services was initiated by incidents that resulted in Mr A being arrested by police, who then sought assessment from mental health professionals.

Diagnosis and treatment and discharge planning

Moorland Ward, Devon Partnership NHS Trust

5.5 On first presentation to mental health services on 10 June 2016, Mr A had let himself into his father's home, made threats to kill his father and then stolen his father's car. He was arrested and when he was assessed in the police station, the Approved Mental Health Practitioner (AMHP) who assessed him described Mr A as thought disordered and psychotic with delusional beliefs. On assessment he appeared dishevelled and neglected and had bizarre beliefs about his parents.

5.6 When he was told he would be admitted to hospital he described bizarre beliefs about religion.

5.7 On 11 June 2016 Mr A was admitted to Moorland View Ward, an acute mental health ward based on the site of North Devon District Hospital. A urine drug screen was completed on admission that tested positive for cannabis.

5.8 At that time the initial differential diagnosis made by CP1 was "drug induced psychosis or schizophrenia".

5.9 Following an incident six days after admission to hospital when Mr A set fire to a bin in his wardrobe and held other patients "hostage", he was transferred to a psychiatric intensive care unit (PICU) at Cygnet Hospital Kewstoke.

5.10 In a referral to forensic services CP1 documented that the diagnosis was "drug induced psychosis or paranoid schizophrenia", but in the discharge summary completed by the trainee doctor reporting to CP1 the diagnosis was documented as "mental and behavioural disorders secondary to multiple substances". Mr A had been treated with intra-muscular (IM) olanzapine (because he had refused oral medication) and one dose of Clopixol Acuphase[25] 100mg.

[25] Clopixol Acuphase injection is used for the initial treatment of acute psychoses including mania and exacerbation of chronic psychoses, particularly where a duration of effect of two to three days is desirable. https://www.medicines.org.uk/emc/product/993/smpc

Nash Ward PICU, Cygnet Hospital Kewstoke

5.11 Shortly after admission to the PICU CP2 documented that Mr A was "likely suffering from a drug induced psychosis". The treatment with Clopixol Acuphase was continued as he refused oral medication. Mr A's detention was upheld by the First Tier Tribunal on 30 June 2016; at that time, he continued to hold the same delusional beliefs that were present on admission to Moorland View Ward.

5.12 On 6 July 2016 he was detained under Section 3 MHA following a request from CP2. In a report to the Tribunal on 24 July 2016 CP2 stated that Mr A's diagnosis was "psychotic disorder, unspecified", but noted that "consideration must be made whether this is a more enduring psychotic illness exacerbated by the use of psychoactive substance". At that time Mr A had been taking oral olanzapine 20mg daily.

5.13 An assessment by the Forensic Service from Devon Partnership NHS Trust (DPT) was conducted on 25 July 2016 (report dated 30 August 2016). This concluded that Mr A:

"…has suffered a first episode of psychosis with features amounting to a diagnosis of Paranoid Schizophrenia (delusions and hallucinations in the absence of substance misuse for more than one month, ICD-10-F20.0) and Mental and Behavioural Disorders due to Cannabis Misuse."

5.14 It was documented that Mr A had responded to treatment with an anti-psychotic medication but recommended that his oral benzodiazepines should be discontinued as they could be masking symptoms of psychosis. The report concluded:

"I would recommend […] subject to Community Treatment Order on his discharge from hospital particularly if there is doubt about his compliance with anti-psychotic medication, substance misuse in the community or if his (sic) and treatment plans."

5.15 At a Section 117 meeting on 12 September 2016 attended by his Care Coordinator from Devon (CCO1), Mr A was told his diagnosis was "…of a schizophrenic type illness with good chance of lasting recovery provided he refrained from substance misuse and comply with community treatment as advised". It was agreed that Mr A did not meet the criteria for a Community Treatment Order[26] (CTO) and because he agreed to comply with tablets, he did not require depot anti-psychotic medication. He was discharged from the Section 3 of the MHA and from hospital on the same day.

5.16 Mr A was followed up by the early intervention team for psychosis (referred to by DPT as the STEP team). He was discharged back to primary care on 24 April 2017 after staff were informed by his former partner Miss D that Mr A had gone to live and work in France for a number of months. The discharge summary documented that the working diagnosis was "drug induced psychotic episode". It was documented at that time that Mr A was "non-concordant with medication", which was olanzapine 20mg daily.

5.17 Following an admission lasting three months, it was concluded by the CP2 (Cygnet Hospital Kewstoke) and the forensic assessment that Mr A's diagnosis was schizophrenia. This was appropriately treated with an anti-psychotic at the maximum dosage recommended by the British National Formulary (BNF).[27]

[26] A Community Treatment Order (CTO) allows a person who has been detained in hospital for treatment to leave hospital (discharged from detention) and receive treatment in the community. The CTO will have rules that the person will be expected to follow and if they do not follow those rules they can be taken to hospital and detained. https://assets.nhs.uk/prod/documents/MH-CoP-Community-Treatment-Orders.pdf

[27] The BNF is a joint publication of the British Medical Association and the Royal Pharmaceutical Society. It is published under the authority of a Joint Formulary Committee which comprises representatives of the two professional bodies, the UK Health Departments, the Medicines and Healthcare products Regulatory Agency, and a national guideline producer. The BNF aims to provide prescribers, pharmacists, and other healthcare professionals with sound up-to-date information about the use of medicines. https://bnf.nice.org.uk/about/preface.html

Informal community care under the STEP team, Devon Partnership NHS Trust

5.18 When he was discharged to the community in 2016, he was followed up by the STEP team in Devon. We consider this to have been appropriate because this was Mr A's first contact with mental health services and his diagnosis meant that he met the criteria for the function of this team.

5.19 At some point between December 2016 and February 2017 he discontinued his medication. After his former partner reported that he had gone to France to live and work for a few months he was discharged back to his GP. The discharge summary to the GP documented his diagnosis as "drug induced psychosis". The reasons for this incorrect diagnosis being documented are not known. However, importantly this meant that if Mr A was referred back to mental health services, it is likely that this diagnosis would be used rather than the correct one of schizophrenia.

MHA assessment in London

5.20 Mr A's next contact with mental health services was on 14 August 2017, four months after his discharge by the early intervention team in Devon and nine months after the last direct contact between mental health services in Devon and Mr A. It is understood that for some time between January 2017 and August 2017 he had been in France, but the date that he returned to the UK was not documented.

5.21 Mr A was arrested in London for driving offences and as he was described as behaving "bizarrely", he was referred for an MHA assessment. A drug test following his arrest was reported to be negative. A medical recommendation had been completed on 18 August 2017 and he was described as "grandiose". The Section 12 doctor said that he had been told that the diagnosis from Mr A's previous admission was "drug induced psychosis", but Mr A reported it was a schizophrenia-like illness. It was documented that he had tested negative for drugs. His presentation was described as paranoid and suspicious about NHS professionals, and he believed he was sectioned unlawfully in the past.

5.22 Both doctors felt that Mr A was delusional and recommended admission under Section 2 MHA. However, a bed could not be found, and he was remanded into HMP Brixton. When he appeared at court on 22 August 2017, an MHA assessment was completed, and he was transferred to Cygnet Hospital Kewstoke on the same day.

Nash Ward PICU, Cygnet Hospital Kewstoke

5.23 On admission to Cygnet Hospital Kewstoke Mr A's urine drug screen was negative. His diagnosis was described as "Antisocial personality traits ?drug induced psychosis", this was despite the fact that his Responsible Clinician (RC) was the same as 12 months previously (CP2). In the ward round records it is documented "No psychotic phenomena, however chronic destabilised personality traits (antisocial type) present". Mr A was commenced on olanzapine 15mg daily.

5.24 On 1 September 2017 he attempted to hit a member of staff and a course of Clopixol Acuphase was commenced. It was also planned to start Clopixol depot 100mg.

5.25 The following week it was documented that he would be given Clopixol depot 200mg every two weeks. It is not clear whether this treatment was started.

5.26 An MHA assessment on 14 September 2017 resulted in detention under Section 3 MHA. It is stated that intention was to keep Mr A free from antipsychotic drugs for the first two weeks of his admission to assess whether he had a drug induced psychosis; however, he required four doses of Clopixol Acuphase because of his presentation. His RC was not one of the two doctors at the MHA assessment, but his (CP2's) view on Mr A's diagnosis was recorded as possibly "schizo-affective disorder, antisocial personality disorder, drug induced psychosis and a possible mood disorder".

Tyler Ward PICU, Cygnet Hospital Blackheath

5.27 On 23 September 2017 Mr A was transferred to another PICU at Cygnet Hospital Blackheath. The reason for the transfer from one PICU to another was documented as "…due to persistent disruptive, provocative behaviour which placed him at risk of assault by fellow patients". The initial impression from CP3 was "Patient with antisocial personality disorder, possible schizoaffective disorder and drug induced psychosis. History of extremely disruptive behaviour". It was documented that there were "no psychotic features evident".

5.28 After a period of treatment with olanzapine 10mg daily and periods of leave which went uneventfully, it was felt he could be transferred back to local services in Devon. As a local open inpatient bed could not be found within services provided by Devon Partnership NHS Trust, he was transferred to an acute ward at Cygnet Hospital Kewstoke. The discharge summary records the following: *"*Provisional Diagnosis: Possible drug induced psychosis, Antisocial Personality difficulties*".*

Sandford Ward, Cygnet Hospital Kewstoke

5.29 Mr A was admitted to an acute ward at Cygnet Hospital Kewstoke as a "step down" from PICU before discharge. He was detained under Section 3 MHA with same RC as on the previous two admissions (CP2).

5.30 At the initial ward round, CP2 cited Mr A's diagnosis as "Psychosis induced by cannabis with [antisocial personality disorder] ASPD traits… no sign of psychosis."

5.31 On 14 November 2017 a ward round and Section 117 meeting took place with Mr A's Care Coordinator from Devon (CCO3) who joined via teleconference. The plan documented was to discharge Mr A to his mother's home in Wiltshire two to four weeks later.

5.32 At a ward round on 21 November 2017 Mr A's RC documented "…without overt signs of psychosis… plan for discharge 27/11/17 when the tribunal sits. A [community mental health team] CMHT in Wiltshire is willing to provide aftercare."

5.33 On 27 November 2017 Mr A was reviewed by CP2 following return from two nights' Section 17 leave at his mother's home in Wiltshire. It was documented that no concerns were reported by Mr A's mother.

"When seen he was euthymic. No signs of psychosis evident. He was polite and coherent… last sense of paranoia 8 weeks ago in Cygnet Blackheath. He is happy with taking olanzapine in the community… Not at all meeting the criteria for detention. He will be transferred to a local CMHT… I rescind Section 3 at 08.00 today."

5.34 A later discharge summary documented Mr A's diagnosis as "Mental and behavioural disorder due to use of Cannabis. Provisional diagnosis of antisocial personality disorder."

Informal community care under North East Wiltshire CMHT, Avon and Wiltshire Partnership NHS Foundation Trust

5.35 An assessment of Mr A on 11 December 2017 documented the following: "… presenting behaviour since 2016 indicates elements of antisocial behaviour and some symptoms of psychosis, which appears to be precipitated by drugs use (cannabis)…".

5.36 Mr A was seen by his Care Coordinator (CCO4) on 15 December 2017 when Mr A reported he was reducing the dose of olanzapine because he did not want to be taking it when working in France. CCO4 expressed some concerns over Mr A's psychosis if he reduced his medication too quickly. However, Mr A left for France on 16 December 2017 so was discharged from the CMHT.

5.37 Mr A's Section 117 aftercare responsibility remained with Devon County Council and NHS Devon CCG following his discharge from Cygnet Hospital Kewstoke. When it was known that he had left the country for France, mental health services in Devon discharged him from Section 117 aftercare.

Summary and comment

5.38 There does not appear to be any explanation in the records from Cygnet Hospital Kewstoke for the change in diagnosis from schizophrenia which was agreed by CP2 at the end of Mr A's first admission to Cygnet Hospital Kewstoke and by the forensic psychiatry assessment in July 2016 during that admission.

5.39 There is no justification in the records for the "provisional" diagnosis of antisocial personality disorder, apart from the descriptions of Mr A's presenting behaviour during the second admission to Cygnet Hospital Kewstoke.

5.40 The fact that Mr A was described as behaving very well on his return to Cygnet Hospital Kewstoke in November 2017 does not seem to have had an impact on CP2's views of his diagnosis. By this time, Mr A had been treated with anti-psychotic medication for at least six weeks and was noted to not show any signs of psychosis. This would suggest that it was psychosis that was driving this behaviour.

5.41 It is difficult to understand why the diagnosis of drug induced psychosis was still being used by the time of his discharge in November 2017:

- Firstly, because when he was arrested in Harrow in August 2017 his drug screen was negative, and on admission to Cygnet Kewstoke several days later, it was still reported as negative, and there is no report of any suspicion or urine drug screens showing evidence of drug use during that admission.
- Secondly, if it was felt that use of drugs was a factor in his psychotic illness, it would be more likely that drug use had precipitated a further episode of his schizophrenia/schizo-affective disorder.

5.42 The issue of coming to the appropriate diagnosis is not just an academic question but is essential to ensure continuity of care between episodes of illness. This is particularly important in patients such as Mr A who do not engage with community services, and who then go on to leave the country.

5.43 The fact that the STEP team recorded a diagnosis of drug induced psychosis would influence anyone who subsequently assessed Mr A and contacted Devon Partnership NHS Trust for information, as was the case when he was assessed in London in August 2017.

5.44 It can also influence treatment, especially decisions about longer-term care following discharge from hospital. For example, a patient diagnosed with a drug induced psychosis might be less likely to be placed on a CTO than a patient with schizophrenia who is known to not engage consistently in the community, not take medication when not detained under the MHA and who may abuse drugs.

