

# VERITA

IMPROVEMENT THROUGH INVESTIGATION

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

**Mr G**

A report for  
NHS England, North Region

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# **1 Introduction**

NHS England, North Region 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 G.

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 may 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.

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

Mr G, a 24-year-old man, was arrested on 22 December 2010 on suspicion of murdering his girlfriend (Miss H). He pleaded guilty to manslaughter and was sentenced to four years in prison. Mr G was diagnosed with drug-induced psychosis, substance misuse with antisocial personality traits. He was receiving care and treatment from Lancashire Care NHS Foundation Trust at the time of the offence.

The Chief Executive of Lancashire Care NHS Foundation Trust commissioned an internal trust investigation into the care and treatment of Mr G.

## **1.2 Overview of the trust**

Lancashire Care NHS Foundation Trust was established in April 2002 and authorised as a foundation trust on 1 December 2007.

The trust provides health and wellbeing services for the population of Lancashire. It specialises in inpatient and community mental health services. The trust also provides community nursing, health visiting and a range of therapy services, including physiotherapy, podiatry and speech & language services.

## 2 Terms of reference

- 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.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying 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 user harming themselves or others.
- Examine the effectiveness of the service user's care plan, including the involvement of the service user and the 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 to the independent investigation**

The investigation team consisted of Chris Brougham, senior consultant from Verita, and Dr Peter Jefferys who provided expert psychiatric advice. Biographies for the team are in appendix A.

Documentary evidence was gathered including national and trust policies and procedures and Mr G's clinical records. We also examined the trust's investigation report and the action plan.

Mr G gave his written consent for us to access his medical and other records for the purposes of the investigation. We met Mr G 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 G was given the opportunity to read a draft of this report before it was finalised.

A meeting was held with Miss H's sister to explain about the independent investigation and share the findings of the report.

We interviewed staff from the trust only where we found a gap in information or an area that required clarification or to find out what developments had taken place in the trust since this incident. The following people were interviewed:

- care coordinator;
- consultant psychiatrist; and
- team manager.

All the evidence was analysed and recommendations have been made to improve services.

This report includes a chronology outlining the care and treatment of Mr G. The analysis appears in sections 7 to 12 where particular issues and themes are highlighted.

Lesley Sargeant, a partner from Verita, peer reviewed this report.

## **4 Executive summary and recommendations**

### **4.1 Executive summary**

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

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 might not identify root causes or find anything in the provision of healthcare that directly caused the incident, it might find things that could have been done better.

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

Mr G had a forensic history. Records show that he had served seven months in a youth offending unit in 2003 for assault. He also had convictions for being drunk and disorderly, possession of weapons and theft but the trust records do not provide details of each conviction or state when some of these offences occurred. In 2009 Mr G was convicted of shoplifting and resisting arrest. He was placed under a probation order but the length and frequency of this order is not documented in the records.

Mr G's GP referred him to mental health services in March 2007. Thereafter, Mr G was supported predominately by the trust's Early Intervention Service (EIS). He was diagnosed with a drug-induced psychosis, substance misuse and antisocial personality traits. Mr G was difficult to engage. He frequently failed to attend outpatient appointments and did not answer or respond to telephone calls and messages. Staff from EIS frequently found him difficult to track down.

In December 2009, Mr G moved into 24-hour supported-living accommodation at Centaur Court. He developed a relationship with a female tenant, Miss H. In 2010, a project worker at Centaur court advised Mr G's care coordinator that Mr G and Miss H argued regularly and that there was aggression from both parties.

Mr G's care coordinator made an unannounced visit to Centaur Court to assess Mr G's progress and presentation. The care coordinator initially spoke with staff members, who reported that Mr G had been well behaved and that there had been no incidents of note. The care coordinator met Mr G at his flat with Miss H. The records note she was able to make her own informed choices and was not vulnerable.

### **4.3 Overall conclusions about care and treatment**

Mr G was reluctant to engage with services but the clinical team made strenuous efforts to locate him to provide him with support.

