

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of

Mr B

A report for
NHS England, North Region

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Authors:
Chris Brougham
Cheryl Hornby

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Verita
53 Frith St
London W1D 4SN

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

E-mail enquiries@verita.net
Website www.verita.net

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1 Introduction

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 B.

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 Mersey Care NHS Trust commissioned an internal Trust investigation into the care and treatment of Mr B.

The internal investigation team made seven recommendations and an action plan was developed to take them forward.

1.1 Background to the independent investigation

Mr B, aged 29, was arrested by the police on 22 March 2012 and charged with the murder of a man on 27 February. He was found guilty and sentenced to life imprisonment with a minimum tariff of 28 years. Mr B is currently detained in a high-security psychiatric hospital.

Mr B was receiving care and treatment from Mersey Care NHS Trust at the time of the incident.

1.2 Overview of the Trust

Mersey Care NHS Trust provides specialist inpatient and community mental health, learning disability and substance misuse services for adults in Liverpool, Sefton and Kirkby.

It has a wider role in providing medium secure services for Merseyside and Cheshire, and high secure services covering the North West of England, the West Midlands and Wales.

2 Terms of reference

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

- 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 Probation Service management of the patient in the MAPPA¹ process.
- Examine the patient's forensic history and establish whether it was appropriately taken into account in the risk assessment and risk management process.
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users 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.
- 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.
- 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.

¹ MAPPA Multi Agency Public Protection Arrangements in England and Wales for the management of high risk offenders.

3 Approach of the independent investigation

The investigation team (referred to in this report as 'we') comprised Cheryl Hornby, a Verita associate, and Chris Brougham, a senior investigator from Verita. Dr Peter Jefferys, honorary consultant psychiatrist, Norfolk & Suffolk NHS Foundation Trust provided professional psychiatry advice. Biographies for the team are given in appendix A.

We examined a range of Trust documents, including national and local policies and procedures, the root cause analysis investigation report carried out by Mersey Care NHS Trust, and supplementary information such as the action plan and records of meetings with staff.

Mr B did not consent for us to access his medical and other records for the purposes of the investigation, but the Caldicott Guardian¹ authorised their release in the public interest.

We interviewed staff only where we found a gap in information or an area that required clarification.

We interviewed the following staff:

- Director of Patient Safety;
- Forensic Integrated Resource Team Manager; and
- Head of Forensic Services.

We met Mr B on 19 June 2014 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. We told him that he would have the opportunity to comment on the draft report before it was finalised.

We attempted to contact Mr B's relatives to ask if they would like to meet with us to share their views on Mr B's treatment and care, but our efforts were unsuccessful.

We also offered to meet with the victim's family but they declined the invitation. We respect their decision.

We met again with Mr B on 18 November 2014 to share the findings of the investigation with him. He advised us that he was not taking his medication at the time of the incident. Written entries in the clinical records indicate that he appeared to be compliant with medication in the three weeks prior to the incident.

We based our findings on analysis of the evidence we received. Our recommendations are intended to improve services. This report includes a

¹ In any healthcare organisation, a senior member of staff with responsibility for keeping patient data secure.

chronology outlining the care of Mr B. The analysis appears in section 7 to 13 where the relevant issues and themes arising from the terms of reference are examined.

Derek Mechen, a Verita partner, provided peer review for this report.

4 Executive summary and recommendations

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 B, 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 might 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 22 March 2012 Mr B was one of five people arrested on suspicion of the murder of a man during a planned robbery on 27 February 2012. He and four co-defendants were convicted in 2013 and received a life sentence with a tariff of 28 years.

4.2 Overview of care and treatment

Mr B received care and treatment from the Mersey Care Trust from 2002 onwards in three different settings. He received care and treatment as an inpatient in the medium secure unit and then from the Trust forensic psychiatric service while he was in prison. On release from prison he was managed initially by the community forensic service and from October 2011 by the Community Mental Health Team.

Mr B was initially referred to the Trust forensic service in 2002 because of concerns about his mental state while on remand in HMP A. He was admitted to the medium secure unit on 6 September 2002 and assessed under section 36¹ Mental Health Act (MHA). The assessment concluded that he was suffering from a psychotic illness with a diagnosis of paranoid schizophrenia. On 22 November 2002 he returned to prison A on remand with medication recommendations and continued forensic service monitoring. Whilst serving his sentence Mr B was moved to different prisons due to his inability to integrate into the prison environment.

¹ Section 36 is used for persons awaiting trial for a serious crime and provides courts with an alternative to remanding a mentally disordered person in prison.

As a result of significant deterioration in Mr B's mental state while at HMP B, he was readmitted on 3 October 2005 under section 47/49¹ to the medium secure unit where he remained for five months before returning to prison. Mr B was subsequently transferred to HMP C.

Shortly before Mr B's expected release date from HMP C in 2008, the forensic service was asked to review him again because of deterioration in his mental state and concerns about his risk to the public. Mr B stated that he believed that he had been drugged and raped in November 2001 and, since that time, believed that his legs were not attached to his body properly and that anyone who saw him walk would know that he had been raped, which made him feel ashamed and guilty.

The clinicians who reviewed Mr B agreed that he was detainable under the Mental Health Act and he was transferred to the medium secure unit under section 47 of the MHA on 1 August 2008. A mental health review tribunal (MHRT) discharged him from detention in November 2008.

The Trust clinicians and the probation service agreed to release Mr B to the community on licence with strict conditions, which included compliance with forensic service monitoring and treatment. However, Mr B did not attend appointments with his probation officer, care coordinator, consultant forensic psychiatrist or community psychiatric nurse (CPN) from the forensic integrated resource team and was consequently recalled to prison in February 2009.

The Trust forensic criminal justice services re-engaged with Mr B in 2010 while he was still in prison and they were closely involved in planning and revising conditions for his discharge on licence, which took effect in early 2011. Mr B was obliged to attend forensic psychiatric outpatient appointments regularly and to allow monitoring by his Trust care coordinator.

The Trust's forensic and community services agreed that if Mr B was mentally stable and compliant he could be transferred to the Community Mental Health Team (CMHT). The plan was to work jointly with the CMHT and transfer his care over to the community consultant after six months if all went well. The CMHT and community consultant were fully involved in the plan and the transfer took effect in October 2011.

Records show that Mr B had been subject to Care Programme Approach (CPA) since his initial contact with the Trust in 2002. He was assessed, allocated a care coordinator and had a care plan in line with Trust policy.

Mr B subsequently attended the outpatient clinic of the community consultant and the CMHT carried out home visits to monitor him. Clinical staff carried out CPA reviews and Mr B's GP was kept fully informed of his progress. Mr B was prescribed antipsychotic medication, which included amisulpride 400mg and olanzapine² 20mg daily. These formed part of his treatment plan throughout this period.

¹ Section 47/49 provides for sentenced prisoners to be transferred to a hospital for treatment of a mental disorder.

² Amisulpride and olanzapine are antipsychotic medications used to treat schizophrenia.

A CPA review was held on 1 February 2012 after Mr B's care coordinator had raised concerns about Mr B's mental state. At the review Mr B reported to the clinical team that he was keeping reasonably well with regard to his mental state, although records show that his preoccupation with perceived deformities in his legs and hips continued. Records show that, at this review, staff discussed a recent incident with Mr B when he had assaulted a man and staff advised him to avoid confrontation.

Mr B met with his care coordinator on 29 February. Records show that Mr B was euthymic¹ in mood and reported no thoughts of harm to himself or others.

On 22 March 2012 Mr B and four other people were arrested by police on suspicion of the murder of a man on 27 February 2012 following a fatal stabbing.

4.3 Overall conclusions of the Independent Investigation

We found that there were no aspects of Mr B's treatment which could have predicted or prevented the incident from happening. This is particularly valid in light of the fact that Mr B's mental state and presentation were essentially unchanged when he was assessed as part of a CPA review on 1 February 2012 shortly before the incident took place.

