

# VERITA

IMPROVEMENT THROUGH INVESTIGATION

**Independent investigation into the care and treatment of**

**Mr J**

A report for  
NHS England, North Region

November 2014

Authors:  
Chris Brougham  
Liz Howes  
Dr Junais Puthiyarackal

© Verita 2014

Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

This report has been written for NHS England, North Region and may not be used, published or reproduced in any way without its express written permission.

**Verita**  
**53 Frith St**  
**London W1D 4SN**

Telephone **020 7494 5670**  
Fax **020 7734 9325**

E-mail [enquiries@verita.net](mailto:enquiries@verita.net)  
Website [www.verita.net](http://www.verita.net)

## Contents

### Introduction and summary

1	Introduction	4
2	Terms of reference	5
3	Approach of the independent investigation	6
4	Executive summary and recommendations	8

### Chronology and issues arising

5	Chronology of treatment and care	11
6	Issues arising	22

### Analysis of themes

7	Formulation of diagnosis and pathway of care	23
8	Care Programme Approach and care plans	26
9	Risk assessments and risk management	30
10	Police forensic history and MAPPA	32
11	Safeguarding	34
12	Predictability and preventability	36
13	The Trust's internal investigation and progress made against the recommendations	38

### Appendices

Appendix A	Team biographies	42
Appendix B	Acronyms used in report	43

# **1 Introduction**

On 29 July 2010 Mr J, aged 29, was arrested for attacking and killing a member of the public. He was found guilty of murder and sentenced to life imprisonment with a minimum term of 16 years.

He had received support from a community mental health team at South West Yorkshire Partnership NHS Foundation Trust from July 2005 up until the incident.

## **1.1 Background to the independent investigation**

NHS England, North Regional Team, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr J.

The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the individual. An independent investigation might not identify root causes or find aspects of the provision of healthcare that directly caused an incident but it will often find things that could have been done better.

The Chief Executive of South West Yorkshire Partnership NHS Foundation Trust commissioned an internal trust investigation into the care and treatment of Mr J. The investigation team made four recommendations. An action plan was developed to take forward the recommendations.

## **1.2 Overview of the Trust**

South West Yorkshire Partnership NHS Foundation Trust provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. The Trust also provides some medium secure (forensic) services to the whole of Yorkshire and the Humber.

## 2 Terms of reference

The terms of reference for the independent investigation, set by NHS England, North Regional Team, in consultation with South West Yorkshire NHS Foundation Trust are as set out below.

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of the offence.
- Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Examine whether safeguarding issues were identified and the appropriate safeguarding protocols were subsequently applied.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.
- Examine the patient's forensic history and establish whether it was appropriately taken into account in the risk assessment and risk management process.
- Examine the effectiveness of the service user's care plan, including the involvement of the service user and his family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with victim support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the investigation team that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post-investigation evaluation.

### 3 Approach of the independent investigation

The investigation team (referred to in this report as 'we') comprised Chris Brougham, senior investigator, and Liz Howes, an associate with Verita. Professional psychiatry advice was provided by Dr Junais Puthiyarackal, a consultant psychiatrist from Humber NHS Foundation Trust. Biographies for the team are given in appendix A.

We examined a range of national benchmarks, including NICE guidance and good practice guidance. We also examined Trust documents, including policies and procedures, the serious incident investigation report and supplementary information such as the action plan and records of meetings with staff.

Mr J gave his written consent for us to access his medical and other records for the purposes of the investigation. We interviewed staff only where we found a gap in information or an area that required clarification or to find out what developments had taken place since this incident.

We interviewed the following staff:

- Director of Nursing, Clinical Governance and Safety;
- Clinical lead for Crisis Resolution Home Treatment Service (CRHT);
- Pathway manager for CRHT;
- Care Programme Approach (CPA) manager;
- Assistant Director of Nursing (Safeguarding);
- Head of Service, Kirklees;
- Mr J's care coordinator;
- Director of Corporate Development; and
- Head of Involvement and Inclusion.

We also held two focus groups with staff from the following teams:

- Single Point of Access;
- Intensive Home Based Treatment Team;
- Community Therapies Pathway;
- Care Management pathway;
- Acute Care Pathway;
- Dual Diagnosis Service; and
- Crisis Resolution Service.

We met Mr J at the outset of the investigation to explain the nature of our work and to inform him that the commissioners of the investigation would probably publish the report in some form. Mr J was given the opportunity to comment on a draft of this report before it was finalised.

We met Mr J's mother at the start of our work to explain about the investigation and to see whether she had any views about Mr J's treatment and care. We contacted her again at the end of the investigation to share with her what we found in our investigation.

We also offered to meet with the victim's family but they chose not to meet with us.

We based our findings on the evidence we received. Our recommendations are intended to improve services.

This report includes a chronology outlining the care and treatment of Mr J. The analysis appears in sections 6 to 13 where relevant issues and themes arising from the terms of reference are examined.

Derek Mechen, a partner from Verita, peer-reviewed this report.

## **4 Executive summary and recommendations**

NHS England, North Regional Team commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr J, a mental health service user.

The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. While the independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident, it might find things that could have been done better.

### **4.1 The incident**

On 29 July 2010 Mr J, aged 29, was arrested for attacking and killing a member of the public. He was found guilty of murder and sentenced to life imprisonment with a minimum term of 16 years. Mr J had received support from a community mental health team at South West Yorkshire Partnership NHS Foundation Trust from July 2005 up until the incident.

### **4.2 Overview of care and treatment**

Mr J had a history of alcohol and cannabis use which contributed to his mental health problems. He suffered from problems related to anger management and unresolved childhood issues. His elder brother was murdered in 1996 and Mr J had difficulty dealing with the bereavement.

In July 2005 Mr J threatened to hang himself and was referred by his GP to the Trust's Crisis Resolution Home Treatment Service (CRHT). It is also noted in Mr J's history that around the same time he started smoking cannabis and had used cannabis ever since. Mr J also reported constant arguments with his girlfriend. At the time of the assessment by CRHT he was on probation for carrying two sharp knives. He also had several previous convictions and had served custodial sentences for violent offences including violence to others, criminal damage and possession of drugs.

Mr J was discharged from the CRHT a month later and followed up by the local Community Mental Health Team (CMHT) and the outpatient department.

He had an allocated care coordinator from the CMHT and was regularly reviewed in the outpatient clinics. He was also offered psychological therapy, anger management courses and referral to local substance misuse services for his continued cannabis use. He did engage with the psychologist but not with the anger management course. He was discharged from the CMHT in September 2007 but had the opportunity to attend outpatient reviews.

In September 2008 Mr J's partner gave to birth to a baby son but she died unexpectedly 10 days later. The CMHT reopened Mr J's case and allocated the same care coordinator. Mr J remained in contact with mental health services until the incident in July 2010.

### **4.3 Overall conclusions of the Independent Investigation**

We found there was no evidence from Mr J's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently. Therefore we conclude that this incident was not predictable.

The homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so.

We note that Mr J had several previous convictions and had served custodial sentences for violent offences, criminal damage and possession of drugs. Despite this, we did not find any evidence to indicate that the Trust should have undertaken any actions or specific interventions that would have prevented the incident.

We found that the incident was therefore not preventable.

Since this incident, the Trust has undergone a major restructure as part of its transformation programme, which has included implementation of a revised CPA policy.