There is evidence that Mr G received regular clinical reviews and that staff liaised with probation and housing services.

There is no evidence to show whether the reported volatile relationship and the possibility of domestic violence were ever discussed within the trust multidisciplinary team or with staff at Centaur Court where Mr G and Miss H were living separately.

A discussion between staff at Centaur Court and the trust would have been helpful so that a decision could be made about whether or not the trust or Centaur Court staff should have sought safeguarding advice or made a safeguarding referral. This discussion may have helped trust staff to decide whether any changes to Mr G's risk management plan were needed.

The trust's annual safeguarding report outlines the significant improvements that have been put in place since this incident. Improvements include the appointment of adult named safeguarding nurses and practitioners. These staff work proactively with all clinicians and managers across the trust to promote and support the identification and appropriate management of abuse.

All relevant trust clinical staff have now received safeguarding training. This includes reinforcing the need to embed routine enquiries about any abuse into the assessment processes and to increase 'professional curiosity' in regard to suspected or potential abuse.

### **4.4 The trust investigation**

The trust carried out a post-incident review. This was in line with trust policy. There was no evidence to show that the trust had made any efforts to locate the victim's family. The investigative process could also have been improved if the trust had commissioned a team rather than one individual to carry out the investigation. Interviewing individual staff and obtaining statements from staff would also promote a more comprehensive approach to the investigation. Since this incident the trust has introduced a new policy and procedure for the investigation of serious incidents.

### **4.5 Recommendations**

1. The trust should carry out an audit to ensure that:
  - police criminal checks are made in line with the joint information sharing protocol between the trust and Lancashire Constabulary; and
  - the information is recorded in the clinical records and details included in the service users risk profile.

2. The trust should continue to audit community mental health teams to ensure that any potential safeguarding issues are flagged up and discussed, and that specialist safeguarding advice is sought when needed.
3. The trust should carry out an audit to ensure that the trust's incident policy and procedure is implemented. This includes ensuring:
  - that an investigation team is commissioned to carry out an investigation into a serious incident, rather than a single person;
  - the team are sufficiently senior, and trained in incident investigation techniques;
  - key members of staff are interviewed during an investigation and that an enduring record of the interviews is made;
  - that the enduring record of interviews and any witness statements should be kept as evidence, to show that a comprehensive approach to the investigation has taken place; and
  - steps are taken to locate the victim's relatives so that support can be offered during the investigation and the findings of the investigation report are shared.

## 5 Chronology of care and treatment

### 5.1 2006

Mr G was first referred to Gannow Lane Primary Care Mental Health Team (PCMHT) at Lancashire Care NHS Foundation Trust by his GP in June 2006. Unbeknown to the trust and the GP, Mr G had changed his name. Consequently he never received the first letter from the trust inviting him to 'opt in' and attend mental health services.

In November 2006, having found his new name and address, the trust wrote to Mr G inviting him to an outpatient appointment but he did not attend.

### 5.2 2007

Mr G was referred to the PCMHT by his GP in March and assessed by a psychiatrist. Mr G presented with paranoid thoughts, reporting that others were out to do him harm (nobody specific). He was low in mood and anxious. He described voices in his head but the nature of these was unclear. He had previously harmed himself deliberately by cutting his arms. Mr G had been drinking alcohol, smoking cannabis and using amphetamines and ecstasy for five years. The psychiatrist concluded that Mr G was suffering from a drug-induced psychosis and mild depression secondary to excessive alcohol intake. He was assessed as not being a risk to himself or others. The psychiatrist made a follow-up appointment to review Mr G.

Mr G was reviewed again in June 2007. His mother attended the appointment with him. They both reported some improvement in Mr G's mental state.

In July 2007, Mr G took an overdose of 70 x 25mg chlorpromazine<sup>1</sup> tablets. He was assessed at the accident and emergency liaison department at Burnley General Hospital. He was then referred to the crisis resolution and home treatment team (CRHTT). This was pending a further planned appointment with the psychiatrist.