From the evidence we have examined, we consider that Mr B's history, behaviour and mental state were carefully and reliably assessed by the forensic service before reaching a diagnosis of schizophrenia. This diagnosis was appropriate and was confirmed on a number of occasions when Mr B was re-assessed and reviewed between 2002 and 2012. We have found no clinical evidence to suggest that Mr B's diagnosis was incorrect.

We found that Mr B's risk management plans are well documented following every Trust service contact with him while in prison from 2002 onwards and while he was in the secure unit. MAPPAs and the probation service were closely involved in formulating and reviewing his risk management plans between 2008 and May 2011. We also note that a plan for managing the risks Mr B presented while living in the community from the start of 2011 onwards was clearly recorded.

Although there is good evidence of multi-agency working and that information about his police cautions and convictions was available to staff attending MAPPA meetings, we were unable to locate a comprehensive list of Mr B's criminal convictions and cautions in the clinical notes. We have made a recommendation that this information should be available in the clinical records of patients with a forensic history.

We found that although there were some shortfalls in CPA and risk assessment documentation late in 2011 and early 2012, there is good evidence that the Trust

¹ Euthymic in mood describes a normal, non-depressed, reasonably positive mood.

consistently assessed Mr B's risk to others accurately and made arrangements to manage these risks on a sound professional basis with multi-disciplinary involvement. However, we were unable to find any evidence that the Trust approved risk assessment form was used after May 2011. We have therefore made a recommendation that the Trust is able to provide assurance that the required improvements are delivered with regard to risk assessment, management and CPA.

The probation service called MAPPA meetings to discuss Mr B's potential community risks and their mitigation when the question of his release from prison was raised in 2008 and again in 2010. The action plans on each occasion took account of clinical views from the Trust's forensic service, which were appropriate, and all the agencies involved recognised the seriousness of his potential for violence. In 2008 and 2010, the decision to release Mr B on licence¹ in order to provide a period of close supervision on his return to the community, was sensible and pragmatic and within the legal timescale. We therefore, consider that the decisions taken by MAPPA were a measured attempt to minimise risk in the community within the legal framework available.

When Mr B's licence expired on 13 June 2008, the probation service no longer had any statutory authority to monitor him. He was not subject to any legally enforceable conditions or restrictions, so he remained under Trust supervision in the community. In conclusion, we make no criticism of probation service actions with respect to Mr B's management between 2008 and 2010 as evidenced by MAPPA records and Trust clinical records.

The internal investigation carried out by the Trust made seven recommendations and the identified actions have since been implemented.

When we met with Trust staff we were told that work has been undertaken to improve the risk assessment and management process across the Trust. This includes a redesign of the risk assessment process to be more formulation-focused².

The Trust internal report recommended that all mental health practitioners and their managers must ensure that they are up to date with core training in risk management and undertake more specialist training. We noted that, in addition to the changes to risk management processes, a pilot for risk assessment training is taking place and if positively received it will subsequently be rolled out across the Trust.

In response to the recommendation made by the Trust internal investigation, we note that the forensic service has reviewed its approach to risk assessment and developed more specialised CPA documentation. The multi-disciplinary assessment now focuses more on gathering information about offending and the nature and context of offending behaviour. In addition, the risk assessment has been reviewed so that it now contains more detail, particularly of past events, and now links with

¹ Licence Prisoners released from prison on licence are required to adhere to certain conditions whilst serving the remaining part of their sentence in the community.

² A clinical formulation is developed from the information obtained from a clinical assessment. Formulations are used to provide the most suitable treatment approach.

HCR-20¹, risk formulation and other specialist risk assessment tools. The HCR-20 is the main body of the risk assessment and the formulations; the summaries and the views collected therein are transferred to the CPA risk assessment.

The Trust internal investigation recommended that “non-forensic practitioners involved with people with a history of violence should have skills in working with this population; including specialist risk assessment tools and personality disorder”. We note that the Trust has developed clinical guidelines for the treatment and management of people with unstable personality disorders which have been implemented across the Trust in association with the psychotherapy service. A personality disorder consultancy service has also been created. This works with teams in the Trust to assist in planning care and provides supervision.

We note that the recommendation regarding induction for all locum psychiatrists working in Mersey Care NHS Trust has been introduced and if now doctors who have not worked in the Trust for more than 12 months must repeat their training before they are re-engaged. In addition, action has been taken to ensure that the caseloads of community care coordinators are kept within an agreed limit and adjusted to take into account the complexity of individual patients. This requires managers to review caseloads regularly and assign them red, amber or green ratings (RAG) ratings.

4.4 Recommendations

The Trust should take steps to ensure that if a service user has a forensic history a comprehensive list of his or her criminal convictions and cautions is available in the clinical records and a process is in place to update this when circumstances change.

The Trust should provide assurance that the systematic changes being made deliver the required service improvements in relation to risk assessment, risk management and CPA.

¹ HCR-20 (Historical Clinical Risk Management-20) is used by practitioners working with patients with a history of violence.

5 Chronology of care and treatment

Mr B was born in Liverpool. His parents separated when he was young and he was taken into care. As a child, he lived in a number of children's homes and with a foster family. He had disrupted schooling and spent some time attending a school for children with disturbed behaviour. He frequently truanted. He left school with no qualifications and poor reading and writing skills.

5.1 Contact with Trust

Mr B's contact with the Trust's services from 2002 onwards was in three settings. He received care and treatment as an inpatient in the medium secure unit and he was followed up by the Trust forensic psychiatric service while in prison. When Mr B was in the community in the year prior to the incident he was managed initially by the forensic service and from October 2011 until the incident in early 2012 by the Community Mental Health Team.

Mr B had a diagnosis of paranoid schizophrenia dating back to 2002 and held delusional beliefs concerning his legs and gait. He believed that he had been drugged and raped in November 2001 and, since that time, believed that his legs were not attached to his body properly and that anyone who saw him walk would know that he had been raped, which made him feel ashamed and guilty.

The clinical team carried out a CPA review on 24 February 2011, although Mr B was not present because he was still on remand in prison. Records show that the prison parole board had refused Mr B parole in December 2010 since a report had not been submitted by his probation officer. The next hearing was scheduled to take place in May 2011.

The clinical records show that at this CPA review the probation service felt it would be in the public interest to have Mr B paroled ahead of his imminent release so that mental health services could engage with him while he was on licence. The clinical team agreed that probation would seek early release on licence and that Mr B could be accommodated in a bail hostel where his medication and behaviour could be closely monitored and supervised.

Mr B's management plan, agreed at the CPA review on 24 February 2011, was as follows:

1. The probation service would seek an early release to a bail hostel
2. The condition of licence was that Mr B must:
 - reside in the bail hostel
 - keep his appointments with his CPN and care coordinator
 - receive support from the community multi-disciplinary team (MDT)
 - allow staff to witness medication compliance
 - accept referral to alcohol/drugs service
 - keep to curfew imposed
3. The probation officer was to clarify with social services what knowledge existed in connection with a family member of Mr B.

4. Although noted that Mr B had not given his consent, information was to be collected from his family, which would be helpful in the overall management and understanding of Mr B.
5. Mr B was to be managed under CPA with joint working between forensic and CMHT (if necessary he could be detained initially, at the medium secure unit following his release from prison.)

On 9 May 2011, Mr B was released from HMP D to a bail hostel (Canning House, Liverpool) under licence until 13 June 2011.

A CPA review held at Canning House on 9 May was attended by Mr B's care coordinator, the consultant forensic psychiatrist, the CPN from the medium secure unit and his probation officer. Mr B told staff that he had settled into the bail hostel and had been pleasantly surprised as to what it was like. He did not want to discuss his mental state, given the number of people at the meeting.

Mr B reported that he had spent some time visiting family members and was being compliant with the terms of his licence. He felt that his medication (amisulpride 400mg daily and olanzapine 20mg daily) was benefiting him. It was noted that Mr B was recorded as still displaying residual symptoms of psychosis, such as anxiety and fear that people were looking at him when he was out.

On 12 May 2011, the consultant forensic psychiatrist reviewed Mr B at the bail hostel. Mr B confirmed that he was still troubled by his longstanding problems in relation to his gait, which he was reluctant to discuss in detail. He still believed that his legs were not attached to his body properly and that anyone who saw him walk would know that he had been raped. The psychiatrist concluded that his symptoms were delusional.