We agree with the Trust's investigation findings that there is insufficient evidence to suggest that Mr J suffered from a mental disorder that needed support from secondary mental health services. His primary problem was cannabis use and this should have been dealt with by Lifeline<sup>1</sup>. He should also have been reviewed by a multidisciplinary team in order to assess if he needed to continue to receive mental health services. We have made a recommendation on this issue.

When we met with Mr J's mother she told us that she thought that Mr J had experienced Post Traumatic Stress Disorder ( PTSD) and asked whether this diagnosis had been considered.

---

<sup>1</sup> Lifeline is an open-access service that offers advice, information and support related to drug and alcohol dependency.

We found there was no evidence to suggest that Mr J was suffering from PTSD. Although Mr J suffered stress, he did not experience any of the symptoms of a diagnosis of PTSD such as flashbacks, nightmares, or extreme anxiety.

We have also commented on the safeguarding elements of this case and noted some good practice. The Trust recognises that the safeguarding agenda shared between itself and the local authority continues to evolve. We found that significant progress has been made since the date of this incident in improving staff awareness of relevant issues and of joint working with other agencies.

When we met with staff, they told us that further integration of the local authority's electronic record systems with those of the Trust would improve the efficiency of administration and give advance warning of safeguarding issues. We have made a recommendation to develop the work that the Trust has already done in this area.

#### **4.4 Recommendations**

- 1 The Trust should take steps to ensure that patients are reviewed by the multidisciplinary team on a regular basis so that timely discharge and relapse plans are put in place.
- 2 The Trust should consider the options available to refine and develop its electronic record systems in order to ensure greater integration of safeguarding, care planning and care delivery systems.

## 5 Chronology of treatment and care

Mr J had a history of alcohol and cannabis use which contributed to his mental health problems. He suffered from problems related to anger management and unresolved childhood issues. His elder brother was murdered in 1996.

### 5.1 Overview of care from 2005 until 2007

Mr J threatened to hang himself in July 2005. He was therefore referred by his GP to the Trust's CRHT.

During the assessment he reported low mood for a year and some anxiety symptoms. He also reported "paranoia"; however, he did not elaborate on this during his assessment.

The health records show that Mr J's brother was murdered in 1996, when Mr J was 14 years old. He had difficulty in coping with this bereavement. The records also show that at around the same time he started smoking cannabis and had used cannabis ever since. Mr J had also reported constant arguments with his girlfriend.

At the time of his assessment Mr J was on probation for carrying two sharp knives. He also had several previous convictions and had served custodial sentences for violent offences including violence to others, criminal damage and possession of drugs.

Mr J was prescribed olanzapine<sup>1</sup>. The following interventions were also discussed:

- to engage in diversional activities
- to attend Lifeline/Way Ahead<sup>2</sup>
- to discuss coping strategies for dealing with anxiety.

He was discharged from the CRHT on 11 August and followed up by the local CMHT and in the outpatient department.

In October 2005 Mr J received a 12 months' suspended sentence for assaulting his girlfriend.

On 18 January 2006 he was assessed by a clinical psychologist who stated that Mr J was suffering from PTSD, anxiety and depression and drug abuse. Mr J was followed up in the short term and placed on the psychology waiting list.

On 5 July 2006 Mr J was referred for an anger management course. The psychiatrist explained in his referral that Mr J had been to an anger management course many years previously but that that had not helped him because he was not motivated at the time.

---

<sup>1</sup> A drug used to treat schizophrenia and acute manic episodes.

<sup>2</sup>Way Ahead is a counselling directory that puts people in touch with professional counsellors or psychotherapists.

Mr J was seen in outpatients on 7 April and a definite improvement was reported. Mr J was referred to Lifeline by his care coordinator.

In October 2006, Mr J failed to attend two consecutive outpatient appointments.

In November 2006, Mr J's mother contacted the CRHT to advise that Mr J had been arrested for violent behaviour and damaging his girlfriend's mother's car. Mr J's mother was concerned that his mental health had deteriorated in the previous two weeks. However, staff from the CRHT were unable to contact Mr J as neither they nor Mr J's mother had his mobile phone number.

On 20 December 2006 Mr J was arrested for threatening his girlfriend. He had a knife in his possession when police attended the scene.

Mr J attended an outpatient appointment in February 2007. He advised that he wasn't always taking his medication. The psychiatrist advised Mr J to continue to take it.

On 20 June 2007 Mr J assaulted his girlfriend's friend.

On 3 July 2007 Mr J's mother contacted the Trust with concerns that he would either kill himself or someone else. Mr J was shouting in the street during her call to the CRHT. Mr J's mother was advised to contact the police; she was unhappy with this advice. It is recorded in the notes that the CRHT did not undertake a visit owing to the risks involved. Mr J's partner rang and was advised to take Mr J to A&E.

In August Mr J attended an outpatient appointment. He was low in mood, displayed poor eye contact and minimal responses to questions. It is recorded in the notes that the care coordinator would visit weekly for the next couple of weeks and he was to organise a referral to Lifeline on the next visit.

During a home visit on 14 August following a telephone call from Mr J who was distressed, a member of the CMHT staff witnessed Mr J being involved in a local dispute to which the police were called.

On 20 August Mr J was discussed in the team meeting in relation to "risks of carrying weapons, anger issues and absence of psychosis". It was agreed that the care coordinator would provide details of Lifeline, discuss the situation with the probation service and discuss with Mr J plans for discharge from the CMHT.

On 7 September 2007 Mr J was discharged from CMHT services following the outcome of the previous home visit. He had been referred to Lifeline.

Mr J continued to receive outpatient services from the Trust; however, we found no evidence in the notes of the aim of Mr J continuing to be seen in outpatients.

On 19 October 2007 Mr J attended his outpatient appointment accompanied by his mother. He told the psychiatrist that he was due in court on 26 October 2007 for assaulting his girlfriend. He also reported that he had reduced his cannabis and

alcohol use since his previous appointment. He said that he had not taken the fluoxetine<sup>1</sup> as previously prescribed to him.

Mr J's mother expressed her concern that he was no longer receiving support from the CMHT. She advised that Mr J's brother's murderer was due to be released from prison soon and that this was causing Mr J some concern. Mr J was due to visit outpatients on 30 November but he did not attend the appointment.

## **5.2 Overview of care and treatment from 2008 until 2010**

Mr J attended an outpatient appointment on 29 February 2008. He reported that he felt low most of the time. His current partner was pregnant but he was worried that she was cheating on him. He told the psychiatrist that he had not followed up the referral to Lifeline for support in reducing his cannabis and alcohol usage but that his probation officer was helping him with his anger management.

Mr J attended an outpatient appointment in April 2008. He reported that he was undertaking a one-to-one anger management course.

On 19 September 2008 Mr J attended an outpatient appointment. He told the psychiatrist that his partner had died shortly after giving birth to their baby. He was now looking after his son as a single parent. Arrangements were made by the Trust to recommence support from the CMHT.

Mr J missed his outpatient appointments in February and March 2009. His care coordinator provided the psychiatrist with an update on the welfare of Mr J's child and the discharge of Mr J and his child from the local authority's children and families team caseload.

On 13 May 2009 Mr J's care coordinator visited him at home. It is recorded in the notes that:

“Mr J presented with low-level paranoia but he was coping with this and with bringing up his son. Mr J was preparing for his son's first birthday.”

Shortly after this was the first anniversary of his partner's death.

The care coordinator encouraged Mr J to contact him for extra support should he require it. Records show that Mr J's family remained supportive.