5.45 It is not surprising that the assessment from AWP came to the conclusion they did regarding diagnosis, because they would have relied on the recommendations from Cygnet Hospital Kewstoke. It was documented, and confirmed during interview with us, that clinical staff in Wiltshire had had concerns about Mr A stopping medication so soon. However, Mr A was not subject to a CTO because he had been discharged from Section 3 immediately prior to discharge from Cygnet Hospital Kewstoke. Therefore, clinical staff in Wiltshire were not able to intervene using the provisions that a CTO would have provided.

Recommendation 1: Cygnet Health Care and Devon Partnership NHS Trust must ensure that any changes to a diagnosis are formally documented and include the rationale and evidence base for such change, and agreed to by the patient's consultant psychiatrist. This information must be included in all relevant discharge communication between clinical services.

Use of a Community Treatment Order (CTO)

5.46 The forensic psychiatry assessment dated 30 August 2016 recommended use of a CTO on discharge from hospital. It was considered by CP2 in discussion with CCO1 (from the STEP team) and was not thought to be necessary.

5.47 In our opinion this decision could be justified as this was Mr A's first admission and he was saying he would take anti-psychotic medication when discharged. However, he quickly reduced the dose, stopped it and left the country.

5.48 It is our view that there appears to be less reason to justify not applying for a CTO before his discharge from Cygnet Hospital Kewstoke in November 2017. As this was the same RC as previously, it is reasonable to believe that CP2 would have been aware of the issues that arose following Mr A's previous discharge in 2016. Therefore, Mr A's statement that he would take the oral anti-psychotic medication following discharge should, at the very least, have been challenged.

5.49 Mr A's plan to leave again for France shortly after discharge was known by CP2 but does not seem to have caused any concerns about the effect this would have on his need to take anti-psychotic medication following discharge in order to remain well.

5.50 Although being on a CTO would not have prevented Mr A from leaving the country, on his return it would have acted as a prompt to assess his mental state. A patient who is subject to a CTO will be expected to comply with certain conditions. In Mr A's case these conditions might have included a requirement to comply with a specific medication regime on the basis of his history of disengagement and poor compliance. Had Mr A previously been subject to a CTO when he presented to the L&D service in February 2019, it might have prompted a more assertive response from services.

5.51 In addition, the presence of a CTO would have provided a framework for the CMHT in Wiltshire to consider a further period of inpatient assessment to assess his mental state when Mr A reported he did not want to take his medication.

Discharge from Section 117 aftercare

5.52 The MHA Code of Practice makes clear that discharge from Section 117 aftercare can only be done when the clinical commissioning group and local authority are satisfied that the patient no longer requires it. The MHA Code of Practice also states that discharge from Section 117 after care cannot be done solely because the patient has been discharged by specialist mental health services.

5.53 When the community team in Devon learned from the community team in Wiltshire that Mr A had left the country, it was documented that Mr A was discharged from Section 117 aftercare and the community team. We sought to understand the rationale for this decision. We were told that at the time there were a lot of patients on the caseload of the Devon community team who were no longer subject to Section 117 aftercare and that there was pressure to discharge patients.

5.54 Under Section 117(2) of the MHA the duty to provide after care arising from a period of detention continues until a decision is made by "the clinical commissioning group or Local Health Board and the local social services authority [that they are] are satisfied that the person concerned is no longer in need of such services".

5.55 There was no evidence that Mr A no longer had mental health needs that required treatment and therefore it is our opinion that Section 117 was inappropriately discharged. Had Section 117 remained in place when the L&D services were asked to assess Mr A in February 2019, it is possible that a more assertive response from services may have been forthcoming.

Recommendation 2: Devon County Council and NHS Devon Clinical Commissioning Group must ensure that discharges from Section 117 aftercare enacted by Devon Partnership NHS Trust on behalf of health and social care commissioners are in keeping with the Section 117 aftercare legislation.

Medication management and monitoring compliance

5.56 As we have previously discussed, on the two occasions that Mr A was discharged from hospital he quickly sought to reduce or stop oral medication.

5.57 On discharge from hospital on 12 September 2016 Mr A very quickly sought to reduce the dose of olanzapine:

- by 27 September 2016 it had been from 20mg to 15mg;
- on 24 October 2016 Mr A reported he was "just about tolerating" 10mg; and
- on 17 November 2016 it was documented that Mr A had reduced the dose to 5mg.

5.58 Mr A attended just four appointments in the community (three with his Care Coordinator (CCO1) and one with a doctor for a medical review). The last direct contact with mental health services was on 17 November 2016 before Mr A went to work in France in January 2017.

5.59 The forensic assessment report that had been completed on 30 August 2016 had stated that clinical staff should consider prescribing depot anti-psychotic medication if Mr A's compliance with oral medication in the community was poor. There is no indication that this option was considered at this point.

5.60 On discharge from hospital on 27 November 2017 Mr A again quickly expressed a desire to reduce or stop medication. In a discussion with his Care Coordinator (CCO4) on 12 December 2017 Mr A stated he found olanzapine 10mg too sedating and sought advice about whether it could be reduced to 5mg or stopped altogether. The following day Mr A reported that he would be leaving in the following 24 hours to work in France for a few months.

5.61 In common with other "second generation" anti-psychotic drugs, olanzapine is much less likely to cause problems with parkinsonian and akathisia side effects which produce tremors and involuntary movements in patients on the older type of anti-psychotic medications. However, it is more likely to cause weight gain, drowsiness and sometimes low blood pressure which might cause some dizziness. Most side effects, including drowsiness, become less prominent after several weeks of treatment.

Risk assessments and risk management plans

Devon Partnership NHS Trust

5.62 The Trust policy on assessment and management of risk is described in the Clinical Risk Assessment and Management Policy issued in June 2016.

5.63 The policy describes actions and responsibilities for different clinicians and managers within the organisation and sets out best practice for effective risk management. This includes:

- *"Risk management being based on an assessment that incorporates a structured clinical judgement approach using valid tools or structured prompts.*
- *Risk assessment not relying on self-reports; information should be corroborated or triangulated where possible. Historic and actuarial factors should be considered in addition to current presentation; this avoids a partial 'cross-sectional' conception of risk providing false reassurance.*
- *Risk management must include guidance and individualised support plans."*

5.64 The policy states that risk assessment using a tool or structured prompt should be undertaken at first presentation to mental health services, then reviewed at a minimum of every six months, or more frequently if clinically indicated.

5.65 The risk screening section of the assessment provides 12 categories and staff are expected to ensure that all categories of risk have a documented clinical rationale, a management plan and observation level. We can see that risk assessments were completed for Mr A on nine occasions; a summary of those assessments can be found in below.

Table 3: Risk assessments and risk management plans completed by Devon Partnership NHS Trust staff

Risk screening categories – inpatient form	
1. Suicide 2. Absconding 3. Deliberate self-harm 4. Self-neglect 5. Non-adherence with treatment 6. Violent, aggressive, intimidating behaviour	7. Inappropriate sexual behaviour 8. Using or supplying drugs or alcohol 9. Arson or accidental fire setting 10. Risk to staff 11. Risk of harmful substance withdrawal 12. Other risk factors

Date	**Diagnosis**	**Current risks** *** See table above for codes**	**Historical risks** *** See table above for codes**	**Risk level and comment**
11/06/2016	First episode psychosis	6; 8	6; 8	Medium Completed on admission to hospital.
13/06/2016	First episode psychosis	2; 5; 6; 8; 10; 11	Unknown	High Mr A's family reported violence and aggression from Mr A including threats to kill his father. Mr A had stated this was because his father asked him to help kill his mother. Mr A had threatened staff with a pool cue. Reported that ward staff sexually assaulted him as a child.
17/06/2016	First episode psychosis	2; 5; 6; 8; 9; 10; 12	2; 5; 6; 8; 9; 10; 11; 12	High Intermittent observations after being intimidating and aggressive towards staff. Started a fire in his room, confrontational towards staff, held other patients "hostage" while fire alarm was activating. Removed to seclusion, no remorse shown.

Date	Diagnosis	Current risks * See table above for codes	Historical risks * See table above for codes	Risk level and comment
29/06/2016	First episode psychosis	Self-neglect Harmful alcohol/drug use Risk to others	N/A	Discharged from Section 2 Cygnet Hospital Kewstoke. Forensic report requested. Remains a risk to others, history of arson, “hostage-taking”, violence and aggression towards staff. Discharge – whereabouts likely to be unknown.
26/07/2016	First episode psychosis	Suffers from major mental illness History and risk of violence Substance misuse	N/A	Risk to others. Currently detained.
06/02/2017	First episode psychosis	Suffers from major mental illness History and risk of violence Substance misuse Risk of self-neglect	N/A	At times of high agitation, risk towards parents and respective partners. Possible return to use of illicit substances will trigger a relapse at some point. Mr A currently in France; date of planned return to UK unknown.
26/04/2017	First episode psychosis		Risk of self-neglect Risks to others – violence, weapons, fire setting	Mr A residing in France – information from Mr A’s Nearest Relative, now former partner. No contact with Mr A since being discharged.
11/02/2019	First episode psychosis	Suffers from major mental illness Violence	Violence	Risk of harm to others through compromised mental state including violence, aggression and assaultive behaviours. Risk of further offending due to current mental state. Risk of accidental harm through current mental state and impulsive risk behaviours. Referred for MHA assessment due to mental state presentation and risks towards others.

Date	Diagnosis	Current risks * See table above for codes	Historical risks * See table above for codes	Risk level and comment
11/02/2019	First episode psychosis	2; 4; 5; 6; 7; 8; 10; 11; 12	2; 5; 6; 8; 9; 10; 11; 12	Level 4 observations Significant risk of recent violence, admit to seclusion in first instance.

5.66 No risk assessments were completed by Trust staff between April 2017 and February 2019, noting that Mr A was out of the country from approximately late 2016 to April 2017, and December 2017 to March 2018. During this time Trust staff had been contacted by:

- Devon and Cornwall Police asking for information about Mr A (1 August 2017);
- Mr A's mother expressing concern that he was again unwell (2 August 2017);
- Devon and Cornwall Police asking for information after Mr A had been reported as a vulnerable missing person (2 August 2017); and
- Devon and Cornwall Police regarding concerns that there was a deterioration in Mr A's mental health (4 August 2017).

5.67 On 14 August 2017 Trust staff from the Criminal Justice Liaison and Diversion Team were asked to assess Mr A after he had been arrested for assaulting a police officer. There is no record of a risk assessment being completed at that time. Despite a discussion being documented with the crisis team, there is no indication that during that assessment Mr A's previously documented risks were reviewed and taken into account.

5.68 On 22 August 2017 Mr A was admitted to Cygnet Hospital Kewstoke after being arrested for dangerous driving. The placement at Cygnet Hospital Kewstoke was funded and overseen by Trust staff.

5.69 On 14 September 2017 staff from the Trust were involved in completing an MHA assessment to consider whether to detain Mr A under Section 3. However, no risk assessment was completed at this time.

5.70 Mr A was referred by CCO3 to Avon and Wiltshire Partnership NHS Foundation Trust in November 2017 prior to his discharge from Cygnet Hospital Kewstoke on 27 November 2017. We have seen no evidence of a risk assessment being updated at that time.

Cygnet Hospital Kewstoke and Cygnet Hospital Blackheath

5.71 Mr A had four periods of admission to services provided by Cygnet Health Care:

- 17 June 2016 to 12 September 2016 to the PICU at Cygnet Hospital Kewstoke;
- 22 August to 22 September 2017 to the PICU at Cygnet Hospital Kewstoke;
- 22 September to 4 November 2017 to the PICU at Cygnet Hospital Blackheath; and
- 4 to 27 November 2017 to the acute ward at Cygnet Hospital Kewstoke.

5.72 Cygnet Health Care uses the Short-Term Assessment of Risk and Treatability (START)[28] risk assessment, and this states that it should be completed for every patient on admission to a ward.

[28] The Short-Term Assessment of Risk and Treatability (START) is a structured tool intended to inform multiple risk domains relevant to everyday mental health clinical practice (e.g. risk to others, suicide, self-harm, self-neglect, substance abuse, unauthorised leave, and victimisation). https://pubmed.ncbi.nlm.nih.gov/17171764/

5.73 We have identified five START risk assessments completed by Cygnet Health Care staff. These have been summarised in **Table 4** below.

Table 4: START risk assessments completed by Cygnet Health Care staff

Date	Signature risk signs	Specific risk estimates	Management plan
16/09/2017	Violence and aggression Cannabis dependent Self-neglect Unauthorised leave	Current risks of: Suicide – low Current and "historic" risks of: Violence – moderate Self-harm – moderate Unauthorised leave – high Substance abuse – moderate Self-neglect – low Being victimised – low	Re-direct and de-escalate Encourage engagement in one-to-one sessions Encourage attendance at drug and alcohol awareness sessions
23/09/2017	Violence and aggression Cannabis dependent Self-neglect Unauthorised leave	Current risks of: Violence – moderate Self-harm – low Suicide – low Unauthorised leave – high Substance abuse – high Self-neglect – high Being victimised – low	One-to-one observations Monitor mental state Monitor vital signs Engage with Mr A daily If aroused or irritable, Mr A and staff to spend time in a quiet environment, offer PRN (as required) medication Encourage engagement in therapy groups
20/10/2017	Violence and aggression Cannabis dependent Self-neglect Unauthorised leave	Current risks of: Violence – low Self-harm – low Suicide – low Unauthorised leave – low Substance abuse – low	One-to-one observations Monitor mental state Monitor vital signs Engage with Mr A daily If aroused or irritable, Mr A and staff to spend time in a quiet environment, offer PRN medication Encourage engagement in therapy groups
04/11/2017	Substance misuse, threatening and violent behaviours, fire setting, Homelessness	Current risks of: Self-harm – low Unauthorised leave – low Current and "historic" risks of: Violence – low Suicide – low	

Date	Signature risk signs	Specific risk estimates	Management plan
		Substance abuse – low Self-neglect – low Being victimised – low	
04/11/2017	Thought disordered, grandiose, threatening behaviour, verbal aggression, substance abuse	"Historic" risks of: Violence – low Unauthorised leave – low Substance abuse – low Self-neglect – moderate Being victimised (if aggressive) – low	Admit to ward 15-minute observations Medications as prescribed

5.74 START is, by definition, a short-term assessment of risk. We have not seen any evidence that consideration was given to assessing Mr A's longitudinal risk.