Mr B reported that he did not have any other symptoms because they had been eased by his medication. However, he felt that his beliefs concerning his hips and gait were not symptoms of his illness. The psychiatrist suggested changing Mr B's medication to clozapine¹ and noted that patient Mr B was reluctant to do so because he was worried that his condition might then deteriorate. The psychiatrist also noted that Mr B displayed clear symptoms of a mental disorder.

In June 2011 Mr B moved from the bail hostel to his mother's address. Clinical staff from the forensic and community mental health services arranged to see him there, but on a number of occasions there was no answer when telephoning or ringing the doorbell, even though it appeared that someone was in. The clinical teams persisted and Mr B was seen on 10 and 20 June by the CMHT and on 28 June 2011 by the consultant forensic psychiatrist, his care coordinator and the CPN at his mother's house.

On 7 July 2011 the consultant forensic psychiatrist reviewed Mr B, and noted that he remained preoccupied with the problems with his hips. Mr B advised that he had had these problems for the past 10 years; that other people knew about his hips and

¹ Clozapine is medication used to treat schizophrenia when previous treatments have been unsuccessful.

therefore what had happened to him. Mr B felt that medication helped him, and he was still reluctant to change to a different antipsychotic medication even though his consultant felt that he would benefit from this. The psychiatrist concluded that Mr B still suffered significant symptoms of his illness (paranoid schizophrenia) and it was agreed to continue offering him support and follow-up and to encourage him to change his medication.

In July 2011 the CPN attempted several times to visit Mr B but he was not available. Again the clinical teams persisted and Mr B was eventually seen by his CPN on 2 August. Mr B failed to attend a medical review on 11 August, but was seen by his CPN on 16 August and the records show that he was being compliant with his medication. He was followed up again on 23 and 30 August by the CMHT.

On 2 September 2011 Mr B attended an outpatient appointment and was seen by his consultant forensic psychiatrist, his care coordinator and the CPN from the medium secure unit. Records show that none of the staff noted any major concerns, and that Mr B was now engaging with mental health services. He was also getting support in identifying accommodation from NOVAS (housing association).

The clinical records show that Mr B's presentation remained the same and that he still did not want a change in his medication to clozapine, even though he was advised again that it might help with his residual beliefs regarding his legs and gait. The records show that Mr B still believed that the 'abnormalities' in his legs were not part of his mental illness and could be rectified only with surgery. The psychiatrist recorded that he did not consider that Mr B's residual delusional beliefs were causing any increase in his risk to himself or others. At this review the psychiatrist offered Mr B psychological therapy but he refused because he did not feel it would be beneficial.

It was also recorded that Mr B had been out of prison for nearly six months and that consideration was to be given to handing him over to the care of the CMHT.

On 27 September 2011 Mr B was assessed by his consultant forensic psychiatrist. Forensic and community mental health services had previously agreed that when Mr B had been manageable and compliant for a six-month period of joint working, a community consultant psychiatrist would take over Mr B's care.

A CPA meeting had been planned for this date with the intention of handing over Mr B's care to his local CMHT, but Mr B's care coordinator was unable to attend so the meeting was recorded as being a routine outpatient appointment. Mr B's CPN from the forensic service was present, and records show that clarification was awaited as to which CMHT consultant psychiatrist would be taking over Mr B's care.

Clinical records show that Mr B had been engaging with his care coordinator and CPN, but erratically, and the clinicians had to chase him up. He rarely disclosed any concerns about his symptoms but that at times he experienced the "same old worries" about his gait.

Mr B continued to refuse to consider changes to his medication (to clozapine), because he felt he was able to cope with his current level of symptoms. It was noted that, overall, Mr B's mental health seemed stable.

A CPA transfer of care review was held on 19 October 2011 by the forensic team, the medium secure unit and Park Lodge CMHT.

At this review Mr B's formulation of his risk behaviour was discussed, as was his current mental state, with his diagnosis recorded as residual symptoms of schizophrenia, although they were stable and did not appear to be associated with any increase in risk to himself or others. It is recorded in the clinical notes that Mr B did not believe that the residual psychotic symptoms (the issues with his hips and gait) were associated with his mental illness. It is also recorded that the medium secure unit would withdraw from Mr B's care.

At the transfer of care review on 19 October 2011, Mr B's management plan was agreed as follows:

- "Following review, his care would be transferred to Park Lodge CMHT.
- He would continue on existing medication – amisulpride 400 mg and olanzapine 20mg."

On 22 November Mr B's care coordinator escorted him to the 'One Stop Shop' (Liverpool City Council – access to services in the community) to register with housing options; and he was also escorted to an estate agent to look for accommodation.

On 20 December 2011, during a joint visit by his care coordinator and a representative from the Whitechapel Centre (resettlement and housing service), Mr B commented that he had burnt his arm with a cigarette but did not explain how or why this had happened. He also advised that his benefits had been stopped, following which his care coordinator telephoned the benefits office and was told that his benefits would be reinstated on receipt of a letter from the care coordinator, which was sent. Mr B told his care coordinator that he had no current thoughts of harming himself or others.

On 1 February 2012 a CPA review was held following concerns raised by Mr B's care coordinator.

At this time, Mr B was living part of the time with his mother, and part of the time at the home of his sister. An accommodation officer was looking into his accommodation needs. During the review, it was noted that Mr B reported keeping reasonably well in his mental health. However, he still had an ongoing preoccupation with the 'deformities' in his legs and hips.

Records show that Mr B had assaulted a man. The care coordinator discussed with Mr B the importance of avoiding confrontation. 'Mr B said that if others attacked him he would get back at them'.

At the CPA review on 1 February 2012 the management plan for Mr B was as follows:

- “To continue medication.
- To continue with CPA from the CMHT.
- A further CPA review to take place in six months, or earlier if required.”

A CPA Review follow up letter dated 8 February 2012 from Mr B’s consultant psychiatrist to his GP notes that Mr B was compliant with his medication, and had no active thoughts of hurting others or any overt homicidal thoughts.

The CPA Review on 1 February 2012 was the last contact Mr B had with mental health services before the incident took place on 27 February 2012.

Mr B met his care coordinator on 29 February 2012. Mr B told him that he did not want to pursue contact with the Whitechapel Centre (resettlement and housing support services) because he wanted a nice flat, which he felt he would not get through the centre. At this time, Mr B was recorded as being euthymic in mood and reported no thoughts of harm to himself or others; he appeared well kempt. At this time his care coordinator was unaware of the incident which had taken place on 27 February 2012.

On 22 March 2012 CPA documentation completed by the criminal justice liaison team recorded that Mr B and four other people had been arrested by police on suspicion of involvement in the murder of a man on 27 February 2012, following a fatal stabbing.

6 Issues arising

In the following sections of the report we analyse and comment on the issues in relation to the care and treatment of Mr B that we have identified as part of our investigation.

We considered the following issues:

- diagnosis and treatment;
- care pathway;
- CPA, risk assessment and management;
- probation service;
- predictability and preventability;
- the Trust's internal investigation; and
- progress on implementing action plan.

7 Diagnosis and treatment

Mr B received care and treatment from the Trust in three different settings. He was an inpatient in the medium secure unit. He received treatment from the Trust ForensHCR-20ic Psychiatric Service while in prison. When he was in the community he was managed initially by the forensic service and from October 2011 until the incident in early 2012 by the Community Mental Health Team. Reliable clinical records describing his presentation, mental health history, mental state and behaviour are available for every stage of his care.

During Mr B's first admission to psychiatric care in 2002 (which followed his transfer from prison), a careful diagnostic assessment was undertaken. His substantial forensic history as a juvenile and young adult was documented. His convictions included theft, affray, burglary, armed robbery, assault, and occasioning actual bodily harm. He showed a range of paranoid delusional symptoms, including auditory hallucinations and a confident diagnosis of paranoid schizophrenia was made. He was treated with antipsychotic medication which produced a significant improvement in his symptoms.