Mr J missed a further outpatient appointment on 22 May 2009, the third consecutive failure to attend. No further appointment was made, the care coordinator was asked to arrange any further appointments if required.

Mr J's care coordinator visited him at home. It is recorded in the notes that Mr J had been threatening and was verbally aggressive towards his mother. He had also kept his mother and sister up until approximately 4.00am discussing the behaviour of his

---

<sup>1</sup> Fluoxetine is used to treat depression.

ex-partner's family at his son's birthday party. It is unclear from the notes whether his mother and sister were willing participants. Mr J calmed down during the care coordinator's visit. Records show that there were no signs of mental illness.

On 26 May 2009 Mr J's sister contacted the CMHT. She reported that Mr J had locked himself and his son in his house over the previous few days and would not speak to anyone but his care coordinator. The message was passed on to the 'buddy system' contact because the care coordinator was on holiday. The contact person visited Mr J and his son. They were both well. Mr J explained that he missed his partner and wanted to grieve in peace.

The CMHT continued to provide support to Mr J throughout the summer. On the whole he remained stable, although he became distressed about the death of his partner at times. He told the CMHT that he had not had any counselling in relation to his bereavement.

In September 2009, the care coordinator carried out a home visit to see Mr J and his mother. The latter had experienced some health problems and was finding it increasingly difficult to continue to support Mr J and his son.

Records show that Mr J was not taking any medication because he did not want to be drowsy when caring for his son. He told the care coordinator that there were times when he felt he would benefit from taking medication.

The care coordinator carried out a home visit on 9 December 2009. He noted that Mr J had lost weight recently and was reported to have had some paranoid ideas. Mr J was due in court the following day concerning an application from his partner's family for visiting rights to his son. In addition, the person who had killed his brother had lodged an appeal for discharge from hospital. Both these issues had caused Mr J some anxiety, with which he was coping by going out walking with his son. The care coordinator carried out a follow-up home visit later in December. Mr J appeared stable and his mother reported that he had coped well with the news of the court case.

### **5.3 Overview of care and treatment during 2010**

During 2010, Mr J received crisis resolution, community mental health and outpatient services.

On 3 February 2010 the care coordinator carried out a home visit. Mr J had been to Wales to visit family and friends. During this visit an ex-girlfriend of his made allegations to the police about his lack of care of his son. As a result Mr J spent the night in police custody. The allegations were not substantiated and a subsequent visit by social services to review the care and welfare of his son identified no concerns. The care coordinator noted that Mr J's mother's health was not good and that she was awaiting surgery. This had implications for her ability to continue to support Mr J and his son.

On 12 March 2010 the care coordinator carried out a home visit following a telephone call from a friend of Mr J's mother. The friend reported that on the previous night Mr J had been visited by the police following an allegation that he was abusing his son. Mr J was shocked that the police insisted on seeing his son and on checking that there was adequate food in the house. It is recorded in the notes that the police left Mr J's house satisfied that his son was being well looked after.

Mr J appeared to have taken the event well, but he was concerned that a malicious phone call had led to the police visit.

The care coordinator provided Mr J with the contact details for the Emergency Duty Service (EDS). The care coordinator planned to visit Mr J the following week to offer further support.

On 14 March 2010 the EDS called the CMHT to ask whether Mr J was known to the mental health services.

Mr J had contacted the EDS about the visit to his home by the police. Although the police had been in contact with the EDS to say they had no concerns for his son's safety, the EDS was now concerned about Mr J's mental health.

During his phone conversation with the EDS, Mr J was reported to have seemed quite paranoid and stated that the police were persecuting him.

Mr J's risk assessment and associated progress notes were forwarded to the EDS at its request. The care coordinator was informed of its concerns.

The care coordinator carried out a home visit on 15 March. Mr J continued to feel as though he had suffered a violation of his human rights and felt undermined as a single parent by the increased activities of social services to check the welfare of his son.

Mr J was convinced that the most recent allegation regarding his treatment of his son had been initiated by the child's maternal grandmother – who was in the process of seeking judicial access to the child. The care coordinator felt that the recent situation had, with some justification, increased Mr J's paranoia – although Mr J did not believe that it had.

In view of the circumstances of the previous few days, the care coordinator decided to discuss the allegations made against Mr J with the EDS.

On 6 March 2010 the care coordinator spoke with a member of the safeguarding children team about the way in which the incident with Mr J had been handled.

The care coordinator made his concerns known about the potential impact on Mr J of social services' proposed action – to undertake a core assessment on the child – given that the recent incident had been initiated by an apparently malicious allegation.

The care coordinator requested a further meeting between himself, his line manager and the manager of the EDS to discuss the issues he had raised.

On 18 March 2010 the care coordinator carried out a home visit. He spoke with Mr J's mother and grandmother, both of whom had looked after Mr J's son on the previous night so that Mr J could go out with friends. Mr J's mother and grandmother were intending to take his son away with them for the weekend to give Mr J a break and to see if anyone made any further allegations of child abuse were made over the weekend.

Mr J's mother felt he was showing signs of low-level paranoia, although she had been informed that the events surrounding Mr J and his son were a "hot topic" in the local community.

Mr J had support from a friend over the weekend. The care coordinator arranged to visit the following week to provide Mr J with further support.

On 29 March 2010 the care coordinator carried out a prearranged home visit. He and Mr J discussed a planned meeting with the children's service regarding the recent unsubstantiated allegation of child abuse. Mr J was resigned to having to attend the meeting but still angry about his treatment by the police and that the focus was on him rather than on the anonymous person who had made the allegation.

It is recorded in the notes that Mr J was independently studying archaeology and planned to pursue this at a higher level.

On 30 March 2010 the EDS contacted the care coordinator and told him that no further investigation of Mr J would be taking place. Mr J was pleased with the decision but felt that the report from the team could be useful in the impending court case regarding access to his son by the maternal grandparent.

Records show that Mr J was settled and that his relationship with his mother had improved. Mr J's mother had looked after his son for the previous couple of days. The care coordinator planned to visit Mr J two weeks later.

On 6 April Mr J's mother contacted the care coordinator to say that Mr J was due in court the following day regarding the request for access to his son. He was convinced that he would lose his son, and his mother was concerned about returning home to face him.

The care coordinator carried out a home visit. Mr J was resigned to losing his son, for which he blamed the system. He had taken his medication prior to receiving the news of the court case. Mr J said he had been experiencing 'racing thoughts', his appetite had gone and he had lost weight.

Although Mr J had previously declined an offer of bereavement counselling, he said he would accept it when he was ready.

On 7 April 2010 Mr J's mother contacted the care coordinator to tell him that the court case had taken place and that the request for access to Mr J's son by the maternal grandmother had been denied.

On 28 April 2010 the care coordinator carried out a home visit but Mr J was not there. The care coordinator spoke with his mother. She reported that he was settled and showed no signs of depression or paranoia. She said she was looking after his son for two nights a week to give him a break and that this arrangement was working well.

On 3 May 2010 Mr J's mother contacted the CRHT expressing concerns that he was not well. The CRHT telephoned Mr J who told them that he had not been well for two years. When Mr J was asked to identify any current triggers to his state of health, he was unable to identify any but said that he was not eating and had suicidal thoughts. When asked about his medication, Mr J said that he had not been taking it.

Mr J when asked what he wanted, Mr J requested that "we come out in a van and take him away". After further discussion Mr J said he would prefer it if his care coordinator was contacted and asked to get in touch with him the following day.