Staff from the CRHTT made several attempts to visit Mr G during the following week but he was not available, so he was discharged. The clinical team discussed Mr G's care and treatment and they agreed to refer him to the EIS.

Mr G was seen by the psychiatrist and staff from the EIS in July. Mr G was accompanied by his mother. He described anxiety, no thoughts of harming himself or others. The psychiatrist made the following plan:

- "Stop the chlorpromazine
- Prescribe citalopram<sup>2</sup>
- Introduce olanzapine<sup>3</sup>
- Follow up by the EIS."

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<sup>1</sup> Antipsychotic medication

<sup>2</sup> An antidepressant used for depression and anxiety

<sup>3</sup> Antipsychotic medication

In August 2007 Mr G was assessed, placed on the care programme approach (CPA) and allocated a care coordinator. A health and social needs assessment was carried out. The record shows that in 2003 Mr G had served seven months in a young offenders' unit for assault. The care coordinator found it difficult to engage with Mr G as he failed to attend planned appointments and did not answer any calls from the care coordinator.

In October 2007 Mr G's GP contacted the EIS to say that Mr G had been to the surgery and was "extremely paranoid".

In November 2007, Mr G attended an appointment with the care coordinator and the EIS team manager. They thought that Mr G seemed to be suffering from a psychosis. They noted his past illicit drug and alcohol use. The care coordinator felt that Mr G could benefit from psychosocial interventions so they offered ongoing support. They also arranged for Mr G to undergo a review later the same month with the team psychiatrist. Mr G did not attend the appointment.

The care coordinator tried to contact Mr G over the next few weeks but he could not find him. The care coordinator found out that Mr G had not been seen by his mother or sister over the past few weeks.

Records show that in 2007 Mr G lived in a flat until he got into arrears with his rent; he then moved in with friends.

### **5.3 2008**

In February the care coordinator visited, unannounced, the accommodation that Mr G was now sharing with several other young adults. Mr G seemed to have been spending much of his time drinking alcohol. He had been in court for non-payment of fines and shoplifting. The care coordinator arranged to see him jointly with the probation service, as Mr G was under a probation order.

Mr G did not keep any of his appointments with probation. He was subsequently arrested for not complying with his order.

In April 2008, a psychiatrist and the care coordinator assessed Mr G during a joint visit. The psychiatrist thought that Mr G had antisocial personality disorder traits but was not convinced that he had any psychotic or depressive symptoms. He was prescribed quetiapine<sup>4</sup> 25mg twice a day to see if it would help with the voices that Mr G said he was hearing.

The care coordinator continued to attempt to contact Mr G to provide support but could not find him. The care coordinator found out that Mr G had been evicted along with all the other tenants for damaging the property. The care coordinator eventually

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<sup>4</sup> Antipsychotic medication

tracked him down via his mother as he had turned up there homeless and had been sleeping on friend's sofa's for several weeks.

The care coordinator met with Mr G in June. Mr G told the care coordinator about a recent court appearance for stealing from a supermarket. He was drunk at the time and resisted arrest. He had also been in the police cells overnight due to breach of bail conditions.

The care coordinator organised accommodation for Mr G at a hostel in Preston. He agreed to stay there and abide by the terms of occupancy, which included no drink or drugs and good behaviour. Mr G didn't settle and got drunk. He breached his conditions of stay so his tenancy was terminated. He was provided with support by the homeless persons team in Preston. Mr G was allowed to return to the hostel but breached the terms of occupancy again by taking drugs. He was therefore refused entry to the hostel again. He returned to the Burnley area and stayed at his sister's house over the Christmas period.

#### **5.4 2009**

The EIS was unable to locate Mr G in the New Year, but the care coordinator eventually found him in temporary accommodation at a hostel in early February. He had not taken his quetiapine since before Christmas and didn't want to start it again. He also said he had not had any illicit drugs since the New Year. He seemed well mentally and denied any psychiatric symptoms.