Very similar clinical features were present during each of Mr B's subsequent admissions, and when he was reviewed and assessed in prison by the forensic services over the next nine years. His delusional symptoms consistently reduced in severity when he was compliant with antipsychotic medication, although he continued to hold residual delusional beliefs concerning his legs and walking, which provided further evidence in support of a diagnosis of schizophrenia. We have noted that there was no change in this primary diagnosis between 2002 and 2012.

We have also noted that an additional diagnosis of antisocial personality disorder was proposed during his second hospital admission in October 2005 but not seriously pursued, although reference was made in 2008 to Mr B's "dissocial personality disorder" traits. It is recorded in a violence risk assessment that Mr B has "gross and persistent disregard for social norms, obligations and rule, low tolerance to frustration and a low threshold for discharge of violence, and marked proneness to blame others". However, no formal diagnosis of personality disorder was made.

Mr B was receiving a high dose of oral antipsychotic medication from 2011 onwards, yet some of his paranoid delusional symptoms persisted. It would be appropriate to conclude that Mr B had treatment-resistant schizophrenia. The Trust's internal investigation appropriately drew attention to NICE guidance¹ on this issue which, had it been followed, may have led to a trial of clozapine.

The 2009 NICE guidelines that were in place when the incident occurred recommend that patients suffering from schizophrenia are offered clozapine if their illness has not responded to other medication.

¹ The National Institute for Health and Care Excellence, which provides guidance and advice to improve health and social care.

7.1 Analysis

Mr B's history, behaviour and mental state were carefully and reliably assessed by the forensic service before it reached a diagnosis of schizophrenia. This diagnosis was appropriate given his presentation. It was confirmed at detailed reviews by the clinical teams looking after Mr B when he was regularly re-assessed over the next decade. There is no clinical evidence to suggest that Mr B's diagnosis should have been changed.

The impact of Mr B's disturbed childhood on his offending behaviour and personality was referred to consistently in diagnostic formulations, which was entirely appropriate. These factors were recorded as relevant to Mr B's care and management plans by those managing him. This is to be commended.

For clinical safety reasons, clozapine needs to be commenced as an inpatient, and it is more than likely that Mr B would have objected to this treatment. In November 2008, when his detention was terminated by an MHRT, there was no legal mechanism for insisting that he took clozapine. It may well be for this reason that there appears to be no written record of the pros and cons of a trial of clozapine for Mr B.

7.2 Conclusion

The impact of Mr B's disturbed childhood on his offending behaviour and personality was referred to consistently in diagnostic formulations. In these circumstances, a formal diagnosis of personality disorder, assuming sufficient evidence was available to make a confident diagnosis (alongside schizophrenia), would have added little to Mr B's care or treatment plan.

There is no indication that Mr B lacked capacity to consent to clozapine in this period, and while Mr B was in prison during 2009 and 2010 the Trust had no powers to insist Mr B was treated with clozapine.

Many complex patients with schizophrenia starting a programme of community treatment have residual psychotic symptoms such as those displayed by Mr B, but are not receiving clozapine. Informal patients have the right to refuse treatment and the intrusive nature of blood test monitoring and the health risk profile associated with clozapine means that many do indeed refuse.

In summary, we have no criticism about the Trust not treating Mr B with clozapine.

8 Pathway of care

Mr B was initially referred to the Trust forensic service in 2002 because of concerns about his mental state in prison on remand. He was assessed in the medium secure unit under section 36 of the MHA and returned to prison with medication recommendations and continued forensic service monitoring.

As a result of significant deterioration in his mental state, Mr B was readmitted in 2005 from prison under section 47/49 to the medium secure unit, where he remained for five months before returning to prison.

Shortly before his expected release date in 2008, the forensic service was asked to review him again because of deterioration in his mental state and concerns about his risk to the public. He was transferred to the medium secure unit under section 47 of the MHA. An MHRT discharged him from detention in November 2008. Agreement was reached between Trust clinicians and probation to release him to the community on licence with strict conditions, including compliance with forensic service monitoring and treatment. He was recalled to prison within weeks because of his failure to comply with the conditions.

The Trust forensic criminal justice services re-engaged with Mr B in 2010 while he was still in prison and were closely involved in planning revised conditions for his discharge on licence, which took effect in early 2011. He was obliged to attend forensic psychiatric outpatient appointments regularly and to allow monitoring by the Trust care coordinator.

The Trust's forensic and community services had agreed that, if Mr B was mentally stable and compliant, a transfer of responsibility to the CMHT and a community consultant could take place after six months. Community services were fully involved in the plan, and the transfer took effect in October 2011. Mr B subsequently attended the outpatient clinic of the community consultant with home visits and monitoring by the CMHT. CPA reviews were held, and Mr B's GP was kept fully informed of progress. Antipsychotic medication, comprising amisulpiride 400mg and olanzapine 20mg daily, formed part of his treatment plan throughout this period.

8.1 Analysis

Mr B's overall management by the forensic service between 2002 and June 2011 was appropriate. It was necessary to transfer him from prison for fuller assessment in 2002 and subsequently in 2005 and 2008. The service appropriately recognised that he had schizophrenia and the importance of treating his psychotic symptoms with antipsychotic medication.

Monitoring of Mr B's mental state while he was in prison was undertaken appropriately by the forensic service and there was also good liaison with prison authorities, the probation service and Trust community services. The plans made jointly in late 2008 and again in late 2010 with the probation service were appropriate

and realistic given that Mr B would be in the community on licence with strict conditions to ensure his compliance with monitoring.

Mr B's community monitoring by both the forensic service and the community service during 2011 and early 2012 was appropriate and to a satisfactory standard. He was seen regularly by the responsible consultant psychiatrist as well as by care coordinators. Any non-attendance by Mr B was promptly followed up and communication with his GP was of a high standard.

The Trust internal report noted that, despite Mr B having a diagnosis of paranoid schizophrenia, there was a lack of adherence to the NICE guidelines for schizophrenia.

The guidelines recommend that patients suffering from schizophrenia be offered cognitive behavioural therapy¹ on either an individual or a family basis. The Trust has told us that since the incident they have put in place an enhanced care team that provides psychological input to people with complex needs and dual diagnosis in the forensic service.

However, in practical terms it is necessary first to consider whether and when appropriate opportunities may have arisen for psychological intervention related to Mr B's personality. For much of the period between 2002 and the end of 2010, Mr B was in prison, sometimes in different parts of the country. The forensic prison liaison service was simply not in a position, for resource and other practical reasons, to undertake such work.

Responsibility for offender behavioural learning for an individual while in prison rests primarily with the prison authorities and the probation service, not with the health service. It must be acknowledged that a high proportion of offenders in prison show features consistent with either mental illness or a personality disorder.

During Mr B's admission to the medium secure unit in late 2005, some attention was given to his personality problems. Within the hospital environment, that knowledge was used to inform his immediate clinical management; however, Mr B was then returned to prison. In 2008, on transfer once again to the medium secure unit from prison, he was angry about not being released on licence. It is highly unlikely that he would have cooperated with more intensive psychological intervention. Repeated MAPPA reviews involving the probation service made no such proposal. Neither did an independent MHRT² pursue the need for psychological intervention while Mr B was a detained patient. The tribunal discharged him in November 2008.

The only other possible opportunity for Mr B's engagement with psychological interventions was during 2011 and early 2012 while he was under community management by Trust services. During this period, the main focus was on maintaining Mr B's clinical stability with sufficiently close monitoring of his mental

¹ Cognitive Behavioural Therapy is a form of therapy that helps individuals to identify and change destructive or disturbing thought patterns that have a negative influence on their behaviour.

² Mental Health Review Tribunal an independent judicial body which reviews the need for continued detention of patients in hospital.

state and circumstances to detect any increase in risk of harm to others. Mr B's insight into his illness remained seriously limited. It is highly unlikely that he would have understood the need for psychological intervention relating to his personality, let alone cooperated with any planned treatment.

8.2 Conclusion

The decision to transfer Mr B's management from the forensic service to community mental health services was taken after full consultation following a six-month period of joint working between the services. There was an excellent handover at a CPA transfer of care review on 19 October 2011 between the forensic team, medium secure unit and Park Lodge CMHT.