Mr J was given the direct number for the CRHT and assured he could phone at any time during the night. Mr J agreed to contact the team if he had any further impulsive thoughts.

Mr J's mother was looking after his son that night. The details of the calls with Mr J's mother and Mr J were faxed to the care coordinator.

The care coordinator visited Mr J at home the following day. Mr J had settled overnight. He reported that he thought a group of local women had taken against him but he did not know why. Mr J was concerned that the second anniversary of his partner's death would take place soon, nine days after his son's birthday.

The care coordinator discussed counselling with Mr J, who said that he was willing to be referred in three months' time when his son had started nursery.

On 7 May 2010 the care coordinator contacted the CRHT because he was concerned about the recent deterioration in Mr J's mental state.

Mr J appeared anxious and agitated, with sweating palms, and he reported not sleeping well. He had been taking his medication but with little effect.

The care coordinator took Mr J into hospital later on the same day. Mr J was seen by medical staff and assessed for intensive home-based treatment.

The following management plan was agreed:

- CRHT would follow up Mr J with daily support over the coming weekend and a review on the Monday;
- Mr J was to take his medication, olanzapine, regularly for the next few days; and
- Mr J was given two tablets of diazepam for use overnight.

On 8 May, a member of staff from the CRHT visited Mr J at home. He appeared drowsy and had taken the remaining diazepam that morning – so would need a further visit that night with some more diazepam. He had slept well which had made him feel better. He would be spending the day with friends because his mother had taken his son for the afternoon.

A further home visit took place the same evening to deliver the diazepam. Mr J was at his mother's house. He appeared over-sedated and was staggering.

The care coordinator carried out a home visit on 10 May. Mr J appeared settled and his mood had improved. Mr J's mother told the care coordinator that the maternal grandmother of Mr J's son had been in contact and wanted to see her grandson on his birthday. Mr J's mother had not shared this information with Mr J as she thought this information would cause him some distress.

The care coordinator informed the CRHT of this and instructed them to discharge Mr J back to his care. He planned to see Mr J again on 14 May.

The RiO<sup>1</sup> progress notes indicate that a CPA review involving Mr J, the care coordinator and a CRHT staff member took place on the same day.

The internal investigation clarified with staff that this review took place as a result of the conversation confirming that Mr J could be discharged back into the care of the care coordinator.

The care coordinator carried out a home visit on 14 May. Mr J appeared settled. He asked for a small supply of diazepam, which the care coordinator arranged for the following week. Mr J reported that he had been offered the opportunity to go to Wales for four weeks which would coincide with the anniversary of his partner's death.

The care coordinator visited Mr J again on 17 May.

On 26 May 2010 the care coordinator carried out another home visit. He found Mr J inside the house rolling a "spliff". Mr J looked shocked and embarrassed.

---

<sup>1</sup> RiO is a clinical information system used to store electronic patient records securely.

Mr J said he was still using cannabis occasionally to help him settle. The care coordinator reiterated the problems associated with illicit drug use. Mr J said he was not feeling paranoid after smoking cannabis. He said he was using the cannabis because he had used up the supply of diazepam, which he had found helpful. Mr J continued to take his olanzapine.

The care coordinator dropped off a small supply of diazepam for Mr J on 28 May.

On 2 June Mr J's mother contacted the care coordinator to say that she was staying in a hostel because she feared her son was going to harm her. Mr J's mother said that he had threatened her and damaged items in her house. Mr J had also threatened two people who were staying at his mother's house. This incident occurred on the night of the anniversary of the death of his partner.

On 4 June the care coordinator visited Mr J at home during the visit Mr J became increasingly angry due to family issues.

On 7 June a member of staff from the child protection team at the local authority contacted the care coordinator to advise that Mr J's neighbour had raised concerns about him and his friends' activities. Mr J had allegedly been partying regularly; the most recent party, on 5 June 2010, had finished at 6.00am. The neighbour had reported them to the environmental health department. Mr J and his friends had made inflammatory remarks towards the neighbour – who had a very young baby and was struggling to cope with the noise and behaviour of Mr J and his friends. The child protection worker also told the care coordinator that there was evidence that Mr J had been using cannabis in the presence of his son.

On the same day the care coordinator undertook a home visit but Mr J was not in. He planned to visit again on 9 June.

On 9 June the care coordinator visited Mr J at home. Mr J did not answer the door despite the lights being on and it appearing that he was in.

On 10 June the care coordinator visited again. Mr J was standing outside his house because he had lost his keys. When asked where his son was, he said he did not know. He had arranged for a neighbour to take care of his son but should have collected him at 8.00am that day but he had not done so. Mr J had no phone number to check the whereabouts of his son but he believed that the neighbour would have taken his son out with her.

The care coordinator raised his concerns with Mr J about the number of times that Mr J was leaving his son with others. He also raised the issue about Mr J causing a disturbance in the area. Mr J disagreed and could not accept that the reports were due to his behaviour. The care coordinator informed Mr J that he would be contacting the child assessment team to make them aware of his concerns.

The care coordinator duly contacted the duty social worker. He made her aware of the previous malicious referral and consequent police visit. He was reassured that this would be taken into account in any planned assessment of Mr J and his son.

The local authority child assessment team visited in the evening and noted the smell of cannabis and that Mr J appeared to be intoxicated.

On 11 June the care coordinator agreed to visit while the duty social worker was with Mr J discussing the use of short-term foster care, which she felt would enable Mr J to address his current problems. Mr J did not agree with this plan. He had contacted his solicitor.

At this time Mr J's son was being looked after by a friend who lived locally and the plans for foster care continued to be considered.

The care coordinator met with Mr J and discussed the recent anniversary of his partner's death. The care coordinator noted that Mr J had lost weight and had not eaten. He expressed no suicidal thoughts and had the contact number for the CRHT should he need it over the weekend. The care coordinator planned to see Mr J again on Monday 14 June.

The care coordinator received a telephone call from Mr J's mother, who had concerns over the effect foster care would have. She explained that the friend currently caring for Mr J's son had given up her job to continue caring for him. The mother also said that when her health had improved she was willing to care for the son; so, too, was her sister, who lived in Wales. The care coordinator passed this information on to the duty social worker, who confirmed that the son was to stay with the friend for the time being.

On 13 June Mr J contacted the CRHT. He said he had been told that he was not to have direct contact with his son but had tried to contact the person caring for his son. He had been unable to do so. He was worried and missed his son.

Mr J told the CRHT that he was not suicidal but frustrated because he did not know what was going on. He felt that the decision by social services had been totally unnecessary and he did not understand why they were worried about his son. He was advised to contact his care coordinator on Monday 14 June. He agreed to do so but said he felt uncomfortable as he believed the care coordinator may have been involved with the recommendation that he should no longer care for his son.

On 16 June the care coordinator contacted the duty social team to get an update on what was being planned for Mr J's son.

The plan was that Mr J's son would be returned to him that evening with the condition that a care plan was agreed and that support for Mr J was increased. Mr J had previously received a service from Sure Start but this had ceased; arrangements were now put in place for it to be reintroduced. The health visitor had seen Mr J's son and had no concerns about his physical well-being.

The duty social care team allowed the care coordinator to explain the plan to Mr J prior to the social work team visiting later in the day.

Mr J showed no emotion when he was told of the plan and continued not to accept that his behaviour had led to this action. He said he was in contact with a solicitor and felt that his human rights had been violated. He told his friends to stay away. He cut the plugs off his stereo and said that he and others would not smoke cannabis in or around the house. He still refused to accept that he and his friends intimidated the neighbours.