5.75 In addition, Mr A's risk was documented at multidisciplinary team ward meetings. **Table 5** below provides a summary of those findings.

Table 5: Risks documented at multidisciplinary team ward meetings

Date	Low risks		Medium risks	High risks
24/08/2017	Self-neglect Absconding Violence and aggression Inappropriate sexual behaviour	Substance misuse Arson Risk to staff	Self-harm Self-neglect Non-compliance Vulnerability	
31/08/2017	Suicide Self-harm Self-neglect Non-compliance	Substance misuse Arson Vulnerability	Absconding Violence and aggression Inappropriate sexual behaviour Risk to staff	
07/09/2017	Suicide Self-harm Self-neglect	Non-compliance Substance misuse Arson	Violence and aggression Inappropriate sexual behaviour Risk to staff	Absconding
7/11/2017	No risks documented			
14/11/2017	Suicide Self-harm Self-neglect Absconding Non-compliance Violence and aggression	Inappropriate sexual behaviour Substance misuse Arson Risk to staff Vulnerability		

Date	Low risks		Medium risks	High risks
21/11/2017	Suicide Self-harm Self-neglect Absconding Non-compliance Violence and aggression	Inappropriate sexual behaviour Substance misuse Arson Risk to staff Vulnerability		

5.76 Mr A's "historic" risks were never documented in multidisciplinary team meetings.

Avon and Wiltshire Partnership NHS Foundation Trust

5.77 Mr A's care and treatment became the responsibility of Avon and Wiltshire Partnership NHS Foundation Trust when he was discharged from Sandford Ward, Cygnet Hospital Kewstoke on 27 November 2017.

5.78 The first risk assessment was completed on 4 December 2017. This risk assessment identified the following risks:

- Risk of harm to himself (suicidal ideation) when he ran into traffic on the motorway while trying to escape from the police. It was documented that he was reported to have been under the influence of drugs and with acute temporary psychosis. Risk rating: medium.
- Risk of harm from others (risk of neglect) related to drug misuse. Risk rating: low.
- Risk of harm to others but no categories identified, and no evidence cited. Risk rating: not assessed.
- Other risk behaviours and issues (incidents involving the police); assault on a police officer documented. Risk rating: low.
- Overall risk rating: low

5.79 A second risk assessment was completed on 11 December 2017. This contained predominantly the same information as the assessment completed the previous week, but further information was added to the risk categories of:

- Risk of harm from others: when mental health deteriorates, and social circumstances exacerbate mental health, the deterioration was evidenced in recent issues of losing accommodation and dangerous driving.
- Risk of harm to others: incidents relating to the threats to his father and stealing his father's car (11 June 2016); setting fire to the wardrobe on the acute ward and subsequently preventing patients from leaving (June 2016); assaulting a police officer (14 August 2017); dangerous driving, failing to stop, refusing a drugs test (22 August 2017); attempts to extort money from a vulnerable patient and antisocial behaviour (September 2017). Risk rating: medium
- Risk of accidents: information relating to harm to others repeated.
- Overall risk rating: medium.

5.80 There did not appear to be any risk management plan arising from these assessments.

5.81 Mr A was not seen again by mental health services in Wiltshire and was discharged back to the care of his GP in Wiltshire following his departure to France.

Summary and comment

5.82 Mr A's risks were significant, particularly when he was in the community and not compliant with recommended treatment. It is our opinion that it would have been beneficial for a longitudinal risk assessment to have been completed during his second inpatient stay.

5.83 Risk assessments should lead to risk formulation and risk management. The risk assessments completed for Mr A appear to be a series of forms with little evidence of a change in recommendations for the management of the risk. The exception to this was the forensic report completed by DPT in August 2016; it included a clear description of his future risk and recommendations for the management of that risk. However, there is no evidence that future decisions regarding Mr A's risk and management were informed by this report.

Recommendation 3: Where a forensic assessment has been undertaken in the previous 12 to 18 months, Cygnet Health Care, Devon Partnership NHS Trust, and any provider contracted by Devon Partnership Trust must follow the advice within unless there is good reason not to do so. In which case they must formally document the rationale why the advice is not being followed.

Recommendation 4: Devon Partnership NHS Trust must ensure that risk assessments lead to risk formulation and risk management.

Serious incident follow-up

5.84 Overnight on 16 to 17 June 2016 Mr A set fire to a wardrobe in his bedroom on Moorland View Ward at North Devon District Hospital. When the fire alarms sounded, he refused to allow fellow patients to leave the ward and barricaded himself with them in the patients' lounge. Ward staff eventually broke through the barricade and Mr A was subsequently managed in seclusion before being transferred to a PICU.

5.85 DPT staff reported the incident to the police immediately (during the night) and requested police attendance. It was documented that the police did not attend straight away because they did not consider it to be an emergency, Mr A was in a "safe place" and that the police would attend in the morning (presumably during normal working hours).

5.86 The incident was reported on the DPT incident management system and the police log number was documented.

5.87 During the following 24 hours DPT staff documented information from a number of other patients who reported that on the evening prior to the incident, Mr A had been asking others for aerosol cans and that he had told another patient that they would not get much sleep that night because it was going to be very hot.

5.88 CP1 sent an email to Devon and Cornwall Police on 28 July 2016 regarding the incident in which he stated that it was his opinion that although Mr A "was suffering with psychotic symptoms during the admission, the incident in question was pre-meditated and calculated". CP1 further documented that he considered that it would be detrimental to Mr A not to proceed with a criminal investigation "because he would learn that he could get away with such behaviour".

5.89 There are no further references in Mr A's clinical records to any later follow-up with the police regarding the incident.

5.90 There is no guidance available to staff to indicate what further action should be taken by frontline staff or managers when such an incident has been recorded and reported to the police. It is also not clear to us what information staff are expected to document in the clinical record of a patient after an incident of this kind.

Recommendation 5: Devon Partnership NHS Trust must provide clear guidance to frontline staff and managers regarding how to escalate concerns relating to criminal offences committed on Trust property. The guidance must also provide clarity about what information staff are expected to document in the relevant clinical record.

Forensic assessment

5.91 Mr A was referred for a forensic assessment in June 2016 following significant risk incidents involving:

- threatening to kill his father;
- stealing his father's car;
- setting fire to his wardrobe on an acute mental health ward; and
- taking patients "hostage" while the fire alarms were sounding.

5.92 The conclusion of that assessment was that Mr A's "insight into his mental disorder and the consequence of his actions when mentally unwell remained poor and untested in a community setting". The assessment also concluded that it would be important for Mental Health Review Tribunals to be aware of these incidents so that in the future Mr A's "care and treatment can be provided assertively under the MHA, if necessary, in order to prevent risk of harm to others".

5.93 The main concern expressed by the forensic assessment was that Mr A had limited insight into his mental disorder and that the structure of the MHA was supporting his good recovery at that time (August 2016). However, without detention under the MHA the risk of harm to himself and others remained unchanged.

5.94 The assessment also clearly stated that if Mr A required treatment in a PICU or a longer period in a secure setting, then re-referral to forensic services could be considered.

5.95 We found no evidence that the recommendations in this assessment were considered during Mr A's second admission to Cygnet Hospital Kewstoke in August 2017. We consider this to be a missed opportunity.

DPT oversight of mental health care needs

5.96 The majority of Mr A's care and treatment was provided by Cygnet Hospital Kewstoke and Cygnet Hospital Blackheath. This is because there was no psychiatric intensive care provision in Devon until the new PICU at Wonford Hospital in Exeter opened in January 2019. This unit became fully operational in April 2019.

5.97 Mr A's admissions to a PICU in June 2016 and then August 2017 were funded by DPT under an Individual Patient Placement contract. NHS Devon CCG had devolved responsibility to DPT to commission individual placements for patients with complex needs or whose needs could not be met by services within Devon.

5.98 DPT is responsible for the whole commissioning function for this group of patients, including planning, procurement, monitoring and evaluation of commissioned services.

5.99 Through this commissioning function DPT has two clear aims:

- to reduce the number of patients placed out of area;
- to ensure financially sustainable services were either provided or commissioned.

5.100 DPT tendered for the provision of PICU services. A one year contract was awarded to Cygnet Hospital Kewstoke from 1 April 2016 for eight male beds. Female beds were placed in Cygnet

Hospital, Beckton, London. The contract was renewable on a yearly basis until the PICU in Exeter provided by DPT was fully operational in April 2019

5.101 We learned that DPT also has contracts with Cygnet Health Care for the provision of acute mental health beds at Taunton and Weston-Super-Mare. Mr A was transferred to an acute bed at Cygnet Hospital Kewstoke on discharge from Cygnet Hospital Blackheath in early November 2017.

5.102 DPT has a clinical team of Urgent and Emergency Care Repatriation Workers. These staff are allocated named units for which they are the point of contact and a caseload of patients for whom they are responsible while the patients are placed out of area. We learned that the workers are the key link:

- internally with the Bed Capacity Team;
- externally with the out-of-area provider;
- externally with the family of the patient who has been placed;
- externally with DPT commissioners.

5.103 It is the responsibility of the Urgent and Emergency Care Repatriation Workers to undertake regular site visits with the out-of-area providers and to participate in the twice-weekly PICU bed telephone call. They are also responsible for uploading any clinical data from the out-of-area provider to the patient's electronic record held by DPT.

5.104 DPT has a quality assurance framework that it applies to all contracts. This includes:

- monthly checks with the Care Quality Commission (CQC).[29] DPT will not contract with any provider that is rated inadequate;
- review of service user and carer feedback, including compliments and complaints;
- site visits;
- review of advocacy reports;
- review of Care Programme Approach (CPA) reports and MHA First Tier Tribunal reports;
- monitoring of achievement of key performance indicators including safeguarding referrals, incidents, staff vacancy rates, use of agency staff, mandatory training compliance.

5.105 DPT produces a provider dashboard for each provider, which is reported to the Directorate Governance Board, and then to the Commissioning Board.

5.106 This approach to the oversight of patients placed in other provider units is very good practice with considerable resources assigned to the function.

5.107 However, when considering the improvements that could have been made in Mr A's longer-term care and treatment, we consider that he would have benefitted from being under the care and treatment of a local team prior to discharge into the community. When discharged from Cygnet Hospital Kewstoke, on both occasions Mr A was discharged straight to a community package of care that he then swiftly disengaged from.

5.108 Although DPT had good oversight of Mr A's pathway in and out of Cygnet Health Care, there was insufficient strategic oversight of his longer-term community-based care and treatment.

[29] The Care Quality Commission (CQC) is the independent regular of health and social care in England. https://www.cqc.org.uk/about-us/our-purpose-role/who-we-are

Recommendation 6: Devon Partnership NHS Trust (DPT) must ensure that there is clearly documented communication and liaison with a patient's clinical team when considering a patient's needs prior to discharge from an independent provider. DPT must also ensure that there is a shared and agreed plan if detention under the Mental Health Act is rescinded by independent providers commissioned by DPT.

Communication with Mr A's mother following his discharge from Juniper Ward PICU

5.109 Following Mr A's admission to Juniper Ward PICU at Wonford Hospital, Exeter, on 11 February 2019, his mother contacted the ward and made arrangements to visit him on 13 February when hopefully his presentation would have been more settled.

5.110 Following Mr A's discharge and concurrent arrest in the early hours of 13 February, ward staff documented that a plan would be required to inform Mrs A of what had happened. Clinical records indicate that the Chief Operations Manager (COM) would be responsible for this.

5.111 Despite this, Mrs A received no contact from any managers at DPT to inform her of Mr A's discharge and when she called the ward, she spoke to a member of staff who did not put the phone on mute and she heard them say "it's his mother and she knows nothing". Mrs A told us she was very distressed that she had no support from any organisation and, despite being Mr A's Nearest Relative and his next of kin, she was not given any information from mental health services.

5.112 Mrs A then spoke to L&D staff to try to establish what was happening, but she was not given any information and was told that staff would escalate her request.

5.113 Mrs A then contacted the AMHP team and was advised that a senior manager from Juniper Ward would be asked to contact her.

5.114 There is no evidence that any manager from DPT contacted her, and this was confirmed to us by Mrs A.

5.115 When an untoward event such as this happens, there should be clear guidance to staff and managers about how communication with families and carers is managed and documented.

Recommendation 7: Devon Partnership NHS Trust must ensure that there is clear guidance for staff and managers about how communication with families and carers is managed and documented if there is a significant issue (such as this) affecting the care of an inpatient.

Missed opportunities on Mr A's return from France

5.116 The terms of reference require us to consider missed opportunities on the occasions when Mr A returned from France.

5.117 It is not clear from Mr A's clinical records when he returned from France on either occasion. We know that he left the UK on two occasions:

- late January/early February 2017; and
- December 2017.

5.118 Records show that in April 2017 Miss D reported that she did not know where Mr A was and that she was unable to comment about his mental state. It was documented at that time that Mr A would be discharged back to his GP with a rapid re-access plan in place if he required further assessment on his return from France.

5.119 Given that Mr A had no previous contact with mental health services prior to him becoming unwell the previous year, we consider this decision to have been appropriate. It is possible that the decision could have been strengthened by ensuring that Mr A's family also had this information.

However, at that time Miss D was nominated as Mr A's Nearest Relative and Mr A was reluctant for information to be shared with his mother.

5.120 To our knowledge Mr A had no contact with mental health services during 2018. The clinical records that we have reviewed do not indicate when he returned to the UK.

5.121 Mr A had been discharged back to the care of his GP in December 2017. At that time, it was documented that Mr A's mother intended to continue to collect medication from the GP and send it to Mr A in France. Again, we consider this to have been an appropriate decision, given that Mr A was not going to be in the UK for several months.

5.122 On this occasion we consider that the decision could have been strengthened by AWP staff by ensuring that Mr A's mother had a clear plan of how to contact mental health services should Mr A become unwell on his return to the UK. However, it is our view that this alone would not have made a material difference without information about Mr A's diagnosis and associated risks being clearly documented.