The Trust investigation makes a valid point about the need for clinicians to improve their knowledge and understanding of the personality development and life circumstances of complex patients such as Mr B. It may well be that some subtle aspects of Mr B's management might have been different if relevant Trust staff had possessed such information. However, given that Mr B's insight into his illness was seriously limited it is unlikely that he would have accepted or benefited from more intensive psychological intervention during the periods when the Trust was responsible for his care.

9 Care Programme Approach, risk assessment and management

In this section we examine the CPA and risk management process followed for Mr B. We consider whether Mr B's extensive forensic criminal history was appropriately taken into account in the risk assessment and management process.

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 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 an integral part of assessment and care planning.

The Trust corporate policy and procedure for the CPA dated March 2011 includes key elements of national policy and best practice. The policy also deals with issues around implementation, review, monitoring and audit. The introduction the document explains:

- why the policy is necessary;
- to whom it applies and where and when it should be applied;
- 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 (procedure).

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 CPA and the outcome of risk assessment should feed back into the overall clinical management.

The MAPPA arrangements are contained in Section 67(6) of the Criminal Justice and Court Services Act 2000. They are a joint protocol between the police, prison and probation services, which form the MAPPA panels, to discuss and manage those who pose a risk of sexual, violent and other dangerous offences. Mental health services are invited to panel meetings to discuss patients, such as Mr B, who are subject to MAPPA.

MAPPA provides a framework for coordinating and channelling multi-agency management, where appropriate and necessary, to protect the public from offenders in the community whose previous offences and current behaviour suggest that they have the potential to cause serious harm to others. MAPPA requires that systems are in place to ensure that relevant information can be shared between and within agencies to contribute towards a comprehensive risk assessment which must be undertaken on all offenders who fall within the MAPPA.

The Trust policy and procedure *A Framework for Multi Agency Public Protection Arrangements (MAPPA) & Health & Risk Assessment Management Meetings (H-RAMM) Review* November 2012 states in appendix 1 that:

“MAPPA is the highest forum for discussing risk and therefore individuals within Mersey Care should prioritise and give a commitment to attend these meetings when invited”.

We have found that MAPPA meetings were attended consistently by both the probation service and Trust forensic service staff, In line with Trust policy.

9.1 Care Programme Approach

Mr B was subject to CPA. He was assessed, allocated a care coordinator and had a care plan in line with Trust policy.

We are in agreement with the two areas of notable practice identified in the Trust internal investigation in relation to CPA which were:

9.2 Transition processes from forensic services to the community mental health team

A period of approximately six months was agreed for joint working between the two teams, during which the forensic consultant psychiatrist retained the consultant role, but both forensic and community care coordinators worked with Mr B and attended MAPPA meetings. The practice here was in line with the Trust CPA policy (appendix 10), which highlights how failure in this respect has often been associated with serious incidents; it was also in line with the SaFE Partnership’s transition protocol (OP 018).

9.3 The care plan May 2011

The care plan recorded by the community care coordinator in May 2011 set out very clearly how the joint services would be working with Mr B, including their approach to regular home visits. Although Mr B was often unavailable for pre-arranged visits, both the forensic CPN and the community care coordinator were assiduous in following up failed appointments, ensuring that Mr B was seen and that he maintained contact with services.

9.4 Risk assessment and MAPPA

Mr B's serious forensic history was well recorded in his clinical records with appropriate reference made to it in his care plan and at CPA reviews throughout his engagement with Trust services.

Detailed risk assessments conducted as part of the CPA review process, which refer to Mr B's forensic history and discuss his risk management, were undertaken in July 2008 (on admission to the medium secure unit); in January 2009 and in May 2011. Although Mr B was subject to CPA and CPA meetings were held subsequently (e.g. on 9 November 2011) with appropriate feedback letters to his GP, which discussed Mr B's risk management, there is no evidence that the Trust approved risk assessment form was used after 2011.

Mr B's continued serious risk of violence to others was consistently acknowledged by Trust services throughout his period of care, albeit that there is no evidence of completion of a Trust risk assessment form after May 2011. A systematic violence risk assessment was undertaken during Mr B's admission to the secure unit in August 2008. We found that the completed risk assessments with respect to harm to others were consistently of a high standard.

The plans for Mr B's risk management after every Trust service contact with him while in prison from 2002 onwards and while he was in the medium secure unit are well documented. MAPPA and the probation service were closely involved in formulating and reviewing his risk management plans between 2008 and May 2011. The rationale for managing Mr B and the risk he presented while living in the community from the start of 2011 onwards were clearly recorded.

An indication of the quality of risk assessment is conveyed by a CPA entry under the heading 'Relapse/Disengagement' shortly before Mr B's brief release on licence in January 2009. The risks were recorded as:

- disengagement from psychiatric services, non-concordant with prescribed regime;
- increased preoccupation with delusional beliefs re: deformity of legs, recurrence of voices and paranoia;
- increased agitation, aggression;
- association with pro-criminal peers, adopting old lifestyle; and
- use of illicit drugs and alcohol.

Between 2008 and 2011 Mr B was subject to MAPPA. This was due to his criminal forensic history and high risk of violence and aggression to others. A management plan was put in place to manage his potential risks in the community and their mitigation when he was released from prison in 2008 and in 2010.

Mr B's extensive forensic history was accurately summarised in a series of psychiatric reports between 2002 and 2011 and was therefore available to Trust staff for the purposes of risk assessment and risk management. However, although there is good evidence of multi-agency working, and copies of his police cautions and

convictions record were available to Trust staff participating in MAPPA meetings, we have been unable to locate a comprehensive easily accessible list of these within Mr B's clinical notes.

The minutes of all MAPPA meetings held between 2008 and 2011 include a detailed risk assessment, taking full account of Mr B's forensic history. Risk management plans are also detailed. We have found that MAPPA meetings were attended consistently by both the probation service and Trust forensic service staff, in line with Trust policy.

9.4.1 Comment

Although we have made no specific criticism of the risk management process, staff told us in interview that work has been undertaken to improve the process across the Trust. This includes a redesign of the risk assessment process so that it is more formulation-focused, providing a clear link between risk assessment and the most suitable management plan.

The Trust internal report recommended that all mental health practitioners and their managers must ensure that they are up to date with core training in risk management and undertake more specialist training. We noted that in addition to the changes to the processes, a pilot for risk assessment training is taking place and will subsequently be reviewed prior to being rolled out across the Trust.

We were told that at the time of this incident, the approach to CPA was Trust-wide and that this meant that it didn't fully meet the needs of the forensic services. For example, the HCR-20 was not part of the CPA process. The forensic service has reviewed its approach to risk assessment and developed more specialised CPA documentation. The multi-disciplinary assessment now focuses more on gathering information about offending and the nature and context of offending behaviour. In addition, the risk assessment has been reviewed to contain more detail, particularly about past events, and it now links with HCR-20, risk formulation and other specialist risk assessment tools. The HCR-20 is the main body of the risk assessment and the formulations, the summaries and the views are collected therein and transferred to the CPA risk assessment.

These improvements were introduced in 2013 and monthly compliance and quality audits are carried out to ensure that each patient has a risk assessment, an MDT assessment, a care plan, and an HCR-20. We were informed that compliance was good, however we have made a recommendation that the Trust should provide assurance that the required service improvements for CPA are made.

The Trust internal investigation recommended that "non-forensic practitioners involved with people with a history of violence should have skills in working with this population; including specialist risks assessment tools and personality disorder". We note that the Trust has developed clinical guidelines for the treatment and management of people with an unstable personality disorder which has been implemented across the Trust in association with the psychotherapy service. A personality disorder consultancy service has also been created. This works with teams in the Trust to assist in planning care and provides supervision.

9.4.2 Conclusion

Although there were some omissions in CPA/risk assessment documentation later in 2011 and early in 2012, there is good evidence that the Trust consistently assessed Mr B's risk to others accurately and made arrangements to manage these risks on a sound professional basis with multi-disciplinary involvement.