Over the next month Mr G did not keep his appointments with probation services and the care coordinator could not find him. In April 2009 the care coordinator spoke to him by phone at his grandmother's house. He said that he had been sleeping at friends' houses.

The care coordinator arranged for Mr G to meet the team consultant psychiatrist for a CPA review. When asked, Mr G described hearing voices saying that he heard up to 10 voices inside his head. He also reported that he had some paranoid ideas regarding people out to get him. He said his mood was up and down. He stated that he had occasional thoughts of suicide. He described an incident when he was sitting on a bridge over the canal and had thoughts of jumping but he was unable to act on these thoughts. The management plan was as follows:

“Recommence quetiapine 50mgs in the morning and 100mgs at night.”

At the end of April, Mr G attended a CPA review. Mr G's probation officer, mother and the care coordinator were also present. Mr G's mother stated that, throughout his life, he had been unable to take responsibility of any sort. He did not have his prescription for quetiapine, saying he had “lost it”. He seemed ambivalent about treatment generally. The care coordinator told Mr G that he had not demonstrated any commitment to engage properly with the EIS and was generally unmotivated regarding treatment. His accommodation remained an ongoing problem.

At the end of May, Mr G was arrested for being drunk and disorderly and was fined £80.00.

The EIS team was unable to contact Mr G for most of July until he made contact with the care coordinator to inform him that he had finished his probation order, and was 'OK'. He also informed the care coordinator that he had an appointment with the local college in August about starting a mechanics course.

Mr G was accepted at a hostel in Blackburn and asked the care coordinator if he could go back on medication. The care coordinator discussed this with the psychiatrist and quetiapine 300 mg was prescribed.

In November, Mr G was assessed by the manager of Centaur Court. He was accepted as a tenant and moved in during December. Mr G received 10 hours of structured support per week from staff at Centaur Court.

The care coordinator visited Mr G at the end of December. Mr G had not been taking his medication and said he had been on a drunken binge. He was dishevelled and claimed he couldn't remember what had happened to him.

## 5.5 2010

A psychiatrist assessed Mr G in January 2010. The psychiatrist noted that he was cooperative and calm. Mr G told the psychiatrist that his mood was fine and that he had no thoughts of self-harm. He accepted that he would need to take his medications. The treatment plan was as follows:

- "Take bloods and check BP and pulse
- Monitor mental state and risks regularly."

In April 2010, the manager of Centaur Court contacted the care coordinator to inform him that Mr G had damaged an internal door. Mr G had been reprimanded, asked to pay for the damage, and reminded that he was putting his tenancy at risk. A month later, the manager contacted the care coordinator again to inform him of an incident in which it was suspected that Mr G had taken mephedrone<sup>5</sup> and was in breach of the tenancy agreement.

The care coordinator visited Mr G in May. Mr G said he had not taken mephedrone but had taken an overdose of quetiapine. He could not give any reason for his actions other than that he had been drinking to excess and had been feeling "fed up".

The care coordinator visited Mr G again in July. Staff at the Centaur Centre reported that Mr G was doing well and had been accepted onto a motorcycle mechanics course. Mr G proposed some unrealistic plans to do the course at Accrington and

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<sup>5</sup> A synthetic mood-altering drug with stimulant properties

live near the college in his tent. The care coordinator felt that although Mr G was showing some motivation to move forward, his attitude more generally was immature and he was not taking responsibility, particularly in relation to his use of alcohol, his compliance with medication, his budgeting and his social activity.

Two weeks later, the manager from Centaur Court contacted the care coordinator to tell him that Mr G had been drinking again, had damaged another internal door, and had got into debt from fines and previous rent arrears. The manager told the care coordinator that Mr G did not accept that the amount of alcohol he drank was a major contributory factor to his antisocial behaviour. Mr G did agree to have an appointeeship<sup>6</sup> put in place so that his financial affairs could be better managed.