Mr J had a supply of medication and said he wanted no further support from the care coordinator. The care coordinator asked him to consider this decision over the next few days. The care coordinator also planned to discuss Mr J's decision with his manager and medical staff on Monday 21 June. We found no evidence that such a discussion took place.

On 24 June, the care coordinator went to visit Mr J but he was not at home. The care coordinator found out that he had gone away for a break.

The care coordinator spoke to Mr J's mother on the telephone who had been unwell. She explained that she had no intention of returning to live near Mr J, because she was unable to support him any longer due to the stress involved.

On 15 July, the care coordinator visited Mr J. He had received a letter from the local authority's children and young people service addressed to his deceased partner and was upset about this. The letter stated that Mr J was letting others in to the house and causing antisocial behaviour. Mr J denied the allegations and felt that the authorities "had it in for" him. He also felt that the situation had deteriorated since his mother left the area. He should have attended a hearing, at the children and young people service about his behaviour on the previous day, but was unable to attend owing to the lack of child care arrangements. Mr J told the care coordinator that he had been taking his medication until recently. He was sleeping well, though, with no paranoid ideation. The care coordinator planned to visit again during the following week.

On 21 July, the care coordinator visited as planned. Mr J was not at home but his new partner explained that he had gone to the shops. The care coordinator waited for 20 minutes but Mr J did not return.

The care coordinator had annual leave scheduled and was not able to see Mr J prior to this commencing.

On 29 July the police telephoned the CMHT explaining that Mr J had been arrested following a disturbance the previous day linked to the death of a man.

Mr J was charged with murder on 30 July 2010.

In February 2011 Mr J was found guilty of murder and sentenced to life imprisonment with a minimum term of 16 years.

## **6 Issues arising**

In the following sections of the report we provide our comments on and analysis of the issues in relation to the care and treatment of Mr J that we have identified as part of our investigation.

We consider the following issues:

- the formulation of diagnosis and pathway of care;
- the CPA and care management;
- risk assessment and risk management;
- forensic history and multi-agency public protection arrangements (MAPPA);
- safeguarding; and
- predictability and preventability.

## 7 Formulation of diagnosis and pathway of care

In this section we examine whether due consideration was given to Mr J's diagnosis and whether he was in the right pathway of care.

### 7.1 Diagnosis

Mr J was first assessed by the CRHT in July 2005. During the assessment Mr J reported that he had experienced low mood for a year and some anxiety symptoms. He also reported "paranoia"; however, he did not elaborate on the assessment. The records show that Mr J's brother had been murdered nine years previously, when Mr J was 14 years old. Mr J had difficulty dealing with this bereavement. The records also note that this was around the same time as he started smoking cannabis – which he had used ever since. Mr J also reported constant arguments with his girlfriend. At the time of assessment he was on probation for carrying two sharp knives. He also had several previous convictions and had served custodial sentences for violent offences including assault, criminal damage and possession of drugs. The CRHT treated him with olanzapine and he was transferred to the CMHT for further support.

#### 7.1.1 Analysis

There is insufficient evidence to suggest that Mr J suffered from a drug-induced psychosis. The notes document that Mr J had "paranoia" but do not describe it in any detail. There is no evidence to suggest the nature of this belief or the conviction with which he held it. No other psychotic symptoms are recorded. From the available evidence, Mr J's primary problems seem to have been dependence on cannabis and traits of dissocial personality, as evidenced by a maladaptive pattern of behaviours including long-term offending, low threshold for resorting to violence and aggression, poor impulse control and low frustration tolerance.

When we meet with Mr J's mother she told us that she thought that he was experiencing Post Traumatic Stress Disorder (PTSD) relating to the death of his brother, the death of his partner and the stress from dealing with social services and asked whether this diagnosis had been considered. We can understand why Mr J's mother thought that a diagnosis of PTSD could be the case.

In January 2006 Mr J was assessed by a psychologist who said he seemed to be suffering from post-traumatic stress, from anxiety and depression and drug abuse. Mr J was placed on the psychology waiting list for counselling, which would have been the recommended treatment for PTSD. His pathway of care would therefore not have changed. Throughout his care and treatment Mr J declined to attend for counselling.

We found there was no evidence to suggest that Mr J was suffering from PTSD. Although he suffered stress we can find no evidence that he experienced any of the symptoms of a diagnosis of PTSD such as flashbacks, nightmares, or extreme anxiety.

## **7.2 Pathway of care**

Mr J was first assessed by the CRHT in July 2005 after threatening to hang himself. In August he was referred to the CMHT. The Trust has told us that it is unable to locate an operational policy for the CMHT that was in place at the time of the incident, so we have been unable to assess whether Mr J met the criteria for receiving services from the CMHT. His main problem was cannabis use, for which he was referred to Lifeline, the local drug and alcohol service.

When we met with Mr J, he told us that Lifeline was unable to help him because it did not provide services for people whose sole problem was cannabis. This was confirmed by staff when we held our focus groups.

The Trust's policy *Clinical Management of Service Users with Dual Diagnosis, October 2008* was in place at the time of the incident and describes dual diagnosis as co-existing mental health and substance misuse disorders.

Mr J was not referred to the dual diagnosis service.

### **7.2.1 Analysis**

The Trust has told us that it is unable to locate an operational policy for the CMHT that was in place at the time of the incident. However, we have seen an undated draft policy which describes the inclusion criteria, regular review of progress against the care plan and discharge planning.

We have made a recommendation, based on our finding that Mr J did not require support from secondary mental health services, about timely discharges to further this work.

## **7.3 Findings**

There is not enough evidence in the records to show that Mr J suffered from a mental disorder that needed support from secondary mental health services.

Mr J's primary problem was cannabis use. He should have been referred to the substance misuse services for a comprehensive assessment of his problems.

There is not enough evidence to show that Mr J suffered from a mental disorder in order to be considered for the dual diagnosis service.

Mr J and his mother received good support while under the care of the mental health services.

#### **7.4 Recommendation**

The Trust should take steps to ensure that patients are reviewed within the multi-disciplinary team on a regular basis so that timely discharge and relapse plans are put in place.

## 8 Care Programme Approach and care plans

In this section we examine how the CPA was used to plan Mr J's care.

CPA is the process mental health services use to coordinate the care of people with mental health problems. The concept was introduced in 1991, and in 1999 *Effective care coordination in mental health services – modernising the care programme approach* set out the arrangements for all adults of working age under the care of secondary mental health services. The key elements of the CPA are:

- systematic arrangements for assessing the health and social care needs of people accepted by specialist mental health services;
- a care plan which identifies the health and social care to be provided from a range of sources;
- a named care coordinator to keep in touch with the service user and to monitor and coordinate care; and
- regular reviews and agreed necessary changes to care plan.

The Department of Health published *Refocusing the care programme approach* in March 2008. This document updated the guidance and emphasised the need to focus on delivering person-centred mental health care. It also confirmed that crisis, contingency and risk management are integral parts of assessment and care planning.

The Trust's CPA and care coordination policy dated June 2010 includes key elements of national policy and best practice guidance, and is referenced. The policy also deals with implementation, review, monitoring and audit.

In the introduction, the policy sets out the following:

- to whom it applies;
- where and when it should be applied;
- why the policy is necessary;
- the duties of key members of staff;
- the underlying beliefs upon which the policy is based;
- the standards to be achieved; and
- how the policy standards will be met through working practices.