We do not consider that the lack of a comprehensive list of Mr B's criminal convictions and cautions in the clinical notes had a bearing on the incident, since this information was available in various sections of Mr B's clinical records. However, we feel that such a summary of information would be helpful for clinicians, particularly if they have only recently become involved in a patient's care.

9.5 Recommendations

The Trust should take steps to ensure that, if a service user has a forensic history, a comprehensive list of his or her criminal convictions and cautions is available in the clinical records.

The Trust should provide assurance that the systematic changes being made deliver the required service improvements in relation to risk assessment, risk management and CPA.

10 Probation service

Mr B was subject to Category 2¹ provisions from mid-2008 onwards while he was still in prison. He had applied for parole and the MAPPA process was initiated to prepare for his possible release. Clinical records made by Trust staff who attended a series of MAPPA meetings between June 2008 and December 2010 together with most MAPPA minutes for this period were made available for this investigation.

MAPPA meetings were chaired by a senior probation service manager and attended by relevant health service staff and police. MAPPA meetings about Mr B were held on a regular basis and at appropriate times in Mr B's care pathway including:

- 30 July 2008 in prison prior to his transfer under section 47 MHA to the medium secure unit.
- December 2008 in the medium secure unit while on licence to the probation service and awaiting accommodation.
- 9 March 2010 after being recalled to prison for breach of licence.
- 15 December 2010 in prison prior to release on licence.
- May 2011 in community when licence conditions had expired and no longer subject to monitoring by the probation service.

10.1 Analysis

The MAPPA meetings were attended consistently by both the probation service and Trust forensic service staff. In December 2010 Mr B was allocated a new probation officer shortly before his discharge because he blamed his longstanding probation officer for his recall to prison in 2009. The minutes of the MAPPA meetings consistently record Mr B as a medium or high risk of showing violence towards the public at large and at high risk of harming homosexuals and sex offenders.

In addition, the minutes refer repeatedly to the high risk of Mr B's non-compliance with mental health services on discharge, partly because of his lack of insight into his own condition. This was a factor in the decisions to release him on licence in December 2008 and again in December 2010, as the conditions associated with a licence would ensure that Mr B was robustly monitored by clinical and probation services.

On 13 June 2008 Mr B's licence expired and the probation service no longer had any statutory authority to monitor him. He was not subject to any legally enforceable conditions or restrictions and remained under Trust supervision in the community.

¹ There are three categories of offender under MAPPA criteria. Category 2 relates to someone who has committed murder or who has been convicted of a criminal offence.

10.2 Comment

The probation service properly called MAPPA meetings to discuss Mr B's potential community risks and their mitigation when the question of his release from prison was raised in 2008 and again in 2010. The action plans on each occasion took account of clinical views from the Trust's forensic service. This was appropriate. All those present at both meetings recognised the seriousness of Mr B's potential for violence.

The MAPPA decisions were a measured attempt to minimise community risk within the legal framework available. On both occasions, the proposal to release Mr B on licence in order to provide a period of close supervision on his return to the community was sensible and pragmatic in the context of the legal timescale.

10.3 Conclusion

No criticism is made of the actions of the probation service with respect to Mr B's management between 2008 and 2010 as evidenced by the MAPPA records and the Trust clinical records.

11 Predictability and preventability

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

11.1 Predictability

We would consider that the homicide was predictable if we found there was evidence from Mr B'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.

11.1.1 Analysis

Mr B had a lengthy history of convictions dating back to 1996. These included theft, affray, failing to surrender to custody, burglary and armed robbery. More significantly, he also has convictions for assault and occasioning actual bodily harm.

Linked to his delusion that in 2001 he had been drugged and raped, which had resulted in damage to his legs, records show that he has consistently told clinicians that he would be violent to anyone he thought was a homosexual. Mr B also consistently stated that he would know someone was homosexual by looking at him.

He is known to have carried out assaults while in prison and also in the medium secure unit.

Mr B attended a CPA review on 1 February 2012 shortly before the incident. Records show that at this time he "denied any thoughts to harm others" but said he would defend himself if he was attacked. Records also show that he was engaging well with mental health services and conforming to the conditions of his licence.

11.1.2 Conclusion

Mr B had an extensive forensic history. His continued serious risk of violence was consistently acknowledged by Trust staff. Risks were assessed and arrangements put in place to try to manage him. Despite this, there was no evidence in Mr B's words, actions or behaviour to predict that that he would assault someone imminently.

11.2 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.

11.2.1 Conclusion

There were no indications when Mr B attended his CPA review on 1 February 2012 that he was at risk of harming others. He was receiving care and treatment in the community and his mental state and presentation were essentially unchanged. The clinical team could not have admitted him to hospital under the MHA since he did not meet the criteria; therefore the clinical team was unable to take steps to prevent the incident.

12 The Trust's internal investigation

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 internal investigation into the care and treatment of Mr B met the requirements set out therein.

12.1 The Trust's internal investigation

The good practice guidance *Independent investigation of serious patient safety incidents in mental health services* (NPSA¹ 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.

The policy also states that a level 3 chief officers investigation will be undertaken when:

- "The incident is of a high public interest.
- Service users of the Trust have been involved in an alleged homicide incident.
- The incident fits the definition of one of the NPSA's Never Events².
- The incident involved the death of a service user whilst they were an inpatient. Article two of the European Convention on Human Rights is likely to be engaged.

"The Chief Executive will agree the terms of reference for the incidents including the panel convened to facilitate the review, which will:

- Be chaired by an executive level member of staff.
- Have an independent/external representative.
- Have a service user/carer representative.
- Members will be representative of the professionals involved in the care delivery.
- Be supported by an administrator.
- The panel should not exceed more than five individuals.

"The report will be formally validated by the Trust board.

"Once the investigatory report has been completed, it will be validated by the Trust's Adverse Incident Group, once the standard required has been achieved

¹ National Patient Safety Agency.

² Never Event this is a largely preventable patient safety incident.

the report and associated action plan will be shared at the Trust board. The integrated Governance will receive updates on progress as regards the implementation of the action plan on a six monthly basis.”

The policy also includes a statement about Being Open¹:

“The Trust fully endorses the Being Open agenda. Service Users and Carers will be actively engaged in the review of untoward incidents. Findings will be shared with them in an open, supportive and transparent manner”.

In this case the Trust did commission an internal investigation into the care and treatment of Mr B. The investigation was led by a non-executive director, and an external medical director was part of the investigation team.

The terms of reference for the internal review stated:

“Two investigatory processes have been undertaken in respect of [Mr B] and [Ms C], but managed as part of one internal review. The review was required to:

1. Establish a chronology of the care and associated events leading up to the incident allegedly involving [Mr B] and [Ms C].
2. Examine the quality and efficacy of the care and treatment provided to [Mr B] and [Ms C] by Mersey Care NHS Trust staff and in particular the processes used for and outcomes of:
 - assessing the services users’ health and social care needs.
 - assessing risk and developing risk management plans.
 - communicating between services and planning such activities as discharge and/or transfer from one service to another.
3. Raise immediate concerns with the Liverpool Clinical Business Unit Director to ensure that any necessary remedial action can be taken without undue delay.
4. If deemed appropriate following initial evaluation of care and treatment, consider any specific issues that the service users may wish to raise, with due regard to confidentiality.
5. To identify if there is a health care related root cause or influencing factors that contributed to the incident occurring.
6. To identify where improvements in practice / systems could be made.
7. To prepare a report for the Board of Mersey Care NHS Trust”.

¹ Being open refers to the NHS framework for open and honest communication with patients when something goes wrong and a patient suffers harm.

The investigation team for the review consisted of:

- Non-Executive Director, Mersey Care NHS Trust (Chair);
- Lead for Psychological Practice, Mersey Care NHS Trust;
- Complaints Lead, Mersey Care NHS Trust;
- Clinical Lead, Low Secure Unit, SaFE Partnerships CBU, Mersey Care NHS Trust;
- Acting Service Director, Addiction Services CBU, Mersey Care NHS Trust;
- Service user/carer representative; and
- Consultant Psychiatrist/Medical Director, Cheshire & Wirral Partnership NHS Foundation Trust.