Inter-agency and inter-service liaison from 8 February 2019 onwards

5.123 The terms of reference for this investigation require us to review the quality of inter-agency and inter-service liaison, communication, decision making and planning from the time of Mr A's detention on 8 February 2019 to the date of the incident. However, this panel has only had access to Mr A's healthcare information.

5.124 Inter-agency and inter-service liaison is considered within the systems report where the evidence gathered has included information from all agencies involved in dealing with Mr A during this period. That report should be reviewed for analysis on this aspect of the terms of reference.

6 Duty of Candour

6.1 We have reviewed the Trust's recording of its actions under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20 (as set out in Appendix C). For NHS organisations, this was introduced on 24 November 2014, and implemented for all other organisations in April 2015. In interpreting the regulation on the Duty of Candour, the Care Quality Commission uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

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

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

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

6.3 We have included the full excerpt of the regulations at Appendix C.

6.4 The regulations are clear that the "*relevant person*" for communication about a notifiable safety incident, to whom Duty of Candour applies, means the service user, or on the death of the service user, a person acting lawfully on their behalf, or where the patients lacks capacity in relation to the matter, a person acting lawfully on their behalf.

6.5 At no time was it documented that Mr A was considered to have lacked capacity. Therefore, in this case, Mr A was the "*relevant person*".

6.6 The Trust Being Open and Duty of Candour policy in place at the time stated that a Trust must review an incident within 48 hours and identify whether it met the requirements for statutory Duty of Candour. If so, the manager must then appoint a lead person to write to the "relevant person" offering an apology within ten working days of the incident being identified. The "relevant person" should also receive a copy of the investigation report.

6.7 There is no indication of any attempts to consider or execute the statutory Duty of Candour responsibility to Mr A. Following an interview with a senior manager from Devon Partnership NHS Trust we were told that although the case was "the most serious we would likely report" it was not

"considered as a patient safety incident". The Trust justified this on the basis that the incidents (the deaths of the elderly gentlemen) did not report specific harm to Mr A.

6.8 We have carefully considered the Trust's stated position and have concluded that there was not a requirement to execute Duty of Candour to Mr A. At the time of the offences, Mr A was not subject to any section of the MHA, he was not on the caseload of the Trust and some efforts had been made to provide him with information about how to access Trust services.

Communication with Mr A's mother

6.9 We heard from Mr A's mother that following the incidents in February 2019, communication by Devon Partnership NHS Trust with her was minimal. Mr A's mother expressed particular discontent about the lack of any information after Mr A's detention under Section 2 MHA had been rescinded in February 2019.

6.10 We have previously made a recommendation to NHS England to produce clear guidance for organisations regarding Duty of Candour when there is an incident that is also the subject of a serious criminal investigation. Therefore, we have not made the same recommendation here.

Recommendation 8: Devon Partnership NHS Trust (DPT) must ensure that local policies clarify how to consider and apply Duty of Candour regarding an incident that is also the subject of a criminal investigation, with the expectation that decisions made should be documented.

6.11 There is no reference in the Duty of Candour or Serious Incident policies to the Trust's approach to engaging families affected by homicide and serious incidents. NHS England (London) Investigation issued guidance in April 2019 on engaging with families after a mental health homicide[30]. This provides clear best practice guidance to mental health provider organisations and states that "families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation". The Trust should review this publication and ensure that its own policy reflects the actions taken by the Chief Executive at the time and the best practice referenced.

Recommendation 9: Devon Partnership NHS Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide: Mental Health-Related Homicide: Information for Mental Health Providers (April 2019) NHS England (London) Investigations.

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

7 Internal investigation

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

- if the investigation satisfied its own terms of reference;
- if all key issues and lessons have been identified and shared; and
- whether recommendations are appropriate and comprehensive and flow from the lessons learned.

7.2 We are also required to:

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

7.3 We have developed a robust framework 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,[31] NHS England Serious Incident Framework (SIF) and the National Quality Board Guidance on Learning from Deaths.[32] We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

7.4 In developing our framework, we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA[2] (or root cause analysis and action, hence 'RCA Squared')[33] which discusses how to get the best out of root cause analysis investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

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

- standards met: 12;
- standards partially met: seven;
- standards not met: six.

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

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

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

7.6 We discuss our analysis below.

Analysis of jointly commissioned internal investigation

7.7 The internal investigation was commissioned jointly by Devon Partnership NHS Trust and Avon and Wiltshire Partnership NHS Foundation Trust. It was undertaken by an external organisation, Enable East. The website for Enable East describes an independent NHS team, offering an alternative to commercial management consultancies. We heard from Devon Partnership NHS Trust that they had previously commissioned Enable East to undertake investigations for them and due to the nature of the incident, it felt appropriate to commission them for this case.

7.8 The NHS England Serious Incident Framework states that internal investigation should be completed within 60 working days. The incidents occurred on 10 February 2019 and the investigation report is dated March 2020. This is beyond 60 working days and although this is not uncommon for investigations where there is an associated complex criminal investigation, there is no explanation in the report of whether there was an extension or a 'stop the clock' agreed.

7.9 NHS Devon CCG was responsible for the oversight of the internal investigation as the incident occurred in Devon and Devon mental health services (rather than AWP) were the last staff to have contact with Mr A. NHS Devon CCG has not provided us with any detailed information about how the extended timeframe was managed.

7.10 Mr A's family was not involved in developing the terms of reference, but the investigator included a summary of an interview with his mother that took place after the conclusion of the criminal proceedings.

7.11 We consider that the internal investigation satisfied the terms of reference set; our findings are detailed in **Table 6** below.

Table 6: Terms of reference for internal investigation

Internal investigation terms of reference To review:		**Niche comment**
1	The engagement, assessment, treatment and care that the patient received from Devon Partnership NHS Trust and Avon and Wiltshire Partnership NHS Foundation Trust from 2017 to 2019 including the quality and scope of risk assessment and management plans, care planning, treatment and level of supervision provided.	The report considered the engagement, assessment, treatment and care that Mr A received from both Trusts.
2	The contact between relevant agencies to assess if risks were fully understood and addressed.	The report considered contact between agencies but did not consider in detail the contact between Cygnet Health Care and its commissioning organisation Devon Partnership NHS Trust. The report mentions that it was reported to the author that Cygnet Health Care had declined to participate in the internal review.

Internal investigation terms of reference To review:		Niche comment
3	The number of contacts that the patient had with the relevant agencies, including Devon Partnership NHS Trust, Avon and Wiltshire Partnership NHS Foundation Trust and the Police, and whether further multi-agency working may have assisted in assessing and mitigating the risk posed by the patient.	Contact between Mr A, Devon Partnership NHS Trust, and Avon and Wiltshire Partnership NHS Foundation Trust is discussed. However, the report does not address whether further multi-agency working may have assisted in assessing and mitigating the risk posed by Mr A.
4	The effectiveness of ongoing care and treatment and whether the service provided accorded with recognised good practice.	Ongoing care and treatment are discussed, alongside what is considered to be good practice.
5	The application and management of the Mental Health Act.	Application and management of the Mental Health Act is addressed.
6	Areas for service improvement and areas of good practice.	Good practice and areas for improvement are set out.

7.12 The report does not describe how root cause analysis tools were used to arrive at the findings and it does not identify care delivery problems or service delivery problems.

7.13 At paragraph 3.32 the report author stated that suggestions were made regarding "fundamental and contributory causes", but it was not possible to gain a complete picture by looking at only one aspect of the range of services provided. Hence the recommendation regarding the need for a multi-agency review.

7.14 There was no use of classification frameworks or examination of human factors. No root cause is described, but the report concluded that "a significant contributory factor may have been his non concordance with his medication".

7.15 Other contributory factors included:

- the diffusion of responsibility regarding his care (across agencies and geographical areas);
- a failure to fully appreciate Mr A's "psychiatric pattern";
- a failure to recognise the level of risk and the extent and pattern of criminal behaviours; and
- the demand on services over the weekend of 8 to 10 February 2019.

7.16 Learning was identified and six recommendations were made for Devon Partnership NHS Trust:

R1 *"The Trust should ensure that it has an agreement in place with partner agencies, which provides a clear procedure and line of communication, to pursue as appropriate criminal investigation and action. This should include the procedure for informing health staff if criminal investigations are not to be pursued. The Trust should also review evidence to determine if the views expressed by staff that appropriate criminal action is not pursued with clients known to mental health services have substance.*

R2 *Trust senior staff should liaise with senior staff in partner organisations to share information from individual organisational investigations and undertake a multi-organisational review of this case. This review should recognise each organisation's legislative requirements and capacity demands and improve the speed of access to services.*

R3 *As the [Devon Liaison and Diversion] DL&D service operating hours, together with the time constraints of PACE regulations, and the reported pressure on [Devon County Council Emergency Duty Team] DCCEDT services compromised the provision of an MHA*

assessment I recommend that DPT ask services commissioners to review current operating arrangements.

R4 As it is possible that partner agencies, including the private hospital provider, Police and Devon County Council, will need to make contact with [Mr A] as part of their investigations, I recommend that any approach to [Mr A] on behalf of AWP and DPT is coordinated with those agencies.

R5 The Caldicott Guardian should be asked to determine how circulation of this report should be managed having consideration of policies on confidentiality, data protection and information governance. This consideration will need to be made jointly with the [Avon and Wiltshire Partnership NHS Foundation Trust] A&W Caldicott Guardian.

R6 The Trust should develop an action plan to address the recommendations contained within this report which meets the minimum requirements for actions listed within the NHS England Serious Incident Framework."

7.17 Six recommendations were made for Avon and Wiltshire Partnership NHS Foundation Trust:

R1 "The Trust should review any existing protocols regarding communication arrangements and agreements with criminal justice agencies to determine if they require development.

R2 Community Clinical Services should be asked to review arrangements to allow patients with complex needs to have timely review by medical staff.

R3 As it is possible that partner agencies, including the private hospital provider, Police and Devon County Council, will need to make contact with [Mr A] as part of their investigations, I recommend that any approach to [Mr A] on behalf of AWP and DPT is coordinated with those agencies.

R4 Community Clinical Services should be asked to review arrangements for ensuring that available patient information is placed on the Trust's clinical records systems in a timely manner.

R5 The Caldicott Guardian should be asked to determine how circulation of this report should be managed having consideration of policies on confidentiality, data protection and information governance. This consideration will need to be made jointly with the [Devon Partnership NHS Trust] DPT Caldicott Guardian.

R6 The Trust should develop an action plan to address the recommendations contained within this report which meets the minimum requirements for actions listed within the NHS England Serious Incident Framework."

Devon Partnership NHS Trust action plan

7.18 The Trust developed an action plan to respond to the recommendations. We have received a copy of the action plan; the heading states that it was last updated in January 2021, but the filename suggests it was updated more recently (on 5 July 2021). When discussing the action plan progress with managers, one person referred to an action plan update on 14 July 2021. We received a further copy of the action plan indicating it was updated in October 2021. This indicates to us that the action plan remains a live document.

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

7.20 Our measurement criteria are set out in **Figure 4** below.

Figure 4: Niche Investigation Assurance Framework (NIAF) action plan assessment criteria

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

Progress of actions

7.21 The Trust provided evidence of actions for each recommendation. A summary of the Trust narrative on progress, along with our detailed comments, can be found in Appendix F.

7.22 Of the six recommendations, we found that four were complete. We had insufficient evidence from the Trust to be able to assess the completeness of the remaining two recommendations.

7.23 Our assessment of progress of Trust actions is set out in **Table 7** below.

Table 7: Devon Partnership NHS Trust action plan progress

Recommendation	Score	Assessment category
1	0	Insufficient evidence to support action progress/action incomplete/not yet commenced
2	3	Action completed but not yet tested
3	0	Insufficient evidence to support action progress/action incomplete/not yet commenced
4	3	Action completed but not yet tested
5	3	Action completed but not yet tested
6	3	Action completed but not yet tested

Devon Partnership NHS Trust recommendation 1

7.24 The action plan dated 3 September 2020 stated that the target date for completion was the end of November 2020, “Dependent upon current COVID response”.

7.25 The action plan dated 13 July 2021 stated that the target date for completion was 30 January 2022.

7.26 The cited evidence of an agreed protocol in place with evidence of its application being checked against any relevant serious incidents reported is not available. The Trust has stated that the Local Security Manager had been in contact with the Police and had confirmed that there was an existing “Protocol for the Exchange of Information between Statutory Agencies in Devon and Cornwall in Relation to Potentially Dangerous or Mentally Disordered Persons”. However, that would require further review. The Trust has stated that the sharing arrangements are “owned” by the Police, and they would be expected to lead in the review of this protocol. The Trust has further cited that, given the ongoing external review (referred to our report), the target date had been extended to allow for the work to be completed.

7.27 The protocol that was provided by the Trust accompanying the action plan is dated November 2017 and is described as "Version 2.0 – Working Version". We have a number of concerns about the protocol:

- There is no indication that the parties to the protocol have signed up to the content.
- The protocol states it should be reviewed annually, but there is no evidence that it has been reviewed since 2017.
- Appendix 3 provides the contact details for the Nominated Officers from organisations. It is intended that this Appendix is removed from any circulation via an insecure route. However, only part of Appendix 3 was removed when the document was provided to us. This includes individual email addresses, rather than a functional email address; i.e. 'mailto:john.smith@thistrust.nhs.net' rather than (for example) 'mailto:infocompliance@thistrust.nhs.net'. Organisations should be encouraged to implement a functional method of applying the protocol to remove the risk of staff being unable to apply the protocol in the event that the Nominated Officer is not available or has changed and the protocol has not been updated.

7.28 We are concerned that the actions proposed by the Trust do not address the reason for this recommendation being made. The recommendation in the internal report follows narrative of a failure to pursue a criminal justice route after Mr A had set fire to NHS property while an inpatient at Moorland View Ward, North Devon District Hospital. We have not been able to clarify why the Trust would wait for the outcome of our external review before implementing this recommendation.