In para 2.3 the policy states:

“Care Programme Approach’ describes the approach used in secondary mental health care to assess, plan, review and coordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex needs and as outlined in ‘Still Building Bridges (DH, 1999)’, and also describes care management functions with local authorities.

“The term ‘Standard Care’ describes the approach used in secondary mental health care to assess, plan, review and coordinate the treatment, care and

support needs for people in contact with secondary mental health services who do not have complex needs. These individuals are more likely to have straightforward needs, have the involvement of one agency or no problems with accessing other agencies/support, and present with lower risk. Individuals who are Fair Access to Care Services (FACS) eligible and who do not have complex needs are likely to be eligible for standard care and, as such, will remain with secondary mental health services.

“Any decision about the individual having their care managed by CPA or standard care must be discussed and agreed with the service user and the practitioners involved in the delivery of care”.

Paragraph 5 addresses the involvement of carers, to which end care coordinators should:

- “Be aware of who the main carers are and their contact details.
- Ensure that the carer has the care coordinator’s contact details and that these are offered in writing.
- Communicate with carers.
- Address issues of confidentiality and consent. (These should not pose an automatic barrier to carer involvement.)
- Offer and conduct a full carer’s assessment when required.
- Produce an individual support plan for the carer when required.
- Promote authority of the carer in the provision of appropriate services for the service user.”

The policy links the process of assessment with care planning, and gives clear guidance on what the care plan should include and the care coordinator’s role within that. The policy also said that for those on standard CPA the care plan may take the form of a clinician’s letter.

## **8.1 Findings**

Mr J was placed on standard CPA, allocated a care coordinator from the CMHT and regularly reviewed in the outpatient clinics. He was also offered psychological therapy, anger management courses and referral to local substance misuse services for his continued cannabis use. He engaged with the psychologist but not with the anger management course. He was discharged from the CMHT in September 2007 but had the opportunity to attend outpatient reviews.

Mr J was last seen by the care coordinator on 15 July. On 21 July, the care coordinator visited as planned. Mr J was not at home but his new partner explained that he had gone to the shops. The care coordinator waited for 20 minutes but Mr J did not return. Due to annual leave the care coordinator was unable to see Mr J again prior to the annual leave commencing. The CRHT was informed of Mr J’s arrest on 29 July.

When we met with Mr J he told us that he had a good relationship with his care coordinator who had helped him through some difficult times; Mr J felt that he could open up to him.

Mr J was assessed as Standard CPA. We did not find any evidence of the rationale for this decision in the notes. However, given the lack of evidence that Mr J suffered from a mental health disorder, Standard CPA seems appropriate.

A care plan was developed by the CRHT when Mr J was first referred in July 2005. We found evidence of care plans dated 18 January 2006, 22 February 2007, 23 October 2008 and 4 May 2010. There are several letters to the GP about the care being provided, but these do not contain details of the level of CPA that applied to Mr J.

We also found a copy of the care plan review undertaken on 4 May 2010, but most of the information in this document was a replication of the previous notes. It is also documented in the electronic case record that Mr J attended his CPA review on 10 May 2010; however, we were unable to find the details of this review.

Mr J was allocated a care coordinator from within the CMHT as per the Trust policy.

## **8.2 Comment and analysis**

Clear documentation of the care plan review, including the rationale for the care plan and the level of CPA remaining in place, should have been available in the case notes.

While the care coordinator was in regular contact with Mr J's mother (who is recorded in the notes as the main carer and who accompanied Mr J to some of his outpatient appointments), we can find no evidence that the mother was involved with the development of his care plan, nor did we find any evidence of a carer's assessment having been undertaken.

During our interviews we were told that the Trust undertakes an annual audit of CPA and reports to Monitor<sup>1</sup> and to commissioners on performance. The Trust is subject to a CQUIN<sup>2</sup> target of 95 per cent of patients, cared for under the CPA, having had an annual review of their care. The Trust has a process by which it assures itself that all clinical areas adhere to CPA standards, including completion of risk assessments, and is actively subject to a performance monitoring process. This process utilises team dashboards to display performance at business delivery unit level down to individual team level. The approach empowers all tiers of management to engage proactively with the service improvements in this area.

---

<sup>1</sup> Monitor is the sector regulator for health services in England, Monitor's job is to make the health sector work better for patients.

<sup>2</sup> The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

Within the CPA process there is a module to review carers' needs. When identified, the information is used to inform the wider care plan. The carers' needs module is subject to an annual review along with the rest of the care plan.

The Kirklees service uses a family therapist to help improve the quality of carers' engagement. Within the wider trust, carers' involvement is supported by the strategy *Our Commitment to Carers*, the implementation of which is led by a dedicated resource, a carers' development officer within each team there are carers' networks and team champions. Carers' engagement is further supported by the provision of training workshops on their involvement and the use of patient experience questionnaires. On acute wards, the Trust runs regular carers' meetings.

### **8.3 Conclusion**

The Trust has made significant improvements in relation to CPA and we have made no recommendation in this area.

## 9 Risk assessments and risk management

In this section we examine the risk management process followed for Mr J.

National policy requires that risk assessment and risk management should be at the heart of effective mental health practice. Risk management should be an integral aspect of the CPA. The outcome of risk assessment should feed back into the overall clinical management.

*National best practice guidance in managing risk in mental health services* (DOH 2007) sets out three risk factor categories. These are:

1. Static factors. These are unchangeable e.g. a history of child abuse or suicide attempts.
2. Dynamic factors. These change over time e.g. misuse of drugs or alcohol.
3. Acute factors or triggers. These change rapidly and their influence on the level of risk may be short-lived.

Trust policy says that risk assessments should be reviewed annually and following any risk incident/potential increase in risk and should involve face-to-face contact between the clinician and the service user.

### 9.1 Findings

We found evidence in the notes that clinicians undertook risk assessments and that the initial risk assessment /management plans were completed on 21 December 2008, 30 September 2009 and 7 May 2010. The section on aggression and violence recorded Mr J's history and that he had not expressed any intent to harm others.

However, we agree with the Trust's serious incident (SI) investigation findings that this section was by and large replicated from the previous year's documentation. The identification of significant risks was based on the history of repeated violence and aggression and consistent irritability. In the weeks prior to the incident, Mr J had displayed aggressive behaviour, such as intimidating a neighbour and threatening his mother, as a result of which she left her home and sought refuge in a hostel.

The risk assessment was not changed to reflect the reduction in support offered by Mr J's mother in February 2010.

Another important factor omitted was the risk to the young child due to Mr J's chaotic drug use and violent behaviour.

A risk management plan was put in place and included:

- assessment by a psychologist;
- referral for anger management;
- monthly home visits to monitor Mr J's mental health/ provide support;
- regular outpatient appointments to monitor mental health and review medication; and
- referral to the CRHT as necessary.

## **9.2 Comment and analysis**

A risk assessment was carried out for Mr J when he was first referred to the CRHT and a risk management plan was put in place. Both were reviewed annually as per trust policy. The content, however, was by and large replicated from the previous year's documentation, although elements of Mr J's circumstances had changed.

## **9.3 Conclusion**

The review of Mr J's risk assessment fell outside of best practice, however from the evidence reviewed and interviews undertaken it is clear that changes are now embedded in current practice we have therefore made no recommendation.

## 10 Police forensic history and MAPPA

In this section we consider Mr J's forensic history and the role of multi-agency public protection agreements (MAPPA).