The Community Service Manager Liverpool CBU, Mersey Care NHS Trust, provided supplementary input to the preparation of the report.

12.1.1 Analysis

The Trust commissioned a root cause analysis investigation in line with national and local policy and good practice.

The terms of reference are clear and contain the names of those undertaking the investigation. We note that the review team approached Mr B's solicitor to invite him to participate in the review or advise the team of any questions he may have. This is in line with *Corporate Policy & Procedure for the Reporting, Management and Review of Adverse Incidents*. We understand that a negative response was received by the Trust. We found no evidence to suggest that efforts were made to contact the victim's relatives.

When we met with staff we were told that, since this incident, the Trust now adheres to the *Being Open Policy (including Duty of Candour)*¹. The Trust always writes to relatives and carers and also the relatives of victims to encourage them to be involved with the investigation (with the service user's consent). The Trust also gives feedback to relatives and carers about the outcome of the investigation.

12.1.2 Conclusion

The Trust commissioned an internal investigation into the care and treatment of Mr B. The seniority of the investigation team was appropriate given the seriousness of the case.

However, the terms of reference did not include reference to the involvement of Mr B's relatives or carers, or those of the victim; we note that efforts were made to engage Mr B in the investigation process via his solicitor but without success. Given

¹ Duty of Candour: NHS providers must be open and transparent with service users about their care and treatment, including when it goes wrong.

the progress that the Trust has made in relation to engaging relatives and carers, we have not made a recommendation on this issue.

12.2 The investigatory process

The Trust investigation policy and procedures set out a clear process for undertaking an adverse incident investigation.

The policy details the responsibilities of the lead investigator and the ways in which staff should be involved in an investigation, including roles and responsibilities, checking for factual accuracy and sharing the findings.

12.2.1 Analysis

We reviewed the Trust internal root cause analysis investigation which was carried out in August 2012. It provides a detailed chronology of the contacts the Trust made with Mr B between 2008 and early 2012. It commended both the transition process followed when Mr B was transferred from the forensic services to a community team and Mr B's May 2011 care plan. We agree with these commendations.

Three distinct "care and service delivery problems" were identified by the review, none of which, it concluded, directly contributed to the occurrence of the incident. The problems were:

- limited understanding of Mr B's psychological functioning/personality and the factors/situations which might elicit violent behaviour;
- weaknesses in risk assessment and risk management; and
- lack of adherence to NICE guidelines for schizophrenia.

The report also identified two areas of notable practice in relation to CPA.

The lessons learned concluded that three clinical aspects had wider future relevance for the safe and effective management of people with a combination of serious mental illness and a significant forensic history.

Lessons learned from the Trust internal investigation report are as follows:

"More robust and systematic clinical strategies are required to engage individuals in mental health services with a history of violence and aggression, in addressing aspects of their background and personality, in order to increase their insight and reduce their proclivity to accept and use violence.

"Risk assessments with potentially violent individuals need to focus on all aspects of their history, lifestyle and personality and lead, where feasible, to robust therapeutic approaches to addressing identified risks. All clinicians need to keep up to date with training in risk assessment and management.

“The presence of psychosis in an individual, and their responsiveness to medication, does not preclude other aspects of their functioning and lifestyle also meriting psychological understanding and intervention. The linking of symptom reduction with decreased risk is not always valid; it is possible that improved mental health, for some people, could increase their participation in criminality.”

12.2.2 Conclusion

We consider that the internal review provides an appropriate clinical chronology with reliable clinical evidence to support its conclusions about care and service delivery weaknesses. In addition, the more generic learning issues identified were almost certainly valid in this case and they have relevance for all mental health services managing people with a combination of serious mental illness and a significant forensic history.

13 Progress on implementing action plan

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

The report identified two areas of notable practice, and made seven recommendations:

1. All mental health practitioners, and their managers, must ensure they are up to date with core training in risk assessment and management; and undertake more specialist training as appropriate and relevant to their caseloads, in line with Trust policy.
2. Locum psychiatrists and other temporary clinical staff should attend appropriate induction and training at the outset of their appointment, irrespective of their previous work in Mersey Care, and the urgency of providing cover. Locum medical staff should receive supervision from their line manager in accordance with British Medical Association (BMA) guidance.
3. Non-forensic practitioners involved with the care of people with a history of violence should have skills in working with this population, including specialist risk assessment tools and personality disorder.
4. Operational protocols for services need to specifically address the remit of practitioners in terms of working with people with a history of serious offending; and provide guidance on the balance required between addressing their mental health needs and monitoring and addressing risk of re-offending.
5. The caseloads of community care coordinators should be kept within an agreed limit, and adjusted according to the person's needs, especially where there are very high levels of complexity.
6. The job plans of community consultant psychiatrists should focus on the needs of people on CPA, especially those with dual diagnosis and or other complex presentations, including a forensic history. (*The Improving Community Services* project is an opportunity to consider this issue.)
7. The attention of managers and practitioners should be drawn to the guidance document referred to in the preceding section, with particular reference to how key staff are initially informed about a serious incident having taken place.

13.1 Analysis

An action plan was developed to take forward the recommendations. There is no evidence that actions were allocated to a lead person and a timescale for completion is not identified. The action plan is included in appendix B.

Since the incident, we have seen evidence that the Trust has introduced a range of training in relation to risk assessment and management. The Trust told us that, in

response to the need for staff training in core risk assessment, training has been introduced across the Trust. This includes training in managing the risks of harm and self-harm, suicide prevention and dual diagnosis.

We have also seen evidence that work is being carried out to improve the risk assessment and management process across the Trust. This has included a redesign of the risk assessment process to be more formulation-focused.

We have seen evidence that all locum doctors employed by the Trust now receive induction training. If they have worked for the Trust previously but have not done so for 12 months or more, they have to repeat the training.

The Trust has developed clinical guidelines for the treatment and management of people with an emotionally unstable personality disorder in response to the recommendation that non-forensic practitioners require additional clinical skills to work with this population. The Trust has also implemented a personality disorder consultancy team that works with mental health teams and also provides some clinical supervision.

When we met with staff we were told that the forensic service has reviewed their approach to risk assessment and management and had developed more specialised CPA process for the service. Their risk assessment now links to the HCR-20. In addition, local guidelines have been developed based on the *Medium, Low & Offender Health Directorate Protocol linked to the policy and procedure for the use of clinical risk assessment tools (SA10)*.

The caseloads of community care coordinators have been reviewed to ensure that caseloads take into account complexity as well as number. Managers RAG rate (assign a red, amber or green rating) the caseloads of their staff and regularly monitor them. There is some work being carried out by the Medical Director which will include a review of the current roles of consultant psychiatrists to ensure that the most senior doctors input into the more complex cases.

When a serious incident is reported, key staff within each clinical area are notified. In addition, serious incidents are discussed at the weekly quality surveillance meeting, which is attended by each clinical area across the Trust.

13.2 Conclusion

From the evidence that we have received, we are satisfied that the recommendations outlined in the Trust's action plan have been put in place to make improvements.

Team biographies

Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its most high-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.

Cheryl Hornby





Cheryl Hornby has more than 20 years' senior management experience in the NHS specialising in Adult Mental Health services. She has led the Partnership Working, negotiating and producing the formal agreements with third sector organisations for the provision of IAPT Services (Improving Access to Psychological Therapies) in a large mental health Trust.

Her previous posts have included Service Manager Adult Mental Health Services, General Manager Mental Health Services for Older People and Head of Partnership.