Devon Partnership NHS Trust recommendation 2

7.29 The Trust has cited our investigation as evidence that this recommendation has been addressed.

Devon Partnership NHS Trust recommendation 3

7.30 The Trust has stated that there will be an internal service review following completion of our multi-agency review to determine any further developments of the service, such as operating hours.

7.31 A further review with the commissioner will also be needed to consider any future service development and impacts on the MHA assessment process. The Trust has stated that the target start date for this work will be within one month of completion of our external review.

7.32 One purpose of the internal investigation was to identify early learning. We are therefore concerned that the Trust has delayed any progress on addressing this recommendation.

Devon Partnership NHS Trust recommendation 4

7.33 The Trust has cited our investigation as evidence that this recommendation has been addressed.

Devon Partnership NHS Trust recommendation 5

7.34 The final report was shared with the commissioner and was closed on Strategic Executive Information System (StEIS)[34] on 22 September 2020.

7.35 The nature of the recommendation does not allow us to assess testing, embeddedness or sustained improvement in relation to this action.

Devon Partnership NHS Trust recommendation 6

7.36 The report and action plan were submitted to commissioners.

[34] StEIS is the system used to report and monitor the progress of Serious Incident investigations across the NHS.

7.37 The nature of the recommendation does not allow us to assess testing, embeddedness or sustained improvement in relation to this action.

Recommendation 10: Devon Partnership NHS Trust must implement the outstanding recommendations from their own report (recommendations 1 and 3) without any further delay.

NHS Devon Clinical Commissioning Group oversight

7.38 NHS Devon CCG had responsibility for oversight of this serious incident. The CCG has a policy that describes the management of serious incidents. This states that when a recognised serious incident occurs it is reported by the provider responsible for the investigation to the CCG and on the Strategic Executive Information System (StEIS).

7.39 Initial notifications are sent to the appropriate teams or individuals within the CCG to whom the serious incident would relate, i.e., commissioners, adult or child safeguarding specialists, or the Director of Nursing.

7.40 When the 72-hour report is received, this is circulated to relevant staff and additional comment is made to the provider if specific or immediate assurance is required.

7.41 Communication takes place between the CCG Safety Systems team and the Risk Management team in the Trust regarding specific incidents, in addition to weekly telephone calls. There was also regular communication on a shared spreadsheet detailing the progress of all serious incidents; this arrangement was in place at the time of the investigation into this incident due to a backlog of serious incidents that in itself required additional oversight.

7.42 When the final draft of an investigation report is received by the CCG, it is allocated to a clinical reviewer for assessment of the quality of the report. The CCG has a standard template for reviewers to complete. This template includes much of the content of the closure checklist provided in the NHS England Serious Incident Framework. However, the template would benefit from revision using the specific questions in the NHS England Serious Incident Framework closure checklist. This would lead to more objective assessments being undertaken, enabling easier identification of reports that do not meet the required standards.

Recommendation 11: The NHS Devon CCG Serious Incident report quality review template should be revised to reflect detailed expectations with NHSE Serious Incident Framework guidance.

7.43 The Trust provided us with a summary of their assessment of the internal investigation in this case:

- Clinical review undertaken
- Multiple services engaged in report
- Not closed on first review due to awaiting more detail / timescales on action plan
- There were no actions highlighted specifically for CCG follow up when the investigation was closed
- The last action plan indicates that NHSE/I have confirmed that they are commissioning an external organisation to complete the review and that it was expected to be completed in 2021.

7.44 We learned from the CCG that the Safety Systems team operates a system of "*provider logbooks*" that provide a central repository of:

- serious incident recommendations and actions;
- information from meetings; and
- quality assurance information.

7.45 This provides a source of ‘soft intelligence’ for all providers and helps to identify trends or areas of concern that CCG patient safety staff may then recommend for themed analysis. This is good practice.

7.46 In April 2021 the CCG received an internal audit report that assessed the way in which serious incidents are managed. The overall assurance was assessed as satisfactory.

7.47 The audit reviewed six areas; those areas and the conclusions are set out in **Table 8** below.

Table 8: NHS Devon Clinical Commissioning Group Final Internal Audit Report: Serious Incidents April 2021 conclusions

Internal audit review area and rating		Internal audit conclusions
Recommendations arising from the CCG’s Review of the Serious Incident Process		There is an appropriate action plan in place that records all the actions raised as a result of the review of the Serious Incident Process, the action lead and the target date for completion. The action plan was approved at the “Nursing and Quality SLT” in October 2020 and its progress will be reported at this meeting on a quarterly basis. As at December 2020, 6 of the 12 actions had been marked as closed. One closed action (action 4) considered that an audit programme of processes should be implemented, to include the effectiveness of changes to the process during 2020. The areas that were to be reviewed in the recommended audit programme include the Serious Incident Decision-making Process; Deletion Process; Serious Incident Closure review; use of Datix and reviewer training. The action plan states that the scope of this internal audit review supports the action’s closure; however, while the agreed scope of our review covers an evaluation of the Serious Incident Closure review timeframes and touches on the use of Datix, it does not provide assurance regarding the other three areas. This action should be reopened as a further review may be required to confirm that the other process changes have been effective.
Compliance with Serious Incident Review timeframe		The current Serious Incident Framework (SIF) requires that the CCG undertakes a review of the final root cause analysis (RCA) report and action plan to ensure it meets requirements for a robust investigation within 20 calendar days. The number of reviewers required to review RCA reports was changed from two to one in March 2020 following the CCG’s Review of the Serious Incident Process to improve the timeliness of completion. This change has not yet been included in the CCG’s Serious Incidents Requiring Investigation Policy. Our review found that there were some delays between the date the RCA report was received and the date the report was sent to reviewers; however, 95% of reports were sent to reviewers within five days. 81% of the reports were reviewed by reviewers (first and second) within 20 days. There has been an improvement in the timeliness of reviews following the change in practice for the review process. The number of days taken to complete reviews that were overdue ranged from 21 to 87 days. The Safety Systems team sends reminders to the reviewers on overdue reviews on a weekly basis and the Nursing and Quality

Internal audit review area and rating		Internal audit conclusions
		Dashboard monitors and records the number of overdue reports received by provider. This information is sent to the Chief Officer on a weekly basis.
Actions from Serious Incident reports are followed up by the CCG		The CCG does not follow up every serious incident action. Actions chosen are currently dependent on the individual reviewer's judgement. Our review of the Provider Action Log found that actions are not consistently monitored to closure. Many actions did not have action leads assigned, target dates for completion recorded and progress updates documented. Not all closed actions had evidence of the action's closure recorded or the date of completion documented. It was recommended following the CCG's review of the Serious Incident Process that a small task and finish group is created to review and reconsider the CCG's role in provider action monitoring to provide a more robust approach and to ensure CCG assurance processes are in place in line with the National Framework. The task and finish group have not yet met. This action was due to be completed by the end of March 2021.
Learning from serious incidents is shared		Learning from serious incidents is shared on an ad hoc basis and as required, but there is no formal process in place to ensure learning is consistently identified and shared. Learning can be identified by the reviewers of RCA reports and also when reporting is completed. There has been minimal reporting on trends of types of incidents in the past year due to Covid-19. One key platform where learning from serious incidents is shared is the Communities of Practice meetings chaired by the Academic Health Science Network (AHSN). The group usually meets four times a year, however these meetings have been postponed due to Covid-19.
Provider serious incident issues are managed		Issues emerging from providers regarding the management of their serious incidents are appropriately escalated within the CCG through the governance framework. Where issues are identified by the CCG, appropriate actions to support the provider were reported.
Management of serious incident risks		There are currently two risks relating to serious incidents recorded on the CCG's Corporate Risk Register. Both are regularly reviewed and reported monthly at the Quality Assurance Committee meetings. Risks that were identified during the CCG's review of the Serious Incident Process, for example, the embeddedness of learning from serious incidents, should be recorded and monitored to ensure there are appropriate controls in place to mitigate these risks. It is understood that Serious Incident Process risks are not recorded due to a wider training issue, and this will be considered as part of our review of risk management at the CCG.

7.48 We were also made aware that the CCG does not follow up every serious incident action. While we recognise that this would require significant resources, we also learned that there was no procedure

for identifying occasions when the CCG might need to have a greater degree of oversight of implementation of provider actions.

7.49 For example, in the case of this incident, the provider action plan has one action that is shown as being nearly two years past the target date for completion. This is of concern particularly as the focus of the recommendation was the management of risk.

7.50 We learned that the CCG will only follow up on the implementation of specific provider actions if the reviewer of the incident report (i.e. the CCG Officer) identifies a particular concern about an aspect or aspects of the report.

7.51 We would recommend that the CCG implements a process to identify high-profile, complex or high-risk serious incidents where the action plan is followed up in detail. This would provide greater assurance.

Recommendation 12: NHS Devon CCG (and any future Integrated Care System) must implement a process to (a) identify high-profile, complex or high-risk serious incidents, (b) ensure that the provider action plan is followed up in detail, (c) seek assurance that all actions are implemented in a timely manner.

Avon and Wiltshire Partnership NHS Foundation Trust action plan

7.52 We heard that when Avon and Wiltshire Partnership NHS Foundation Trust received the final report from Enable East the organisation was focussing on responding to the challenges posed by the Covid-19 pandemic. One of the consequences was that there were significant pressures in delivering clinical services, and standard operating procedures had been amended to allow staff to focus on clinical work.

7.53 Therefore, the usual process of a report being subject to a multidisciplinary and multi-agency panel for ratification did not take place. Neither was the relevant clinical team involved in developing an action plan. The Director of Nursing asked a senior manager to develop an action plan independently of the clinical team and this was accepted by the organisation.

7.54 In Avon and Wiltshire Partnership NHS Foundation Trust the relevant clinical teams hold responsibility for the action plan, and therefore the action plan was later shared with them. In very serious incidents (such as this case) action plans are scrutinised at a multidisciplinary Learning and Improvement Panel that is chaired by the Medical Director. At this meeting the clinical team are required to present updates on their action plans. There are three reasons for that meeting:

- reassurance that actions have been completed;
- assurance of evidence of improvement and if the actions are not making a difference consideration of what needs to be done differently; and
- to support the team if they are struggling to implement an action, in order to review it together.

7.55 This action plan was considered by the Learning and Improvement Panel in 2020 and was discussed in full. The decision was made that the action plan needed to be revised to deliver the changes required. The Clinical Director then devised a new action plan for those recommendations. It is the revised action plan that we have reviewed for the purpose of this report.

Progress of actions

7.56 The Trust provided evidence of actions for each recommendation. A summary of the Trust narrative on progress, along with our detailed comments, can be found in Appendix G. Our assessment criteria is set out on page 61 above.

7.57 Of the six recommendations, we found that three were complete and two were significantly progressed. We had insufficient evidence from the Trust to be able to assess the completeness of the remaining recommendation.

7.58 Our assessment of the progress of Trust actions is set out in **Table 9** below.

Table 9: Avon and Wiltshire Partnership NHS Foundation Trust action plan progress

Recommendation	Score	Assessment category
1	3	Action completed but not yet tested
2	2	Action significantly progressed
3	3	Action completed but not yet tested
4	2	Action significantly progressed
5	0	Insufficient evidence to support action progress/action incomplete/not yet commenced
6	3	Action completed but not yet tested

Avon and Wiltshire Partnership NHS Foundation Trust recommendation 1

7.59 The Trust has stated that no protocols were in place and that no formal protocol has been developed. However, the probation service was invited to attend (and does attend) the locality interface meeting. Technically, the fact that there were no protocols in place and the Trust has reviewed this, means that the action is complete. However, there remains a risk that without a formal protocol, the closer working arrangements that have recently been developed will be at risk of deterioration should there be a change in leadership in either organisation.

Avon and Wiltshire Partnership NHS Foundation Trust recommendation 2

7.60 The Trust has reported that medical reviews take place in accordance with the Care Programme Approach Policy, which states at least annually. The Trust has also reported that there are no concerns with delays, and that patients can be seen urgently if required.

7.61 The Trust has provided a snapshot of patients requiring a review as at 10 October 2021. This shows that:

- 16 patients were overdue a review;
- 4 patients were due to be reviewed within the following 7 days;
- 1 patient was due to be reviewed in the following 7 to 14 days;
- 54 patients were due to be reviewed in the following 3 months;
- 277 patients were due to be reviewed in the following 3+ to 11 months; and
- 29 patients had been reviewed in the previous month.

7.62 There is no evidence that the Trust has considered Standard Operating Procedure (SOP) expectations in relation to review of caseloads by the multidisciplinary team.

7.63 We therefore consider that there is evidence this action has been significantly progressed but is not yet complete.

Avon and Wiltshire Partnership NHS Foundation Trust recommendation 3

7.64 The report and action plan were submitted to commissioners.

7.65 The nature of the recommendation does not allow us to assess testing, embeddedness or sustained improvement in relation to this action.

Avon and Wiltshire Partnership NHS Foundation Trust recommendation 4

7.66 The Trust has provided an agenda for the meeting of the Wiltshire Finance and Planning, Business and Performance Group held on 14 September 2021 as evidence that this action has been completed.

7.67 The Trust has developed a self-assessment tool to for use as part of clinical supervision to audit between two and five care plans per month. The tool has 11 questions or standards to be assessed and encourages documentation of good practice and areas for improvement. We do not have information about how widely used this tool is, nor the impact it has made to clinical practice.

7.68 It is therefore our assessment that this action is significantly progressed, but not yet complete or tested.

Avon and Wiltshire Partnership NHS Foundation Trust recommendation 5

7.69 The Trust has stated that this action was completed on 30 April 2020. No evidence has been provided to support this statement and therefore we are unable to assess the completeness of the action.

Avon and Wiltshire Partnership NHS Foundation Trust recommendation 6

7.70 The report and action plan were submitted to commissioners.

7.71 The nature of the recommendation does not allow us to assess testing, embeddedness or sustained improvement in relation to this action.

NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group oversight

7.72 Bath and North East Somerset, Swindon and Wiltshire (BSW) CCG had responsibility for oversight of the action plan developed by Avon and Wiltshire Partnership NHS Foundation Trust.

7.73 BSW CCG has advised that the case is discussed at Learning and Review Panel meetings that are chaired by AWP and attended by staff from the CCG Nursing and Quality team. CCG staff are reported to be integral to the oversight and scrutiny of the action plan.

7.74 BSW CCG has further advised that the action plan was last reviewed by the AWP Learning and Review Panel on 24 October 2021 when the last action was closed because assurances were given that it had been completed. The action plan was also reviewed by the BSW CCG Serious Incident Panel; closure of the serious incident was agreed in November 2021.

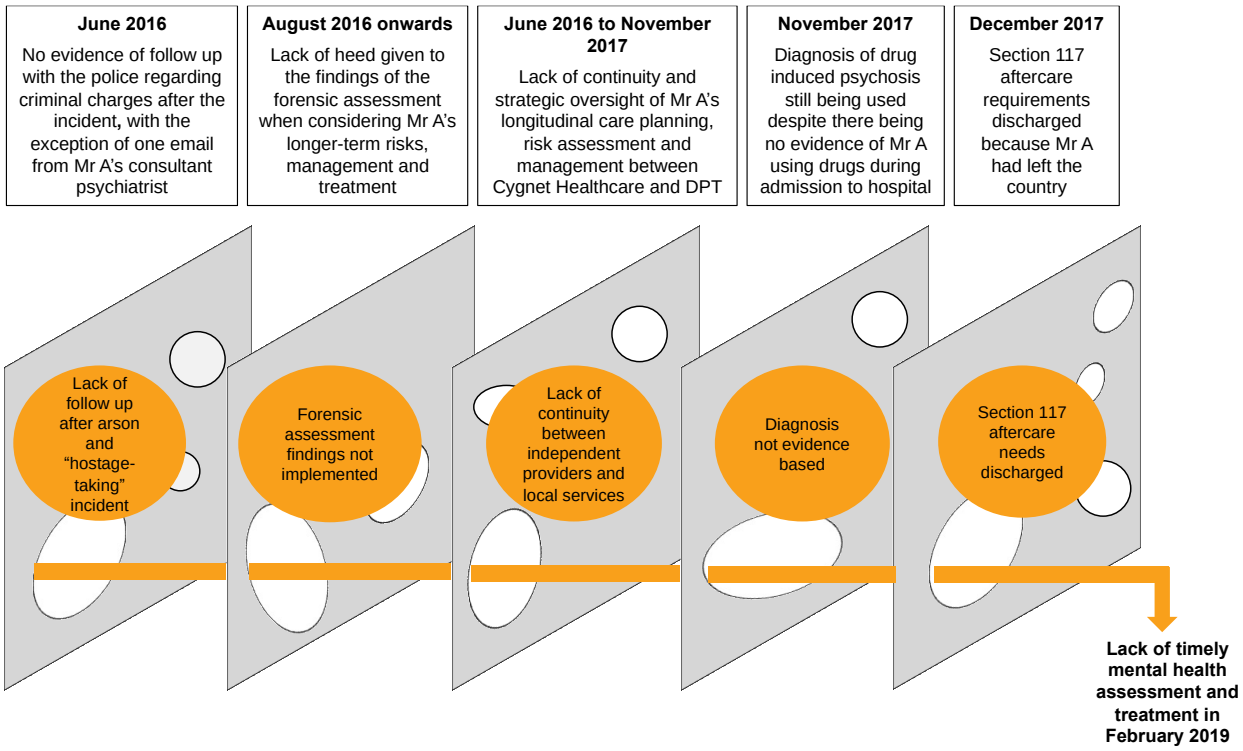
7.75 It is unclear to us how BSW CCG can close a serious incident on StEIS when action plans remain open for other organisations (i.e., DPT).

8 Conclusions and recommendations

8.1 We found that a number of elements of Mr A's mental health care and treatment could have been managed differently.

8.2 The diagram below illustrates the James Reason[35] model of incident risk analysis. The individual elements represent points in Mr A's care pathway where alternative actions could have been taken. Decisions made about Mr A's treatment and follow-up prior to December 2017 contributed to the lack of timely mental health assessment and treatment in February 2019.

Figure 5: James Reason model of incident risk analysis



8.3 There was insufficient follow-up with the police by Trust staff regarding criminal charges being brought against Mr A following the incident of arson and "hostage-taking" on Moorland View Ward in June 2016. CP1 documented that he had emailed Devon and Cornwall Police on 28 July 2016 when he provided his opinion that the incident was "pre-meditated and calculated" despite Mr A suffering from psychotic symptoms at the time of the incident. CP1 also documented that he considered it would be detrimental to Mr A not to proceed with a criminal investigation "because he would learn that he could get away with such behaviour".

8.4 The forensic assessment completed in August 2016 concluded that Mr A's insight into his mental disorder and the consequences of his actions when unwell remained "poor and untested in a community setting". It recommended that:

- Mr A's care and treatment be provided "assertively under the MHA… in order to prevent risk of harm to others";
- a Community Treatment Order (CTO) be considered on discharge from hospital;
- re-referral to forensic services be considered if Mr A required further treatment in a psychiatric intensive care unit (PICU).

[35] Human error: Models and management by James Reason https://www.behavioursafetyservices.com/wp-content/uploads/2017/03/Reason-Paper-Human-Error.pdf

8.5 Mr A's diagnosis was documented by the forensic assessment in August 2016 and by CP2 at Cygnet Hospital Kewstoke in September 2016 as schizophrenia. There does not appear to be any explanation in the records from Cygnet Hospital Kewstoke for the change in diagnosis to drug induced psychosis on discharge in November 2017. Mr A's drug screen was negative when he was arrested in London, and it was still reported as negative on admission to Cygnet Hospital Kewstoke a few days later. There were no reports of any suspicion of him using drugs during his admission and no urine drug screens showing evidence of use of drugs during this time.

8.6 A diagnosis can influence treatment plans, especially decisions about longer-term care following discharge from hospital. The issue of documenting an appropriate diagnosis is essential to ensure continuity of care between episodes of illness. This is particularly important for patients who are reluctant to engage with community services and who are transient, as was the case with Mr A.

8.7 Mr A was discharged from Cygnet Hospital Kewstoke twice (12 September 2016 and 27 November 2017). On both occasions he was discharged directly into the community. There was a lack of strategic oversight of Mr A's longer-term needs as a result of this discharge decision. This meant there was a lack of continuity regarding his longitudinal care planning, risk assessment and management between Cygnet Hospital Kewstoke and local services in Devon.

8.8 When services in Devon learned that Mr A had gone to France for a second time, after his discharge from Cygnet Hospital Kewstoke to community services in Wiltshire, this resulted in a decision to discharge him from Section 117 aftercare. There was no evidence that Mr A's mental health needs no longer required aftercare for his mental health needs and this decision was not in accordance with the MHA Code of Practice.

8.9 It is our opinion that the combination of these elements meant that when Mr A presented in crisis in February 2019, mental health staff were making decisions based on incomplete knowledge of Mr A's mental health history.

8.10 There is no documentary evidence of consideration of decision making about Duty of Candour. Following an interview with a Trust senior manager we were told that although the case was "*the most serious we would likely report*" it was not "*considered as a patient safety incident*". The Trust justified this on the basis that the incident did not report specific harm to Mr A. Nonetheless, Mr A's mother was invited to contribute to the internal investigation.

8.11 We have carefully considered the Trust's stated position and have concluded that there was not a requirement to execute Duty of Candour. At the time of the offence, Mr A was not subject to any section of the MHA, he was not on the caseload of the Trust and some efforts had been made to provide him with information about how to access Trust services.

8.12 We found no reference in the Duty of Candour or Serious Incident policies to the Trust's approach to engaging families affected by homicide and serious incidents. NHS England (London) Investigation issued guidance in April 2019 on engaging with families after a mental health homicide.[36] This provides clear best practice guidance to mental health provider organisations and states that "*families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation*".

8.13 The internal investigation report satisfied the terms of reference set, and suggestions were made regarding "fundamental and contributory causes", but it was not possible to gain a complete picture by looking only at one aspect of the range of services provided. Thus, a recommendation was made regarding the need for a multi-agency review.

8.14 No root cause is described, but the report concluded that "*a significant contributory factor may have been his non concordance with his medication"*.

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

8.15 The internal report made six recommendations for Devon Partnership NHS Trust (DPT) and six recommendations for Avon and Wiltshire Partnership NHS Foundation Trust (AWP).

8.16 Our assessment of the progress of DPT's action plan found that of the six recommendations, four were complete. We had insufficient evidence from the Trust to be able to assess the completeness of the remaining two actions.

8.17 Our assessment of the progress of AWP's action plan found that of the six recommendations, four were complete. We had insufficient evidence from the Trust to be able to assess the completeness of the remaining two actions.

8.18 NHS Devon CCG provided evidence that it had reviewed the internal investigation report and had signed off the action plan. We found that the CCG's oversight and monitoring processes could be strengthened by detailed follow-up of action plans relating to high-profile, complex, or high-risk serious incidents.

8.19 BSW CCG has reported that it has monitored AWP's action plan through attendance at the AWP Learning and Review Panel meetings. BSW CCG has further advised that the action plan was last reviewed by the AWP Learning and Review Panel on 24 October 2021 when the last action was closed because assurances were given that it had been completed. The action plan was also reviewed by the BSW CCG Serious Incident Panel; closure of the serious incident was agreed in November 2021.

Recommendations

8.20 This independent investigation has made 12 recommendations to be addressed to improve learning from this event.

Recommendation 1: Cygnet Health Care and Devon Partnership NHS Trust must ensure that any changes to a diagnosis are formally documented and include the rationale and evidence base for such change, and agreed to by the patient's consultant psychiatrist. This information must be included in all relevant discharge communication between clinical services.

Recommendation 2: Devon County Council and NHS Devon Clinical Commissioning Group must ensure that discharges from Section 117 aftercare enacted by Devon Partnership NHS Trust on behalf of health and social care commissioners are in keeping with the Section 117 aftercare legislation.

Recommendation 3: Where a forensic assessment has been undertaken in the previous 12 to 18 months, Cygnet Health Care, Devon Partnership NHS Trust, and any provider contracted by Devon Partnership Trust must follow the advice within unless there is good reason not to do so. In which case they must formally document the rationale why the advice is not being followed.

Recommendation 4: Devon Partnership NHS Trust must ensure that risk assessments lead to risk formulation and risk management.

Recommendation 5: Devon Partnership NHS Trust must provide clear guidance to frontline staff and managers regarding how to escalate concerns relating to criminal offences committed on Trust property. The guidance must also provide clarity about what information staff are expected to document in the relevant clinical record.

Recommendation 6: Devon Partnership NHS Trust (DPT) must ensure that there is clearly documented communication and liaison with a patient's clinical team when considering a patient's needs prior to discharge from an independent provider. DPT must also ensure that there is a shared and agreed plan if detention under the Mental Health Act is rescinded by independent providers commissioned by DPT.

Recommendation 7: Devon Partnership NHS Trust must ensure that there is clear guidance for staff and managers about how communication with families and carers is managed and documented if there is a significant issue (such as this) affecting the care of an inpatient.

Recommendation 8: Devon Partnership NHS Trust (DPT) must ensure that local policies clarify how to consider and apply Duty of Candour regarding an incident that is also the subject of a criminal investigation, with the expectation that decisions made should be documented.

Recommendation 9: Devon Partnership NHS Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide: Mental Health-Related Homicide: Information for Mental Health Providers (April 2019) NHS England (London) Investigations.

Recommendation 10: Devon Partnership NHS Trust must implement the outstanding recommendations from their own report (recommendations 1 and 3) without any further delay.

Recommendation 11: The NHS Devon CCG Serious Incident report quality review template should be revised to reflect detailed expectations with NHSE Serious Incident Framework guidance.

Recommendation 12: NHS Devon CCG (and any future Integrated Care System) must implement a process to (a) identify high-profile, complex or high-risk serious incidents, (b) ensure that the provider action plan is followed up in detail, (c) seek assurance that all actions are implemented in a timely manner.

Good practice

8.21 Devon Partnership NHS Trust (DPT) has implemented a robust procurement and contract management process that is applied to all non-forensic placements for patients whose needs cannot be met by services provided the Trust.

8.22 DPT has a detailed quality assurance process that is applied to all such providers and has a policy of not placing patients with any unit that is rated as inadequate.

8.23 When plans were being made to discharge Mr A from Cygnet Hospital Kewstoke his Care Coordinator from DPT had a short period of time to arrange for a transfer of his care to Avon and Wiltshire Partnership NHS Foundation Trust (AWP). Despite the short timeframe this was achieved, and Mr A was followed up by AWP within 24 hours of discharge and by DPT within seven days of discharge.

Appendix A Terms of reference

Purpose of the review

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

The outcome of this review will be managed through corporate governance structures in NHS England, the clinical commissioning groups (CCGs)[37] and the provider's formal Board subcommittees.

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.

Devon Partnership NHS Trust (DPT) (in collaboration with Avon and Wiltshire Partnership NHS Foundation Trust (AWP)) commissioned an independent level 2 root cause analysis (RCA) investigation. This investigation will build on that review in the following areas:

1. Produce a full chronology (from inpatient admission in 2016) of [Mr A's] contact with mental health, primary health care and third sector services to determine if his healthcare needs and risks were fully understood and reflected in the most recent treatment plans.
2. Review the application of the Care Programme Approach, including discharge planning in line with provider guidance, national policy and best practice, with particular reference to [Mr A's] planned relocation to France in December 2017.
3. Review the application of policies/protocols for monitoring medication compliance/shared care.
4. Determine whether there were any missed opportunities to engage other services and/or agencies to support [Mr A] on his return from France.
5. Identify any factors that hindered the risk assessment and management processes and what plans were put in place to mitigate those risks at the time of [Mr A's] detention on 8 February 2019.
6. Review the quality of inter-agency and inter-service liaison, communication, decision making and planning at the time of [Mr A's] detention on 8 February 2019 to the date of the incident(s).
7. Determine whether there were any missed opportunities to engage other services and/or agencies to support [Mr A's] family.
8. Having assessed the above, comment on relevant issues that may warrant further investigation.
9. Make recommendations for the provider, CCG and/or NHS England as appropriate.