By the end of August, Mr G had entered into a sexual relationship with another resident at Centaur Court, Miss H. Staff reported that he was spending most of his time with her and that, apart from an incident some weeks previously when he got drunk and smashed his TV, he had been very well. Mr G and Miss H had asked if they could live together but this was not possible at Centaur Court as the hostel provided only single occupancy.

A psychiatrist carried out a CPA review in October. The care coordinator and a support worker from Centaur Court were also present at the review. The psychiatrist noted that Mr G's main problems seemed to relate to when he drank alcohol, because after drinking he became more prone to aggressive outbursts. The psychiatrist also noted that Mr G had entered into a relationship. The psychiatrist made the following management plan:

- "Refer to the community alcohol team
- Refer to anger management
- Continue with Mr G's current care plan
- Continue with the quetiapine at 150 mg daily."

In November the care coordinator telephoned Centaur Court and asked a project worker for an update on Mr G. The project worker did not give any detail of a specific incident, but described Mr G's relationship with his girlfriend as 'explosive, with regular arguments and aggression from both parties'.

In December the care coordinator made an unannounced visit to Centaur Court to assess Mr G's progress and presentation. The care coordinator initially spoke with staff members, who reported that Mr G had been well behaved and that there had been no incidents of note.

The care coordinator met Mr G at his flat with his girlfriend. The records note she was able to make her own informed choices and was not vulnerable within the relationship. The flat was untidy but both were tidying it up because Mr G's father was visiting them later.

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<sup>6</sup> An appointee is a person who has been appointed by the Department of Work & Pensions (DWP) or a local authority to receive welfare benefits on behalf of someone who is unable to manage his or her own affairs.

Mr G informed the care coordinator that he wished to move from Centaur Court with his girlfriend in the New Year. The care coordinator found that, although he was receiving his medication, he hadn't been taking it. Records show that he had not been drinking alcohol for the past two months.

The care coordinator discussed Mr G's debts with staff, as these had implications for any future applications for alternative housing.

On 22 December, the regional operations director for SLC Paragon Care<sup>7</sup> contacted the care coordinator to advise him that Mr G had been involved in the death of his girlfriend. She had been found dead in his flat. Mr G had voluntarily contacted the police and was in custody at Burnley police station.

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<sup>7</sup> The company that manages Centaur Court

## **6 Issues arising**

In the following sections of the report we analyse and comment on the issues we have identified as part of our investigation into the care and treatment of Mr G.

The themes are:

- the formulation of diagnosis and subsequent management;
- the CPA;
- risk assessment and risk management;
- safeguarding;
- predictability and preventability; and
- the trust internal investigation and report.

## **7 The formulation of diagnosis and subsequent management**

In this section we examine how Mr G's diagnosis was reached and whether the management plans that were put in place were adequate.

Mr G was first assessed by a psychiatrist in March 2007. A provisional diagnosis was formulated. The findings of a systematic history and mental state examination were documented. The psychiatrist noted that Mr G had low mood and a fear that people had been following him and were "going to harm him", that he drank to excess and used cannabis, amphetamines and ecstasy.

Mr G was reviewed again in May and June 2007. His mother attended the appointments with him. Her views about Mr G were recorded and taken into consideration.

The psychiatrist concluded that Mr G was suffering from drug-induced psychosis secondary to drinking alcohol to excess.

The psychiatrist reviewed G's diagnosis in July 2007. He reached the same diagnosis. Mr G's symptoms remained essentially unchanged over the next year, albeit with fluctuations in intensity.

In April 2008 a slightly different opinion was provided by another psychiatrist, who noted that "on this occasion I am not convinced that Mr G has any psychotic or depressive symptomatology, but clearly he has antisocial personality traits".

No changes in Mr G's diagnosis were made over the following 18 months, during which he was regularly reviewed by the care coordinator and psychiatrists.

Although Mr G had not been formally diagnosed as having a personality disorder as well as a drug-induced psychotic illness, his personality difficulties were well understood by the clinical team.