Trust action plan

ACTION PLAN EMANATING FROM ADVERSE INCIDENT

| | | | |
|----------------------|------------|-----------------|--------------------------|
| Name of service user | [Mr B] | Incident Number | WEB19865 STEIS 2012/7633 |
| Date of Incident | 27/02/2012 | Report Date | August 2012 |


| No. | Recommendation | Actions Taken | Evidence of completed recommendations |
|-----|--|---|--|
| 1 | All mental health practitioners, and their managers, must ensure they are up to date with core training in risk assessment and management; and undertake more specialist training as appropriate and relevant to their caseloads, in line with Trust policy. | <ul style="list-style-type: none"> An e-learning package has been created regarding risk assessment and management with input from Clinical Leads and other Mental Health Trusts to ensure it is fit for purpose. The Trust is currently migrating its servers to 'The Cloud' which has caused a slight delay in this going live but this should be completed by Summer 2014. Self-Harm Training Packages (including Harm Minimisation) are provided to the Trust by Harm Ed. There has been one Trust-Wide |  Agenda.doc  Self Harm Training Jan to Mar 2014.doc  Self Harm Training Mar to April 2014.doc  Dual Diagnosis Training Flyer 2014-1 |

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| | | <p>'Dare to Share' Event in September 2013 which was positively evaluated. Further Training Sessions have been provided for Staff in 2014 with 7 full-day sessions taking place. More are booked for the rest of 2014.</p> <p>– Harm Ed</p> <ul style="list-style-type: none"> • The provision of Suicide Prevention Training by Dr Caroline Logan has been stopped due to lack of lack of funding. This has been raised as a concern by the Director of Patient Safety and sessions are being arranged for those who have already undertaken and completed the Suicide Prevention Advanced Level Courses to provide training for other staff across the Trust. These begin in Summer 2014. • Dual Diagnosis Training Sessions and Network Events for staff are also regularly provided and monitored by the Dual | |

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| | | Diagnosis Development group which meets bi-monthly. | |
| 2 | Locum psychiatrists and other temporary clinical staff should attend appropriate induction and training at the outset of their appointment, irrespective of their previous work in Mersey Care, and the urgency of providing cover. Locum medical staff should receive supervision from their line manager in accordance with British Medical Association (BMA) guidance. | All Locum Drs that become Mersey Care NHS Trust employees received Induction Training (coordinated by the Medical and Additional Staffing Team) and if they have worked at the Trust previously but have not done so for 12 months they repeat their training. | |
| 3 | Non-forensic practitioners involved with the care of people with a history of violence should have skills in working with this population, including specialist risk assessment tools and Personality Disorder. (Engagement with the forthcoming DoH bidding process to enhance liaison between mental health and local probation teams may also assist with this.) | The Trust has developed clinical guidelines for the treatment and management of people with an Emotional Unstable Personality Disorder, this has been implemented across the Trust in association with the Psycho - Therapy Service. To assist this process, funding was obtained to develop a Personality Disorder Consultancy Team. This Team includes both permanent and sessional staff with significant expertise in this area of work. A service user with lived experience in this area and a high level of training experience is a key team member. | |

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| | | <p>The consultancy service works with teams to help them plan the care a person requires and develop the extended and personalised care plan that is an essential part of the guidance. This plan will include contingency arrangements and crisis plans for when service users require emergency interventions short term inpatient stays are recommended within increased community support on discharge.</p> <p>The consultancy team offer ongoing supervision to staff to support them in caring for this complex group of people who typically are high risk of suicide and self-harm.</p> <p>Between May 2013 - April 2015, the target is for the team to deliver 126 consultations. This approach both supplements and supports the ongoing training programme that is provided for staff which includes: -</p> <ul style="list-style-type: none"> • The delivery of the nationally approved knowledge and understanding framework (KUV) training programme. | |

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| | | <p>This awareness-raising three-day training event has been provided to 659 staff members across the Trust and has been very well evaluated by them and increased generic understanding of the needs of people with a Personality Disorder.</p> <ul style="list-style-type: none"> • Extended care planning, twelve sessions per year to help staff understand how to engage service users with a personality disorder in participating in the development of their care plan. • Interventions seminars, six per year outlining the content and skills used within Mentalisation Based Treatment (MBT) and Dialectic Behavioural Therapy (DBT) for clinical staff. | |

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| | | <ul style="list-style-type: none"> <li data-bbox="1041 320 1507 608">Dedicated Practitioners course – will commence in June 2014, and will take staff who have undertaken the KUV and helps them develop their understanding of and skills in treating people with a Personality Disorder. <p data-bbox="992 651 1507 1161">The Trust also provides individual and group therapy for service users via the Psychotherapy Service as well as providing the Rotunda Day Therapeutic Community Programme for people with complex needs related to personality disorder. A business case is currently with Commissioners to develop further the pathway available to people with a Personality Disorder, this programme will use funds currently used for out-of-area treatments.</p> | |
| 4 | Operational protocols for services need to specifically address the remit of practitioners in terms of working with people with a history of serious offending; and provide guidance on the balance required between addressing their mental health needs and monitoring | The service has developed CPA guidelines including guidance for staff for the completion of the newly developed risk assessment and risk formulation CPA document, in addition the new care plan, which |  <p data-bbox="1543 1283 1727 1331">SA10 draft version March 2014.doc</p> |

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| | <p>and addressing risk of re-offending. (Consultation with practitioners in the local Personality Disorder MCT-Probation pilot service at Resettle may be helpful in considering this.)</p> | <p>incorporates My Shared Pathway with an emphasis on recovery but also includes the management of risk.</p> <p>The CPA Guidelines link to:</p> <ul style="list-style-type: none"> • Mersey Care NHS Trust SA10 Risk Policy relating to Clinical Risk Assessment Tools • My Shared Pathway and Recovery Outcomes. <p>There has been a move towards a single care/risk management plan and an outcomes-based approach to planning. The CPA assessment is used to produce a risk management plan as part of the overall multidisciplinary care plan, incorporating the risk assessment processes and other relevant documents being used in routine multidisciplinary care (e.g., risk formulation document used in clinical team meetings, My Shared Pathway, My safety and Risks document). There is evidence of the use of new CPA documentation and</p> | |

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| | | <p>My Shared Pathway in making clinical and risk management decisions.</p> <p>On addition local guidelines have been developed based on SA10 through discussions with the Psychological Practice Group and Quality and Effectiveness Group within the Secure Division. The introduction of local interpretation of SA10 has ensured:</p> <ul style="list-style-type: none"> • Formulation of risks are developed by the MDT and are a recognised output from the CPA process • This ensures more informed decision-making for patients, family and staff • Provides a better understanding of risk and decision-making through increased access to a broader spectrum of specialist assessments • Improved structure and format of risk related communication with external agencies | |

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| | | <ul style="list-style-type: none"> Allowed for refinement for pre-admission documentation as well as timescales and focus of immediate risk assessments such as START and HCR-20. | |
| 5 | <p>The caseloads of Community Care Coordinators should be kept within an agreed limit, and adjusted according to the person's needs, especially where there are very high levels of complexity.</p> | <ul style="list-style-type: none"> Local Services have integrated both Crisis Resolution Home Treatment and Assertive Outreach Teams into community teams as part of Neighbourhood Resource Centres across the Trust. The current caseloads of care coordinators are being reviewed and changed to ensure equality across the team. Managers are RAG rating the caseload and staff will be allocated accordingly. There is also a work stream addressing the size of community caseloads (releasing capacity) which is ongoing. | |
| 6 | <p>The job plans of Community Consultant Psychiatrists should result in focus on the</p> | <p>The new model of care work that is being led by Dr Fearnley, Medical</p> | |

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| | needs of people on CPA, especially those with dual diagnosis and/or other complex presentations, including a forensic history. (The <i>Improving Community Services</i> project is an opportunity to consider this issue.) | Director, will include a review of the current roles of Consultant Psychiatrists in the care of service users with the objective of targeting the time and input of the most senior clinical staff to those patients of greatest need and risk. | |
| 7 | The attention of managers and practitioners should be drawn to the guidance document referred to in the preceding section, with particular reference to how key staff are initially informed about a serious incident having taken place. | <ul style="list-style-type: none"> • Notifications of Serious Untoward Incidents are sent to Key Staff within in each Clinical Area when they are reported on to the STEIS system. • They are also discussed at the weekly Quality Surveillance Meeting, which has membership from each Clinical Area across the Trust. • Oxford Model events are hosted which share learning from Serious Incidents. Each Clinical Business Unit is required to hold a minimum of 3 Oxford Model Events a year. | |