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

10. If the investigation satisfied its own terms of reference.

[37] Following legal review it was agreed to clarify that this referred to NHS Devon CCG and NHS Bath and North East Somerset, Swindon and Wiltshire CCG.

11. If the investigation was completed in a timely manner.
12. If all root causes and potential lessons have been identified, SMART[38] recommendations made and shared within the organisation.
13. Whether recommendations are appropriate and comprehensive and flow from the lessons learned and root causes.
14. Whether the subsequent action plan reflects the identified contributory factors, root causes and recommendations, and those actions are comprehensive.
15. Progress made against the action plan.
16. Processes in place to embed any lessons learned and review whether those changes have had a positive impact on the safety culture of the provider services.
17. Whether the provider's clinical governance processes in managing the level 2 investigation were appropriate and robust.
18. Whether the CCG governance/assurance processes in managing the commissioning of the level 2 investigation and its subsequent recommendations were appropriate and robust.
19. Further recommendations for improvement to patient safety and/or governance processes as appropriate.
20. And review the provider's application of its Duty of Candour to the family of the perpetrator and the victim.

Timescale

The review process starts when the investigator receives the provider documents, and the review should be completed within six months thereafter.

Initial steps and stages

NHS England will:

21. 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.
22. Arrange an initiation meeting between the provider, commissioners, investigator and other agencies willing to participate in this review.

Outputs

23. We will require monthly updates and, where required, for these to be shared with families, CCGs and providers.
24. A final report that can be published, is easy to read and is followed by 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 style guide to be followed).
25. 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 CCG with these meetings where appropriate.
26. A final presentation of the review to NHS England, CCGs, the provider Board and staff involved in the incident, as required.

[38] SMART: Specific (simple, sensible, significant). Measurable (meaningful, motivating). Achievable (agreed, attainable). Relevant (reasonable, realistic and resourced, results-based). Time bound (time-based, time limited, time/cost limited, timely, time-sensitive).

27. A briefing document of key learning points that can be shared with the regions, CCGs and providers.
28. The investigator will deliver learning events/workshops for the provider, staff and commissioners if appropriate.

Other

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

Appendix B Professionals involved

Pseudonym	Role	Team	Organisation
AMHP1	Approved Mental Health Practitioner	Emergency Duty Team	Devon Partnership NHS Trust
AMHP2	Approved Mental Health Practitioner	North Devon AMHP Team	Devon Partnership NHS Trust
AMHP3	Approved Mental Health Practitioner	North Devon	Devon Partnership NHS Trust
AMHP4	Approved Mental Health Practitioner	North Devon AMHP Team	Devon Partnership NHS Trust
CCO1	Senior Mental Health Practitioner	North Devon Specialist Team for Early Psychosis (the STEP team)	Devon Partnership NHS Trust
CCO2	Community Mental Health Nurse	North Devon Specialist Team for Early Psychosis (the STEP team)	Devon Partnership NHS Trust
CCO3	Care Coordinator		Devon Partnership NHS Trust
CCO4	Care Coordinator		Avon and Wiltshire Partnership NHS Foundation Trust
CJLD1	Community Mental Health Nurse	Criminal Justice Liaison and Diversion team (CJLDT, later referred to as Liaison and Diversion (L&D)	Devon Partnership NHS Trust
CP1	Consultant Psychiatrist	Moorland View Ward	Devon Partnership NHS Trust
CP2	Consultant Forensic Psychiatrist	Sandford Ward	Cygnet Kewstoke
CP3	Consultant Psychiatrist	North Devon Specialist Team for Early Psychosis (the STEP team)	Devon Partnership NHS Trust
CP4	Consultant Psychiatrist	Tyler Ward psychiatric intensive care unit	Cygnet Hospital Blackheath
CP5	Consultant Psychiatrist	Juniper Ward psychiatric intensive care unit	Devon Partnership NHS Trust
CP6	Consultant Psychiatrist on duty		Devon Partnership NHS Trust
L&D1		Devon Liaison and Diversion Service	Devon Partnership NHS Trust
L&D2		Devon Liaison and Diversion Service	Devon Partnership NHS Trust

Pseudonym	Role	Team	Organisation
L&D3		Devon Liaison and Diversion Service	Devon Partnership NHS Trust
HCA1	Health Care Assistant	Moorland View Ward	Devon Partnership NHS Trust
HCP1	Health Care Professional		G4S
ISD1	Independent Section 12 Approved Doctor	N/A	N/A
JD1	Junior Doctor	North Devon Specialist Team for Early Psychosis (the STEP team)	Devon Partnership NHS Trust
PH1	Pharmacist	Moorland View Ward	Devon Partnership NHS Trust
RCO1	Unplanned Care Repatriation Coordinator		Devon Partnership NHS Trust
RMN1	Staff Nurse	Moorland View Ward	Devon Partnership NHS Trust
RMN2	Staff Nurse	Moorland View Ward	Devon Partnership NHS Trust
RMN3	Staff Nurse	Moorland View Ward	Devon Partnership NHS Trust
S121	Section 12 Doctor		
S122	Section 12 Doctor		
SAS1	Associate Specialist Doctor	Crisis resolution and home treatment team, East and Mid Devon	Devon Partnership NHS Trust
SHO1	Senior House Officer	Moorland View Ward	Devon Partnership NHS Trust
WM1	Ward Manager	Moorland View Ward	Devon Partnership NHS Trust

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

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

The regulation applies to registered persons when they are carrying on a regulated activity.

The Care Quality Commission (CQC) can prosecute for a breach of parts 20(2)(a) and 20(3) of this regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action.[39] See the offences section[40] of the CQC guidance for more detail.

The regulation in full:

20.—

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

[39] The Care Quality Commission can take regulatory action as the regulator of health and social care services in England to address a registered person's breach of a regulation, condition of registration or other relevant requirement. https://www.cqc.org.uk/guidance-providers/regulations-enforcement/glossary-terms-used-guidance-providers-managers#regulatory-action

[40] The offences section of the Care Quality Commission guidance sets out the regulations that if breached, may be prosecuted directly. https://www.cqc.org.uk/guidance-providers/regulations-enforcement/offences

7. In this regulation—

   “apology” means an expression of sorrow or regret in respect of a notifiable safety incident;
   “moderate harm” means—

   a. harm that requires a moderate increase in treatment, and
   b. significant, but not permanent, harm;

   “moderate increase in treatment” means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);
   “notifiable safety incident” has the meaning given in paragraphs (8) and (9);
   “prolonged pain” means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;
   “prolonged psychological harm” means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;
   “relevant person” means the service user or, in the following circumstances, a person lawfully acting on their behalf—

   c. on the death of the service user,
   d. where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or
   e. where the service user is 16 or over and lacks capacity in relation to the matter;

   “severe harm” means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user’s illness or underlying condition.

8. In relation to a health service body, “notifiable safety incident” means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—

   a. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user’s illness or underlying condition, or
   b. severe harm, moderate harm or prolonged psychological harm to the service user.

9. In relation to any other registered person, “notifiable safety incident” means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional—

   a. appears to have resulted in—
      i. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user’s illness or underlying condition,
      ii. an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,
      iii. changes to the structure of the service user’s body,
      iv. the service user experiencing prolonged pain or prolonged psychological harm, or
      v. the shortening of the life expectancy of the service user; or
   b. requires treatment by a health care professional in order to prevent—
      i. the death of the service user, or
      ii. any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

Appendix D Niche Investigation Assurance Framework (NIAF): Internal investigation report

Rating	Description	Number
	Standards met	12
	Standards partially met	7
	Standards not met	6

Standard		Niche commentary	
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident	The report identifies that it is an external review of the care and treatment offered to Mr A from Avon and Wiltshire Partnership NHS Foundation Trust and Devon Partnership NHS Trust. It is not common that organisations take a joint response to such a serious incident, but we consider that it was appropriate in this case.	
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	The terms of reference include the scope and type of investigation and what is to be investigated. All are appropriate.	
1.3	The person leading the investigation has skills and training in investigations	The report does not provide details of the skills and training of the person who led the investigation. The investigation was conducted by an organisation called Enable East. Their website states that Enable East is an "innovative, independent NHS team … [assisting] other organisations to deliver effective projects with measurable improvements. As a 'common sense' alternative to commercial management consultants we offer a professional and flexible approach at competitive NHS rates."	
1.4	Investigations are completed within 60 working days	The incident occurred on 10 February 2019 and the investigation report date is March 2020. This is beyond 60 working days, but the report clearly stated that the police requested that the review be postponed until after the judicial process had concluded.	
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The report is written in plain English without typographical errors.	
1.6	Staff have been supported following the incident	There is no reference in the report to how staff were supported.	
Theme 2: Thoroughness			
2.1	A summary of the incident is included, that details the outcome and severity of the incident	There is a summary of the background to the incident, and of the actions after the Trust became aware of the incident.	
2.2	The terms of reference for the investigation should be included	The terms of reference are included.	

Standard		Niche commentary	
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people	The report describes that the internal investigation team met with relevant staff, reviewed organisational clinical records, and referenced both Trusts' policies and national guidance. Contributory factors are briefly discussed.	
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	There is no mention in the report that either Trust offered any support to Mr A's mother following the incident. There is no indication that any of the victims' families were approached during the investigation.	
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	The report provides a summary of an interview with Mr A's mother. There is no indication that any of the victims' families were invited to have input to the investigation.	
2.6	A summary of the patient's relevant history and the process of care should be included	A summary of Mr A's relevant history and process of care was included.	
2.7	A chronology or tabular timeline of the event is included	A chronology of Mr A's care was included.	
2.8	The report describes how RCA tools have been used to arrive at the findings	The report does not describe how RCA tools were used to arrive at the findings.	
2.9	Care and service delivery problems are identified (including whether the problems identified related to care delivery or service delivery)	Care and service delivery problems are identified but not described as care or service delivery problems.	
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	Contributory factors are briefly discussed, but there was no use of classification frameworks or examination of human factors.	
2.11	Root cause or root causes are described	The report states that it was difficult to complete a full root cause analysis without the involvement of all agencies in the investigation.	
2.12	Lessons learned are described	Problems are identified that both contributed to the outcome and did not contribute to the outcome.	
2.13	There should be no obvious areas of incongruence	There were no obvious areas of incongruence.	
2.14	The way the terms of reference have been met is described, including any areas that have not been explored	The way in which the terms of reference have been met is set out clearly.	
Theme 3: Lead to a change in practice – impact			
3.1	The terms of reference covered the right issues	The terms of reference covered the right issues.	

Standard		Niche commentary	
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	The report considers what factors contributed to poor care and missed opportunities, but these are not directly linked with how a recurrence might be prevented.	
3.3	Recommendations that relate to the findings and lead to a change in practice are set out	Six recommendations were made for both organisations (DPT and AWP), not all relate to the findings.	
3.4	Recommendations are written in full, so they can be read alone	Recommendations are written in full, so they can be read alone.	
3.5	Recommendations are measurable and outcome-focused	Some recommendations are measurable, however not all recommendations would necessarily lead to a change in practice.	

Appendix E Definition of the term 'root cause'

The term 'root cause' has been referred to since as early as 1905, when the root cause of a problem with health care in the Rhondda Valley was reported in the Lancet. [41]

Over the years since, the term 'root cause' has been used in investigation methodology, where safety investigations have been conducted using root cause analysis principles.

Thinking has developed to move on from simply identifying the root cause as the most basic causal factor to one that, if changed, would have changed the outcome.

The purpose of carrying out root cause analysis investigations is to make improvements so that the chance of error is reduced or removed. In order to do this, one cannot simply look for the most basic causal factor but must look for the most basic causal factor which could be corrected.

As a result, root cause analysis methodology now refers to the root cause being the most basic/earliest causal factor which is **amenable to management intervention**. There are numerous examples of this available in generic root cause analysis guidance, for example:

In the 2008 TapRooT® Book,[42] the definition of root cause was changed to:

"A Root Cause is the absence of a best practice or the failure to apply knowledge that would have prevented the problem."

The most useful definition identified to date is the one used by Paradies and Busch (1988), which is: "the most basic cause that can be reasonably identified and that management has control to fix."[43]

"A root cause is the most basic causal factor or factors which, if corrected or removed, will prevent recurrence of a situation", writes John Robert Dew, EdD, in an article published in the proceedings of the 56th Annual Quality Congress in 2002.

"There is honest disagreement as to whether or not an error can be attributed to a single root cause ... or whether there will be a cluster of causes", Dew adds.

Dew presents five basic root causes:

- *"Putting budget before quality.*
- *Putting schedules before quality.*
- *Putting politics before quality.*
- *Arrogance.*
- *Lack of understanding of knowledge, research, and education."*

Applying safety methodology to healthcare was accepted by the National Patient Safety Agency. The National Patient Safety Agency root cause analysis training tools and guidance refer to the root cause as follows:

"A fundamental contributory factor. One which had the greatest impact on the system failure.

One which, if resolved, will minimise the likelihood of recurrence both locally and across the organisation."

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

[42] The 2008 TapRooT® Book is available at this link: http://www.taproot.com/store/Books/

[43] Root cause definition as set out by the Health and Safety Executive 2001 https://www.hse.gov.uk/research/crr_pdf/2001/crr01325.pdf

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

However, with the increasing chance of litigation, it is increasingly difficult for organisations to simply identify learning from an investigation.

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

They have produced guidance on the subject, and they have renamed root cause analysis as RCA² (or root cause analysis and action, hence 'RCA Squared'). In the guidance pack they make the following statement:

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

In addition, the following is included:

Why Is "Human Error" Not an Acceptable Root Cause?