Mr G presented with psychotic symptoms of mild severity and was suitable for community management. He was supported in the main by the EIS. This service promotes early detection of mental illness, educates service users about psychosis and provides direction for those seeking help who are aged between 14 and 35. The care coordinator and other clinicians developed a positive therapeutic relationship with Mr G. There were significant compliance problems with medication which the service addressed, with some level of success.

### **7.1 Conclusion**

Mr G was managed within the EIS. There is evidence that staff, particularly the care coordinator, made considerable efforts to track down Mr G and provide him with support and monitoring. These interventions were appropriate and largely successful. As a consequence there was some improvement in Mr G's mental state and functioning.

There is also evidence that staff liaised with housing agencies to arrange appropriate accommodation.

There are no significant criticisms to be made of the pathway of care adopted for Mr G and its implementation.

## 8 The Care Programme Approach

In this section we examine the CPA and management process to determine whether Mr G was cared for in line with national and trust procedures.

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 Department of Health published *Refocusing the Care Programme Approach* in March 2008. This document updates the guidance and highlights 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 policy states that service users who are on CPA will:

- “be allocated a care coordinator [care coordinator];
- have an agreed care plan; and
- receive regular reviews.”

Mr G was on CPA, allocated a care coordinator and had a care plan. There is evidence that the clinical team carried out regular reviews and updated his care plan accordingly.

### 8.1 Conclusion

Mr G was appropriately cared for in line with trust CPA policy and procedures.

## **9 Risk assessment and risk management**

National policy outlines that risk assessment and risk management should be at the heart of effective mental health practice. Trust policy states that all service users should have a risk assessment completed. Any identified risks or safety issues should be incorporated into the service-user's care plan and reviewed as appropriate for up to a maximum of 12 months.

A clinical risk management tool developed by the Sainsbury Centre in 2000 advised NHS trusts that, in order to assess risk accurately, information must be gathered from relevant parties, including:

- the patient;
- carers, friends;
- relatives;
- other team members/other teams;
- other statutory or voluntary sector mental health agencies; and
- police, probation and courts.

There is reliable documentary evidence in Mr G's clinical records that staff carried out systematic risk assessments and CPA reviews on a regular basis. Mr G himself, staff from housing and Mr G's relatives all contributed to these assessments.

Mr G had a forensic history. Records show that he had served seven months in a youth offending unit in 2003 for assault. He also had convictions for being drunk and disorderly, the possession of weapons and theft, but the trust records do not provide details of each conviction or state when these offences occurred. In 2009 Mr G was convicted for shoplifting and resisting arrest. He was placed under a probation order but the length and frequency of this order are not clearly documented in the records. The care coordinator told us that Mr G was impulsive, immature and that he would steal to get money to fund his alcohol problem.

Criminal offences and convictions were identified and clarified with Mr G and his mother, and the trust liaised with probation services to obtain information. The trust did not request a criminal check from the police. This would have been useful so that the trust could document the type and nature of the offences in detail. This information would have helped to build up a more accurate forensic criminal history and been available to the multidisciplinary team.

### **9.1 Conclusion**

The trust complied with both local operational policies and Department of Health guidance on risk assessment and management but there were omissions in relation to obtaining and documenting an accurate forensic criminal history. There were also some shortcomings in relation to safeguarding. These are discussed below.

## **9.2 Recommendation**

The trust should carry out an audit to ensure that:

- police criminal checks are made in line with the joint information sharing protocol between the trust and Lancashire Constabulary; and
- the information is recorded in the clinical records and details included in the service users risk profile.

## **10 Safeguarding**

Like all NHS bodies, Lancashire Care NHS Foundation Trust has a statutory duty to ensure that arrangements are in place to safeguard and promote the welfare of children and young people and to prevent and protect vulnerable adults from abuse or the risk of abuse.

The current government definition of domestic violence and abuse is:

“any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality”.