We could find no comprehensive list of Mr J's police forensic history in the notes, but the clinicians providing care were aware of a significant number of offences. He had several convictions and served custodial sentences for violent offences including assault, criminal damage and possession of drugs. A letter to Mr J's GP from the senior house officer (SHO) in psychiatry dated 30 January 2006 states that Mr J had 60 convictions for burglary, assault, carrying offensive weapons and also car theft.

During the period July 2005 to June 2007 it is documented in the notes that the following incidents occurred:

- in July 2005 he was placed on probation for carrying two sharp knives;
- in October 2005 Mr J received a 12 months' suspended sentence for assaulting his girlfriend;
- on 29 November 2006 Mr J was arrested for violent behaviour and damaging his girlfriend's mother's car;
- on 20 December 2006 Mr J was arrested for threatening his girlfriend and he had a knife when police attended the scene; and
- on 20 June 2007 Mr J assaulted his girlfriend's friend.

MAPPA arrangements manage the risk posed by the most serious sexual and violent offenders. The police, probation and prison services and other agencies are brought together to share information so that risk assessments and risk management plans can be put in place.

There are three categories<sup>1</sup> of offender under MAPPA criteria:

“Category 1 – Registered sexual offender

“Category 2 – Murderer or an offender who has been convicted of an offence under Schedule 15 of the Criminal Justice Act and:

- who has been sentenced to 12 months or more in custody; or
- who has been sentenced to 12 months or more in custody and is transferred to hospital under s.47/s.49 of the Mental Health Act 1983 ('MHA 1983'); or
- who is detained in hospital under s.37 of the MHA 1983 with or without a restriction order under s.41 of that Act.

“Category 3 – Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management.”

---

<sup>1</sup> <http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf>

## **10.1 Findings**

Mr J had several convictions and had served custodial sentences for violent offences, including assault, criminal damage and possession of drugs. A letter to Mr J's GP from the SHO in psychiatry dated 30 January 2006 states that Mr J had 60 convictions for burglary, assault, carrying offensive weapons and also car theft.

It is documented in the notes that at the time of assessment in July 2005 he was on probation for carrying two sharp knives. In October 2005 he received a 12 months' suspended sentence for assaulting his girlfriend. He was arrested for violent behaviour and damaging a car in November 2006. He was again arrested for threatening his girlfriend and possession of a knife in December 2006. In June 2007 he assaulted his girlfriend's friend.

## **10.2 Comment and analysis**

Obtaining an accurate police forensic history is an important part of risk assessment and management to ensure that all factors are taken in account. There is no evidence that this happened in this case. At interview staff told us that the Trust has a process for liaising with the police over a patient's forensic history to ensure a full history and risk profile are obtained. This information is requested for patients who are known or thought to have a forensic history and then decline to expand on this information.

## **10.3 Conclusion**

Whilst there is no evidence that there was an accurate police forensic history obtained for Mr J the trust now have a process in place for obtaining a full history and risk profile. We have therefore made no recommendation.

## **11 Safeguarding**

The Trust policy and procedures on safeguarding and promoting the welfare of children in place at the time of the incident incorporate the West Yorkshire consortium multi-agency safeguarding procedures. The policy states that:

“The procedure is for all agencies to follow and Part 3 of the policy addresses how staff can comply with the West Yorkshire policy and procedures. In Part 2, the policy addresses how the needs of children should be routinely considered as part of the care programme approach (CPA) process and in day-to-day work with patients/service users. This is with a view to supporting patients with parenting responsibilities and their families and to preventing children from experiencing significant harm or impairment to their health or development”.

### **11.1 Findings**

We found that the mental health services did engage with the safeguarding team and that information was shared when there was an investigation with regard to child care. However, we could find no evidence in the notes of when Mr J’s child was originally referred to social services after the death of his mother, Mr J’s partner.

There were several issues relating to the care of Mr J’s child:

1. In March 2009 Mr J’s family was discharged from the children and families’ caseload as the team no longer had concerns about the parenting skills. However, Mr J had an extensive history of cannabis use and there was no mention of regular screening for the use of cannabis as part of the assessment by the social services.
2. During the home visit by the care coordinator on 22 May 2009, Mr J was threatening and verbally aggressive to his mother. There is no evidence in the notes that this was reported to the social services.
3. On 26 May 2009 Mr J’s sister contacted the CMHT raising concerns that over the previous few days Mr J had locked himself in his house with his son and would not speak to anyone but his care coordinator. There is no evidence in the notes that this was reported to the social services.
4. Mr J’s continued cannabis use and the impact of this on his ability to parent the young child should have been communicated to the social services.

### **11.2 Good practice**

On 14 March 2010 the CMHT was contacted by the emergency social services duty team following a referral by the police. Mr J had been visited by the police on 11 March in the light of allegations that he was abusing his son. This followed an

anonymous call to the police. There is good practice here to highlight information-sharing between the agencies.

### **11.3 Comment and analysis**

We heard at interview and in discussion with the focus groups that we saw, that the Trust now works closely with local authorities to ensure that safeguarding issues are addressed and that policies and procedures are adhered to. The Trust has ensured that capacity exists to support safeguarding. In addition, there is a named doctor for safeguarding along with six clinical safeguarding advisors and eight practice governance coaches who support safeguarding at a clinical level. Safeguarding is an inherent process to risk assessment and within the CPA process. The Trust is currently trialling a new two-stage mental health assessment process which incorporates risk and safeguarding issues.

We also heard that the Trust assures itself of its performance through an annual audit of cases open to clinicians to ensure compliance with policy. The Trust offers and ensures that staff attend training in safeguarding at basic awareness level 1 and level 2. The Trust has provided us with evidence of the training figures. These figures are monitored monthly to ensure compliance with the 80% target set by the Trust.

The Trust told us that it recognises that safeguarding is an evolving agenda shared between itself and local authority colleagues, and that significant progress has been made since this incident in improving staff awareness of issues and of joint working with other agencies.

When we met with staff they told us that further integration of electronic record systems between the local authority and the Trust would be helpful. This would improve the efficiency of administration and give advance warning of safeguarding issues.

### **11.4 Conclusion**

The Trust has made significant improvements in taking forward the safeguarding agenda. Further improvements to the electronic record systems would promote integration.

### **11.5 Recommendation**

The Trust should consider the options available to refine and develop its electronic record systems and thereby ensure greater integration of systems in regard to safeguarding, care planning and care delivery.

## **12 Predictability and preventability**

In this section we examine whether the incident could have been predicted or was preventable.

### **12.1 Predictability**

We would consider that the homicide was predictable if we found there was evidence from Mr J's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

Mr J had several convictions and served custodial sentences for violent offences including violence to others criminal damage and possession of drugs. He had problems with his anger management and had failed to engage when referred to an anger management course.

Mr J's care coordinator last saw him on 15 July when he reported that Mr J had been taking his medication until recently and that he was sleeping well with no paranoid ideation.

The care coordinator visited on 21 July as planned. Mr J was not at home but his new partner explained that he had gone to the shops. The care coordinator then went on leave, Mr J was aware of how to contact the CRHT should he need to but there is no evidence that Mr J's case was handed over to a colleague. We were informed at interviews with staff that a buddy system has now been implemented to cover annual leave and absences of staff.

#### **12.1.1 Finding**

Although Mr J had an extensive forensic history that included harm to others, we found there was no evidence from Mr J's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently. The incident was therefore not predictable.

### **12.2 Preventability**

The homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but didn't take the steps to do so.

Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

We found no evidence to indicate that staff had the knowledge, opportunity or means to prevent the homicide from taking place. When the care coordinator last visited

Mr J on 15 July we found no evidence that any further action should have been taken – for example, admission to hospital that may have prevented the incident. The care coordinator was on annual leave at the time of the incident, but when Mr J had felt unwell in the past he had contacted the CRHT for help and advice. He did not do so on this occasion.

#### 12.2.1 Finding

We found that the incident was not preventable.

## **13 The Trust's internal investigation and progress made against the recommendations**

The terms of reference for this investigation include assessing the quality of the internal investigation and reviewing the Trust's progress in implementing the action plan.

In this section we examine the national guidance and the Trust's incident policy to determine whether the investigation into the care and treatment of Mr J met the requirements set out in these policies.

### **13.1 The Trust's internal review**

The good practice guidance *Independent investigation of serious patient safety incidents in mental health services* (NPSA February 2008) advises that, following a homicide, an internal NHS mental health trust investigation should take place to establish a chronology and identify underlying causes and any further action that needs to be taken. The Trust policy also advises that an internal investigation should take place following a serious incident to see if any lessons can be learnt. In this case, the Trust did commission an internal review into the care and treatment of Mr J. The review was led by an external SI investigator.

The Trust introduced the investigation of incidents, complaint and claims policy in 2008 to learn from experience. This policy was still in place at the time of this incident.

The Trust policy says that "red (serious) incidents will always be the responsibility of at least the general manager or equivalent. Investigation will usually be by a team with at least the lead investigator independent of the service".

The Trust policy also states that:

"Where possible and appropriate the service user, family and/or carers of service users involved in a serious incident will be contacted to establish their possible care and support requirements, and to explain and discuss the investigation process".

The terms of reference for the internal review were:

"To examine:

- the care service user X was receiving at the time of the incident (including that from non-NHS providers, e.g., voluntary/private sector);
- the suitability of that care in view of X's history and assessed health and social care needs;

- the extent to which that care corresponded with statutory obligations, relevant national guidance, trust policies, including any team or service operational policies and professional standards;
- relevant professional and clinical judgments and decision-making;
- the adequacy of the risk assessment and care plan and their use in practice; and
- the interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs, with particular reference to the Care Programme Approach (CPA), referral and discharge processes;

“To identify:

- actions taken following the incident to manage the immediate situation, to provide support to those affected and to improve services;
- any significant care concerns, including:
  - those that had a direct impact on the outcome of the incident;
  - those that did not have an impact on the outcome of the incident;
- any areas of particularly good practice; and
- findings and learning points for improving systems and services;

“To undertake:

- a root cause (causal) analysis of the significant care concerns that had a direct impact on the incident outcome;

“To make:

- realistic recommendations to address the findings and learning points to improve systems and services and learn lessons for the future.”

## **13.2 The investigative process**

The Trust investigation policy and procedures set out a clear process for undertaking a red (serious) incident investigation.

This policy details the responsibilities of the lead investigator and the ways in which staff should be involved in an investigation, including conducting interviews – requesting witness statements and transcribing interviews, which should be signed by the staff member.

## **13.3 Recommendations and action plans**

In this section we look at the Trust's progress in implementing the action plan resulting from the internal investigation report.

The report set out several areas that needed improvement and included four recommendations.

The Trust's CRHT and CMHT should satisfy themselves that:

- the systems and support intended to ensure that regular CPA reviews take place are adhered to in accordance with trust policy;
- when CPA reviews are recorded as having taken place, the reviews take place in accordance with the Trust's CPA policy and guidance; and
- for those individuals subject to the CPA who are arrested and subsequently held in prison, liaison takes place with the appropriate prison services as soon as is possible in order to ensure continuity of care.

In addition to the above recommendations, the Trust should ensure that:

- the processes in place to retrieve externally archived manual clinical notes and associated records are fit for purpose.

### **13.4 Findings**

The Trust commissioned an SUI investigation in line with national and local good practice.

However, the SUI investigation did not fully comply with trust policy and procedure in the following particulars.

- The terms of reference are clear but do not include the names of the investigating team or include the involvement of family and/or carers of Mr J.
- Transcripts were not taken of the interviews held with staff during the investigation process.
- We found no evidence that Mr J's family or carers were involved in the Trust investigation.
- The final report is dated November 2010, the incident having happened on 29 July 2010. The policy says that investigations of this nature should be completed within eight weeks of the incident unless a different timescale is agreed with the service manager, head of service or general manager. We have seen evidence that an extension was agreed in this case.

An action plan was developed by the Trust to take forward the recommendations. Each recommendation was allocated to a lead person and a timescale was identified.

The Trust has given us evidence that it has put the recommendation in place; however, the original timescales for the completion of the action plan slipped.

The CPA and the care coordination policy and procedural guidance have been reviewed, and a procedure for archiving paper records has been developed. RiO will minimise the need for archiving paper records in the future.

We held interviews with senior managers and met with two focus groups comprising clinicians who were familiar with the new CPA guidance. Annual audits are undertaken to provide assurance that demonstrates compliance across the services.

We heard from the Trust that the investigation policy was reviewed and that the investigating and analysing incidents complaints and claims to learn from experience policy (December 2010) has been implemented.

Work has since been undertaken on the action planning process with increased monitoring via the governance groups. Training has also been undertaken with lead investigators and the Trust now employs four full-time lead investigators who are supported by six other individuals.

Given the above, we are assured that the Trust has made improvements in this area and we have made no recommendations.

### **13.5 Post-incident investigation and governance**

The Trust has a comprehensive governance process for the management of serious incidents. The process uses the Datix reporting system to highlight alerts as incidents occur and to track post-incident reviews and monitor subsequent actions. The process and incident reports are overseen by the director of nursing who has responsibility for patient safety. Completed post-incident reports are reviewed by an incident review sub-committee which ensures the completion of the report within nationally agreed timescales, the quality of the report and the appropriateness of the recommendations made.

The Trust supports this process of post-incident reviews through deployment of four whole time equivalent dedicated investigation staff and a programme of training in root cause analysis and report writing. The Trust also delivers a series of learning events to ensure that lessons learnt are disseminated.

The Trust's approach to serious incidents is both comprehensive and systematic and there is evidence that it has refined its processes since this incident.

### Team biographies

#### Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its highest-profile investigations and reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations and individual management reviews. As head of training, Chris has developed and delivered courses on different aspects of systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people.

#### Liz Howes

Liz Howes has 20 years' experience of senior management in the NHS, specialising in mental health and learning disabilities. Liz led on a service improvement project in mental health services as part of a national pilot with the National Institute for Mental Health in England, and was responsible for leading a multi-agency project plan for the re-provision of homes for people with learning disabilities. This involved providing alternative accommodation and ensuring mainstream services for residents that promoted social inclusion and personalised care. Her previous posts have included interim director of learning disabilities and specialist services and head of services redesign and information services at Leicestershire Partnership NHS Trust; and director of mental health services at Leicestershire and Rutland Healthcare NHS Trust.

### Acronyms used in report

NICE – The National Institute for Health and Care Excellence

CRHT – Crisis Resolution Home Treatment Service

CPA – Care Programme Approach

CMHT – Community Mental Health Team

PTSD – Post-traumatic Stress Disorder

EDS – Emergency Duty Service

MAPPA - Multi-agency Public Protection Arrangements

FACS – Fair Access to Care Services

CQUIN – The Commissioning for Quality and Innovation

SI – Serious Incident

SHO – senior house officer

MHA – Mental Health Act