While it may be true that a human error was involved in an adverse event, the very occurrence of a human error implies that it can happen again. Human error is inevitable. If one well-intentioned, well-trained provider working in his or her typical environment makes an error, there are system factors that facilitated the error. It is critical that we gain an understanding of those system factors so that we can find ways to remove them or mitigate their effects.

Our goal is to increase safety in the long term and not allow a similar event to occur. When the involved provider is disciplined, counseled, or re-trained, we may reduce the likelihood that the event will recur with that provider, but we don't address the probability that the event will occur with other providers in similar circumstances. Wider training is also not an effective solution; there is always turnover, and a high-profile event today may be forgotten in the future. This is reflected in Figure 3, the Action Hierarchy, which is based upon safety engineering principles used for over 50 years in safety-critical industries. Solutions that address human error directly (such as remediation, training, and implementation of policies) are all weaker solutions. Solutions that address the system (such as physical plant or device changes and process changes) are much stronger. This is why it's so important to understand the system factors facilitating human error and to develop system solutions.

Review teams should not censor themselves when it comes to identifying corrective actions. This is important because the team's job is to identify and recommend the most effective actions they can think of, and it is leadership's responsibility to decide if the benefit likely to be realized is worth the investment, in light of the opportunity cost and its impact on the system in general. Only the top leadership of an organization can accept risk for the organization, and this is a responsibility that should not be delegated to others. ◆

The term root cause in a systems/root cause analysis investigation remains as identified by the National Patient Safety Agency (England):

"The most significant contributory factor, one that had the most impact on system failure and one that if resolved would minimise the likelihood of a re-occurrence."

Appendix F Niche Investigation Assurance Framework: Action plan progress for Devon Partnership NHS Trust

Our measurement criteria:

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

Recommendations made for Devon Partnership NHS Trust	
1	*The Trust should ensure that it has an agreement in place with partner agencies, which provides a clear procedure and lines of communication, to pursue as appropriate criminal investigation and action. This should include the procedure for informing health staff if criminal investigations are not to be pursued. The Trust should also review evidence to determine if the views expressed by staff that appropriate criminal action is not pursued with clients known to mental health services have substance.*
2	*Trust senior staff should liaise with senior staff in partner organisations to share information from individual organisational investigations and undertake a multi-organisational review of this case. This review should recognise each organisation's legislative requirements and capacity demands and improve the speed of access to services.*
3	*As the [Devon Liaison and Diversion] DL&D service operating hours, together with the time constraints of PACE regulations, and the reported pressure on [Devon County Council Emergency Duty Team] DCCEDT services compromised the provision of an MHA assessment I recommend that DPT ask services commissioners to review current operating arrangements.*
4	*As it is possible that partner agencies, including the private hospital provider, Police, and Devon County Council, will need to make contact with [Mr A] as part of their investigations; I recommend that any approach to [Mr A] on behalf of AWP and DPT is coordinated with those agencies.*
5	*The Caldicott Guardian should be asked to determine how circulation of this report should be managed having consideration of policies on confidentiality, data protection and information governance. This consideration will need to be made jointly with the A&W Caldicott Guardian.*
6	*The Trust should develop an action plan to address the recommendations contained within this report which meets the minimum requirements for actions listed within the NHS Serious Incident Framework.*

Rec	Action to address recommendation	Niche comment and assessment	
1	A clear protocol will be developed that clearly documents internal and external reporting routes for cases that involve a criminal investigation and communication to staff involved. This will include links with external agencies	The cited evidence of an agreed protocol in place with evidence of its application being checked against any relevant serious incidents reported is not available. The Trust has stated that the Local Security Manager had been in contact with the Police and had confirmed that there was an existing "Protocol for the Exchange of Information between Statutory Agencies in Devon and Cornwall in Relation to Potentially Dangerous or Mentally Disordered Persons". However, that would require further review. The Trust has stated that the sharing arrangements are "owned" by the Police, and they would be expected to lead in the review of this protocol. The Trust has further cited that given the ongoing external review (referring to our report), the target date had been extended to allow for the work to be completed. The protocol that was provided by the Trust accompanying the action plan is dated November 2017 and is described as "Version 2.0 – Working Version". We have a number of concerns about the protocol: • There is no indication that the parties to the protocol have signed up to the content. • The protocol states that it should be reviewed annually, but there is no evidence that it has been reviewed since 2017. • Appendix 3 provides the contact details for the Nominated Officers from organisations. It is intended that this Appendix is removed from any circulation via an insecure route. However, only part of Appendix 3 was removed when the document was provided to us. This includes individual email addresses, rather than a functional email address; i.e. john.smith@thistrust.nhs.net rather than (for example) infocompliance@thistrust.nhs.net. Organisations should be encouraged to implement a functional method of applying the protocol to remove the risk of staff being unable to apply the protocol in the event that the Nominated Officer is not available or has changed and the protocol has not been updated. The action plan dated 3 September 2020 stated that the target date for completion was the end of November 2020, "Dependent upon current COVID response". The action plan dated 13 July 2021 stated that the target date for completion was 30 January 2022.	

Rec	Action to address recommendation	Niche comment and assessment	
2	A joint homicide review and Devon Safeguarding Adults Board review is being undertaken, which will reflect the requirements of this recommendation.	The Trust has cited Niche's investigation as evidence that this recommendation has been addressed.	
3	There will be an internal service review following completion of the multi-agency review (recommendation 2) to determine any further developments of the service, such as operating hours. Further review with the commissioner as needed (as required) to consider any future service development and impacts with MHA assessment process.	The Trust has stated that the target start date for this work will be within one month of completion of the external review (our report). One purpose of the internal investigation was to identify early learning. We are therefore concerned that the Trust has delayed any progress on addressing this recommendation.	
4	Links to recommendation 2 as the joint review will provide a single route of contact for the review. There will be limited if any further contact required by AWP or DPT outside of the joint review.	The Trust has cited Niche's investigation as evidence that this recommendation has been addressed.	
5	The Caldicott Guardian will work with the Trust Safer Information team to agree the public report which will accord with the Caldicott principles. An agreed report or summary will be available for wider publication or circulation as needed.	The final report was shared with the commissioner and was closed on StEIS on 22 September 2020. The nature of the recommendation does not allow us to assess testing, embeddedness or sustained improvement in relation to this action.	
6	The action plan will be developed and submitted to the Trust Executive team for review and approval. The action plan will have been completed and submitted to the commissioner with the full report.	The report and action plan were submitted to commissioners. The nature of the recommendation does not allow us to assess testing, embeddedness or sustained improvement in relation to this action.	

Appendix G Niche Investigation Assurance Framework: Action plan progress for Avon and Wiltshire Partnership NHS Foundation Trust

Our measurement criteria:

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

Recommendations made for Avon and Wiltshire Partnership NHS Foundation Trust	
1	*The Trust should review any existing protocols regarding communication arrangements and agreements with criminal justice agencies to determine if they require development.*
2	*Community Clinical Services should be asked to review arrangements to allow patients with complex needs to have timely reviews by medical staff.*
3	*As it is possible that partner agencies, including the private hospital provider, Police, and Devon County Council, will need to make contact with [Mr A] as part of their investigations; I recommend that any approach to [Mr A] on behalf of AWP and DPT is coordinated with those agencies.*
4	*Community Clinical Services should be asked to review arrangements for ensuring that available patient information is placed on the Trust's clinical records systems in a timely manner.*
5	*The Caldicott Guardian should be asked to determine how circulation of this report should be managed having consideration of policies on confidentiality, data protection and information governance. This consideration will need to be made jointly with the DPT Caldicott Guardian.*
6	*The Trust should develop an action plan to address the recommendations contained within this report which meets the minimum requirements for actions listed within the NHS Serious Incident Framework.*

Rec	Action to address recommendation	Niche comment and assessment	
1	Review the current existing protocols regarding communication arrangement with criminal justice agencies Establish regular contact between Wiltshire locality and probation services to improve working relationship and communication In conjunction with stakeholder, develop any required amendments into a revised protocol. Revise any existing protocols as appropriate.	The Trust has stated that no protocols were in place and that no formal protocol has been developed. However, the probation service was invited to attend (and does attend) the locality interface meeting. Technically, the fact that there were no protocols in place and the Trust has reviewed this, means that the action is complete. However, there remains a risk that without a formal protocol, the closer working arrangements that have recently been developed will be at risk of deterioration should there be a change in leadership in either organisation.	
2	Review current arrangements and guidance relating to Community Service Managers with Medical Leads Ensure relevant local standard operating procedure or protocol details expectations in relation to: (1) Annual Reviews (2) Waiting lists for medical reviews (3) Review of caseloads by multidisciplinary team	The Trust has reported that medical reviews take place in accordance with the CPA Policy, which states at least annually. The Trust has also reported that there are no concerns with delays, and that patients can be seen urgently if required. The Trust has provided a snapshot of patients requiring a review as at 10 October 2021. This shows that 16 patients were overdue a review; 4 patients were due to be reviewed within the following 7 day; 1 patient was due to be reviewed in the following 7 to 14 days; 54 patients were due to be reviewed in the following 3 months; 277 patients were due to be reviewed in the following 3+ to 11 months; and 29 patients had been reviewed in the previous month. There is no evidence that the Trust has considered standard operating procedure (SOP) expectations in relation to review of caseloads by the multidisciplinary team.	
3	Actioned during investigation; no action to take now investigation complete	The report and action plan were submitted to commissioners. The nature of the recommendation does not allow us to assess testing, embeddedness or sustained improvement in relation to this action.	

Rec	Action to address recommendation	Niche comment and assessment	
4	Trust Clinical Record Keeping guidance states that all community clinical records should be updated within three days of the activity taking place. To review local community teams' adherence to this. The Trust has ensured guidance was available to staff and has stated that compliance and performance would be monitored through audit of local community teams.	The Trust has provided an agenda for the meeting of the Wiltshire Finance and Planning, Business and Performance Group held on 14 September 2021 as evidence that this action has been completed. The Trust has developed a self-assessment tool to for use as part of clinical supervision to audit between two and five care plans per month. The tool has 11 questions or standards to be assessed and encourages documentation of good practice and areas for improvement. We do not have information about how widely used this tool is, nor the impact it has made to clinical practice.	
5	Plan for circulation of report within Wiltshire locality	The Trust has stated that this action was completed on 30 April 2020. No evidence has been provided to support this statement.	
6	The Trust should develop an action plan to address the recommendations contained within this report which meets the minimum requirements for actions listed within the NHS Serious Incident Framework.	The report and action plan were submitted to commissioners. The nature of the recommendation does not allow us to assess testing, embeddedness or sustained improvement in relation to this action.	

Appendix H Questions from the families of the victims

Questions from Mr P's family

Question		Response
1	When Mr A was in custody in Barnstaple Police Station his mother contacted the Police and told them about his declining mental health and that his behaviour was in response to this and this had happened on previous occasions when his medical health was in decline. Why wasn't his mother's opinion/concerns about this decline taken into account by Police, mental health professionals or doctors who saw him prior to his release from custody and the appropriate action taken?	This question has been discussed in the Systems Report. Please refer to that report for further detail of our response. Mr A's mother's concerns on 8 February 2019 were logged by police and he was helped to find a bed at the safe sleep centre. He had been seen the L&D that day and no mental health concerns were noted. Mr A's mother's concerns that Mr A may be relapsing were not shared by police, but these had come after L&D staff assessed him. Mr A's mother called again on 10 February 2019, and police made enquiries about his whereabouts with mental health staff (Street Triage Team). Mr A was identified as a medium risk missing person.
2	Mr A had previously been admitted to mental health hospitals after suffering a deterioration in his mental health. This would appear to be due to his own failure to take his prescribed medication, which made his mental health decline. Why on his release from the last hospital he was admitted to was nothing put in place by the mental health professionals/GP to support him taking the medication or to make him take his medication? Why was there no follow-up by any mental health professionals/GP?	In this report we have discussed how the use of a Community Treatment Order may have been of benefit (Use of a Community Treatment Order (CTO)) and the limitations of this section of the Mental Health Act given that Mr A went to France within three weeks of being discharged from hospital in November 2017.
3	We as a family would like to know what happened in the months and weeks prior to the incidents in Mr A's life before he came to Devon. And whether any family or friends of Mr A contacted the mental health professionals or discussed among themselves seeing a decline in Mr A's mental health.	In this report we have included documented contact from Mr A's mother and his former partner Miss D. Mr A's mother contacted mental health services in February 2019 expressing concern about his mental state. We do not have information of Mr A's whereabouts in the period 16 December 2017 to October 2018, aside from believing that he had spent some time in France. We know that he consulted his GP in Wiltshire in late October 2018 January 2019, and attended A&E in London in December 2018. In January 2019, the GP did not identify any mental health concerns.

Question		Response
4	Why was Mr A released from police custody on two occasions having not received the	This question has been discussed in the Systems Report. Please refer to that report for further detail

Question		Response
	appropriate level of mental health assessment by the mental health professionals?	of our response. On 8 February 2019 Mr A was assessed by L&D staff as not needing mental health intervention. On 9 February 2019 Mr A was assessed by the FME who determined that Mr A did not require a MHA assessment.
5	Before his release from police custody, how much information was gathered from the various other agencies or other sources to complete an appropriate assessment of his mental health? Other sources include mental health establishments outside Devon and Cornwall, his mother, GP records and mental health services in Devon and Cornwall.	This question has been discussed in the Systems Report. Please refer to that report for further detail of our response. No background information was available to the FME who assessed him. It would not be usual practice for an FME to source information about a detained person from other agencies.
6	If these incidents had happened between Monday to Friday would there have been a different outcome to Mr A's assessment and treatment in custody, i.e. a better outcome? Therefore, as a family we are asking if there is adequate mental health staffing at weekends and access to mental health records to fully assess someone like Mr A if they are in custody over a weekend compared to a weekday.	This question has been discussed in the Systems Report. Please refer to that report for further detail of our response. We cannot speculate on the potential outcome of an assessment. However it is our view that there was at the time a lack of equivalence and there were system pressures that impacted on decision-making regarding Mental Health Act assessments out of hours.

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