In November 2010, the care coordinator telephoned a project worker from Centaur Court for an update on Mr G. The project manager told the care coordinator that the relationship between Mr G his girlfriend was ‘explosive’. She did not give any detail of a specific incident, but said Mr G and his girlfriend argued regularly and that there was aggression from both parties.

In December 2010, the care coordinator made an unannounced visit to Centaur Court to assess Mr G’s progress and presentation. The care coordinator initially spoke with staff members. They told the care coordinator that Mr G had been well behaved and that there had been no incidents of note.

The care coordinator met Mr G who was at his flat with his girlfriend. The records show that she was able to make her own informed choices and was not vulnerable within the relationship. The flat was untidy but both were tidying it up because Mr G's father was visiting later.

### **10.1 Conclusions**

There is no evidence to show whether the reported volatile relationship and the possibility of domestic violence were ever discussed within the trust multidisciplinary team or with staff at Centaur Court where Mr G and Miss H were living separately.

A discussion between staff at Centaur Court and the trust would have been helpful so that a decision could be made about whether or not the trust or Centaur Court staff should have sought safeguarding advice or made a safeguarding referral. This discussion may have helped trust staff to decide whether any changes to Mr G’s risk management plan were needed.

### **10.2 The progress the trust has made since this incident**

Since this incident, the safeguarding adult agenda has become more prominent nationally. In line with this, the trust has made significant improvements to strengthen its approach.

The trust's annual safeguarding report of 2013/14 sets out the evidence and measures that the trust now has in place for safeguarding children, young people and adults.

The report outlines that engagement with key partners is now in place and that the trust is compliant with the requirements of the three local safeguarding adult boards<sup>8</sup>.

The trust has developed a three-year strategic approach to maintain safe and effective safeguarding services. It has strengthened arrangements for safeguarding by appointing named adult safeguarding nurses and practitioners to work proactively with all staff and managers across the trust to support it in the identification and appropriate management of vulnerable adults.

Clinical teams are now supported by Safeguarding Adult Mental Health Capacity Act Champions. These and the safeguarding team work with clinical teams to prevent the escalation of safeguarding incidents by timely and appropriate interventions.

All relevant trust clinical staff have received safeguarding training. This training includes reinforcing the need to embed routine enquiry about any abuse into assessment processes and increase 'professional curiosity' in regard to suspected or potential abuse. The trust also carries out audits across all services to measure whether all the safeguarding procedures are in place and being used.

### **10.3 Recommendation**

The trust should continue to audit community mental health teams to ensure that any potential safeguarding issues are flagged up and discussed, and that specialist safeguarding advice is sought when needed.

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<sup>8</sup> Local safeguarding adults boards ensure that all agencies work together to minimise the risk of abuse to vulnerable adults and to protect those subject to abuse.

## **11 Predictability and preventability**

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

### **11.1 Predictability**

We assess predictability based on the following principle:

The homicide would have been predictable if there was evidence from Mr G'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 G had a criminal history. His convictions included being drunk and disorderly, possession of weapons, assault and theft, but there is no evidence that he ever presented in an aggressive or violent way towards staff. There was evidence of aggression between Mr G and his girlfriend, but this was never fully explored. A multiagency team discussion should have taken place about this once trust staff had been alerted to it. We cannot speculate, however, about whether holding this discussion would have alerted staff that Mr G might become violent imminently.

### **11.2 Preventability**

We assess preventability based on the following principle:

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.

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.

Mr G was managed in the community. He never presented in a way that indicated that he needed to be admitted to hospital, so he could not have been sectioned under the mental health act and taken into hospital. Staff therefore did not have any legal means or opportunity to detain Mr G to prevent the incident from occurring.

We cannot speculate about whether staff would have gained the knowledge and the opportunity to prevent the incident if a multiagency team discussion had taken place when it became apparent that there was a volatile relationship between Mr G and Miss H.

## 12 The trust's internal investigation

The terms of reference for this independent 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 G met the requirements set out in them.

The National Patient Safety Agency (NPSA) good practice guidance, *Independent investigation of serious patient safety incidents in mental health services*: February 2008, stipulates 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.

Good practice also highlights that staff should be interviewed or write statements, depending on how central they are to the case being investigated. There should be an enduring record of the interview, which should be signed by the staff member.

The trust policy also advises that an internal investigation should take place following a serious incident to see if any lessons can be learned.

In this case, the trust undertook an internal investigation, appointed a post-incident review investigator to lead it, and developed its terms of reference. These terms are outlined below:

- 1 "To review the care and treatment of the service user.
- 2 To provide a detailed narrative of events of the incident.
- 3 To identify any care delivery problems that may have arisen in relation to the direct provision and process of care.
- 4 To identify any service delivery problems associated with the process of service delivery, focusing particularly on the processes and systems in place within East Lancashire EIS.
- 5 To identify any factors contributing to the identified care or service delivery problems.
- 6 To explore any barriers to optimal care and any initiatives that could be adopted to minimise the likelihood that such an incident would occur again under similar circumstances.
- 7 To explore any identified barriers to optimal care and initiatives that could be adopted to improve the quality and safety of services for all in light of the review's more general findings."

## **12.1 The investigative process**

The post-incident reviewer:

- consulted national and trust policies and procedures to use as benchmarks;
- gathered appropriate documentary evidence, such as Mr G's clinical records;
- used the NPSA contributory factors framework to drill down to find out if there were any root causes; and
- met with Mr G's family to explain the investigation and provide support.

The post-incident reviewer operated in line with trust procedures and held a post incident review meeting with a group of staff.

There is no evidence that the post-incident reviewer tried to find the victim's relatives to involve them and support them during the investigation.

## **12.2 Action plans**

The post-incident reviewer did not make any recommendations, so there was no need for the trust to develop an action plan.

## **12.3 Conclusions**

The trust commissioned a post-incident reviewer to carry out the investigation. A more comprehensive approach would have been to:

- commission an investigation team with the clinical and managerial expertise to carry out the review;
- carry out individual interviews with key staff and obtain statements from staff who were involved in, but not central to, the case; and
- attempt to locate the victim's relatives in order to involve them and support them during the trust investigation.

Since this incident the trust has introduced a new policy and procedure for the investigation of serious incidents. The new policy and procedure promotes a more comprehensive and systematic approach to the investigation of serious incidents

## **12.4 Recommendation**

The trust should carry out an audit to ensure that the trust's serious incident investigation policy and procedure is implemented. This includes ensuring:

- that an investigation team is commissioned to carry out an investigation into a serious incident, rather than a single person;
- the team are sufficiently senior, and trained in incident investigation techniques;

- key members of staff are interviewed during an investigation and that an enduring record of the interviews is made;
- that the enduring record of interviews and any witness statements should be kept as evidence, to show that a comprehensive approach to the investigation has taken place; and
- steps are taken to locate the victim's relatives so that support can be offered during the investigation and the findings of the investigation report are shared.

### Team biographies

#### Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its highest-profile mental health 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. 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. Chris heads up Verita's office in Leeds.

#### Peter Jefferys

Peter is an experienced consultant psychiatrist and former trust medical director. He is currently a non-executive director for Norfolk & Suffolk NHS Foundation Trust. He has investigated unexpected mental health deaths for district and regional health authorities, the Mental Health Act Commission and CQC as well as conducting extensive suicide audits. He is a former advisor to the Parliamentary and Health Services Ombudsman, chairs MPTS (GMC) Fitness to Practice Panels and serves on mental health review tribunals.

## Appendix B

### Acronyms used in report

NICE - The National Institute for Health and Care Excellence

EIS - Early Intervention Service

PCMHT - Primary Care Mental Health Team

CRHTT - Crisis Resolution and Home Treatment Team

CPA - Care Programme Approach

DWP – Department of Work and Pensions

NPSA - National Patient Safety Agency